



State Innovation Model Operational Plan Public Feedback Version

May 31, 2016

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A. Project Summary

1 - Project Summary

Reinventing Michigan's health care system is one of Governor Rick Snyder's top priorities. The ambitious vision is shared by individuals and organizations across the State who desire to both improve the health of all Michiganders and have a health care system that provides better quality and experience at lower cost.

In 2014 the Governor shared a vision for "healthy, productive individuals, living in communities that support health and wellness, with ready access to [an] affordable, patient-centered and community-based system of care" as part of the State's Blueprint for Health Innovation. In early 2015 the Governor released his vision for new ways of structuring government that puts people first, with the goal of helping all Michiganders succeed, no matter their stage in life.

At the core of the Governor's vision as reflected in the Blueprint for Health Innovation, is an efficient, effective, and accountable government that collaborates on a large scale to provide good service to Michiganders. The State Innovation Model (SIM) Test program is a continuation of the state's effort, specifically as it pertains to Michigan's health care system.

With this Round 2 SIM Test Awardee Operational Plan the State lays out, in detail, the four core innovative models the state will implement to support the Governor's vision for reinventing Michigan's health care system:

Population Health Component Elements

Community Health Innovation Regions/Collaborative Learning Networks:

The State strongly believes in the value of a community-based organizing mechanism that improves linkages and coordination among health care providers and community partners to meet the whole health needs of an individual. As such, the SIM program team will launch a small number of Community Health Innovation Regions (CHIRs) in 2017 with the goal of establishing additional CHIRs throughout the state by 2018. As regional governing bodies, CHIRs will define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between community and health entities. CHIRs will align closely with the Governor's vision for health care transformation in the state. CHIRs will additionally leverage efforts from such programs as the Pathways to Better Health demonstration. CHIRs will be required to focus on reducing Emergency Department utilization, a State priority, while also assessing community needs and proposing investment in additional regional-specific health improvement goals.

Care Delivery Component Elements

- **Patient-Centered Medical Homes:** The Patient-Centered Medical Home (PCMH) is the core pillar of the SIM strategy for coordinated care delivery. PCMHs will begin implementation in the fall of 2016 in partnership with Medicaid Managed Care Organizations. The SIM program team will work in alignment with commercial payors and Medicare to support increased adoption of the PCMH model within the state.
- **Accountable Systems of Care:** A small number of Accountable Systems of Care (ASC) will be launched in regions where they are well positioned to deliver meaningful quality improvements and cost avoidance through stronger clinical, administrative, and technological integration across participating providers. The SIM program team will initially test this model in 2017, and look to scale it over the following years, based on learnings from the test.
- **Value Based Payment:** Building on the established benefits of the PCMH initiative in Michigan, coupled with the ASC model the State will seek value based payments through the Practice Transformation payments, Care Coordination fees and Shared Savings opportunities using upside only and voluntary downside risk models. These payment models and funding mechanisms will be linked to participation requirements, and performance metrics.

Enablers

Program leadership will enable the SIM vision for health care transformation through robust Model Test component implementations utilizing newly enhanced and existing data interoperability and healthcare information technology, value-based payments, and common provider scorecards.

Data Interoperability and Healthcare Information Technology

Data interoperability is central to Michigan Department of Health and Human Services' vision of promoting better health outcomes, reducing health risks, and supporting stable and safe families while encouraging self-sufficiency. Health Information Technology (HIT) capabilities will be built to directly enable SIM models and support overall health care transformation.

Enabling interoperability of electronic health information in the near term will require meaningful action from public and private stakeholders in order to (1) establish a coordinated governance framework and process for statewide and nationwide health IT interoperability, (2) improve technical standards and implementation guidance for sharing and using a common clinical data set, (3) enhance incentives for sharing electronic health information according to common technical standards and guidelines, starting with a common clinical data set, and (4) clarify privacy, sharing and other security requirements that enable interoperability.

Michigan will support ongoing state efforts to enhance the exchange of electronic health information and will support the SIM vision for health care transformation with four core objectives. These include: (1) enabling SIM program performance, comprehensive evaluation, and reporting; (2) supporting care coordination; (3) enabling payment model analytics and reporting; and (4) providing a population health monitoring toolset to support greater interoperability between health care and community entities. Greater detail on the SIM HIT/HIE solution to support the program vision for health care transformation is provided in section C10 (Health Information Technology).

Value based payment

The State's objectives to improve the delivery of coordinated care across the state will be encouraged through the implementation of value-based payment models. Participating providers within the SIM program population health models – PCMH and ASC – will move toward assumption of total cost of care accountability with a minimum expectation that they will participate in shared savings or two-sided risk models, respectively, by the third year of participation. The payment model design includes payment weighting and threshold that ensure meaningful differentiation in compensation between high- and low-performing providers.

In addition to being accountable for total cost of care, PCMH, and ASC shall be accountable to quality, patient experience, and utilization metrics that ensure the delivery of high quality, highly effective care for Michiganders. These metrics will be standardized on a common Michigan SIM provider scorecard as defined below.

Common provider scorecard

Provider performance metrics will be aligned across payors in a common provider scorecard that will be adopted by payors and providers participating in PCMH and ASC. A common scorecard will lower administrative burden across providers related to metrics reconciliation and will encourage a consistent set of behaviors and priorities. This effort, which includes work from the Michigan Health Information Network Shared Services Payor Qualified Organization and the Michigan State Medical Society, is described in more detail in Section C7 (Quality Measure Alignment).

Foundation for Health Care Innovation

The SIM program has a strong foundation to build on the State of Michigan's aspirational agenda for health care innovation, including:

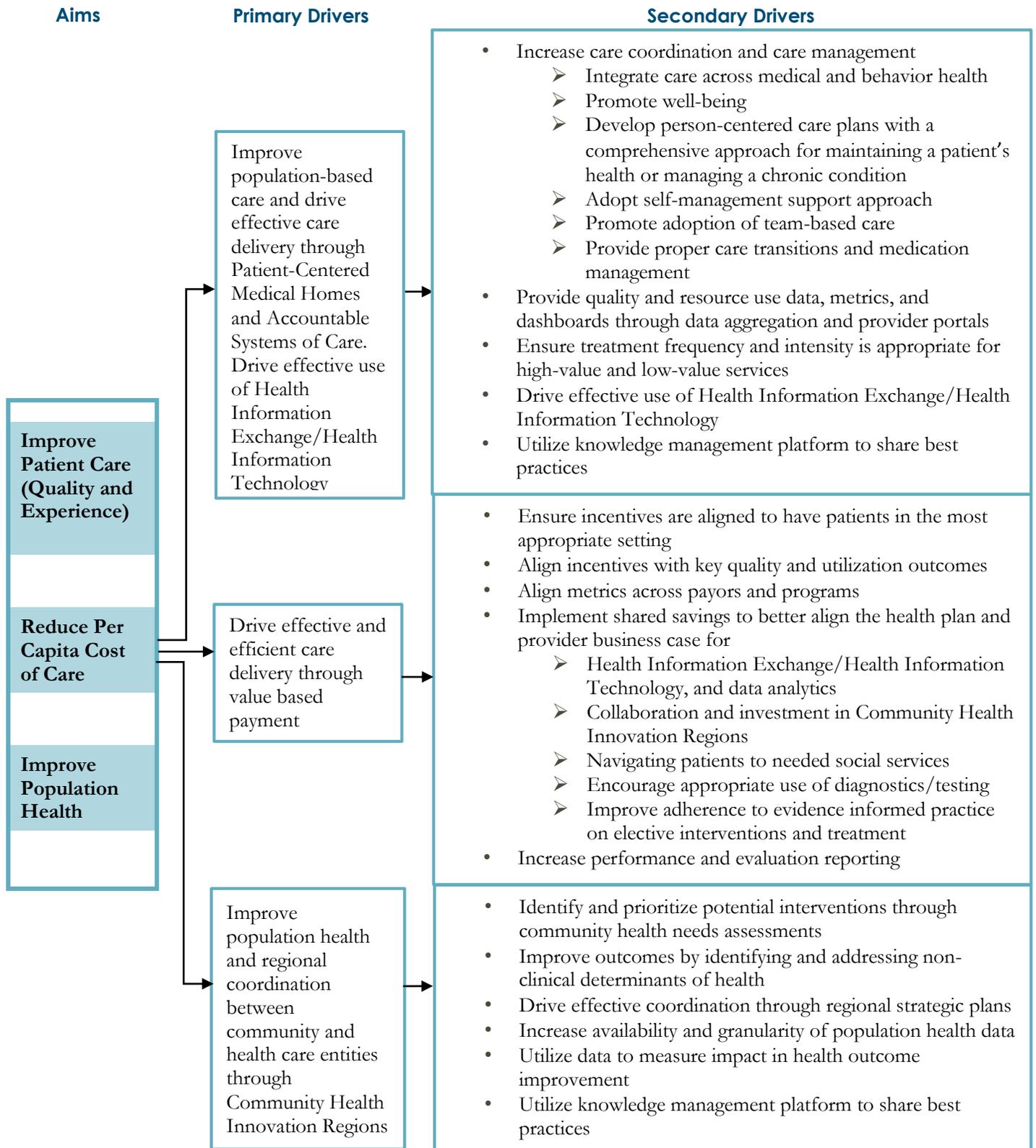
- The Michigan Primary Care Transformation (MiPCT) project: the largest multi-payor PCMH demonstration in the country
- Blue Cross Blue Shield (BCBSM) PCMH Initiative: the largest multi-payor PCMH demonstration in the nation has a strong and successful presence in Michigan

- Federally Qualified Health Center (FQHC): FQHCs are community-based organizations that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status
- MI Health Link: a collaboration between Michigan and the federal government to coordinate care for people who are eligible for both Medicaid and Medicare (Dual Eligibles)
- Health Homes: coordinated care delivery models to integrate primary care with behavioral health care for those with serious and persistent mental illness
- Michigan Health Information Network: a governing body enabling the exchange of clinical data across participating payors and providers
- Michigan Pathways to Better Health: collaboration with care coordination agencies to deploy community health workers who help identify community-based services to support health needs

The SIM program team will continue to build upon this foundation through the implementation of four core SIM component models. The State of Michigan's plan for operationalizing PCMH, ASC, Value Based Payments, and CHIRs is defined within this document.

2 - Driver Diagram

Figure A2.1 Driver Diagram



Measures by Aim/Primary Driver

Table A2.1 Measures by Primary Driver

Aim	Key Performance Metrics	Primary Driver	Select Structure and Participation Metrics
Improve Patient Care (Quality and Experience)	<ul style="list-style-type: none"> • Comprehensive Diabetes Care composite • Childhood Immunization Status • Cervical Cancer Screening • Chlamydia Screening in Women • Adult BMI Assessment • Controlling High Blood Pressure • Breast Cancer Screening • Immunizations for Adolescents • Lead Screening in Children • Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention • Well-Child Visits in the First 15 Months of Life • Adolescent Well-Care Visits • Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan • Cesarean section rate • Patient-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey items 	Improve population-based care and drive effective care delivery through Patient-Centered Medical Homes and Accountable Systems of Care	<ul style="list-style-type: none"> • Total number of beneficiaries receiving care through an ASC • Total number of beneficiaries receiving care through a SIM PCMH • Total number of providers participating in SIM supported ASC
Improve Population Health	<ul style="list-style-type: none"> • Teen birthrates (birth by age of mother) • Infant mortality • Premature newborns • Low birth weight newborns • Prevalence of hypertension among adults • Adult obesity rate • Percent of adults reporting fair or poor health • Number of mentally unhealthy days in last 30 • Number of physically unhealthy days in last 30 • Chlamydia prevalence 	Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions	<ul style="list-style-type: none"> • Number of individuals attributed to an ASC within a CHIR test region • Number of health providers participating in CHIRs within test regions • Number of public health departments participating in CHIRs within test regions • Number of other local government units participating in CHIRs within test regions • Number of non-profit organizations participating in CHIRs within test regions

	<ul style="list-style-type: none"> • Childhood immunization status rates • Rates of adequate physical activity for adults • Rates of inadequate daily consumption of fruits and vegetables for adults • Rates of excessive alcohol consumption for adults • Rates of adult cigarette smoking 		<ul style="list-style-type: none"> • Number of Community Mental Health Services agencies participating in CHIRs within test regions • Number of non-health care businesses participating in CHIRs within test regions • Number of payors participating in CHIRs within test regions
Reduce Per Capita Cost of Care	<ul style="list-style-type: none"> • Total cost of care • Hospital Services • Professional Services • Post-acute care • Imaging • Pharmacy 	Drive effective and efficient care delivery through value based payment	<ul style="list-style-type: none"> • Total number of beneficiaries receiving care through an ASC • Total number of beneficiaries receiving care through a SIM PCMH • Total number of providers participating in SIM supported ASC/OSC/ACO

3 - Core Metrics and Accountability Targets

Michigan is committed to successfully implementing its vision and transforming the business of health care in the state. Clear metrics will be critical in order to track progress toward this vision and address potential implementation issues as they arise.

The metrics and accountability targets by which the State will measure progress include participation metrics, clinical metrics addressing both utilization and quality of care, and population health metrics. Monitoring participation metrics will ensure that Michigan’s model test achieves broad-based impact across the state (e.g., multiple payors, providers, patients, geographies, etc.). Establishing benchmarks for clinical quality metrics will ensure that State Innovation Model (SIM) Test components are impacting the health and patient experience for Michigan residents. Adopting targets for utilization metrics will ensure that coordinated care delivery models and value-based payment models are driving cost avoidance while improving care delivery and population health.

Participation, clinical quality and utilization, and cost metrics are outlined below in Table A3.1: SIM Core Metrics. The participation metrics align with core model components: Patient-Centered Medical Homes, (PCMH) Accountable Systems of Care (ASC), and Community Health Innovation Regions (CHIR), while the quality, utilization, and cost performance metrics proposed reflect the ongoing measure alignment work described in section C7 (Quality Measures Alignment).

Additional participation and quality metrics will be included as needed, including population health metrics and cost/utilization metrics. Quarterly accountability targets for participation will be defined as regional planning matures and will be included in future Operational Plan updates.

Table A3.1 SIM Core Metrics

Metric Area	Metric Title	Proposed Metric Definition/Description
<i>Participation Metrics</i>		
Participation Metrics	Population impacted by SIM (by model)	Total number of beneficiaries receiving care through a SIM PCMH
Participation Metrics	Population impacted by SIM (by model)	Total number of beneficiaries receiving care through an ASC
Participation Metrics	Population impacted by SIM (by model)	Total number of beneficiaries receiving care through a SIM PCMH or ASC
Participation Metrics	Providers Participating in SIM (by model)	Total number of providers participating in SIM PCMH model
Participation Metrics	Providers Participating in SIM (by model)	Total number of providers participating in SIM supported ASC
Participation Metrics	Providers Participating in SIM (by model)	Total number of providers participating in SIM PCMH or ASC
Participation Metrics	Provider Organizations participating in SIM (by model)	Total number of practices participating in SIM PCMH model

Participation Metrics	Provider Organizations participating in SIM (by model)	Total number of practices participating in SIM supported ASC
Participation Metrics	Provider Organizations participating in SIM (by model)	Total number of practices participating in SIM PCMH or ASC
Participation Metrics	Provider Organizations participating in SIM (by model)	Number of hospitals participating within ASCs
Participation Metrics	Payors participating in SIM (including aligned models)	Total number of payors participating in SIM PCMH payment model, by Alternative Payment Model (APM) category
Participation Metrics	Payors participating in SIM (including aligned models)	Total number of payors participating in SIM supported ASC payment model, by APM category
Participation Metrics	Payors participating in SIM (including aligned models)	Total number of payors participating in SIM PCMH or ASC payment model, by APM category
Participation Metrics	Total number of provider organizations participating in CHIRs	Total number of ASCs participating in CHIRs within test regions
Participation Metrics	Total number of public health departments participating in CHIRs	Total number of public health departments participating in CHIRs within test regions
Participation Metrics	Total number of other local government units participating in CHIRs	Total number of other local government units participating in CHIRs within test regions
Participation Metrics	Total number of non-profit organizations participating in CHIRs	Total number of non-profit organizations participating in CHIRs within test regions
Participation Metrics	Total number of Community Mental Health (CMH) services participating in CHIRs	Total number of CMH services agencies participating in CHIRs within test regions
Participation Metrics	Total number of (non-healthcare) businesses participating in CHIRs	Total number of non-health care businesses participating in CHIRs within test regions
Participation Metrics	Total number of payors participating in CHIRs	Total number of payors participating in CHIRs within test regions
<i>Quality, Utilization, and Cost Metrics</i>		
Quality and Performance Metrics	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Quality and Performance Metrics	Cervical Cancer Screening	Percentage of women aged 21-64 years who, received one or more Pap tests to screen for cervical cancer

Quality and Performance Metrics	Chlamydia Screening in Women	Percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period
Quality and Performance Metrics	Comprehensive Diabetes Care: Blood Pressure (BP) Control	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had their most recent BP reading under 140/90 mm Hg.
Quality and Performance Metrics	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Quality and Performance Metrics	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Quality and Performance Metrics	Comprehensive Diabetes Care: Eye Exam (retinal) performed	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.
Quality and Performance Metrics	Adult Body Mass Index (BMI) Assessment	Members age 18-74 who had an outpatient visit with a BMI documented during the measurement year or the year prior
Quality and Performance Metrics	Controlling High BP	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (< 140/90mmHg) during the measurement period
Quality and Performance Metrics	Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
Quality and Performance Metrics	Breast Cancer Screening	Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months
Quality and Performance Metrics	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.
Quality and Performance Metrics	Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday
Quality and Performance Metrics	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
Quality and Performance Metrics	Well-Child Visits in the First 15 Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported:
Quality and Performance Metrics	Adolescent Well-Care Visits	Members 12-21 years old in the measurement year that have had at least ONE “Well Care” visit (school physical, pap, post-partum visit)

Quality and Performance Metrics	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Quality and Performance Metrics	Patient Experience	Relevant Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey items (items to be determined)
Utilization	Cesarean section rate	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)
Utilization	Hospital admissions	Hospital admission rate per 1000 population
Utilization	All-cause readmissions	Number of acute inpatient hospital stays for patients aged 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, as well as the predicted probability of an acute readmission
Utilization	Emergency department visits	ED visits per 1000 population
Cost	Standardized Per Member Per Month (PMPM) Costs	Total Resource Use Population-based PMPM Index
Population Health Metrics		
Health Indicators - At-Risk Pregnancy	Teen birthrates (birth by age of mother)	Live births for mothers aged 19 or younger per 1,000 women per year
Health Indicators - At-Risk Pregnancy	Infant mortality	Number of infant deaths per 1,000 live births
Health Indicators - At-Risk Pregnancy	Premature newborns	Live births with less than 37 completed weeks gestation, percent of total
Health Indicators - At-Risk Pregnancy	Low birth weight newborns	Live births weighing less than 2,500 grams, percent of total
Health Indicators	Adult hypertension prevalence	Among all adults, the proportion reporting that they were ever told by a doctor that they had High Blood Pressure (HBP). Women who had HBP only during pregnancy and adults who were borderline hypertensive were considered to not have been diagnosed.
Health Indicators	Adult obesity rate	Among all adults, the proportion of respondents whose BMI was greater than or equal to 30.0.
Health Indicators	Percent of adults reporting fair or poor health	Among all adults, the proportion reporting that their health, in general, was either fair or poor
Health Indicators	Number of mentally unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor mental health, which includes stress, depression, and problems with emotions, during the past 30 days.

Health Indicators	Number of physically unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor physical health, which includes physical illness and injury, during the past 30 days.
Health Indicators	Chlamydia prevalence	Number of chlamydia cases per Michigan resident
Health Indicators	Childhood immunization status rates	Percentage of children with documentation confirming school required immunizations, or having at least one dose of each of the required immunizations awaiting receipt of subsequent doses to be administered at appropriate intervals
Health Behaviors	Rates of adequate physical activity for adults	Among all adults, the proportion reporting that they do either moderate physical activities for at least 150 minutes per week, vigorous physical activities for at least 75 minutes per week, or an equivalent combination of moderate and vigorous physical activities and also participate in muscle strengthening activities on two or more days per week.
Health Behaviors	Rates of inadequate daily consumption of fruits and vegetables for adults	Among all adults, the proportion whose total reported consumption of vegetables/ fruits (including juice) was less than one time per day.
Health Behaviors	Rates of excessive alcohol consumption for adults	Among all adults, the proportion reporting consumption of five or more drinks per occasion (for males) or four or more drinks per occasion (for women) at least once in the previous month.
Health Behaviors	Adult cigarette smoking	Among all adults, the proportion reporting that they had ever smoked at least 100 cigarettes (5 packs) in their life and that they smoke cigarettes now, either every day or on some days.

4 - Master Timeline for SIM

The State will plan, design, implement, operationalize and evaluate multiple Model Test components in a staged approach to advance and test the SIM vision for healthcare transformation in Michigan. For three years, starting August 1 2016, the SIM Initiative will launch a phased implementation approach aimed at four component areas, including core components of Care Delivery and Population Health along with support components of Program Management & Governance and Technology. Within each of the four component areas, sub-components are identified with specific activities critical to a successful implementation. While the implementation period begins on August 1 of 2016, the pre-implementation phase focused on design and stakeholder coordination efforts began February 2015, and run up to the first implementation phase.

The master timeline in this section provides a visual representation of implementation and operationalization of all the components, sub-components and activities, coupled with estimated timeframes, in which they will be executed. The timeline identifies each of the implementation years, with indicators for SIM quarters, years and monthly calendar periods. Additional detail on the core components that will be implemented is available in section B (Detailed SIM Operational Plan) of this document. Sections C1 (Program Governance, Management Structure and Decision-making Authority) and C10 (Health Information Technology) provide additional parameters and operational detail regarding support components

To provide context around each of the activity phases represented on the timeline, blocks of time have been labeled as one of 5 phases. The phases include Initiation & Planning, Detailed Design, Implementation, Readiness Validation and Operations. To get an understanding of the type of activities that take place in each phase, a bulleted list is outlined below.

Standard Michigan State Innovation Model Process Phases

Initiation & Planning

- Clearly define the objectives and scope of SIM components
- Develop high-level timeline and resources requirements
- Define the governance and management structure for the component implementation
- High-level business requirement development

Detailed Design

- Detailed business requirement finalization
- Functional analysis and Business process design
- Technical solution identification and design
- Develop detailed program schedule and work plan

Implementation

- Execute SIM component work plan as scheduled
- Incorporate business process as designed
- Technical solutions developed
- Readiness, validation and operational scheduled development

Readiness Validation

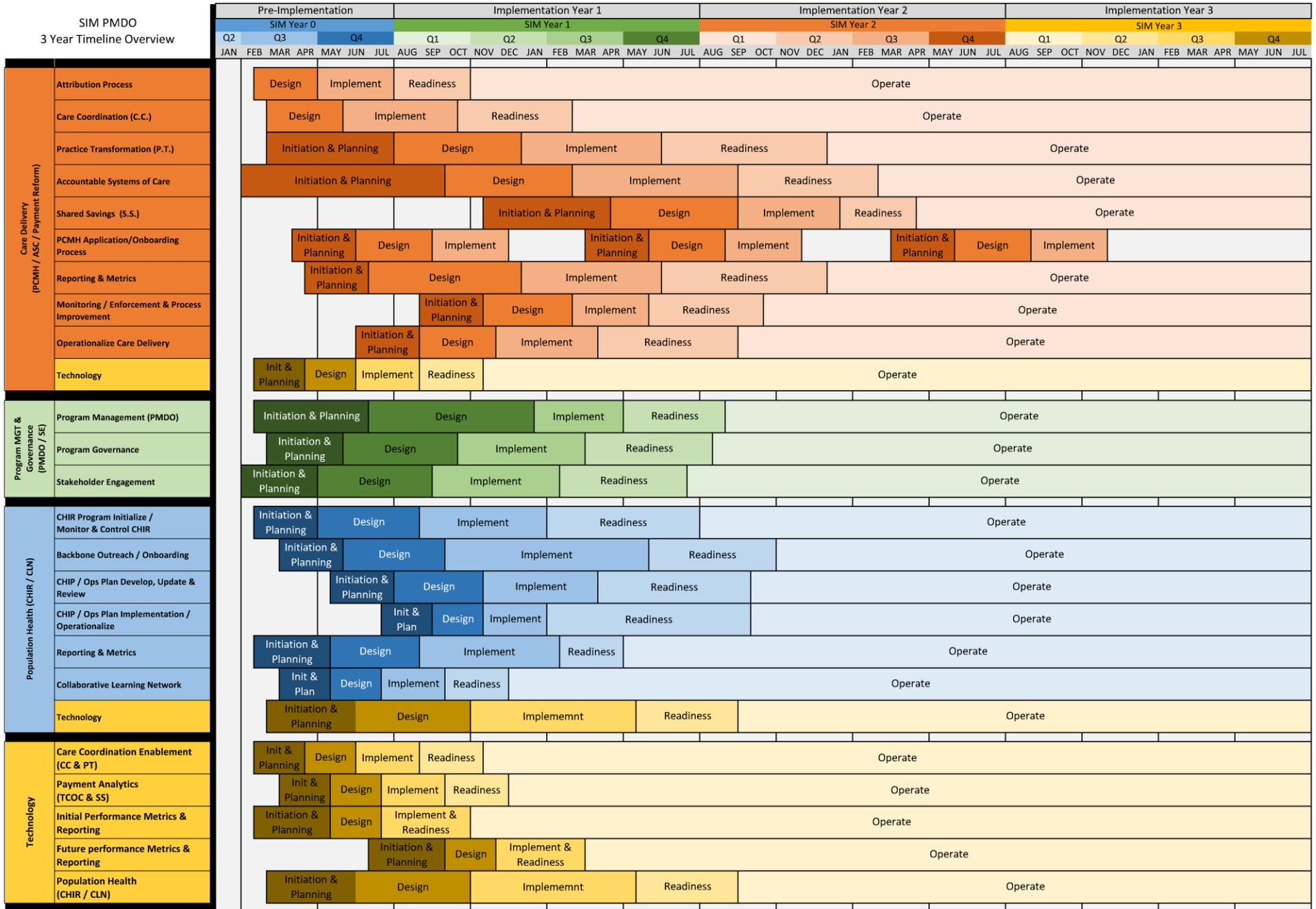
- Business rules and requirements verified
- SIM component business process validated
- Technical solution tested and verified
- SIM leadership operational approval

Operations

- SIM component launch
- Monitor and control SIM components
- Manage governance and change control
- Performance review & improvement recommendations

Each of these blocks of time are estimates, and that the timeline will remain flexible in order to accommodate any shifts in activity as they arise. Final timelines and milestone dates will be developed based on participant feedback, ongoing design session output and MDHHS SIM leadership decisions. Please see section C1 (Governance, Management Structure and Decision Making Authority) for more information. The SIM implementation and operational teams will oversee the execution of these activities, with the support of the designated program implementation management team and will be responsible for maintaining the program timeline. A general timeline of these components, sub-components and phases are outlined below in Figure A4.1 (Michigan's SIM Overall Timeline) below.

Figure A4.1 Michigan's SIM Overall Timeline



Care Delivery: Quarterly Timeline and General Focus

The Care Delivery portfolio consists of multiple Model Test components focused on transforming how primary care is delivered and measured, along with how practices are provided compensation for these activities. In the fall of 2016, SIM will begin to implement supporting infrastructure and the first wave of Patient-Centered Medical Homes statewide. PCMH will launch with providers who have accreditation through existing, approved Patient-Centered Medical Home programs and participate in the Michigan Primary Care Transformation initiative and those within the CHIR/Population Health regional Model Test boundaries. SIM will begin to launch the next waves of Patient-Centered Medical Homes in five of Michigan's ten Prosperity Regions in year 2 and the remaining five Prosperity Regions in year 3. This scale up plan will result in a statewide PCMH by year three of the Model Test period.

Care Delivery Timeline

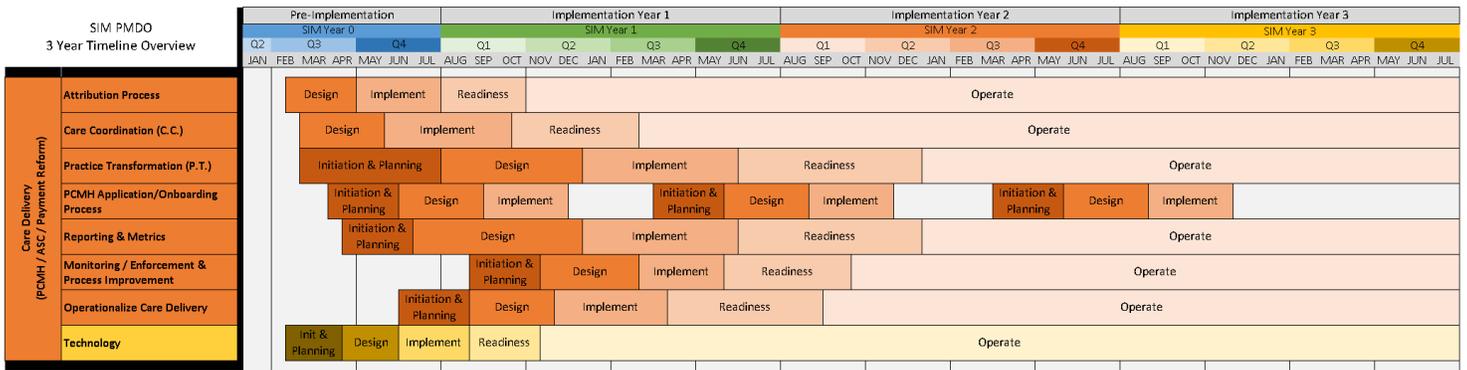
Stakeholder engagement, particularly with potential participating payors and providers, will be a priority during the first quarter of 2016. In parallel, the SIM teams will finalize design choices around the Patient-Centered Medical Home care delivery and payment models, recruit providers, and finalize technical requirements for launch during the first and second quarters of 2016 in preparation for a January 2017 launch.

Michigan Primary Care Transformation funding will expire in December 2016. The State will launch Patient-Centered Medical Homes on January 1, 2017 to ensure no lapse for current PCMH participants that are part of the Michigan Primary Care Transformation Demonstration Project.

The baseline data for the first Patient-Centered Medical Home reports will be collected starting on October 1, 2016, and the first performance period will begin on January 1, 2017. Reports will be released every quarter throughout the performance period. For the first six months of participation, all PCMH's will receive Care Coordination payments as data is collected on performance. After the six-month grace period, Care Coordination payments will be tied to Care Coordination activities. Practice Transformation payments for initial participants will be paid early in 2017, and the first Shared Savings payments for year 1 participants will be released in October 2018: five months after the end of the first performance period to account for three months of claims run-out and two months for performance analytics and payment processing.

A quarterly view on Patient-Centered Medical Home launch timelines, along with bulleted activities are outlined below in Figure A4.2 (Patient-Centered Medical Home Timeline). A more detailed description of activity is available in the Component Summary within Section B1 (Narrative Summary of Component/Project).

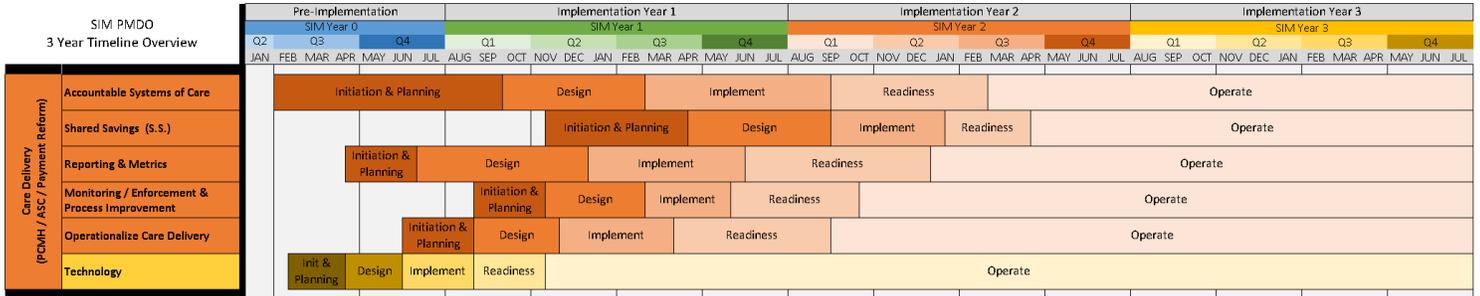
Figure A4.2 Patient-Centered Medical Home Timeline



Accountable Systems of Care Timeline:

Michigan completed the initial round of Accountable Systems of Care capability assessments in 2015. A small number of test sites were selected based on these capability assessments in January 2016. Final design of Accountable Systems of Care will be developed in partnership with other key stakeholders, including providers, Medicaid health plans, commercial insurers, Medicare health plans, and self-insured employers. A quarterly view of phases and detailed activities are outlined below.

Figure A4.3 Accountable Systems of Care Timeline



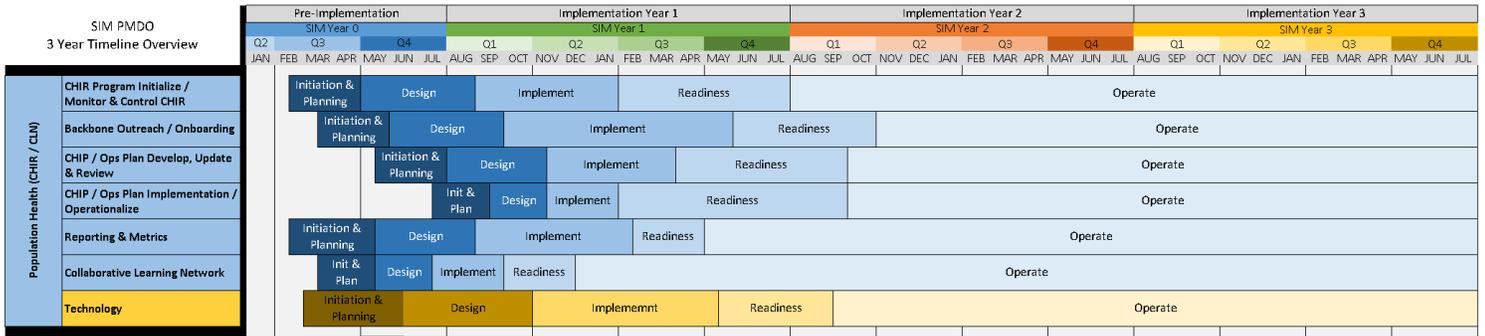
Population Health Timeline:

The second major component of the SIM initiative is Population Health with sub components of Community Health Innovation Regions (CHIR) and the Collaborative Learning Network (CLN). With the Community Health Innovation Regions, capability assessments were completed in 2015. Efforts in the first and second quarters of 2016 will focus on selecting test sites, engaging test sites for their plans to operationalize Community Health Innovation Regions, and finalizing arrangements to provide funding for Community Health Innovation Regions through applications for grant funding. Finally, the first round CHIRs will begin their efforts starting in early 2017.

The Collaborative Learning Network begins its final design work in May 2016 with initiation for year 1 planned for later in 2016. During this period, IHI will develop and implement an interconnected

Collaborative Learning Network focused on the interaction of partners in the CHIR including ASCs and PCMHs. More detail about Population Health timelines, and the corresponding sub components and activities are found in Figure A4.4 (Population Health Timeline) below, as well as Section B for core components.

Figure A4.4 Population Health Timeline



5 - Budget Summary Table

In Development

B. Detailed SIM Operational Plan

1 – Narrative Summary of Component/Project

Mentioned previously, reinventing Michigan’s health care system is one of Governor Rick Snyder’s top priorities. Transforming the Michigan health care continuum to provide better quality health and experience at a lower cost is an ambitious vision shared by many across the state, but when achieved will improve the health of all Michiganders. In 2014 the Governor shared a vision for “healthy, productive individuals, living in communities that support health and wellness, with ready access to [an] affordable, patient- centered and community-based system of care” as part of the state’s Blueprint for Health Innovation. To support the Governor’s visions, this State Innovation Model (SIM) operational plan details the following SIM components:

- Population Health (CHIR/Collaborative Learning)
- Coordinated Care Delivery (PCMH, ASC, Payment Reform)

Targeted Regional, Community-Level Population Health Initiative

Virtually all health care is delivered at the local level. Working together, communities can bring about changes that will improve health for the people they serve. Driven by local partners, SIM will support a regional approach that provides resources to communities. Each region will contain the following components later described in more detail:

- Community Health Innovation Region
- Collaborative Learning Network
- Accountable Systems of Care

Beginning in late 2016, Michigan will begin implementing Community Health Innovation Regions (CHIRs) to address statewide and regional population health. All CHIRs will be required to target Emergency Department (ED) utilization, a statewide SIM goal, and other targeted populations or health metrics that may be of regional concern or priority. Targeted populations will be limited to one of two SIM priorities: a) the chronically ill, or b) at-risk pregnant women.

The CHIR will be focused on making an impact on two fronts:

- Clinical/Community Linkages – Through the following methods, the CHIR model will create a foundation for providing a holistic view of a person and preventing utilization of high cost health care services:
 - community partnerships that connect clinicians to the community
 - health intervention prioritization and alignment
 - technical investments/assistance, governance and accountability

- Population Health – The CHIR will provide a structure and develop mechanisms that enhance the ability of each region to invest in socio-economic factors that influence health and allow for each region to identify its most salient capacity gaps and pressing population health challenges. Using coordinated Community Health Needs Assessments and regionally aligned Community Health Improvement Plans, population health strategies will be focused on interventions that will produce the highest degree of impact.

Coordinated Care Delivery and Value-Based Payment Reform

Michigan will transform the business model of health care to deliver better health, better care with improved access, and lower cost trend through reform and alternative payment methodologies. The State will do so by promoting coordinated care delivery models and shifting payment from fee-for-service models to mechanisms that reward providers for effective care coordination and high-quality, cost-effective care.

There are three complementary strategies to our plan for coordinated care delivery:

- Patient-Centered Medical Home: the Patient-Centered Medical Home is the core pillar of our coordinated care delivery strategy. Patient-Centered Medical Homes will be rolled out statewide by January 1, 2017. Our goal is that nearly every Michigander will be attributed to a Patient-Centered Medical Home that proactively manages their health with a focus on chronic disease management and primary prevention by 2019. The SIM teams will leverage experience with the successful Michigan Primary Care Transformation Project (MiPCT) where possible.
- Accountable Systems of Care: a small number of Accountable Systems of Care will be launched in select regions where the establishment of a coordinating infrastructure across Patient-Centered Medical Homes and other providers will deliver meaningful value.
- Value based payment models: Improvements in provider behavior within Patient-Centered Medical Homes and Accountable Systems of Care will be rewarded through provider participation in shared savings or two-sided risk models, respectively, care coordination payments and practice transformation funding.

2 – Detailed SIM Component Narratives and Summary Tables

Community Health Innovation Region

The State believes in the value of a community-based organizing mechanism composed of partners from many different fields who will work together for better population health and health care at lower costs. Given the complex nature of the health system and the substantial impact of social, economic, behavioral, and environmental factors on health and health care, no one sector alone can achieve significant improvements in population health. Broad partnerships will be needed across the health system and beyond.

To be effective and sustained over time, these partnerships will take a collective impact approach, with a long-term commitment to a common agenda, shared measures, and effective strategies for engaging the community in improving health and the health care delivery system while containing costs. These partnerships will be organized using the structure and process of the SIM Community Health Innovation Region (CHIR), which is the name for both the geographic region of operation of the collaborative, as well as the entity of stakeholders that enact the activities of the CHIR.

Community Health Innovation Regions (CHIR) are a core component of Michigan's State Innovation Model operational plan, and their mission will be to align priorities across health and community organizations. The CHIR structure supports both an integration of health care services and social services, as well as a method to target resources toward upstream prevention rather than downstream intervention. The key focus of CHIRs will be on primary preventions across previously defined set of Michigan winnable battles (e.g., immunization, smoking cessation, obesity management) and other determinants of health (e.g., housing, substance abuse) for the SIM priority populations (i.e., super-ED utilizers, at-risk pregnancies, and multiple chronic conditions). CHIRs will drive broad, but coordinated initiatives, including community health needs assessments and community health improvement plans; and develop processes to define and measure outcomes and support for implementation and operationalization.

CHIRs will be convened by a backbone organization that will serve as the fiduciary for the regional activities. The backbone has no special authority within the governance structure of the CHIR governing body, and is solely tasked to support its membership in the decision-making and implementation of consensus activities for their SIM funding. The diverse stakeholder will be convened with the objective of unifying current and new initiatives to drive to shared goals. These cross-sector partners will come together within a geographic region with the common aim of improving population health and reducing disparities. Regional collaboratives will achieve these aims by aligning existing initiatives and addressing systems issues that underlie poor health and breaking down silos to collectively address broad determinants that impede health and drive up health care costs. In summary, the overall goal of the CHIR is to develop community capacity to improve population health. The objectives of the CHIR are to:

- Leverage the existing, well-developed capacity in communities to bring regional partners together to identify and address community health needs.
- Develop and implement linkages between healthcare and community-based agencies to address social determinants of health.
- Enhance local policy, identify cross-organization programmatic and procedural enhancements, and advance built environment efforts to encourage health and wellness.
- Further develop high level organizations, and sophistication in terms of governance, partnership, data collection and information sharing, and integrated service delivery.

CHIRs will leverage existing initiatives that are already underway in our State to improve health outcomes and support accessible, integrated medical, behavioral and human services in different regions. The local CHIR plan for SIM funding requires a comprehensive inventory of existing services, programs, organizations, and

funding sources, to ensure each region utilizes the SIM process to build upon the assets of their community, and develop structures and processes that integrate such established resources.

The State will also reference existing initiatives when reviewing the local CHIR operational plan. Especially when the CHIR develops its approach for clinical-community linkages, the State will look to elements from established models such as the Michigan Pathways to Better Health Community Hub and Children's Healthcare Access Program (CHAP) that align with CHIR goals for this component. Some such elements within these models that are consistent with our stance towards the clinical-community linkage element of the CHIR include but are not limited to:

- Connecting clients to needed health and local social services to improve their health and resulting decrease in health care costs
- Centralized hubs that identify and connect at-risk people with identified conditions to community health workers through referral partnerships with providers and payers. These community health workers coordinate service delivery across health care and human services to provide the most comprehensive solution tailored to each individual depending on their needs (e.g., transportation services for Diabetics to help with their appointments)
- Principles of finding populations that are at or are expected to be at greatest risk, provide evidence based health and social services, and measure and evaluate benchmarks and final outcome

This model of CHIRs also ties closely with the State's goals for an Integrated Services Delivery model by incorporating a person-centric view to health transformation in our State.

While a small number of models similar to CHIRs have been implemented within the country, best practices to achieve impact at scale have not yet been well established. Based on this, the CHIR initiative will be tested within five state selected regions. Selected regions include:

- Jackson County
- Muskegon County
- Genesee County
- Northern Region
- Washtenaw and Livingston County

The State will do this by supporting the specified regions for targeted CHIR implementation and tracking progress, assigning accountability, and refining guidelines based on lessons learned and ultimately releasing for statewide adoption.

The State will require all Accountable Systems of Care (ASCs) to be a part of CHIRs for our test. This will tie with our objective of making CHIRs financially self-sustainable in the longer-term by inviting interests from

the local stakeholders (e.g., multiple payers, providers, ASCs, employers, etc.) who are willing to fund CHIRs initiatives based on the measurable impact to care delivery and population health goals.

Given the complex nature of health system redesign, the CHIR backbone organization will support participation in and feedback to the learning and improvement system. The CHIRs will be expected to integrate lessons learned and make adjustments to improve processes and outcomes in an iterative cycle of continuous improvement. CHIRs will facilitate a process to develop and define how to measure improvement. Representatives from the CHIR will contribute to a core set of community performance measures with input from relevant stakeholders, collaborating with the SIM Commission (see C2 Stakeholder Engagement) to align metrics across local and state level for taking action on relevant data. The backbone entity convening CHIRs will be responsible for data collection, analysis, and public reporting of performance measures at the community level, whether this function is provided for by CHIR membership or otherwise subcontracted. The entity will also maintain a community dashboard to track cross-sector alignment, community specific measures, target performance, and compare level of improvement against target performance goals. The State will build infrastructure and capabilities to integrate these reports, supplement additional data as applicable and available and juxtapose program measures to provide holistic impact assessment.

The State will provide support to CHIRs to engage all partners in common strategies for system change and continuous improvement. During the fall of 2016, a statewide SIM Population Health committee, within the SIM Commission, will review CHIR operational plan feedback, participant input, performance monitoring, identifying gaps to performance, encouraging collaboration and sharing best practices across CHIRs.

HIE/HIT functionalities within our State will be leveraged where possible to provide test participants a coordinated technology platform that will connect them with existing Michigan HIT/HIE efforts and other CHIRs. This could potentially be achieved by undertaking new initiatives such as including CHIR social/behavioral service providers into the Healthcare Provider Directory using the existing data systems and building on existing efforts such as the inclusion of Community Health Workers in Active Care Relation Service functionality to support attribution.

Community Health Innovation Regions: Service model

Community Health Innovation Regions (CHIRs) will align regional priorities across medical and non-medical entities to improve the health of Michiganders. CHIRs will conduct a community health needs assessment, including development of plan with strategic priorities for health improvement in the community; Health care delivery systems, local health departments, Medicaid health plans, Community health mental authorities, and other community stakeholders must work collaboratively with the assistance of the administrative staff of the CHIR to conduct and/or align Community Health Needs Assessments (CHNAs). Specifically, the CHIR will require the backbone to submit a single CHNA with formal signoff from:

- Non-profit hospitals
- Local public health department

- Medicaid health plans
- Community mental health authorities

With input from the CHNA, and informed by community voice, the CHIRs will create a new or modify existing Community Health Improvement Plans to establish a shared, community-wide strategic plan that will identify and implement strategic priorities for improving health in the region. Furthermore, using input from the CHIP the backbone will facilitate the creation of a detailed CHIR operations plan that describes how they will strengthen community/clinical linkages and improve population health.

Within the local CHIR operations plan, CHIRs will develop and effectively champion strategic interventions to drive improvements in health and health care; examples of strategic interventions include:

- Coordinated institutions: Integration of medicine, public health, and community resources in addressing health priorities (e.g., a community-wide approach to childhood obesity)
- Coordinated processes: Establishment of greater integration across the health system and organized entry points for access to care with links to coordinated community services
- Coordinated community: Development of a systematic approach to individual and community-wide public engagement in improving health and health care

Throughout these activities, the CHIR will focus on a methodology of implementation that allows the cohort of SIM CHIRs to test and document potential approaches for best practices, in order to inform their CHIR cohort, the State Department of Health and Human Services, and post-SIM CHIRs. In addition, the CHIR should identify non-programmatic context issues, such as the presence of multiple Accountable Systems of Care in the region and the resulting impact on support requirements and operational complexities. In the CHIR activities and its regional context, the CHIR should be a structure and process by which the State can identify policy levers that enhance the operations of the CHIR members.

The State will define model test regions geographically by zip codes which may cross traditional boundaries (e.g. counties, prosperity regions). The population attributed to the CHIR will be defined as the general population within the specified zip codes after State defined inclusion and exclusion criteria have been applied. The inclusion and exclusion criteria will be developed through interdepartmental collaboration at the State and input from stakeholders

Collaborative Learning/Process Improvement

The State is committed to synthesizing the many lessons from the SIM Test regions in order to best understand how to pursue a post-SIM approach to health system transformation. In order for the State to be best positioned to develop enabling policies that recognize the diverse contexts of the different regions in Michigan, it is essential for the CHIR to utilize the collaborative learning network in its design and implementation of collective impact strategies.

The goals of the Collaborative Learning Network are to:

- To build capacity among participants for cross-sector collective impact
- Encourage and support ASCs and CHIRs in setting shared goals and measures
- To provide mechanisms to share lessons learned across stakeholders
- To build capacity for continuous improvement and action
- To promote accountability for outcomes
- To connect participants to other partners across the state and nation

A CHIR-specific component of the Collaborative Learning approach is to support the development and enhancement of community dashboards, which will incorporate CHIR-related metrics. As the CHIRs work to consolidate CHNAs and collaborative CHIPs, the State will support a common platform to assist regions in their use of such CHNAs to further integrate clinical and community metrics. The collaborative learning approach will provide the structure and process to accommodate for nuanced variations amongst different regions and will be the vehicle for developing and testing the clinical-community linkage and community improvement plans.

The State is also committed to ensuring that best-practices of Collective Impact are utilized in CHIR evolution and reporting. Such indicators of progress are:

- Pursuit and inclusion of diversity into regional decision-making
- Development and maintenance of strong partnerships
- Use of support systems for learning and improvement across organizations
- Monitoring of population health improvement measures
- Ensuring status of Backbone as a neutral convener that facilitates cross-sector efforts
- Support for linkages between health care delivery system and community services
- Pursuit of a system-change approach to collective impact

The Collaborative Learning system will allow SIM participants to engage in shared learning and troubleshooting across regions and among different affinity groups. To support regional interaction with the Learning System, the SIM will support in-person meetings 3 times per year, as well as a range of individual coaching for each CHIR. A plethora of CLN activities are being considered and as the learning/educational needs of CHIR participants become salient the CLN activity list will become finalized.

CLN activities can be summarized in the following list:

- Seminars
- Webinars
- Summits
- Coaching
- On-site visits
- Templates

- Conference Calls
- Body of Knowledge
- Technical Assistance

Technology Enhancements for CHIR Operations

In addition to the CHIR structure, services, and improvement processes, the SIM looks to advance the integration of technology solutions among CHIR stakeholders. Two specific applications of these technology enhancements are with regard to the Community Health Needs Assessment and the monitoring of the population health status of the Community Health Improvement Plan through a community dashboard.

The technology solution must be able to juxtapose statistical indicators alongside program service usage on a dashboard. In addition, the platform will interface with HIT systems in order to extract relevant SIM-specific utilization data. The role of such a platform in the SIM is to deepen clinical-community linkages, and facilitate shared decision-making. It is the aspiration of the State that a shared platform, such as this, will enhance the ability of health systems to become active and involve key stakeholders in the community planning and economic development efforts that are important influences upon community wellbeing.

The pursuit of technology enhancements should occur in an integrated fashion, across clinical and community partners. Partial solutions will not be receive preference, in contrast to solutions that enabled the CHNA process to be an ongoing monitoring activity that is inclusive of community stakeholders and governmental partners. The aim of technology enhancements for CHIR operations is the identification and/or development of a single platform that has the potential for post-SIM sustainability among clinical and community partners. The state also remains highly interested an a standard solution that could be tested across the SIM cohort, in order to pursue a single solution for statewide CHNA use, that can also consistently enable clinical-community discussions about which community programs move the need on what statistical indicators of wellbeing in their region. It is the aspiration of the State that such standardization would be instrumental in enabling a collective impact approach, and building the foundation for most robust public-private partnerships to influence the socio-economic and environmental determinants of health.

Community Health Innovation Regions: Participating Entities

Communities require cross-sector partnerships to build the culture and capacity to work together and address broad determinants of health. Community Health Innovation Regions (CHIRs) will require a core set of entities with optionality to add others depending on regional variations and needs of target populations. Local context and prioritized actions/interventions will drive the decision of each local CHIR on inclusion of optional entities. Mandating some entities will ensure standards of care are maintained while providing flexibility to include more entities dependent on needs of the target population.

Required Stakeholders:

- Community Members

- Local public health department
- Accountable Systems of Care Community mental health service providers
- Medicaid health plans
- Other payors

Other critical stakeholders may include:

- Employers and Purchasers
- Payors
- Community organizations
- Human service providers
- Behavioral health
- Philanthropy
- Local government
- Community and economic development
- Community safety and corrections
- Education Institutions
- Housing
- Transportation
- State Associations
- Other non-profit organizations (e.g., civic centers, advocacy organizations, research institutes, etc.)

The CHIR structure seeks to leverage the existing regional infrastructure of Michigan collaborative endeavors. Each region will build upon its own collaborative landscape to maximize the institutional histories of regional stakeholders. The principle for participation in the CHIR is that each regional backbone organization, governing body, and the entire CHIR membership will utilize the SIM CHIR opportunity as a means to enhance their existing collaborative processes, and utilize the Collective Impact framework to embed a partnership process among the health care institutions and community partners. As such, the contractual requirements of the CHIR are limited to only those few that are necessary to ensure proper functioning and accountability of the CHIR to the larger SIM objectives. Most design principles of the CHIR, however, are left to the discretion of the regional stakeholders, with the express purpose of being minimally prescriptive.

Alternative support for the CHIR will be provided by means of policy levers, Michigan Medicaid Health Plans (MHPs) are now incentivized to support several integral aspects of the CHIR approach, including:

- Participation with CHIRs, ASCs, and SIM activities
- Support clinical-community linkages and community health worker interventions
- Participate in community-wide CHNAs
- Address health disparities

- Contract with community-based organizations to address social determinants and root causes with the community.
- Incorporating data on social determinants of health into support for population health management

The following contractual requirements of the CHIR are incumbent upon the Backbone Organization, Governing body, and membership of the CHIR.

Table B2.1 CHIR Contractual Requirements

Req. Number	Area	Requirement
1	Contracts and Legal Agreements	In each region, there is one CHIR with a single backbone organization, which is required to be a legal entity that acts as fiduciary.
2		When subcontracting core functions, the backbone organization must develop formal agreements with partners that clearly define responsibilities in the partnership
3		The CHIR is comprised of cross-sector partners that work together to improve population health. Among the decision-making body and workgroups that comprise the CHIR, the following partners are required constituencies: representation from providers from Accountable Systems of Care, hospital leadership from each hospital partner, health plans, local public health departments, and Community Mental Health agencies.
4		The CHIR decision-making body is required to approve participation in the SIM Model Test. Participation will constitute both the financial and staffing resources necessary to support the decision-making body throughout the Model Test.
5	Population/ demographics	The State will define geographic boundaries by zip codes in partnership with the CHIR. Inclusion and exclusion criteria will be applied to the population within the selected zip codes.
6	Staffing CHIR	The CHIR backbone organization is required to hire and provide the funding for designated administrative and project management staff to support and implement the work of the CHIR. Such financial contributions can be arranged through in-kind staff and resources that provide sufficient capacity for the CHIR decision-making body to carry out its required duties.
7	Governance	The CHIR backbone organization is required to convene a decision-making body including, at a minimum, representation from providers from Accountable Systems of Care; health plans, local public health, business, community organizations, and philanthropy.
8		The CHIR decision-making body is required to have a decision-making process that is well defined and transparent, and will document the proceedings of the group to ensure that the decision-making protocols are followed.
9		The CHIR is required to have shared priorities and strategies developed by the decision-making body, with broad partnership engagement and based upon the needs of the community. The shared priorities or strategies must include High Emergency-Department Utilizers, and at least one of the other SIM populations (At-risk Pregnancies and Individuals with Multiple Chronic Diseases).

10	Commitment To Model Test Engagement	The CHIR is required to participate in the SIM evaluation and must demonstrate implementation of processes that will contribute to performance targets during the course of the Model Test
11		The CHIR must participate in collaborative learning networks (CLN). Participation includes contribution to the body of knowledge and discussion around the SIM Test implementation in their local region, in addition to use of the CLN to inform their own decision-making body.
12		Representative(s) from the CHIR must be engaged in the Population Health Committee.
13		Representative(s) from the CHIR must be actively engaged on the Population Health Advisory Board (PHAB).
14	CHIR Functions	The CHIR must enable the development and successful execution of systems that integrate ASC/PCMH health care delivery and human services (e.g., human services hubs).
15		The CHIR must support a cross- sector effort to achieve consensus participation in a single community-wide Community Health Needs Assessment (CHNA). The single CHNA will coordinate with all entities that are required to conduct a CHNA (e.g., non-profit hospitals, local public health departments, community mental health, etc.), and identify additional areas for assessment and solutions beyond the traditionally healthcare-related programs of the Community Health Needs Assessment. Resulting from this community-wide CHNA, the CHIR decision-making body will work to jointly develop community wide strategies to address priorities for improving population health and controlling health care costs.
16		The CHIR must commit to focusing on Emergency Department Utilization, and at least one of the following: chronic disease management or high risk teen pregnancy.
17		The CHIR must develop a plan for sustainable financing of the CHIR beyond the project period. Sustainable financing plans should provide support for the recommended strategies resulting from the community-wide CHNA.
18	CHIR Technology	Provide support for clinical-community linkage systems such as the Pathways Community Hub, the Children’s Healthcare Access Program (CHAP) or others.
19		Pursue a shared dashboard of SIM measures that CHIR participants are accountable for.

Community Health Innovation Regions: Infrastructure/Processes

The overall value of investing resources in the Community Health Innovation Region (CHIR) comes about from the CHIR’s ability to build the capacity of the region to sustain improvements in population health and advance health equity. A core component of success in this capacity building is the ability of the CHIR to build new relationships among diverse stakeholders, in ways that identify their common interests (e.g., creating partnerships and collaborations that leverage the interconnection among housing, transportation, and

chronic disease management). Keeping people healthy and building healthy communities that support the health and wellbeing of residents will benefit many stakeholders across the region and state in terms of better health and reduced costs. In order to fulfill its role CHIRs will require the following infrastructure and process:

- CHIRs will be supported by a backbone organization (in addition to the decision making authority consisting of diverse stakeholders) that serves as the legal entity of the CHIR and which will be responsible for:
 - Assembling a set of local stakeholders that will coordinate to improve health outcomes by addressing other determinants of health
 - Defining and measuring program goals and success metrics
 - Applying for and disbursing funds
 - Potentially providing infrastructure support for CHIR goals
- A formal decision-making body will develop the guidelines for decision-making, and create the operational structures that will coordinate activities across partners to improve health outcomes. The decision making body will be comprised of representation from partners critical to achieving the goals of the CHIR as defined in the list of mandated entities. Decision making processes will be established such that it clarifies what types of decisions are made, how decisions are made, and by whom. There may be guidelines or bylaws that specify how the cross sector collaborative will make final decisions, such as by voting majority, or super majority, etc.
- SIM Population Health committee will oversee and monitor CHIRs and provide cross-collaboration between multiple CHIRs across the state
- HIE/HIT systems will provide data collection, sharing and evaluation support
- Other existing infrastructure and programs will be leveraged where possible (e.g., existing quality improvement initiatives, collaborative learning network)

Community Health Innovation Regions: Backbone

The backbone organization will be responsible for scheduling meetings, setting agendas with partner input, documenting conversation, facilitating discussion and decision-making, and providing follow-up support to partners to drive execution of partnerships and implementation activity. The backbone organization will also be responsible for ensuring data collection, analysis, and reporting functions are conducted to facilitate and support the discussion and decision-making process, but does not confer special responsibility.

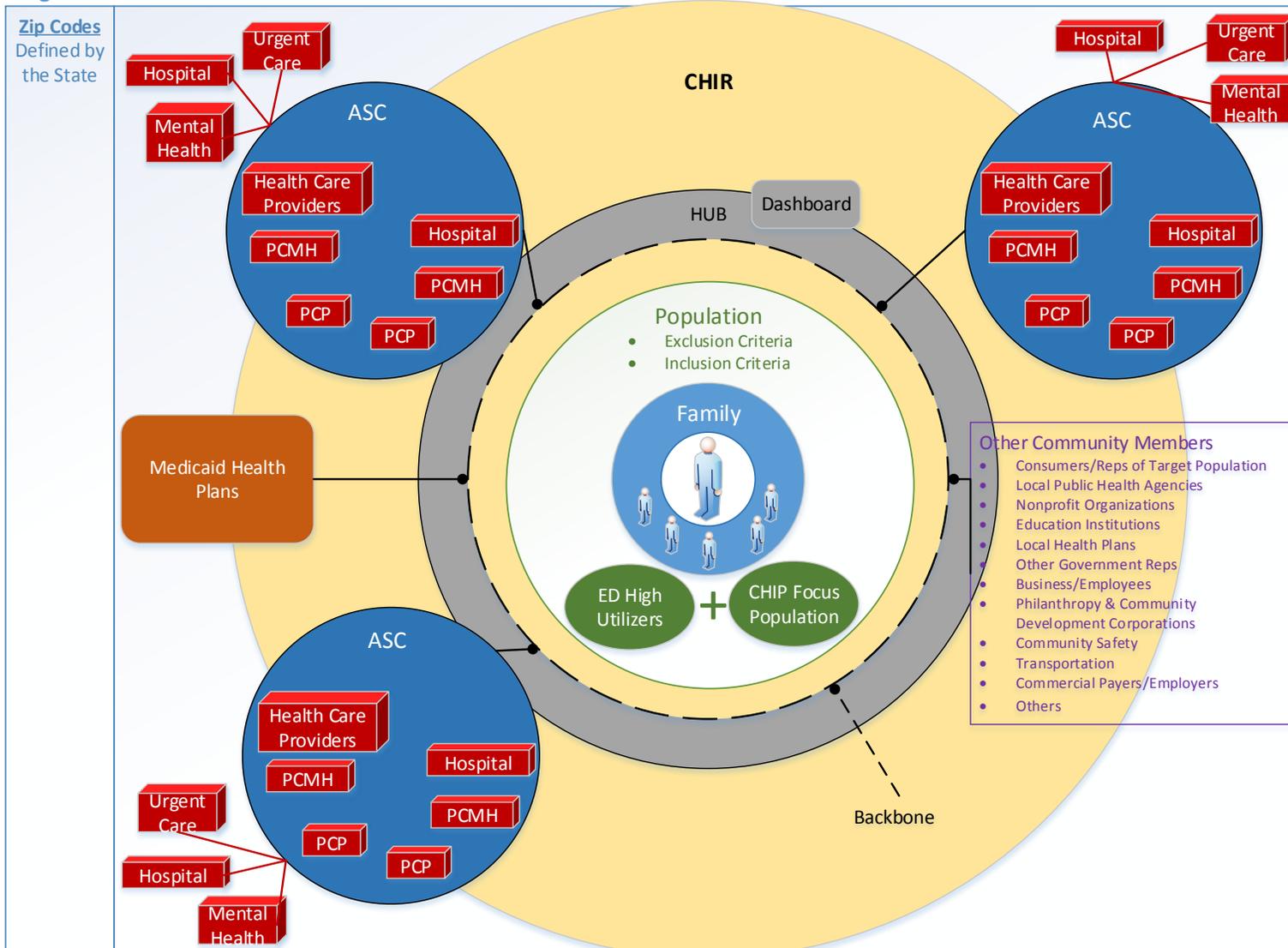
Each region has one backbone organization that provides for governance and contracts with the State of Michigan. Some CHIR functions may be assumed by partnering organizations. The rationale for organizing regions with a single backbone organization is to ensure that local efforts to improve health are coordinated across sectors and that the resources of that region effectively and efficiently target the strategic priorities of the area. In the SIM model, the backbone organization for the CHIR can be any group, organization, or agency that can serve as a neutral convener (e.g., local public health, health systems, multi-purpose collaboratives, university-based organizations, etc.).

Specific details on the role and core functions of the convening backbone entity are described below:

- The backbone organization will act as the neutral convener of the CHIR partners, and organize and sustain their collective efforts to improve health outcomes in the region. Initially, the backbone organization will be required to assure that the CHIR achieves agreed upon performance measures. Over time, the decision-making body may oversee greater accountability that could include payment structures
- The backbone organization will be a legal entity that will sign a contract to specify the responsibilities of the CHIR backbone organization as participant in our test
- The backbone organization will develop and support a formal decision-making structure and administrative staff to coordinate activities across the partners
- The backbone organization will act as the fiduciary
- While the backbone organization may contract certain functions to other organizations, only one lead entity can act as the CHIR backbone organization within the region, with the responsibility for assuring all functionality of the collaborative
- In each region, there will be a backbone organization with designated administrative staff to support the work of CHIRs: this lead organization will serve as the neutral convener of regional partners, assuring a shared aim, measures, and aligned efforts to address strategic priorities
- The backbone entity, with support from administrative staff, will assume the responsibility for sustainable financing, performance improvement, and assures the continuing commitment of partners to the goals of better care, equity, population health, and lowering health care cost
- Paid full time administrative staff might be required for the CHIR. Staff will carry out the day-to-day organizational and administrative functions, including logistical support, management, and quality improvement processes. Staff will act as operational lead, organizing and coordinating the decision making body. In addition, it is optimal if CHIRs' administrative staff might include a designated performance measurement lead
- The backbone will develop the approach for data collection, data analysis, and dashboard related content regarding performance metrics and measurement.

Figure B2.1 Regional Model

Regional Model



Community Health Innovation Regions: Value/Measurement

The CHIR is a governance process and structure to better organize key partners in a local area around common target populations, improvement goals, and activities. This structure enhances the ability for cross-sector partnership and will help improve the coordination of service delivery between Medicaid health plans, ASCs, and community agencies. The value proposition of the CHIR involves both short- and long-term endeavors. In the long-term, the value of the CHIR is its ability to strengthen community capacity to address broad-based, upstream risk that leads to healthcare utilization and health disparities. This long-term value will be pursued by utilizing the CHIR to enhance the ability for healthcare providers and payers to invest in upstream prevention; and building stronger linkages among community organization, economic development initiatives, and governmental programs so that funding can be aligned.

In the short-term, the value proposition of the CHIR is to enhance clinical-community linkages among healthcare services and community-based social services, and to provide a structure and a process for communities to work together in a health in all policies approach to collective impact. This short-term value will be pursued by program partnership, institutional collaboration, regional data collection, and regional inventories of programs that will inform service gap identification.

The CHIR will work with the backbone, ASC, Medicaid health plans, and other payers within the region in order to support data enhancements. This will involve aspects such as:

- Data collection
- Data transmission to Data Aggregator for storage, analysis, and reporting
- Enhanced methods for patient attribution in non-clinical settings
- Ability for community organizations to send information to be included in client EHRs
- Ability for community organizations to receive referrals for service from healthcare institutions and providers
- Coordinated reporting processes and other data coordination among providers and payers (e.g., MCOs)

The CHIR will need to identify the data needs relative to their priorities, target population(s), partners, activities, and goals. The CHIR will need to develop a method for reporting in relation to the CHIR boundaries, and if required, the State will work with the CHIR to implement information technology (IT) solution in order to carry out the aforementioned initiatives in accordance with the functional goals outline above. The IT solutions must connect health care providers with community organizations, and transmit data to the SIM data aggregator for storage, analysis, and reporting. The data must be used to inform initiative operations, improvements, and community-wide dialogue for change. Specifically, the CHIR must use data to:

- Inform regional planning that impacts community development
- Assist health systems to improve health equity

- Facilitate cross-sector partnerships
- Contribute to regional dashboards of wellbeing indicators and program statistics
- Synthesize Community Health Needs Assessments and Community Health Improvement Plans
- Coordinate community benefit funds disbursements in alignment with other community development funding.

Additional technical planning and requirements gathering will be necessary before a technical solution can be finalized. The CHIR will leverage advances in data gathering and reporting, to support SIM regions in their goal for better coordinated care and more integrated human services:

- Assessments are currently being conducted through the health system by many community partners including public health (which is responsible for varied assessments), and health systems (CHNA). CHIRs can build upon data collection through these assessments
- Clinical data that is available through the Michigan Health Information Network provides a significant opportunity for alignment during the Model Test. CHIRs can partner with ASCs to advance the development of the data flows that better informs care coordination with respect to the socio-economic and environmental determinants of health.
- New methods for data analytics provide an opportunity for CHIRs to improve targeted strategies for example data using the Perinatal Period of Risk framework.
- LHDs have a range of Cross-Jurisdictional Sharing (CJS) efforts in place, which represent advances in data sharing and reporting. CHIRs will utilize CJS efforts in their region, and look to replicate best practices of other CJS models that are not currently practices in their health department, when applicable.
- Local HHS have a significant role to play in generating service data on at-risk populations. CHIRs will partner with MDHHS Services to pursue new models of case management, and leverage existing data enhancements such as the Integrated Service Delivery model.

The CHIR will work with the State to identify a suitable core set of indicators to inform their data efforts. Such measures may include statistical indicators and interim measures, as well as organizational process measures and program performance data. Some examples may include, average life expectancy, % uninsured, % of adult population that had a dentist visit within the year, education, poverty, crime statistics, severe housing problems. The following table illustrates how CHIRs will be measured for success initially.

Table B2.2 CHIR Measurements for Success

Objective	Signs of Progress
1. Neutral convener to facilitate cross-sector efforts	<ul style="list-style-type: none"> • List of regular meetings scheduled by backbone governance organization • List of participation among required representatives on governing body • Inclusion of mandatory representation per CHIR requirements • Documentation of governance meetings

	<ul style="list-style-type: none"> • Identification of groups not present at CHIR roundtable, or solicited for input via committees and/or workgroups as it relates to the target population(s) of the CHIR • Identification of regional groups that backbone organization and/or governing body does not have representation at, and remediation plan to integrate CHIR leaders with such identified initiatives as they relate to the target population(s) of the CHIR
2. Development and maintenance of strong partnerships	<ul style="list-style-type: none"> • Documentation of past and current partnerships • Identification of partnership risks • Partner engagement and satisfaction • Provide resources to encourage collaboration • Promote ongoing communication • Prospective list of future needs required of partnerships
3. Support for linkages between health care delivery system and community service providers	<ul style="list-style-type: none"> • Demonstrate the way in which the region assures linkages between health care delivery system human services and public health (e.g. Pathway, 211, etc.) • Promote community resource availability to health care delivery systems • Written document for value proposition completed • Inventory existing linkages
4. Pursuit of inclusion and diversity into regional decision-making	<ul style="list-style-type: none"> • Document continuous outreach process for recruitment • Establish leadership support for partners • Conduct routine survey of partners for ongoing assessment of community perceptions of inclusion and diversity
5. Use of support systems for learning and improvement across organizations	<ul style="list-style-type: none"> • Participate in Summit • Participate in CLN • Works with Coach to improve performance and share lessons (can get this data from coaches) • Complete Implementation Plan • Establish processes for sharing partnership successes • Use evidence-based protocols that promote continuous improvement • Identify institutional staffing and infrastructure needs for participation in learning and improvement processes
6. Monitoring of population health improvement measures, and accountability to outcomes	<ul style="list-style-type: none"> • Compile cross-organizational list of institutional output measures • Develop outcome-related measures • Dashboard completed (and reports data in a manner that reveals health inequity) • Pursued jointly created and supported agenda among partners • Engage partnership members in assessing their own progress on a regular basis • Participate in process to define incentives for institutional and shared target goals
7. Support for population health workforce development	<ul style="list-style-type: none"> • Gap analysis for workforce needs in community completed • Facilitate conversation among clinical and community partners around workforce transitions • Identify cross-institution partnerships and linkages that can address current and future workforce gaps

	<ul style="list-style-type: none"> •
<p>8. Development of sustainable financing strategy for CHIR</p>	<ul style="list-style-type: none"> • Plan for sustainable financing completed • Conduct inventory of organizational funding, including program revenue, in-direct expenses, and discretionary funds • Identify opportunities for alignment of organizational services, including coordinating with publicly funded programs • Develop communication plan to increase awareness of funding opportunities and coordinate submissions • Convene workgroup with healthcare institutions, in order to explore alignment of clinical and community programs in a way that begins to provide the capability for attribution • Identify opportunities through the Community Health Improvement plan for clinical savings to be invested upstream

CHIR Implementation

The State will begin regional engagement by finalizing the backbone organization selection process and provide guidance to prepare the backbone for the CHIR to convene. Where applicable, the organizations may propose a process for defining and finalizing items such as interventions and measures. The desired outcome of the initial engagement will be to develop and/or verify a governance model, management structure, intervention proposal, and measurement plan for implementing their CHIR model in alignment with the State’s principles, and supportive of the SIM priorities and target populations. The CHIRs will be informed of the contracting calendar, and available resources and funding for their efforts once they are well-defined, modeled, planned, and justified.

Additionally, the SIM Commission structure and its committees will engage stakeholders during the decision-making and input solicitation processes. The SIM Community Health Innovation Regions have a wide variety of stakeholders. The CHIR component of the State Innovation Model seeks to incorporate a diverse range of stakeholders that have not historically seen themselves as health-related, or been recognized by the healthcare community as community stakeholders of health system transformation. The stakeholders impacted by the CHIR will include local community-based organizations that impact the Social Determinants of Health, and who have their operations influenced by changes in social service-related needs.

Community Health Innovation Regions: Funding

A pool of funds (see C4 - Population Health Budget) will be made available to Community Health Innovation Regions to support administrative functions and/or programs. This pool will be subdivided amongst all 5 CHIRs. Each region, if approved, will receive a fixed budget appropriated for administrative functions and a health improvement budget appropriated to fund action/intervention projects. The health improvement budget amounts will vary amongst regions and the yearly disbursement amounts will be weighted based on regional Medicaid beneficiary population.

Administrative functions will include activities required to operationalize CHIRs (e.g., provision of meeting space) and health improvements will include actions/interventions proposed by CHIRs to enhance community capacity through the alignment of existing programs in addition to development of any new programs (as needed). Potential sources of funding for these areas will include financial/in-kind support from local participating entities (e.g., Accountable Systems of Care), test funding, and other public/private grants. The CHIR will need to develop a financing plan that identifies and utilizes these potential sources of funding to support its goals, activities, and outcomes.

To qualify for administrative funding, the backbone organization must meet a defined list of requirements, including but not limited to the following: must be a legal entity, exhibit governance maturity, and willing and able to function as the CHIR fiduciary. If the backbone organization meets all the requirements, a fixed amount of administrative dollars will be available to the CHIR.

To qualify for health improvement funding the CHIR must have completed:

- CHNA
- CHIP
- Operational Plan

Within the operational plan the CHIR must address the following health interventions:

- Emergency Department Utilization
- Choose between Chronic Disease Management or Healthy Babies

After these three deliverables have been completed, the CHIR will be asked to develop a budget and submit for approval. The State will review the submitted deliverables and after a series of feedback loops, will release funding when the operations plan has been approved.

The State assistance to test participants will vary depending on existing support from local stakeholders. For administrative function, the State will provide limited funding for a project manager to convene governing body comprising of local stakeholders. Participating entities will be expected to provide in-kind contributions, (e.g., personnel time to serve as representatives on governing body). The CHIRs will define programs based on the community health needs assessment; these programs will largely be supported by existing public/private funding. Test/other grants could provide “seed” funding for building upon or enhancing coordination of existing activities; or new programs that cannot be supported by alternative grants/funds.

Community Health Innovation Regions: Monitor/Control

The State will monitor the project to identify potential areas where technical assistance might be necessary. This active monitoring is accomplished through regular phone calls with the backbone, review of progress reports, prior-approval requests to utilize funding, correspondence from the backbone, audit reports, site

visits, and other information available to the State. After funding is released to a CHIR at minimum will participate in the following:

- Bi-Weekly Calls (or an alternative frequency as negotiated between the State and the CHIR backbone organization)
- Submit Funding Requests and Financial Invoices
- Quarterly Performance Reports
- On Site Visits
- Annual Performance Reports
- Yearly CHIP/Operation Plan updates
- Submit metrics/measures

Community Health Innovation Regions: Sustainability

The sustainability of multi-sector partnerships will require local stakeholders to invest in the backbone structures and infrastructure costs for the staff and decision-making body. CHIRs will need to demonstrate a broad base of financial support from their local partners (e.g., from health plans, businesses, Community Benefit funding, and philanthropy) to fund the administrative staff, operational costs of the management of the CHIR, including the decision-making body activities.

CHIRs will need to develop new models for sustainable financing for community resourcing. The backbone organization and CHIR partners will need to achieve greater balance in investments in health care and other social determinants of health and marshal available resources within (and outside of) the community to improve health and health care, including but not limited to:

- Community benefit dollars (as required by IRS)
- Community investment/development funds (as required by the Community Reinvestment Act)
- Philanthropic funding
- Federal, state and local funding (e.g., Metropolitan Planning Organizations investing transportation dollars in a healthy built environment)
- Community trust funds
- Funding streams that represent a shared savings from a high-performance health system
- Expanding billing for services by local public health departments
- Comprehensive payment reform that pays for value

For a more complete list of existing programs providing funding support to broad population health initiatives, please refer to section C3 within this operation plan. These funding sources will be leveraged either by the State or by the regions (in their application process) as and when applicable based on the relevance of funding programs to CHIRs' target population (e.g., super-utilizers) and/or interventions (e.g., smoking cessation).

Over time, the CHIR will have to demonstrate value by enhancing existing cross-sector collaboratives to improve health outcomes and reduce health risks. As these community partnerships demonstrate the ability to collaborate across partners, engage leadership in the community, and demonstrate improved health outcomes, they will garner broad-based support and funding from local stakeholders. Our test will assess the feasibility of CHIRs to become funded through payments made by local payers who are at financial risk of their membership, or Accountable Systems of Care for the value of services provided by the CHIRs. As applicable, these models will be included for testing during the project period.

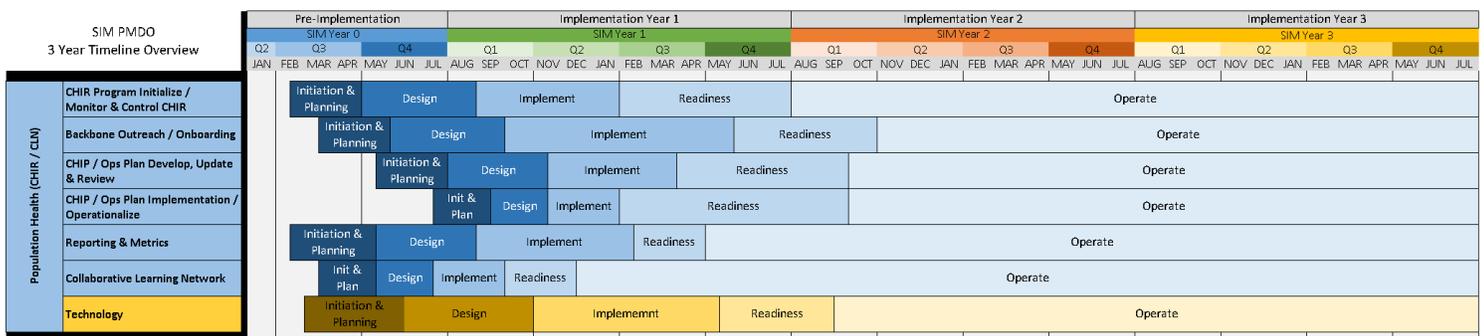
Community Health Innovation Regions: Scale-up Plan

Community Health Innovation Regions are a relatively new model for us and will need to be tested. When the State defined the number of CHIRs to test, considerations were made to ensure that the number of test sites do not exceed the bandwidth / capacity of the Model Test, or our ability to provide meaningful seed funding for test site initiatives. The State selected a diverse mix of CHIRs for testing to ensure that the mix of test sites can provide insights/best-practices into how CHIRs could be launched across various regions and market landscapes in our State. The State will start with the five selected regions:

- Jackson
- Muskegon
- Washtenaw & Livingston
- Genesee
- Northern Michigan

The SIM model will document the resource needs and feasibility to expand the concept to other regions across the state. Before such decisions can be made, the unit cost of CHIRs will need to be determined, along with the cost of collaborative learning and other supports. Figure B2.2 (Population Health Timeline) represents the current Population Health Component Timeline.

Figure B2.2 Population Health Timeline



Community Health Innovation Regions: Component Summary Table

In the following Table B2.3 (CHIR Component Summary Table) we define the steps that will be taken to implement Community Health Innovation Regions at scale. These steps align with the steps outlined in the master timeline in Section A4 (Master Timeline) of this operational plan. The activities in this component summary table represent necessary activities for health care transformation across multiple health system actors including the State of Michigan (e.g., the State Innovations Model Executive Team, the State Innovations Model Leadership Team, designated SIM Commission and its committees, and the Michigan Department of Health and Human Services, including the Medicaid department), Medicaid Managed Care Organizations, commercial payers, participating providers, and other actors.

The State of Michigan will include expected expenditures and a view on expected vendor support by activity category as our budget and vendor selection process is finalized.

Table B2.3 CHIR Component Summary Table

Activity Category	Activity	Driver	Measure
CHIR Program Initialize / Monitor & Control	Develop/verify governance model and processes		
	Develop communication plan for CHIR/backbone outreach and schedule onsite visits, conference calls, etc		
	Establish governance cadence: <ul style="list-style-type: none"> • Bi-weekly (or as otherwise determined) meetings • Financials invoices Quarterly progress reports		
	After CHIP/Ops plan implementation begins establish yearly reviews and onsite visits		
	Develop CHIR performance improvement plans and/or expel practices that do not comply with eligibility and technical requirements		
	Monitor CHIR eligibility and compliance with technical requirements and milestones		
	Develop CHIR strategy/approach for verifying and enforcing technical requirements and milestones post enrollment		

Backbone Outreach / Onboarding	Validate strategy/approach for participant recruitment & enrollment		
	Refine technical requirements & qualifications for CHIRs		
	Select CHIR test sites		
	Select & Onboard Backbone organizations		
	Build / modify process for participants to enroll and qualify for CHIRs		
	Disperse administration funds		
	Design CHIR grant program		
	Revisit and/or amend contracts regularly based on monitoring and enforcement mechanism		
	Manage re-contracting process for test participants		
	Develop approach for a single community wide Community Health Needs Assessment		
	Assess viability for setting up CHIRs in additional regions		
	CHIP / Ops Plan Development, Update, & Review	Launch test sites	
Share and finalize test model design with CHIR oversight committee and test participants			
Execute MOAs/MOUs with CHIR participants			
Finalize/Approve CHIR CHIPs / Ops Plans			
Finalize TA / Resource List			
Yearly CHIP / Ops Plan Updates			
Complete CHIR capacity assessments			
CHIP / Ops Plan Implementation / Operations	Define expectations for how CHIR administrative activities and programs will be funded		
	Launch CHIR grant program		
	Distribute CHIR grant funding for selected participants		
	Implement Operational Plans		
	Execute vendor contracts		
	Assess viability for CHIRs to be funded through a portion of PCMH / ASC Shared Savings		
Reporting & Metrics	Define CHIR metrics		
	Design report templates		
	Develop strategy to gather non-claims data, if any for reports		

	Develop approach for report generation/quality metric entry		
	Develop business requirements		
	Develop/purchase reporting software as needed		
	Gather data		
	Generate reports		
	Distribute reports		
	Determine refinements/additions to reports and data collection methodologies		
Collaborative Learning Network	Design provider education/engagement strategy approach, for both outbound and inbound communication for CHIRs		
	Equip CHIR participants: curriculum, training		
	Update support system, as needed		
	Develop/obtain CHIR education material, videos, curriculum, etc.		
	Distribute participant education materials		
	Address participant inquiries/appeals		
	Engage/consult to CHIRs and assign coaches		
	Address design inquiries		
Technology	Collect and share best practices through Learning Health Systems		
	Develop/purchase hub technology as needed		
	Develop/purchase Dashboard technology as needed		
	Design/Develop/Implement data flow for measure/metric aggregation		
	Design/Develop/Implement data flow for HPD, ACRs, Common Key		

Accountable Systems of Care

An Accountable System of Care (ASC) is an organization of providers that comes together for the purpose of collaborating and coordinating care across the health care continuum. Up to nine ASCs will operate within the five State Innovation Model (SIM) test regions across the state. Each ASC will be required to actively participate in the Community Health Innovation Region in its region, must include primary care providers (PCPs), and may formally include other provider and facility types, e.g. cardiologists, oncologists, endocrinologists, behavioral health professionals, hospitals, and health systems. If these types of additional

providers are not formally included in the ASC, the ASC must show that it has developed strong referral relationships with these providers.

The Role of Accountable Systems of Care

The ASC will organize a broad range of providers into a clinically integrated network that shares accountability for coordinating care across care settings and for delivering high-quality, cost-effective care within their care settings.

The Patient-Centered Medical Home (PCMH) will continue to serve as the principal agent “quarterbacking” the care of patients within an ASC. However not all PCPs in an ASC must be certified as a PCMH. Each ASC will be required to have a minimum percentage of PCPs in its network that are certified as PCMHs and work with its other PCPs to become certified.

The ASC will drive clinical integration across PCPs (both those that are PCMHs and those that are not) and other participating providers by:

- Enabling coordinated care – including systems, relationships, and workflows – across the care continuum,
- Planning for transitions of care, e.g. coordinate inpatient discharge
- Enabling clinical data interoperability
- Pooling resources via increased scale (e.g. access to ASC-level resources)
- Providing a platform for shared services to nested PCMHs (e.g. quality improvement, data collection)
- Engaging supportive healthcare services outside the ASC
- Promoting clinical and behavioral health integration

As noted above, ASC networks must include PCPs. In addition, ASCs will need to include formally, or have relationships with, a spectrum of providers along the health care continuum who have committed to delivering high-quality, cost-effective care and coordinating care.

At a minimum, participating ASCs must be capable of:

- Organizing, standardizing, monitoring, and improving clinical care processes across a network of Providers including primary care, specialists, behavioral health, and hospitals,
- Signing contracts with (multiple) payors based on the new payment models being tested,
- Conducting legal and financial transactions among providers that are participating as part of the ASC, and
- Being accountable for cost, quality and health outcomes of a defined population, covering at least 1,000 attributed patients for each payor with whom the ASC contracts.

In order to share in savings, an ASC must have a minimum of 5,000 attributed patients across payors, and to share in both savings and risk, an ASC must have a minimum of 10,000 attributed patients.

Patient Inclusion and Attribution

ASCs will serve the needs of a broad array of individuals (e.g., healthy individuals, those with single or multiple chronic diseases) enrolled in Medicaid managed care. ASCs will be required to develop targeted initiatives focused on improving care for the high priority populations including emergency department super-utilizers, high-risk pregnancies, and patients with multiple chronic conditions.

Consistent with the PCMH initiative, the following Medicaid populations will be excluded from participating as part of an ASC for purposes of SIM. Please see the Care Delivery PCMH section of this document for a full list of exclusions. Over time, Michigan would like to expand the reach of ASCs to include the Medicaid population that is not enrolled in managed care.

Individuals will be attributed to an ASC based on their selection of a PCP. If an individual selects or is assigned to a PCP that is part of an ASC, then the individual will be attributed to the ASC. The current Medicaid Health Plan (MHP) -administered system of attribution, including auto-assignment algorithms, would continue unchanged: 1) beneficiary chooses health plan and PCP; 2) if beneficiary does not choose an MHP, s/he is assigned one; and 3) if beneficiary does not choose a PCP, the MHP assigns a PCP.

Attribution to an ASC will be linked to the location of the PCP, so that all Medicaid managed care members being seen at a PCP site that participates in an ASC are attributed to the ASC regardless of whether or not the Medicaid member resides within a SIM test region. Attribution to the ASC will not be limited to Medicaid members that reside within boundaries of a SIM test region.

Care Delivery Committee

A specific Care Delivery Committee will be established to provide clinical and operational input and recommendations on decisions related to the PCMH and ASC components. The governance body will include a range of clinical staff (primary care, behavioral health, and specialty providers), administrative/ financial staff, physician organization representatives, and payor representatives and will drive to agreement on issues related to accreditation, attribution, and metrics.

Value-based Payment Models to Support Accountable Systems of Care

ASCs combine delivery system reform (organization of provider networks for collaboration and coordination) with payment reform (tying payment to value – including a combination of cost containment and quality performance measurement). The ASC payment model, which builds the potential for providers to share in savings and/or risk based on performance on cost and quality measures, fits within Category 3 of

the Health Care Payment Learning and Action Network (LAN) alternative payment model (APM) framework.

An ASC's participating providers will deliver care to patients and will be reimbursed according to their current network provider contracts with health plans. To implement the ASCs for Medicaid, new ASC payment models for retrospective shared savings/risk will augment and leverage the existing MHP provider contracts. Similarly, commercial payors that contract with ASCs may do so on top of their current contracting mechanism with individual network providers. Over time, ASCs may transition to a prospective population-based payment model.

If an ASC achieves cost savings and meets quality targets for its attributed population, it will be eligible to share in savings. An ASC may also agree to take on financial risk, with potential for greater financial reward of savings, if it has a minimum membership level (e.g., 10,000 attributed lives) and meets financial stability requirements.

To determine whether an ASC is eligible to share in savings or risk for a given performance period, the State will determine a risk-adjusted Total Cost of Care (TCOC) for the attributed population. While the State is finalizing its TCOC methodology, the aim is to include as comprehensive a set of services as possible to reduce potential for cost shifting across funding streams. The State also intends to include care coordination fees paid to PCMHs as part of its TCOC calculation. If it is not possible to include acute, behavioral health and some Long Term Services and Supports (LTSS) up front in the TCOC, the State plans to phase in the inclusion of each of these services into the TCOC over time.

The State will conduct a retrospective reconciliation, comparing estimated to actual cost of care for attributed patients in each ASC to consider whether there have been any cost savings attributable to the ASC. Prior to sharing in any savings, the State will also measure the ASC's performance relative to quality benchmarks. If quality benchmarks are met, and if the ASC meets a minimum savings threshold (e.g., 2 percent), ASCs will be able to share in savings.

The potential for providers to share in savings through ASCs will have direct impact on provider behavior, promote provider flexibility and innovation, align incentives with desired behaviors/health care transformation goals, and avoid adverse incentives. ASCs will be required to share a minimum percentage of savings with PCPs. ASCs will have flexibility as to how the remainder of savings is shared, including sharing a greater percentage with the PCPs.

Care Coordination Fees

PCMHs that participate in ASCs will continue to directly receive care coordination payments to compensate practices for performing care coordination functions not traditionally covered under fee-for-service payment models. Care coordination fees represent category 2 payments under the LAN APM framework: fee-for-

service with a link to quality. These care coordination payments will be made directly to PCMHs on a per-member-per-month basis.

ASC Measures and Accountability

ASCs will be required to report on key measures of clinical quality and patient experience and meet minimum performance standards for a subset of key measures to participate in any shared savings arrangements.

To ensure that there is as little burden as possible and increase alignment and collaboration across involved entities, the proposed measure set aligns the quality metrics to be used for both ASCs and PCMHs with those used to measure MHPs, to the extent possible.

ASC performance monitoring requires a number of capabilities by different types of partners: ASCs, PCMHs, MHPs, data aggregator vendor and other payors. For example, initially, ASC performance monitoring requires:

- ASCs to have the capability to readily access, download, and utilize timely reports on key measures of clinical quality and patient experience.
- MHPs to continue supplying timely and accurate claims and encounter data to Michigan Department of Health and Human Services (MDHHS).
- The State to build new or leverage existing data infrastructure to:
 - Standardize claims and encounter data from participating payors.
 - Calculate performance metrics.
 - Display ASC dashboards.
 - Make data and information available to ASC providers through an ASC portal.

Preliminary data aggregator requirements have been drafted for SIM and will be aligned with final Model Test operational plans

ASCs will have responsibility for assisting providers (including PCMHs) in using performance data to improve systems of care and address gaps for specific patients. Any selected ASCs will have developed the capacity necessary to perform this role.

Quality Metrics

The ASC Initiative will utilize the core set of 27 quality measures established by the Physician-Payor Quality Collaborative (PPQC) the foundation for shared savings linked quality thresholds. These metrics include:

Adult BMI Assessment	Childhood Immunization Status	Well Child Visits 15 months	Well Child Visits 3-6 years
Colorectal Cancer Screening	Immunizations for Adolescents	Adolescent Well Care Visits	Follow-up for ADHD
Appropriate Treatment for URI	Appropriate testing for pharyngitis	Lead Screening	Imaging Studies for Low Back Pain
CDC: Hemoglobin A1c Testing	CDC: Hemoglobin A1c Poor Control	CDC: Eye Exam Performed	CDC: Medical Attention for Nephropathy
CDC: Blood Pressure Control	Controlling High Blood Pressure	Weight Assessment + Counseling	Tobacco Use Screening and Cessation
Screening for Depression + Follow-up	Avoidance of Antibiotics for Bronchitis	Prenatal & Postpartum Care	Cervical Cancer Screening
Breast Cancer Screening	Chlamydia Screening	Antidepressant Medication Management	

The Care Delivery Committee within the SIM Commission will review the metrics above and recommend a potential subset to be used in year one. SIM's governing body will review committee recommendations, evaluation requirements and program goals when determining final metrics and targets. SIM component metrics will be reviewed on an annual basis for new and planned additions, removals and updated performance thresholds and accountability targets. Initial accountability targets and metrics are outlined in section A3 (Core Metrics and Accountability Targets).

Implementation and scale-up plan

ASCs will be implemented in the five SIM test regions. Each ASC will be required to meet the State's certification guidelines. See Section D (Appendix) for Draft ASC Certification Guidelines. To participate, ASCs will need to be certified by the State, unless the organization is the same legal entity that currently has a participation agreement with the Center for Medicare and Medicaid Services (CMS) as a Medicare Shared Savings Program (MSSP) or a Next Generation Accountable Care Organization (ACO). If the potential ASC participates as the lead organization in MSSP or a Next Generation ACO, the State will allow the potential ASC to attest to meeting the ASC requirements.

The State has identified nine potential ASCs within the five SIM test regions. The SIM team will work with identified ASCs initially to support the activities required for SIM ASC certification and implementation in early 2017. Depending on ASC readiness, organizations may begin contracting with MHPs in or after January 2017.

Plan to be Multi-payor

By modeling the ASC program in part on the MSSP, Next Generation ACO, and current activity in the commercial market, the ASC is aligned with multiple payor efforts in the state. While ASCs will not be statewide during the SIM grant, MHPs and other commercial payors can and will continue to contract with ASC-like entities to meet goals of increased implementation of alternative payment models in both the Medicaid and Commercial market.

Integration With Other Care Delivery Models

The ASC model being implemented in Michigan is explicitly linked to both PCMH and the CHIRs. ASCs will leverage PCMHs as the core of their organizational structure and the key to attribution of members. While not all primary care providers in an ASC will be required to be PCMHs, the State will require increasing adoption of PCMH across the State and within ASCs. The ASC model will build on practice transformation of PCMHs, and increase collaboration and coordination across multiple provider types across the continuum of care.

ASCs will be required to participate actively in CHIRs and must attest to their willingness to participate as part of their certification process. ASCs and CHIRs will work together to focus on population health needs in their particular region and will further expand the scope of coordinated care by addressing patients' other determinants of health by linking to supportive and wellness services. CHIRs will take a population-based approach to addressing the health and wellness needs of ASCs patients.

As noted above, the ASCs will be implemented through contracts with the State's MHPs. These MHPs are paid a capitation, which encourages efficiency. Their provider networks, however, generally continue to receive fee-for-service payments. To drive transformative change, incentives between the MHP and contracted providers must be aligned. ASCs, built on payment models that promote efficiency and high quality care, are vehicles to align incentives vertically. By creating shared accountability through risk-based arrangements with ASCs, MHPs can better align the financial incentives of the provider community with their own financial incentives. MHPs¹ that serve Medicaid members in at least one of the five SIM test regions will be required to make a good faith effort to contract with ASCs. An MHP will not be required to contract with an ASC if the ASC would be expected to have less than 1,000 MHP members attributed to the ASC based on the ASC PCP network and the MHP members attributed to those PCPs. MDHHS Manage Care

¹ The eight MHPs who operate in SIM Test regions include: Aetna; Blue Cross, HAP, McLaren, Meridian, Molina, Priority and United.

leadership will delineate expectations regarding MHPs' roles in implementation of the ASC financial model, including obligations regarding calculation and payment of shared savings and/or collection and analysis of ASC quality performance measures.

Accountable Systems of Care: Component Summary Table

The following table defines the steps that will be taken to implement ASC. These steps align with the steps outlined in the master timeline in Section A4 of this operational plan. The activities in this component summary table represent necessary activities for health care transformation across multiple health system actors including the State of Michigan (e.g., the SIM Executive Team, the SIM Leadership Team, designated SIM component projects and related committees, and the MDHHS, including the Medicaid department), MHPs, commercial payors, participating providers, and other actors.

The State will include expected expenditures and anticipated vendor support by activity category as budget and vendor selection process is finalized.

Table B2.3 ASC Component Summary Table

Party	Readiness	Impact
<i>Contracting and Payment</i>		
MDHHS	<ul style="list-style-type: none"> • Participation expectations for ASCs are in draft form and must be finalized and vetted with stakeholders prior to launch • Requirements to coordinate care management between ASCs and MHPs should build off of PCMH care coordination expectations • The ASC payment model must be finalized; drafts have been prepared; recommendations must be made for: <ul style="list-style-type: none"> ○ an acceptable methodology for calculating ASC TCOC benchmarks ○ use of quality gates or ladders, risk corridors, and risk sharing levels • Must confirm that no new waivers are necessary • A monitoring plan must be developed and implemented 	<ul style="list-style-type: none"> • In the short term, MDHHS can subcontract for tasks in order to be ready for launch in FY17; however, MDHHS Medical Service Administration (MSA) staff will need to provide feedback and guidance as well as participate in stakeholder engagement throughout 2016 • Ongoing ASC design sessions with MHPs and State • MDHHS or an actuarial contractor will have to: <ul style="list-style-type: none"> ○ calculate ASC specific benchmarks for shared savings ○ calculate TCOC for each ASC and resulting ASC payment balance ○ communicate the share of savings to be paid by each MHP to each ASC
MHPs	<ul style="list-style-type: none"> • Some MHPs are already implementing alternative ASC-type payment models • MHP engagement with SIM has not fully begun 	<ul style="list-style-type: none"> • MHPs in areas where ASCs operate will need to make a good faith effort to contract with ASCs. MHPs will be asked to include certain ASC participation requirements and payment model language in new contracts between the MHPs and the ASCs <ul style="list-style-type: none"> ○ MHPs will need to review and comment on ASC requirement and payment language • According to proposed timeline MHPs must be ready to disburse shared savings payments annually beginning in Summer/Fall 2018 • ASC providers will be required to accept Medicaid beneficiaries – this could bring new providers into MHP networks

ASCs	<ul style="list-style-type: none"> • ASCs that were interviewed for SIM report readiness to implement shared savings, and in most cases are similarly reporting for Medicare • Contractual relationships and infrastructure are largely in place as determined through surveys and interviews • ASCs require data and increased analytic capability and HIT/HIE infrastructure to manage population health • ASCs report provider engagement in transformation as an ongoing area of focus • Majority of ASCs have requested to participate in Collaborative Learning Networks 	<ul style="list-style-type: none"> • During the remainder of FY16, ASCs will work with SIM staff and subcontractors to: <ul style="list-style-type: none"> ○ develop an operational plan to ensure readiness to comply with administrative requirements beginning FY17 ○ enhance community linkages through CHIR participation • ASCs may require new contractual relationships with providers as well as new processes for patient engagement • ASCs will need to demonstrate readiness to fulfill the terms of the participation agreement to the State prior to the effective date of contracts between the ASCs and the MHPs • ASCs will need to contract with MHPs based on program requirements
Providers	<ul style="list-style-type: none"> • Because of the variation in provider readiness, the SIM ASC component is recommended for testing rather than statewide implementation • Many providers in MI currently participate in Medicare ACO models and other related commercial models, and are well poised to participate as ASCs. • PCMH and other initiatives (see above) have prepared a significant number of providers to move to ASC-type payment reform 	<ul style="list-style-type: none"> • To avoid significant administrative complexity it is highly recommended that PCPs be a member of only one ASC • This need not necessarily limit PCP ability to work with multiple health systems and specialists – who can work with multiple ASCs • In many markets ASCs will be led by health systems which provide administrative capacity – in such markets independent PCPs may choose to join a physician-led Provider Organizations or Independent Practice Association (and most already are members of such entities)
Medicaid Beneficiaries	<ul style="list-style-type: none"> • The ASC model should be invisible to the beneficiary, except for the messaging that his/her care team is working to provide higher quality, better coordinated, patient-centered care, and that his or her team has developed preferred relationships with other providers to facilitate effective coordination 	<ul style="list-style-type: none"> • While beneficiaries may continue to select their providers as before, there are advantages in terms of better coordinated care when they remain within the ASC for their care

Data Aggregation To Support Attribution, Shared Savings, and Performance Measurement

<p>MDHHS</p>	<ul style="list-style-type: none"> ● MDHHS already requires MHP submission of claims and encounter data into a data warehouse that will support TCOC and shared savings calculations ● MDHHS has made investments in the following infrastructure that will be further developed: <ul style="list-style-type: none"> ○ Data aggregator vendor (attribution dissemination, performance metric calculation, data standardization for evaluation/performance monitoring, provider portals/dashboards) ○ Health Provider Directory (provider/ASC affiliation) ○ Active Care Relationship Service use case (attribution reconciliation) ● MDHHS has participated in the existing Physician Payor Quality Collaborative (PPQC) which has: <ul style="list-style-type: none"> ○ selected core clinical metrics ○ developed a plan to pilot test submission based initially on the BCN format already in use for MiPCT ○ convened payors who are in discussions to align incentive programs around core metrics 	<ul style="list-style-type: none"> ● Business Requirements need to be developed and include: <ul style="list-style-type: none"> ○ Upgrades to MMIS ○ Submission of Medicaid data to the data aggregator vendor ○ Additional investments in the data aggregator vendor and Michigan Health Information Network use cases ● ASC success requires access to Medicaid claims data, this may require MDHHS to: <ul style="list-style-type: none"> ○ Work to make CC360 data available to participants ○ Sign DUAs with ASCs ● Continued MDHHS participation in multi-stakeholder collaboration, including alignment of Medicaid quality metrics building on the PPQC
<p>MHPs</p>	<ul style="list-style-type: none"> ● Attribution will not change initially from current PCP assignment methods ● MHPs will continue to submit claims and encounter data to MDHHS via Community Health Automated Medicaid Processing System 	<ul style="list-style-type: none"> ● MHPs will need a system to access and track PCP/ASC affiliation data in order to track beneficiary attribution ● MHPs will likely want to verify State shared savings calculations, which will require building TCOC algorithms

<p>ASCs</p>	<ul style="list-style-type: none"> • Disbursement of the patient attribution list will rely on existing process and the data aggregator vendor’s data infrastructure. Nearly all potential ASCs participate in MiPCT, and are familiar with this process. • Initial quality metrics will be claims-based, and/or those selected by the multi-stakeholder PPQC • MiPCT participating ASCs have been sending eCQMs to the data aggregator vendor in a format first specified by Blue Care Network • Due to Blue Cross Blue Shield Michigan Physician Group Incentive Program requirements, most ASCs already have capability to submit ACRS files • Many potential ASCs are already able to share attribution and performance data with their affiliated providers 	<ul style="list-style-type: none"> • With TCOC responsibility, it will be more urgent for ASCs to reconcile any discrepancies in patient attribution records with those of MHPs and other participating payors; this will be facilitated through ACRS use case in future years • ASCs will be required to report provider affiliation through state determined process • ASCs will continue to enhance eCQM submission • ASCs will continue to work with participating providers to share with them attribution and performance data
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Patient-Centered Medical Home

Special Note: The PCMH section of this draft operational plan for public feedback contains limited content and specificity due to recent Centers for Medicare and Medicare Services (CMS) announcements regarding multi-payer primary care programming. MDHHS is currently considering the impact of CMS’ announcements on the Michigan SIM PCMH efforts and will be providing a more detailed view of the SIM PCMH work during a webinar on May 11, 2016 at 3:30pm.

The Patient-Centered Medical Home will serve as the patient’s primary touch point with the health care system. It will promote and oversee the delivery of coordinated care across providers and will effectively engage consumers to improve health and health outcomes. In doing so, the Patient-Centered Medical Home will improve the health of Michiganders through a range of levers including improved care coordination and chronic disease management as well as primary and secondary prevention.

The role of the Patient-Centered Medical Home will be to deliver high-quality, efficient primary care; promote the delivery of integrated and coordinated care; and to collaborate with high-value downstream providers.

Patient-Centered Medical Homes will drive health improvements and cost avoidance through several sources of value in both the near and longer-term, including care coordination and chronic disease management, effective diagnosis and treatment setting, referral to high-value providers/facilities, reduction in emergency department utilization and other forms of acute care, secondary prevention, and primary prevention.

In addition to delivering high-quality, efficient primary care, Patient-Centered Medical Homes will be responsible for serving as the “quarterback” for primary care by coordinating across multiple providers and care settings to understand and holistically address the health needs of each patient. Patient-Centered Medical Homes will fulfill these aims through:

- Development of personalized, patient-centered care plans;
- Team-based delivery of comprehensive, highly accessible healthcare and care management services;
- Coordination and support for effective transitions of care;
- Provision of referral decision support, scheduling and follow-up;
- Collaboration and intentional interfacing with other providers to promote an integrated treatment approach;
- Engagement of supportive services through community-clinical linkages;
- Leadership in patient education, self-care and caregiver engagement;
- Utilization of registry functionality and technology-enabled quality improvement strategies to support population health.

Value-based payment models will be provided to support these PCMH practice capabilities and transformation.

Plan to be multi-payor

The Patient-Centered Medical Home will be a multi-payor effort. MDHHS will take a lead role in Patient-Centered Medical Home implementation (e.g., including facilitating establishment of necessary performance measurement and payment mechanisms). Our intention is for PCMH transformation in Michigan to include and be supported in partnership with Medicaid managed care organizations, Medicare, and commercial payors. We are seeking participation of Medicare in advanced primary care activities in the state and currently considering multiple approaches including the Comprehensive Primary Care Plus program and custom Medicare participation in SIM demonstration option. We are also continuing conversation with commercial payor partners.

Value-based payment model to support Patient-Centered Medical Homes

The value-based payment models under Michigan’s health strategy care transformation will reflect aspects of guidance on alternative payment models recently released by CMS via the Health Care Payment Learning and Action Network. This guidance includes four categories of payments that describe the progressive relationship between payments and the link to quality and value (note Michigan’s Patient-Centered Medical Home model will include some but not all of these categories):

As the guidelines describe, movement from category 1 to category 4 requires increasing levels of provider accountability for total cost of care and quality of care, and an increasing focus on population health

management. The Patient-Centered Medical Home payment model– and the Accountable Systems of Care payment model– will reflect these priorities as well as a “glide path” for transitioning to APMs by providers.

The Patient-Centered Medical Home payment model will support Patient-Centered Medical Home strategy objectives to transform the healthcare ecosystem and advance the Triple Aim goals of improved quality, improved access, and cost avoidance. Patient-Centered Medical Home payments will reflect several guiding principles: payment streams will have direct impact on provider behavior, enable provider flexibility and innovation, not expose providers to undue risk, and minimize adverse incentives.

Participating payors will adopt standardized metrics on a common provider scorecard which supports and ensures accountability for the PCMH payment model. Common metrics being established through the Michigan State Medical Society Physician Payor Quality Collaborative will be utilized to the fullest extent that they align with Michigan’s goals for care delivery transformation and Triple Aim goals.

Work Groups and Committees: Patient-Centered Medical Home and Accountable Systems of Care

A work group and / or committee within the SIM governance structure will provide clinical and operational input and recommendations on decisions related to the Patient-Centered Medical Home and Accountable Systems of Care. This body will include a range of health care providers (e.g., primary care, behavioral health, and specialty providers), representatives from provider organizations, representatives from the MDHHS, and representatives from payor organizations.

This body’s mandate as it pertains to Patient-Centered Medical Homes will be to review and make recommendations regarding PCMH capabilities and expectations, prioritize participation requirements for Michigan’s Patient-Centered Medical Home Initiative, and review PCMH Initiative design and strategies to offer constructive feedback for improvement and advancement.

Implementation and scale-up

Given existing experience with the Patient-Centered Medical Home model in Michigan, the Patient-Centered Medical Homes meeting participation requirements within SIM’s 5 regional test locations (Jackson County; Muskegon County; Genesee County; Northern Region; and the Washtenaw and Livingston counties area) in addition to existing MiPCT practices outside SIM’s regional test locations will be offered an opportunity to participate. An intent to participate process will be initiated with these PCMHs in May 2016. Formal applications to participate will start as early as June 2016, but may not be complete until Fall 2016. Further announcements will provide more specific instructions for those wanting to participate. PCMH year 1 participation will begin January 1st, 2017. Additional Patient-Centered Medical Homes will be enrolled in annual waves.

3 – Risk Assessment and Mitigation Summary

In Development

C. General SIM Operational and Policy Areas

1 – SIM Governance, Management Structure and Decision-making Authority

Governor’s Office Engagement

Michigan’s Department of Health and Human Services (MDHHS) Director Nick Lyon, as a member of the Governor’s Cabinet, routinely updates Governor Snyder on the progress and accomplishments of the Michigan State Innovation Model Test team as well as the broader state of health care and innovation efforts in the state. The Governor is engaged in, and supportive of, the state’s efforts to create a more sustainable, efficient, and effective health care system. Further, a Governor’s office representative is included on the SIM Executive Stakeholder team, fostering additional communication, interaction and alignment with state executive leadership.

Governance and Management Structure

The State Innovation Model (SIM) Test components Michigan has selected to implement require a broad representation of the State’s Department of Health and Human Services (MDHHS) decision-makers, subject matter experts and operational specialists along with other public and private stakeholders and participants. To meet these unique requirements, a governance and management structure has been developed to support the implementation and operational needs by maximizing the flow of information from, and among, stakeholders to the appropriate program decision-making, development and implementation teams. A robust SIM program-level governance structure, fully integrated with component-specific bodies, public/private committees, and addition project teams and subject matter work groups has been established. The Michigan SIM Test program and operational governance design maximizes the engagement of key State, public and private stakeholders with the program design, implementation and operational teams while ensuring an appropriate matrix of oversight, management and accountability.

Throughout the lifecycle of SIM implementation and operationalization the SIM teams will supplement the formal governance, committee, and operational structure with additional stakeholder engagement for broad-based input. These stakeholder engagement forums will include preliminary and participant focus groups and engagements, statewide public outreach events, and targeted participant preparedness workshops, and other component-specific and learning sessions. Please see section C2 (Stakeholder Engagement) of this plan for detailed stakeholder engagement strategy. The overall governance approach and structure will be assessed regularly to ensure effectiveness and modified, as needed, to better meet overall program needs. The structure has been designed to deliver quality implementations and meet timeline and integration goals.

High-Level Organization Chart

The following diagram represents the organizational structure and relationships among primary and secondary component teams, initiative management, vendors, governance and other key facets of the framework that encompasses the State Innovation Model (SIM) Test landscape in Michigan. Information on key personnel for each business or integration unit in the SIM organization chart is listed in Figure C1.1 (Michigan SIM Organizational Chart).

Figure C1.1 Michigan SIM Organizational Chart

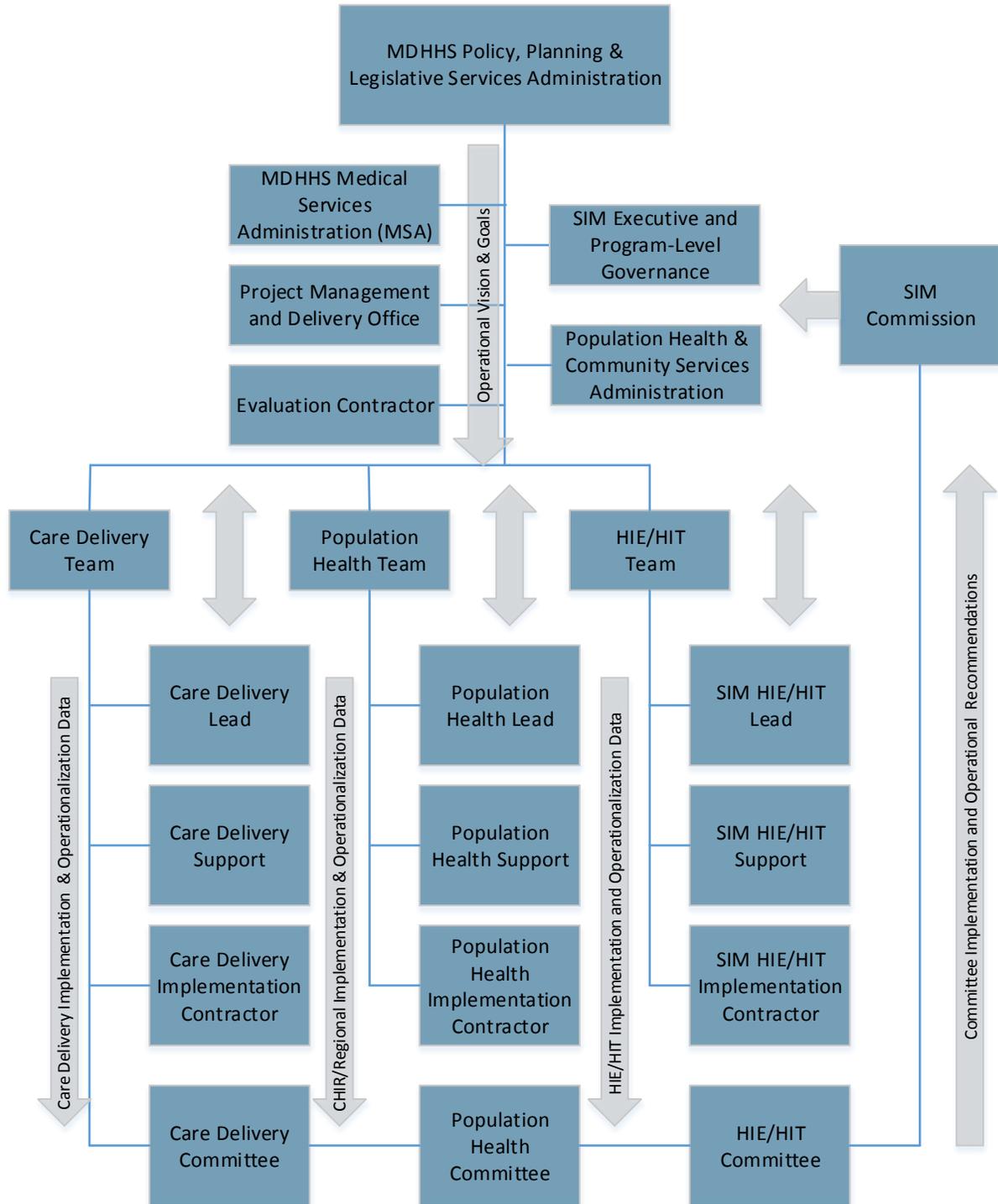


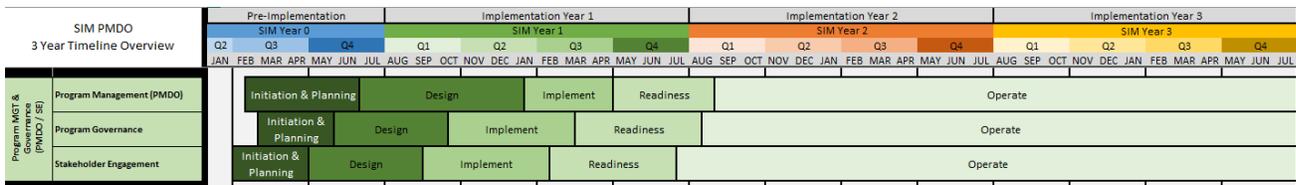
Table C1.1 SIM component Key Staff Directory

Component/Area	Position/Title	First Name	Last Name
Program Management and Governance	Program Director	Elizabeth	Hertel
Program Management and Governance	Program Lead	Thomas	Curtis
Care Delivery	Care Delivery Lead	Phillip	Bergquist
Population Health	Population Health Lead	Earnest	Cawvey
Program Management and Governance	Technology Lead	Kim	Bachelder
Program Management and Governance	Program Manager	Andrew	Spencer
Program Management and Governance	Program Manager	Mark	Cascarelli

Michigan’s SIM Test Governance and Operational Framework

Expanding on the organization framework (Figure C1.1 Michigan SIM Organizational Chart) the following narrative fleshes out the constituent component teams (core and supporting) across governance, management, implementation and operational perspectives. Stakeholder engagement and public/private collaboration is also represented. The subsequent narratives section provides additional detail regarding the guiding framework, processes and operational aspects key to initiating, planning, designing, implementing and operating the SIM model test components.

Program Governance and Management Timeline



SIM Executive Stakeholders

The SIM initiative has the full support of, and direct oversight by, a broad representation of State executives across agencies and branches. The SIM Executive Stakeholders are an identified group of State officials with the authority and influence to drive policy, legislation and internal support for the SIM components’ planning, implementation and operationalization activities. Coordinating other State departments, outside the

Department of Health and Human Services, is a key lever in ensuring innovation is executed, recognized and disseminated across agency and statewide. The Executive Stakeholder body receives detailed quarterly reports and is provided additional information as needed or requested.

Table C1.2 SIM Executive Stakeholders

SIM Executive Stakeholders	
Name	Title
Nick Lyon	Director, Dept. of Health & Human Services (MDHHS)
Tim Becker	Sr. Chief Deputy Director, MDHHS
Kurt Krause	Director, MDHHS Legal Affairs Administration
Chris Priest	Director, MDHHS Medical Services Administration
Elizabeth Hertel	Director, MDHHS Policy, Planning & Legislative Services
Geralyn Lasher	Director, MDHHS External Affairs & Communication Administration
Linda Zeller	Director, MDHHS Behavior Health & Developmental Disabilities Administration
Terry Beurer	Director, MDHHS Field Operations Administration
Linda Pung	General Manager for MDHHS, Michigan Department of Technology, Management & Budget (MDTMB)
Sue Moran	Director, MDHSS Population Health & Community Services Administration
Chris Harkins	Director, Office of Health and Human Services at State Budget Office
Jamie Zaniewski	Advisor, Office of the Governor
Joshua Traylor	Michigan CMS/CMMI Liaison

SIM Executive Governance Team (Vision)

SIM Executive Team members are those executives within the State directly responsible for executing the State’s vision of a redesigned health care system. The SIM Executive Team establishes a clear vision for SIM that aligns with the broader requirements, State health goals and external stakeholder interests. The composition of the SIM Executive Team is a select sub-set of the Executive stakeholders leading offices, agencies and bureaus that are integral to the implementation and operationalization of SIM components in Michigan. This is an official governing body that convenes quarterly to review plans, progress, issues, risks and outcomes and recommends/approves potential changes to the high-level scope and vision of the SIM initiative in Michigan. This group convenes quarterly and is supplied monthly program status reports and additional information as needed or requested.

Table C1.3 SIM Executive Governance Team Roster

SIM Executive Governance Team Roster	
Name	Title
Elizabeth Hertel	Director, MDHHS Policy, Planning & Legislative Services
Kathy Stiffler	Director, Bureau of Medicaid Care Management & Quality Assurance
Karen Parker	Director, MDHHS Business Integration Center Administration
Chris Priest	Director, MDHHS Medical Services Administration
Linda Zeller	Director, MDHHS Behavior Health & Developmental Disabilities Administration
Sue Moran	Director, MDHSS Population Health & Community Services Administration

SIM Program Governance Team (Strategy)

The SIM Program Team established the SIM strategic plan which defines the programs goals, objectives, detailed components’ scope, implementation plans, metrics and performance measurements. The strategic plan and operational framework is the foundational basis of SIM in Michigan and serves as the framework for implementation-level planning, execution and operationalization. The SIM Program Team is ultimately accountable for the successful execution of the program and maintaining alignment with the State and MSHHS’ executive vision. Members provide direct program oversight and have final approval for all matters pertaining to the SIM program including resources, budget, and scope. The body convenes monthly, receives monthly program and weekly component status reports and additional information as requested. To ensure continued alignment of the SIM objectives throughout implementation, the SIM Program Governance Team directs, and may hold, key SIM Program Management and Delivery Office positions.

Table C1.4 SIM Program Governance Team Roster

SIM Program Governance Team Roster	
Name	Title
Elizabeth Hertel	Director, MDHHS Policy, Planning & Legislative Services

Tom Curtis	MDHHS SIM Business Owner
Cynthia Green-Edwards	Director, MDHHS Supporting Services Bureau
Dr. Clare Tanner	SIM Lead, Michigan Public Health Institute
Phillip Bergquist	MDHHS SIM Care Delivery Business Owner
Meghan Vanderstelt	MDHHS SIM HIT/HIE Business Owner
Kathleen Stiffler	Director, Bureau of Medicaid Care Management & Quality Assurance
Linda Scarpetta	Director, Division of Chronic Disease and Injury Control

SIM Program Management and Delivery Office

The MDHHS has chartered a special-purpose program management office, the SIM Program Management and Delivery Office (PMDO), to manage the overall SIM initiative, governance and component implementations in Michigan. The PMDO plays a critical role in driving the successful delivery of State Innovation Model implementation and operational test goals. The PMDO is accountable for integrated planning, design, implementation and coordinated operationalization between the component, participant and stakeholder entities and governance bodies' functions and processes that need to come together efficiently and collaboratively in order to achieve the State's SIM Test goals. The PMDO will include program and project professionals, MDHHS SIM program leadership and business owners as well as skilled State and other professional resources across Care Delivery, Payment Reform, Population Health, HIT/HIE and Delivery Support areas. A detailed description of the PMDO including specific roles and responsibilities can be found in the sub-section below.

SIM Intra-and Inter-Departmental Collaboration

The State Innovation Model initiative is ensuring visibility by convening, and keeping regularly informed, a broad group of State stakeholders and potentially impacted functional area leaders. This engagement activity includes the Subject Matter Expert Management Team meetings, Michigan Department of Health And Human Services Project Management Office's Business Integration Center and focused SIM Component Project Planning, Implementation, Operational Teams and Work Groups.

Public/Private SIM Commission

The SIM Commission will serve as the primary public/private body charged with tracking progress and effectiveness of the initiative and advise the state leadership during the implementation of the Model Test components. The commission will offer guidance and perspective on overarching model test decisions. It will also review consensus recommendations made by committees and, where differences exist, make recommendations to department leadership on how to resolve them.

The SIM Commission will include senior-level state planners from MDHHS, the Governor's office, key contractors, and executive leaders from participants in the model test as well as non-participants whose

engagement, support and influence will be important for expanding the model component and concepts in the state (i.e., scaling up). The group is likely to comprise approximately 20 people, and will meet bi-monthly. In addition to the primary commission, committees will be established around the core SIM components outlined in sections B1 and B2 of this plan. The committees planned include;

- Population Health Committee (CHIR/CLN Focus)
- Care Delivery Committee (ASC, PCMH, Payment Reform)
- HIT/HIE Committee (Infrastructure Capabilities & Reporting)

A full representation of the SIM Commission, and its constituent committees, their composition and detailed charge is covered in section C2 (Stakeholder Engagement).

MDHHS Subject Matter Expert Management Team

The Subject Matter Expert Management Team brings together Michigan Department of Health and Human Services office, bureau and department managers on a bi-monthly basis to review SIM activities and progress. The meetings are used to increase visibility and promote coordination between core SIM teams and related State programs and policy areas. The SIM Leadership Team and PMDO will work with the Subject Matter Expert Management Team to promote opportunities for integration and enhancement between the SIM demonstration project and existing State programs and policies.

Michigan Department of Health and Human Services Business Integration Center

The Michigan Department of Health and Human Services Project Management Office will serve as the conduit for managing SIM dependencies within the State that are outside the SIM PMDO scope of operations. The SIM PMDO will work with Business Integration Center (BIC) to leverage processes and program management teams already in place to support the Michigan Department of Health and Human Services. Examples of this may include changes to the State claims payment system, Community Health Automated Medicaid Processing System (CHAMPS), required to support SIM Accountable Systems of Care and PCMH enrollment and attribution or State Health Information Exchange (HIE) implementations.

Component Project Teams and Supporting Workgroups

The SIM initiative will leverage a formal project management methodology and a supporting SME work group process to facilitate the development of critical detailed planning and implementation artifacts, operational guidelines and deliverables. Utilizing dedicated subject matter experts with input from SIM foundational material, other state resources, academic and industry thought leaders, public/private collaboration bodies and other supporting bodies, project teams and committees will ensure that the deliverables align with rules, policy, and other constraints while enabling the SIM program to achieve its primary goals. All component project teams will have charters to ensure alignment within the governance structure and the roles and responsibilities of each body and its participants.

SIM Program Management & Delivery Office

The SIM Program Management & Delivery Office (PMDO) is responsible for coordinating the successful implementation of the SIM test and component programs within the overall governance model and operating framework. The PMDO will establish a framework to coordinate, support, track and report on the portfolio of projects, activities and other engagements that will be required over the lifetime of the SIM effort. The base processes and foundation will incorporate the capabilities, expectations of the key members and overall SIM requirements to drive implementation and execution of the SIM test in Michigan. The PMDO will provide standards and the application of best practice solutions across program and project structure, governance, management, measurement, communication, risk management, change control and other related processes required to effectively and efficiently meet SIM implementation goals.

PMDO Staffing, Roles & Responsibilities

Initial roles and staffing levels for the core PMDO is listed in Table C1.5 (PMDO Roles and Responsibilities). The staffing plan and resource requirements are continually examined and modified, as needed, to meet the current and anticipated needs of the SIM implementation in Michigan.

Table C1.5 PMDO Roles and Responsibilities

Role	Responsibility	#
Program Director	The SIM Program Director is responsible for direct oversight, decision-making and ensuring the overall success of SIM. Responsibility for the successful alignment of other agency efforts, as appropriate; to ensure that work is coordinated and synchronized and SIM goals are met.	1
Business Owner	The SIM Business Owner is responsible for monitoring the day-to-day work of the SIM initiative ensuring program vision and direction from the SIM Program Director and State leadership and governance bodies are fully realized. Responsibility for ensuring the program meets MDHHS SIM goals and supports related statewide objectives.	1
Program Implementation Manager	The SIM Program Implementation Manager has overarching responsibility and accountability for the SIM program requirements, solution design and implementation while directing SIM planning and design and advising portfolio project managers and teams on best practice approaches. Ensures the design, implementation operationalization align with overall near- and long-term SIM goals and objectives. Works closely with the Program Operations Manager to coordinate work, report status and mitigate risks and issues during the lifetime of the SIM Model Test.	1
Program Operations Manager	The SIM Program Operations Manager has overarching responsibility and accountability for the SIM initiatives activities. The SIM Program Operations Manager ensures that processes are established and enforced, gathers and communicates project status to clients and management, working closely, and in alignment, with the SIM Project Director and Business Owner and Implementation Manger.	1

Sr. Project Manager	The Project Managers have overarching responsibility for their assigned SIM projects. All project managers work directly with the PMDO Managers, Project/Track Lead and impacted Business Owners. The PMO Manager defines, schedules, controls, and adjusts all tasks and workloads of the projects.	3
Sr. Business Analyst	The Business Analyst facilitates business process improvement via the methodical investigation, analysis, review and documentation of functional business specifications. This resource supervises and mentors the business analysis team by directing the requirements development process through the elicitation, analysis, specification and verification of multiple levels of requirements from an end-to-end perspective and supports the ongoing management of the requirements.	3
Program Coordinator	The Coordinator will be responsible for scheduling and facilitating business, program and project teams meetings and minutes and other follow-up activities. The project coordinator will work closely with the Business Owner and Program Managers to ensure the communication and other processes are meeting expectations and goals.	1

SIM Program Management and Delivery Office Scope

Governance

Implement and operate an efficient and representative governance model that aligns with the decision-making, oversight and issue resolution processes required to operate the SIM test. Facilitate activities that allow approval, direction and decisions to be sought from the correct level of governance in a timely fashion with clear escalation paths and outcome expectations.

Stakeholder Engagement

Develop and implement an internal stakeholder engagement strategy and plan that allows all program participants to engage in valuable dialogue regarding aspects of the program, portfolio of projects and the broader SIM initiative fostering informed decision making and accountability while seeking understanding and solutions to issues of mutual concern.

Scope Management

Develop and implement a program scope management approach and plan that facilitates; gathering of approved requirements, development of vetted solution design based on requirements. Facilitate the identification of shared program goals and benefits, and implement and steward an efficient change control process for SIM component deliverables, implementation parameters and other operational requirements.

Communication Management

Develop and implement appropriate methods of project- and program-level information collection, screening, formatting, and distribution that is fully aligned with the governance, scope management, stakeholder engagement and other program components. Monitor the flow of information ensuring that the

critical links are established and the regular exchange among program sponsors, stakeholders and project teams, of ideas, and information occurs.

Issue & Risk Management

Develop and implement a risk management plan and approach that identifies roles, risk identification methodology, tracking processes, analysis procedures, escalation protocols and response planning, monitoring, mitigating and reporting on all program and project-level risks. Additionally develop and implement an aligned issue management approach that provides for a reliable and visible method for all program participants and project teams to raise, prioritize, assign and track issues to resolution.

Quality Control

Work with sponsors, stakeholders and policymakers to establish appropriate quality control measures and monitoring processes to ensure program scope, schedule and overall integrity is maintained through all phases the SIM Model Test.

Schedule Management

Develop and implement a schedule management plan and approach that provides for a comprehensive and integrated schedule of program activities, portfolio project and other activities to be accurately and concisely maintained throughout all phases of the SIM Model Test.

Grant Management

Provide grant-related budgetary, scheduling, compliance and other administrative support required during the execution of the CMS/CMMI State Innovation Model grant. Facilitate the integration of fiduciary processes and requirements with implementation and operational plans and funding models.

Contract Management

Develop appropriate and customized approaches for vendors supporting SIM and Model Test participant contracting. Establish and maintain policies, processes and procedures that ensure complete contract compliance by establishing close coordination with the track leads, tactical leadership and project teams. Assist in identifying the critical terms and conditions within the contract, integrating them into the program and project plans and working with all parties to manage contract milestones and/or deliverables.

Program Document & Deliverable Management

Establish a document management approach and SharePoint document repository for all program and project documentation including deliverable- and document-based workflows that aligns with drafting, review and approval processes for all types of program material expected over the course of the SIM Model Test.

Component Planning, Integrated Implementation and Operational Management

The formal SIM Governance and Program Management and Delivery Office structures and functions, outlined in this section, serve as the overall oversight and support base for the SIM Test component implementations in Michigan. Each SIM Test component has varying integration, implementation and

operational goals but operate under a common structure and standards set. This coordination enables the collective goals of the SIM Test in Michigan to be achieved.

The State has aligned the SIM initiative around two primary and 2 secondary implementation areas. The primary implementations represent the core Model Test components and the related activities. The secondary implementation areas represent the support and infrastructure required to successfully execute the primary Model Test components and performance evaluation.

- Primary Components:
 - Population Health
 - Community Health Innovation Regions (CHIR)
 - Collaborative Learning Network (CLN)
 - Care Delivery
 - Patient-Centered Medical Home (PCMH)
 - Accountable Systems of Care (ASC)
- Secondary Components:
 - SIM Program Governance (Management and Stakeholder Engagement)
 - Technology & Related Infrastructure

Primary Model Component Governance and Management

To meet component-specific scope and drive to implementation goals, a sub-set of the overall SIM governance is augmented, as needed, and extended to govern the component project. This allows the component implementation teams to operate effectively while maintaining direct ties to the overall program governance. This ensures those decisions, approvals and other issues that are unable to be resolved within the component implementation-level governance are expeditiously escalated and addressed. The PMDO facilitates the integration of component- and program-level governance. The primary components, Care Delivery and Population Health, are the primary aim drivers for the SIM implementation in Michigan. The secondary components, Technology and Program Management/Governance, are supportive drivers for the primary components and work to provide an enablement and facilitation infrastructure for Model Test execution.

Both secondary and primary components operate under a standard set of project management rules and requirements. A common, shared approach ensures that all component projects have a consistent level of planning, design, implementation and operational artifacts. These standards include common approaches for reporting, issues and risk management, escalation paths, integration planning and other common processes. Each component team maintains a similar timeline of activities and dates that feeds an overall master timeline where detailed integration and cross-component dependencies are identified and managed. Additionally, component work plans and breakdown structures are maintained to ensure the SIM Test is progressing toward implementation and operating goals.

Common Program and Project Standards, Issue/Risk, Deliverables, Reporting, & Escalation

The PMDO has established standard processes and methodologies for a wide range of program and project activities, deliverables and other program output. These standards are intended to foster consistency and ensure that initiation, planning, design, implementation, readiness and operationalization phases and deliverables are comparable and useful across the entire initiative. This also drives analogous progress/status, issue, risk and other communication across all components.

A shared issue and risk management methodology is utilized across all SIM Test components and constituent implementation teams. The issues and risks are identified, reviewed and updated regularly by vendors, component teams and governance members, program management and executive leadership. The review of current risks and open issues is a standard weekly activities required during weekly status meetings for all core Model Test components (Care Delivery, Population Health) and supporting components (HIT/HIE and Program Management) . These meetings bring key program and specific component implementation and leadership representation, along with vendor, SME and others, as required, to review not only issues and risks, but activity, progress, status, upcoming milestones and other current work. Issues and risks that are unable to be resolved by component-level teams will be escalated to the program team.

The PMDO evaluates escalated items and determines whether ad-hoc program governance measures should be enacted or if an item can be added to the next occurrence of the monthly program governance team meeting without impacting schedule and other program-level considerations. Those items requiring immediate attention are analyzed and potential mitigation strategies developed for presentation to the program governance team members accountable for the component originating the escalated item. An immediate solution, decision or other resolution strategy will be documented and communicated to remaining program governance members, component teams, and other impacted stakeholders. Issues and risks deemed safe to hold until the next program governance team meeting will also be analyzed and recommendations developed to be presented to the entire SIM governance body. A resolution or mitigation, if determined/selected, is similarly documented and communicated to component, integrator and other stakeholders, as needed. In the unlikely event that the program governance team is unable to resolve an issue or determine an acceptable mitigation strategy, a similar strategy will be employed with the executive level governance team that gathers quarterly.

Communication across, and among, the component teams, program leadership, public private commission/committees and stakeholders also occurs within a standard framework of required and ad-hoc communication methods. Established standards around team communication include required weekly meetings for component teams to focus on the activities, milestones, deliverables, schedule, scope, issues, risks and other component material. A SIM-wide meeting methodology includes standard agenda, minutes and action item documentation. Distribution and follow-up on meeting output also follows a prescribed weekly schedule to ensure that leadership, implementation, operational and support teams have full visibility to the current state and activity of each component teams as well as overall program progress and health.

Additional Agencies to be Engaged in SIM Governance and Management Processes

Additional state agencies will be engaged in the implementation of SIM model components through the formal governance structure outlined above and in broader internal stakeholder engagement efforts. These agencies include:

- **Medical Services Administration (MSA)**

Administers Medicaid and will have a key role implementing payment reform for Medicaid beneficiaries, including submitting needed waiver applications or state plan amendments, defining program requirements, and contracting with health plans

- **Population Health & Community Service Administration**

Responsible for many aspects of public health policy and programming, contracts with local health departments, and oversees maternal and child health programming; the Public Health Administration will provide expertise and programmatic guidance to the development of CHIRs

- **Behavioral Health and Developmental Disabilities Administration**

Directs delivery of publicly funded mental health, developmental disabilities, and substance abuse services

- **Agency for Aging and Adult Services**

Allocates and monitors state and federal funds for all Older Americans Act services, including nutrition, community services, and care management

- **Legal Affairs**

In collaboration with the Attorney General, will advise on anti-trust concerns and other legal items related to model implementation

- **Michigan Department of Licensing and Regulatory Affairs (LARA)**

Responsible for the state's regulatory environment oversight and safeguards citizens while supporting business growth and job creation

- **Department of Insurance and Financial Services (DIFS)**

Administers and regulates licenses and related entities across potential SIM participants and stakeholders.

- **MDHHS Office of the Inspector General (OIG)**

The Office of Inspector General (OIG) audits and investigates suspected misuse of Michigan's Medicaid program. The office recover overpayments, issues administrative sanctions, and refers cases of suspected fraud for further criminal investigation and potential prosecution.

Mechanisms to coordinate private and public efforts

The primary mechanisms for coordinating with private and public efforts are the SIM Commission and committees, along with other stakeholder engagement efforts detailed in Section C2 (Stakeholder Engagement) of this operations plan. The program and component governance and SIM commission interaction is designed to facilitate engagement with additional payors, private and public stakeholders (both model test participant and non-participants), including, but not limited to, sharing information, recommendations, consultation, advice and receiving consensus and vetted feedback to incorporate into the

decisions and planning, design, implementation and operational phases per component scope I as document in section B2 (Component Summary Tables) and the timelines included in Section A4 (Master Timeline).

Integration or alignment with legislative and executive authority

The state will use the full breadth of regulatory and legal authority available to support the SIM and related health system transformation strategies and implementations, including

- Applying current regulatory authority and requirements in the Medicaid Health Plan contract to provide Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan
- Considering adaptations to existing regulatory authority, as needed, to meet SIM Test goals.
- Assessing and communicating the need to changes to state laws and policy to support health care transformation related to SIM
- Collaborating with all applicable and required federal partners; the Center for Medicare and Medicare Innovation programs, State Plan Amendment and waivers as needed, Medicare participation in payment initiatives, collaborations with the Centers for Disease Control and Prevention and Health Resources and Services Administration

Roles and Responsibilities for Existing and New Staff or Contractors to Support SIM activities

Please see sub-section 2 of C2, (Program Governance and Management Structure) for a list of key roles and responsibilities of the Program Management and Delivery Office. Additional contractors currently engaged with MDHHS in support of component planning, design and implementation are listed in the table C1.6.

Table C1.6 SIM Planning and Support Contractors

Role	Responsibility
Bailit Health Purchasing	<ol style="list-style-type: none"> 1. Review, revise, and collaborate with the MDHHS Medical Services Administration toward finalization of policies and documentation related to program development; 2. Consistent with the overall Medicaid Managed Care RFP approach, assist in the development and finalization of the SIM payment model requirements and documentation; 3. Provide feedback to the MDHHS Medical Services Administration related to proposed accountable system of care payment arrangements, to include feedback on payment model methodologies, accountable care delivery system requirements, community organization requirements, data collection and reporting requirements, and governance requirements for: Shared Savings, Episode-based Payment, Global Capitation; 4. Provide strategic advice to the MDHHS Medical Services Administration related to implementation of accountable systems of care and communication to Medicaid health plans.
Institute for Health Improvement	<p>The project will begin with strategic collaboration with the Michigan SIM team to develop a plan that will be implemented during the first two years of implementation. MDHHS, existing quality improvement coaches in Michigan, and stakeholders within ASCs and CHIRs will be engaged as IHI prepares a two year plan that includes:</p> <ol style="list-style-type: none"> 1. Creation of ASC and CHIR Teams 2. Individualized coaching relationships by which an IHI improvement advisor works with ASC and CHIR teams and stakeholders 3. Learning sessions for year 1 and year 2 regional participants and state-level stakeholders 4. Online virtual programming, tools, and technical assistance resources 5. Guided tests of change 6. Regular cross-sector affinity groups 7. Peer mentoring 8. Leadership Academy 9. Train-the-trainer
Michigan Public Health Institute	<ol style="list-style-type: none"> 1. Program Monitoring and Evaluation 2. Population Health Planning
Public Sector Consultants	<p>PSC will be on contract to engage stakeholders to ensure that:</p> <ol style="list-style-type: none"> 1. All relevant parties are aware of and familiar with the MDHHS's SIM Strategic and Operational vision; 2. Those most critical to its success are fully engaged and providing productive input to implement the MDHHS's SIM Strategic and Operational vision, and 3. The plan for engaging stakeholders is comprehensive and cohesive.
Segal and Company	<ol style="list-style-type: none"> 1. Program design and implementation consultation on patient-centered medical home, accountable systems of care, community health innovation

	<p>regions, and payment arrangements—particularly as they relate to SIM investment strategies for proving the business case for sustainability and multi-payer alignment.</p> <p>2. Provide Subject Matter Expert feedback on program requirements, implementation management, and strategically establishing requirements and targeting investments for greatest impact.</p> <p>3. Serve as the primary advisor regarding commercial and employer engagement strategies.</p>
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Recruitment and Training of Staff and Contractors

The State will employ existing practices for recruitment of new SIM staff, including, long-term specialist affiliated resources, program/project management professionals and other specialized resources. Three approaches will be utilized:

- Approach 1: State employees from various involved agencies and departments will be added to the team based on availability, budget and subject matter area and domain expertise. This will also depend on the ability of respective departments to reach cross-department agreements for resources from their existing pools.
- Approach 2: Secondly, affiliate resources (individuals) will be contracted through the Michigan Public Health Institute (MPHI) for specific roles in the SIM effort. The roles/responsibilities of these resources, as well as their projected budget, must be approved by the Center for Medicare and Medicaid Services/the Center for Medicare and Medicaid Innovation before being contracted.
- Approach 3: Consultant/vendor integrators will be brought in for planning, implementation and operational support around specific functional and component areas/tracks within the SIM Test program. These engagements will also require the Center for Medicare and Medicaid Services/the Center for Medicare and Medicaid Innovation scope of work and budget approval.

These approaches will be considered in light of whether the required work is for statewide initiatives or regional testing, and all applicable state and the Center for Medicare and Medicaid Innovation approved/preferred approaches to soliciting qualified resources would apply.

Training for all new and existing staff or contractors to fulfill their roles

The training plan for new and existing staff or contractors consists of two primary focuses:

1. Defining a holistic State Innovation Model (SIM) Test overview for both new staff and contractors brought in to support the effort and Michigan Department of Health and Humans Services employees whom are not directly impacted by SIM, but for whom general awareness of the effort will be highly beneficial.

2. Providing deep content domain-specific training for new team members. The training will be developed on an ongoing basis in recognition of the constant and significant evolution of the best content for the training. Training will be delivered in the most convenient format for users, whether that is written materials, shared electronic documents, webinars or other media.

In addition to the above training materials related to SIM, the state has developed a training approach for new and existing staff or contractors across four phases:

1. New hire/contract documentation: Procurement process completed (RFI/RFP/Sole Source) including approval, finalization and signing the contract.
2. Pre-work tasks: Procuring State network account (email address), badges, and work space; confirming scope, schedule, deliverables, and responsibilities with assigned manager; and finalizing any other State HR documentation.
3. Early phases of work: Reviewing the onboarding guide and reviewing communication and document management plans.
4. Reporting and status updates: Confirming with the assigned manager the following: escalation path, reporting structure and cadence, checkpoint meeting cadence; and status update template/requirements.

Staff and contractors will be held to existing fraud and abuse standards. It is the responsibility of every SIM team member, employee, supervisor, manager and executive to immediately report suspected misconduct or dishonesty to [their supervisor, internal audit, legal, other]. Supervisors, when made aware of such potential acts by subordinates, must immediately report such acts. Any reprisal against any participant, stakeholder or other reporting individual because that individual, in good faith, reported a violation is strictly forbidden.

Method for state to evaluate SIM activities to support continuous quality improvements

The SIM Program Governance Team and PMDO will monitor core program implementation metrics and performance relative to program targets and goals to identify opportunities for continuous quality improvement. As a special-purpose program management office the MDHHS PMDO leans heavily on ongoing assessment of overall program implementation goals and plan, progress and time/cost constraints to measure effectiveness and potential areas of improvement. This continuous process allows us to bring process, policy and other program- and implementation-level changes to bear, as needed.

In addition to Continuous Quality Improvements related to the SIM program itself, entities which contract with the State as part of SIM will need to comply with the Quality Improvement and Program Development requirements similar to those found in the Comprehensive Health Care Program (CHCP) services contract for Medicaid Health Plans in the State of Michigan. Relevant text from the request for proposal includes the following:

- Contractor must have a written plan for the Quality Assessment and Performance Improvement Program that includes, at a minimum, the following:
 - Contractor’s performance goals and objectives
 - Lines of authority and accountability
 - Data responsibilities
 - Performance improvement activities
 - Evaluation tools

2 – Stakeholder Engagement

Engagement of key internal and external stakeholders, thought leaders, and participants will be a priority activity and component of the design and implementation of the State of Michigan’s State Innovation Model test’s vision for health care transformation. The overarching strategy for engaging stakeholders is a twofold staged approach: a core participant engagement and a broader SIM Commission and committees which are part of the overall operational governance structure.

The stakeholder engagement components of the SIM Test in Michigan will unfold in three phases: (1) Design; (2) Launch/Implementation; and (3) Operate, Evaluate, and Improve. This section provides an overview of the work to be completed by the State (a) with input through statewide meetings, an online survey, and regional meetings during the first two phases of model test implementation, and (b) through committees during the third phase of model test implementation and operationalization. The work to be completed during Phase 1 and Phase 2 is intended to aid the implementation of the model test and ensure stakeholders are well-informed of the model components. The work to be completed during Phase 3 begins a new process for stakeholder engagement consisting of targeted public/private and participant committees that will interact with one another, and a hierarchical structure integrated into the overall initiative governance and operating model.

Phase 1: Design (January 2016 – June 2016)

The State has completed a comprehensive implementation recommendation process, developing detailed design and plans for implementing each of the primary and supporting components of the SIM Test in Michigan. Groups of staff and contractors are focused on two primary and two supporting components:

- Primary Michigan SIM Components
 - Care Coordination (PCMH, ASC, Payment Reform)
 - Population Health (CHIR, Collaborative Learning)
- Secondary Michigan SIM Components
 - HIT/HIE (Monitoring, Evaluation, Accountability, Participation Metrics)
 - Operations (Stakeholder Engagement, Management, Governance)

The design decisions and other recommendations coming out of the initial planning were translated into shareable documents that could be widely disseminated. This information fed into a process during which

interested stakeholders were invited—to varying degrees depending on their likely level of involvement in the model test—to offer feedback and input on the preliminary design decisions and next steps.

The State prepared for the public roll out by hosting a meeting of key external stakeholders whose input and buy-in is critical to SIM's ultimate success. This Key Leadership Summit was designed to prepare for statewide webinars with a wider audience. The SIM program staff identified the information to share with external stakeholders, and used the Key Leadership Summit to identify needs for clarity before sharing with additional external stakeholders. Following the summit, the SIM program staff and MDHHS leadership made additional decisions regarding the SIM model components and how implementation may be altered depending on feedback and other communication with initial stakeholders. This information was then shared at a statewide webinar.

Introductory Statewide Webinars (April 2016)

To kick-off its stakeholder engagement efforts, the State held a series of webinars in April 2016 to provide an overview of the SIM model test, the decisions made by the State about model components, and questions on which the State was seeking further input. These webinars served to provide high-level, yet detailed information about the model test so that interested stakeholders could provide thoughtful input. The webinars included an Overview of the SIM Program, a presentation of Care Delivery (PCMH, ASC and Payment Reform) concepts and approach and a presentation of Population Health (CHIR and CLN) activity and goals.

Statewide Stakeholder Survey (April 2016)

Following the webinar, the State fielded an online survey of SIM stakeholders to obtain feedback and input on specific aspects of SIM model decisions. The survey addressed all three webinars as well as solicited public feedback on the Operational Plan to be incorporated into the final revision.

Regional Meetings with Potential Model Test Participants (June – July 2016)

Following the webinars and online survey, the State intends to meet with small groups of potential model test participants in the regions where the ASCs and CHIRs are to be implemented. The meetings will include providers likely to participate in PCMHs and ASCs, leaders of likely CHIR backbone organizations, and payors that would be responsible for implementing the value-based payment models to support the participating providers.

These stakeholder sessions will be used to discuss in greater depth the plans for implementing the model components, including performance measures, patient attribution models, PCMH accreditation requirements, CHIR functions, and HIT/HIE needs and requirements. Note that HIT/HIE elements and design decisions will be discussed as part of each of these meetings rather than in a separate meeting. The State will share its decisions and input it has received through the online survey, and it will seek additional input and, to the

extent possible, agreement from these regional stakeholders on how to put the model components in place. Leading up to the meetings, the State will determine which of the design decisions are open to refinement and which are not.

The State will decide in which regions meetings will be held, and will identify and invite the appropriate participants. The meetings will be held in all regions likely to participate in the Regional/CHIR component of the SIM Test in Michigan.

Statewide CHIR Session (TBD)

The State will also convene CHIR backbone organizations in a single meeting to discuss and respond to CHIR design decisions. Discussions with potential CHIR participants are likely to include questions about the organization and operating model of CHIRs, how the success of CHIRs will be measured, and how the State can best support the continuous improvement of CHIRs. This statewide session among the regional CHIRs will be informed by and coordinate with the Collaborative Learning approach, which will support the backbone organizations in their exploration and synthesis of learning on similar topics.

Statewide Summit to Share Final Decisions and Program Parameters (July 2016)

Following the regional and statewide meetings with targeted groups of stakeholders, the State will hold a summit to share its final decisions and plans for implementing and launching the model test components. The summit will be used as the kick-off for the launch and implementation (Phase 2) of the model test. At the summit, participants will learn more about the regions in which the ASC and CHIR models will be tested and details regarding the participating entities, patient attribution methodologies, performance measurement and tracking, and how HIT/HIE will be used to support the model test. Summit participants will also learn about opportunities for future stakeholder engagement.

Phase 2: Implementation/Launch (July – September 2016)

In the Implementation/Launch phase, the State will have made the majority of the decisions needed to launch the SIM model components. It will use this quarter to continue to inform stakeholders of those decisions through a variety of means, including community forums, online webinars, and development of written materials.

The SIM team will design the forums and webinars to reach the appropriate audiences and share the information they need. The forums and webinars will also provide an opportunity for stakeholders to ask questions about the model components and the plans for operation, evaluation, and improvement that will occur in Phase 3 of the model test. Related to HIT/HIE, the State may share examples of provider dashboards and information about HIT/HIE tools to support care coordination as well as ensuring that participating providers are aware of the HIT/HIE support available to them as they implement the model components.

During this phase, the State will also work with multiple contractors to develop a plan to establish committees that will provide advisory input on PCMHs, ASCs, CHIRs, HIT/HIE, and payment models when Phase 3 begins in the fall of 2016.

Phase 3: Operate, Evaluate, and Improve

Beginning in the fall of 2016, most of the components of the SIM model test will move into Phase 3: Operate, Evaluate, and Improve. At that point, the program will build towards a structure for continuous engagement of stakeholders both in, and outside of, the model test. The State will establish a high-level working group called the SIM Commission and a set of committees that will provide ongoing input into the operation of the PCMHs, ASCs, and CHIRs, as well as HIT/HIE needs and payment models. The SIM Commission and potential committees are described below. Final decisions on committee design and charges will be established as the areas for ongoing input and feedback become clearer during Phases 1 and 2 of the Michigan SIM Test stakeholder engagement.

Charters for the commission and each committee will be developed during the implementation/launch phase, at which time members will be recruited. Charters will include the committee's charge, primary questions for deliberation, and the process for arriving at consensus recommendations, how communication with other committees will be handled, and an initial schedule of meetings.

SIM Commission

The SIM Commission will track progress of the initiative and advise the State leadership during the implementation of the components. The commission will offer guidance on overarching model test decisions. It will also review consensus recommendations made by committees and, where differences exist, make recommendations to department leadership on how to resolve them.

The SIM Commission will include senior-level state planners from MDHHS, the Governor's office, key contractors, and executive leaders from participants in the model test as well as non-participants whose engagement and buy-in will be important for expanding the model(s) in the State. The group is likely to comprise about 20 people, and will meet bi-monthly.

Care Delivery Committee

A committee will be formed to provide input on PCMHs and ASCs as the models become operational. The committee will review information from performance reports shared with participating PCMH practices and ASCs, and engage in discussions about model test results and potential solutions to challenges. The committee will also provide input on the payment models in place and offer recommendations for refinement, if necessary. In general, the committee is likely to deliberate on and make recommendations for PCMH/ASC model analytics and design, reporting, payment, and provider engagement. Some of the

committee's recommendations are likely to inform the work of the Population Health and HIT/HIE Committees.

The committee will comprise a range of clinical staff (primary care, behavioral health, and specialty providers), administrative/financial staff, physician organization representatives, consumers, and payor representatives. The committee will include model test participants as well as non-participants, and will include state staff who can provide subject matter expertise. The committee will have no more than 30 participants, all of whom will have gone through an objective selection process designed to ensure broad representation of providers and payors on the committee. The group is likely to meet monthly.

Population Health Committee

The Population Health Committee will be formed to support the alignment of the SIM program with population health initiatives, with a particular focus on community health innovation regions. The committee will develop recommendations for refining the CHIR model design based on CHIR test site performance and promote the use of evidence-based practices to advance population health. The committee will also provide guidance for the development and implementation of the State's Population Health Improvement Plan.

Committee members are likely to include representatives of CHIR model test sites, stakeholders who are interested in forming CHIRs in other areas of the state, population health experts, MDHHS Population Health and Community Services representatives, consumers, and other interested stakeholders. The committee will have no more than 30 participants, all of whom will have gone through an objective selection process designed to ensure a diverse range of stakeholder representatives. The committee is likely to meet quarterly.

HIT/HIE Committee

The HIT/HIE committee will provide recommendations and input on HIT/HIE decisions related to the design and operationalization of the four core HIT/HIE elements supporting coordinated care delivery and value-based payment models: (1) capabilities to evaluate and report on SIM program performance; (2) care coordination tools and support; (3) infrastructure enabling payment model analytics and reporting; and (4) a population health toolset to support greater interoperability between health care and community entities.

The HIT/HIE Committee will be comprised of leaders in HIT/HIE from across the state, including representatives from the Michigan Department of Health and Human Services, the State's Chief Information Officer's office, and representatives from participating payors and providers. The final composition of the Committee will be determined and approved by the SIM Program Governance team and overall SIM Commission.

Additional Stakeholder Communication Channels

In addition to communication via the SIM Commission and committees, the SIM program will provide information and communication to interested parties through multiple sources throughout the duration of the test. A State of Michigan Department of Health and Human Services public facing website will provide key updates and developments to inform the public and Stakeholders of recent news, upcoming events, and will serve as a resource for storing documents and making them available for public review. An email LISTSERV has been created and is used to email newsletters, announcements, presentations, and other SIM program related mass communications.

- The State of Michigan website can be found [here](#) or at: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html
- To get more information about registering for the SIM LISTSERV interested parties should send an email to: SIM@mail.mihealth.org

Collaborative Learning Networks

Collaborative Learning Networks will support the success of pilot participants across the state by:

- Facilitating collaboration among CHIRs, ASCs, and PCMHs to improve outcomes for SIM priority populations;
- Building community capacity for continuous improvement and action;
- Supporting population health measurement, and promoting accountability for outcomes; and
- Identifying promising practices and policies, and sharing lessons learned.

The State has elected to prioritize Collaborative Learning Network development for CHIRs. Key components of the Collaborative Learning Network for CHIRs are expected to include:

- Assessment of readiness to improve population health;
- Development of CHIR-specific operational plans;
- Support through in-person summits and webinars;
- Support through coaching;
- Support for community health measurement;
- Support for technical assistance; and
- Support through an online platform with resources that are useful for Model Test participants.

Staff will transmit relevant lessons learned and suggested policy changes, as surfaced in Collaborative Learning Activities, to the SIM Commission. The SIM initiative intends to share promising practices/policies and lessons learned in the CLN broadly, to include interested parties other than the Model Test participants.

Stakeholders

Stakeholders in the SIM program will include health care providers/systems, commercial payors/purchasers, state hospital and medical associations, community-based and long term support providers, consumer advocacy organizations, and, as applicable, tribal communities.

Participating payors are required to implement key features of the proposed payment model. The primary mechanism to ensure Medicaid payors implement key features of the model and fully participate is the Comprehensive Health Care Program (CHCP) services contract for Medicaid beneficiaries in the service areas within the state of Michigan. The contract includes language requiring all Medicaid Health Plans (MHPs) participate in SIM. Component participation must include, but is not limited to, Accountable Systems of Care and Community Health Innovation Regions in applicable regions and payment reform. Further, the contract includes language which also requires payors to comply with several Management Information Systems and HIT/HIE requirements which meet the requirements set out in C10 (Health Information Technology). Further, a number of MHPs will participate in the public/private committees where they will provide meaningful input into, and feedback on, the design and implementation of the SIM effort. Data collection and sharing among and between participant stakeholders is covered, in detail, in section C.12 (Data Collection, Sharing, and Evaluation)

Participating Medicaid Health Plans

The following Medicaid Health Plans have been identified as potential participants in the SIM program.

- Aetna Better Health of Michigan
- HAP Midwest Health Plan
- Harbor Health Plan, Inc
- McLaren Health Plan
- Meridian Health Plan of Michigan
- Molina Healthcare of Michigan
- Priority Health Choice
- Total Health Care
- United Healthcare Community plan, Inc.
- Upper Peninsula Health Plan

Participating Accountable Systems of Care

The following Accountable Systems of Care have been identified as potential participants in the SIM program.

- Jackson Health Network
- Affina Health Network
- Genesys Physician Hospital Organization
- Professional Medical Corporation
- McLaren Physician Partners
- University of Michigan Health System
- Northern Michigan Health Network
- Integrated Healthcare Associates
- Wexford/Crawford Physician Hospital Organization

Participating Backbone Organizations (CHIRs)

The following Backbone Organizations and CHIRs have been identified as potential participants in the SIM program.

- Center for Healthcare Research & Transformation
- Health Improvement Organization

- Muskegon Health Project
- Greater Flint Health Coalition

Potential Additional Stakeholders for Inclusion in Committees and Broader Engagement Activities

The following list of stakeholders provides a starting point for selection of organizations and individuals that might be engaged over the course of the model test. Many may be invited to provide input and counsel through participation in committees or through broader stakeholder engagement activities. Broader activities are likely to include forums held in different areas of the State to ensure input received is inclusive of the diverse geographic regions. They may also include webinars where information is shared with a large group of people at one time. Throughout the model test period, forums and webinars (as appropriate) should be held to inform stakeholders of progress and/or receive feedback.

Health Systems/ACOs

- Accountable Healthcare Alliance
- Allegiance Health
- Ascension Health
- Beaumont Health System
- Covenant HealthCare
- Detroit Medical Center/MI Pioneer ACO
- Henry Ford Health System
- Hurley Medical Center
- Lakeland Health
- Mackinac Straits Health System
- McLaren Health Care
- Munson Healthcare
- Oakwood ACO
- Southeast Michigan Accountable Care (SEMAC)
- Sparrow Health System
- Spectrum Health
- Trinity Health
- University of Michigan Health System
- Upper Peninsula Health System

Physician Organizations

- Consortium of Independent Physician Associations
- Detroit Medical Center PHO LLC
- Greater Macomb PHO
- Henry Ford Medical Group
- Henry Ford Physician Network
- Huron Valley Physicians Association PC
- Integrated Health Associates Inc.
- McLaren Physician Hospital Organization

- MedNetOne Health Solutions
- Michigan Healthcare Professionals PC
- Northern Physicians Organization
- Oakland Physicians Network Services
- Oakland Southfield Physicians PC
- Olympia Medical Services PLLC
- Professional Medical Corp.
- The Physician Alliance LLC
- United Physicians Inc.
- United Outstanding Physicians LLC
- University of Michigan Faculty Group Practice
- Wayne State University Physician Group

Physicians/Clinical Leaders

- Belal Abdallah MD, board chair, Oakwood ACO LLC
- Yassir Attalla MD, board chair, Southeast Michigan Accountable Care (SEMAC)
- John “Jack” Billi MD, University of Michigan Health System
- Wendy Frush, Chief Nursing Officer/Officer of Operations, Mackinac Straits Health System
- James Grant MD, Oakland University William Beaumont School of Medicine (immediate past president, MSMS)
- Mona Hanna-Attisha MD, Hurley Medical Center
- Robert Jackson MD, Medical Director, Accountable Healthcare Alliance
- David M. Krhovsky MD, Spectrum Health (President-elect, MSMS)
- Stuart Lockman MD, Detroit Medical Center (President of MI Pioneer ACO)
- S. "Bobby" Mukkamala MD, Hurley Medical Center (Vice-chair, MSMS Board of Directors)
- Rose Ramirez MD, Mercy Health (President, MSMS)
- Lawrence Reynolds MD, Mott Children’s Health Center
- Amy Schultz MD, Allegiance Health
- David Share MD, Blue Cross Blue Shield of Michigan (Chair, MSMS Board of Directors)
- State Hospital and Medical Associations
- Michigan Health and Hospital Association
- Michigan State Medical Society
- Michigan Osteopathic Association
- Michigan Pharmacists Association
- Michigan Academy of Family Practice
- American Academy of Pediatrics – Michigan Chapter

Commercial Payors/Purchasers

- Michigan Association of Health Plans and its members (e.g., Priority Health, Molina, HAP)
- Blue Cross Blue Shield of Michigan
- Michigan County Health Plan Association
- Michigan Chamber of Commerce
- The Economic Alliance for Michigan
- Michigan Manufacturers Association
- Small Business Association of Michigan
- Service Employees International Union – Healthcare Michigan

- Michigan Education Special Services Association (MESSA)
- Detroit Regional Chamber of Commerce
- Greater Detroit Area Health Council

Community-based and Long-term Support Providers

- Area Agencies on Aging Association of Michigan
- Health Care Association of Michigan
- Michigan Primary Care Association
- Michigan Association of Community Mental Health Boards
- Michigan Center for Rural Health
- Michigan Association for Local Public Health
- Paraprofessional Healthcare Institute
- Washtenaw Health Initiative
- Greater Flint Health Coalition
- Jackson County Health Improvement Organization

Consumer Advocacy Organizations

- Arab American & Chaldean Council (ACC)
- AARP
- Michigan League for Public Policy
- Michigan Consumers for Healthcare
- MichUHCAN
- Tribal Communities
- Inter-Tribal Council of Michigan

HIT/HIE

- Michigan Health Information Network and the Trusted Data Sharing Organizations:
- Administrative Network Technology Solutions INC. (ANTS)
- Great Lakes Health Connect
- Henry Ford Health System
- Ingenium
- Jackson Community Medical Record
- Michiana Health Information Network
- Northern Physicians Organization
- Patient Ping
- Southeast Michigan Health Information Exchange
- Upper Peninsula Health Information Exchange

3 – Plan for Improving Population Health

The SIM Plan for Improving Population Health (PIPH) seeks to align with and enhance the existing State Health Improvement Plan of Michigan (SHIP)², in order to leverage the SIM process to further effect

² https://www.michigan.gov/documents/mdch/MDCH_SHIP_FINAL_8-16-12_400674_7.pdf

population health endeavors beyond the SIM Test period. The current State Health Needs Assessment (SHNA) and SHIP are in effect through 2017, with an update scheduled for the 2017-2022 period. The current SHIP supports the Michigan Health and Wellness 4x4 Plan³, and presents further opportunity to leverage the DHHS strategy to advance the SIM health system transformation goals. The present focus of the State Health Improvement Plan has the following population health emphases:

- Promotion healthy behaviors
- Reduction of obesity rate
- Decreased substance abuse and tobacco use
- Promotion of mental health

These endeavors will remain integral to Michigan’s strategy to improve population health. However, the State Innovation Model brings addition support and momentum to the population health improvement efforts of Michigan. The strong alignment of the SIM priority populations (High-ED Utilization, Multiple Chronic Conditions, and At-Risk Pregnant Women) with the existing SHIP will be expanded upon during the revised SHNA and SHIP process in 2017.

The integration of the SIM PIPH with the State Health Improvement Plan will also enhance the alignment of SIM priority population strategies with the current National Prevention Strategy. Specifically, there are several components of the CHIR that support the four strategic directions of the National Prevention Strategy:

Healthy and Safe Community Environments – A main goal of the CHIR governance structure and operational components is to promote cross-sector decision making that explores a ‘health in all policies’ approach to how the socio-economic and environmental determinants of health can support health care institutions’ pursuit of population health strategies and health system transformation. These components specifically relate to two areas of the National Prevention Strategy:

- Integrate health criteria into decision making, where appropriate, across multiple sectors
- Enhance cross-sector collaboration in community planning and design to promote health and safety

Clinical and Community Preventative Services – A core component of the CHIR operations is the implementation of a clinical-community linkage strategy to enable community service referrals and integration within the clinical care setting. This requirement also enhances the prioritization of SDOH information within the clinical care setting. These components align with two areas of the National Prevention Strategy:

3

https://www.michigan.gov/documents/healthymichigan/Michigan_Health_Wellness_4x4_Plan_387870_7.pdf

- Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.
- Enhance coordination and integration of clinical, behavioral, and complementary health strategies.

Empowered People – A key component of the CHIR, ASC, and PCMH strategies of the State Innovation model is to support communities in their identification of both local and state policies that would better enable local actors to pursue health system transformation. The CHIR structure also supports the engagement of community members in the planning of population health programming. These approaches support the following area of the National Prevention Strategy:

- Engage and empower people and communities to plan and implement prevention policies and programs.

Elimination of Health Disparities – The Michigan SIM priority populations have a strong focus on health disparities. Michiganders with Multiple Chronic Condition, High-ED Utilization, or At-risk Pregnant Women all are influence by health disparities across class, race, and geography. Through the CHIR, ASC, and PCMH tracks of the Michigan SIM, the State looks to eliminate health disparities. This approach aligns with the following areas of the National Prevention Strategy:

- Ensure a strategic focus on communities at greatest risk.
- Reduce disparities in access to quality health care.
- Increase the capacity of the prevention workforce to identify and address disparities.
- Support research to identify effective strategies to eliminate health disparities.
- Standardize and collect data to better identify and address disparities.

In addition to the SIM alignment with the National Prevention Strategy, the core of the State’s SIM Plan for Improving Population Health over the next four years will develop concurrently with the State Health Improvement Plan. As the current Plan concludes in 2017, there will be another round of SHNA and SHIP processes, which will actively engage with SIM leadership. In the meantime, the State has a series of ongoing population health efforts, some of which are components of the existing SHIP and others, which are unique but powerful programs. Additionally, the State has defined several strategies as core components to SIM Community Health Innovative Regions, which will play an integral role in the state’s population health efforts over the SIM period, and with the start of the next 5-year State Health Improvement Plan.

As such, the below section outlines the three elements of the plan to improve population health as part of the SIM effort:

- Alignment with the Michigan State Health Improvement Plan
- Integration of ongoing population health efforts across the state
- Improved linkages and coordination between health care providers and community entities through Community Health Innovative Regions

Michigan's Health Improvement Plan

The state is currently working with its 5-year State Health Improvement Plan, 2012-2017, and is embarking on a State Health Needs Assessment in 2017 to draft the next 5-year SHIP. The following sections cover three topics: (1) Michigan's current State Health Improvement Plan, (2) Michigan's State Health Needs Assessment, and (3) Michigan's plan for developing its next Population Health Improvement Plan.

State Health Improvement Plan

In 2012, Michigan launched their current 5-year State Health Improvement Plan, which is a comprehensive plan to address population health. The State Health Improvement Plan focuses on addressing obesity and has a number of initiatives focused on creating a healthier Michigan.

The State Health Improvement Plan identified a number of initiatives including education and awareness, developing partnerships to drive population health, and developing a larger infrastructure to support these initiatives long term. At the core of the plan are four healthy behaviors (maintain a healthy diet, engage in regular exercise, get an annual physical exam and avoid all tobacco use) and four key health measures (body mass index, blood pressure, cholesterol level and blood sugar level). This plan is scheduled to be updated in 2017.

The State will consider the opportunity to align common provider scorecard metrics and core program metrics to encourage provider behaviors that contribute to improved health and healthcare outcomes related to the priorities as defined in Michigan's Plan for Improving Population Health.

State Health Assessment

The Michigan Department of Health and Human Services has contracted with the Michigan Public Health Institute to design and facilitate the next iteration of the State Health Needs Assessment and State Health Improvement Plan. A State Health Assessment is a prerequisite for Public Health Accreditation Board accreditation, which is a new credential that Michigan Department of Health and Human Services has identified as a priority in the coming years. The State Health Assessment is the focus of Public Health Accreditation Board Domain 1 Standard 1, and will support increased rigor among public health entities in Michigan. The accreditation process will result in a State Health Assessment that meets Public Health Accreditation Board standards, as well as fulfill the routine update of the State Health Improvement Plan and identify new priority health issues for the State of Michigan.

The State Health Needs Assessment will be driven by leadership from Michigan Department of Health and Human Services and will include multi-sector, diverse partners collaborating to identify and examine data about health in Michigan, resulting in clear, data-driven priorities for the future of health in the state. Activities will include organizing a leadership team to oversee the process, identifying and convening stakeholders, gathering primary and secondary data, using data to identify health issues and assets as well as

health disparities and social determinants, prioritizing health issues in collaboration with stakeholders, and making assessment findings available to the public.

The State Health Needs Assessment will be used to address issues identified about the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community resources available to improve the health status. Key steps and provisional timings are forthcoming during the State approval process of the SHNA/SHIP contract, with expected update to this section by the start of the State fiscal year in September. Overall timeline includes:

- Organize the assessment process in cooperation with Michigan Department of Health and Human Services Population Health and Community Services Administration leadership: Month 1-5
- State Health Status Assessment: Month 2-7
- State Themes and Strengths Assessment: Month 3-8
- State Public Health System Assessment: Month 3-8
- Forces of Change Assessment: Month 5-7
- Facilitate the identification of strategic issues and priorities: Month 9-11
- Develop an assessment report of the SHNA in compliance with Public Health Accreditation Board standards: Month 11-12

The state has assessed areas in which its Strategic Health Assessment and State Health Improvement Plan align with the Plan for Improving Population Health as laid out by SIM. The state assessment has covered goals, key content areas, requirements and processes. The State Health Improvement Plan will be developed in such a way that it meets the requirements for the Public Health Accreditation Board as well as fulfills the purposes of the State Innovation Model.

The State is utilizing the Mobilizing for Action through Planning and Partnerships (MAPP) approach for the State Health Assessment. The Mobilizing for Action through Planning and Partnerships approach is a public health system-wide assessment and planning process which prioritizes issues and resources. It is a six phase approach beginning with the organization and partnership development phase. The end of phase one is the plan for population health assessment which is created primarily by the State health Assessment Leadership committee in conjunction with partners. Phase two is “Visioning” and results in the creation of vision and values statements. In the third phase, the State will form subcommittees relating to a Public Health System assessment, the State health status assessment, the community themes and strengths, and the forces of change assessment. Phases four and five involve identifying the strategic issues and formulating goals and strategies. The final phase, phase six, is the action cycle which involves implementation.

The organizational structure and roles for the Strategic Health Assessment process are laid out in the Table C3.1 (State Health Assessment) below.

Table C3.1 State Health Assessment

State health assessment: Organizational structure and roles overview				
Organizing for success	SHA Leadership Committee Core support team			
Visioning	State health System Partners Core support team			
Assessments	Public Health System Assessment Subcommittee	State Health Status Assessment Subcommittee	Community Themes and Strengths Subcommittee	Forces of Change Assessment Subcommittee
Identify strategic issues	SHA Leadership Committee & State Health System Partners Core support team			

Plan for Improving Population Health

The Plan for Improving Population Health creation process will bring together partners to align on a shared set of goals and an overall strategic direction. From this core foundation, the State will be able to implement change for the health of Michigan. The collaborative process will be used to identify and collect data and information, identify health issues, and identify existing state assets and resources. As noted above the Population Health Improvement Plan will be developed following completion of the State Health Needs Assessment.

The Michigan SIM priority populations and metrics noted in the Operational Plan align with the conditions of the CMMI to improve the health of the entire state population, improve the quality of health care across the state, and to reduce health care costs. The Michigan SIM goals and strategies outlined in this Operational Plan and further described in this section of the PIPH align with the population health metrics developed by the CMMI/CDC team. Further, the PIPH addresses the core measures in this plan through its SIM Quality Utilization Outcomes, Cost, and CHIR Metrics measures set.

The Michigan SIM is dedicated to regional tests of change by supporting variation of SIM health system interventions that are adapted to the local context of each of the five SIM regions. Each of the SIM regions will conduct their own population health needs assessment to complement the State Health Needs Assessment. This local needs assessment will coordinate among currently established assessments (e.g., hospital Community Health Needs Assessment, Community Mental Health agencies’ needs assessments, local public health departments required epidemiology reports, etc.), in order to utilize the SIM PIPH in a way that builds upon these efforts rather than duplicates existing resources.

The official SIM PIPH will be submitted as the State Health Needs Assessment and State Health Improvement Plan are confirmed in 2016-2017. At this time, the official format for the PIPH will be submitted to CMS.

Ongoing Population Health Initiatives

The State will continue to identify ongoing population health initiatives with complementarity to the vision for at-risk populations and the state's five winnable battles⁴. These initiatives include but are not limited to:

Nutrition, Physical Activity, and Obesity (NPAO) Program: The goal of Michigan's Nutrition, Physical Activity, and Obesity (NPAO) Program is to prevent and control obesity and other chronic diseases through healthful eating and physical activity. This goal will be achieved through strategic public health efforts aimed at increasing the number of policies and standards in place to support physical activity and healthful eating, increasing access to and use of environments to support healthful eating and physical activity, and increasing the number of social and behavioral approaches that complement policy and environmental strategies to promote healthful eating and physical activity.

- **Healthy Weight Partnership:** The Michigan Healthy Weight Partnership was established for the purpose of overseeing the implementation and evaluation of Michigan's obesity state plan to address the epidemic of obesity. Michigan's plan is called "Michigan Healthy Eating and Physical Activity Plan: A Five Year Plan". Members include over 50 state, local, public and private organizations who assisted with the creation of the state plan and/or whose organizations are actively engaged in completing activities consistent with the state plan's objectives. The Michigan Healthy Weight Partnership is a state-wide partnership that is facilitated by the Michigan Nutrition, Physical Activity, and Obesity Prevention (NPAO) Program at the Michigan Department of Health and Human Services through funding from the Centers for Disease Control and Prevention (CDC) Division of Nutrition, Physical Activity and Obesity (DNPAO).
- **Prevent Block Grant:** This initiative involves implementation of evidenced-based population strategies aimed to have collective impact on increasing healthy lifestyles by decreasing tobacco use and obesity (through increased physical activity and healthy eating) among high risk, vulnerable populations. The strategies will be implemented in two SIM Community Health Innovation Regions (CHIRs), one urban and one rural (TBD). Strategies of "Getting to the Heart of the Matter in Michigan" include: implementation of tobacco cessation interventions into routine clinical care; increasing access to healthy foods and places for physical activity; and conducting a media campaign to increase participation in "Getting to the Heart of the Matter in Michigan" activities.
- **Diabetes Self-Management Education Certification Program:** To increase availability and improve the quality of diabetes self-management education, the Michigan Department of Health and Human Services, Certification Program has developed review criteria based on national standards. The

⁴https://c.ymcdn.com/sites/www.mpca.net/resource/resmgr/Clinical_Conference_2015_/2015_Clinical_Conference_MDHH.pdf

Certification Program staff provide consultation services related to the standards and certification process. Programs that meet criteria and are certified are eligible for Medicaid reimbursement.

- **Michigan's Diabetes Prevention Program:** Michigan's Diabetes Prevention Program collaborates strategically to increase the delivery of evidence-based prevention messaging and programs such as the National Diabetes Prevention Program to high risk populations to reduce diabetes risk. The National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes and is offered in many Michigan communities through delivery organizations.
- **Michigan Partners on the PATH:** Personal Action Toward Health (PATH) is a chronic disease self-management program that helps participants build the skills they need for the day-to-day management of a chronic disease. PATH is a six-week workshop and covers topics including healthy eating, relaxation techniques, problem solving, and communication skills.
- **The Michigan Department of Health and Human Services Tobacco Section** team is dedicated to changing the negative health and economic impact of tobacco by:
 - Providing help and support for smokers who want to quit: Multiple resources are available including the Michigan Tobacco Quitline, which offers free provider referrals, free counseling, and free nicotine replacement therapy to those who qualify.
 - Promoting smoke-free air spaces, both indoors and out of doors: Michigan has statewide smoke-free air laws that protect residents and visitors from exposure to secondhand tobacco smoke in public places. The most comprehensive one is Public Act 188 of 2009, Michigan's Smoke-Free Air Law, which protects residents and visitors in all the state's restaurants, bars and businesses, including hotels and motels. Many landlords and rental housing management companies have adopted smoke-free policies for their residents. In fact, Michigan now leads the nation in the number of public housing commissions that have adopted smoke-free policies.
 - Protecting youth from exposure to secondhand smoke: There are a number of activities across the state of Michigan related to this endeavor including Michigan State Board of Education policies on 24/7 Tobacco-Free Schools and a toolkit from the Board of Education for 24/7 Tobacco-Free Schools.
 - Continuing to raise awareness about other tobacco products, both the old (such as spit tobacco) and the new, emerging products
 - Educating and empowering population groups that bear a higher-than-average burden from tobacco use and secondhand smoke exposure: The Michigan Department of Health and Human Services Tobacco Program provides funding for the Michigan Multicultural Network (MCN), which works to promote awareness about the risks of tobacco use and its impact on the communities most disparately affected by tobacco use. The agencies that comprise the Network serve African Americans; American Indians; Arab Americans; Asian Americans; Chaldean Americans; Hispanics/Latinos; people who are lesbian, gay, bisexual, or transgender; and veterans.

4 – Health Care Delivery System Transformation Plan

Providers across the state and across the care continuum participate in integrated or virtually integrated delivery models

The SIM program will have multiple levels of provider integration within the program’s plan for health care transformation. First, primary care providers may choose to integrate to create Patient-Centered Medical Homes. These Patient-Centered Medical Homes would, in turn, be responsible for coordinating care with the broader network of health care providers who are involved in the delivery of care to their patient panel. Second, Accountable Systems of Care will serve as an additional level of formal integration across Patient-Centered Medical Homes and the broader network of specialists, hospitals, and other health care providers involved in the provision of care to a specified set of patients. Accountable Systems of Care will have shared workflows, processes, and infrastructure that strengthen clinical integration. In addition, Accountable Systems of Care will have shared accountability for delivering high-quality, highly effective care to their patient panels under two-sided risk-sharing models. Third, Community Health Innovation Regions will integrate not only health care providers but also community entities and state agencies within a given region. Community Health Innovation Regions will be governing bodies, supported by a legal backbone.

Over 80% of payments to providers from all payors are in fee-for-service alternatives that link payment to value

The SIM program will launch two value-based payment models to support coordinated care delivery models, including: shared savings for Patient-Centered Medical Homes in participation with ASCs and two-sided risk models for Accountable Systems of Care. These efforts are part of a larger statewide approach to increase the percentage of payments to providers that are fee-for-service alternatives that link payment to value.

Every resident of the state has a primary care provider who is accountable both for the quality and for the total cost of their health care

The Patient-Centered Medical Home is the core pillar of the Michigan vision for health care transformation and will be nested into Accountable Systems of Care, further embedding the primary care focus into health care transformation and getting closer to the goal of having as many Michiganders as possible having a primary care provider who is accountable for quality and total cost of care.

Care is coordinated across all providers and settings

Care will be coordinated across primary care providers within the Patient-Centered Medical Home and the Accountable Systems of Care. Patient-Centered Medical Homes will drive care coordination in several ways, including developing care plans to capture a comprehensive approach for maintaining a patient’s health or managing a chronic condition, supporting transitions of care, and engaging supportive services where necessary. Accountable Systems of Care will ensure care coordination through several mechanisms, including

enabling systems, relationships and workflows across the care continuum; planning for transitions of care; and enabling clinical data interoperability.

There is a high-level of patient engagement and quantifiable results on patient experience

Patients will be engaged via the Patient-Centered Medical Home which will be patients' primary touch point with the healthcare system. Primary care providers will be charged with patient education and engaging patients on chronic disease management. Core metrics for Patient-Centered Medical Homes and Accountable Systems of Care include patient engagement measured by surveys and other tools along with care coordination activity monitoring and reporting. Providers will have to perform above a minimum threshold on these metrics to be eligible to receive shared savings. Thresholds will be developed and established utilizing analysis of current and historical data, participant feedback and other stakeholder input. Additional metric and measure information can be found in sections A3 (Accountability and Measures), C7 (Quality Measure Alignment) and C11 (Program Monitoring and Reporting). Patients experience will also be involved in other public outreach and collaborative engagement as described in Section C2 (Stakeholder Engagement).

Quantifiable results on patient experience will be gleaned through the state's use of the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The state currently employs the Consumer Assessment of Healthcare Providers and Systems health plan survey. Pertinent to the Patient-Centered Medical Home, the state may employ the Patient-Centered Medical Home Consumer Assessment of Healthcare Providers and Systems survey to assess patient experience with Patient-Centered Medical Homes. Similarly, the state may employ the Accountable Care Organization Consumer Assessment of Healthcare Providers and Systems survey to assess patient experience with Accountable Systems of Care. Results from these surveys will be shared with a number of groups inside and outside of the state.

Providers leverage the use of health information technology to improve quality

Rollout of prioritized use cases is a primary mechanism for ensuring that providers will leverage the use of HIT to improve quality. Two examples of such use cases are Admission – Discharge – Transfer (ADT) service and Advanced Medication Reconciliation (AMR). Together these use cases will impact care delivery in the state across multiple dimensions, including clinical and information technology.

The set of prioritized use cases are described in detail in Section C10 (Health Information Technology). One use case is AMR. AMR is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Another use case is an ADT service. ADT notification is widely regarded as a keystone to improving patient care coordination through health information exchange. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. Alerts are then sent to update physicians and care management teams on a patient's status, thus improving post-discharge transitions, prompting follow-up, improving

communication among providers, and supporting patients with multiple or chronic conditions. ADT notifications also support the identification of patients who are frequent or high users of the health care system, which allows providers to steer these patients toward clinical and non-clinical interventions that may reduce unnecessary overutilization by preventing avoidable emergency department visits and hospital readmissions.

There is an adequate health care workforce to meet state residents' needs

Section C9 (Workforce Capacity Monitoring) identifies efforts underway to ensure that there is an adequate healthcare workforce in the state, including information on workforce capacity and health care workforce capacity programs.

Providers perform at the top of their license and board certification

All care delivery models will rely on providers to operate at the top of their license. One of the guiding principles for health care transformation is to encourage care to be delivered by the right provider, in the right place, at the right time. Two mechanisms for ensuring providers perform at the top of their license and board certification are the state's Licensing and Regulatory Authority and the terms in the contract for Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan.

Managed Care Plans participating in the Medicaid program must comply with the requirements of the Michigan Compiled Law 500.3528 regarding the credentialing and re-credentialing of providers within the Contractor's network. This includes specific language relating to ensuring that enrollees are licensed by the State and are qualified to perform their services throughout the life of the contract.

The Licensing body within the state is the Department of Licensing and Regulatory Affairs, which regulates licensing with community and health systems, specifically the Health Facilities Division within the Bureau of Community and Health Systems. The Division is responsible for state licensing of hospitals (acute and psychiatric), freestanding surgical outpatient facilities, hospices (agencies and residences), partial psychiatric hospitalization programs, and substance abuse programs. The Division also conducts federal certification and survey activities for Michigan providers that want to participate in the Medicare/Medicaid programs (home health agencies, end stage renal disease facilities, rural health clinics, etc.). Finally, the Division conducts state plan reviews and construction permits for state licensed health facilities.

Performance in quality and cost measures is consistently high

The SIM program will align participating payors and providers on a common provider scorecard that includes quality, access, patient experience, outcomes, and utilization measures. Participating payors will provide data to build performance reports for Patient-Centered Medical Homes and Accountable Systems of Care based on standard performance metrics and measure. Quarterly performance reports with benchmarking of

provider performance are planned. High-performing providers will potentially receive larger compensation in the form of shared savings.

Value-based payment models implemented under the SIM program’s health care transformation strategy will directly incentivize providers to work towards cost avoidance and quality. Shared savings payment models within Patient-Centered Medical Homes and Accountable Systems of Care will encourage providers to deliver high-quality, efficient care in an appropriate treatment setting by linking shared savings payments to total cost of care accountability.

Population health measures are integrated into the delivery system

Two potential approaches which the state will take to integrate population health measures into the delivery system are (1) requiring Community Health Innovation Regions to measure population health metrics and (2) incorporating population health metrics into the state’s data warehouse.

On the first approach, Table C4.1 (Community Health Innovation Region Measures) is a draft list of population health measures which will be measured for each Community Health Innovation Region. The Population Health Committee will review the metrics and identify which should be measured. The Population Health Committee will assess the feasibility of capturing and measuring these metrics, with potential sources of data including Behavioral Risk Factor Surveillance System oversamples and data from vital records.

Table C4.1 Community Health Innovation Region Measures

Domain	SIM Target Populations	Measures
Health Indicators - At-Risk Pregnancy	Teen birthrates (birth by age of mother)	Live births for mothers aged 19 or younger per 1,000 women per year
Health Indicators - At-Risk Pregnancy	Infant mortality	Number of infant deaths per 1,000 live births
Health Indicators - At-Risk Pregnancy	Premature newborns	Live births with less than 37 completed weeks gestation, percent of total
Health Indicators - At-Risk Pregnancy	Low birth weight newborns	Live births weighing less than 2,500 grams, percent of total
Health Indicators	Adult hypertension prevalence	Among all adults, the proportion reporting that they were ever told by a doctor that they had High Blood Pressure (HBP). Women who had HBP only during pregnancy and adults who were borderline hypertensive were considered to not have been diagnosed.
Health Indicators	Adult obesity rate	Among all adults, the proportion of respondents whose BMI was greater than or equal to 30.0.
Health Indicators	Percent of adults reporting fair or poor health	Among all adults, the proportion reporting that their health, in general, was either fair or poor
Health Indicators	Number of mentally unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor mental health, which includes

		stress, depression, and problems with emotions, during the past 30 days.
Health Indicators	Number of physically unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor physical health, which includes physical illness and injury, during the past 30 days.
Health Indicators	Chlamydia prevalence	Number of chlamydia cases per Michigan resident
Health Indicators	Childhood immunization status rates	Percentage of children with documentation confirming school required immunizations, or having at least one dose of each of the required immunizations awaiting receipt of subsequent doses to be administered at appropriate intervals
Health Behaviors	Rates of adequate physical activity for adults	Among all adults, the proportion reporting that they do either moderate physical activities for at least 150 minutes per week, vigorous physical activities for at least 75 minutes per week, or an equivalent combination of moderate and vigorous physical activities and also participate in muscle strengthening activities on two or more days per week.
Health Behaviors	Rates of inadequate daily consumption of fruits and vegetables for adults	Among all adults, the proportion whose total reported consumption of vegetables/ fruits (including juice) was less than one time per day.
Health Behaviors	Rates of excessive alcohol consumption for adults	Among all adults, the proportion reporting consumption of five or more drinks per occasion (for males) or four or more drinks per occasion (for women) at least once in the previous month.
Health Behaviors	Adult cigarette smoking	Among all adults, the proportion reporting that they had ever smoked at least 100 cigarettes (5 packs) in their life and that they smoke cigarettes now, either every day or on some days.

The second potential approach for integrating population health variables into the delivery system would be adding relevant population health fields into the state’s data warehouse. Population health variables will be assessed by the Community Health Innovation Region/Population Health components for both relevance and feasibility. Potential variables to be included are:

- Individual (Race, Ethnicity, Language, Age, Gender (sexual orientation), etc.)
- Physical Environment (Neighborhood Safety, Home Hazards, Homelessness, Crowded Housing, etc.)
- Social (Income, Occupation, Incarceration History, Citizenship Status, Military Status, etc.)

Data is used to drive health system processes

The SIM program team will define use cases to ensure that clinical and claims data is used to drive health system processes. Data will be used in four key ways to support health system processes: (1) SIM

Performance Metrics and Reporting, (2) Care Coordination Enablement, (3) Payment Model Analytics and Reporting and (4) Population Health Toolset.

The set of prioritized data collection, transport, storage and analytic use cases are described in Section C10. One use case is the Active Care Relationship Service (similar to patient provider attribution service in other states). This service will enable alerts to providers in active care relationships with patients and coordinate the entire care team with changes to patient status in real time. Another use case is an Admission – Discharge – Transfer service. The ADT Service uses an advanced algorithm to compare patient information from the ADT message to information provided by those who have an active care relationship with the patient. The service then pushes the ADT message to patient-authorized providers or organizations using the notification preferences in the statewide health provider directory. The recipient of the notification can then make the appropriate determination of action necessary to coordinate effective care to the patient. Other prioritized use cases include a Health Provider Directory and Discharge Medication Reconciliation.

5 – Payment and/or Service Delivery Model(s)

In Development

6 – Leveraging Regulatory Authority

In Development

7 – Quality Measures Alignment

Michigan is currently working toward aligning all participating payors and providers on a common provider scorecard to assess and reward provider performance in Accountable Systems of Care and Patient-Centered Medical Homes.

The State will align closely with the Physician-Payer Quality Collaborative (PPQC) to this end. The PPQC is a multi-stakeholder initiative focused on aligning and streamlining quality measure processes. The Physician-Payer Quality Collaborative is led by the Michigan State Medical Society (MSMS) with support from the Michigan Health Information Network Shared Services (MiHIN). In Year 1, Michigan will aim to establish reporting on the clinical quality and utilization metrics in its Core Metrics set articulated in Table A3.1, which represent a subset of measures identified by the PPQC. These metrics were selected based on multiple considerations including:

- The presence of the metric in the initial PPQC ten-measure pilot set
- Whether a particular metric is a CMMI priority metric for SIM
- The ease of which a data aggregator could collect, store, and disseminate the data

Background, History, and Next Steps for the PPQC

The PPQC’s measure alignment work was motivated by the Michigan State Medical Society Executive Council of Physician Organizations identifying quality measure alignment as their top priority for 2015 and beyond in a member survey. MiHIN holds a quarterly Payer Qualified Organization Day, where commercial and state payors also unanimously identified quality measure processes as a significant pain point needing improvement. The Michigan State Medical Society and Michigan Health Information Network Shared Services then partnered to form the Physician-Payer Quality Collaborative to bring all groups to the table to find solutions.

The Collaborative has been working over the last several months to identify a set of quality metrics which demonstrate participating payors’ commitment to reducing the administrative and reporting burden to providers in the state. Multiple payors in the state have contributed to the effort, including Medicaid, Blue Cross Blue Shield of Michigan, Meridian, Molina, Priority, and United Healthcare. Given the progress to date it is expected that alignment on the final set of quality measures across all payors in the state will be completed within 12 months.

In addition to aligning on metrics overall, other efforts of the above body which are relevant to ongoing efforts on metric alignment include “Data Capture and Collection” and “Harmonization Financial Incentives & Pay for Performance.” The effort on data capture and collection will focus on developing standards and to efficiently and accurately record, store, and transmit data necessary to calculate selected quality measures. Sources of data can include clinical supplemental data, insurance claims, laboratories, and others. This group will also work toward standardization of provider lists, credentialing, and performance reports, including the timeliness of data. Additionally, once quality measures are calculated, the group will identify ways that results and any identified gaps in care can be communicated back to providers in a meaningful and accessible way. Michigan’s core Model Test components, Population Health and Care Delivery, and related supporting component teams will be aligned with these activities through the continued membership of the Medical Services Administration, key Medicaid Health Plans, and participating PCMH and ASC providers in the PPQC.

8 – SIM Alignment with State and Federal Initiatives

In Development

9 – Workforce Capacity

In Development

10 – Health Information Technology

Rationale

A. Michigan HIT/HIE Approach and Background

The SIM Technology Implementation Team is working towards an HIT/HIE solution that leverages existing technology investments in order to create building blocks towards a long-term vision of data interoperability. An interoperable Health Information Technology (HIT) ecosystem makes the right data available to the right people at the right time across products and organizations. The State believes that building towards this level of interoperability is essential for payment and care delivery reform.

Four core technology pillars will be implemented to support the healthcare transformation goals of the Michigan SIM Test. The technology pillars are:

- Performance Metrics and Reporting
- Care Coordination Technology
- Payment Model Analytics and Reporting
- Population Health Toolset

B. Foundational Use Case Building Blocks

There are four building blocks, or foundational use cases, that are critical to the success of the establishment of the technology pillars. The implementation of the use cases will be facilitated by the Michigan Health Information Network (MiHIN) and the trusted data sharing organizations within the MiHIN network. MiHIN and the data sharing organizations are critical SIM partners in achieving the interoperability goal.

1. Statewide Active Care Relationship Services

The first use case is the Statewide Active Care Relationship Service (ACRS). This is a physician-patient centric attribution that is based on declared relationships established directly from the physician or provider organizations. The timely and more clinically-aligned nature of the ACRS approach serves as an ideal foundation for a variety of care coordination, quality reporting, and evaluation capabilities. Further, the regular feeds of the ACRS file will be used to help populate the Health Provider Directory.

2. Healthcare Provider Directory

The second use case is the Health Provider Directory (HPD). This is a statewide directory of healthcare providers that collects demographic, contact, and electronic service information. Authorized healthcare organizations and health professionals can use the HPD to submit, update and look up electronic addresses and electronic service information to facilitate secure exchange of health information. The HPD will also be utilized as the source for SIM participation metrics, thus providing the ability to define the SIM population and create a denominator for the SIM Test.

3. Common Key Service

The third use case is the Common Key Service (CKS). This is a statewide service that enhances patient matching to facilitate the exchange of health information across disparate data systems. The service assigns a

unique key that is stored and attached to the patient in the State of Michigan's Master Person Index (MPI), and shared with all systems exchanging information about that patient. This reliable matching capability improves patient safety and data integrity in all use cases when information about a specific patient is shared. SIM will utilize the CKS to effectively identify, match, and track the SIM patient population.

4. SIM Relationship and Attribution Management Platform

Lastly, the care delivery approaches and payment reform models in SIM further heighten the need for an effective process for linking (or attributing) each patient to a provider. SIM is currently working with MiHIN to expand upon the current ACRS statewide service in order to create a streamlined relationship and attribution management platform. The platform will enable a consistent shared process for communicating and tracking affiliations and linkages among SIM stakeholders. This management platform will also support tracking participation in health plan/payment models and programs such as SIM, Michigan Primary Care Transformation Project (MiPCT), Meaningful Use, and MI Health Link (also known as the Duals Demonstration project).

Figure C10.1 provides additional detail on the four core technology pillars, as well as the relationship and attribution management platform.

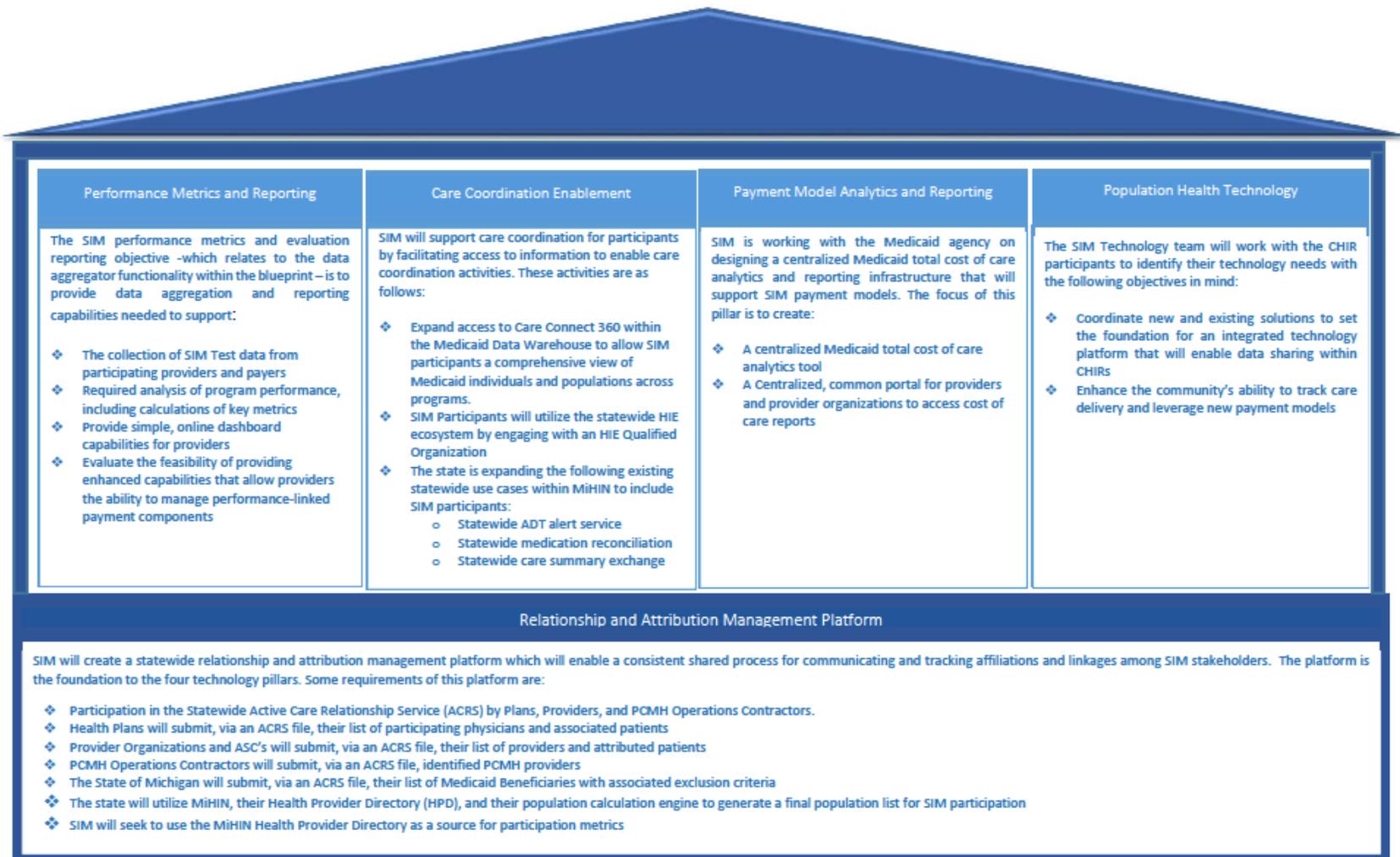


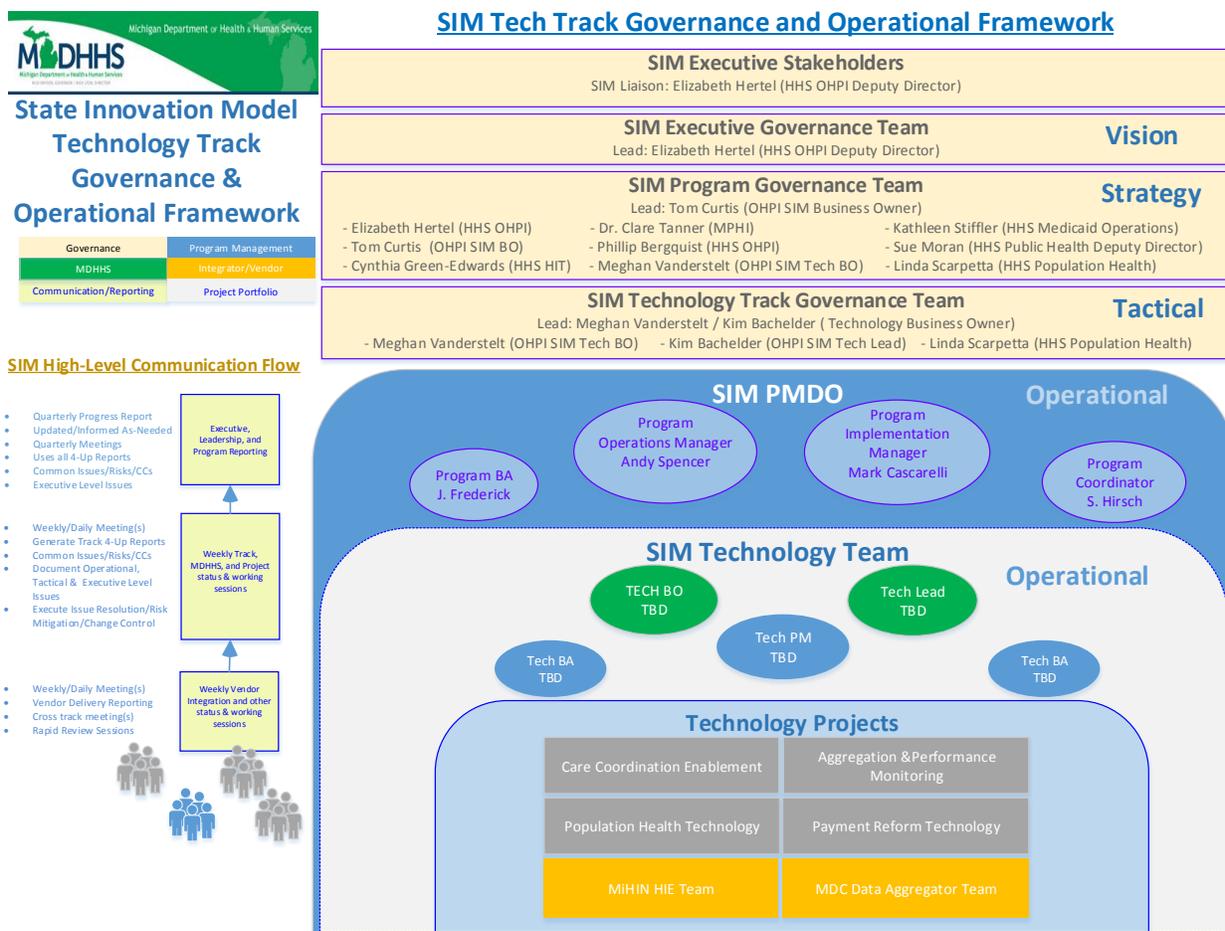
Figure C10. 1 Relationship and Attribution Management Platform

Governance

A. Overview of SIM Governance for Healthcare Information Technology

Healthcare Information Technology (HIT) will be governed by a subset of the overall SIM governance structure, as outlined in section C1 (SIM Governance, Management Structure, and Decision-making Authority). The SIM Technology Team manages the HIT/HIE requirements, implementations, integrations, and other SIM-dependent technology and interfaces. The Technology Team’s primary goal is to implement the core model test component technological components while maintaining alignment and compliance to State and Federal standards and related initiatives. Additional alignment, communication and idea flow with participants and stakeholders (both public and private) will be facilitated via the HIT/HIE Committee, which is part of the overarching SIM Commission for public/private SIM-related engagement. Figure C10.2 (Technology Component Governance) depicts the high-level technology team and its overall composition and linkages the SIM Governance Structure.

Figure C10. 2 Technology Component Governance



B. SIM Technology Implementation Team

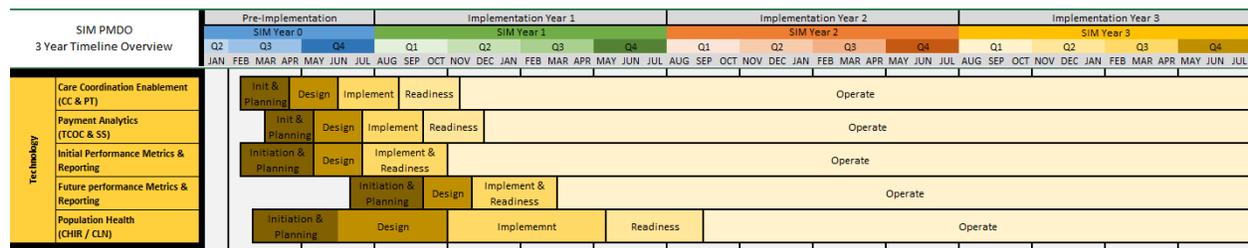
The SIM Technology Implementation Team is a chartered project managing the portfolio of technology initiatives that has been established to support implementation and operationalization of the SIM component initiatives – Community Health Innovation Regions (CHIRs), Patient-Centered Medical Homes (PCMHs) and Accountable Systems of Care (ASCs).

The goals of the technology initiative portfolio are to:

- Strengthen primary care infrastructure
- Support coordinated care for individuals with intensive support needs
- Improve systems of care to ensure appropriate utilization of healthcare services
- Build capacity within communities to improve population health
- Reduce administrative complexity

Tentative Year 1 Technology Implementation Team Timeline

Figure C10.3 Technology Component Timeline



C. SIM Commission and HIT/HIE Committee

The SIM Commission will monitor overall progress of the SIM initiative, engage their organizations and advise State leadership on strategy and alignment with organization priorities during the SIM implementation. The commission will offer guidance on overarching model test decisions. It will also review consensus recommendations made by committees and, where needed, make recommendations on how to resolve discrepancies.

The HIT/HIE committee will provide recommendations and input on HIT/HIE decisions related to the design and operationalization of the core HIT/HIE elements supporting coordinated care delivery and value-based payment models.

D. MiHIN and MOAC Committee for SIM Governance Use

The SIM Technology Implementation Team will leverage the existing MiHIN MOAC governance model to introduce new use cases into the HIE infrastructure as new data exchange needs are established within SIM.

Policy

The SOM will leverage current regulatory levers already in-place to accelerate participant adoption of existing state infrastructure and new models.

A. Medicaid contract HIT/HIE requirements and Medicaid integration efforts

The State will leverage policy and existing and new contracts to accelerate HIT/HIE adoption.

Contracted Medicaid Health Plans (MHPs) must join MiHIN, and engage and incentivize their provider network to increase the number and percentage of network providers that are members of Health Information Exchange Qualified Organization (HIE QO) also known as sub-state HIEs.

- MHPs must, by the end of Contract Year One, join MiHIN as a Qualified Organization.
- MHPs must, by the end of Contract Year One, report to MDHHS the number and percentage of contracted providers connected to a HIE QO.
- MHPs must, by the end of Contract Year Two, submit to MDHHS a plan to offer incentives for providers to join a HIE QO.
- MHPs incentive plan must prioritize:
 - Provider capability to, at a minimum, receive admission, discharge and transfer (ADT) messages.
 - Provider participation in the statewide Active Care Relationship Service (ACRS) thereby enabling access to the Common Key Service.
 - Provider participation in the statewide Medication Reconciliation MiHIN Use Case for the purpose of sharing patient medication information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities.
 - Provider adoption of e-prescribing and e-portals in accordance with national and State laws and ONC regulations and standards for meaningful use.

Additional HIT/HIE-related language and requirement amendments may be made to accommodate the full scope of the SIM Model Test in Michigan. New regulations to support HIT/HIE adoption in the state would be continuously monitored during the SIM Test period and incorporated as feasibility allows.

B. Medicaid EHR incentive program

The Centers for Medicare & Medicaid Services (CMS) offers, through provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to certain medical providers participating in Medicaid. These incentives are available to those Medicaid providers who meet eligibility requirements and meaningfully use a Certified Electronic Health Record Technology (CEHRT).

Overarching goals of this program include:

- Enhancing care coordination and patient safety;
- Reducing paperwork and improving efficiencies;
- Facilitating electronic information sharing across providers, payors, and state lines; and,
- Enabling data sharing using state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN).

Michigan Department of Health and Human Services (MDHHS) has established rules and guidelines to advance the adoption and meaningful use of certified Electronic Health Record (EHR) technology through the Medicare and Medicaid Electronic Health Record Incentive Programs authorized by the Health Information Technology for Economic and Clinical Health Act (HITECH). These incentive programs will advance Michigan's Health Information Technology (HIT) plan in alignment with SIM Model Test and national goals outlined in this plan.

C. Office of National Coordinator Interoperability Roadmap

The Office of the National Coordinator (ONC) for Health Information Technology roadmap focuses on actions that will enable a majority of individuals and providers across the care continuum to send, receive, find and use a common set of electronic clinical information at the nationwide level by the end of 2017. Although this near-term target focuses on individuals and care providers, interoperability of this core set of electronic health information will also be useful to community-based services, social services, public health and the research community. This includes standardized data elements, such as demographics, that will enable better matching, linking, and aggregation of electronic health information across all systems and platforms.

The four most important actions for public and private sector stakeholders to take to enable nationwide interoperability of electronic health information through health IT in the near term are: (1) establish a coordinated governance framework and process for nationwide health IT interoperability; (2) improve technical standards and implementation guidance for sharing and using a common clinical data set; (3) enhance incentives for sharing electronic health information according to common technical standards, starting with a common clinical data set; and (4) clarify privacy and security requirements that enable interoperability. The Model Test in Michigan will ensure that these stakeholders are engaged throughout the Model Test period.

As part of SIM, the State will align with other federal funding initiatives to advance interoperability across the care continuum such as utilization of Medicaid Advanced Planning Document (APD) funding to develop and adopt additional use cases to promote data exchange and interoperability for the Model Test and beyond.

Infrastructure

In Development

Technical Assistance

In Development

Summary

Healthcare Information Technology is a critical enabler to support Michigan's SIM participants in implementing the Triple Aim targets as outlined in this operational plan. In support of the State of Michigan and SIM goals the HIT/HIE infrastructure must enable the SIM technology pillars of care coordination, payment reform, population health and evaluation program data.

The State will begin to launch the technology pillars in the fall of 2016 in support of the SIM Patient-Centered Medical Home portion of the Care Delivery component, as well as begin the planning for, and identification of, the Community Health Innovation Region model test technical requirements.

11 – Program Monitoring and Reporting

SIM Test participants provide quantifiable measures for regularly monitoring the impact of the proposed model, including the effectiveness of the policy and regulatory levers applied under the SIM Test, on the three key outcomes of (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending. Measures should be selected with a focus on the particularized state health demographics and health needs the Model Test proposal aims to address.

The Michigan SIM Test will track and monitor the following areas:

- Hospital Readmission Rates
- Emergency Department Visits
- Patient Experience
- Diabetes Care
- Tobacco Use
- Obesity
- Total Cost of Care Per Member Per Month
- Behavioral Health

Monitoring for Quality, Cost, and Health Outcomes

In order to measure three key outcomes – (1) strengthening population health, (2) transforming the health care delivery system, and (3) decreasing per capita health care spending – Michigan will leverage the initial quality and utilization metrics described in Section A3 (Core Metrics and Accountability Targets) of this document. The final measure set will be refined in collaboration with the Centers for Medicare & Medicaid Services, and SIM participant stakeholders over the course of the SIM Test period. A crosswalk between CMMI recommended measures and Michigan’s proposed initial measure set is provided in Table C11.1 below. Claims and encounter data, supplemented by clinical data and survey measurement (for patient experience), will be the primary sources for monitoring and reporting on performance on these measures (see C10: Health Information Technology).

Reporting using the state’s entire population as the denominator is not feasible at present for many of the measures outlined in Section A3 (Core Metrics and Accountability Targets). However, Michigan will seek to expand the number of individuals included in the denominator to the greatest extent possible over the course of the Model Test. The State anticipates to report, where possible, the population health measures outlined in A3 (Core Metrics and Accountability Targets) using the statewide population as the denominator. The Behavioral Risk Factor Surveillance System (BRFSS) survey, along with information from Michigan’s vital records systems and immunization registry, will be the primary sources of data for population health-related monitoring and reporting.

Table C11.1 CMMI Recommendations and Michigan Proposed Metric Crosswalk

CMS Recommended Measure	Proposed Core Set Metrics
1. Hospital Readmission Rates	Plan all-cause readmissions
2. Emergency Department Visits	Emergency Department Visits
3. Patient Experience	PCMH CAHPS
4. Diabetes Care	Comprehensive Diabetes Care composite ⁵
5. Tobacco Use	Tobacco Use: Screening and Cessation Intervention; BRFSS Adult cigarette smoking
6. Obesity	Adult BMI Assessment; BRFSS Adult obesity rate, Rates of adequate physical activity for adults, Rates of inadequate daily consumption of fruits and vegetables for adults
7. Total Cost of Care PMPM	Total Resource Use Population-based PMPM Index
8. Behavioral Health	Screening for clinical depression; BRFSS Number of mentally unhealthy days in last 30; Rates of excessive alcohol consumption for adults

Michigan is also developing care coordination measures for beneficiaries assigned to PCMH practices or providers, potentially leveraging G-codes and care management-related CPT codes.

Participation Monitoring

In addition to monitoring outcomes, Michigan will also monitor program implementation. Many, but not all, of these measures are discussed in C3 (Plan for Improving Population Health). Participation monitoring will include certain items specific to ASCs/PCMHs and CHIRs:

- ASCs and PCMHs:** Michigan will track the number of providers and provider organizations participating, including compliance with SIM-developed expectations. For PCMHs this will include, among other items, ensuring the maintenance of a specified ratio of SIM-eligible patients to care managers. For ASCs, this will include, among other items, ensuring the execution of shared savings contracts that reflect the SIM guidelines (see Sections C4 and C5).
- CHIR social service navigation:** The particular approach to monitoring of CHIR-provided navigation services will vary depending on the models adopted by each CHIR (e.g., Pathways Community Hubs). The State anticipates that, at a minimum, Michigan will monitor the number of individuals served, the services provided, and the extent to which individuals’ needs were met. Michigan will seek to promote adoption of a common platform for reporting community navigation services provided to residents.

⁵ HbA1C Poor Control rates may not be included initially depending on availability of clinical information.

- **Other CHIR activities:** Michigan will track the engagement of key organizations – as well as individuals with lived experience – participating in CHIR governance and operations. Section A3 lists some of the organizational types whose participation is to be tracked. Michigan will also track CHIR reporting on the common measurement platform, through which CHIRs will report on their local region-specific measures. In addition, Michigan will monitor the activities of CHIRs through regularly written progress reports to be submitted quarterly by CHIRs as well as bimonthly check-in calls with CHIR staff. These monitoring activities will include the development and execution of CHIR-developed operational plans. Lastly, Michigan will require CHIR organizations receiving grant support from Michigan SIM to regularly report on the expenditures of any funds.

Across all components, Michigan will use capacity assessments, reports from improvement coaches, and feedback through stakeholder committees (see Section C2: Stakeholder Engagement) to monitor the experience of participation (e.g., perceived level of burden, opportunities for improving model design, utility of SIM-provided supports, including HIT/HIE and CLN, etc.) as well as the development of skills and expertise for continuous improvement within Model Test participants. In addition, lessons learned will be routinely “harvested” by Michigan staff, with reports documented and catalogued on an online collaboration platform. SIM will support a formative evaluation for purposes of monitoring and gathering of lessons learned.

12 - Data Collection, Sharing, and Evaluation

In Development

13 – Fraud and Abuse Prevention, Detection, and Correction

In Development

D. Appendix

State Innovation Model Acronyms and Abbreviations

HIE	Health Information Exchange
HIT	Health Information Technology
MiPCT	Michigan Primary Care Transformation Project
MOAC	MiHIN Operations Advisory Committee
MSSP	Medicare Shared Savings Program
NCQA	National Committee for Quality Assurance
PCMH	Patient-Centered Medical Home
PGIP	Physicians Group Incentive Program (BCBS)
CHIR	Community Health Innovation Region
CHNA	Community Health Needs Assessment
CMS	Center for Medicare & Medicaid Services
FQHC	Federally Qualified Health Center
MSMS	Michigan State Medical Society
ACO	Accountable Care Organization
ASC	Accountable Systems of Care
CHIR	Community Health Innovation Regions
CLN	Collaborative Learning Network
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
IHI	Institute for Healthcare Improvement
MDC	Michigan Data Collaborative
MiHIN	Michigan Health Information Network
MPHI	Michigan Public Health Institute
PMDO	Project Management and Delivery Office
PMPM	Per Member Per Month
TCOC	Total Cost of Care

Accountable Systems of Care Certification Guidelines

ASC Participation Agreements and Contracts

- ASCs will attest to required characteristics and will agree to SIM participation requirements, as part of an initial participation agreement, e.g. Memorandum of Agreement- (MOA).
- The MOA will be executed between a participating ASC and MDHHS.
- The MOA will outline ASC responsibilities and expectations, minimum requirements for the contracts between ASCs and payers/MHPs and guidelines for payment methodology options.
- ASCs will complete an abbreviated annual renewal process to continue program participation including amendment(s) to the participation MOA if applicable.
- ASC must negotiate in good faith with interested MHPs.
- ASCs will be required to execute a contract with interested MHPs and other payers in addition to the ASC participation MOA with DHHS.

- DHHS and MHPs may require periodic amendments to an ASC's contract.
- Initially and annually, DHHS will provide a template for ASC-MHP contract amendments that participating entities can use for this purpose.

Governance

- ASC must have an Executive Director responsible for the activities of the ASC and must designate a chief medical officer
- ASC must have a governing board that oversees the operations of the ASC
- ASC must have Conflict of interest policy for disclosing relevant financial interests for governing body
- Governing board must include proportional representation of providers within the ASC's network, including participation of PCP providers, as well as representatives from community-based organizations, and consumer representative(s)

Participation in Community Health Innovation Regions (CHIRs)

- ASC must agree to actively participate in the applicable Community Health Innovation Region (CHIR) in its SIM Test Region. Specifically the ASC must:
 - support the goals and operations of a CHIR,
 - participate in the CHIR's decision-making body,
 - through the CHIR, coordinate with other community providers and stakeholders to draft a single community health needs assessment for the community,
 - support the CHIR in the analysis of community health information,
 - coordinate with the CHIR on cross-sector efforts to improve health and health care,
 - participate in the regional development of shared priorities among the CHIR's members,
 - work with the CHIR to integrate community-based primary and secondary prevention and wellness initiatives with the preventive care efforts of the ASC,
 - assist the regional CHIRs with identification of sustainable funding for community improvement initiatives, and
 - share performance data with regional CHIRs.

Participation in SIM Activities

- The ASC must participate in SIM Initiative activities, including but not limited to activities related to SIM evaluations.
- The ASC must actively participate in any SIM collaborative learning networks applicable to ASCs. These activities will include periodic web-based or in person learning opportunities and successful strategy sharing sessions.
- ASCs will work with SIM to generate multi-payer and multi-stakeholder (provider association, continuing education providers etc.) collaboration surrounding practice support to stimulate alignment.

Attribution

- In order to share in Medicaid savings, an ASC must have a minimum of 5,000 attributed patients
- In order to be able to increase share of savings, and to take on shared risk, an ASC must have a minimum of 10,000 attributed patients.
- If a member's PCP participates in an ASC, patients will be automatically attributed to the ASC based upon the primary care provider selection/assignment on record with the applicable payer/MHP.
- While most Medicaid members will be eligible from PCMH and ASC initiatives, some will be excluded to start including beneficiaries that are dual eligibles or currently part of MI Health Link, 2703 Health Homes, and PACE.
- Only patients served by participating payers that do not fall into an excluded beneficiary population will be attributed to PCPs/PCMHs and their affiliated ASC for the purposes of SIM

ASC Provider Network

- ASC must include sufficient number of PCPs/PCMHs to serve attributed members, including age-appropriate PCPs such as pediatricians.
- A minimum percentage of FTE PCPs in each ASC must be practicing in recognized/certified PCMHs, the remainder must be working in practices pursuing PCMH recognition/certification. ASCs must continue to increase the minimum percentage of PCPs that are PCMHs in Year 2 and Year 3 of SIM.
- ASC provider networks can include (but are not required to include) additional providers, such as hospitals, specialists, behavioral health providers, etc.
- ASCs must demonstrate a relationship with specialty care and behavioral health providers in addition to one or more hospitals which accept patient referrals and agree to cooperate with PCMH care coordination activities.
- ASCs must have written agreements in place with provider network that describe provider responsibilities as part of the ASC and that also describes the ASC's plan for allocating/distributing shared savings (or risk as applicable), consistent with SIM ASC requirements.
- In these written provider agreements, the ASC shall require its network providers to agree/attest to a group of applicable participation requirements including:
 - data access and use including HIT/HIE and EHR requirements,
 - practice features like 24/7 clinician access,
 - completion of a standardized self-assessment process on an annual basis to measure and track PCMH implementation maturity over time,
 - coordination and referral requirements,
 - enrollment as a Michigan Medicaid Provider in compliance with all standard provider policies for participation with Medicaid, and
 - participation in SIM Initiative activities such as those related to the SIM evaluation.

Care Management /Care Coordination

- ASC must have way of identifying patients for different levels of care management (predictive modeling)]
- At a minimum, CM must be available to SIM target populations: ED super-utilizers, those with multiple chronic conditions, and pregnant women.
- ASC must work with MHPs to jointly develop and implement:
 - Care coordination and care management standards for providing care management services to enrollees who have significant behavioral health issues and complex physical co-morbidities based on patient needs and goals, and,
 - Processes for providing coordinated complex care management and care coordination services to Enrollees who have significant behavioral health issues and complex physical co-morbidities.

Integration of Physical and Behavioral Health (BH) Care

- ASCs must
 - develop a plan to increase integration of physical and behavioral health care
 - support training on evidence-based behavioral health screening tools for primary care providers,
 - establish and identify key personnel who are responsible and accountable for BH integration activities, including establishing a structure for ongoing communication and collaboration with MHPs to facilitate the integration of behavioral health care and primary care.
 - work collaboratively with MHPs to coordinate the provision of services to enrollees who have significant behavioral health issues and complex physical co-morbidities.
- ASCs must develop relationships with the CMHCs and be able to share data with CMHCs

Clinical Protocols

- ASC must develop/implement relevant clinical protocols
- ASCs must implement evidence-based practices, such as medication management and motivational interviewing
- ASCs must conduct discharge planning for beneficiaries, as well as planning for other care transitions

Quality Measurement

- ASCs must have a Quality Improvement Committee which includes the Chief Medical Officer.
- ASCs must measure and monitor performance metrics required by SIM and by health plans.
- ASCs must conduct or participate in a patient experience survey related to SIM and/or MHP participation as defined in the ASC MOA.
- ASCs must meet or exceed quality performance targets in order to be eligible for shared savings
- ASCs must support and utilize a core set of quality measures established by SIM as the foundation for shared savings linked quality thresholds for PCMHs and ASCs. To support standard measures

and multi-payer participation, the SIM quality measures will align with CMS/AHIP agreement on performance measures.

- Initially, the core SIM quality metrics will include a subset of the following measures:

Adult BMI Assessment	Childhood Immunization Status	Well Child Visits 15 months	Well Child Visits 3-6 years
Colorectal Cancer Screening	Immunizations for Adolescents	Adolescent Well Care Visits	Follow-up for ADHD
Appropriate Treatment for URI	Appropriate testing for pharyngitis	Lead Screening	Imaging Studies for Low Back Pain
CDC: Hemoglobin A1c Testing	CDC: Hemoglobin A1c Poor Control	CDC: Eye Exam Performed	CDC: Medical Attention for Nephropathy
CDC: Blood Pressure Control	Controlling High Blood Pressure	Weight Assessment + Counseling	Tobacco Use Screening and Cessation
Screening for Depression + Follow-up	Avoidance of Antibiotics for Bronchitis	Prenatal & Postpartum Care	Cervical Cancer Screening
Breast Cancer Screening	Chlamydia Screening	Antidepressant Medication Management	

- The SIM Care Delivery Committee will evaluate metrics selected on an annual basis and recommend additions, removals and/or adjustments to applicable performance thresholds for SIM’s governing body to approve.

Information Technology

- ASCs will be required to possess and maintain the following:
 - Connection to a Health Information Exchange (HIE) Qualified Organization (QO), also known as sub-state HIEs,
 - Ability to participate in MiHIN/HIE use cases applicable to SIM (e.g. Admit-Discharge-Transfer Notification Service),
 - A patient registry or EHR registry functionality,
- ASCs must be able to share relevant data and information with PCPs, PCMHs, and other ASC network providers
- ASCs must have capacity to develop provider profiles, identify gaps in care, and develop processes to effectively use the data in order to improve care and meet patient needs.

Total Cost of Care Methodology

- TCOC methodology will compare actual costs of care for the attributed ASC population to the expected TCOC for a designated performance period.

- The expected TCOC will be calculated based on a historical baseline of expenditures for the same attributed population; considerations will be made for panel members who are not in the ASC for the entire ASC performance period.
- MHP members must have been in the plan AND in a PCP/PCMH that is part of the ASC for a minimum time period for that member's experience to be counted in the shared savings calculations.
- The expected TCOC for the ASC would be net of savings the health plan is expected to achieve under current rates without an ASC

Shared Savings/Risk Calculations

- A minimal savings level must be met based on the TCOC methodology and taking into account the statistical significance of the calculated savings level attributed to the ASC.
- If minimal savings target is met, then ASC will share in savings with the MHP; the amount of potential shared savings will increase where the ASC takes on risk
- When a PCMH is part of an ASC, total cost of care related risk will be pooled within the ASC.
- Shared savings payments for all associated PCMHs will be made to the ASC and the ASC will hold responsibility for distributing savings to the providers in its network using a methodology approved by SIM.
- ASC must provide a minimum percent of savings with participating PCPs/PCMHs.

Financial Solvency and Financial Guarantee

- ASCs accepting downside risk would need to meet financial requirements as determined by the state (and/or by the MHP)
- If an ASC enters into an arrangement that provides for shared losses with a downside risk limit or risk corridor that:
 - exceeds a certain percentage of the total cost of care, ASCs will be required to furnish financial reports regarding risk performance on a [semi- annual] basis to the contracted MHP(s) and to the state.
 - exceeds a certain percentage of the total cost of care, the ASC must meet financial reserve and risk based capital requirements required of an MHP, with oversight by the Department of Business Regulation.
- ASCs that enter into downside risk arrangements that exceed a percentage of the total cost of care must obtain a financial guarantee in an amount equal to a certain percentage of its total expected medical expenditures for attributed beneficiaries for the relevant performance year. The financial guarantee must be in one or more of the following forms:
 - funds placed in escrow;
 - a line of credit as evidenced by a letter of credit; and/or
 - a surety bond.