

State Innovation Model – Report 1

(FY2018 Appropriation Act - Public Act 107 of 2017)

March 1, 2018

Sec. 1144. (1) From the funds appropriated in part 1 for health policy administration, the department shall allocate the federal state innovation model grant funding that supports implementation of the health delivery system innovations detailed in this state's "Reinventing Michigan's Health Care System: Blueprint for Health Innovation" document. This initiative will test new payment methodologies, support improved population health outcomes, and support improved infrastructure for technology and data sharing and reporting. The funds will be used to provide financial support directly to regions participating in the model test and to support statewide stakeholder guidance and technical support.

(2) Outcomes and performance measures for the initiative under subsection (1) include, but are not limited to, the following:

(a) Increasing the number of physician practices fulfilling patient-centered medical home functions.

(b) Reducing inappropriate health utilization, specifically reducing preventable emergency department visits, reducing the proportion of hospitalizations for ambulatory sensitive conditions, and reducing this state's 30-day hospital readmission rate.

(3) By March 1 and September 1 of the current fiscal year, the department shall submit a written report to the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, and the state budget office on the status of the program and progress made since the prior report.

(4) From the funds appropriated in part 1 for health policy administration, any data aggregator created as part of the allocation of the federal state innovation model grant funds must meet the following standards:

(a) The primary purpose of the data aggregator must be to increase the quality of health care delivered in this state, while reducing costs.

(b) The data aggregator must be governed by a nonprofit entity.

(c) All decisions regarding the establishment, administration, and modification of the database must be made by an advisory board. The membership of the advisory board must include the director of the department or a designee of the director and representatives of health carriers, consumers, and purchasers.

(d) The Michigan Data Collaborative shall be the data aggregator to receive health care claims information from, without limitation, commercial health carriers, nonprofit health care corporations, health maintenance organizations, and third party administrators that process claims under a service contract.

(e) The data aggregator must use existing data sources and technological infrastructure, to the extent possible.



Michigan Department of
Health & Human Services

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Michigan Department of Health & Human Services

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State Innovation Model (SIM)

Section 1144, FY 18 MDHHS Budget Report I

Policy, Planning, and Legislative Services Administration

State Innovation Model (SIM)

Contents

1	STATE INNOVATION MODEL EXECUTIVE SUMMARY.....	1
1.1	POPULATION HEALTH COMPONENTS	1
1.2	CARE DELIVERY.....	3
1.3	TECHNOLOGY	4
1.4	SIM PROGRAM MANAGEMENT	5
2	LEGISLATIVE UPDATE.....	6
2.1	POPULATION HEALTH.....	6
2.2	CARE DELIVERY.....	7
2.3	TECHNOLOGY	9
3	EVALUATION	11
3.1	LEGISLATIVE UPDATE	11
3.2	LEGISLATIVE METRICS AND MEASURES.....	12
4	BUDGET.....	16
4.1	LEGISLATIVE UPDATE	16

1 State Innovation Model Executive Summary

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan nearly \$70 million over 4 years to test and implement an innovative model for delivering and paying for health care in the state. The award, made through the CMS State Innovation Model (SIM) initiative, was based on a plan submitted by the state in 2014, “Reinventing Michigan’s Health Care System: Blueprint for Health Innovation.”

The state, through the Michigan Department of Health and Human Services (MDHHS), has organized the work of implementing its SIM initiative under three main umbrellas: Population Health, Care Delivery, and Technology. The Population Health component has at its foundation community health innovation regions, or CHIRs (pronounced “shires”), which are intended to build community capacity to drive improvements in population health. The Care Delivery component encompasses a patient-centered medical home (PCMH) initiative and the promotion of alternative payment models. The Technology component is where the state is leveraging its statewide infrastructure and related health information exchange (HIE) initiatives to enable and support advances in population health, payment, and care delivery strategies.

Recognizing that clinical care accounts for only about 20 percent of health outcomes while socioeconomic, environmental, and behavioral factors account for the other 80 percent; the state has focused efforts in each of these areas on developing and strengthening connections among providers of clinical care (e.g., physician offices, health systems, and behavioral health providers) and community-based organizations that address social determinants of health. Clinical-community linkages are emphasized heavily in the state’s guidance for both CHIRs and PCMHs participating in the SIM initiative. Alternative payment models can provide a way for clinical providers to receive financial support for connecting patients to community resources, and the state’s technology solutions support the exchange of health information among partners.

1.1 Population Health Components

Community Health Innovation Regions

Community Health Innovation Regions (CHIRs) form the foundation of the Population Health component of the SIM initiative. A CHIR is a broad partnership of community organizations, local government agencies, business entities, health care providers, payers, and community members that come together to identify and implement strategies that address community priorities. The state selected five regions of the state in which to test the CHIR model. Each of the five SIM CHIRs is supported by a backbone organization that serves as a fiduciary and acts as a neutral convener for the CHIR’s governing body.

State Innovation Model

Status Report Sec. 1144

CHIR Regions and Backbone Organizations

CHIR Region	Backbone Organization (BBO)
Genesee County	Greater Flint Health Coalition
Jackson County	Jackson Health Improvement Organization
Livingston-Washtenaw Counties	Center for Healthcare Research and Transformation
Muskegon County	Muskegon Community Health Project
Northern Region	Northern Michigan Public Health Alliance

The overarching mission of each CHIR is to align priorities across health and community organizations and support the broad membership of the CHIR in developing and implementing improvement strategies aimed at addressing social/economic conditions to reduce Emergency Department (ED) utilization. Specifically, CHIRs will assess community needs, define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between health entities/systems with community-based organizations and social service agencies.

Each CHIR backbone organization receives a fixed amount of SIM funding to support administrative functions and a health improvement budget that varies based on the number of Medicaid beneficiaries in the region. Health improvement funding is used to support activities such as designing and implementing clinical-community linkages or other programs, policies, or environmental strategies to improve the health of their communities.

All CHIRs are required to focus initially on reducing emergency department utilization while also assessing community needs and identifying region-specific health improvement goals. Each CHIR has identified a lack of housing supports as a problem in their region impacting emergency department use. In the coming year, CHIRs will collaborate to develop a program to improve coordination among housing programs and help people find safe, affordable, and stable housing.

To support clinical-community linkages, each CHIR established a “hub” system to serve people identified as needing assistance with social determinants of health. Referrals are made to the hub from community-based organizations and primary care providers participating in the SIM PCMH Initiative. These community-based organizations and primary care practices screen patients using a common assessment tool and make referrals to the hubs when needs are identified. Each CHIR has developed a data sharing system to electronically track referrals and use of services. The hubs reached full implementation in February 2018.

Accountable Systems of Care

The 2014 Blueprint for Health Innovation and previous reports highlighted the use of Accountable systems of care (ASCs) in the State’s proposed service delivery model. ASCs are health systems, physician organizations, or physician hospital organizations in the five CHIR regions who are committed to supporting the community priorities and health improvement activities as identified by local CHIR governance bodies. While some CHIRs

State Innovation Model

Status Report Sec. 1144

have partnered with ASCs, capitalizing on their relationships with PCMHs, SIM has shifted much of its focus away from ASCs and onto the CHIR, allowing for a more concentrated effort on clinical-community linkages.

Plan for Improving Population Health

The Centers for Medicare and Medicaid Services (CMS) requires that the State of Michigan develop a statewide plan to improve population health as part of the health system transformation efforts over the four-year performance period. The finalized Plan for Improving Population Health (PIPH) must be delivered to CMS, with the expectation to begin implementing the plan before SIM activities end. The plan will strive to reflect how state population health initiatives and health system transformation efforts are coordinated; and how activities under SIM are aligned with the state's existing population health priorities.

Operational plans for Test Years 1 and 2 included a focus on aligning the Plan for Improving Population Health with the revised State Health Improvement Plan and State Health Needs Assessment, necessary components of the Public Health Accreditation Board accreditation process. Alignment between those efforts will continue to be a priority, with the PIHP building from the existing State Health Needs Assessment and State Health Improvement Plan for Michigan. As the Public Health Accreditation Board accreditation process is revisited, revising those documents will be done in collaboration with the PIPH.

1.2 Care Delivery

Patient-Centered Medical Home

With the state's focus on person- and family-centered care and strong evidence that the PCMH model delivers better outcomes than traditional primary care, the patient-centered medical home has been viewed, from the outset, as the foundation for a transformed healthcare system in Michigan. The SIM PCMH Initiative is built upon the principles of a patient-centered medical home that generally define the model regardless of the designating organization. Value is placed on the core functions of a medical home such as enhanced access, whole person care, and expanded care teams that focus on comprehensive coordinated care.

More than 320 primary care practices are participating in the SIM PCMH Initiative. These practices represent more than 2,200 primary care providers and 340,000 Medicaid beneficiaries. Approximately 15 percent of the total Medicaid beneficiary population in the state is eligible for participation in the SIM PCMH Initiative. While the PCMH Initiative has participating practices statewide, approximately 50 percent of the practices are in a SIM CHIR region.

All participating practices are required to invest in clinical practice improvement activities, including the development and continued enhancement of clinical-community linkages. Practices based within a SIM CHIR region are encouraged to work in close collaboration with CHIR partners to develop shared processes and support the alignment of interests and goals across the community, inclusive of clinical systems and community-based organizations. In addition, practices must invest in population health management by

State Innovation Model

Status Report Sec. 1144

empowering their patient population and utilizing feedback reports to drive actionable change through quality improvement.

The state has established a payment model specific to the SIM PCMH Initiative to support practice transformation and care coordination. Each practice participating in the PCMH Initiative will receive payments for its attributed eligible Medicaid beneficiaries. Practices will receive payments to support practice transformation (i.e., investment in practice infrastructure and capabilities) as well as payments to support care management and coordination. The participating payers are the 11 Michigan Medicaid Health Plans.

Alternative Payment Models

In developing its model for health system transformation, the state understands the importance of providing incentives for delivering care based on value rather than on the number of services delivered. Alternative payment models (APMs) provide incentive payments to healthcare practices for providing high-quality and cost-efficient care. The state is working to promote the use of APMs through two primary strategies: (1) setting goals for the use of APMs, starting with payers in the Michigan Medicaid program, and (2) creating a multi-payer payment and service delivery model, including a formal partnership with CMS for Medicare alignment. The state's overarching goal in promoting APMs is to promote service delivery innovation and maximize the opportunities for providers to receive enhanced reimbursement for improving patient health.

The MDHHS SIM team worked closely with the Medical Services Administration managed care team to implement elements of the SIM alternative payment methodology (APM) strategy through the fiscal year 2017 Medicaid health plan (MHP) contract. MDHHS has adopted the Healthcare Payment Learning and Action Network (LAN) APM Framework as its method for classifying provider payment types. The LAN APM Framework is one of the most widely used approaches for organizing and measuring APM progress. To support MHPs in developing plans for increasing use of APMs, MDHHS is establishing guidelines on preferred APMs.

The state is continuing to engage public and commercial payers in conversations on the potential for multi-payer alignment, including payment strategies, quality measurement policies, and data sharing to reduce providers' administrative burden and improve delivery system performance. The statewide HIE infrastructure can support these efforts by providing a common platform for standardized data sharing.

1.3 Technology

SIM Initiative Technology Support

Michigan has established the Relationship and Attribution Management Platform (RAMP) to ensure a foundation for supporting care coordination and identifying relationships between patients and providers. RAMP either currently supports or will support several critical aspects of care management and coordination, including a health provider directory, a system for tracking active care relationships between patients and healthcare providers, exchange of quality-related data and performance results, and sending admission-discharge-transfer (ADT) notifications. Leveraging the statewide health information

State Innovation Model

Status Report Sec. 1144

exchange infrastructure in the development of RAMP allows the state to take advantage of a widespread network of networks to increase interoperability and support the goals of the initiative.

The SIM technology team has continued work related to the Quality Measure Information (QMI) use case, which will enable healthcare providers to transmit clinical quality measures electronically. The QMI use case will provide Medicaid and other payers the ability to access and view quality measures across all their providers.

To support CHIR technology needs, the SIM technology team is working to develop a use case for the collection and reporting of social determinants of health data, identifying the data-sharing needs and requirements of CHIRs and community-based organizations, and establishing standards for the technology platform and data requirements of clinical-community linkages.

1.4 SIM Program Management

Governance Structure

The governor's office continues to be engaged in the State Innovation Model (SIM) Program through regular cabinet updates on SIM progress and accomplishments from the Department of Health and Human Services (MDHHS) Director's office. Additional oversight and engagement is accomplished through a governor's office liaison working closely with Policy, Planning, and Legislative Services, the administration within MDHHS charged with administering and executing the SIM grant in Michigan.

Since June of 2017, MDHHS has implemented and operationalized an updated SIM organizational and governance structure. Specifically, the expansion of leadership and governance includes an Executive Leadership Team consisting of departmental directors from the Medical Services Administration (MSA); Population Health Administration; and the Policy, Planning, and Legislative Services Administration. This newly-expanded executive representation and governing body has ensured alignment with broader departmental vision, goals, and related objectives. This input and guidance has been essential in the oversight and success of ongoing operations and SIM planning cycles.

Program and Portfolio Management

The Policy, Planning and Legislative Services Administration continues to operate a chartered program management office, the State Innovation Model Program Management and Delivery Office (SIM PMDO), to establish an effective and formal authoritative framework to coordinate, support, track, manage and report on the portfolio of projects, activities and related endeavors that will be required over the lifetime of the State Innovation Model Test initiative in Michigan. The Program Management and Delivery Office is responsible for maturing and evolving the department's SIM program vision, strategy, best practices, standards, and other custom processes. Additional and significant support is being provided to the portfolio of component project management. The PMDO mandate also includes operating an integrated operative governance model across all SIM components that includes program, project, operational and executive representation required to establish, guide, and provide oversight.

State Innovation Model

Status Report Sec. 1144

The SIM Program Management and Delivery Office (PMDO) continues to plan, implement and manage the program operational model, ensuring strategy is realized and effective processes followed. Analysis of key component and program performance indicators and other operational data is used to identify potential gaps or other inefficiencies. The PMDO has streamlined contract and funding request management processes expediting the ability to fund engagements with vendors, partners, participants, etc.

The Program Management and Delivery Office diligently applies proven program and project management processes and other custom organization and initiative controls required to meet the State Innovation Model Test near-, mid- and long-term business requirements and goals.

The PMDO also continues to supplement the formal governance and operational structure with additional ad hoc and regular participant and other stakeholder engagements. These include, but are not limited to, a possible new steering committee with focus on the Community Health Innovation Region (CHIR) Initiative and Evaluation and Measurement. These advisory committees are comprised of subject matter experts from various MDHHS departments and administrations, and other key personnel and Michigan SIM partners. Additional input is also sought and gathered via participant workshops, learning sessions, and other component- and program-wide activities.

2 Legislative Update

2.1 Population Health

The CHIRs have been extremely busy over the last six months implementing previously approved local operational plans. In parallel, the State team has been updating and designing new programmatic guidance. Though federal approval has caused some delay in implementation, the population health initiatives have continued to make substantial progress.

Key programmatic accomplishments for this time period included:

- Disbursing administrative, transformational and operational funds
- Continuing to bolster CHIR readiness with System Change (ABLE) Training to bring together community partners to address health disparities and health inequities.
- Convened Backbone Organization (BBO) Staff and key regional stakeholders for an annual CHIR Summit which provided a forum for CHIRs to share future plans and for the SIM Team to convey future Population Health vision and strategy.
- Drafted updated CHIR Participation Guidance
- Updated the CHIR communication strategy which includes a technical assistance program and a CHIR collaboration website.
- Strengthening and growing partnership both within and across CHIR regions
- Developing new, shared approaches to data sharing
- Designing a Housing program to be launched in all 5 CHIR regions.
- Engaging CHIRs in evaluation and quality improvement planning.

State Innovation Model

Status Report Sec. 1144

Key regional accomplishments for this time period included:

- Each CHIRs clinical-community linkages “hub” model is fully operational,
- All CHIR governance structures are developed.
- Each CHIR developed and launched a common social determinants screening tool; this tool is used to identify individuals’ social needs and link them to community resources.
- CHIRs continue to implement approved local operation plans, including additional interventions and health information technology implementation.
- The Northern Region is the first to complete the entire ABL e Change training series. The CHIR has activated four implementation teams to execute community change strategies designed during the training.

2.2 Care Delivery

Patient-Centered Medical Home

The SIM PCMH Initiative continues to enable Medicaid funding for patient-centered care and provide opportunities to increase the number of practices invested in primary care transformation. The Care Delivery team continues to work closely with the Department's Medical Services Administration managed care team to operationalize actuarially sound Care Management and Coordination, and Practice Transformation payments for Initiative Participants approved by Care Delivery Component Governance and facilitate Medicaid Health Plan (MHP) relationship and acceptance of delivery and payment model through regular participation in MHP Operations meetings. This work has provided a foundation for its first operational year and continues to be critical within the second operational year as efforts to identify sustainability mechanisms unfold.

Through technical assistance webinars, meetings and other communications, the team continues to support the activities previously described, and continue to bolster participating practices through the expansion and enhancement of the PCMH Initiative Participant Guide. Additional efforts have been focused on operating and improving the Relationship Attribution Management Platform (RAMP) as the foundation for patient population identification and payment facilitation. Finally, significant efforts have been geared towards the development of Initiative Participants support opportunities. These supports include the drafting of Practice Transformation Collaborative Learning structure, Care Manager training curriculum, and other opportunities to effectively engage participants and support overall success.

Key accomplishments for this time period included:

- The PCMH Initiative team including key contractual partners hosted a Q3 (July - August 2017) and Q4 (September – December 2017) Quarterly Update virtual

State Innovation Model

Status Report Sec. 1144

meeting; 200 participants attended with favorable engagement and positive evaluation

- Participant Quarterly Progress Report for both Q3 and Q4 was developed, disseminated, collected, analysis completed to identify key successes and areas to address in coming months through participant support activities
- The PCMH Initiative Team issued 8 Corrective Action Plans (CAPS) to 8 participants during the third quarter, these compliance mechanisms were sought to correct participant non-compliance with Health information Exchange use case participation requirements. By the end of the quarter 5 CAPS were appropriately resolved, with 2 resolved in quarter 4, and one that remains open and under continued monitoring.
- Launched a virtual Care Management and Coordination Affinity Group, supporting those that serve adult and pediatric populations (3 events with 3 topics covered)
- Hosted live virtual office hour sessions on the following topics: Initiative Quality Measures and Dashboards; 2018 Initiative Participation, Integrated Service Delivery
- Hosted 3 regional summits in October. The theme of the summits was “Taking Michigan Forward with Team-Based Care.” Over 700 individuals from participating practices and physician organizations attended.
- Continued regularly planned 2017 Practice Transformation Collaborative events with national partner Institute for Healthcare Improvement. Designed and launched a focused intensive collaborative learning network for a cohort of Initiative Participants geared towards strengthening systemic clinical community linkage efforts in 2018.
- Continued regular monthly newsletters
- Both Care Management and Coordination, and Practice Transformation payments were coordinated through blended funding model and disseminated to participants through partnering Medicaid Health Plans for Q2 (April – June 2017), and Q3 (July – September 2017)
- Utilizing the RAMP as the foundational process to support attribution, individual monthly patient lists Quarterly Aggregate patient lists were released to Participants.
- Designed a comprehensive technical assistance (TA) plan to support Initiative participants in the 2018 calendar year. Building off successes in 2017, the Initiative has added to monthly TA schedules to ensure at least one virtual topic focused session per month and has added a Care Coordination Collaborative series to the plans for 2018.
- The Care Coordination Collaborative, while in its early development is focused on bringing together SIM stakeholders, including Medicaid Health Plans, Community Health Innovation Regions, and Patient Centered Medical Home Initiative participants. Events will be focused on sharing information and working collaboratively to identify ways to efficiently serve a shared patient population.

State Innovation Model

Status Report Sec. 1144

Alternative Payment Models

The state is continuing its work to promote the meaningful use of APMs through health plans in the Michigan Medicaid program. The overarching goal is to promote service delivery innovation and maximize the opportunities for providers to participate in performance-based payment models.

MDHHS has developed a broad Alternative Payment Model strategy in partnership with the state's Medicaid Health Plans to increase the spread of APMs and make a wider variety of APMs available to support innovative care delivery efforts.

During FY17, MDHHS issued a request for information to providers, hospitals, and physician organizations to help inform the creation of an initial APM strategy. This feedback helped to define the department's direction on preferred APMs. MDHHS also designed preliminary state-preferred APM concepts through discussions and meetings with MHPs over a period of several months.

During FY17, MDHHS conducted a significant amount of planning and development work to support the APM strategy, including establishing the MHP APM workgroup, collecting baseline APM reporting from all MHPs, defining the Department's high-level APM strategy, establishing the first APM strategic plan format, defining state-preferred APM models and/or concepts, and receiving the first draft of each MHP's APM three year strategic plan for increasing APMs that incentivize providers for performance improvement and cost effectiveness. These steps form the basis for the Department's first year of APM implementation (FY 18) and provide a platform to build upon in achieving the Department's APM strategic objectives over the course of the Medicaid Health Plan contract.

Key accomplishments for this time period included:

- MHPs submitted their draft APM strategic plans for FY18 – FY20 to the state at the end of August. These plans were reviewed and provided feedback. Final plans are now scheduled to be submitted on December 5th.
- MDHHS developed and shared the quality strategy for MHPs to include in their APMs. MDHHS is working with MHPs to refine and finalize the drafted quality strategy.
- MDHHS is working to finalize the state preferred APM PCMH model in collaboration with the MHPs, which will be critical to PCMH sustainability in Medicaid.
- MDHHS is working to develop an implementation plan template to track and evaluate MHPs APMs.

2.3 Technology

SIM leveraged existing federal- and state-funded initiatives to define, implement and test a multi-payer statewide data sharing infrastructure and Relationship Attribution Management Platform (RAMP). The state will continue to be engaged in the multi-payer Health Directory Data Governance and maintain the established configuration management, requirements definition, and data quality best practices established under SIM.

State Innovation Model

Status Report Sec. 1144

The MDHHS Data Sharing Workgroup established under SIM will continue to pursue ongoing alignment of state initiatives. It will continue to focus on standard data formats, efficient data flow, timely use of data and transitioning claims-based metrics to quality data. Also, increased efforts will be focused on the effective use of data rather than data transfer. SIM Technology work will continue through the MDHHS Data Sharing Workgroup to continue the advancement and appropriate use of health care data exchange use cases including, but not limited to, Admission, Discharge, and Transfer (ADT) and Quality Metrics. The SIM technology team has made great strides, in conjunction with MDHHS, to leverage existing standards and processes for improved data governance and usage agreements.

Michigan continues to support population health goals by coordinating with CHIRs to collect information about social determinants of health and to assess each individual CHIR's technical needs. SIM Technology is working with MDHHS to extract data and reports to define target populations which remains critical to the success of the Population Health Housing Program.

Key accomplishments for this time period included:

- Data Stewardship
 - The SIM Technology team began reviewing data requests from CHIR's Internal and external evaluation teams to ensure the appropriate data use agreements are in place.
 - The team continued reviewing, approving, and implementing appropriate solutions for providing reporting and/or data sets for incoming data requests.
- SIM performance and evaluation tool
 - The SIM technical team managed the monthly attribution process of the Relationship and Attribution Management Platform.
 - The team continued to look for additional opportunities to optimize the Relationship and Attribution Management Platform (RAMP) and reduce the time it takes to produce the monthly file.
- Care coordination enablement
 - Continued working with the SIM Care Delivery team and our partner, Michigan Data Collaborative (MDC), to develop and test the approved and expanded metrics and utilization measures using the RAMP.
 - The SIM Technical team worked with MDC and the Care Delivery team to define future release metrics and utilization measures.
 - Worked with MDC and the Care Delivery Team to upgrade and release measures meeting HEDIS 2018 specifications.
 - Our partner, Michigan Health Information Network Shared Services (MiHIN), continued technical onboarding of clinical quality data from PCMH participants in anticipation of supporting the release of expanded metrics.
- Payment model analytics and reporting
 - Continued utilizing the Relationship and Attribution Management platform to determine the SIM population to denote who will receive Care Coordination and Practice Transfer Fees payments in the PCMH initiative.

State Innovation Model

Status Report Sec. 1144

- The team continued data validation of the monthly attribution assignments.
- Continued reporting to SIM PCMH's and Medicaid Health Plans their SIM affiliated members via monthly reports.
- Population health toolset
 - The technology team reviewed CHIR team's technology solutions.
 - Continuing to work with the Michigan State Housing Development Authority (MSHDA) and the Michigan Coalition Against Homelessness (MCAH) to begin the collection of Homeless Management Information System (HMIS) data to support CHIR determinants of health reporting needs.
 - The team is evaluating and implementing technical solutions needed to house and analyze the HMIS data.

3 Evaluation

3.1 Legislative Update

The state-evaluation continues to be led by the Michigan Public Health Institute (MPHI) in collaboration with the Michigan Department of Health and Human Services (MDHHS), the System exCHANGE team at Michigan State University, University of Michigan Child Health Evaluation and Research Center, and Michigan Data Collaborative. The impact evaluation component aims to collect and analyze information on emerging outcomes that will justify continued investment in the model by key stakeholders after the State Innovation Model (SIM) program concludes. The formative evaluation component aims to surface lessons learned along the way that provide real-time information to SIM stakeholders to aid in implementation and will inform how the state and other stakeholders should modify, scale, and spread the models during and/or post-SIM.

The evaluation will focus on three interrelated areas that cross both the Patient-Centered Medical Home (PCMH) and Community Health Innovation Region (CHIR) tracks:

1. Care management and coordination
2. Clinical-Community Linkages
3. Community change

The evaluation will look at the process and the outcomes of primary care embedded care management and care coordination, as well as coordinated care across clinical and community settings. In terms of the Clinical-Community Linkages, the evaluation will focus specifically on the process and outcomes related to the screening for social determinants of health, referral for identified social needs, and follow-up activities. In the area of community change, the evaluation will focus on the CHIR structure and leadership for collective impact; on community alignment, including the participation of PCMH, provider organizations, and health systems; and on sustainability and policy changes that are created because of these efforts.

State Innovation Model

Status Report Sec. 1144

3.2 Legislative Metrics and Measures

Section 1144 of the legislative boilerplate contained mandates for outcomes and performance measures for the initiative to be collected and included in this report. The list of measures included, but were not limited to, the following:

- Increasing number of physician's practices fulfilling PCMH functions,
- Reducing inappropriate health utilization, specifically reducing
 - Preventable Emergency Department (ED) visits,
 - Reducing the proportion of hospitalizations for ambulatory sensitive conditions, and
 - Reducing the state's 30-day hospital readmissions rate.

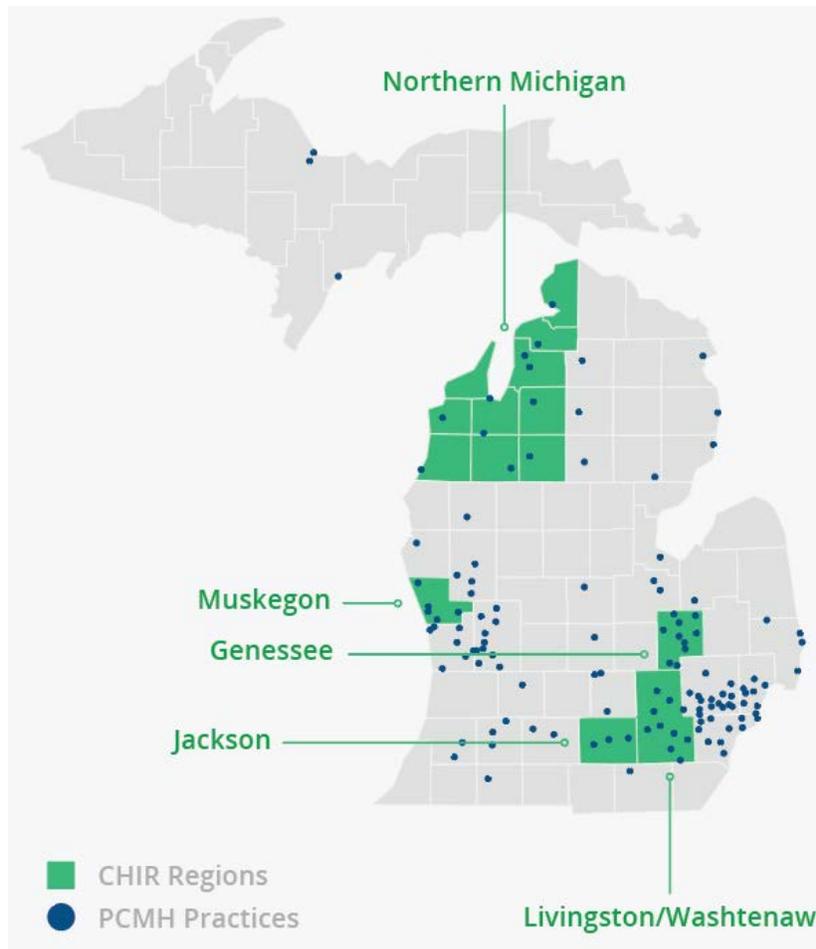
For this semi-annual report we are considering the dates between 10/01/2016-09/30/2017. There are some differences in reporting these metrics from the Fiscal Year 2017 report. One difference is the population. We are now only including populations that are attributed to a SIM-Patient Center Medical Home (PCMH) whether in a Community Health Innovative Region (CHIR) or not. Previously, we only included populations that were in CHIRs. In addition, the utilization metrics are of the full PCMH population including pediatric populations and include mental health admissions or ED visits. This is in contrast to the prior report where we only focused on Medicaid beneficiaries age 18 to 64 in the CHIR region. The methodology for calculating the rates also differs from the previous report where we reported rates in terms of per 1000 member months. This report shows as rate per 1000 attributed members of all ages. Summary of measures:

- As compared to the previous primary care demonstration (Michigan Primary Care Transformation Demonstration or MiPCT) the SIM PCMH Initiative has been able to increase the average number of Medicaid beneficiaries served from 250,000 to 350,000 (on average) and increased the number of participating Medicaid providers from 1500 to over 2100 (a 28% increase).
- 30-Day All-Cause Readmission shows a risk-standardized readmission rate for beneficiary population that are attributed to a PCMH and were hospitalized at a short-stay acute-care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. This metric also includes mental health hospitalizations.
- Emergency Department Visits assesses ED utilization among PCMH population. Mental Health ED visits are included.
- Hospital Admissions is the rate of admissions of attributed patients to a hospital.

It continues to be premature to report on Reducing Preventable Emergency Department visits for this reporting cycle, but plans are still in place to produce this metric in subsequent legislative reports. The performance measures are also displayed by the five SIM regions.

State Innovation Model

Status Report Sec. 1144



REGION	PRACTICES	PROVIDERS	BENEFICIARIES
Jackson	11	52	17,288
Livingston/Washtenaw	40	378	47,208
Muskegon	24	135	44,907
Genesee	62	152	42,400
Northern *	22	175	47,566
Total SIM Region	159	892	199,369
TOTAL Non-SIM Region	165	1,246	141,338
TOTAL **	324	2,138	340,707

* Antrim, Emmet, Wexford, Kalkaska, Leelanau, Missaukee, Benzie, Charlevoix, Manistee, Grand Traverse

** Beneficiary count based on est. February 2018 data.

State Innovation Model

Status Report Sec. 1144

Rate of Ambulatory ED Visits per 1000 attributed members (FY2017 10/01/2016-09/30/2017)

CHIR	County	Numerator	Denominator	Rate
CHIR 1: Genesee	Genesee	24,963	37,921	65.8
CHIR 2: Jackson	Jackson	14,564	16,114	90.4
CHIR 3: Muskegon	Muskegon	32,633	27,653	118.0
CHIR 4: Northern	10 Counties	21,833	29,128	75.0
CHIR 5: Livingston/ Washtenaw	2 Counties	24,660	37,123	66.4
Overall Total (All CHIRs)		118,653	147,938	80.2
Outside CHIR (Non-SIM)		134,048	176,380	76.0
Total ED Visits		252,701	324,318	77.9

Rate of Hospital Admissions per 1000 Attributed Member Months (FY2017 10/01/2016-09/30/2017)

CHIR	County	Numerator	Denominator	Rate
CHIR 1: Genesee	Genesee	4,388	37,921	11.6
CHIR 2: Jackson	Jackson	1,891	16,114	11.7
CHIR 3: Muskegon	Muskegon	2,318	27,653	8.4
CHIR 4: Northern	10 Counties	2,650	29,128	9.1
CHIR 5: Livingston/ Washtenaw	2 Counties	3,596	37,123	9.7
Overall Total (All CHIRs)		14,843	147,938	10.0
Outside CHIR (Non-SIM)		17,385	176,380	9.9
Total Hospital Admissions		32,228	324,318	9.9

State Innovation Model

Status Report Sec. 1144

30-day All-Cause Readmission, Including Mental Health FY2017 (10/01/2016 - 09/30/2017)

CHIR	County	Numerator	Denominator	Rate
CHIR 1: Genesee	Genesee	178	1,365	13.0
CHIR 2: Jackson	Jackson	80	631	12.7
CHIR 3: Muskegon	Muskegon	35	466	7.5
CHIR 4: Northern	10 Counties	56	640	8.8
CHIR 5: Livingston/ Washtenaw	2 Counties	176	1,168	15.1
Overall Total (All CHIRs)		525	4,270	12.3
Outside CHIR (Non-SIM)		751	5,028	14.9
Total All-Cause Readmission		1,276	9,298	13.7

State Innovation Model

Status Report Sec. 1144

4 Budget

4.1 Legislative Update

The SIM program and its component initiatives highlighted in this report have been funded by the CMS/CMMI cooperative grant agreement. The State of Michigan is poised to continue the implementation and operationalization of a set of initiatives and related strategies that will:

1. Build upon and expand the PCMH foundation in the state,
2. Pilot the development of capacity in communities to partner with healthcare organizations, and
3. Enhance existing and develop new HIE capabilities available for all providers across the state.

Based on challenges and lessons learned during the previous SIM years, the State of Michigan believes it has a strong, unified strategy that will more efficiently bring payment reform, care delivery changes, and population health improvement efforts to scale within the SIM project period; thereby increasing the potential for sustainability.

The table below highlights the specific expenditures across standard CMS grant budget categories. The contractual line includes the funding for numerous program and component planning, implementation and operational teams as well as other specific contractual needs to support the broader SIM goals. The expenditures across the categories below represents only the budgeted and realized in the 6 months that are encompassed in this report. The spending includes engagements facilitated through both direct State of Michigan master contractual agreements and other contracts and engagements through the designated SIM fiduciary, Michigan Public Health Institute.

Categories	Budgeted	Expenditures*
Personnel	\$ 171,248.00	\$ 44,308.83
Fringe Benefits	\$ 132,032.00	\$ 30,091.91
Equipment	\$ 16,038.00	\$ -
Supplies	\$ -	\$ 19,672.12
Travel	\$ 23,225.00	\$ (921.26)
Other	\$ 39,690.00	\$ -
Contractual	\$ 30,332,631.27	\$ 9,612,929.47
Total Direct Charges	\$ 30,7145,864.27	\$ 9,706,081.07
Indirect Cost	\$ 202,452.00	\$ (128,327.82)
Total	\$ 30,917,316.27	\$ 9,577,753.25

* The expenditure time period is from 8/1/17 to 1/31/18. FY 2018 first quarter expenditures are preliminary.