State Innovation Model (SIM)
Progress Report 1

(FY2019 Appropriation Act - Public Act 207 of 2018)

March 1, 2019

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) On a semiannual basis, 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.

MDHHS

Michigan Department of Health & Human Services

State Innovation Model (SIM) Section 1144, FY 19 MDHHS Budget Report

Policy, Planning, and Legislative Services Administration

State Innovation Model (SIM)

Contents

1 State Innovation Model Executive Summary

In 2015, the Centers for Medicare and Medicaid Services (CMS) awarded the State of Michigan approximately $70 million over four 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.

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 initiatives to enable and support advances in population health and payment and care delivery strategies.

Recognizing that 20 percent of the factors that influence a person's health outcomes are related to access and quality of care while socioeconomic, environmental, and behavioral factors account for 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 non-medical factors impacting 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.

Together, these three components form the foundation for transforming healthcare delivery and payment in Michigan. CHIRs provide a community-based structure for engaging critical partners in identifying and addressing local health challenges with an eye toward preventing the need for intensive use of medical and social services. Patient-centered medical homes and other providers, supported by alternative payment models, will develop stronger connections with community resources and be encouraged to develop innovative approaches to service delivery. Technology that supports connections and information sharing across a diverse array of partners will provide the infrastructure needed to create better, more efficient, and more comprehensive care for Michiganders.

1.1 Population Health Components

1.1.1 Community Health Innovation Regions

CHIRs form the foundation of the Population Health component of the SIM initiative. A CHIR is a unique model for improving the wellbeing of a region and reducing unnecessary medical costs through collaboration and systems change. CHIRs engage a broad group of stakeholders to identify and address factors that affect residents' health, such as housing, transportation, and food

insecurity, as well as access to high-quality medical care. The CHIR model creates a neutral space for partners to unite around a common vision, aligning their objectives and services to meet the needs of the community. The result is a community that is purposeful in its response to residents' needs, creating conditions that meaningfully support an individual's ability to have a higher, more productive quality of life.

CHIR partners are organized by a neutral backbone organization that facilitates the development and implementation of key strategies, creating the necessary capacity to sustain progress on stated objectives. CHIR steering committees provide a clear leadership structure and promote shared accountability among partners for aligning their resources to address priority community health needs. It takes a comprehensive group of committed organizations to meet the needs of a community because no one entity can do it alone. The state selected five regions in Michigan in which to test the CHIR model. Each of the five SIM CHIRs are supported by a backbone organization that serves as a fiduciary and acts as a neutral convener for the CHIR's governing body.

CHIR Regions and Backbone Organizations

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 inappropriate emergency department 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

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

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 were 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 fourth and final year of SIM, CHIRs will continue to address this need by collaborating with the state to implement portions of the Health through Housing initiative referenced below.

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 Patient-Centered Medical Home 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.

1.1.2 Health Through Housing Initiative

MDHHS has launched the Health through Housing initiative -- a multifaceted approach to partner housing and healthcare information and resources. The initiative consists of four components:

- **Conducting a frequent user pilot** with housing service providers to connect identified homeless and high cost Medicaid clients with housing and other crucial services to directly impact their health and well-being. Four agencies in three CHIR communities (Livingston-Washtenaw, Muskegon, and Northern) are currently working with their target population to secure permanent housing and get connected to other resources.
- **Using data analytics** to identify vulnerable individuals experiencing homeless who show high Medicaid utilization and cost, prioritize them for housing and address other social determinants of health. MDHHS and the Michigan Coalition Against Homelessness has developed the mechanisms necessary for matching data from the Michigan State Homeless Management Information System to Medicaid utilization data. In addition, it has developed the necessary data use agreements and release of information forms to ensure data is shared securely and appropriately. The Department is currently working on a technology solution that will routinize this data match to access current information.
- **Building capacity** among housing and homeless service providers to enhance their capabilities as providers of permanent supportive housing and strategizing the most appropriate ways of accessing additional funding for tenant-based services. MDHHS intends to submit new waiver language to the Center for Medicare and Medicaid Services by April 2019 articulating the tenant support activities it would like to include in its state Medicaid plan. Once the waiver is approved, MDHHS will be working with a consultant to develop and deliver training academies to permanent supportive housing providers with a priority on the CHIR communities.
- **Improving local homeless response systems** in CHIRs to reduce barriers to housing, build better integrated partnerships between the healthcare and housing communities, and improve overall patient outcomes. Three of the five CHIR communities have assessed their systems gaps and are currently developing their strategies for addressing them. Two CHIR communities have developed initial concepts and will be conducting their system assessments in the second quarter of the fiscal year.

1.1.3 Plan for Improving Population Health

As part of the State Innovation Model Round 2 funding, each awardee must develop a statewide plan to improve population health as part of the health system transformation efforts over the four-year cooperative agreement. MDHHS made steady progress towards the development of our Plan for Improving Population Health in SIM Year 3. MDHHS selected the Deputy Director of the Population Health Administration as the Business Owner responsible for leading the Plan's development to ensure alignment with future, broader public health assessment and planning activities. MDHHS also formed an internal workgroup, which includes partners from Medical Services Administration and Behavioral Health and Developmental Disabilities Administration to guide the development of the Plan and to support alignment across department administrations. In SIM Year 3, the Workgroup began meeting monthly and accomplished several milestones with facilitation support from the Michigan Public Health Institute (MPHI), including reaching consensus on the vision and purpose of the Plan; developing a broad outline and guiding principles; creating a strategy for stakeholder engagement; and forming subcommittees to inform components of the Plan.

The purpose of Michigan's Plan for Improving Population Health is to: "Describe how Michigan is creating health, equity, and wellbeing through clinical and community-based prevention strategies that address the social determinants of health." Michigan's Plan is grounded in the idea that population health will improve if we work across sectors to leverage our resources to address the root causes of health inequity and improve access to the conditions that promote health. One key aspect of Michigan's Plan is rather than focusing on a specific health outcome, the Plan will be directed at addressing the social determinants that underlie disparities in multiple health outcomes. The Plan for Improving Population Health will focus on highlighting these disparities by using data-driven, broad population health focused metrics and will highlight evidence-based programs that impact large sectors of Michigan citizens. Following robust discussions on the current state of health in Michigan and the ideal future state, the current vision statement for the Plan is: "Creating fair, just, and equitable conditions so all people in Michigan thrive and achieve optimal health." The mission statement is: "To leverage the collective power of community partnerships to create conditions that foster health, equity, and wellbeing." These statements may be modified through the process of gathering stakeholder feedback during Award Year 4.

1.2 Care Delivery Components

1.2.1 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 approximately 2,200 primary care providers and more than 350,000 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, roughly 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 empaneling 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 comprehensive holistic care management and coordination services at the practice level. Payment methodology will advance over time to progress from foundational to performance-based. Michigan's 11 Medicaid Health Plans have participated by directing State designated payment amounts to State-approved PCMH practices based on performance metrics.

1.2.2 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) exploring the feasibility of a multi-payer alignment around quality improvement and technology infrastructure. 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 Medical Services Administration managed care team implemented elements of the SIM APM strategy through the Medicaid Health Plan (MHP) contract. MDHHS has adopted the Healthcare Payment Learning and Action Network APM Framework as its method for classifying provider payment types. The Healthcare Payment Learning and Action Network APM Framework is one of the most widely used approaches for organizing and measuring APM progress. The managed care team has collected baseline data about the percentage of medical spend for each health plan in each Healthcare Payment Learning and Action Network category. The managed care team has also approved three-year strategic plans for each health plan to increase the use of categories three and four in alignment with the Medical Services Administration's quality improvement goals.

To further the goal of aligning implementation of APMs with quality improvement needs while also streamlining incentivized measures at the provider level, the managed care team has also implemented regional-based quality measurement requirements. Medicaid health plans implementing APM contracts in each region are required to utilize quality measures identified as disparately low performing relative to other areas of the State. Finally, the managed care team has been working with Actuary to carve the PCMH pass-thru payments into the Medicaid health plan capitation rates following the SIM period. The carve in will correspond with performance bonus

criteria the managed care team will develop and implement as part of the fiscal year 2020 capitation withhold pool. The bonus criteria will ensure Medicaid health plans are utilizing the additional capitation payment to sustain PCMH operations at an acceptable level.

1.3 Technology

1.3.1 SIM Initiative Technology Support

Michigan established the Relationship and Attribution Management Platform in early 2017. Components of the platform continue to function in an integral manner to generating patient lists to participating providers within the SIM PCMH Initiative. For the past year it has provided funding to Medicaid Health Plans for payments to providers belonging to those provider organizations participating in the PCMH Initiative. These same PCMH providers are also exchanging a variety of message types through Michigan's statewide data sharing infrastructure. PCMH participants are actively participating in the Active Care Relationship Service; Admission, Discharge and Transfer messages; Health Directory; and the Clinical Quality Measure Reporting and Repository use cases. The SIM technology team continues to provide oversight of the Relationship and Attribution Management Platform by monitoring the ongoing monthly attribution files for accuracy and timeliness.

The SIM Technology team is supporting the Care Delivery's initiative to collect social determinants of health data. We are currently receiving test files from participating providers and performing validation to ensure a successful production launch in mid-February 2019. Once live, the data will be routed on a real time basis to our SIM Evaluator, MPHI, to produce and deliver reports to the SIM program.

Regarding the CHIR technology needs, the SIM technology team is supporting the use case for the collection and reporting of social determinants of health data. The SIM technology team is developing the data-sharing and technology platform requirements needed to implement clinical-community linkages. Technology and lessons learned from the PCMH social needs screening initiative will be used to support the CHIR social determinants of health data requirements.

The team continues to work with the CHIRs and the MDHHS Bureau of Community Services to support their initiative of providing housing vouchers to highly vulnerable homeless individuals. The collection, integration and analyzing of the Homeless Management Information System (HMIS) and Medicaid data aids in locating and distributing housing vouchers for the identified individuals and their Permanent Supportive Housing organizations. The SIM Technology team, working with the Michigan Coalition Against Homelessness state agency and MDHHS, was able to define data and technical requirements for gathering HMIS data needed to support the above initiative. Once defined, the team implemented technology and processes to pull HMIS and Medicaid data into the SIM Sandbox for analytics purposes. The team then performed extensive analytics around this data and provided detailed reports to appropriate stakeholders.

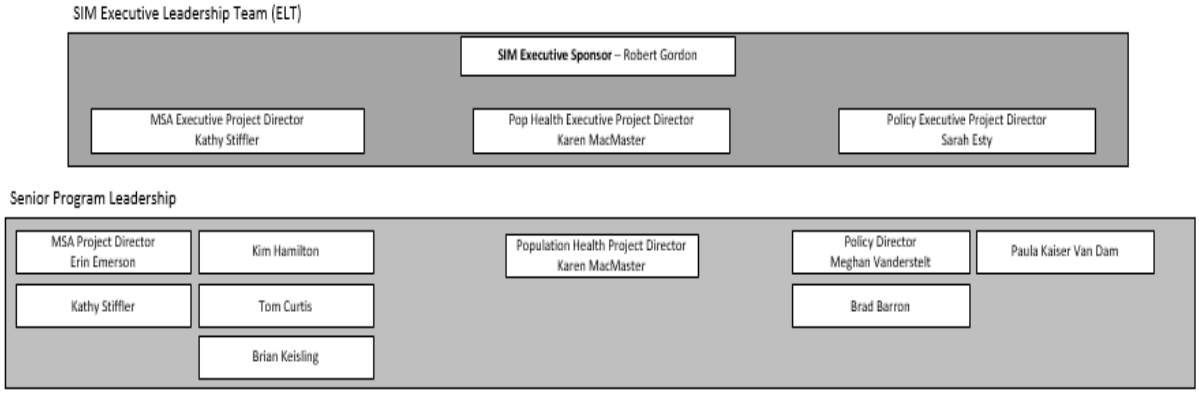
1.4 SIM Program Management

The governor's office continued to be engaged in the State Innovation Model (SIM) Program through regular cabinet updates on SIM progress and accomplishments from former Director Nick

Lyon and former Deputy Director Nancy Vreibel. Additional 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. As the state transitions to a new administration, the SIM program intends to maintain this engagement with Director Robert Gordon and his deputy director staff.

1.4.1 Governance Structure

During Award Year 2, an updated SIM organization and governance structure was approved and implemented by MDHHS. Specifically, the expansion of leadership and governance includes an Executive Leadership Team consisting of departmental directors from the Medical Services Administration; Population Health Administration; and the Policy, Planning, and Legislative Services Administration. Similarly, during Award Year 3, additional representation was added from the MDHHS Bureau of Community Services to reflect the added focus on housing within the CHIR initiative. This newly-expanded executive representation and governing body ensures the work initiated by the SIM grant is aligned with broader departmental vision, goals, and related objectives. Regular monthly governance meetings are planned, where status, planning, issues, risks, and other program-related topics are discussed; resolutions and mitigations are formulated; and decisions are documented. This input and guidance is essential in the oversight and success of ongoing operations and SIM planning cycles.



1.4.2 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, 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 Program Management and Delivery Office 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.

The SIM Program Management and Delivery Office 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 Program Management and Delivery Office 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 Program Management and Delivery Office 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 Initiative and the Plan for Improving Population Health. 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

2.1.1 Community Health Innovation Regions

The local CHIRs continued to stabilize their Clinical-Community-Linkages (CCLs) and supporting interventions. The CHIRs are now operating under their updated operating plans, which became effective October 1, 2018, and will continue through the remainder of the SIM Model Test period.

A convening of CHIR Backbone Organizations was held October 4, 2018, with 55 participants attending. At this meeting, the state CHIR team facilitated discussions regarding evaluation activities, the Plan for Improving Population Health, the Housing Initiative, CCL processes, and the CHIR sustainability plan.

In the last quarter of 2018, CHIRs prepared and submitted proposals describing how they plan to improve the homelessness response system in their communities. Under a contract with MDHHS, the Corporation for Supportive Housing is providing technical assistance to each of the five CHIRs in this work. Onsite meetings were held in most CHIR communities to assess the current status of the homelessness response system and what improvements could be made to better serve residents of the communities. This work will continue through the rest of the SIM Model Test period.

Additionally, many of the CHIRs have completed or will complete a comprehensive systems-change training program led by Michigan State University called the ABLe Change Framework. The ABLe

Change Framework is a model designed to help communities and states more effectively address the significant social issues affecting children, youth, and families. The model is based upon that premise that communities can achieve transformative results when they make local system and community conditions the intentional targets of their change initiatives, when they pursue the effective implementation of their efforts, and when they build a community engagement infrastructure that supports real-time learning and action across diverse stakeholders and sectors.

Over the past six months the CHIRs have worked to improve the functioning of their CCL and supporting interventions.

Some accomplishments this reporting period include:

Genesee:

- Modified Hub case management software to capture documentation necessary for aligning with State evaluation metrics
- Updated case management system to better track CCL Hub referral reasons and outcomes
- Trained Specialty Hub staff on new case management software documentation procedures
- Developed and distributed a survey for Community Referral Providers to better understand how referrals are handled once accepted
- Continued working with University of Michigan Child Health Evaluation and Research (CHEAR) to define and finalize CCL Client Satisfaction Survey Pilot Process
- Worked to complete 2018 Community Data Scorecard analyzing data from three commercial and four Medicaid partnering health plans
- Began developing Scorecard presentation for Genesee CHIR backbone organization leadership which will inform development of Community Health Needs Assessment
- Convened Community Health Needs Assessment Subgroup adding Genesee County Health Department as a new member. The Subgroup reviewed and revised a community member survey to gather feedback from residents on what they perceive to be the greatest health challenges and factors impacting health for Genesee County. The Subgroup also created a stakeholder survey and outlined the distribution process for each

Jackson:

- Cultural competency training has been added to the professional development offerings and qualify for the provider incentive program
- The Jackson backbone organization approved a process for a cross-network grant application to the Jackson Community Foundation for system change strategies to address inequity
- Completed final two days of ABLe Change training
- 95 community stakeholders attended cross-cultural workshops
- Approved a new CCL structure for 2019 to include a Governance and Sustainability committee, Strategy Oversight and Coordination committee and three learning communities; Hub User, Technology and Social Service Navigation/Care Coordination
- Hub Terms of Use Agreement approved
- Hub licensing payment structure approved

- Approved Memorandum of Understanding for Hub participating agencies
- Confirmed data element definitions with MPHI and MDHHS to inform CCL Summary Data reporting capability and submitted the initial set of data
- "Jackson Care Hub" selected for name of hub
- PCMH practices have completed 3048 social determinants of health (SDoH) screens between August 1, 2018 through August 31, 2018 - 379 referrals were sent to the social service navigator
- 596 agencies are mapped across 37 resource domains
- Realigning CCL Workgroup infrastructure
- Two hub trainings held
- Average of 15 agencies using the hub
- Efforts to connect additional agencies include trainings and the development of promotional materials
- Developed three Year Action Plan
- 259 SDoH screens conducted leading to 709 referrals
- After hours call center pilot is launched
- E-visits went live in all medical group primary care practices on September 12, 2018
- Secured location for second community living room
- 129 visits by 59 unique guests to the Crisis Respite Center – 97 percent successfully treated without hospitalization

Muskegon:

- Developed a faith-based pilot and onboarding faith-based representatives to screen and refer clients
- Created informational cards to introduce people to the MiBridges referral site
- Created Return on Investment for community organizations and implanting it into the CCL
- The Resilience Zone door to door resident survey found that vacant lots and condemned houses are a key concern. The advisory group has started work with the Muskegon County Land Bank to get feedback and to influence resource allocation in the area
- Outreach continues to payers, to the State-wide budget effort, and to local funders including the Chamber of Commerce and the Community foundation

Northern:

- Compiled and submitted CCL summary level metrics for January through June 2018
- Continued pilot of screening tool in 32 PCMHs
- Screened nearly 20,000 thus far
- Refined screening tool questions resulting in an increased proportion of clients accepting Hub services
- Hired VISTA volunteer to facilitate enrollment in MiBridges
- Organized three "Basic Needs" teams for each HUB region composed of members of the four Action Teams
- Continued Where for Care advertising/social media campaign and distribution of Where for Care tool kit, magnets, and wallet cards

- Created vision and mission for Health in All Policies initiative
- Applied for the 2019 Culture of Health Prize from the Robert Wood Johnson Foundation
- Secured agreement with United Health Care for reimbursement for Community Connections HUB services (made two agreements; other one is with McLaren Health Plan)
- Developed grant proposal to Health Resources and Services Administration (HRSA) for a Rural Health Network Development Planning Grant to expand Northern Michigan CHIR and submitted on November 30
- Held joint meeting of the governing bodies of the Northern Health Plan, Northern Michigan CHIR, and Northern Michigan Public Health Alliance to explore expansion of the Northern Michigan CHIR

Livingston-Washtenaw:

- Aetna gave access to Livingston-Washtenaw CHIR hub staff, so that hub staff and Aetna care managers can coordinate information and care between the Livingston-Washtenaw CHIR CCL intervention and Aetna care managers. Together, Aetna and Livingston-Washtenaw CHIR hub staff selected a family to jointly manage as a test case of coordinating the two types of care coordination
- Predictive model adding 18 participants per week
- Control participants added to intervention
- 50 screens as part of intervention
- 30,000 total screens with about 10 percent positive for at least one need (one quarter only; nearly 100,000 screens in total)
- UNITE group (nonprofit hospitals) are identifying common programs and program measures to initiate a more aligned approach in meeting community needs

The State SIM team, and its contractors supported CHIR activities via:

- Ongoing communication with CHIRs via site visits, phone calls, bi-monthly newsletters and attending local CHIR meetings (governance and workgroups)
- Monthly Cohort Collaboration calls
- Reviewed/submitted Unrestriction Requests to CMS, both in the Operations Plan and individually
- Planned/provided ABLe Change training
- Planned for in-person backbone organization meeting in October. Next convening will be February 2019
- Continued development of updated CHIR Participation Guide and structured response template for local submission
- Continued development of the CHIR model and plans for sustainability

2.1.2 Health Through Housing Initiative

MDHHS, with support from the Michigan State Housing Development Authority and the Michigan Coalition Against Homelessness, has launched the Health through Housing initiative -- a multifaceted approach to partner housing and healthcare information and resources. The initiative consists of four components:

- **Conducting a frequent user pilot** with housing service providers to connect identified homeless and high cost Medicaid clients with housing and other crucial services to directly impact their health and well-being.
- **Using data analytics** to identify vulnerable individuals experiencing homeless who show high Medicaid utilization and cost, prioritize them for housing and address other social determinants of health.
- **Building capacity** among housing and homeless service providers to enhance their capabilities as providers of permanent supportive housing and strategizing the most appropriate ways of accessing additional funding for tenant-based services.
- **Improving local homeless response systems** in CHIRs to reduce barriers to housing, build better integrated partnerships between the healthcare and housing communities, and improve overall patient outcomes.

Frequent User Pilot

By providing Housing Choice Vouchers and supportive services to a targeted group of homeless Medicaid high utilizers, four pilot agencies in three Michigan communities will have the opportunity to demonstrate how permanent housing and supportive services directly impact this population's health and well-being. Participants are provided long term rental assistance along with short term case management to stabilize physical and behavioral health conditions. The frequent user pilot is functioning as of October 1, 2018, in three CHIR communities: Northern Michigan, Livingston-Washtenaw (pilot agency is only serving Washtenaw County), and Muskegon. Each participating pilot agency is now working with their target population to assist them with obtaining housing, providing the support to connect these individuals with needed resources, and help make a smooth transition into permanent housing.

Data Analytics

Bringing together data from the Homeless Management Information System (HMIS) and the statewide Medicaid data warehouse, MDHHS has created an opportunity to identify and evaluate a population of clients experiencing homelessness with high Medicaid costs and/or utilization. This data can potentially produce key information to prioritize the most vulnerable individuals for housing and health resources. By using these analytics, people could be served more quickly and with a greater impact to their overall well-being. Ongoing data matching will allow for routine monitoring of enrollment information, thereby improving coverage for this vulnerable population while also reducing delays and unnecessary administrative costs. The initial match has been completed and refined and MDHHS is currently working to establish a process that will routinize a match between the two data sets.

Capacity Building

Meeting the needs of a homeless population with serious health conditions is a unique challenge. Housing providers must be skilled at delivering the array of services and supports found in quality permanent supportive housing. To assist agencies with building these skills, MDHHS is partnering with national technical assistance provider, Corporation for Supportive Housing, to offer targeted training for providers to identify and actively improve their capacity to deliver quality permanent supportive housing. In addition, the funding landscape for critical support services is changing -- driving housing programs to seek new sources to fund service delivery. Medicaid is the first step,

but other opportunities exist as well. MDHHS is following other states by applying for a waiver through CMS that would allow reimbursement for selected tenant-based support services.

Most permanent supportive housing providers, however, are not Medicaid-billable agencies and will need training and support to achieve accreditation. MDHHS will offer training and consultation through the Corporation for Supportive Housing to agencies that are seeking to become eligible to bill Medicaid directly for housing-based services or contract with a partnering Medicaid-billable agency.

Improving Local Homeless Response Systems

The goal of the "Improving the Homeless Response System" initiative is to support each CHIR community in their efforts to address current barriers and ensure that individuals and families experiencing homelessness can be housed quickly and permanently. To address these barriers, each participating CHIR is eligible to receive assistance through January 31, 2020, to develop and implement a plan that will have a significant positive impact on the community's ability to serve its homeless population. Each community will receive technical assistance from the Corporation for Supportive Housing, to assist them with identifying system gaps or barriers as well as structuring their plan proposal. The development and implementation of this plan is a collaborative effort between the CHIR backbone organization and the local homeless Continuums of Care demonstrating the partnership between healthcare and housing systems. Three of the five CHIR communities have been working to identify the gaps in their systems and develop strategies to implement positive change. The other two CHIR communities have developed initial concepts and will be working to build out their strategies over the next few months.

2.1.3 Plan for Improving Population Health

Michigan's Plan for Improving Population Health will focus on three main components: healthcare delivery, clinical-community linkages, and community conditions. The Plan will target social determinants of health at each of these layers, focusing on strategies to change systems and pursue equity. The Plan will build on Michigan's SIM design by identifying opportunities to (1) shift practices within the healthcare delivery system to include identifying basic needs and linking clients with community services, (2) create stronger linkages between clinical and community services and settings, and (3) shift community conditions so that the environments in which people live promote health, including the physical, service, social, and economic environment. Through SIM, Michigan focused on coordinating efforts between the care delivery system and organizations in the community. However, the deep health inequities across the state cannot be addressed without changing the conditions in which people live. The Plan for Improving Population Health will build on capacity built through SIM and across the state to address social determinants of health through strategies that connect people with services and strategies that change conditions.

Two Plan for Improving Population Health committees meet monthly to inform the development of various sections of the Plan; the Health Status Committee and the Public Health Capacity Committee. Guiding principles were created to guide the work of each committee, and each operates under a committee charter. MDHHS staff with special knowledge and expertise in each area (health status and public health capacity in Michigan) comprise the committees. Additionally, each committee has an appointed committee chair, responsible for providing direction of the work, with facilitation support from the MPHI. The Health Status Committee is charged with identifying

indicators that articulate the health status of Michiganders, with intentional emphasis on the social determinants of health. The Public Health Capacity Committee is charged with identifying the available public health capacity in Michigan across programs and initiatives focused on social determinants and identifying needs and gaps in capacity impacting population health.

Michigan's Plan will be completed in SIM Year 4. The Public Health Administration's SIM Workgroup will guide the development of the Plan, forming ad hoc committees as needed to address Plan components. The Public Health Administration's SIM Workgroup will engage partners to help identify potential strategies for addressing social determinants of health, identify existing levers that can support moving these strategies into action, and develop an implementation plan.

A key area of focus for Year 4 will be generating robust stakeholder engagement and ownership for the strategies outlined in the Plan, as well as the implementation of the Plan. The final draft of the complete Plan will go to public comment for Michiganders in September 2019. The final deliverable of the Plan will be submitted to CMS in January 2020.

2.2 Care Delivery

2.2.1 Patient-Centered Medical Home

The SIM Patient-Centered Medical Home (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 (Medicaid) managed care team to operationalize actuarially sound Care Management and Coordination, and Practice Transformation payments for Initiative Participants. This work has provided a foundation for sustainability mechanisms using the Medicaid managed care division's relational, contractual, and incentive levers with Medicaid health plans.

Through technical assistance webinars, meetings and other communications, the team continues to support the activities previously described, and continues to bolster participating practices through the expansion and enhancement of the PCMH Initiative Participation Guide. Additional efforts have been focused on improving the patient population identification and payment facilitation process. Finally, significant efforts have been geared towards the development of Initiative Participants' support opportunities. These supports include the formation of the Care Coordination Collaborative, Care Manager training curriculum, and other opportunities to effectively engage participants and support overall success.

Key accomplishments for this reporting period included:

- The PCMH Initiative team in collaboration with key contractual partners hosted a 3rd quarter (October) Quarterly Update virtual meeting; 130 participants attended with favorable engagement and positive evaluation
- Participant Semi-Annual Practice Transformation and 2nd quarter 2018 Progress Reports were analyzed with key findings presented to stakeholders

- Participant Quarterly Progress Report for 3rd quarter 2018 was developed, disseminated, collected and summarized
- Participant Quarterly Progress Report for 4th quarter 2018 was developed, disseminated, and collected for summary and analysis in 1st quarter 2019 to identify key successes and areas to address in coming months through participant support activities
- Continued participant compliance and monitoring activities including:
    - Issued and tracked 10 Corrective Action Plans for CCL and health information exchange compliance
    - Issued four audits across all participants in the Care Management and Coordination areas of: PCMH Certification, Care Management Longitudinal Training, Dashboard and Patient List Access
- Hosted live virtual 2019 PCMH Initiative Launch Webinar attended by over 120 participants
- Hosted live virtual office hour sessions on the following topics: Patient Experience Survey: Evaluation and Methodology, Community Integrated Paramedicine, Addressing Adolescent Obesity, Attracting and Retaining Care Managers/Care Coordinators, CCL Data Partnership (and four subsequent workgroup sessions), Evaluation-Provider Survey Results, Patient and Family Advisory Councils, Plan for Improving Population Health, and Tracking and Monitoring Codes
- Continued regular monthly newsletters including a recurring segment on current literature and participant best-practice sharing
- With ongoing support of the multi-stakeholder Care Coordination Collaborative Planning Committee, hosted a second virtual event on September 24, which built upon the goal of the Care Coordination Collaborative to provide assistance with care coordination activities to improve patient care
- In conjunction with multi-stakeholder planning committee, held three regional 2018 Summits October through November 2018. Presented and provided event support across all three Summits engaging 534 total participants in “Seamless Partnerships for Effective Patient Care”
- Developed the Care Management Improvement Reserve (CMIR) for implementation in 2019 whereby participants will be required to reach requisite benchmark for care management/coordination services or risk having funds withheld until performance is improved
- Developed the Performance Incentive Program to award performance-based incentive payments to SIM PCMH Initiative participating organizations; worked extensively with contractor partners to define methodology and operationalization of an approach to incentive calculation which considers both quality and utilization performance within a landscape of mixed pediatric and adult SIM PCMH Initiative patient populations
- Received and reviewed 2019 Intent to Continue Participation submissions and evaluated against compliance and performance standings
- Revised and prepared 2019 Participation Agreement and Guide for legal review and dissemination to Initiative participants
- Both Care Management and Coordination and Practice Transformation payments were coordinated and disseminated to participants through partnering Medicaid Health Plans for

3rd quarter (July – September 2018). Note that Award Year 3 funding for Care Management and Coordination and Practice Transformation payments does not include SIM federal funds

- Utilizing the Relationship Attribution Management Platform as the foundational process to support attribution, individual monthly patient lists were released August 2018 through January 2019; aggregate patient lists were released to Participants as appropriate
- PCMH Team evaluated applicants for approval to receive two additional award opportunities to enhance Initiative participants' advancements in the areas of capacity building for health information exchange and CCL data sharing
- Coordinated collaborative effort between multiple vendors and Initiative participants engaged in the CCL Data Partnership initiative to develop and test Social Determinants of Health screening data exchange. Received and performed structural and qualitative analyses on test files received from 10 participating Physician Organizations
- PCMH Initiative Team worked collaboratively with APM Team to refine proposed sustainable core PCMH model Discovery Template with which to engage MHPs to inform development of more comprehensive PCMH model as part of post-SIM sustainability planning
- The PCMH Initiative Team evaluated State-Preferred PCMH Model Interest Applications, encompassing 290 practices, for final determination and recommendation to Medicaid Health Plans to support their contracting efforts
- Held 2019 PCMH Initiative planning session with PCMH contractor partners to strategize process improvements, plan 2019 virtual learning and support opportunities, evaluate initiative participant feedback for actionable program enhancements and review participant feedback on sustainability
- Launched the 2019 Care Coordination Collaborative, Summit and the (newly formed) Pediatric Office Hours Curriculum Planning Groups. Participant membership to the Care Coordination Collaborative and Summit planning groups were expanded to include some returning 2018 along with new members to increase diversification of the groups.
- Inform and coordinate with Medicaid Health Plans on Initiative operations through bi-weekly operations meetings.

2.2.2 Alternative Payment Models

The state is continuing its work to promote the meaningful use of Alternative Payment Models (APM) through health plans in the Michigan Medicaid program. The overarching goal is to increase the opportunities for providers to participate in performance-based payment models, improve quality of care for Medicaid beneficiaries, and create some consistency for providers. MDHHS has developed a broad APM 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 the reporting period, the Medicaid Managed Care and Quality Improvement and Program Development section finalized their evaluation of Medicaid Health Plan PCMH programs to further inform the development of the PCMH state-preferred model, that will be a required component of the fiscal year 2020 capitation withhold program. Additionally, the Quality Improvement and Program Development team worked on adding an additional data collection tab for MHP implementation of APMs that includes gathering the amount of incentives offered to providers that

go "uncollected" or unpaid. The intent is to document the incentive opportunities MHPs are offering to providers to supplement the existing data collection regarding the amount of incentives actually paid.

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.

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 messages 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 and is extracting data and creating reports to define target populations which remains critical to the success of the Health through Housing Program.

Key accomplishments for this time period included:

Data Stewardship

- The SIM Technology team continues reviewing and helping facilitate the submission and approval process for the remaining data requests from the CHIR's Internal and external evaluation teams.

SIM performance and evaluation tool

- The SIM technical team continued to monitor and manage the monthly attribution process of the Relationship and Attribution Management Platform, correcting data issues as needed.
- The team continued to work the Michigan Data Collaborative (MDC) to produce the federally required quarterly progress report measures.

Care coordination enablement

- The SIM technology team implemented a solution for collecting social determinants of health information from SIM PCMH's. We are currently in the testing phase.
- Continued working with the SIM Care Delivery team and our partner, MDC, to develop and test expanded metrics and utilization measures using the Relationship and Attribution Management Platform. Our partner, Michigan Health Information Network, continued technical onboarding of clinical quality data from PCMH participants.

Payment model analytics and reporting

- Continued utilizing the Relationship and Attribution Management platform to determine the SIM population to denote who will receive Practice Transfer Fees payments in the

PCMH initiative. Continued reporting to SIM PCMH's and Medicaid Health Plans their SIM affiliated members via monthly reports.

Population health toolset

- Worked with the Michigan State Housing Development Authority (MSHDA) and the Michigan Coalition Against Homelessness (MiCAH) to further define business requirements needed for the collection of Homeless Management Information System (HMIS) data.
- The team utilized the HMIS technical solution to receive two new rounds of HMIS data for matching with Medicaid claims and continued analyzation. Data matching results continue to be provided to MDHHS to help identify highly vulnerable homeless individuals.
- Worked with MDHHS and MiCAH to begin the work related to creating an automatic, monthly data feed of HMIS data to support continued evaluation and reporting.

Sustainability

The SIM technology team continues to support MDHHS and all SIM components as they define their sustainability plan for SIM by evaluating and supporting any technical solutions needed to make the transition(s).

3 Evaluation

3.1 Legislative Update

The state-evaluation continues to be led by the MPHI in collaboration with 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 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 focuses on three interrelated areas that cross both the PCMH and CHIR tracks:

1. Care Management and Coordination
2. Clinical-Community Linkages
3. Community Change

The evaluation of Care Management and Care Coordination includes both process and outcome components. Process analyses are based on PCMH track reporting (Quarterly reports and Practice Transformation Reports) and focus on implementation progress and barriers. Outcome analyses are based on PCMH provider staff responses to survey items as well as patient reported outcomes through paper- and telephone-based surveys. In addition to these methods, outcomes related to care management will be assessed through analyses of Medicaid usage and costs.

The evaluation of CCLs also includes process and outcomes components. Process analyses are based on PCMH track reporting (Quarterly reports and Practice Transformation Reports) and focus on implementation progress and barriers. Additional process analyses will be based on both CHIR-submitted metrics related to screening for social determinants of health and referrals for social services (both referrals opened, and referrals closed). These metrics will be tracked over time to measure changes in implementation. The outcome evaluation of CCLs includes provider surveys, patient/client experience surveys, analyses of individual-level CCLs data submitted by CHIRs and PCMHs, and analyses of Medicaid usage and costs for clients served by a CHIR hub.

The evaluation of community change focuses 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. Process and outcome analyses will be based on qualitative interviews, observations, review of CHIR meeting minutes and other documentation. In addition, a Collective Impact survey is being used to assess the attitudes and experiences of CHIR members, partners, and stakeholders within each participating community.

To facilitate a participatory approach to the evaluation design and to support stakeholder buy-in, the evaluation team created an Evaluation Advisory Committee, which meets monthly, and consists of representatives from CHIR, MDHHS, and each of the organizations supporting the evaluation.

The evaluation team performed the following statewide evaluation activities this reporting period:

- The statewide evaluation design has been finalized and approved by MDHHS SIM leadership.
- The state evaluation lead (MPHI) has a fully executed Data Use Agreement and letter of sponsorship in place with MDHHS to allow for the transfer of data from PCMH and CHIR participants and access to the Michigan Medicaid Data Warehouse.
- The division and operationalization of evaluation responsibilities across the evaluation contractors (MPHI, MSU, CHEAR and MDC) has been finalized with each contractor currently engaged in their respective components.
- MPHI has developed, presented, and obtained buy-in from the SIM PCMH leadership of a logic model consisting of three main components for the PCMH evaluation: PCMH core capabilities, embedded care management/care coordination, and incorporation of social determinants of health in the care process.
- Indicators/information and potential data sources have been identified for each PCMH evaluation question provided by the SIM PCMH state leadership.
- The MPHI evaluation team has gained access to raw survey data and have started compiling and processing the various data sets from surveys and quarterly reports filled up by participating PCMH providers.
- A Collective Impact Survey has been finalized and is currently being administered to CHIR members, partners, and stakeholders. For CHIR members, the survey is yielding a response rate in excess of 70 percent.
- A CCLs questionnaire for providers has been finalized. It is embedded within the CHIR Collective Impact survey that is currently being administered. It will also be administered to PCMH participants beginning August 1.

- Two CHIRs have volunteered to participate in a Client Experience Survey this fall. These CHIRs will help finalize survey content as well as implementation protocols.
- A Patient Experience Survey is being developed and will be finalized later this summer.
- MPHI is currently developing appropriate cross-track comparison groups for the evaluation.

Discussions with MPHI, MDC and the PCMH track leads continued this quarter to identify, refine and update the SIM evaluation metrics using the 2018 HEDIS specifications when applicable, and to develop specifications for additional metrics approved in the updated Operational Plan. Several of the new metrics that MDC still does not have the specifications finalized are more complicated and required several more MPHI-MDC-PCMH workgroup discussion sessions, as well as exploring of resources including experts from the MDHHS Medicaid Actuarial Office and from the National Committee for Quality Assurance.

The evaluation activities of the Michigan SIM project are made up of three evaluation teams: MPHI, Michigan State University (MSU) lead by Dr. Pennie Foster-Fishman, and University of Michigan CHEAR Center. Below are findings and activities from all three teams from the past six months.

MPHI Evaluation Team six-month update

In service of the statewide evaluation, MPHI has completed a survey of health care stakeholder attitudes and experiences with clinical community linkages as well as a first round of analyses of SIM care management recipients. During this quarter, provider agreements and logistics were finalized for the sharing of individual-level social determinants of health screening and clinical community linkage data for evaluation purposes, including linkage to Medicaid utilization and costs. Detailed information is as follows:

I. Clinical Community Linkage Provider Survey: This survey was completed by 470 SIM-associated primary care providers, care managers, care coordinators, Patient Centered Medical Home administrators, and Physician Organization administrators. Results suggest that Health care providers participating in Michigan's SIM are reporting high levels of motivation for and progress in implementing screening for patients' social determinants of health and referral for social services. SIM is providing needed resources and supports to align these efforts across participating health systems and communities. Providers are beginning to report that SIM-supported efforts are yielding positive impacts on patient health, provider awareness and activities, practice-level policies, and system-level supports for cross-sector collaboration.

II. Care Management Analyses: MPHI has also completed a first round of analyses of Medicaid utilization for SIM care management recipients. Results found that over 15,000 SIM PCMH attributed patients have a documented care management/care coordination (CM/CC) claim in 2017. These claims were not distributed equally. The following variations were noted:

- Among SIM PCMH beneficiaries, Priority Health, followed by Upper Peninsula Health Plan and McLaren had the highest proportion of members with a CM/CC claim; additionally, 3.5 percent of non-SIM Priority Health members received CM/CC services.
- The following Physician Organizations have a higher than average proportion of SIM patients who received CM/CC services: Answer Health, independent practices, PMC, Covenant, Hackley Community Care, Cherry Health, Holland, Metro Health, and Spectrum.

- Of the CHIRs Muskegon and Genesee had the highest proportion of SIM beneficiaries receiving CM/CC services.
- Among SIM beneficiaries, residents of prosperity region 6 (East) had the highest proportion of having received a CM/CC service; among non-SIM beneficiaries, prosperity region 4 (West) had the highest proportion.

As one might expect, older beneficiaries were much more likely to have CM/CC services than younger people.

- Interestingly, within SIM, both adults and children of white and black racial categories had CM/CC services at similar proportions; however, among non-SIM beneficiaries, whites received CM/CC at a higher proportion than blacks.

MPHI noticed substantial differences in the type of CM/CC services received by SIM and non-SIM beneficiaries.

- SIM beneficiaries were much more likely to receive multiple CM/CC services.
- SIM beneficiaries were much more likely to receive face-to-face CM/CC services.
- Non-SIM beneficiaries were much more likely to have had only a care transition CM/CC service than other type of service.
- SIM beneficiaries were much more likely to have a CM/CC service within two weeks of an acute hospitalization.

In general, and not surprisingly, CM/CC services were directed to beneficiaries with multiple chronic conditions.

- Among SIM pediatric beneficiaries receiving CM/CC services, top diagnoses were asthma, other upper respiratory disease, and anxiety disorders. Nearly 44 percent had some sort of mental illness/behavioral health diagnosis.
- Among SIM adult beneficiaries receiving CM/CC services, top diagnoses were hypertension, other nutritional/endocrine/metabolic disorders, and mood disorders. Nearly 80 percent had some sort of mental illness/behavioral health diagnosis.

Finally, MPHI looked at beneficiaries based on residence within areas marked by socio-economic deprivation. Even though most PCMHs were not yet screening for social needs in 2017, MPHI did find that SIM beneficiaries residing in high deprivation zip codes to be over represented among those receiving CM/CC services.

MSU Evaluation Team six-month update

The MSU evaluation team has the primary focus of the Collective Impact Evaluation. During the last six months, the MSU team developed, administered, and analyzed 604 surveys to CHIR members, partners, and stakeholders representing 310 organizations. The team also performed a total of 113 interviews with 39 members; 27 partners; 22 stakeholders; and 25 backbone organization staff. Targeted focus groups were also held with community health workers, health plans, and backbone organizations. The findings of these surveys and interviews reveal that the CHIRs have promoted a level of cross-sector coordination, alignment, and synergy that did not previously exist. By making social determinants of health the focus of the work, the CHIRs have launched a paradigm change. Their efforts are transforming people's lives. Due to the CHIR work, people are now getting support before unmet needs become a healthcare crisis. Throughout the evaluation process, the MSU evaluation team has been providing rapid results to the state and to the individual CHIRs. The MSU team has conducted three presentations to state leaders and has provided a summary of the cross-CHIR survey findings and a two-page summary document that highlights the value and impact of the CHIRs' work. The MSU team has provided customized survey

findings to each CHIR and has presented key findings to their backbone organizations. The MSU team has also completed and delivered the first of five playbooks integrating quantitative and qualitative findings customized for each CHIR. The playbook is the foundation for the CHIR sense-making session. The first sense-making session was held in February 2019 at the Northern Michigan CHIR and other CHIR sessions are in the planning phase. CHIRs will use the data and sense-making sessions to develop system level strategies to continue to embed the CHIR work in the community and to address scalability and sustainability moving forward.

University of Michigan CHEAR Evaluation team six-month update

Client Experience Surveys

There is strong interest in understanding the impact of the CHIRs on the clients they serve. In the past six months, CHEAR has worked with two CHIRs to implement the client experience survey pilot test; after several months of planning, data collection was done from October 2018 to January 2019. Results are currently being compiled, and a summary will be shared with MDHHS leadership in February-March 2019.

Patient Experience Surveys

There is strong interest in understanding the impact of social determinant of health (SDoH) screening in the primary care setting. To this end, CHEAR is conducting a multi-component patient experience survey. Part 1 involves a one-page mailed survey (with option to complete online) sent to a sample of Medicaid enrollees (or parents of pediatric patients) seen at a PCMH participating site in the prior quarter. The one-page survey asks: if the patient recalls answering SDoH questions at the PCMH site, if they endorsed an SDoH need; if the PCMH offered information or referral; general views on SDoH screening at the PCMH site; and willingness to be contacted for a follow-up telephone interview. The survey was developed in conjunction with SIM PCMH leadership and with input from PCMH sites. Surveys were mailed beginning in November 2018 and continue to this date. Part 2 involves telephone interviews with survey respondents who reported that they had an SDoH need or who reported negative views on SDoH screening in primary care. The interviews include a combination of fixed-choice and open-ended questions to allow patients to describe their experiences with screening, getting assistance, and other interactions with the PCMH site. With patient permission, interviews are recorded, and descriptions transcribed, to allow for more comprehensive analysis of data. Interviews began in December 2018 and continue to this date.

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,
    - the proportion of Hospitalizations for Ambulatory Care Sensitive Conditions, and
    - the state's 30-day Hospital Readmissions Rate.

For this semi-annual report, the reporting period for the measures is from July 2017 to June 2018. Consistent with the report for the first half of FY 2018, the measures are of the eligible populations of Medicaid beneficiaries that are attributed to a SIM PCMH whether in a CHIR or not. Previously in the FY 2017 reports, the populations for the measures were Medicaid beneficiaries aged 18 to 64 only in the CHIR regions who may or may not have been attributed to a PCMH. In addition, the utilization metrics for the current report are of the full PCMH population including pediatric populations and include mental health admissions or ED visits. The methodology for calculating the hospital admission and ED rates also differs from the FY 2017 reports where rates were reported in terms of per 1000-member months. This current report presents the rates per 1000 attributed members of all ages.

Summary of measures:

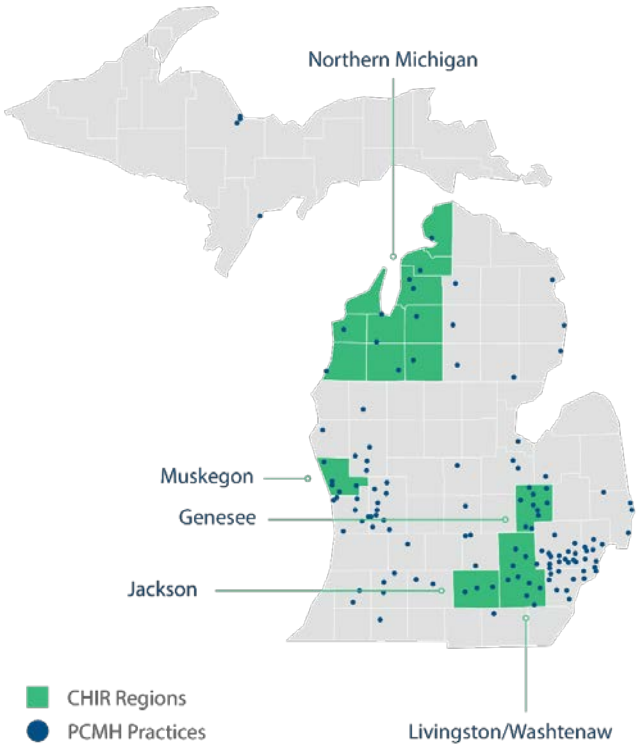
- 30-day all-cause readmission shows a risk-standardized readmission rate for beneficiary population that are attributed to a PCMH, were hospitalized at a short-stay acute-care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. This metric also includes mental health hospitalizations.

- Emergency department visits assesses ED utilization among PCMH population. Mental health ED visits are included. This measure is the rate of ambulatory ED visits per 1000 attributed members of all ages.

- Preventable emergency department visits measure the rate of preventable ED visits per 1000 attributed members of all ages.

- Acute Hospital Utilization measure assesses the risk-adjusted ratio of observed-to-expected inpatient admission and observation stay discharges during the measurement year reported by surgery, medicine and total among members 18 years of age and older.

The performance measures are also, for your convenience and understanding, displayed by the five SIM regions.



PCMH Measures

REGION	PRACTICES	PROVIDERS	BENEFICIARIES
Jackson	11	51	21,863
Livingston/Washtenaw	39	379	38,814
Muskegon	23	139	30,498
Genesee	56	135	42,023
Northern *	18	172	31,735
Total SIM Region	136	825	164,933
TOTAL Non-SIM Region	163	1,256	183,969
**TOTAL ** **	**299**	**2,132**	**348,902**

QUALITY							
		Claims Plus QMI			Claims Only		
ID	Measure Description	Num	Deno	Percent	Num	Deno	Percent
107	Breast Cancer Screening	8,605	11,718	73%	8,541	11,720	73%
108	Cervical Cancer Screening	41,826	69,625	60%	41,170	69,756	59%
110	Chlamydia Screening in Women	10,356	15,593	66%	10,293	15,593	66%
111	Diabetes Eye Exam (retinal) performed	7,542	13,459	56%	6,606	13,459	49%
103	Diabetes Hemoglobin A1c (HbA1c) Testing	11,872	13,522	88%	11,250	13,522	83%
113	Diabetes Medical Attention for Nephropathy	11,985	13,459	89%	11,944	13,459	89%
PEDIATRIC QUALITY							
		Claims Plus QMI			Claims Only		
ID	Measure Description	Num	Deno	Percent	Num	Deno	Percent
105	Adolescent Well-Care Visits	29,790	64,856	46%	28,907	64,856	45%
109	Childhood Immunization Status	3,869	10,439	37%			
114	Immunization Status for Adolescents	6,732	7,856	86%			
144	Immunization Status for Adolescents with HPV	2,923	7,856	37%			
101	Lead Screening in Children	7,816	10,439	75%	7,816	10,439	75%
115	Well-Child Visits in the First 15 Months of Life	7,887	10,713	74%	7,244	10,713	68%
116	Well-Child Visits in 3rd thru 6th Years of Life	29,487	41,877	70%	29,068	41,877	69%
QUALITY - OUTCOME MEASURES (New for this reporting period)							
ID	Measure Description	Num	Deno	Percent			
106	Adult BMI Assessment	60,318	89,745	67%			
102	Controlling High Blood Pressure	11,679	26,635	44%			
148	Depression Screen	8,806	155,493	6%			
149	Depression Follow Up	1,239	1,529	81%			
104	Diabetes Blood Pressure Control	6,562	13,522	49%			
125	Diabetes Hemoglobin A1c Poor Control (>9%)	8,676	13,522	64%	*		
120	Tobacco Use Screening and Cessation Intervention	460	13,600	3%			
121	Weight Assessment and Counseling for Nutrition and Physical Activity for Children	35,858	104,126	34%			
UTILIZATION							
ID	Measure Description	Num	Deno	Rate (Per 1,000)			
151	Acute All-Cause Readmission	907	7,645	119			
146	Acute Hospital Admissions	9,480	253,067	37			
166	Ambulatory Care Sensitive Condition (ACSC) Admissions - Overall Adult Composite	2,188	172,649	13			
119	Emergency Department Visits	187,336	253,067	740			
147	Preventable ED Visits	101,368	253,067	401			
TOTAL COST - New for this reporting period							
ID	Measure Description	Num (Total Med and Rx Cost)	Deno (Total Member Months)	Rate Total Cost PMPM			
182	Total Cost PMPM	$ 979,756,193.49	3,693,323	$ 265.28			
CHRONIC CONDITIONS							
ID	Measure Description	Num	Deno	Percent			
135	Chronic Condition Asthma	28,979	350,353	8%			
150	Chronic Condition Diabetes	15,918	350,392	5%			
134	Chronic Condition Hypertension	38,899	350,305	11%			
139	Chronic Condition Obesity - Any	80,714	350,392	23%			
136	Chronic Condition Obesity - Overweight	27,616	350,392	8%			
137	Chronic Condition Obesity - Moderate	14,463	350,392	4%			
138	Chronic Condition Obesity - Severe	51,012	350,392	15%			
	Reporting Period: July 2017 - June 2018						
	Population based on June 2018 Filtered SIM PCMH File (SPF) Attribution						
	Quality Measures based on HEDIS 2018						
	MDC Release 6.01						
	* Note lower percentage indicates better quality for this measure						
	Added with this submission						

PCMH Utilization by CHIR regions

UTILIZATION - PCMH Initiative				
ID	**Measure Description**	**Num**	**Deno**	**Rate**
146	Acute Hospital Admissions	9,480	253,067	37
151	Acute All-Cause Readmission	907	7,645	119
119	Emergency Department Visits	187,336	253,067	740
147	Preventable ED Visits	101,368	253,067	401

Measure Description	**CHIR**	**Num**	**Deno**	**Rate**
Acute Hospital Admissions	GENESEE	1,228	31,326	39
	JACKSON	607	12,332	49
	LIVINGSTON/WASHTENAW	1,074	29,626	36
	MUSKEGON	615	21,903	28
	NORTHERN	717	21,964	33
	OUTSIDE	5,239	135,916	39
	TOTAL	***9,480***	***253,067***	***37***
All-Cause Readmission	GENESEE	93	847	110
	JACKSON	78	538	145
	LIVINGSTON/WASHTENAW	117	896	131
	MUSKEGON	32	502	64
	NORTHERN	55	585	94
	OUTSIDE	532	4,277	124
	TOTAL	***907***	***7,645***	***119***
Emergency Department Visits	GENESEE	19,290	31,326	616
	JACKSON	9,690	12,332	786
	LIVINGSTON/WASHTENAW	18,811	29,626	635
	MUSKEGON	24,440	21,903	1,116
	NORTHERN	15,022	21,964	684
	OUTSIDE	100,083	135,916	736
	TOTAL	***187,336***	***253,067***	***740***
Preventable Emergency Department Visits	GENESEE	9,834	31,326	314
	JACKSON	5,051	12,332	410
	LIVINGSTON/WASHTENAW	9,979	29,626	337
	MUSKEGON	14,514	21,903	663
	NORTHERN	7,693	21,964	350
	OUTSIDE	54,297	135,916	399
	TOTAL	***101,368***	***253,067***	***401***

Reporting Period: July 2017 - June 2018
Population based on June 2018 Filtered SIM PCMH File (SPF) Attribution
MDC Release 6.01

4 Budget

The SIM program and its component initiatives highlighted in this report have been funded through a cooperative grant agreement with Centers for Medicare and Medicaid Services innovation center. The SIM program continues to execute component initiatives based on the Centers for Medicare and Medicaid Services approved operational plan and budget. The scale and pace of expenditures throughout the award year (February 1, 2018 through January 31, 2019) proceeded at the highest level of any SIM award year. Consequently, these expenditures have made significant contributions to the engagements necessary to progress SIM goals. While we anticipate realizing a high percentage of the expenditures identified in the annual budget, a portion will remain unspent and will be carried forward to Award Year 4. The final budget year will utilize these excess funds to further bolster the ongoing operations, sustainability planning and transition of SIM component initiatives to MDHHS operations.

4.1 Legislative Update

The table below highlights the specific expenditures across standard Centers for Medicare and Medicaid Services 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 six months that are encompassed in this report. The spending includes engagements facilitated though both direct State of Michigan master and standard contractual agreements and other contracts and engagements through the designated SIM fiduciary, MPHI.

Categories	12 mos. Budget	6 mos. Expenditures
Personnel	$ 228,354	$ 89,993.04
Fringe Benefits	$ 47,833	$ 67,839.68
Equipment	$	$
Supplies	$	$ 14,949.76
Travel	$ 18,672	$ 3,815.25
Other	$ 570,000	$
Contractual	$ 17,930,831	$ 6,658,210.53
Total Direct Charges	$ 18,795,690	**$** 6,834,808.26
Indirect Cost	$	$
Total	**$ 18,795,645**	**$ 6,834,808.26**

The budget period is 12 months, beginning February 1, 2018 through January 31, 2019 while the reported expenditure period spans August 1, 2018 to January 31, 2019. Due to the timing of the posting of expenses into the State's accounting system, not all December 2018 and January 2019 expenses are included in the totals above.