State Innovation Model Report 2

(FY2016 Appropriation Act - Public Act 84 of 2015)

September 1, 2016

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. Over the next 4 years 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 data aggregator must 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

RICK SNYDER, GOVERNOR
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State Innovation Model

Section 1144, FY 16 MDHHS Budget Report

Office of Health Policy & Innovation (OHPI)

State Innovation Model (SIM)

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1 Executive Summary

1.1 Vision

In his 2015 State of the State address, Governor Rick Snyder outlined a vision for an efficient, effective, accountable government in Michigan that collaborates at scale to deliver services in a "smarter, person-centered way with less fragmentation."

The state's vision for health care transformation is a continuation of the Governor's overall vision for the state specifically as it pertains to Michigan's health system. By implementing **coordinated care delivery models** and by investing in **supporting innovations** including value-based payment and enhanced data interoperability, we will deliver upon a three-part goal: better health, better care with improved access, and cost avoidance.

The vision includes health care transformation for Michiganders across all payor populations – Medicaid, Medicare, and Commercial. The support of all payors and joint working across all state agencies will be paramount in realizing this vision. This report reflects activities conducted and accomplishments during the most recent period of **Planning and Design** for the State Innovation Model (SIM) Project in partnership with the Center for Medicare and Medicaid Services (CMS). Implementation of the healthcare delivery, payment, and population health improvement models is expected to begin during the 2016-2017 project year.

1.2 Coordinated Care Delivery Models

Coordinated care delivery models are at the core of the state's vision for health system transformation:

- **Care Delivery:** The Patient Centered Medical Home is the core pillar of our strategy for health system transformation. Patient Centered Medical Homes will improve quality and drive cost avoidance with a focus on high-quality chronic care management, improved care transitions, referrals to highly effective downstream providers, and improved selection of treatment and care settings. The Patient Centered Medical Home model will expand upon existing models within the state by increasing alignment across payors (thereby lowering the administrative burden on providers), providing improved information to provider teams to support their decisions, and introducing total cost of care accountability to reward those Patient Centered Medical Homes who best manage the needs of their patients.

- **Community Health Innovation Regions:** Meeting the whole health needs of Michiganders will require effective linkages and coordination among health care providers and community partners. Community Health Innovation Regions will identify and advance regional health priorities, address other determinants of health, and align local efforts with state priorities including Integrated Service Delivery and Michigan's five Winnable Battles. Community Health Innovation Regions will be supported by a legal infrastructure and will have clear priorities, budgets, and governance structures to enable this coordination.

- **Advanced Payment Models:** The State's objectives to improve the delivery of coordinated care across the state will be encouraged through the implementation of alternative payment models, including but not limited to Medicaid managed care beneficiaries. Building on established benefits of the PCMH initiative in Michigan and coupled with existing Medicaid Health Plan (MHP) contract payment reform requirements, the State will seek to increase alternative based payments to Michigan providers. These alternative payments will include PCMH Practice Transformation payments, Care Coordination fees and increased implementation of alternative payment models (APMs) with shared savings/shared risk and population-based payment models through Medicaid, Medicare and commercial payors.

1.3 Innovations in support of these models

We will support the state's vision for health care transformation through enhanced data interoperability and health information technology, and common performance measures.

Data interoperability and Health Information Technology

Data interoperability is central to the Michigan Department of Health and Human Services' vision of promoting better health outcomes, reducing health risks, and supporting stable and safe families while encouraging self-sufficiency. Health Information Technology and Health Information Exchange capabilities will be enhanced to directly enable coordinated care delivery and value-based payment models and will support overall health care transformation.

There are four goals to our solution for enhanced date interoperability and health information technology:

- Enabling the performance, evaluation, and reporting for the four coordinated care delivery models
- Supporting care coordination
- Providing a population health toolset.

Meaningful action from public and private stakeholders will be essential to achieving the interoperability of electronic health information. Major steps are to (1) employ a coordinated governance framework and process for health IT interoperability, (2) improve technical standards and implementation guidance for sharing and using a common clinical data set, (3) enhance incentives for sharing electronic health information according to common technical standards, starting with a common clinical data set, and (4) clarify privacy and security requirements that enable interoperability. We will build on existing governance structures, e.g., the Michigan Health Innovation Network, thoughtfully engage with internal state agencies, and convene the appropriate stakeholders across our state to this end.

Common provider measures

Payors will align on the provider performance metrics measures that will be adopted for Patient Centered Medical Homes. Common measures will lower the administrative burden across providers related to metrics reconciliation, and will encourage a consistent set of behaviors and priorities. This effort will build upon the existing efforts around metric

alignment, including the Michigan State Medical Society Physician Payor Quality Collaborative.

1.4 Implementation plan

We are preparing for implementing care delivery components through Medicaid Managed Care Organizations in annual waves of enrollment by region. Currently, the SIM team is preparing to implement wave I Patient Centered Medical Homes which includes Patient Centered Medical Homes with pre-existing third party accreditation in the selected regions as well as Michigan Primary Care Transformation Patient Centered Medical Homes across the state. We will enroll additional providers each year. All five state-selected Community Health Innovation Regions will be planning their implementation design in 2016-2017.

Through the implementation of these coordinated care delivery models and supporting innovations, we will establish a pragmatic path toward an aspirational vision for health care transformation. We firmly believe in the potential to deliver better health, better care with improved access, and cost avoidance for all Michiganders with the effective mobilization and coordination of key internal and external stakeholders.

2 SIM Project Management and Delivery Office

2.1 Governance Structure

The Office of Health Policy and Innovation has chartered a 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 other engagements 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 facilitating the governance activities across all governance bodies (Operational, Program and Executive).

2.2 Staffing

The Program Management and Delivery Office has added additional business analysts, project managers and a program coordinator. The Michigan Department of Health and Human Services has also transitioned additional State resources to the State Innovation Model initiative on both full and part-time basis, these resources include Medicaid Operation subject matter experts, Actuarial Specialists, Public Relations and other pertinent areas. Additional requisitions and position have been filled for multiple SIM roles, specifically a Patient Centered Medical Home Lead/Business Owner, Community Health Innovation Region Lead/Business Owner, Evaluation/Measurement Lead, and a Contract and Grant Management Specialist. A complete staffing plan including future estimates is included in the Operational Plan.

2.3 Project Management

The Program Management and Delivery Office has established and augmented State Innovation Model processes around internal and external reporting, Operations Plan finalization process, requirement review, implementation recommendation process, issue/risk tracking and management, change control, and deliverable review and approval. The Program Management and Delivery Office is applying the proven program

and project management processes and other organization and initiative controls required to meet the State Innovation Model Test near-, mid- and long-term expectations and related milestones.

3 Care Delivery Components

3.1 Background

Michigan's Blueprint for Health Innovation established the Patient Centered Medical Home as the foundational element of health system transformation in our state. Michigan's State Innovation Model Patient Centered Medical Home Initiative focuses on ensuring Patient Centered Medical Homes deliver high quality, efficient primary care, promote the delivery of coordinated care and to refer to and collaborate with high-value providers.

Furthermore, the State Innovation Model Patient Centered Medical Home Initiative places special focus on and supports Patient Centered Medical Homes in serving as a critical health facilitators by coordinating across multiple providers and care settings to understand and holistically address the health needs of each patient. Patient Centered Medical Homes will fulfill this focus by:

- Developing care plans to capture a comprehensive approach for maintaining a patient's health or managing a chronic condition;
- Supporting transitions of care, for example timely patient follow-up post discharge;
- Providing referral decision support and scheduling, for example recommending high-quality, efficient specialty providers and helping to schedule appointments;
- Interfacing with other providers, including communicating with other specialists and behavioral health professionals to promote an integrated treatment approach;
- Engaging supportive services, for example home health, where necessary for proper disease management;
- Leading patient relationships to support patient education on health, self-care and follow-up after major encounters;
- Developing and utilizing patient registry functionality to support population health improvement.

There is an ever-increasing body of knowledge to support implementation of Patient Centered Medical Homes and the approach being undertaken by State Innovation Model. The Patient Centered Primary Care Collaborative collects and analyzes studies and research regarding the cost, utilization, quality and access changes associated with PCMH projects across the United States. One of their recent reports, released in January 2015, aggregated outcomes from 28 peer-reviewed studies, state government program evaluations, and industry reports which demonstrated significant achievements in cost, utilization, and quality.

The effectiveness of the Patient Centered Medical Home model and foundational nature of the medical home is also evident in Michigan where it is estimated that approximately 5,200 providers are already choosing to practice in a Patient Centered Medical Home

accredited setting. A significant majority of Michigan's current Patient Centered Medical Home providers have been accredited through Blue Cross Blue Shield of Michigan's Patient Centered Medical Home program, however several other accreditation programs are in use by Michigan Patient Centered Medical Homes as well. The robust spread of Patient Centered Medical Home models in Michigan over the course of the last several years and the number of currently accredited Patient Centered Medical Home practices (representing approximately one third of Michigan's 16,200 active primary care providers) have provided a significant base and momentum to build upon for the State Innovation Model Patient Centered Medical Home Initiative.

3.2 Legislative Update

Since the Michigan Blueprint for Health Innovation was completed and the State of Michigan received funding to test and evaluate its multi-payer health system transformation elements, a broad team from the Michigan Department of Health and Human Services has been working toward implementing the Patient Centered Medical Home Initiative.

Michigan's State Innovation Model team has been working with MDHHS and external stakeholders to transform the Patient Centered Medical Home concepts outlined in the Blueprint into comprehensive strategies that are steering planning and implementation. This process, based on an iterative design approach which increased strategy detail progressively, delivered the base for Michigan's State Innovation Model operational plan.

Using those strategies, the Patient Centered Medical Home -focused team members came together with staff members from various administrations in the Michigan Department of Health and Human Services in late 2015 to develop implementation recommendations which moved the Patient Centered Medical Home Initiative toward an actionable implementation plan. The State Innovation Model Patient Centered Medical Home Initiative implementation recommendations include: scalability and statewide spread, a PCMH accreditation approach, provider eligibility and participation requirements, eligible patient populations, patient attribution strategy, Patient Centered Medical Home payment model, health information technology requirements, Patient Centered Medical Home support infrastructure and performance measurement. The implementation recommendation process also served to ensure alignment and integration across the Michigan's health and human services infrastructure and with Michigan's other State Innovation Model test components.

The Patient Centered Medical Home Initiative implementation recommendations were reviewed and approved in early January, providing the direction needed to undertake implementation efforts. To-date, those implementation efforts have included:

- Analyzing technical design and business requirements for the Patient Centered Medical Home Initiative to set the stage for collaboratively finalizing those details with partners;
- Building out a robust Patient Centered Medical Home Initiative implementation plan and timeline to ensure proper management and governance (both within the Michigan Department of Health and Human Services and with stakeholders) of the Initiative as it moves forward;

- Ensuring continuity and a supportive transition with the Michigan Primary Care Transformation Project to ensure the State Innovation Model leverages the infrastructure and best practices of the Michigan Primary Care Transformation Project as a base for the Patient Centered Medical Home Initiative;
- Developing a stakeholder engagement approach (which began in March 2016) to evaluate, provide feedback and garner collaborative leadership regarding how the Initiative moves forward;
- Dedicating and supporting an internal team of the Michigan Department of Health and Human Services staff across administrations to focus on operationalizing the Patient Centered Medical Home Initiative;
    - A key step in aligning with Medicare will be the submission of a PCMH custom option approach to Medicare to obtain authority for Medicare to participate in Michigan's custom option, which will be developed in the summer/fall 2016. In addition, Michigan will continue to monitor any developments with the CPC+ program. Because CPC+ features many of the same goals that overlap with SIM, the State of Michigan is evaluating a potential alignment with this initiative as it relates to the custom Medicare participation option.
    - Developing PCMH on boarding and application processes as well as education/training to support providers;
    - Calculating payments per member per month for practice transformation and care management payments to providers.
- Structuring consulting and vendor relationships to support implementation of key Patient Centered Medical Home Initiative requirements.

The State Innovation Model Patient Centered Medical Home Initiative will continue its implementation efforts in the months to come leading up to a January 1, 2017 Initiative launch date.

4 Accountable Systems of Care

4.1 Legislative Update

A small number of Accountable Systems of Care (ASC) will be supported in CHIRs. ASCs are health systems, physician organizations, or physician hospital organizations in the 5 selected CHIR regions. ASCs are groups of providers, consisting of at least primary care providers, who are committed to supporting the community priorities and health improvement activities as identified by the CHIR local governance body. ASC participation in a CHIR includes participating in decision-making, aligning with priorities and goals of the CHIR, and acceptance of SIM grant funding to implement projects in line with the community health priorities. SIM grant funding for each region will be limited to operations and activities that can be tied directly back to the region's health priorities and coordination plans to impact those priorities. Therefore, SIM grant funding for each region may be allocated to ASCs at the discretion of the CHIR governing body, of which ASCs are a member. ASCs operating in CHIR locations are well positioned to deliver meaningful quality improvements and cost avoidance in furtherance of the overall goals of their local CHIR, through stronger clinical, administrative, and technological integration across participating providers.

5 Community Health Innovation Region

5.1 Legislative Update

The Community Health Innovation Region concept is intended to develop and strengthen partnership between and among health care providers and community organizations for the overarching purposes of:

- Better serving the current health-related needs of individuals, including the social determinants of health (e.g., access to food, housing, transportations, safety, and other essential needs).
- Coordinating health-improvement efforts across clinical and community partners as to exert maximum impact on long-term population health.

Community Health Innovation Regions are intended to be anchored by credible, adequately-resourced "backbone organizations" based in the communities they serve. The backbone organization is responsible for convening cross-sector partners, facilitating consensus on community health priorities, brokering relationships among partners to address priorities, and establishing measures of success. Since the State Innovation Model project began, the State Innovation Model Team has worked to operationalize the theoretical concepts of the Community Health Innovation Region contained in the Blueprint into actionable items for regions to enact.

To identify suitable backbone organizations to lead Community Health Innovation Region efforts across Michigan, capacity assessment surveys were released in early April of 2015 to understand interest and capacity among community-based organizations in Michigan. Twenty capacity assessments, were analyzed for experience and apparent ability to be a multi-sector collaborative leader and convener in their community. The team selected 15 organizations that showed capacity for this role, and held a series of interviews with the applicants' leadership teams to further discuss their readiness for participation. These discussions resulted in the team's selection of the following of 5 regions:

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

Preliminary initiation, design and planning work has been began with the backbone organizations in each selected region.

The State Innovation Model Team expects to finalize plans for the approach to implementation and roll-out. These decisions will include:

- Disbursing capacity-building awards to Community Health Innovation Regions
- Delivering group and individual technical assistance to Community Health Innovation Region
- Monitoring the success, and measuring the value, of the Community Health Innovation Region

- Developing (or strengthening existing) partnerships between Community Health Innovation Regions and local Accountable Systems of Care.
- Engaging participants into a Collaborative Learning Network that will accelerate their documentation, synthesis, and uptake of lessons learned during the State Innovation Model on how to pursue health system transformation by changing the business model of healthcare with a bottom-up, top-enabled approach.

Through iterative stakeholder engagement processes, Community Health Innovation Region backbone organizations will continue to have opportunities to offer feedback on design decisions, which have been formalized in the Operational Plan submitted to the Centers for Medicare & Medicaid Services in June of 2016. On a yearly basis, the Operational Plan submitted to the Centers for Medicare & Medicaid Services will be updated and CHIR backbone organization feedback incorporated.

In addition to the Operational Plan submitted to the Centers for Medicare & Medicaid Services, the MDHHS team has developed a CHIR Participation Guide to provide an implementation framework for executing SIM Community Health Innovation Region goals and objectives in a local context. The CHIR Participation Guide provides useful information regarding administrative aspects of the project and includes a Local Operational Plan Template which provides a format for the CHIRs' local operational plan for project implementation.

6 Data Interoperability and HIT

6.1 Legislative Update

The Michigan State Innovation Model test will support ongoing state efforts to enhance the exchange of electronic health information and will support our vision for health care transformation with four core objectives. These include: (1) enabling State Innovation Model program performance, evaluation, and reporting; (2) supporting care coordination;; and (3) providing a population health toolset to support greater interoperability between health care and community entities.

The State Innovation Model performance and evaluation reporting tool will provide data aggregation and reporting capabilities needed to support required analysis of program performance and provider quality dashboard reporting. To support these initiatives, the State will work towards standardized, base requirements in reporting and format to providers. This would assist in creation of provider performance dashboards described above by linking existing capabilities with the data aggregator. For the Michigan SIM test, we will pilot the creation of common electronic mechanisms via the Michigan Health Information Network's use-case factory approach for providers to enter quality data (across all payors) and access performance reports via a common platform housed within the Michigan Data Collaborative.

Access to data is a key enabler of care coordination, and Michigan is continuing to drive the adoption of electronic health records and build the healthcare information exchange infrastructure. This will enable improved coordination for medically complex individualsand increased transparency into the health of Michiganders. The exchange of integrated clinical data among healthcare stakeholders (e.g., payors, providers), including the

longitudinal patient registry will be enabled by HIE within the SIM test regions and be critical to care delivery and payment innovation. Michigan Health Information Network will lead the effort on clinical data exchange by serving as the "network of networks". Several Michigan Health Information Network use cases prioritized for State-wide launch (e.g., discharge medication, Admission Discharge Transfer notification, Active Care Relationship Service, HPD, Common Key Service) would support the care coordination efforts for State Innovation Model testing. In addition, use cases championed regionally by health systems would be leveraged where applicable to support roll-out of new Care Coordination models.

Additional analytics and reporting will be required to support the payment models being deployed. The infrastructure to support this would be developed and deployed by MiHIN, MDHHS in collaboration with Medicaid / managed care organizations. Michigan will establish standardization guidelines for all payors (Medicaid/Managed Care Organizations, Commercial) to ensure that the program realizes the potential benefits from the multi-payor effort. This may include elements such as report format, high-level payment mechanisms and quality metrics. Each payor will build (potentially leveraging external vendors) and maintain their individual analytics and reporting infrastructure.

Providers, Payors, and community stakeholders will require technology tools to (1) improve care delivery to Michiganders, (2) support population heath, and (3) succeed in advanced payment models. The Michigan State Innovation Model will help enable a population health toolset to support greater interoperability between the health care and community entities. Within the test, SIM will coordinate existing technological solutions, encourage interoperable platforms for all stakeholders, and support development of new infrastructure capabilities in order to set the foundation for a learning health system.

To-date, HIT implementation efforts have included:

- A PCMH Operations module which allows PCMH operations contractor the ability to manage PMCH applications, monitor accreditation, and provide data for day-to-day operations.
- The SIM Relationship and Attribution Management platform has been designed and currently entering the last stages of approval before implementation begins. The platform will enable a consistent shared process for communicating and tracking affiliations and linkages among SIM stakeholders.
- A set of quality and utilization measures have been defined and approved in alignment with CMS reporting requirements.