

State Innovation Model – Report 2

(FY2018 Appropriation Act - Public Act 107 of 2017)

September 1, 2018

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

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

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

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

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

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

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

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

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

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

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





Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

State Innovation Model (SIM)

Section 1144, FY 18 MDHHS Budget Report

Policy, Planning, and Legislative Services Administration

State Innovation Model (SIM)

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1 State Innovation Model Executive Summary

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

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

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

1.1 Population Health Components

Community Health Innovation Regions

Community Health Innovation Regions (CHIRs) form the foundation of the Population Health component of the SIM initiative. A CHIR is a broad partnership of community organizations, local government agencies, business entities, health care providers, payers, and community members that come together to identify and implement strategies that address community priorities. The state selected five regions 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.

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CHIR Regions and Backbone Organizations

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 Healthcare Research and Transformation
Muskegon County	Muskegon Community Health Project (Mercy Health)
Northern Region	Northern Michigan Public Health Alliance

The overarching mission of each CHIR is to align priorities across health and community organizations and support the broad membership of the CHIR in developing and implementing improvement strategies aimed at addressing social/economic conditions to reduce 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 service agencies.

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

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

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

Health Through Housing Initiative

The challenges associated with reducing high emergency department utilization and housing homeless Michiganders with significant physical and mental health disabilities have overlapped in several recent state projects, including SIM. All CHIRs have identified housing as a significant barrier and identified the need for additional resources and

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assistance. The lack of stable housing is a shared concern among the healthcare community as well as human services providers within the regions.

MDHHS is poised to begin a multi-faceted project that is working to improve health outcomes and reduce the overuse of emergency department services by the chronically homeless through an initiative we are calling, “Health through Housing.” This initiative focuses on the use of data integration, improving the homeless response system, and a local permanent supportive housing pilot in selected communities to develop strategies that will positively impact the long-term health and housing stability of highly vulnerable individuals experiencing long term homelessness. MDHHS’ efforts are based on other state and local programs across the country that have participated in various research studies. The anticipated start date is October 1, 2018.

Plan for Improving Population Health

CMS requires that the State of Michigan develop a statewide plan to improve population health as part of the health system transformation efforts over the four-year performance period. The finalized Plan for Improving Population Health (PIPH) must be delivered to CMS, with the expectation to begin implementing the plan before SIM activities end. The plan will strive to reflect how state population health initiatives and health system transformation efforts are coordinated; and how activities under SIM are aligned with the state’s existing population health priorities. Along with identifying existing initiatives in Michigan that align with the state’s priorities, this plan will identify areas in which the state can build capacity to advance the work of the CHIRs and PCMHs with their focus on Social Determinants of health and will include actionable plans for how to begin implementing this work.

Operational plans for Test Years 1 and 2 included a focus on aligning the Plan for Improving Population Health (PIHP) with the revised State Health Improvement Plan and State Health Needs Assessment, necessary components of the Public Health Accreditation Board accreditation process. MDHHS experienced unforeseen circumstances across an array of issue areas including a departmental merger and a public health crisis. This delayed the pursuit of Public Health Accreditation Board accreditation and the accompanying State Health Needs Assessment and State Health Improvement Plan. While alignment between those efforts will continue to be a priority, the PIPH will build from the existing State Health Needs Assessment, State Health Improvement Plan for Michigan, and those areas identified as priorities through the CHIR and PCMH Social Determinant of Health screening assessments.

1.2 Care Delivery

Patient-Centered Medical Home

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

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

The state has established a payment model specific to the SIM PCMH Initiative to support practice transformation and care coordination. Each practice participating in the PCMH Initiative will receive payments for its attributed eligible Medicaid beneficiaries. Practices will receive payments to support practice transformation (i.e., investment in practice infrastructure and capabilities) as well as payments to support care management and coordination. Michigan's 11 Medicaid health plans have participated by directing state designated payment amounts to State-approved PCMH practices based on performance metrics.

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

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The state is continuing to engage public and commercial payers in conversations on the potential for multi-payor alignment, including quality measurement policies and data sharing infrastructure to improve delivery system performance.

1.3 Technology

SIM Initiative Technology Support

Michigan previously established the Relationship and Attribution Management Platform (RAMP) to ensure a foundation for supporting care coordination and identifying relationships between patients and providers. RAMP currently supports several critical aspects of care management and coordination, including a health provider directory, a system for tracking active care relationships between patients and healthcare providers, exchange of quality-related data and performance results, and sending admission-discharge-transfer (ADT) notifications. Leveraging the statewide health information exchange infrastructure in the development of RAMP allowed the state to take advantage of a widespread network of networks to increase interoperability and support the goals of the initiative. The SIM technology team continues to provide oversight by monitoring the ongoing monthly attribution files for accuracy and timeliness.

The SIM technology team continues to onboard SIM PCMH participants for the work related to the Quality Measure Information (QMI) use case, which will enable healthcare providers to transmit clinical quality measures electronically. These measures are currently being integrated into the PCMH Care Coordination measures as needed. The QMI use case will provide Medicaid and other payers the ability to access and view quality measures across all their providers.

The SIM Technology team began supporting the Care Delivery's initiative to collect social determinants of health data. We continue to define the technical requirements and evaluate the necessary data sharing agreements needed to meet this goal.

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.

The team is also working 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 will aid in locating and distributing housing vouchers for the identified individuals and their Permanent Supportive Housing organizations.

1.4 SIM Program Management

Governance Structure

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

MDHHS has implemented and operationalized an updated SIM organizational and governance structure. The expanded governance body includes an executive leadership team consisting of departmental directors from the Medical Services Administration (MSA); Population Health Administration; and the Policy, Planning, and Legislative Services Administration. In July 2018, SIM governance formally added representation from the Behavioral Health and Developmental Disabilities Administration (BHDDA) to the Executive Leadership Team. This executive representation and governing body continues to ensure alignment with broader departmental vision, goals, and related objectives. This input and guidance has been essential in the oversight and success of ongoing operations and SIM sustainability planning.

Program and Portfolio Management

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

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

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

The PMDO also continues to supplement the formal governance and operational structure with additional ad hoc and regular participant and other stakeholder engagements. These include, but are not limited to, a possible new steering committee with focus on the CHIR Initiative and evaluation and measurement. These advisory committees are comprised of subject matter experts from various MDHHS departments and administrations, and other

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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

Community Health Innovation Regions

The local CHIRs continued to stabilize their CCLs and supporting interventions. The CHIRs have submitted their new operating plan, which spans the remainder of SIM. State feedback on these plans has been provided with final approval to be given to the regions by the end of September 2018. A CHIR convening will be held in October 2018 following the approval of their operating plans.

Two regional convenings with the CHIR backbone organizations were held, the first on February 28th and the second on May 30th. In February, CHIRs were updated on evaluation efforts, a working session regarding data sharing barriers was facilitated, and a discussion with Medicaid was held to identify potential sustainability strategies. In May, each CHIR presented high level overviews of their regional activities to federal representatives from the CMS. Site visits were held with each region during the month of June, during which the state team provided input on the development of each region's operating plans, received a detailed status update and had preliminary discussions regarding post-SIM sustainability.

Planning activities for the housing initiative accelerated during this quarter. Discussions regarding data sharing agreements started and will be ongoing into the current period. Approval was obtained for initial data feeds from the HMIS. Data matching with Medicaid claims was successful. Efforts will continue to improve match rate and define analytics.

Over the past six months the CHIRs have worked to launch pilots of CCL and supporting interventions.

Some accomplishments this reporting period include:

- Genesee: Piloted CCL process (conducting screening and referrals in pilot PCMH practices; customized care management software and trained hub staff on its use; began compiling and analyzing social determinants of health screening data.
- Jackson: Completed days 1-2 ABL e Change training, focusing on equity (over 60 stakeholders participated); Continued planning upstream interventions, including the Community Livingroom and youth programs.
- Livingston-Washtenaw: Received first output of the predictive model; from this list, provided outreach and enrolled individuals who were assigned to a specialty HUB; began processes to compile and analyze social determinants of health screening data.

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- Muskegon: Continued processes of restructuring governance and work groups; Convened housing and food security work groups, leveraging existing community resources and coalitions; Further defined CCL workflow to support full launch
- Northern: Collected primary data to support inclusion of obesity and emergency department utilization into Child Health Insurance Program (CHIP); collected primary data to inform intervention to reduce inappropriate use of the Emergency Department (ED); Completed days 5/6 of ABL e Change training with plans to put interventions and other activities into action

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 Technical Assistance and Cohort Collaboration calls
- Reviewed/submitted Unrestriction Requests to CMS, both in the Operations Plan and individually
- Planned/provided ABL e Change training
- Planned for in-person backbone organization meeting in February and May
- Continued development of updated CHIR Participation Guide and structured response template for local submission
- Continued development of the CHIR model and plans for sustainability

During this reporting period, the northern CHIR was featured as a SIM success story in our most recent report to CMS. The northern Michigan CHIR completed their ABL e Change training and established actionable strategies that incorporated what they learned and developed through the training. The training (carried out over the course of three two-day sessions) gathered 90+ cross-sector community partners from across the region. Together, the group identified barriers to health for the region's residents by reviewing health needs assessments and conducting primary research with community members. During the first two-day training session, the community partners identified five primary barriers: lack of access to healthy food, limited transportation, housing insecurity, limited opportunities to participate in physical activity, and social isolation. To obtain resident input, participating stakeholders not only surveyed the individuals who seek services at their respective organizations through individual interviews, but in addition took part in community events (e.g. school open houses) to gather data from the public. During the final two-day training session, the partners worked to identify strategies for promoting the issues across the community to ensure their incorporation in the development of policies across all sectors. The strategy design teams have begun to meet regularly and are partnering with coalitions and organizations to move their identified strategies forward, while also exploring potential funding streams to sustain their efforts.

Health Through Housing Initiative

MDHHS is leading a multi-faceted project that is working to improve health outcomes and reduce the overuse of emergency department services by the chronically homeless through an initiative we are calling, "Health through Housing." This initiative focuses on the use of data integration, improving the homeless response system, and a local permanent supportive housing pilot in selected communities to develop strategies that will positively

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impact the long-term health and housing stability of highly vulnerable individuals experiencing long term homelessness.

MDHHS has partnered with the Michigan Coalition Against Homelessness (MCAH) to integrate statewide data on currently homeless individuals and matching it to their Medicaid utilization to identify a target population of high-cost, high-need clients that can be prioritized for permanent housing. The initial match of the two databases has begun and once the population has been identified, this match will be run routinely. This data will be used to guide local homeless response systems in addressing their highest-need clients as well as to inform state partners including MDHHS when crafting policy and programs to serve this population.

Michigan submitted language in an 1115 waiver to CMS asking for specific tenant-based services to be reimbursable with Medicaid through Michigan's behavioral health carveout. CMS has communicated with MDHHS that it should submit a different waiver (such as a 1915i) requesting to include these services. This alternate submission is being discussed by MDHHS. It should be noted that reimbursement of these services would be much more impactful if sufficient funding was included to cover them within the carveout. If CMS approves the addition of services, MDHHS will offer customized training to permanent supportive housing providers across the state through a national TA provider on how to become (or contract with) a Medicaid billable agency.

MDHHS, through SIM funding, is providing funding and program support to four local permanent supportive housing providers in three CHIR communities through January 2020 to house and stabilize high utilizers of healthcare services and frequent users of emergency departments that are experiencing homelessness. This pilot is modeled after other frequent user demonstration projects operated across the country which have evaluated the impact of stable, permanent supportive housing on the health outcomes of this highly vulnerable population. The Michigan State Housing Development Authority (MSHDA) has partnered with MDHHS on this pilot and committed up to 200 housing choice vouchers which provides long-term rental subsidy for pilot participants. Results of this pilot will be used to improve the quality of available permanent supportive housing, inform state and local government on housing and health policy, influence housing and educate both the housing and healthcare community about the impact of housing stability on care, cost, and outcomes.

Plan for Improving Population Health

MDHHS made steady progress toward developing Michigan's Plan for Improving Population Health (PIPH) 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 mental health and Medicaid to guide the development of the PIPH and to support alignment across department admirations. 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 PIPH; developing a broad outline and guiding principles; creating a strategy for stakeholder engagement; and forming subcommittees to inform components of the PIPH.

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Michigan's PIPH 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. As such, the workgroup selected the three buckets of prevention framework from the Center for Disease Control and Prevention (CDC) to organize the PIPH. This framework emphasizes the importance of integrating the '3 buckets' of traditional clinical prevention, innovative clinical prevention, and total population/community-wide intervention¹. The PIPH will be organized around this framework; however, rather than focusing on a specific health outcome, the PIPH will be directed at addressing the social determinants that underlie disparities in multiple health outcomes. Following robust discussions on the current state of health in Michigan and the ideal future state, the current vision statement for the PIPH is:

"Michigan's vision for population health is for public health, healthcare, and other sectors to work together to improve health and achieve equity. Fundamental to this vision is the pursuit of equity, which requires addressing root causes of inequity, such as racism and other systems of oppression, and their effects on basic needs, such as housing, safety, health care, and education. A focus on prevention, requires policy and environmental solutions and investments in strategies to keep people physically and mentally healthy, ultimately reducing healthcare costs and the burden of preventable disease."

Two PIPH committees meet monthly to inform the development of various sections of the PIPH; 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 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.

The internal workgroup has developed a broad stakeholder engagement plan to use to gather input at various levels. At this stage of the process, specific activities and strategies to involve stakeholders have been identified and will set the stage for activities in the last year of the SIM cooperative agreement. Some examples of upcoming stakeholder engagement strategies include:

- A technical assistance call attended by the CHIRs to provide an update on the PIPH progress, and solicit feedback on direction and priorities;
- A convening of Michigan local health department health officers, to solicit feedback on specific areas of focus for population health;
- Attend meetings existing, established meetings with Michigan health plans, physician organizations, and hospitals to gather feedback on the plan and discuss future implications with implementation;

¹ The 3 Buckets Framework: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5558207/>

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- Involve representatives from Medicaid to identify areas of potential collaboration with Michigan Medicaid health plan incentive programs.

2.2 Care Delivery

Patient-Centered Medical Home

The SIM PCMH Initiative continues to enable Medicaid funding for patient-centered care and provide opportunities to increase the number of practices invested in primary care transformation. The care delivery team continues to work closely with the department's Medical Services Administration managed care team to operationalize actuarially sound Care Management and Coordination, and Practice Transformation payments for initiative participants. 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 continue 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 including key contractual partners hosted a Q1 (April) Quarterly Update virtual meeting; 115 participants attended with favorable engagement and positive evaluation
- Participant Quarterly Progress Report for Q4 2017 was analyzed Q1 2018.
- Participant Quarterly Progress Report for Q1 2018 was developed, disseminated, collected, and analyzed March-May 2018 to identify key successes and areas to address in coming months through participant support activities
- Continued participant compliance and monitoring activities including:
 - Issued, received, reviewed and provided feedback on 28 Requests for Information for Clinical-Community Linkages (CCL)
 - Issued and tracked 8 Corrective Action Plans for CCL and HIE compliance
 - Issued 72 audits across 12 participants in the Care Management and Coordination areas of: Monthly Care Team Meetings, EHR Utilization, Alternative Visits, 24/7 Access, Practice Consent and 30% Open Access.
- Participant Semi-Annual Practice Transformation Report was collected and analyzed January – February 2018.
- 2018 Participation Agreements were collected from 37 Participating organizations representing 342 practice sites and over 2,100 providers in Q1 2018.
- Hosted live virtual 2018 PCMH Initiative launch webinar attended by over 250 participants.

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- Hosted live virtual office hour sessions on the following topics: Integrated Service Delivery, Michigan 211, Care Management and coordination tracking codes, evaluation, Implementing CCLs processes, Care Management and Coordination benchmarks and cornerstones for developing a care manager Orientation. Additional pediatric office hour sessions were implemented and covered the following: Adverse Childhood Experiences (ACES) and Social Determinants of Health (SDoH) screening, Engaging families – Common challenges across the chronic conditions
- Participant Quarterly Progress Report for Q2 was developed and disseminated for collection and analysis in July 2018.
- Continued regular monthly newsletters including a recurring segment on current literature and participant best-practice sharing
- Continued to work with multi-stakeholder Care Coordination Collaborative Planning Committee and hosted first virtual event on June 15, 2018 which included a variety of speakers from Medicaid Health Plans, SIM PCMH initiative participants, and MDHHS staff.
- Continued to work with multi-stakeholder planning committee to plan 2018 Summits to occur October and November 2018. Developed agenda, secured speakers and event locations, sent communications to participants regarding event dates, and marketed registration platform which was disseminated May 2018.
- Updated and released versions 2-4 of the 2018 participation guide, highlighting intent around social need screening domains required by MDHHS, and added outlined compliance plans around care management benchmarks.
- Both Care Management and Coordination, and Practice Transformation payments were coordinated and disseminated to participants through partnering Medicaid health plans for Q4 (October – December 2017) and Q1 (January – March 2018) efforts. Note that AY3 funding for Care Management and Coordination, and Practice Transformation payments does not include SIM federal funds.
- Utilizing the RAMP as the foundational process to support attribution, individual monthly patient lists were released January through June 2018. Aggregate patient lists were released to participants as appropriate.
- Application process was developed for two additional award opportunities to enhance Initiative participants' advancements in the areas of capacity building for HIE and CCL data sharing.
- PCMH Initiative team worked collaboratively with APM team to develop sustainable core PCMH model and discovery template with which to engage MHPs to inform development of more comprehensive PCMH model as part of post-SIM sustainability planning.

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.

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During the reporting period, the Medicaid managed care Quality Improvement and Program Development (QIPD) section finalized their evaluation of the 3-year strategic plan submission for all 11 Medicaid health plans in Michigan. QIPD's efforts have yielded a valid and reliable set of data regarding MHP adoption of APMs in Michigan during FY 16 and FY 17, and a solid foundation for evaluating and scoring MHP performance moving forward; as well as for beginning conversations with other insurers in the state as it relates to Medicaid's efforts for encouraging APMs. Valid and reliable data collection is essential to consider utilizing the incentives to evaluate and reward performance in increasing APM use.

In addition, QIPD, PCMH, and other SIM team members drafted a final PCMH state-preferred APM model. This is the first APM model to be implemented through this approach. The APM model will be available for MHPs to begin implementing on their own during FY or CY 19 and will become a required component of the QIPD capitation withhold program beginning in FY 20 (with a likely CY 20 adoption period for MHPs given their provider contracts tend to run on calendar years). The purpose for the 18-month lead time is to allow MHPs time to renegotiate their provider contracts to incorporate elements of the State-preferred PCMH model as appropriate.

2.3 Technology

SIM leveraged existing federal- and state-funded initiatives to define, implement and test a multi-payer statewide data sharing infrastructure and RAMP. The state will continue to be engaged in the multi-payer health directory data governance and maintain the established configuration management, requirements definition, and data quality best practices established under SIM.

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 Population Health Housing Program.

Key accomplishments for this time period included:

- Data Stewardship
 - The SIM Technology team reviewed and helped facilitate the submission and approval process for data requests from CHIR's Internal and external evaluation teams.
 - The team continued reviewing and facilitating the submission and approval process for incoming SIM data requests, implementing appropriate solutions as they are approved.
- SIM performance and evaluation tool
 - The SIM technical team continued to monitor and managed the monthly attribution process of the RAMP.
 - The team implemented new procedures that allowed us to optimize the RAMP and reduce the time it takes to produce the monthly file.

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- Care coordination enablement
 - Continued working with the SIM care delivery team and our partner, Michigan Data Collaborative (MDC), to develop and test expanded metrics and utilization measures using the RAMP Our partner, Michigan Health Information Network (MiHIN), continued technical onboarding of clinical quality data from PCMH participants in anticipation of supporting the release of expanded metrics.
 - The SIM technology team is working with the Care Coordination team to define a technical solution for gathering and reporting out social determinants of health information from SIM PCMH's.
- Payment model analytics and reporting
 - Continued utilizing the RAMP 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 MSHDA and the MCAH to define the business requirements needed for the collection of HMIS data to support CHIR reporting needs.
 - The team implemented technical solutions needed to house and analyze the HMIS data. Once housed, the team worked with the state to match the data against Medicaid claims to identify highly vulnerable homeless individuals. This work will allow for federally funded housing vouchers to be provided to those individuals determined to be chronically homeless.
 - The SIM technology team is working with the CHIR team to define a technical solution for gathering and reporting out social determinants of health information being collected by the CHIR's.
- Sustainability
 - The SIM technology team is supporting 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 the MDHHS, the System exChange team at MSU, University of Michigan Child Health Evaluation and Research Center, and MDC. 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:

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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 of each 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, Child Health Evaluation and Research (CHEAR) and MDC) has been finalized with each contractor currently engaged in their respective components.

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- MPHI has developed, presented, and obtained buy-in from the SIM PCMH leadership of a logic model consisting of 3 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%.
- 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 Health Employer Data Information Service (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 National Committee for Quality Assurance (NCQA).

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 April 1, 2017 to March 31, 2018. Consistent with the report for the first half of FY 18, the measures are of the eligible populations of Medicaid beneficiaries that are attributed to a SIM-PCMH

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whether in a CHIR or not. Previously in the FY 17 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 17 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:

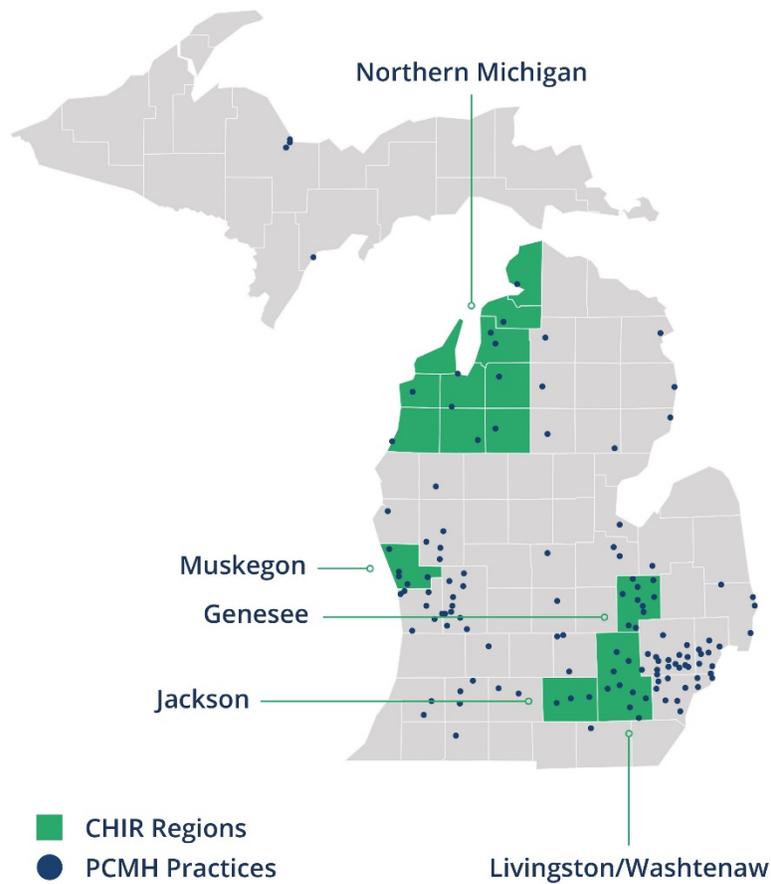
- As compared to the previous primary care demonstration (Michigan Primary Care Transformation Demonstration or MiPCT) the SIM PCMH initiative has been able to increase the average number of Medicaid beneficiaries served from 250,000 to 350,000 (on average) and increased the number of participating Medicaid providers from 1500 to 2168 (a 30.8% increase).
- For this reporting period, the measure on hospital admissions has been changed to focus only on acute hospital admissions in accordance with the Health Employer Data Information Service (HEDIS) 2018 specifications for acute hospital utilization. This measure is the rate of acute inpatient utilization (discharges) per 1000 attributed members of all ages.
- 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 (ED) 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.
- New to this reporting cycle is the table on preventable emergency department visits. The measure shows the rate of preventable ED visits per 1000 attributed members of all ages.

While the hospitalization utilization measure included in the current report shows the rate of all acute hospitalizations, plans are in place to generate the rate of hospitalizations for ambulatory care sensitive conditions. This metric will be included in subsequent legislative reports.

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

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REGION	PRACTICES	PROVIDERS	BENEFICIARIES
Jackson	11	51	18,840
Livingston/Washtenaw	40	364	41,708
Muskegon	24	142	29,564
Genesee	60	144	42,242
Northern *	21	188	30,665
Total SIM Region	156	889	163,019
TOTAL Non-SIM Region	168	1,279	187,373
TOTAL **	324	2,168	350,392

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

** Beneficiary count based on June 2018 data.

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Rate of Acute Hospital Admissions per 1000 Attributed Members (Reporting period: April 2017 to March 2018)

Region	County	Numerator	Denominator	Rate
Jackson	Jackson	533	11,090	48
Livingston/Washtenaw	2 Counties	1,042	28,513	37
Muskegon	Muskegon	606	20,832	29
Genesee	Genesee	1,265	31,076	41
Northern	10 Counties	714	21,576	33
Total SIM Regions (all CHIRs)		4,160	113,087	37
Total Non-SIM Regions (Outside CHIRs)		5,149	131,877	39
Overall Total Acute Hospital Admissions		9,309	244,964	38

30-day All-Cause Readmission Rate per 1000 Discharges (Reporting period: April 2017 to March 2018)

Region	County	Numerator	Denominator	Rate
Jackson	Jackson	49	478	103
Livingston/Washtenaw	2 Counties	103	874	118
Muskegon	Muskegon	29	481	60
Genesee	Genesee	111	865	128
Northern	10 Counties	47	559	84
Total SIM Regions (all CHIRs)		339	3,257	104
Total Non-SIM Regions (Outside CHIRs)		527	4,171	126
Overall Total All-Cause Readmission		866	7,428	117

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**Rate of Ambulatory ED Visits per 1000 Attributed Members
(Reporting period: April 2017 to March 2018)**

Region	County	Numerator	Denominator	Rate
Jackson	Jackson	9,340	11,090	842
Livingston/Washtenaw	2 Counties	18,601	28,513	652
Muskegon	Muskegon	23,513	20,832	1,129
Genesee	Genesee	19,219	31,076	618
Northern	10 Counties	15,035	21,576	697
Total SIM Regions (all CHIRs)		85,708	113,087	758
Total Non-SIM Regions (Outside CHIRs)		97,833	131,877	742
Overall Total Ambulatory ED Visits		183,541	244,964	749

**Rate of Preventable ED Visits per 1000 Attributed Members
(Reporting period: April 2017 to March 2018)**

Region	County	Numerator	Denominator	Rate
Jackson	Jackson	4,923	11,090	444
Livingston/Washtenaw	2 Counties	9,781	28,513	343
Muskegon	Muskegon	14,059	20,832	675
Genesee	Genesee	9,616	31,076	309
Northern	10 Counties	7,688	21,576	356
Total SIM Regions (all CHIRs)		46,067	113,087	407
Total Non-SIM Regions (Outside CHIRs)		53,111	131,877	403
Overall Total Preventable ED Visits		99,178	244,964	405

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4 Budget

4.1 Legislative Update

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

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

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

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

Categories	Budgeted	Expenditures
Personnel	\$ 228,354	\$ 70,900.31
Fringe Benefits	\$ 47,833	\$ 50,954.30
Equipment	\$	\$ -
Supplies	\$ -	\$ 5,247.53
Travel	\$ 18,672	\$ 2,688.03
Other	\$ 570,000	\$ -
Contractual	\$ 17,930,831	\$ 5,478,798.67
Total Direct Charges	\$ 18,795,690	\$ 5,608,588.85
Indirect Cost	\$	\$ 0
Total	\$ 18,795,645	\$ 5,608,588.84

The expenditure time period is from 2/21/18 to 7/15/18, Due to the timing of the posting of expenses into the State's accounting system, not all June and July 2018 expenses are included in the totals above.