



# State Innovation Model Operational Plan

August 19, 2016

# Table of Contents

<b>A. Project Summary .....</b>	<b>3</b>
<i>A1 - Project Summary.....</i>	<i>3</i>
<i>A2 – Driver Diagram .....</i>	<i>8</i>
Figure A2.1 Driver Diagram .....	8
Table A2.1 Measures by Primary Driver.....	9
<i>A3 - Core Metrics and Accountability Targets .....</i>	<i>11</i>
Table A3.1 SIM Core Metrics.....	12
<i>A4 - Master Timeline for SIM .....</i>	<i>19</i>
Figure A4.1 Michigan’s SIM Overall Timeline.....	21
Figure A4.2 Patient-Centered Medical Home Timeline .....	23
Figure A4.3 Population Health Timeline .....	24
<i>A5 Budget Summary Table .....</i>	<i>25</i>
Table A5.1 Year 1 Budget.....	25
<b>B. Detailed SIM Operational Plan .....</b>	<b>27</b>
<i>B1 – Narrative Summary of Component/ Project.....</i>	<i>27</i>
<i>B2 – Detailed SIM Component Narratives and Summary Tables.....</i>	<i>29</i>
<i>Community Health Innovation Regions.....</i>	<i>29</i>
Table B2.1 CHIR Requirements.....	35
Table B2.2 CHIR Measurements for Success .....	39
Figure B2.1 Population Health Timeline .....	44
Table B2.3 CHIR Component Summary Table .....	44
<i>Patient-Centered Medical Home .....</i>	<i>47</i>
Table B2.4 Three Year Scale-Up .....	54
Table B2.6 PCMH Component Summary Table .....	58
Table B2.7 APM Component Summary Table .....	64
<i>B3 – Risk Assessment and Mitigation Summary.....</i>	<i>65</i>
Table B3.1 SIM Risk Response Plan .....	65
<b>C. General SIM Operational and Policy Areas .....</b>	<b>70</b>
<i>C1 – SIM Governance, Management Structure and Decision-making Authority .....</i>	<i>70</i>
Figure C1.1 Michigan SIM Organizational Chart.....	71
Table C1.1 SIM component Key Staff Directory .....	72
Table C1.2 SIM Executive Stakeholders.....	72
Table C1.3 SIM Executive Governance Team Roster.....	73

Table C1.4 SIM Program Governance Team Roster.....	74
Table C1.5 PMDO Roles and Responsibilities .....	76
Table C1.6 SIM Program Affiliate Roles and Responsibilities.....	78
Table C1.7 SIM Planning and Support Contractors. ....	85
<i>C2 – Stakeholder Engagement.....</i>	<i>88</i>
<i>C3 – Plan for Improving Population Health .....</i>	<i>99</i>
Table C3.1 State Health Assessment.....	104
<i>C4 – Health Care Delivery System Transformation Plan.....</i>	<i>108</i>
<i>C5 – Payment and/ or Service Delivery Model(s).....</i>	<i>112</i>
<i>C6 – Leveraging Regulatory Authority.....</i>	<i>115</i>
<i>C7 – Quality Measures Alignment .....</i>	<i>119</i>
<i>C8 – SIM Alignment with State and Federal Initiatives .....</i>	<i>121</i>
<i>C9 – Workforce Capacity.....</i>	<i>127</i>
<i>C10 – Health Information Technology.....</i>	<i>132</i>
Figure C10.1 SIM Relationship and Attribution Management Platform with Technology Pillars .....	133
Figure C10.2 Technology Component Governance.....	136
Figure C10.3 SIM Technology Overview .....	139
Figure C10.4 Michigan’s Network of Networks .....	141
Figure C10.5 Detailed SIM Relationships and Attribution Management Platform .....	142
Figure C10.6 Example of Common Key Assignment using statewide ADT service.....	145
Table C10.1 Phase I Quality Measures.....	147
Table C10.2 Phase I Utilization Measures .....	148
Figure C10.7 Technology Component Timeline.....	155
Figure C10.8 Technology Component Timeline-Related Activities.....	156
<i>C11 – Program Monitoring and Reporting .....</i>	<i>158</i>
Table C11.1 CMMI Recommendations and Michigan Proposed Metric Crosswalk .....	159
Table C11.2 SIM Monitoring.....	160
<i>C12 - Data Collection, Sharing, and Evaluation .....</i>	<i>162</i>
<i>C13 – Fraud and Abuse Prevention, Detection, and Correction .....</i>	<i>165</i>
<b>D. Appendix .....</b>	<b>168</b>
<i>D1. State Innovation Model Acronyms and Abbreviations.....</i>	<i>168</i>
<i>D2. Multi-Payor Engagement Plan.....</i>	<i>170</i>
<i>D3. HIE/HIT Implementation Year 1 Timelines and Milestones.....</i>	<i>180</i>
<i>D4. Care Delivery Artifacts .....</i>	<i>186</i>
<i>D5. Community Health Innovation Region (CHIR) Participation Guide and Local Operational Plan Template for Year One - DRAFT.....</i>	<i>192</i>

# A. Project Summary

---

## A1 - Project Summary

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

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

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

With this Round two SIM Test Awardee Operational Plan the State lays out, in detail, the core innovative models the state will implement and test in support of the Governor's vision for reinventing Michigan's health care system. The Model Test in Michigan is organized into the following 3 core components:

- Population Health
- Care Delivery
- Alternative Payment Models

To enable the core Model Test components, a wide range of governance, stakeholder engagement, health information technology and other activities are also fully defined in this plan. These supplemental supporting processes, infrastructure and oversight will ensure the components' and overall Model Test goals are fully met. The governance model includes a public/private commission and committee structure and formal State executive- and program-level governance bodies. The structure allows vision, strategy and operational recommendation and decisions to flow from all appropriate stakeholders and participants. Health Information Technology (HIT) initiatives will support patient and provider attribution, standard performance metrics, payment model reforms and other critical system interoperability.

## Population Health Component Elements

### Community Health Innovation Regions/Collaborative Learning Networks:

The State strongly believes in the value of a community-based organizing mechanism that improves linkages and coordination among health care providers and community partners to meet the whole health needs of an individual. The SIM program team will launch 5 Community Health Innovation Regions (CHIRs) in 2017. Given the unique requirements of the CHIR concept, part of the test will be to determine the launch needs

and associated costs, in addition to the broader core population health tests. Additional implementation and operational maturity may be required for all 5 CHIRS to reach a satisfactory operating level. As such, the State will evaluate and make decisions regarding the feasibility of scale up and spread based on the lessons learned from the 2016-2017 CHIR implementations.

As regional governing bodies, CHIRs will assess community needs, define regional health priorities, support regional planning, increase awareness of community-based services, and increase linkages between the community and health entities and systems. CHIRs will align closely with the State's vision for health care transformation in Michigan. All CHIRs will be required to focus on reducing Emergency Department utilization, a statewide priority, while also assessing community needs and proposing investment in additional regional-specific health improvement goals.

### **Accountable Systems of Care:**

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.

## **Care Delivery Component Elements**

### **Patient-Centered Medical Homes:**

The Patient-Centered Medical Home (PCMH) is the core pillar of the SIM strategy for coordinated care delivery. The State will begin to implement the SIM PCMH initiative through its Medicaid Managed Care Organizations in the fall of 2016. The SIM program team will work in alignment with commercial payors and Medicare to support increased adoption of the PCMH model within the state. 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.

## Enablers

Program leadership will enable the SIM vision for health care transformation through robust Model Test component implementations utilizing newly enhanced and existing data interoperability and healthcare information technology, alternative payment models, and common provider measures.

### Alternative Payment Methods

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. These alternative payment models and funding mechanisms will be linked to provider participation requirements and performance metrics.

Over 1.6 million Medicaid beneficiaries in the state are enrolled in 11 health plans. Michigan will leverage language in its existing Medicaid Health Plan contracts to require increased use of APMs with accountable provider systems. The state will require MHPs to annually report on their use of these provider payment methods consistent with the APM categories and sub-categories defined through the Health Care Payment Learning Action Network (LAN). The LAN framework includes a trajectory of categories for payment models that allows for payer evolution and innovation while driving toward alternative based payments. The LAN format is designed to enable payers to consistently categorize alternative provider payment models for commercial, Medicaid, and Medicare Advantage lines of business.

The State will encourage all payors to contract with providers using APM methodologies included in Categories 3B and 4 of the LAN. The state will further encourage that payment model design includes payment adjustments based on provider performance to specified thresholds that ensure meaningful differentiation in compensation between high- and low-performing providers. Based on information gathered during pre-implementation stakeholder engagement, the State expects a large majority of ASCs within the 5 CHIR regions to report participation in APM methodologies within the SIM timeframe. The State also expects payors to report APM participation with health systems, physician organizations, and physician hospital organizations outside of the 5 CHIR regions.

Using these new payment methodologies, providers across Michigan will be more accountable for total cost of care and be accountable to quality, patient experience, and utilization metrics that ensure the delivery of high quality, highly effective care for Michiganders. These metrics will be standardized on a common Michigan SIM provider measures as defined below.

### Consistent Performance Metrics

As part of the MI SIM Test, provider performance metrics will be aligned across payors in common performance measures that will be adopted by SIM participating payors and providers. The SIM team will

support collaborative efforts to align provider measures across Medicaid health plans and to the extent feasible, align provider metrics across commercial payers and Medicare. Michigan will leverage the efforts of the Physician-Payer Quality Collaborative (PPQC) around establishing a core, shared set of measures and standardized performance reporting. Common measures across the care continuum will lower administrative burden across providers related to metrics reconciliation and will encourage a consistent set of behaviors and priorities, as described in more detail in Section C7 (Quality Measure Alignment).

## **Data Interoperability and Healthcare Information Technology**

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

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

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

## **Foundation for Health Care Innovation**

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

- The Michigan Primary Care Transformation (MiPCT) project: the largest multi-payor PCMH demonstration in the country
- Blue Cross Blue Shield (BCBSM) PCMH Initiative: the largest multi-payor PCMH demonstration in the nation has a strong and successful presence in Michigan
- Federally Qualified Health Center (FQHC): FQHCs are community-based organizations that provide comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status
- MI Health Link: a collaboration between Michigan and the federal government to coordinate care for people who are eligible for both Medicaid and Medicare (Dual Eligibles)

- Health Homes: coordinated care delivery models to integrate primary care with behavioral health care for those with serious and persistent mental illness
- Michigan Health Information Network: a governing body enabling the exchange of clinical data across participating payors and providers
- Michigan Pathways to Better Health: collaboration with care coordination agencies to deploy community health workers who help identify community-based services to support health needs

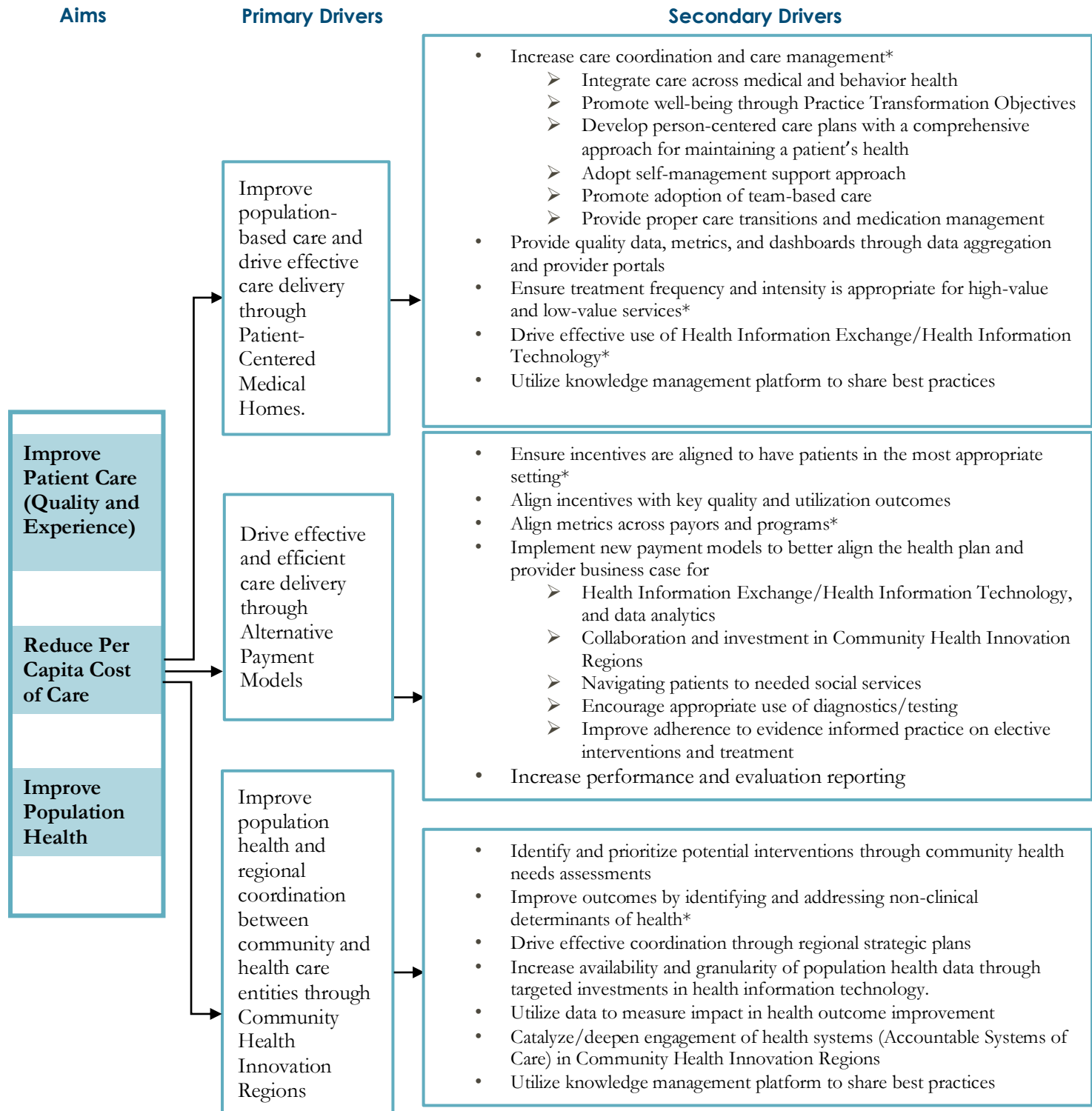
The SIM program team will continue to build upon this foundation through the implementation of the core SIM component. The State of Michigan's plan for operationalizing PCMH, Alternative Based Payments, and CHIRs is defined within this document.



## A2 – Driver Diagram

Many secondary drivers – particularly those with asterisks – impact primary drivers other than the primary drivers they are directly associated with in this depiction.

Figure A2.1 Driver Diagram



## Measures by Aim/Primary Driver

Michigan's SIM program will measure progress toward achieving its aims through metrics spanning clinical quality, health care utilization, cost, and population health domains. Progress toward affecting the Primary Drivers described above will be assessed as a function of participation metrics and programmatic implementation information.

Metrics related to the aims of Michigan's SIM program and selected structure and participation metrics related to its Primary Drivers are provided in Table A2.1 (Measures by Primary Driver) below. Michigan intends to report on most of these metrics to CMS. Measures to be reported to CMS and quantifiable targets associated with each are listed in A3: Core Metrics and Accountability Targets. Information around the approach to monitoring progress is provided in Section C11 (Program Monitoring and Reporting).

Table A2.1 Measures by Primary Driver

Aim	Quality and Utilization Metrics	Primary Driver	Select Structure and Participation Metrics
Improve Patient Care (Quality and Experience)	<ul style="list-style-type: none"> <li>Comprehensive Diabetes Care composite</li> <li>Childhood Immunization Status</li> <li>Cervical Cancer Screening</li> <li>Adult BMI Assessment</li> <li>Controlling High Blood Pressure</li> <li>Breast Cancer Screening</li> <li>Colorectal Cancer Screening</li> <li>Immunizations for Adolescents</li> <li>Lead Screening in Children</li> <li>Breast Cancer Screening</li> <li>Chlamydia Screening</li> <li>Timeliness of prenatal care</li> <li>Well-Child Visits in the First 15 Months of Life</li> <li>Adolescent Well-Care Visits</li> <li>Patient Experience</li> <li>Patient-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey items</li> </ul>	Improve population-based care and drive effective care delivery through Patient-Centered Medical Homes	<ul style="list-style-type: none"> <li>Total number of beneficiaries receiving care through a SIM PCMH</li> </ul>
Improve Population Health	<ul style="list-style-type: none"> <li>Percent of adults reporting fair or poor health or poor health Premature newborns</li> <li>Number of mentally unhealthy days in last 30</li> <li>Number of physically unhealthy days in last 30</li> </ul>	Improve population health and regional coordination between community and health care entities	<ul style="list-style-type: none"> <li>Number of individuals attributed to a PCMH within a CHIR test region</li> <li>Number of health providers participating in</li> </ul>

	<ul style="list-style-type: none"> <li>• Childhood immunization status rates</li> <li>• Rates of excessive alcohol consumption for adults</li> </ul>	through Community Health Innovation Regions	<p>CHIRs within test regions</p> <ul style="list-style-type: none"> <li>• Number of public health departments participating in CHIRs within test regions</li> <li>• Number of other local government units participating in CHIRs within test regions</li> <li>• Number of non-profit organizations participating in CHIRs within test regions</li> <li>• Number of Community Mental Health Services agencies participating in CHIRs within test regions</li> <li>• Number of non-health care businesses participating in CHIRs within test regions</li> <li>• Number of payers participating in CHIRs within test regions</li> </ul>
Reduce Per Capita Cost of Care	<ul style="list-style-type: none"> <li>• Hospital admissions</li> <li>• All-cause readmissions</li> <li>• Emergency department visits</li> <li>• Standardized Per Member Per Month (PMPM) Costs</li> </ul>	Drive effective and efficient care delivery through Alternative Payment Models	<ul style="list-style-type: none"> <li>• Total number of beneficiaries receiving care through a SIM PCMH</li> <li>• Total number of providers in the SIM regions participating in an APM</li> </ul>

## A3 - Core Metrics and Accountability Targets

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

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

Participation, clinical quality and utilization, and cost metrics are outlined below in Table A3.1: SIM Core Metrics. The participation metrics relate to the core model components: Patient-Centered Medical Homes, (PCMH) Accountable Systems of Care (ASC), and Community Health Innovation Regions (CHIR). The quality, utilization, and cost performance metrics proposed reflect the ongoing measure alignment work described in section C7 (Quality Measures Alignment). Population health measures included below are intended to be especially relevant for emergency department super-utilization, SIM's Year 1 priority population.<sup>1</sup> Additional metrics related to the other two priority populations (individuals with multiple chronic conditions, and healthy mothers and babies) are included for purposes of monitoring and establishing baseline values.

Accountability targets for claims-based measures have generally been drawn from the Michigan Medicaid HEDIS 2015 Results Statewide Aggregate Report.<sup>2</sup> Accountability targets have been informed by Michigan's performance relative to national performance as well as recent in-state trends. Accountability targets are high relative to baseline performance where national benchmarks suggest more opportunity for improvement, and vice versa.<sup>3</sup> Quality targets are based on the most recent statewide performance information available and information on national benchmarks and thresholds.<sup>4</sup> Baselines and targets for acute care utilization and costs will be updated once information is available on SIM-participating providers. Measures and targets may be adjusted based on feasibility (e.g., barriers to medical record review), and to ensure that the target is calculated using the same source/processes that will be used for ongoing reporting/monitoring.

---

<sup>1</sup> Michigan Department of Community Health. *Recommendations for Addressing the Needs of High Utilizers/Super Utilizer Patients in Michigan*. December 2014. [https://www.michigan.gov/documents/mdch/High-Super\\_Utilizer\\_Report\\_Healthy\\_MI\\_Act\\_12-2014\\_487676\\_7.pdf](https://www.michigan.gov/documents/mdch/High-Super_Utilizer_Report_Healthy_MI_Act_12-2014_487676_7.pdf). Accessed June 1, 2016.

<sup>2</sup> Michigan Department of Health & Human Services. *Michigan Medicaid HEDIS 2015 Results Statewide Aggregate Report*. November 2015. [http://www.michigan.gov/documents/mdhhs/MI2015\\_HEDIS-Aggregate\\_Report\\_514922\\_7.pdf](http://www.michigan.gov/documents/mdhhs/MI2015_HEDIS-Aggregate_Report_514922_7.pdf). Accessed June 1, 2016.

<sup>3</sup> NCQA. *2015 Accreditation Benchmarks and Thresholds – Mid-Year Update*.

<sup>4</sup> NCQA. *2015 Accreditation Benchmarks and Thresholds – Mid-Year Update*. September 2015. [http://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds\\_MidYearUpdate.pdf](http://www.ncqa.org/Portals/0/HEDISQM/2015%20BenchmarksAndThresholds_MidYearUpdate.pdf). Accessed June 1, 2016.

Additional participation and quality metrics will be included as needed. Quarterly accountability targets for participation will be defined as regional planning matures and will be included in future Operational Plan updates. Annual accountability targets will be updated based on input from the SIM committees as well as updated information on performance, as to ensure targets remain ambitious but realistic.

Table A3.1 SIM Core Metrics

Category	Metric Title	Proposed Metric Definition/Description	Y1 Medicaid Accountability Target	Comment
Participation	Population impacted by SIM (by model)	Total number of beneficiaries receiving care through a SIM PCMH	397,030	95% of potentially eligible baseline population (417,926). Updated baseline data available February 2017.
		Total number of beneficiaries within CHIR boundaries	970,000	Current figure based on total 2015 population in primary counties of each CHIR region. Updated baseline data available February 2017.
	Providers Participating in SIM (by model)	Total number of providers participating in SIM PCMH model	2,434	95% of potentially eligible baseline providers (2,562). Updated baseline data available February 2017.
	Provider Organizations participating in SIM (by model)	Total number of practices participating in SIM PCMH model	621	95% of potentially eligible baseline practices (654). Updated baseline data available February 2017.
	Payers participating in SIM (including aligned models)	Total number of payers participating in SIM PCMH payment model, by Alternative Payment Model (APM) category	Category 2C: 15	Counts from MiPCT, plus MHPs. Updated baseline data available May 2017.
		Total number of payers participating in SIM by APM category	15	Counts from MiPCT, plus MHPs. Updated baseline data available May 2017.
	Total number of provider organizations participating in CHIRs	Total number of ASCs participating in CHIRs within test regions	9	Readiness assessments. Updated baseline data available November 2016.
	Composition of ASCs participating in CHIRs	Total number of hospitals participating in CHIRs via ASC agreement	7	Readiness assessments. Updated baseline data available November 2016.
		Total number of other provider organizations participating in CHIRs via ASC agreement	TBD	Readiness assessments. Baseline data available November 2016.

	Total number of public health departments participating in CHIRs	Total number of public health departments participating in CHIRs within test regions	5	Assume 1 public health department per CHIR. Updated baseline data available November 2016.
	Total number of other local government units participating in CHIRs	Total number of other local government units participating in CHIRs within test regions	10	Assume 2 local government units (e.g., major municipality and county) per CHIR. Updated baseline data available November 2016.
	Total number of non-profit organizations participating in CHIRs	Total number of non-profit organizations participating in CHIRs within test regions	20	Assume 20 non-profits total. Updated baseline data available November 2016.
	Total number of Community Mental Health (CMH) services participating in CHIRs	Total number of CMH services agencies participating in CHIRs within test regions	5	Assume 1 CMH per CHIR. Updated baseline data available November 2016.
	Total number of (non-healthcare) businesses participating in CHIRs	Total number of non-health care businesses participating in CHIRs within test regions	10	Assume 2 per CHIR. Updated baseline data available November 2016.
	Total number of payers participating in CHIRs	Total number of payers participating in CHIRs within test regions	9	Assume all MHPs with presence in CHIR areas, plus at least one commercial plan. Updated baseline data available February 2017.
<b>Quality, Utilization, and Cost</b>	Childhood Immunization Status (Combination 10)	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	41.0%	2015 Michigan Medicaid baseline: 36.9% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with in-state trend of +3.1%. Accountability target reflects trend plus 1 percentage point increase. Updated baseline data available May 2017.
	Comprehensive Diabetes Care: Blood Pressure (BP) Control	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had their most	70.2%	2015 Michigan Medicaid baseline: 65.9% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of +2.3%.

		recent BP reading under 140/90 mm Hg.		Accountability target reflects trend plus 2 percentage point increase. Updated baseline data available May 2017.
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	88.5%	2015 Michigan Medicaid baseline: 86.0% (equal to 2015 50 <sup>th</sup> national percentile), with trend of +0.5%. Accountability target reflects trend plus 2 percentage point increase. Updated baseline data available May 2017.
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	37.8%	2015 Michigan Medicaid baseline: 35.8% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of -1.4%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Comprehensive Diabetes Care: Eye Exam (retinal) performed	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.	61.5%	2015 Michigan Medicaid baseline: 59.5% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of -3.5%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Adult Body Mass Index (BMI) Assessment	Members age 18-74 who had an outpatient visit with a BMI documented during the measurement year or the year prior	90%	2015 Michigan Medicaid baseline: 90.3% (above 2015 90 <sup>th</sup> national percentile), with trend of +4.3%. Accountability target reflects maintenance of performance. Updated baseline data available May 2017.
	Controlling High BP	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<	64.1%	2015 Michigan Medicaid baseline: 62.1% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles),



		140/90mmHg) during the measurement period		with trend of -1.5%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.	87.4%	2015 Michigan Medicaid baseline: 83.7% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of +1.7%. Accountability target reflects trend plus 2 percentage point increase. Updated baseline data available May 2017.
	Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday	82.4%	2015 Michigan Medicaid baseline: 80.4% (between 2014 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of -0.1%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Breast Cancer Screening	Women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months	61.7%	2015 Michigan Medicaid baseline: 59.7% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with in-state trend of -2.9%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Cervical Cancer Screening	Women aged 21-64 years who received one or more Pap tests to screen for cervical cancer	70.5%	2015 Michigan Medicaid baseline: 68.5% (between 2015 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with in-state trend of -2.9%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.



	Colorectal Cancer Screening	Patients 50 through 75 years of age who had appropriate screening for colorectal cancer	TBD	Michigan baseline not available. Baseline data available May 2017.
	Timeliness of prenatal care	The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.	TBD	Baseline data available May 2017.
	Well-Child Visits in the First 15 Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life.	66.8%	2015 baseline: 64.8% (between 2014 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of -8.3%. Accountability target reflects 2 percentage point increase. Updated baseline data available May 2017.
	Adolescent Well-Care Visits	Members 12-21 years old in the measurement year that have had at least ONE “Well Care” visit (school physical, pap, post-partum visit)	59.8%	2015 baseline: 54.0% (between 2014 50 <sup>th</sup> and 75 <sup>th</sup> national percentiles), with trend of -3.8%. Accountability target reflects trend plus 2 percentage point increase. Updated baseline data available May 2017.
	Patient Experience	Relevant Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey items (items to be determined). Survey efforts will align with CAHPS administration efforts currently underway in Michigan.	TBD	TBD
	Hospital admissions	Hospital admission rate per 1,000 population	TBD	2014 Medicaid MiPCT baseline: 111 per 1,000 population. Target to be calculated once benchmark can be updated with performance from SIM-participating providers.* Updated baseline data available May 2017.
	All-cause readmissions	Number of acute inpatient hospital stays for patients aged 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.	TBD	2014 MiPCT Medicaid baseline: 120 per 1,000 admissions. Target to be calculated once benchmark can be updated with performance from SIM-participating providers.*

				Updated baseline data available May 2017.
	Emergency department visits	ED visits per 1000 population	TBD	2014 MiPCT Medicaid baseline: 787 per 1,000 population. Target to be calculated once benchmark can be updated with performance from SIM-participating providers.* Updated baseline data available May 2017.
	Standardized Per Member Per Month (PMPM) Costs	Standardized PMPM cost calculated using Medicaid fee schedule	TBD	2014 MiPCT Medicaid baseline: \$98.70 (does not include pharmacy, dental, vision, PHIP-covered behavioral health, chiropractic, non-emergency transport, and certain other services). Target to be calculated once benchmark can be updated with performance from SIM-participating providers.* Updated baseline data available May 2017.
	Chlamydia Screening in Women	Percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period	62.03% ; 79.99%	5% increase from baseline. 2015 Medicaid Statewide HEDIS aggregate report.
<b>Population Health Metrics</b>	Percent of adults reporting fair or poor health Premature newborns	Among all adults, the proportion reporting that their health, in general, was either fair or poor.	N/A	Year 1: monitor only for baseline purposes. Baseline data available Fall 2017.
	Number of mentally unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor mental health, which includes stress, depression, and problems with emotions, during the past 30 days.	N/A	Year 1: monitor only for baseline purposes. Baseline data available Fall 2017.
	Number of physically unhealthy days in last 30	Among all adults, the proportion reporting 14 or more days of poor physical health, which includes physical illness and injury, during the past 30 days.	N/A	Year 1: monitor only for baseline purposes. Baseline data available Fall 2017.
	Rates of excessive alcohol	Among all adults, the proportion reporting consumption of five or	N/A	Year 1: monitor only for baseline purposes.

	consumption for adults Adult obesity rate	more drinks per occasion (for males) or four or more drinks per occasion (for women) at least once in the previous month.		Baseline data available Fall 2017.
--	---	---	--	------------------------------------

\* We believe MiPCT performance may not be a suitable baseline given that there is limited overlap between current MiPCT providers and health care providers in the SIM regions. We want to ensure that utilization and cost targets are reasonable given the historic patterns associated with participating providers.

The following measures – also with relevance for emergency department super-utilization – are under active consideration for inclusion. All can be potentially ascertained through Michigan’s BRFSS survey.

- During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation?
- During the past 30 days, for about how many days have you felt sad, blue, or depressed?
- During the past 30 days, for about how many days have you felt worried, tense, or anxious?

## A4 - Master Timeline for SIM

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

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

To provide context around each of the activity phases represented on the timeline, blocks of time have been labeled as one of 3 phases. The phases include Planning & Design, Implementation, Readiness & Operationalize. To get an understanding of the type of activities that take place in each phase, a bulleted list is outlined below.

### Standard Michigan State Innovation Model Process Phases

#### Planning & Design

- Clearly define the objectives and scope of SIM components
- Functional analysis and Business process design
- Develop timeline and work plan, including resources requirements
- Business requirement development & approval

#### Implementation

- Execute SIM component work plan as scheduled
- Engage stakeholders involved in business process
- Technical / business process strategy executed
- Readiness, validation and operational schedule development

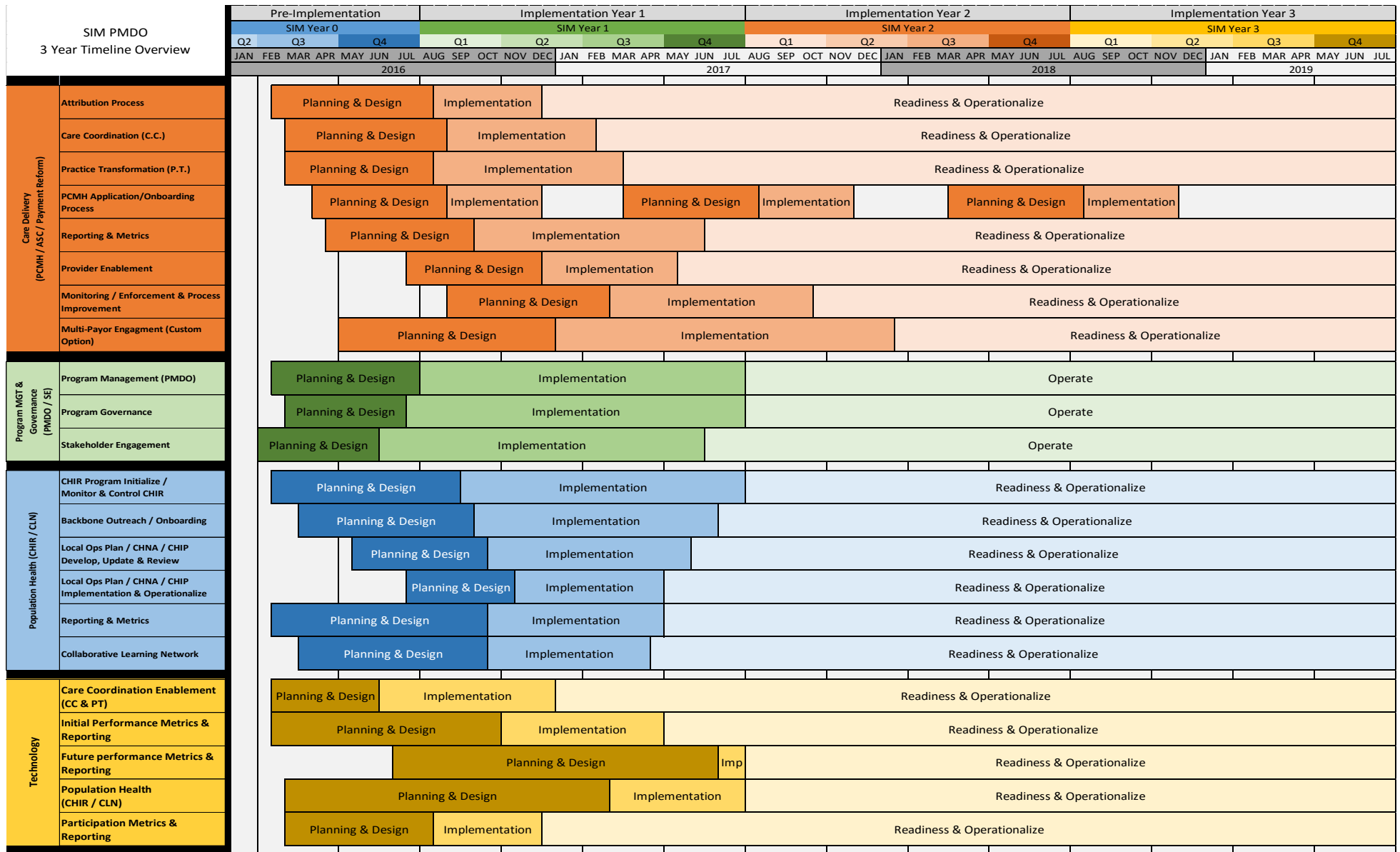
#### Readiness & Operationalize

- Business process and requirements verified
- Implemented strategy tested and verified

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

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

Figure A4.1 Michigan's SIM Overall Timeline



## Care Delivery: Quarterly Timeline and General Focus

The Care Delivery portfolio consists of multiple Model Test components focused on transforming how primary care is delivered and measured, along with how practices are provided compensation for these activities. In the fall of 2016, SIM will begin to implement supporting infrastructure and the first wave of Patient-Centered Medical Homes statewide. The PCMH initiative will launch with providers who have applied to participate and meet all of the participation requirements. These requirements include having accreditation through existing accrediting bodies, as well as being either a current MiPCT PCMH practice in good standing or being located in one of the identified year one PCMH prosperity regions. SIM will begin to launch the next waves of Patient-Centered Medical Homes in five of Michigan's ten remaining Prosperity Regions in year 2 and the remaining five Prosperity Regions in year 3. This scale up plan will result in a statewide PCMH by year three of the Model Test period.

### Care Delivery Timeline

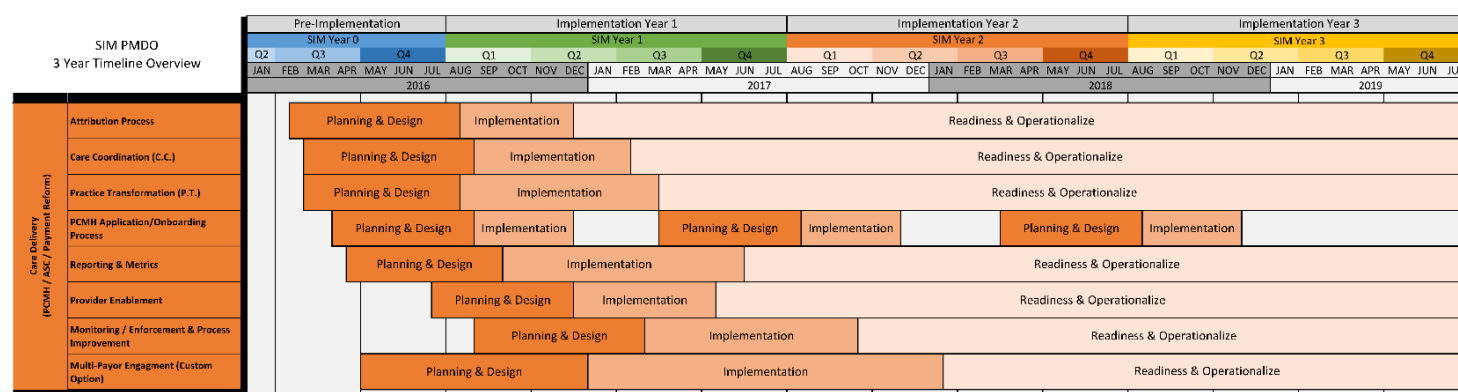
Stakeholder engagement, particularly with potential participating payors and providers, will be a priority during the fourth quarter of SIM Year 0 (June – July 2016) through the first quarter of SIM Year 1 (Aug-Sept 2016). In parallel, the SIM teams will finalize design choices around the Patient-Centered Medical Home care delivery and payment models, recruit providers, and finalize technical requirements for initialization during the first and second quarters of 2016 in preparation for a January 2017 launch.

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

The baseline data for the first Patient-Centered Medical Home reports will be collected starting on October 1, 2016, and the first performance period will begin on January 1, 2017. Reports will be released every quarter throughout the performance period. For the first six months of participation, all PCMH's will receive Care Coordination payments as data is collected on performance. After the six-month grace period, Care Coordination payments will be tied to Care Coordination activities. Practice Transformation payments for initial participants will be paid early in 2017.

A quarterly view on Patient-Centered Medical Home launch timelines, along with bulleted activities are outlined below in Figure A4.2 (Patient-Centered Medical Home Timeline). A more detailed description of activity is available in the Component Summary within Section B2 (Detailed SIM Component Narratives and Summary Tables).

Figure A4.2 Patient-Centered Medical Home Timeline



See Figure A4.1 for view of the complete timeline

## Population Health Timeline:

The second major component of the SIM initiative is Population Health with sub components of Community Health Innovation Regions (CHIR) and the Collaborative Learning Network (CLN). With the Community Health Innovation Regions, capability assessments were completed in 2015. Efforts in the first and second quarters of 2016 will focus on selecting test sites, engaging test sites for their plans to operationalize Community Health Innovation Regions, and finalizing arrangements to provide funding for Community Health Innovation Regions through applications for grant funding. Finally, the first round CHIRs will begin their efforts starting in early 2017. Below are major milestones scheduled for completion during implementation year 1, additional funding and activity details are found in Section B2 (Detailed SIM Component Narratives and Summary Tables).

- Administration funding, planning and design funding, and health improvement funding disbursed.
- CHIR governance models finalized and operationalized
- CHIR participants identified and meetings convening
- Year 1 and Year 2 local operations plans Completed

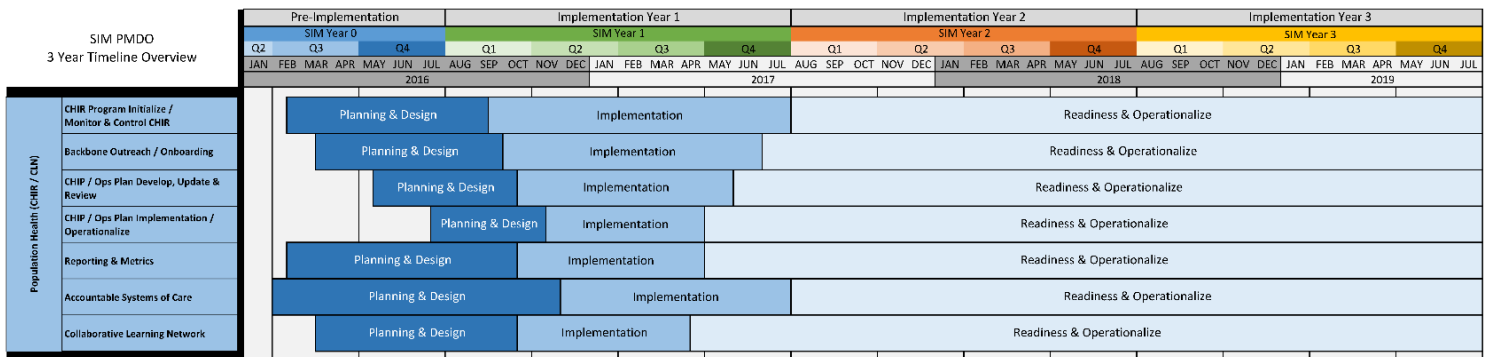
The Collaborative Learning Network begins its final design work in May 2016 with initiation for year 1 planned for later in 2016. During this period, IHI will develop and implement an interconnected Collaborative Learning Network focused on the interaction of partners in the CHIR including ASCs and PCMHs. Below are major milestones scheduled for completion during implementation year 1, additional funding and activity details are found in Section B2 (Detailed SIM Component Narratives and Summary Tables).



- Backbone organization onsite visits and coaching calls
- Learning sessions #1, #2, and #3
- Readiness assessments

More detail about Population Health timelines, and the corresponding sub components and activities are found in Figure A4.3 (Population Health Timeline) below, as well as Section B for core components.

Figure A4.3 Population Health Timeline



See Figure A4.1 for complete timeline

## A5 Budget Summary Table

Michigan is committed to the successful implementation and execution of the State Innovation Model Test components, and its primary supporting enablers; e.g. program management, stakeholder engagement and health information technology. The State has developed a funding allocation with full support of the core SIM Test components implementations. The budget is divided into the functional areas that encompass the entirety of the expenditures of the initiative in Michigan.

- Care Delivery & Payment Reform (PCMH & ASC)
- Population Health / Community Health Innovation Regions (CHIR) & Collaborative Learning Network (CLN)
- Technology (HIE/HIT, Metric Data, Reporting & Support)
- SIM Program Management Office, Stakeholder Engagement and Evaluation

Budget table A5.1 represent planned yearly expenditures determined to be most effective in meeting, or exceeding, the SIM Test goals. The projected budget for implementation years 2 and 3 will be reviewed regularly and compared to SIM operational data to determine if modifications are required. Program change control processes and rules will be applied to all changes to baseline budget as documented here.

Table A5.1 Year 1 Budget

SIM Budget Summary, Grant Year 2, Implementation Year 1			
SIM Component/Project Area	Projected Expenditure	Primary Driver(s)	Metric
Care Delivery			
Implementation Staff and Support	\$ 212,350	Improve population-based care and drive effective care delivery through Patient-Centered Medical Homes	Launch Michigan PCMH program in 5 SIM regions and former MiPCT practice outside regions.
Project Management and Administration	\$ 283,200		Develop and Launch SIM Attribution of Practices and Beneficiaries.
Patient Centered Medical Home (PCMH)	\$2,350,000		Initiate PMPM-based Care Coordination fee payments to participant PCMH practices.
Operations Contractor Practice Transformation Grant Funds	\$2,000,000		Initiate Provider Measures utilizing SIM performance and utilization metrics.
Care Delivery and Payment Policy and Strategy Consultants	\$ 585,216		Develop and Implement Multi-Payor strategy including custom Medicare engagement.
Collaborative Learning Networks (CLN)	\$ 350,000		
<b>Total</b>	<b>\$5,780,766</b>		

<b>Population Health</b>			
<b>Implementation Staff and Support</b>	\$ 282,306	Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions	Develop and implement clear CHIR participant and operational requirements and processes. Engage backbones in planning and other preliminary activities.
<b>Project Management and Administration</b>	\$ 331,925		Steward development of a Community Health Improvement Plan for each region.
<b>Community Health Innovation Region Consultation and Survey</b>	\$ 213,878		Develop reporting and related metrics approach for tracking CHIR performance and utilization.
<b>Community Health Innovation Regions Grant Funds (CHIR)</b>	\$3,800,000		Develop Accountable System of Care integration strategy to support population health and APM goals.
<b>Collaborative Learning Networks (CLN)</b>	\$1,000,000		Establish Collaborative Learning Network within 5 regions inclusive of all participants.
<b>Total</b>	\$5,628,109		
<b>Technology</b>			
<b>Implementation Staff and Support</b>	\$ 265,950	Improve population-based care and drive effective care delivery through Patient-Centered Medical Homes	Plan, Design and Implement the technical solution required to enable care coordination and practice transformations to flow.
<b>Project Management and Administration</b>	\$ 525,600	Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions	Plan, Design and Implement the technical solution required to enable metrics reporting and analytics for Care Delivery components.
<b>Analytics and Reporting Design</b>	\$ 250,000	Drive effective and efficient care delivery through alternative payment methods	Plan, Design and Implement the technical solutions required to support the Population Health components.
<b>Health Information Exchange (Participation Metrics, Attribution &amp; Clinical Measures)</b>	\$1,300,000		
<b>Total</b>	\$2,341,550		
<b>Program Management</b>			
<b>Program Leadership and Support</b>	\$1,632,606	Improve population-based care and drive effective care delivery through Patient-Centered Medical Homes	Management Structure and Authority Established. Program Staff Resourced and On-boarded.
<b>Project Management and Administration</b>	\$ 796,085	Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions	Program Governance Established. Vendors and Integrators Contracted.
<b>Evaluation &amp; Stakeholder Engagement</b>	\$ 714,125	Drive effective and efficient care delivery through alternative payment methods	Establish Stakeholder Engagement Structure. Implement Issue, Risk, Status, Progress and other reporting constructs necessary to effectively monitor and control the SIM initiative.
<b>Total</b>	\$3,142,816		
<b>Total</b>	\$16,893,242		

## B. Detailed SIM Operational Plan

---

### B1 – Narrative Summary of Component/Project

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

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

### Targeted Regional, Community-Level Population Health Initiative

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

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

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

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

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

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

## Coordinated Care Delivery and Alternative Payment Reform

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

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

- **Patient-Centered Medical Home:** the Patient-Centered Medical Home is the core pillar of our coordinated care delivery strategy. Patient-Centered Medical Homes will be rolled out statewide by January 1, 2017. Our goal is that nearly every Michigander will be attributed to a Patient-Centered Medical Home that proactively manages their health with a focus on chronic disease management and primary prevention by 2019. The SIM teams will leverage experience with the successful Michigan Primary Care Transformation Project (MiPCT) where possible.
- **Accountable Systems of Care:** a small number of Accountable Systems of Care will be integrated into Community Health Innovation Regions where the establishment of a coordinating infrastructure across Patient-Centered Medical Homes and other providers will deliver meaningful value.
- **Alternative payment models:** Improvements in provider behavior within Patient-Centered Medical Homes and Accountable Systems of Care will be rewarded through provider participation in alternative payment models as implemented by Medicaid and other payors.

## B2 – Detailed SIM Component Narratives and Summary Tables

### Community Health Innovation Regions

The State believes in the value of a community-based organizing mechanism composed of partners from many different fields, who will work together for better population health and health care at lower costs. Given the complex nature of the health system and the substantial impact of social, economic, behavioral, and environmental factors on health and health care, no one sector alone can achieve significant improvements in population health. Broad partnerships will be needed across the health system and beyond. To be effective and sustained over time, these partnerships will take a collective impact approach, with a long-term commitment to a common agenda, shared measures, and mutually reinforcing strategies for engaging the community to improve health and the health care delivery system while containing costs.

These partnerships will be organized using the structure and process of several SIM Community Health Innovation Regions (CHIRs) across the state. The CHIR is the name for both the geographic region of operation for each of the SIM test sites, as well as the group of stakeholders that enact the community-oriented work of the SIM population health endeavors. The CHIR component is the complement to the clinically-orientation components of the SIM. The CHIR provides a two-way organizing structure, enhancing the ability of community partners to interact with healthcare stakeholders, as well as the ability of clinical entities to identify and coordinate upstream investments into the community conditions that contribute to the healthcare needs, health disparities, and health equity issues within their health system service areas.

While a small number of models similar to CHIRs have been implemented within the country, best-practices to achieve impact at scale have not yet been well established. Based on this, the CHIR initiative will be tested within five state-selected regions to best inform health system transformation approaches in Michigan beyond the State Innovation Model. The selected regions include:

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

### Mission, Objectives, and Overall Approach

The overarching mission of each CHIR will be to align priorities across health and community organizations, and support the broad membership of the CHIR in executing improvement strategies. The CHIR structure supports both the integration of health care services and social services, as well as the targeting of resources toward upstream prevention rather than downstream intervention. CHIRs will implement initiatives focused on both: (1) primary prevention (interventions to prevent disease before it occurs) to improve health outcomes and reduce disparities, as well as (2) addressing the social determinants of health (e.g., housing,

crime, food insecurity, etc.) that impact residents' ability to stay healthy and/or manage disease through linkages between health care and social services. These efforts will prioritize the improvement of outcomes for the SIM priority populations: individuals at risk of high ED utilization, pregnant women and babies, and individuals with multiple chronic conditions. For the pursuit of initiatives that impact these 3 SIM priority populations, the SIM will work to align with the National Governors' Association to define the threshold for defining high ED utilizers. The lowest threshold of 5+ ED visits per year will allow the greatest latitude to the CHIRs in their approach for intervention. For this priority population, CHIRs will be encouraged to identify and implement strategies and interventions that target individuals at-risk of high ED utilization, meaning that the CHIR should be targeting individuals with risk characteristics common to those individuals who become high ED utilizers, not necessarily those already fitting the criteria. For individuals with multiple chronic conditions, it is up to the region to determine the locus of conditions that is most meaningful to address, with an emphasis on the interconnections among the SIM priority populations and metrics. Participation in the Collaborative Learning Network will provide information about chronic disease prevalence, regional burden, cost, common disease clusters, and proven and promising approaches to prevention and management. For the pregnant women and infants as a SIM priority population, the CHIR strategies and interventions should also allow flexibility to identify and support mothers who are at-risk for these conditions, not necessarily those already manifesting them (e.g. Women who are not currently pregnant but are of child-bearing age and who are at-risk for poor gestational health and birth outcomes, based on identified risk factors, rather than women who are already pregnant and likely to experience poor birth outcomes or who are experiencing pregnancy complications).

In addition, objectives for the CHIR will also include:

- Enhancement of local policy, identification of cross-organization programmatic and procedural improvements, and development of a built environment that encourages health and wellness.
- Further development of capacity and sophistication for effective and efficient governance, partnership, data collection and information sharing, and integrated service delivery.
- Ensuring alignment with existing, related initiatives underway in Michigan.

The configuration of the CHIR is built upon broad-based membership of the community. This membership should be inclusive of the regional landscape, and include comprehensive representation of regional actors that influence the socio-economic and environmental factors of health. The designated entity responsible for ensuring the functionality of the CHIR is fulfilled by the Backbone Organization. They are the guarantor of the contractual requirements of the CHIR [Appendix D5: CHIR Participation Guide], whether they are fulfilled by the Backbone Organization itself or through sub-contract with another entity. Where expedient, the Backbone Organization should leverage the regional assets of partner organizations to fulfill roles of the CHIR Backbone, such as convening, facilitation, and administration.

The Backbone Organization serves as the fiduciary for the CHIR. However, decisions about spending are made collectively by the CHIR governing body (of which the Backbone Organization will be a member). The



Backbone Organization itself does not have any disbursement authority for CHIR funding, except for the yearly administrative funding allocated to the it to carry out administrative responsibilities to (e.g. convening and, facilitating the membership and governing body), and providing program management for the operations of the CHIR governing body. The disbursement authority for general CHIR funds from the SIM rests with the CHIR governing body. The Backbone Organization has no special authority within the governance structure of the CHIR governing body, and is solely charged with supporting its membership in the decision-making and implementation of consensus activities. The Backbone Organization is intended to be a neutral convener that facilitates cross-sector, systems-change efforts, as determined by the CHIR membership.

The State is committed to ensuring that best-practices of collective impact are used in CHIR activities. In addition to the approaches outlined above, such best-practices include:

- Pursuit and inclusion of diversity in regional decision-making,
- Use of support systems for learning and improvement across organizations, and
- Monitoring of population health improvement measures.

SIM expects that the CHIR structure and processes for fulfilling their requirements will vary considerably across regions, and in accordance with local contexts. It is the preference of the State that each region utilize structures and processes that best leverage existing momentum with the region, and maximize the assets that are brought to bear in the collective impact approach to clinical-community linkages. In addition, this operational plan remains conceptual and local implementers will inform an operation model for local nuance as it relates to the framework laid out by the State. Therefore, the State will remain open to feedback from the regional sites through the lifetime of the project period by means of an iterative development cycle. Through a collaborative learning network, robust governance structure, and yearly planning updates, regions will update and improve their local operational models [Appendix D5: CHIR Participation Guide]

## Alignment

Each CHIR will complete a comprehensive inventory of existing services, programs, organizations, and funding sources. This preliminary requirement of the CHIR Backbone Organization is intended to ensure that each CHIR will build upon the assets of their community, and develop structures and processes that integrate with established resources.

In pursuing primary prevention efforts, each CHIR should ensure that the SIM endeavors within their region align with existing endeavors across the state such as the Michigan Health and Wellness 4x4 Plan and Department of Health and Human Services' Winnable Battles campaign, as well as leverage and enhance each regions' local array of prevention endeavors.



In developing clinical-community linkage programs, CHIRs will be encouraged to draw on tested models, such as the Michigan Pathways to Better Health Community Hub and Children’s Healthcare Access Program (CHAP). Key elements of these programs include:

- Connecting clients to needed health and local social services to improve their health and avert acute care utilization through the services of community health workers. Drawing on referral partnerships with providers and payers, these community health workers coordinate service delivery across health care and human services to provide comprehensive solutions tailored to the needs of each individual (e.g., transportation services to keep medical appointments).
- Emphasizing the provision of services for populations that are at, or are expected to be at, greatest risk.
- Improving the coordination of service delivery between health plans, health care providers, and community agencies.
- Tracking and monitoring of service referrals, utilization, and successful adherence to the social service equivalent of the prescribed course of care.

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

The State will require all Accountable Systems of Care (ASCs) to be a part of CHIRs for the SIM. For more details regarding the role of the ASCs within a CHIR please refer to the CHIR Participation Guide. ASC integration and interaction with the CHIR structure and processes will advance the SIM objective to make the CHIR operations financially self-sustainable in the longer-term by engaging local stakeholders (e.g., multiple payers, providers, ASCs, employers, etc.) in the foundational work of the CHIR, and positioning them to become increasingly aware of and invested in the work of the CHIR. This integration with ASCs also makes such institutions better able to leverage the potential value proposition of the CHIR structure and processes and make community investments more coordinated and effective than otherwise possible. It is the aspiration and intention of the SIM that these organizations will be willing to fund CHIR initiatives after the SIM period, based on their measurable contribution to population health goals. Although specific funding sources and amounts have not been prescribed, each CHIR will be tasked with developing a sustainability plan as part of their local operations plan. [Appendix D5: CHIR Participation Guide].

## **Community Health Needs Assessments, Community Health Improvement Plans, and Local Operational Plans**

Drawing on partners’ work, CHIRs will conduct and/or consolidate existing Community Health Needs Assessments (CHNAs). These assessments will identify strategic priorities for health improvement in the community. In doing so, health care delivery systems, local health departments, Medicaid health plans, community health mental authorities, federally qualified health centers (FQHCs), and other community stakeholders will work collaboratively with the assistance of the administrative staff of the CHIR. It is expected that the aforementioned stakeholders will formally approve of the new or revised document, and that it will leverage each entities existing process for community needs assessments in a proposed plan for the

coordination of future assessments in beyond SIM (e.g., hospital CHNAs, Local Public Health Department assessments, Community Mental Health Agency assessments, United Way Community Needs Assessments, etc., will have more coordination among their development and solicitation of stakeholder input, including the ongoing work and standing committees associated with their intermediary monitoring between such assessment reports). The CHIR will support the diverse entities required to conduct community needs assessments to fulfill existing obligations through the new CHNA process, with a commitment to minimize parallel processes and duplication among CHIR members.

With input from this consolidated CHNA process, and informed by community voice, the CHIRs will create a new (or modify an existing) Community Health Improvement Plan (CHIP) to establish a shared, community-wide strategic plan for improving health in the region. The CHIP should identify how each service providing entity within the CHIR will contribute to the priorities identified in the CHNA, and how the CHIR will support its community in ongoing performance monitoring to develop data-informed processes and decision-making structures that utilize the CHNA and CHIP in an ongoing fashion beyond the required intermittent updates.

In alignment with the CHIP, each CHIR will assemble a local operational plan specific to SIM describing plans for improving population health and developing community/clinical linkages. The use of an operational plan is intended to allow the cohort of SIM CHIRs to test and document promising practices, in order to inform their CHIR cohort, the Michigan Department of Health and Human Services, and post-SIM CHIRs. CHIR work should be documented and structured as to help the State identify policy levers that can enhance the operations of all CHIR members.

## Participating Entities

Communities require cross-sector partnerships to most effectively address broad determinants of health. CHIRs will be required to engage a core set of entities, with support and encouragement for adding additional key partners. Required CHIR participants will include:

- Community members with lived experience
- Local public health departments
- Accountable systems of care and other health care providers
- Community mental health service providers
- Medicaid health plans
- Other payers

Other critical stakeholders may include, but are not limited to:

- Employers and purchasers
- Additional health care providers, including behavioral health providers
- Community-based organizations

- Human service providers
- Philanthropy
- Local government
- Community and economic development
- Community safety and corrections
- Education institutions
- Housing
- Transportation
- State associations
- Other non-profit organizations (e.g., civic centers, advocacy organizations, research institutes, etc.)

## Backbone Organization

The Backbone Organization will be responsible for facilitating discussion and decision-making, scheduling meetings, setting agendas with partner input, documenting conversations, and providing follow-up support to partners to drive execution of implementation activity. The Backbone Organization will also be responsible for ensuring data collection, analysis, and reporting functions are conducted to facilitate and support the discussion and decision-making process. The Backbone Organization is the contracted entity for the SIM CHIR contracts, but the authority of the CHIR is vested within the governing body of the CHIR. The CHIR membership will be much larger than governing body members, and the CHIR governing body may organize work groups in addition to providing representatives of the CHIR to sit on other standing committees within its community. The Backbone Organization and CHIR governing body should pursue CHIR membership engagement in a way that does not create parallel processes or duplicative workgroups, and maximizes its leverage of the existing community infrastructure and momentum.

Each CHIR Backbone Organization indicated a commitment to contribute to the obligations of the Backbone Organization in its SIM – CHIR capacity assessment, and demonstrated financial and organizational capacity to donate in-kind and financial support to the functions of the CHIR Backbone functions. In addition to this contribution, the Backbone Organization will receive approximately \$160,000 per year to fulfill these administrative obligations, separate from the SIM grants made to the CHIR initiatives at-large. This total was calculated using average cost estimates from the State of Michigan to provide project management and coordination services and supplies for completing core administrative activities, for more funding details please see Appendix D5 [CHIR Participation Guide].

The Backbone Organization may provide for these functions itself or through the subcontract of other organizations. It is critical that the Backbone Organization neither exercise, nor be perceived as exercising, undue influence in the priorities and resource allocation decisions of the CHIR. The Backbone Organization must operate as a neutral, fair facilitator, and should demonstrate its commitment to this principle from its initial method of fulfillment of these duties.

Each region has one Backbone Organization that serves as the administrative representative and liaison to the State on behalf of the CHIR governing body, and contracts with the State of Michigan. The fiduciary function of the Backbone Organization is solely for contracting purposes, and funds disbursed to the Backbone Organization for the CHIR activities will remain under control of the CHIR governing body for disbursement. Some CHIR functions may be assumed by partnering organizations. The rationale for organizing regions with a single Backbone Organization is to ensure that local efforts to improve health are coordinated across sectors and that the resources of that region effectively and efficiently target the strategic priorities of the area. In the SIM model, the Backbone Organization for the CHIR can be any group, organization, or agency that can serve as a neutral convener (e.g., local public health, health systems, multi-purpose collaboratives, university-based organizations, etc.).

Specific details on the role and core functions of the convening backbone entity are included in Table B2.1 below.

## Responsibilities and Expectations

The contractual requirements of the CHIR are intended to ensure proper functioning and accountability of the CHIR to the larger SIM objectives. Most design principles of the CHIR, however, are left to the discretion of the regional stakeholders.

Satisfying all of the CHIR requirements in table B2.1 is the joint responsibility of the Backbone Organization, governing body, and membership, and will be tracked by MDHHS to ensure compliance.

Table B2.1 CHIR Requirements

Item Number	Area	Requirement
1	Contracts and Legal Agreements	In each region, there is one CHIR with a single Backbone Organization. The backbone is a legal entity and serves as a fiduciary for the CHIR. The CHIR backbone (or designee of the backbone) serves as a neutral convener.
2		When subcontracting core functions, the Backbone Organization must develop formal agreements with partners that clearly define responsibilities in the partnership.
3		The CHIR Backbone Organization applies for and disburses funds through their local operational plan process.
4		The CHIR includes the organizations and community members described under “Participating Entities.”
5	Population	The State will define geographic boundaries by zip codes in partnership with the CHIR. Inclusion and exclusion criteria will be applied to the population within the selected zip codes.
6	Staffing	The CHIR Backbone Organization is required to hire or contract for dedicated administrative and project management staff. SIM Funding will be provided to the Backbone Organization to cover a portion of the administrative costs associated with Backbone functions. Other capacity

		and financial contributions necessary to fulfill the Backbone requirements may be arranged through in-kind staff or resources as will provide sufficient capacity for the CHIR decision-making body to carry out its required duties.
7	Governance	The CHIR Backbone Organization ensures the convening of a decision-making body that includes, at a minimum, the organizations listed in the required section of “Participating Entities.”
8		The CHIR decision-making body is required to have a transparent, well-defined decision-making process. This may include guidelines or bylaws that specify how final decisions will be made.
9		The proceedings of the CHIR decision-making body must be documented.
10		The CHIR decision-making body is required to approve the local operational plan prior to submission for funding.
11	Commitment To Model Test Engagement	The CHIR is required to participate in the SIM evaluation.
12		The CHIR must participate in collaborative learning networks (CLN). Participation includes contribution to the body of knowledge and discussion around the SIM Test implementation in their local region, in addition to use of the CLN to inform their own implementation.
13		The CHIR must appoint a member or multiple members as representative(s) to be engaged in the Statewide SIM Population Health Committee.
14		The CHIR must develop an operational plan. The operational plan must align with the CHNA and CHIP (see no. 17), and include a plan for sustainable financing of the CHIR beyond the project period.
15	CHIR Functions	The CHIR must ensure the development and successful execution of systems that integrate health care delivery and human services (e.g., human services hubs).
16		The CHIR is required to have shared priorities and population health improvement strategies that are (a) developed by the CHIR members and (b) endorsed by the CHIR decision-making body. The priorities and population health improvement strategies must be grounded in and responsive to the needs of the community. The shared priorities or strategies must include efforts to improve care and outcomes for individuals at risk of high-ED-utilization, and the other SIM Priority Populations pursued by the region (healthy mothers and babies or individuals with multiple chronic conditions).
17		The CHIR must ensure the completion of a single community-wide CHNA, and CHIP. The single CHNA will coordinate with all entities that are required to conduct a CHNA or similar assessment, and may utilize existing community assessments to inform its consolidated analysis. It is not expected that community assessments be conducted prior to the required renewal for the purposes of the SIM.
18		Resulting from the community-wide CHNA, the CHIR decision-making body will jointly develop community wide strategies to address priorities for improving population health and controlling health care costs with a consolidated CHIP. The CHIP will identify the ways in which the existing inventory of services within their region contribute to the

		priorities identified in the CHNA, and in relation to the CHIR work to impact the SIM priority populations.
--	--	---

SIM resources – including financial support, coaching, and technical assistance – will be available to support CHIRs in fulfilling these requirements. Many of these supports will be delivered through the Collaborative Learning Network.

## Collaborative Learning Network

The purposes of the Collaborative Learning Network (CLN) are to:

- Build capacity among participants for cross-sector collective impact
- Encourage and support CHIRs in setting shared goals and measures
- Provide mechanisms to share lessons learned across stakeholders
- Build capacity for continuous improvement and action
- Promote accountability for outcomes
- Connect participants to other partners across the state and nation
- Synthesize the lessons of the SIM participants to inform post-SIM pursuits of health system transformation across Michigan

The Collaborative Learning Network will allow SIM participants to engage in shared learning and troubleshooting across regions and among different affinity groups. To support regional interaction, SIM will support in-person meetings three times per year, as well as a range of individual coaching for each CHIR. In addition to summits and coaching, a number of CLN activities are being considered. These include: webinars, on-site visits, templates, resource libraries, and "on-demand" technical assistance.

SIM recognizes that it is critical for CLN supports to avoid imposing rigid processes and to enable and support variation across local contexts. Accordingly, the structure and content of CLN will be responsive to input from participants.

## Technology and Data Needs to Support CHIRs

SIM seeks to facilitate the use of data and the adoption of technology among CHIRs that will support operations, enable improvements, and generally enhance the community-wide dialogue for change.

The technology platform(s) envisioned will present statistical indicators alongside program service usage information through a dashboard. Ideally, the platform(s) will seamlessly interface with relevant IT systems in order to extract relevant SIM-specific utilization data.

Specifically, the platform(s) will:



- Facilitate tracking and cross-organizational coordination in support of clinical-community linkages (across the health care provider, CHIR or CHIR-designated linkage provider, and the payer);
- Support completion of the CHNA process, and ongoing monitoring and updating by CHIR partners;
- Support monitoring of population health status;
- Support data-driven resource allocation and investment decisions (including, to the extent possible, community benefit fund disbursement);
- Enable tracking of implementation for the CHIP; and
- Facilitate broad engagement of CHIR partners in understanding performance on local and SIM-wide measures of interest

As discussed above, SIM will seek to ensure the availability of a common, sustainable solution (or set of solutions) across CHIRs, but will avoid requiring standardization.

SIM will explore opportunities for:

- Linking client-specific CHIR information to MiHIN as to facilitate care coordination and sharing of information around the social determinants of health;
- Otherwise enabling information from community organizations to be included in client EHRs;
- Enhanced methods for patient attribution in non-clinical settings;
- Data transmission to a data aggregator for storage, analysis, and reporting; and
- Enabling community organizations to receive referrals for service from healthcare institutions and providers.

The State will provide support to CHIRs to engage all partners in common strategies for system change and continuous improvement. During the fall of 2016, a statewide SIM Population Health committee, within the SIM Commission, will review CHIR operational plan feedback, participant input, and performance monitoring, as well as identifying gaps to performance, encouraging collaboration and sharing best-practices across CHIRs. HIE/HIT functionalities within our State will be leveraged where possible to provide test participants a coordinated technology platform that will connect them with existing Michigan HIT/HIE efforts and other CHIRs. This could potentially be achieved by undertaking new initiatives such as including CHIR social/behavioral service providers into the Healthcare Provider Directory using the existing data systems and building on existing efforts such as the inclusion of Community Health Workers in Active Care Relation Service functionality to support attribution.

## Value and Measurement

The value proposition of the CHIR involves both short- and long-term endeavors. In the long-term, the value of the CHIR is its ability to strengthen community capacity to address broad-based, upstream risk that leads to healthcare utilization and health disparities. This long-term value will be pursued by (a) encouraging and enabling health care providers and payers to invest more effectively/efficiently in upstream prevention, and (b) building stronger linkages among community organization, economic development initiatives, and governmental programs so that funding can be aligned.

In the short-term, the value proposition of the CHIR is to enhance clinical-community linkages among healthcare services and community-based social services, and to provide a structure and a process for communities to work together in a “health-in-all” approach to collective impact. This short-term value will be pursued through program and institutional collaboration, regional data collection, and regional program alignment.

To gauge progress in achieving these value propositions, the CHIR will work with the State to identify a suitable core set of indicators to inform their data efforts. These measures will include, but not be limited to, the items outlined in section A3 (some of the A3 items not pertinent to the Year 1 focus on ED-use may be used for monitoring only). In addition to outcomes, self-reported measures will be validated by MDHHS and will include organizational process measures and short-term program performance data. The following table illustrates preliminary plans for how CHIRs will be measured for success initially. The measurement approach will be finalized after consultation with the CHIRs prior to the solicitation for the local CHIR operational plans in January 2017.

Table B2.2 CHIR Measurements for Success

Objective	Signs of Progress
1. Neutral convener to facilitate cross-sector efforts	<ul style="list-style-type: none"> <li>• Schedule of decision-making body meetings</li> <li>• List of CHIR participants and decision-making body members</li> <li>• Inclusion of mandatory representation per CHIR requirements</li> <li>• Documentation of meetings</li> <li>• Identification of groups not present at CHIR roundtable, or solicited for input via committees and/or workgroups</li> </ul>
2. Development and maintenance of strong partnerships	<ul style="list-style-type: none"> <li>• Documentation of past and current partnerships</li> <li>• Identification of partnership risks</li> <li>• Partner engagement and satisfaction</li> <li>• Identification of relevant regional groups not yet participating in CHIR, and plans for outreach</li> <li>• Prospective list of future needs required of partnerships</li> </ul>
3. Support for linkages between health care delivery system and community service providers	<ul style="list-style-type: none"> <li>• Inventory of existing linkages</li> <li>• Demonstrate the way in which the region assures linkages between health care delivery system human services and public health (e.g. Pathways, 211, etc.)</li> <li>• Promote community resource availability to health care delivery systems</li> <li>• Written document for value proposition completed</li> </ul>
4. Pursuit of inclusion and diversity into regional decision-making	<ul style="list-style-type: none"> <li>• Document continuous outreach process for recruitment</li> <li>• Establish leadership support for partners</li> <li>• Conduct routine survey of partners for ongoing assessment of community perceptions of inclusion and diversity</li> </ul>
5. Use of support systems for learning and improvement across organizations	<ul style="list-style-type: none"> <li>• Participation in Summit and CLN activities</li> <li>• Works with Coach to improve performance and share lessons</li> <li>• Completion of local operational plan</li> </ul>



	<ul style="list-style-type: none"> <li>• Use evidence-based protocols that promote continuous improvement</li> <li>• Identify institutional staffing and infrastructure needs for participation in learning and improvement processes</li> </ul>
6. Monitoring of population health improvement measures, and accountability to outcomes	<ul style="list-style-type: none"> <li>• Dashboard completed (and reports data in a manner that reveals health inequity)</li> <li>• Pursued jointly created and supported agenda among partners</li> <li>• Engage partnership members in assessing their own progress on a regular basis</li> </ul>
7. Support for population health workforce development	<ul style="list-style-type: none"> <li>• Gap analysis for workforce needs in community</li> <li>• Facilitate conversation among clinical and community partners around workforce transitions</li> </ul>
8. Development of sustainable financing strategy for CHIR	<ul style="list-style-type: none"> <li>• Plan for sustainable financing completed</li> <li>• Conduct inventory of organizational funding, including program revenue, in-direct expenses, and discretionary funds</li> <li>• Identify opportunities for alignment of organizational services, including coordinating with publicly funded programs</li> <li>• Develop communication plan to increase awareness of funding opportunities and coordinate submissions</li> <li>• Identify opportunities through the CHIP for clinical savings to be invested upstream</li> </ul>

## CHIR Implementation

The State will begin regional engagement by finalizing the Backbone Organization selection process and providing guidance to prepare the Backbone Organization for the CHIR governing body and membership to convene. Where applicable, the organizations may propose a process for defining and finalizing items required for Implementation period operation. The desired outcome of the initial engagement will be to develop and/or verify a governance model, management structure, intervention proposal, and measurement plan for implementing their CHIR model in alignment with the State's principles, and that is supportive of the SIM priorities and target populations. The CHIRs will be informed of the contracting calendar prior to the Implementation period in August, and available resources and funding for their efforts once they are well-defined, modeled, planned, and justified.

## Funding

A pool of funds (see C4 - Population Health Budget) will be made available to Community Health Innovation Regions to support administrative functions and/or programs. Each approved region will receive a fixed budget appropriated for the administrative functions and a health improvement budget appropriated to fund action/intervention projects. For year 1, planning and design funds are a one-time disbursement to support the CHIRs in the assessment, planning and early design activities that will help to set the course for their local approach for the rest of the project. The early disbursement of these funds will ensure that each CHIR is sufficiently supported to execute project start-up activities.

The health improvement budget amounts will vary among regions, and the yearly disbursement amounts will take into consideration the regional Medicaid beneficiary populations.

Administrative functions will include activities required to operationalize CHIRs (e.g., provision of meeting space) and support the decision-making processes of the governing body and the engagement of CHIR membership. Health improvement activities will include actions and interventions proposed by CHIRs to enhance community capacity through the alignment of existing programs, in addition to development of any new programs (as needed). Potential sources of funding for these areas will include financial/in-kind support from local participating entities, SIM funding, and other public/private grants. The State of Michigan is committed to exploring its ability to contribute to the 'bottom-up, top-enabled' approach of the SIM regions, by identifying additional opportunities to further align State funding in local regions; it is the expectation of the State that the CHIR will be instrumental in this identification. Please refer to Appendix D5: [CHIR Participation Guide] for more information regarding fund usage and disbursement details.

To qualify for administrative funding, the Backbone Organization must meet a subset of the requirements outlined in Table B2.1, including but not limited to status as a legal entity and ability to function as a natural convener and fiduciary.

To qualify for health improvement funding, the CHIR must complete additional requirements listed in Table B2.1, including no. 14, 17, and 18 (Local Operational Plan, CHNA, and CHIP). In year 1, submission of a Local Operational Plan is required to receive health improvement funding; the Plan must include a schedule and approach for development of the CHNA and CHIP. In Year 2 and Year 3, to receive health improvement funding the Local Operational Plan must also include the completed CHNA and CHIP deliverables, in addition to the other required Plan items. Each year, the Local Operational Plan will serve as a vehicle to monitor budget disbursements against proposed activities from the previous year Plan, and the CHIR will submit budget revisions for approval to the State via the local operational plan. The State will review the submitted deliverables and release funding after operational plan approval. The goal of these prerequisites is to ensure that the new configuration of the CHIR membership and governing body has sufficient input into the requests made through SIM to fulfill the responsibilities of the CHIR in a way that maximizes the utilization of existing regional activities.

Accountable Systems of Care (ASC) that participate as members of the Community Health Innovation Region (CHIR) will be eligible for grant funding through the Backbone Organization. Funded activities must be aligned with the community health priorities and health improvement activities agreed upon by the CHIR governance, submitted to the State as part of the local operational plan, and approved by the SIM governance. More funding details regarding ASCs can be found in Appendix D5: (CHIR Participation Guide).

The State assistance to SIM participants will vary depending on existing support from local stakeholders. SIM can provide limited funding for administrative staff and other key personnel (see B2.1 requirement no. 6). While recognizing the resource constraints of many CHIR participants, organizations will generally be

expected to provide some in-kind contributions (e.g., personnel time to serve as representatives on governing body), and the CHIR governing body should ensure that it fully solicits participation from key regional stakeholders without duplication of efforts (e.g., some CHIR workgroups may rely on the attendance of other standing committees in the community, rather than the creation of their own processes and request for community leaders to attend duplicative meetings). The CHIRs will select and fund initiatives based on their CHNA, which are targeted to the SIM priority populations; these activities will largely be supported by existing funding, with the goal of mutually reinforcing activities as a primary outcome of the CHIR-supported alignment of services and programs. SIM resources are intended to serve as “seed” funding for building upon or enhancing coordination of existing activities, or to develop new initiatives that cannot be supported by alternative grants/funds, and should generally build community capacity to deliver such provision of services beyond SIM. The SIM funding must contribute to initiatives that impact the SIM priority populations; the process to affirm the relation of initiatives to the SIM priority populations is detailed further in Appendix D5: (CHIR Participation Guide), which requires initiatives to be included in a driver diagram that documents their relationship to the SIM priority populations and the strategy by which such investment will improve the SIM the priority population outcomes. It is expected that the CHIR will continue to undertake the broad array of activities already underway in their region, and will utilize the CHIR structure and operations to enhance the implementation of these efforts. While such efforts are integral to the work of the CHIR, many concurrent activities operated under the auspice of the CHIR during the SIM period will not be eligible for SIM funding.

## Approach to Monitoring

The State will actively monitor the work of the CHIRs. This monitoring will be accomplished through regular monthly phone calls with the Backbone Organization, review of routine progress reports (quarterly and annually), prior-approval requests to use funding, correspondence from the Backbone Organization, budget reports, site visits, and other information available to the State. Please refer to the CHIR Participation Guide for more information regarding monitoring activities.

## Sustainability

The sustainability of multi-sector partnerships will require local stakeholders to invest in the Backbone Organization structures and infrastructure costs for the staff and decision-making body. CHIRs will need to develop a broad base of financial support from their local partners (e.g., from health plans, businesses, community benefit resources, and philanthropy) to support ongoing costs associated with the management of the CHIR and its work. One of the principal aspirations of the CHIR structure and processes is to better develop multi-agency infrastructure and procedures that enable the largess of regional healthcare institutions to be more efficiently directed toward the community development work of the CHIR, in an ongoing basis. Technical assistance and coaching will be available to support this work. Please refer to Appendix D5: (CHIR Participation Guide) for more information regarding CHIR sustainability planning.

Alternative support for the CHIR will be provided by means of policy levers at the State level, and through existing mandates such as the Michigan Medicaid Health Plans (MHPs) incentives to support several integral aspects of the CHIR approach, including:

- Participation with SIM activities
- Support clinical-community linkages and community health worker interventions
- Participate in community-wide CHNAs
- Address health disparities
- Contract with community-based organizations to address social determinants and root causes with the community
- Incorporating data on social determinants of health into support for population health management

## Spread

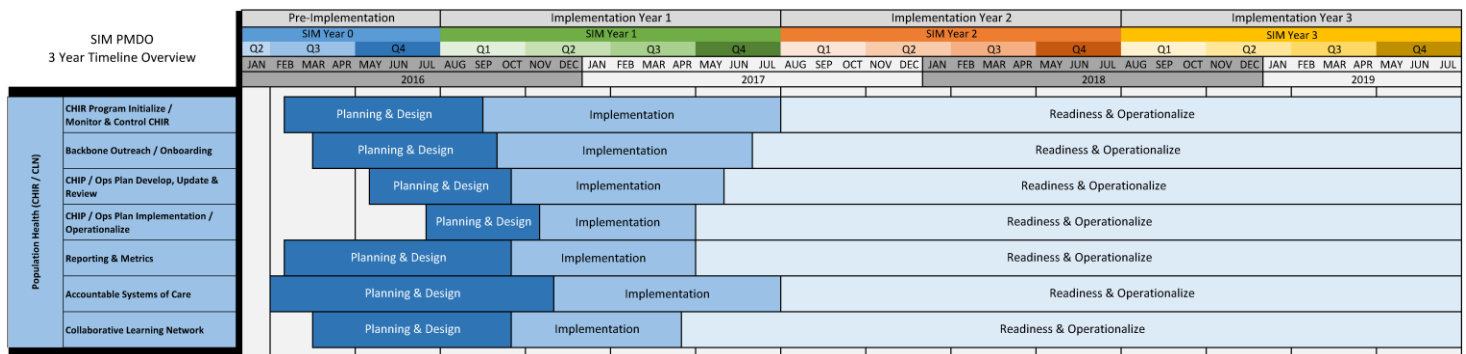
Community Health Innovation Regions are a relatively new model and will need to be tested. It is expected that various configurations of fiduciary structures and compositions of governing bodies will be able to fulfill the mandate of the CHIR, in a way that best adapts to the regional landscape of partners and is most responsive to local conditions. When the State defined the number of CHIRs to test, considerations were made to ensure that the number of test sites did not exceed the capacity of SIM, or SIM's ability to provide meaningful seed funding for test site initiatives. The State selected a diverse mix of CHIRs for testing to ensure that the mix of test sites can provide insights into the best-practices of how CHIRs could be launched across various contexts throughout Michigan.

SIM will document the resource needs and analyze the feasibility of expanding the model to other regions. It is the expectation of the State that the SIM CHIR sites will maintain an interest in supporting peer communities during and beyond the SIM period, to maximize the State's leverage of the SIM test. Peer support may come in many forms, such as webinars, summits, conference calls, knowledge transfer, documentation sharing, etc., and the extent to which support will be available will be contingent upon the feasibility of spreading the model to other regions. The SIM Population Health committee will also oversee and monitor CHIR implementation and provide cross-collaboration between multiple CHIRs across the state, and the State expects the CHIR to leverage other population health endeavors for the spread and scale of the CHIR functions, such as:

- Local Public Health Departments range of Cross-Jurisdictional Sharing (CJS) efforts, which represent advances in partnership, data sharing and reporting. CHIRs will utilize CJS efforts in their region, and look to replicate best-practices of other CJS models that are not currently practices in their health department, when applicable.
- Local Departments of Human Service role to play in generating service data on at-risk populations. CHIRs will partner with MDHHS Services to pursue new models of case management, and leverage existing data enhancements such as the Integrated Service Delivery model.

It is the goal of such alignment, that the SIM period positions the CHIR structure and processes to best leverage and integrate with these types of existing, cross-sector capacities in their community. It is the overarching goal of the CHIR to address the non-clinical factors that influence health status, quality of life, and life expectancy, and to integrate these socio-economic and environmental determinants of health into the clinical-community partnerships of the CHIR membership.

Figure B2.1 Population Health Timeline



See Figure A4.1 for complete timeline

## Community Health Innovation Regions: Component Summary Table

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

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

Table B2.3 CHIR Component Summary Table

Sub-Component	Activity	Description
<b>CHIR Program Initialize/Monitor &amp; Control</b>	Validate Governance Model	Develop/verify governance model and processes
	Design Communication Plan	Develop communication plan for CHIR/Backbone Organization outreach and schedule onsite visits, conference calls, kick off meetings, etc.

	Establish Governance Cadence	Schedule Bi-Weekly meetings (or as otherwise determined) Financial Invoices Quarterly progress reports After implementation begins, establish yearly reviews and onsite visits
	Develop CHIR Performance Improvement Plans	Develop CHIR performance improvement plans and/or expel practices that do not comply with eligibility and technical requirements
	Monitor Eligibility/ Compliance to CHIR Program	Develop and implement an approach to monitor CHIR eligibility, compliance with technical requirements and completion of project milestones.
<b>Backbone Outreach/ Onboarding</b>	Recruitment and Enrollment	Validate strategy/approach for participant recruitment and enrollment
	CHIR Requirements	Refine technical requirements and qualifications for CHIRs
	Region Selections	Select CHIR test regions
	Backbone Selection	Select & Onboard Backbone Organizations
	Enrollment Process	Build/modify process for participants to enroll and qualify for CHIRs
	Administration Fund Dispersion	Disperse administration funds
	CHIR Grant Program	Design CHIR grant program
	Contract Amendments	Revisit and/or amend contracts regularly based on monitoring and enforcement mechanism
	Contract Monitoring	Manage re-contracting process for test participants
	Single CHNA	Develop approach for a deployment of a single community wide Community Health Needs Assessment, with expectation that existing reports will be synthesized into a first round analysis
<b>CHIP/Ops Plan Development, Update, &amp; Review</b>	Setup additional CHIRs	Assess viability for setting up CHIRs in additional regions
	Launch CHIRs	Officially, launch CHIR designs and begin convening CHIR governance meetings
	Finalize Model Design	Share and finalize test model design with test participants
	Execute Contract/ Agreements	If applicable, execute MOAs/MOUs with CHIR participants
	Approve Initial Local Ops Plan	Finalize/ Approve CHIR CHIPs/Local Ops Plans
	Yearly Local Ops Plan Update	Yearly the CHIP & local ops plan will be updated and submitted to MDHHS for review/approval
	Readiness Assessments	Complete CHIR readiness assessments
	Funding Process Defined	Define expectations for how CHIR administrative activities and programs will be funded



<b>CHIP/Ops Plan Implementation/ Operationalize</b>	Launch Funding Process	Launch CHIR grant process to provide CHIR health improvement funds
	Disperse CHIR Health Improvement Funds	Distribute CHIR Health Improvement funding for selected participants
	Implement local operations plan	CHIRs will begin implementing the submitted local operations plan
	Execute Vendor Contracts	Execute vendor contracts
	Measurements	MDHHS, in conjunction with the CHIRs will define a core set of CHIR metrics as well as regional specific sets.
	Design report templates	MDHHS will design report templates
<b>Reporting &amp; Metrics</b>	Data Collection Strategy	Develop strategy to gather non-claims data, if any for reports
	Data Reporting Strategy	Develop approach for report generation/quality metric entry
	Define Business Requirements	Work with CHIRs to fully develop CHIR business requirements
	Gather Data	After CHIRs are launched, CHIRs and MDHHS will begin reporting and gathering data at regular intervals.
	Report Generation	Based on the data collected, reports will need to be generated at regular intervals.
	Report Distribution	Using the generated reports, reports will need to be distributed at regular intervals.
	Update/Adjust Report Design & Intervals, if needed.	Determine refinements/additions to reports and data collection methodologies
	Design/Implement CLN impact measurement approach	An approach will be developed to measure collaborative learning activities to determine impact.
<b>Collaborative Learning Network</b>	Distribute Education Material	Distribute participant education materials
	CHIR Participant Training	Equip CHIR participants: curriculum, training
	CHIR Participant Feedback	Work with CHIR participants to address participant inquiries/appeals
	Assign Coaches	Engage/consult to CHIRs and assign coaches
	Address design inquiries	Work with CHIRs to address any design questions/modifications
	Launch IHI CLN Activities	Launch CLN activities which may include webinars, seminars, trainings, conference calls, etc.
	Implement Learning Health Systems	Collect and share best-practices through Learning Health Systems



## Patient-Centered Medical Home

This section details the next transformative step for Patient-Centered Medical Homes (PCMH) in Michigan. The PCMH model described in this document will become a premier model for advanced primary care in Michigan and will leverage experience gained from the Michigan Primary Care Transformation Project (MiPCT) demonstration. This document outlines the guidelines in which Patient-Centered Medical Homes will follow when establishing, or continuing their operation of a PCMH in Michigan under the State Innovation Model (SIM) Initiative.

Patient-Centered Medical Homes are the foundation for coordinated care delivery strategies for the SIM Test Initiative. Michigan's SIM PCMH efforts are centered on further spreading the PCMH model of care, continuing measurable improvements in quality, health outcomes and patient satisfaction, and increasing PCMH participation in alternative payment methodologies. These efforts are intentionally building upon the MiPCT Project gains, which includes sustaining involvement of MiPCT providers and multi-payer participation, as well as leveraging the project's existing infrastructure and advancing the project model. The MiPCT Project is the largest Multi-Payer Advanced Primary Care Practice demonstration in the country serving over 1.2 million patients with 350 primary care practices, 37 physician organizations, 1,800 primary care providers and over 400 specially-trained Care Managers participating. While MiPCT set a solid framework which SIM PCMH activity can be built upon, the State Innovation Model aims to expand the PCMH Initiative when the MiPCT demonstration period ends on December 31st of 2016.

Michigan currently has approximately 5,200 providers already choosing to practice in a PCMH accredited setting. Of these, the majority of current Michigan providers (Approximately 88%) have been accredited through Blue Cross Blue Shield of Michigan's PCMH program, and another 10% are recognized by the National Committee for Quality Assurance. Current PCMH providers in the state represent about 32% of total active primary care providers in the state, which represents a significant base to build upon, yet leaves a great opportunity for growth.

For the next three years, starting January 1, 2017 SIM has identified a set of overall goals in which all activities are driving toward, the PCMH track has specific objectives in which the success of the implementation will be measured. These objectives include:

- Increasing the percentage of active primary care providers practicing in PCMH settings.
- Increasing the percentage of Michigan residents receiving primary care services in a PCMH setting.
- Increasing the percentage of active primary care providers participating in Category 3B or higher Alternative Payment Methodologies. More information about proposed payment models can be found in C5 (Payment & Service Delivery Models)
- Continuing measurable improvements in quality of care, health outcomes and patient satisfaction measures
- Making a positive impact on PCMH's understanding and management of their patients' healthcare cost.

As the SIM Test moves from planning to implementation the development of targets for these objectives will be explored. Through the application process and onboarding of the PCMH Initiative participants the MDHHS staff and PCMH Operations contractor will analyze key characteristics of each practice. Utilizing both responses from the application itself and a subsequent practice level self-assessment, the current capacity of the 2017 participants will be identified, allowing for the development of specific targets. Additionally, this process will allow for the development of specific practice supports in order to ensure a standard level of achievement amongst all participants. Additional metrics, including the utilization metrics outlined in Table C10.2 (Phase I Utilization Measures) will be essential in monitoring the participating practices understanding of their patients' healthcare costs; while the use of the Health Information Technology solutions C10 (Health Information Technology) will aid in demonstrating the patient service utilization.

The PCMH will serve as the patient's primary touch point with the healthcare system and will focus on the development of personalized, patient-centered care plans as a means of delivering high quality and affordable care. This focus will be realized by implementation of comprehensive, team-based care delivery and coordination activities. These care-coordination activities include the support for effective transition of care, assistance in scheduling and following up with both patients and specialist physicians alike. This collaboration and intentional interfacing with other providers to create an integrated treatment approach through community-clinical linkages is paramount in the success of PCMH's ability to deliver high quality and cost-effective service to its population. In doing so, the PCMH will improve the health of Michiganders through a range of levers including improved care coordination and chronic disease management as well as primary and secondary prevention.

Over the next three years, scale-up efforts will be considered as a way of reaching the goal of statewide implementation by 2019. This goal is contingent upon capacity within not only SIM, but the State's Medicaid budget and commercial payer partners as well. Based on our current understanding of activity and budget restrictions, the following scale-up strategy is the best estimation of how SIM will reach its 2019 goal of statewide implementation.

- Year One: PCMHs meeting participation requirements within SIM's 5 regional test locations and existing MiPCT practices meeting participation requirements outside SIM's regional test locations will be offered an opportunity to participate.
- Year Two: The PCMH Initiative will expand to a subset of the Michigan prosperity regions chosen by SIM's governing body in consultation with PCMH stakeholders.
- Year Three: The PCMH Initiative will expand into the remaining Michigan Prosperity regions.

As the SIM PCMH Initiative works to expand upon the foundation of the MiPCT demonstration in the year 2017, an Intent to Participate (ITP) process was opened to PCMH accredited organizations within SIM's 5 regional test locations, as well as current MiPCT PCMH participants across the state. Following a three week open period, the Intent to Participate was closed with over 700 primary care practices responding with

interest in the SIM PCMH Initiative. All practices that completed the (ITP) will be invited to complete an application to further identify those practices that are prepared to fully engage in this initiative. The ITP and application process will be utilized in the future to bring the PCMH initiative to scale and reach the 2019 goal of statewide implementation. As the PCMH Initiative comes to scale, the ITP and application process will be available targeted regions as outlined by the Governor's Regional Prosperity Initiative and approved by the SIM governing body. As the 5 SIM regional test locations coincide with counties within four of the ten Prosperity Regions, thoughtful consideration will be given to service area expansion in the years to follow.

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

When reviewing the following sections on the PCMH Initiative strategy and components, consider that an overarching focus is addressing the activities put forward in the Blueprint and that practice characteristics, including accreditation and eligibility, are created to ensure highly capable participants without being overly exclusive. Identifying patient attribution rules that support new payment and care models must support best practices and be innovative and promising for the participating PCMH. Finally, it is important to evaluate our performance monitoring approach, and that it strike a balance between ensuring accountability and limiting additional administrative overhead.

## Accreditation and provider eligibility

As a way of ensuring Patient-Centered Medical Homes deliver high quality and high-value care, each participating PCMH must receive accreditation from one of the authorized accrediting bodies approved by the SIM PCMH Governance. The criteria for PCMH accreditation methodologies include:

- Ensure the delivery of high quality care and coordinated care activities
- Take a balanced approach to accreditation, by ensuring quality without unnecessarily restricting participation
- Enable providers to participate in Patient-Centered Medical Homes payment models effectively and without undue exposure to insurance risk
- Promote ease of transition of existing Patient-Centered Medical Homes within the state.

Each of the following accrediting bodies have been identified as meeting the methodologies listed above, and while the list is not exhaustive, it is the current list being considered:

- National Committee for Quality and Assurance (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (TJC)

- Blue Cross Blue Shield of Michigan / Physician Group Incentive Program (BCBSM/PGIP)
- Utilization Review Accreditation Commission (URAC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)

Our accreditation methodology will leverage existing PCMH recognition and designation programs, as well as the approach used by the MiPCT project. The decision to utilize this accreditation methodology was strongly based on two ideas. One, many existing Patient-Centered Medical Homes have already invested substantial resources in demonstrating alignment while earning their current designation. Secondly, while it is desirable from a SIM PCMH Governance perspective to be as inclusive as possible when approving a PCMH, there is not enough evidence to support creating a custom accreditation method that ensures the same high-quality requirements already part of the current industry standards. Both of these examples are best, and most easily achieved by utilizing the accrediting bodies identified above. In addition to the identified accreditation options previously listed, there will be mandatory components that the SIM PCMH Governance determines required for participation. These include, but are not limited to; having an ONC certified Electronic Health Record (EHR) with stage 1 meaningful use attainment. Having connection to a Health Information Exchange (HIE) Qualified Organization (QO), also known as sub-state HIE. One must be enrolled as a Michigan Medicaid provider in compliance with all standard provider policies. Embedded care management / coordination staff meeting standards set by the Initiative and a patient registry or EHR registry functionality operational will also be required. Currently, a list of additional requirements are being evaluated and an approved list will be confirmed shortly.

Providers who deliver primary care and fulfill Michigan's list of PCMH accreditation and participation requirements as recommended by the clinical/operational working group (described below in Patient-Centered Medical Home / Care Delivery Governance) and approved by SIM Governance will be eligible to participate in the Initiative. Potential provider types eligible to participate include family physicians, general practitioners, geriatricians, pediatricians, internal medicine physicians, obstetrician / gynecologists, nurse practitioners, physician assistants, and safety net providers (federally qualified health centers, rural health clinics, and Indian health services).

## **Patient inclusion and attribution**

Patient-Centered Medical Homes will meet the needs of a broad array of individuals, including healthy individuals, as well as those with single or multiple chronic diseases. However, a significant portion of the Initiative's performance metrics and payment methodologies will be targeted toward patients with more significant healthcare needs and costs including Michigan's SIM target populations: high utilizers of emergency department services, and patients with multiple chronic diseases. Aligning with the National Governors Association, high-ED utilization will be defined as 5 or more ED visits per 12 months. Chronic conditions that will be prioritized include but are not limited to diabetes, hypertension, depression, and obesity. The quality metrics as described in Table A3.1 SIM Core Metrics have been aligned with the focus on these target populations.

Several Medicaid and Medicare beneficiary populations will be excluded from the PCMH Initiative population. Historically, inclusion and exclusion rules are written at a practice level, however, for the SIM PCMH Initiative the decision was made to construct rules at the beneficiary level. This decision was made to allow practices to participate in multiple programs and initiatives while limiting the opportunity for duplicate payments for the same type of services. The beneficiary population for the SIM PCMH Initiative is outlined in Appendix D4. (Care Delivery Artifacts – Inclusion & Exclusion Criteria). Although the needs of persons with development disabilities, long-term services and support needs, or more serious behavioral health needs will be met through current care delivery mechanisms, we will work to identify opportunities for alignment between Patient-Centered Medical Homes and existing behavioral health efforts. This includes both community behavioral health clinics and health home efforts.

In order to identify if a patient falls within one of the included populations for SIM PCMH, various existing indicators will be used. The general process to identify participating providers, as well as patient population at each PCMH within the initiative is as follows.

1. SIM provider participation is determined through the PCMH application process. Providers complete an intent to participate preliminary screening followed by a complete application and participation agreement, which is evaluated against PCMH Initiative requirements by the PMCH Operations Contractor. The resulting evaluation is sent to SIM Leadership for final selection and approval of participating providers.
2. The State of Michigan will apply the approved exclusion criteria detailed in Appendix D4. (Care Delivery Artifacts – Inclusion & Exclusion Criteria) to the Medicaid population to determine the Medicaid SIM eligible population. Medicaid beneficiaries must have full Medicaid coverage, be a Medicaid health plan member, not be enrolled in an excluded Medicaid benefit plan and not have third party coverage which would duplicate the Initiative's payment model
  - a. Identify if patient is full Medicaid and Medicaid Managed Care only. (Level of Care 7 or 11), then
  - b. Identify if patient is associated with specific Benefit Plan IDs, then
  - c. Exclude based on other Insurances using TPL (Third Party Liability) information.
3. Medicaid SIM eligible population will be declared as SIM participating if the attributed Medicaid Health Plan provider (PCP) is a SIM Participating provider.

The Relationship & Attribution Management Platform detailed in section C10 provides the infrastructure necessary for completing the participation calculation and reporting.

For the Medicaid managed care population, patients will be attributed to a PCMH based on their selected/assigned primary care provider. **The PCMH Initiative will focus its short-term payment model on care management payment using a two-tier approach and practice transformation payment.** Private payers participating in the Initiative will be encouraged to use one or both of these approaches for their beneficiary populations. Only patients served by participating payers that do not fall into an excluded beneficiary population will be attributed to PCMHs for the purposes of the PCMH Initiative.

## Patient-Centered Medical Home / Care Delivery Governance

A work group and a governance structure within the SIM Test will provide clinical and operational input and recommendations on decisions related to the Patient-Centered Medical Homes. Along with this internal work group and governance structure, external groups will be engaged to better steer PCMH's towards their objectives. This stakeholder engagement process is fully outlined in C2 (Stakeholder Engagement).

The basic structure of the Patient-Centered Medical Home / Care Delivery Governance follows that which is created for the entire State Innovation Model(SIM) Test. Complete details of this full SIM Governance structure can be found in section C01 (General SIM Operational and Policy Areas). The Patient-Centered Medical Home and Care Delivery Governance focus on clinical and operational input, along with recommendations on decisions related to the PCMH model being implemented for the SIM PCMH Initiative.

The SIM Commission has three-tier committee approach, in which each level has overlapping participants to ensure appropriate representation during each phase. In the context of PCMH and Care Delivery, the structure is as follows.

- 1) Full SIM Program Governance
- 2) A Care Delivery Governance which is a subset of the overall program governance focused on PCMH / Care Delivery and has representation from the SIM Program Governance
- 3) A Care Delivery Commission, with public / private sector participation to provide suggestions and direction along with representation from Care Delivery Governance.

This body's mandate as it pertains to Patient-Centered Medical Homes, and the Care Delivery component as a whole, will be to review existing PCMH designation programs, prioritize requirements for Michigan's PCMH accreditation. These examples do not identify the full charge of the governance and commission, but instead gives a basic understanding of the scope in which the governance and commission bodies will address.

## Alternative Payment Model to support Patient-Centered Medical Homes

Our intention for health care transformation in Michigan is to include Medicaid managed care organizations, Medicare payors, and commercial payors as a way of creating multi-payor alignment. The PCMH Initiative will address multi-payor alignment within its efforts by working with health care systems to align operational activities in order to increase the efficiency and effectiveness of health care delivery in Michigan. To that end, the SIM Initiative will implement a process aimed at creating multi-payor alignment strategies for Medicare, Medicaid, Commercial (insured), Commercial (Self-Insured) and Self-Insured employers. Medicaid will take a lead on PCMH implementation with activities including, but not limited to, facilitating establishment of necessary performance measurement and incentive payment mechanisms. Concurrently, the SIM Team will utilize available resources to develop a custom PCMH demonstration option for Medicare engagement (pursuant to CMS approval). For commercial health plans, the plan is to maximize Multi-Payor alignment through the use of key stakeholder input, the tools identified in the Multi-Payer Alignment Strategy and a



formal process to identify, scrutinize and prioritize those strategies. For more detail on the specific approach on employing multi-payor alignment, please reference section C5 (Payment and Service Delivery Models).

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

- 1) Fee-for-service, no link to quality, e.g. traditional fee for service, diagnosis related groups not linked to quality
- 2) Fee-for-service, link to quality, e.g. pay-for-performance, performance bonuses
- 3) APMs (Alternative Payment Models) built on fee-for-service architecture, e.g. upside risk sharing, downside risk sharing
- 4) Population-based payment, e.g. capitation

As the guidelines describe, movement from category 1 to category 4 requires increasing levels of provider accountability for total cost of care and quality of care, and an increasing focus on population health management. The PCMH payment model outlined below reflects these priorities as well as a "glide path" for increasing adoption of risk by providers.

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

Patient-Centered Medical Homes will deliver care to patients and will be reimbursed according to contracted rates from Medicaid MCOs and commercial payors. They will in addition receive practice transformation payments, care coordination payments, and have minimum requirements to participate in advanced payment models. Over the next three years, the SIM PCMH Initiative will engage Medicaid, Medicare and commercial payors to participate, and will leverage a phased approach to engagement. For initiative year one, Medicaid will implement Practice Transformation and Care Management PMPM Payments in addition to existing Medicaid Health Plan operated incentive structures. Both the Care Management PMPM and the Practice Transformation PMPM are being calculated in partnership with the State's actuary, partly based on actual Medicaid claims data from practices likely to participate in the Initiative (those PCMHs were identified through the intent to participate process). In 2017, Medicare will continue its Chronic Care Management and Transitional Care Management payments while the Custom Options is designed and negotiated. Commercial payor payments will be aligned with the goals of the Initiative with some anticipated payment structure variation across payors. In year two, to the extent possible, Medicaid and Medicare payment models will be aligned and commercial payor participation will be encouraged with expected variations across payors.



Finally, year three will bring additional payment model refinement, increased multi-payor alignment and covered populations. This concept is outlined in Table B2.4 (Three Year Scale-Up) below.

Table B2.4 Three Year Scale-Up

	Initiative Year 1 2017	Initiative Year 2 2018	Initiative Year 3 2019
PCMH Medicaid	Interim payment model implementation	Payment model alignment (to the extent possible) with custom option	Payment model refinement and growth
PCMH Medicare	Interim chronic and transitional care management payments	Custom option payment model implementation	
PCMH Commercial	Sustain current commercial payer participation	Commercial payer participation growth	
Broad APMs	Collect Michigan’s APM baseline and establish goals	Progressively increase percentage of payment in APMs	

*Please note that timelines are approximate.*

### Custom Option for Medicare Engagement

One of the main goals for the State Innovation Model (SIM) Test Initiative is to ensure the SIM Test is a multi-payor effort. While much of the engagement has been solidified concerning Medicaid participation, the implementation of the Comprehensive Primary Care Plus (CPC+) program has prompted SIM Governance to review how to engage Medicare in SIM. Following that review, the State's preference continues to be pursuing a custom PCMH demonstration option. However, if CPC+ is implemented statewide in Michigan the State will pursue the efforts needed to negotiate a custom option with Medicare that complements CPC+ and provides for the coexistence of these programs as needed.

In order to develop and implement a custom PCMH option in partnership with CMS, a series of tasks have been identified that will move the State toward completion. It is expected that the work required will take approximately 12-18 months to complete, and in order for the custom Medicare option to be successful, will need to have a large amount of collaborative engagement from physician organizations, providers and CMS.

### Practice transformation payments

Participating practices will receive a PMPM payment based on their beneficiaries attributed to SIM. This payment will come directly from the participating payers, although the State will be supporting the Medicaid Health Plan payment participation with dedicated actuarial soundness funds. All practice transformation

payments will be tied to clear and measurable milestones identified as a part of the standardized reporting structure to be developed and monitored by the PCMH Operations contractor. Successful progress toward or completion of the goal will need to be demonstrated during each reporting period. Failure to demonstrate successful implementation of the selected transformation objective may result in loss of future payments. For more information on practice transformation payments, refer to Appendix D4 (Care Delivery Artifacts). The rate in which practice transformation payments will be paid has not been confirmed, however; the current MiPCT rate is \$1.50 for Medicaid populations. The PMPM amount is currently under calculation based on the response from the Intent to Participate (ITP) process, and will be released along with the PCMH Initiative application.

Along with the practice transformation payments, practices will receive support (e.g., from vendors, MCOs, others) in deciding how to invest practice transformation payments to make best use of the funds. Possible investment areas will include HIE / HIT systems, workflow management systems, training, and hiring new support staff.

Patient-Centered Medical Homes that are already receiving practice transformation reward, and care management support payment streams through participation in the MiPCT demonstration will continue receiving these payments through the end of the demonstration project in December 2016. In January 2017, these practices will qualify to receive the new payment streams described above if they choose to participate in the PCMH model under SIM.

### **Care coordination payments**

Patient-Centered Medical Homes will also receive care coordination payments directly from the participating payers, to compensate practices for performing care coordination functions not traditionally covered under fee for service models. Care coordination fees represent category 2 payments under the CMS alternative payment model guidance: fee-for-service with link to quality. These payments would be made continuously on a PMPM basis. For the first six months that a PCMH participates in the SIM Test, care coordination payments will be paid under a “grace period” as performance measure data is collected. After this grace period, care coordination payments will be paid to practices on their ability to demonstrate successful implementation of care coordination activities based on the standard metrics and participation requirements. Additional information can be found in Appendix D4 (Care Delivery Artifacts). The PCMH operations contractor will regularly monitor participants across these metrics and participation requirements; measuring the percent of beneficiaries receiving Care Management/Care Coordination services, and timely follow up after discharge, and ensuring participating practices maintain the defined Care Management/Care Coordination staff to beneficiary ratio. Failure to meet the participation requirements and metrics for Care Management/Care Coordination may result in loss of future payments.

The magnitude of the care coordination PMPM incentive will be based on the estimated time cost to providers and practices of delivering desired care coordination activities. The rate in which Care Management/Care Coordination will be paid has not been confirmed, however; the current MiPCT rate is \$3.00 for Medicaid populations. The PMPM amount is currently under calculation based on the response

from the Intent to Participate (ITP) process, and will be released along with the PCMH Initiative application. The basic approach is to follow a two tier pricing structure based on Medicaid eligibility category as a starting point for further risk adjustment in future years. While Practice Transformation payments will be paid across both Aged, Blind and Disabled (ABAD) populations and Temporary Assistance for Needy Families (TANF) beneficiaries, the Care Coordination payments will be paid at different rates for the two, with the ABAD population getting paid at a higher rate due to being a more complicated and involved population. This model is not intended to be long term, but instead a solution until the custom Medicare option is completed and fully integrated.

## **Metrics**

Participating payors will be expected to adopt standardized measures described in more detail in Section C7 (Quality Measure Alignment). These measures are grouped in two general types of measure, quality measures and utilization measures. Both types of measures will be standardized to the greatest extent possible across payors, and are generally referred to as the Common Measures. The Data Aggregator will be the tool responsible for collecting and reporting on these Common Measures, both quality and utilization, and the specific details on how this tool will facilitate this work can be found in section C11 (Program Monitoring and Reporting) later in this document.

## **Quality Measures**

The major focus of Quality Measures is to provide feedback to users on the degree in which patients are receiving the appropriate care management and the consistency in which it's being delivered. Examples may include information on well child visits, the rate of adult preventative screenings and counseling for the treatment of alcohol and tobacco use.

Quality measures will be rolled out in a phased approach. During the first year there will be quality measures collected and reported. These measures are ones that are either currently being collected in the MiPCT program, or are supported by the HEDIS '15 measurements. The following year will see the introduction of an additional 8 Quality Measures to bring the total to 27. For detail on the definition of these 27 Quality Measures, review table C10.1 (Phase I Quality Measures) in section C10 (Health Information Technology).

## **Utilization Measures**

Utilization Measures will have a slightly different focus when considered for PCMH tracking. While the information will still be collected and reported by using the Data Aggregator, the major focus of Utilization Measures is to determine if patients are receiving appropriate care, and if that care is delivered in the appropriate setting. Ultimately, utilization measures will help contain health care cost while improving patient experiences and outcomes. To those means, four utilization measures will be leveraged during the course of SIM Test Initiative and will be implemented during year one of the Test. Details on each of the utilization measures can be found by reviewing table C10.2 (Phase I Utilization Measures) in section C10 (Health Information Technology) later in this document.

## Implementation and scale-up plan

### Standardization

We will seek to drive a high-degree of standardization in the design and implementation of Patient-Centered Medical Homes (PCMH). Standardization in PCMH design decisions can deliver meaningful value to patients, providers, and payors. This can achieve care improvements through consistent messaging, ability to maximize economies of scale when appropriate through shared infrastructure, and ability to decrease administrative burden and complexity for providers. At the same time, differences will be encouraged to enable payors to innovate and improve their ability to serve the diverse set of patient populations served by providers / payors. For example, payment methodologies will be standardized to reduce administrative burden, while Patient-Centered Medical Homes will individually select the care delivery improvements they will make to earn these payments.

### Scale-up

Given existing experience with the PCMH model in Michigan, each PCMH meeting participation requirements within SIM's five regional test locations (Jackson County; Muskegon County; Genesee County; Northern Region; and the Washtenaw and Livingston counties area) in addition to existing MiPCT practices outside SIM's regional test locations will be offered an opportunity to participate during the inaugural year.

Many providers in Michigan are already participating in existing PCMH programs such as the MiPCT demonstration, federally qualified health centers' Patient-Centered Medical Homes, and Blue Cross Blue Shield of Michigan's Physician Group Incentive Program. In 2015, there were roughly 1,500 physician providers already participating in the MiPCT demonstration and the expectation is that the majority of these physician providers will choose to participate in SIM PCMH as well.

Our PCMH models will be enrolled in annual cohorts of regions beginning in October 2016. Cohorts will be launched on an annual basis to reduce administrative complexity (e.g., related to performance measurement and incentive payments). Participation in the first cohort will be open to any existing PCMH that has achieved accreditation from one of the approved accreditation mechanisms, and falls within one of the five identified regions or was a participant in the MiPCT demonstration. We expect that many of the current MiPCT practices will choose to participate in this initial cohort, with this first cohort's reporting period beginning in October 2016, and their performance period beginning in January of 2017. Providers currently participating in MiPCT are already receiving performance reports. This overlapping period, October through December of 2016, will help to minimize potential disruption. Before October 2016, other interested practices that do not currently have care management and required reporting capabilities will be required to invest in technologies required to meet these program requirements.

Each of the subsequent years will extend the opportunity to a subset of Michigan's prosperity regions to participate in SIM PCMH, with a plan by the end of year three to have statewide adoption in Michigan.

## Integration with other care delivery models: Community Health Innovation Regions

The Patient-Centered Medical Home (PCMH) will be a core pillar of Michigan's transformed healthcare ecosystem. While the PCMH will continue to be the hub of primary care and healthcare delivery, through Clinical-Community Linkages, a PCMH will integrate with Community Health Innovation Regions (CHIRs) and their community partners. These partners include providers, physician organizations and payors as well as various community organizations. This collaboration to engage the local community and to improve health and health care delivery systems, while containing costs will be the focus for each CHIR in the state. For more information on how the CHIR model is designed, review section B2 (Community Health Innovation Regions) in this document.

## Patient-Centered Medical Home: Component Summary Table

In the following table, we define the steps as outlined to fully implement Patient-Centered Medical Homes at scale. These steps align with the sub-components outlined in section A4 (Master Timeline for SIM) of this operational plan. The activities in Table B2.6 (PCMH Component Summary Table) represent necessary activities for health care transformation across multiple health system actors including the State of Michigan (e.g., the SIM Executive Team, the SIM Leadership Team, designated SIM work groups and committees, and the Michigan Department of Health and Human Services (MDHHS)), Medicaid Managed Care Organizations, commercial payors, participating providers, and other actors.

The activity outlined in the component summary table are listed in the order they are expected to be completed along with the expected vendor support identified. This table will continually be adjusted as our budget and vendor selection process is finalized.

Table B2.6 PCMH Component Summary Table

Sub-Component	Activity	Responsible
<b>PCMH Application &amp; Onboarding</b>	Plan and Design Process	PMDO / CVI / MDHHS
	Introduction Webinar	MDHHS / CVI
	Letter of Intent	MDHHS / CVI
	Application Process	MDHHS / CVI
	Selection & Orientation	MDHHS / CVI
	Contracts and Agreements	MDHHS / CVI
	Reporting / Compliance and Monitoring	MDHHS / CVI
	Operate	MDHHS / CVI
<b>Care Coordination</b>	Define Care Coordination objectives and success criteria	MDHHS / CVI
	Define Care Coordination measures (Common Measures), including success criteria	Tech / CVI / MDHHS
	Determine Care Coordination payment schedule	PMDO / CVI / MDHHS
	Develop supporting HIE / HIT to manage Care Coordination data integration (e.g., ACR's, Common Key, ADT)	Tech / MDHHS

	Develop payment disbursement process	Tech / CVI / MDHHS
	Provide support & Training to PCMH participants to ensure successful implementation of Care Coordination efforts	Tech / CVI / MDHHS
	Define specific Care Coordination inclusion / exclusion exceptions (if any)	MDHHS
<b>Practice Transformation</b>	Define Practice Transformation objectives and success criteria	MDHHS / CVI
	Define Practice Transformation menu for practices to choose their focus	MDHHS / CVI
	Define specific Practice Transformation inclusion / exclusion exceptions (if any)	MDHHS
	Define payment rates for Practice Transformation	MDHHS
	Define process to communicate qualifying panel numbers to payers for calculation and processing of payments	MDHHS / CVI
	Define Practice Transformation payment dates, including measurement intervals	MDHHS
	Implement Practice Transformation payment model as defined	MDHHS / CVI
	Provide support & training to PCMH providers for practice transformation efforts	CVI
	Collect Practice Transformation efforts and results	CVI
	Report on efficacy of practice transformation efforts	CVI
	Share best practices for successful practice transformation efforts	CVI
	Define role of payer in providing, both one-time and on-going support for practice transformation for PCMH	MDHHS
<b>Reporting &amp; Metrics</b>	Develop approach for report generation / quality metric entry for PCMH	Tech / MDHHS
	Gather / integrate all claims and non-claims (e.g., portal) data for PCMH	Tech
	Capture, store and transmit clinical data to analytic engine for PCMH reporting and metrics(as needed)	Tech
	Develop strategy to gather non-claims data if any for PCMH reports	Tech / MDHHS
	Develop / purchase software for reporting on PCMH metrics	Tech / MDHHS
	Design PCMH report templates	Tech / MDHHS
	Gather PCMH data	Tech
	Generate PCMH reports	Tech
	Define PCMH quality metrics and practice transformation milestones	Tech / MDHHS
	Distribute provider dashboards	Tech
<b>Patient Attribution</b>	Define PCMH base patient attribution definitions	MDHHS
	Define Total Cost of Care attribution exceptions	MDHHS
	Define risk adjustment methodology	MDHHS
	Define QA production algorithms including: Total Cost of Care calculation, risk adjustment, risk stratification and patient attribution	MDHHS
	Identify refinements to algorithm for PCMH	MDHHS
	Implement algorithm refinements for PCMH	MDHHS



<b>Monitoring / Enforcement &amp; Process Improvement</b>	Develop PCMH strategy / approach for verifying and enforcing technical requirements and milestones post enrolment	Tech / CVI / MDDHS
	Address PCMH design inquiries	MDHHS / CVI
	Monitor PCMH eligibility and compliance with technical requirements and milestones	Tech / CVI / MDDHS
	Determine refinements and additions to reports and data collection methodologies for PCMH	Tech / CVI / MDDHS
	Monitor program integrity	CVI
	Engage & consult to individual PCMH's as needed	CVI
	Develop PCMH performance improvement plans and/or expel practices that do not comply with eligibility and technical requirements	Tech / CVI / MDDHS
	Re-align with payers on which elements of PCMH should be standardized: aligned in principle or different by design	Tech / CVI / MDDHS
	Revisit and / or amend contracts regularly based on monitoring and enforcement mechanism	MDHHS
<b>Provider Enablement</b>	Design provider education / engagement strategy approach, for both outbound and inbound communication for PCMH	MDHHS / CVI
	Address payor / provider inquiries / appeals related to PCMH's	MDHHS / CVI
	Develop / obtain PCMH education material, videos, curriculum, etc.	MDHHS / CVI
	Distribute PCMH education materials	MDHHS / CVI
	Collect and share best practices through Learning Health Systems	MDHHS / CVI
	Refine education / engagement strategy approach	MDHHS / CVI
	Modify PCMH education material, videos, curriculum to reflect refinement modifications	MDHHS / CVI
<b>Multi-Payor Engagement (Custom Option)</b>	Decide between CPC+, Custom Option and Hybrid approach for Medicare Engagement (Custom Option)	PMDO / MDHHS / Bailit
	Develop process for designing custom option (This Activity List)	PMDO / MDHHS / Bailit
	Hold Key Concept Meeting	PMDO / MDHHS / Bailit
	Create outline for Concept Paper (Custom Option Guidelines)	PMDO / MDHHS / Bailit
	Draft Concept Paper	Bailit
	Initiate 1115 Waiver	MDHHS / HMA
	Internal Revision of Concept Paper	MDHHS
	Update Draft Concept Paper	Bailit
	Share Concept Paper with external stakeholders	MDHHS / Bailit
	Collect and integrate feedback from external stakeholders	MDHHS / Bailit
	Submit Concept paper and 1115 Waiver to CMS	MDHHS / Bailit / HMA
	Obtain CMS Approval	MDHHS
	Payor negotiations and contracting	MDHHS



## Risks and Mitigation Strategies for Patient-Centered Medical Homes

Patient-Centered Medical Homes will play an important role in advancement of our goals towards improving population health. Our vision for health care transformation is aspirational and therefore carries risks. We believe that transparent identification of these risks will enable us to mitigate risks to the extent possible and ensure successful achievement of our transformation vision.

These risks include:

- The need to generate broad-based support and buy-in across multiple stakeholders (e.g., Medicaid health plans, commercial insurers, Medicare health plans, providers, provider organizations), many of whom have diverse priorities
- Challenges with creating incentives sufficient to drive meaningful change in provider behavior and cost avoidance
- Potential for Patient-Centered Medical Homes to not adequately focus on patient engagement
- Challenges with Patient-Centered Medical Homes and Community Health Innovation Regions not establishing efficient networks to coordinate across the continuum
- Potential for total cost of care accountability to incentivize underutilization of medically appropriate care
- Potential for care coordination payments and process-related metrics to create overutilization of services across all patients, even when not medically appropriate or necessary
- High resourcing / vendor need required to support concurrent launches of Patient-Centered Medical Homes and Community Health Innovation Regions
- Significant HIE/HIT capability building necessary to enable full achievement of Patient-Centered Medical Home goals

We propose the following corresponding strategies to mitigate impact of the risks identified above:

- We will meaningfully engage stakeholders at key points in strategy development and implementation; payors will contribute meaningfully on areas including attribution methodology, accreditation methodology, metrics, payment adjudication, etc.
- One of the guiding principles of payment model design will be to create incentives that directly influence provider behavior. Payment streams will be of sufficient magnitudes to drive changes in provider behavior
- Patient engagement will be one of the core activities of the Patient-Centered Medical Homes. There will be process metrics related to patient engagement and education to ensure Patient-Centered Medical Homes focus on this activity

- We will provide Patient-Centered Medical Homes with practice transformation payments to support practice set-up costs including establishment of required technology
- Core metrics will include quality guardrails to ensure that providers do not under-utilize medically appropriate care
- Core metrics will include process metrics to ensure that care coordination activities are performed appropriately according to patient needs
- MDHHS will perform an internal capacity assessment to determine needed staffing and capabilities to execute on SIM vision and will staff program office appropriately
- HIE/HIT design decisions to date and future decisions will reflect needs of the various care delivery models. For more information, see section C10 (Health Information Technology)

We will continue to address risks to our health transformation vision as they arise. For a more detailed look of the SIM Test core component risk and mitigation strategy, review section B3 (Risk Assessment & Mitigation Strategy) in this document.

## Alternative Payment Models

Leveraging the buying power of Medicaid through its health plans and current requirements on MHPs to implement value-based purchasing arrangements, the State will amend MHP contracts to add specific APM threshold targets in terms of the amount of populations or premiums that are required to be associated with advanced payment models (as defined by the State and consistent with LAN categories) over the term of the Contract, including that a certain percentage of APMs qualify in LAN categories 3B and 4 and require MHPs to share savings/risk with providers. The State will require that the APM include a quality standard gate prior to a provider being able to share in any savings under an APM. In addition, the amended Contract will include specific APM reporting requirements through which the MHPs will share detailed information on these APM models with the State. These reports will allow the State to assess how MHPs are doing to meet their own Contract requirements, and to provide reporting for the SIM Test.

By incentivizing the MHPs to meet these advanced payment model, the State will further a goal of SIM to transform the health care delivery system in a way that allows providers to receive financial incentives for improved quality and cost outcomes. MHPs will be required to contract with health systems and other providers that form advanced payment model arrangements. They will have the ability to develop these relationships that work best for the providers and plans. The State will provide best practice information and templates to MHPs to support plan efforts to implement these initiatives. In addition, through SIM, the State will work to encourage commercial health plans to align with Medicare and Medicaid and set their own targets for increasing APMs with an emphasis of LAN categories 3B and 4.

## Implementation and scale-up plan

Medicaid Health Plans will be required to begin reporting on number of providers with which it contracts using alternative payment methodologies and will be further required to increase that percentage in each contract year, including increasing APMs within LAN categories 3B and 4. The State will provide MHPs with guidelines and contracting templates to encourage MHP implementation of payment reform strategies that hold systems of providers accountable for care. By implementing through the MHPs, this strategy will be implemented statewide beginning in 2016 and the numbers of beneficiaries who receive care from providers paid through an APM will increase over the 3 years of the SIM.

## **Plan to be Multi-payor**

By leveraging the current Medicaid Health Plan contract which requires increased use of alternative payment methodologies and by requiring reporting using the LAN categories, Michigan is aligning its payment reform efforts with the activities ongoing in the Medicare and commercial markets. Michigan will encourage commercial plans to report their use of APMs using the LAN categories as well. Given current Michigan provider participation in MSSP and the Next Generation ACO, and current activity in the commercial market, this approach provides consistency across Medicare, Medicaid and Commercial payors. This statewide effort will allow MHPs and other commercial payors to continue to contract with accountable care organizations and organized systems of care to meet goals of increased implementation of alternative payment models in both the Medicaid and Commercial market.

## **Integration with Other Care Delivery Models**

We expect that MHPs and commercial payors will leverage PCMHs as the core of entities with which they contract using APMs. Categories 3B and 4 of the LAN build on practice transformation of PCMHs, and increase collaboration and coordination across multiple provider types across the continuum of care.

By implementing APMs leveraging existing State contracts with MHPs, the State is taking advantage of a real opportunity to transform the provider payment and delivery systems. MHPs are paid a monthly capitation, which encourages efficiency. Today however, their provider networks generally continue to receive fee-for-service payments. To drive transformative change, incentives between the MHP and contracted providers must be aligned. By encouraging and incentivizing MHPs to contract with providers using payment models that promote efficiency and high quality care, incentives will be aligned between MHPs and their provider networks. By creating shared accountability through risk-based arrangements, MHPs can better align the financial incentives of the provider community with their own financial incentives. As part of the contract amendments between the State and the MHPs, MDHHS Managed Care leadership will delineate expectations regarding MHPs' roles in implementation of these payment models.

## **APM Component Summary Table**

The following table defines the steps that will be taken to implement alternative payment methodologies. These steps align with the steps outlined in the master timeline in Section A4 of this operational plan. The

activities in this component summary table represent necessary activities for health care transformation across multiple health system actors including the State of Michigan (e.g., the SIM Executive Team, the SIM Leadership Team, designated SIM component projects and related committees, and the MDHHS, including the Medicaid department), MHPs, commercial payors, participating providers, and other actors.

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

Table B2.7 APM Component Summary Table

Sub-Component	Activity	Responsible
Payment Reform	Develop requirements for MHPs to increase payment reform, encouraging increased use of payment models that focus on sharing in accountability through costs and quality	
	Define standard quality measures to be recommended for use to measure provider performance	
	Develop standard templates for agreements between MHPs and accountable provide systems, based on best practices	
	Develop reports, following LAN definitions, on MHP activity towards payment reform.	
	Execute contract amendments with MHPs that focus on increased payment reform.	
	Collect reports from MHPs on progress towards implementing APMs	

## B3 – Risk Assessment and Mitigation Summary

The intent of the following section is to provide background on our risk assessment and management plan while also providing a program risk register, high-level risk analysis, and the potential risk responses. See section C1 (SIM Governance, Management Structure and Decision-making Authority) for more details on the risk management responsibilities of the PMDO.

### Risk Management Plan and Approach:

The risk management methodology addresses both internal and external project risks associated with the SIM initiative. The risk management approach and the risk register will be regularly reviewed throughout the project to identify, document and monitor risks and mitigation strategies.

The program manager is responsible for facilitating sessions with initiative stakeholders and integrators to identify risks. A risk manager role is assigned to each risk, with the responsibility of developing, documenting and, potentially, executing risk response plans. The component project manager is responsible for monitoring the status of all project risks and escalating as appropriate to the program governance team.

### Risk Response Plan

The risk action plan includes the agreed-upon specific actions that will be taken to implement the chosen response strategy, budget and times for responses, contingency or fallback plans, and the level of residual risk expected to remain after the strategy is implemented.

A decision must be made at the time of a risk triggering event to determine the appropriate response. The decision will be on a case-by-case basis, based on the nature and timing of the event.

Table B3.1 SIM Risk Response Plan

<b>Risk</b>	Difficulties/delays related to contracting and procurement processes				
<b>Risk Response Detail</b>	A contract manager is being acquired to manage contracts. Standard processes and procedure are being developed to ease future contracting burden.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Resources	Program	High	High	Mitigation	Budget and Contracting Lead

<b>Risk</b>	High resourcing / vendor need required to support concurrent launches of Patient- Centered Medical Homes and Community Health Innovation Regions				
<b>Risk Response Detail</b>	MDHHS will perform an internal capacity assessment to determine needed staffing and capabilities to execute on SIM vision and will staff program office appropriately.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Resources	Program	High	Med	Mitigation	Program Managers & MDHHS Lead
<b>Risk</b>	Information Technology – unable to get SIM supporting technology infrastructure in place within SIM timeframe				
<b>Risk Response Detail</b>	The PMDO has established Project Management resources and Governance responsible for all technical requirements to help identify and handle SIM component dependencies and requirements.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Technical	Program	Med	Med	Mitigation	SIM Technical Lead
<b>Risk</b>	Sustaining the engagement of key stakeholders: <ul style="list-style-type: none"> <li>• Risk of “burn out” among SIM stakeholders attending multiple meetings/calls</li> <li>• Multiple ongoing health care related initiatives in the state may lead to “reform fatigue” and result in disengagement</li> </ul>				
<b>Risk Response Detail</b>	The PMDO holds Stakeholder engagement at a high priority. It is vital to engage stakeholders early in the process and allow the dialogue to continue through implementation for each year. Refer to Section C2 for an explanation of our Stakeholder Engagement approach.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Resources	Program	High	High	Mitigation	SIM Program Managers & MDHHS Leads
<b>Risk</b>	Schedule – Availability of resources, frequency and length of meetings risks fatigue and burn out for implementation teams.				
<b>Risk Response Detail</b>	The PMDO maintains an integrated master schedule and a process to update as new details become available. Resource leveling and other techniques will be employed to ensure the program has the resources and other assets in place to meet the implementation and operational goals. Status of the Schedule is also reported weekly for each SIM component. Schedule Risks and issues are escalated per the governance model and handled expeditiously.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Schedule	Program	Med	Med	Mitigation	Program Manager
<b>Risk</b>	State Staffing - Loss of key personnel - within SIM Office, governance structure, and other organizations				

<b>Risk Response Detail</b>	SIM is a very complex initiative that requires support from the State to acquire resources. In addition to PMDO support, Affiliate positions have been created to support SIM component responsibilities from the State of Michigan.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Resources	Program	High	High	Mitigation	MDHHS Leadership
<b>Risk</b>	Potential for Patient-Centered Medical Homes will inadequately focus on patient engagement.				
<b>Risk Response Detail</b>	Patient engagement will be one of the core activities of the Patient-Centered Medical Home. There will be process metrics related to patient engagement and education to monitor Patient-Centered Medical Homes in this area.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Quality	Care Delivery	Med	Low	Mitigation	Care Delivery Lead
<b>Risk</b>	Potential for care coordination payments and process-related metrics to create overutilization of services across all patients, even when not medically appropriate or necessary.				
<b>Risk Response Detail</b>	Core metrics will include process metrics to ensure that care coordination activities are performed appropriately according to patient needs. Payment models will be updated and enhanced to address utilization issues.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Financial	Payment Reform	Med	Med	Mitigation	Care Delivery Lead
<b>Risk</b>	Inability of the convening entity of a CHIR to garner sufficient commitment from critical entities within the region				
<b>Risk Response Detail</b>	Approval of the Community Health Innovation Region application is contingent upon key stakeholder participation in the governance of the Community Health Innovation Region, including representation from individuals from disadvantaged populations. To assure that the backbone organization garners sufficient commitment and engagement from a broad array of cross sector partners, the Operational Plan will require a detailed plan for partner engagement. Technical assistance support through coaches and peer-to-peer learning will assure that best practices are incorporated as Model Test participants continually improve their ability to engage partners. In addition, we will mandate a list of entities to be included as a part of CHIRs and hence make CHIR application approval contingent on local stakeholder support.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Resources	Population Health	Med	Med	Mitigation	Population Health Lead
<b>Risk</b>	Inability to measure CHIR impact on cost and quality in the SIM Test period.				
<b>Risk Response Detail</b>	A highly effective formative evaluation team will be contracted to assure that the metrics and the measurement systems are optimized. Working with the SIM Governance and Model Test participants, core measures will be developed and reported through dashboards across all				



	CHIR test participants. CHIR backbone staff are accountable to collect, analyze, and report on these core measures, as well as additional metrics (mostly process measures) that have been identified for tracking progress at the regional level.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Financial, Performance	Population Health	Med	Med	Mitigation	Performance Measurement and Evaluation Lead
<b>Risk</b>	Absence of sustainable funding sources for CHIRs.				
<b>Risk Response Detail</b>	To assure that all CHIRs transition to sustainable funding for community resourcing during the Model Test, each CHIR will be required to propose a sustainable funding model within their Operational Plan.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Financial	Population Health	High	Med	Mitigation	MDHHS Leadership, Population Health Lead
<b>Risk</b>	Low participation in PMCHs				
<b>Risk Response Detail</b>	An intent to participate process, broad PCP and PCMH engagement and concise Application and Onboarding process have been developed and can be augmented to bring additional practices on line, as needed to meet participation goals.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Performance	Care Delivery	High	Low	Mitigation	Care Delivery Lead
<b>Risk</b>	Provider Fatigue				
<b>Risk Response Detail</b>	The variety of programs, initiatives and incentives for providers, in Michigan, culminate in a potential risk that providers will become fatigued by the coordination and other activities required to meet SIM participation requirements. The plan design will be to allow providers to continue normal operations with incremental change paced such that fatigue will be minimized.				
<b>Risk Type</b>	<b>Affected SIM Components</b>	<b>Impact</b>	<b>Probability of Issue</b>	<b>Risk Handling Type</b>	<b>Risk Manager</b>
Functional	Care Delivery	High	Low	Mitigation	Care Delivery Lead

The table below lists and describes the standard risk types that are used to categorize project risks.

Table B3.2 Risk Types

<b>Risk Type</b>	<b>Risk Type Description</b>
<b>External</b>	Any risk related to environmental factors largely outside the control of the project (such as cultural, legal or regulatory).
<b>Financial</b>	Any risk related to the budget or cost structure of the project (such as increase or decrease in the project-related budget).
<b>Functional</b>	Any risk related to the overall function of the product (such as requirements or design) being developed by the project.
<b>Quality</b>	Any risk related to the quality requirements of the project.
<b>Organization</b>	Any risk related to internal, client, organizational or business changes (such as executive leadership role changes).
<b>Performance</b>	Any risk associated with the performance of the application (such as response time, stress testing and development environments).
<b>Project management</b>	Any risk related to the management of the project (such as communications, status reporting and issues management).
<b>Resource</b>	Any risk related to project resources (such as the addition or removal of resources).
<b>Schedule</b>	Any risk related to the Project Work Plan and related tasks (such as extensions or reductions of the project timeline).
<b>Scope</b>	Any risk related to project scope (such as process, module and development objects).
<b>Technical</b>	Any risk related to software or hardware, including infrastructure related to the project.
<b>General</b>	Any risk that cannot be categorized into one of the above categories.

Table B3.3 Severity Ratings

<b>Severity Rating</b>	<b>Assessment of Severity/Risk Rating Description</b>	<b>Rank</b>
<b>High</b>	Significant impact on project baselines	3
<b>Medium</b>	Controllable impact on cost, schedule and performance	2
<b>Low</b>	Minor impact on cost, schedule and performance	1

## C. General SIM Operational and Policy Areas

---

### C1 – SIM Governance, Management Structure and Decision-making Authority

#### Governor's Office Engagement

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

#### Governance and Management Structure

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

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

## High-Level Organization Chart

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

Figure C1.1 Michigan SIM Organizational Chart

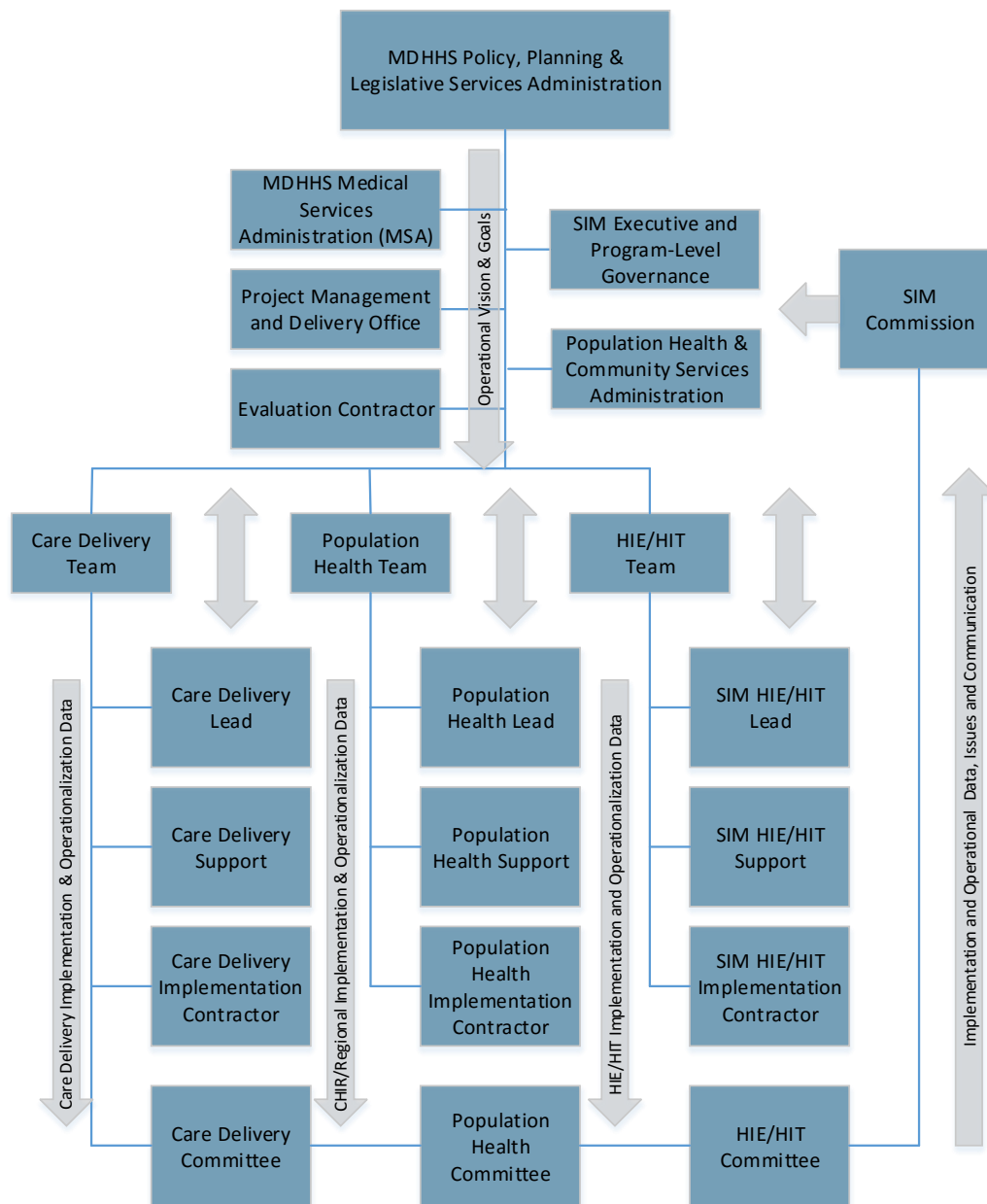


Table C1.1 SIM component Key Staff Directory

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

## Michigan's SIM Test Governance and Operational Framework

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

## SIM Executive Stakeholders

The SIM initiative has the full support of, and direct oversight by, a broad representation of State executives across agencies and branches. The SIM Executive Stakeholders are an identified group of State officials with the authority and influence to drive policy, legislation and internal support for the SIM components' planning, implementation and operationalization activities. Coordinating other State departments, outside the Department of Health and Human Services, is a key lever in ensuring innovation is executed, recognized and disseminated across agency and statewide. The Executive Stakeholder body receives detailed quarterly reports and is provided additional information as needed or requested.

Table C1.2 SIM Executive Stakeholders

SIM Executive Stakeholders	
Name	Title
Nick Lyon	Director, Dept. of Health & Human Services (MDHHS)
Tim Becker	Sr. Chief Deputy Director, MDHHS
Kurt Krause	Director, MDHHS Legal Affairs Administration
Chris Priest	Director, MDHHS Medical Services Administration
Elizabeth Hertel	Director, MDHHS Policy, Planning & Legislative Services

<b>Geralyn Lasher</b>	Director, MDHHS External Affairs & Communication Administration
<b>Linda Zeller</b>	Director, MDHHS Behavior Health & Developmental Disabilities Administration
<b>Terry Beurer</b>	Director, MDHHS Field Operations Administration
<b>Linda Pung</b>	General Manager for MDHHS, Michigan Department of Technology, Management & Budget (MDTMB)
<b>Sue Moran</b>	Director, MDHSS Population Health & Community Services Administration
<b>Chris Harkins</b>	Director, Office of Health and Human Services at State Budget Office
<b>Jamie Zaniewski</b>	Advisor, Office of the Governor
<b>Joshua Traylor</b>	Michigan CMS/CMMI Liaison

## SIM Executive Governance Team (Vision)

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

Table C1.3 SIM Executive Governance Team Roster

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

## SIM Program Governance Team (Strategy)

The SIM Program Team established the SIM strategic plan which defines the programs goals, objectives, detailed components' scope, implementation plans, metrics and performance measurements. The strategic plan and operational framework is the foundational basis of SIM in Michigan and serves as the framework for implementation-level planning, execution and operationalization. The SIM Program Team is ultimately

accountable for the successful execution of the program and maintaining alignment with the State and MDHHS’ executive vision. Members provide direct program oversight and have final approval for all matters pertaining to the SIM program including resources, budget, and scope. The body convenes monthly, receives monthly program and weekly component status reports and additional information as requested. To ensure continued alignment of the SIM objectives throughout implementation, the SIM Program Governance Team directs, and may hold, key SIM Program Management and Delivery Office positions.

Table C1.4 SIM Program Governance Team Roster

<b>SIM Program Governance Team Roster</b>	
<b>Name</b>	<b>Title</b>
<b>Elizabeth Hertel</b>	Director, MDHHS Policy, Planning & Legislative Services
<b>Tom Curtis</b>	MDHHS SIM Business Owner
<b>Phillip Bergquist</b>	MDHHS SIM Care Delivery Business Owner
<b>Meghan Vanderstelt</b>	MDHHS SIM HIT/HIE Business Owner
<b>Kim Hamilton</b>	Director, MDHHS Managed Care Division
<b>Linda Scarpetta</b>	Director, Division of Chronic Disease and Injury Control

## **SIM Program Management and Delivery Office**

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

## **SIM Intra-and Inter-Departmental Collaboration**

The SIM initiative is ensuring visibility by convening, and keeping regularly informed, a broad group of State stakeholders and potentially impacted functional area leaders. This engagement activity includes the Subject Matter Expert (SME) Management Team meetings, MDHHS Project Management Office’s Business Integration Center (BIC) and focused SIM Component Project Planning, Implementation, Operational Teams and Work Groups.



## Public/Private SIM Commission

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

The SIM Commission will include senior-level state planners from MDHHS, the Governor's office, key contractors, and executive leaders from participants in the Model Test as well as non-participants whose engagement, support and influence will be important for expanding the model component and concepts in the state (i.e., scaling up). The group is likely to comprise approximately 20 people, and will meet bi-monthly. In addition to the primary commission, committees will be established around the core SIM components outlined in sections B1 (Narrative Summary of Component/Project) and B2 (Detailed SIM Component Narrative and Summary Tables) of this plan. The committees planned include;

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

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

## MDHHS Subject Matter Expert Management Team

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

## Michigan Department of Health and Human Services Business Integration Center

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

## Component Project Teams and Supporting Workgroups

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

## SIM Program Management & Delivery Office

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

## PMDO Staffing, Roles & Responsibilities

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

Table C1.5 PMDO Roles and Responsibilities

Role	Responsibility
Program Director	The SIM Program Director is responsible for direct oversight, decision-making and ensuring the overall success of SIM. Responsibility for the successful alignment of other agency efforts, as appropriate; to ensure that work is coordinated and synchronized and SIM goals are met.
Business Owner	The SIM Business Owner is responsible for monitoring the day-to-day work of the SIM initiative ensuring program vision and direction from the SIM Program Director and State leadership and governance bodies are fully realized. Responsibility for ensuring the program meets MDHHS SIM goals and supports related statewide objectives.

Program Implementation Manager	The SIM Program Implementation Manager has overarching responsibility and accountability for the SIM program requirements, solution design and implementation while directing SIM planning and design and advising portfolio project managers and teams on best practice approaches. Ensures the design, implementation operationalization align with overall near and long-term SIM goals and objectives. Works closely with the Program Operations Manager to coordinate work, report status and mitigate risks and issues during the lifetime of the SIM Model Test.
Program Operations Manager	The SIM Program Operations Manager has overarching responsibility and accountability for the SIM initiatives activities. The SIM Program Operations Manager ensures that processes are established and enforced, gathers and communicates project status to clients and management, working closely, and in alignment, with the SIM Project Director and Business Owner and Implementation Manager..
Sr. Project Manager(s)	The Project Managers have overarching responsibility for their assigned SIM projects. All Project Managers work directly with the PMDO Managers, Project/Track Lead and impacted Business Owners. The PMDO Manager defines, schedules, controls, and adjusts all tasks and workloads of the projects.
Sr. Business Analyst(s)	The Business Analyst facilitates business process improvement via the methodical investigation, analysis, review and documentation of functional business specifications. This resource supervises and mentors the business analysis team by directing the requirements development process through the elicitation, analysis, specification and verification of multiple levels of requirements from an end-to-end perspective and supports the ongoing management of the requirements.
Program Coordinator	The Coordinator will be responsible for scheduling and facilitating business, program and project teams meetings and minutes and other follow-up activities. The project coordinator will work closely with the Business Owner and Program Managers to ensure the communication and other processes are meeting expectations and goals.

## Affiliate Staffing, Roles & Responsibilities

SIM program leadership has identified roles that require skill sets that may not be readily available within The State. These roles will be filled by leveraging the existing State of Michigan Master Contract to bring on MPHI Affiliate resources. The roles and responsibilities of program Affiliates are listed in Table C1.6 (SIM Program Affiliate Roles and Responsibilities). All Affiliates will report directly to and be managed by State of Michigan leadership and serve, primarily, as Track Leads to drive project implementation efforts as well as fill roles in analytics and program assistance.

Table C1.6 SIM Program Affiliate Roles and Responsibilities

<b>Role</b>	<b>Responsibilities</b>
<b>SIM Analytics and Evaluation Coordinator</b>	The SIM Analytics and Evaluation Coordinator supports the State Innovation Model team as a whole using analytics, evaluation design and research to explore the impact of SIM's strategies and interventions, lead project monitoring, evaluation and learning analytics activities for the program. The role requires analysis and research to be applied to determine policy impacts and make suggestions to leadership. The role will function under the direction of the MDHHS SIM Program Lead and oversee the development, implementation, and improvement of the SIM Collaborative Learning Network (CLN) processes, evaluating complex public health program, projects, and activities.
<b>SIM CHIR/CLN Project Assistant</b>	The SIM Project Assistant will directly support the SIM Community Health Innovation Region (CHIR) and Collaborative Learning Network (CLN) program managers by providing administrative support, team coordination, and entry-level business analysis. In this role, the Project Assistant must be proficient in carrying out a range of professional research and analysis while learning more refined methods of the work and expectations of the State of Michigan. The role includes administrative responsibilities including participation in meetings, note taking, meeting scheduling and facilitation and following up on CHIR and CLN Action Items as directed by the program leadership.
<b>SIM Technology Integration Coordinator</b>	The SIM Technology Integration Coordinator will support the State Innovation Model team as a subject matter expert in the Health Information Technology and Health Information Exchange policy areas. The Technology Integrator Coordinator will serve as the Health Information Analyst performing a full range of research and analysis related to the Department's health information exchange and information technology projects and initiatives. Specifically, this position will be recognized as the recognized resource evaluating data sharing policy considerations related to care coordination, consumer engagement, public health messaging, and health information exchange development.
<b>SIM PCMH Coordinator</b>	The PCMH Coordinator will oversee execution of the Michigan State Innovation Model (SIM) Patient-Centered Medical Home (PCMH) Initiative implementation plan, with special attention paid to multi-payer integration and multi-stakeholder engagement. The PCMH Initiative Coordinator will be responsible for facilitating partnerships between clinical practices, medical associations, physician organizations, and health systems at the State and local levels to build PCMH maturity and efficacy in Michigan. The PCMH Initiative coordinator will functionally lead development and operationalization of SIM PCMH strategies, particularly as it relates to planning, implementing, monitoring, and sustaining the PCMH stream of work.
<b>Contract and Grant Management Coordinator</b>	The Budget, Grants, and Contracts Coordinator will be responsible for coordinating the development, execution, and management of grant programs and contracts including the development and management of budgets related to grant programs and executed contracts. The Coordinator will work closely with MPHI financial management staff, MDHHS grants and contracts staff, SIM project management staff, and

	SIM leadership and governance to develop, execute, and monitor grant programs and contracts related to overall SIM implementation. The Coordinator will function as a subject matter expert including the delivery of clear and useful analyses, recommendations, and reports.
<b>Population Health Integration Coordinator</b>	Under the direction of the MDHHS Division of Chronic Disease and Injury Control Director, oversees cross-program projects and workgroups, and coordinates Division programs with the State Innovation Model (SIM) Blueprint for Health and other complex statewide healthcare and community services transformation initiatives to support achievement of population health goals. Participates in the development of the SIM Population Health Plan. Responsible for forging linkages at the local and state levels, identifying opportunities and facilitating integration of evidence-based chronic disease and injury/violence strategies with other programs and agencies, both within and outside of state government.
<b>Epidemiologist</b>	The epidemiologist affiliate will be responsible for coordinating the development and reporting of population health data, including and especially relative to population health improvement monitoring and population health improvement planning. The epidemiologist affiliate will be responsible for supporting the development of the State Population Health Improvement Plan.
<b>Program Assistant</b>	The associate will be responsible for coordinating the calendars of lead State of Michigan SIM staff: the Lead Specialist, Technology Specialist, Technology Lead, and other Payment/Care Delivery Specialists or Leads directed the State of Michigan SIM strategy and activities. The associate will also be responsible for developing, coordinating, and managing project communications, including website updates, listserv messages, and project-related emails or letters. The associate may also be asked to take notes, disseminate minutes, manage documents and track action items for meetings related to the associate's responsibilities.

## SIM Program Management and Delivery Office Scope

### Governance

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

### Stakeholder Engagement

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

## **Scope Management**

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

## **Communication Management**

Develop and implement appropriate methods of project and program-level information collection, screening, formatting, and distribution that is fully aligned with the governance, scope management, stakeholder engagement and other program components. Monitor the flow of information ensuring that the critical links are established and the regular exchange among program sponsors, stakeholders and project teams, of ideas, and information occurs.

## **Issue & Risk Management**

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

## **Quality Control**

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

## **Schedule Management**

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

## **Grant Management**

Provide grant-related budgetary, scheduling, compliance and other administrative support required during the execution of the Centers for Medicare and Medicaid Services (CMS)/ Center for Medicare and Medicaid Innovation (CMMI)SIM grant. Facilitate the integration of fiduciary processes and requirements with implementation and operational plans and funding models.



## **Contract Management**

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

## **Program Document & Deliverable Management**

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

## **Component Planning, Integrated Implementation and Operational Management**

The formal SIM Governance and PMDO structures and functions, outlined in this section, serve as the overall oversight and support base for the SIM Test component implementations in Michigan. Each SIM Test component has varying integration, implementation and operational goals but operate under a common structure and standards set. This coordination enables the collective goals of the SIM Test in Michigan to be achieved.

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

- Primary Components:
  - Population Health
    - Community Health Innovation Regions (CHIR)
    - Collaborative Learning Network (CLN)
    - Accountable Systems of Care (ASC)
  - Care Delivery
    - Patient-Centered Medical Home (PCMH)
    - Alternative Payment Methods (Value-Based Payments, Payment Reform)
- Secondary Components:
  - SIM Program Governance
    - Project & Program Management
    - Stakeholder Engagement
  - Technology & Related Infrastructure



## Primary Model Component Governance and Management

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

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

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

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

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

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

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

## **Additional State Agencies Engaged in SIM Governance and Management Processes**

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

- **Medical Services Administration**

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

- **Population Health & Community Service Administration**

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

- **Behavioral Health and Developmental Disabilities Administration**

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

- **Agency for Aging and Adult Services**

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

- **Legal Affairs**

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

- **Michigan Department of Licensing and Regulatory Affairs**

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

- **Department of Insurance and Financial Services**

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

- **MDHHS Office of the Inspector General**

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

## **Mechanisms to coordinate private and public efforts**

The primary mechanisms for coordinating with private and public efforts are the SIM Commission and committees, along with other stakeholder engagement efforts detailed in Section C2 (Stakeholder Engagement) of this operations plan. The program and component governance and SIM commission interaction is designed to facilitate engagement with additional payors, private and public stakeholders (both Model Test participant and non-participants), including, but not limited to, sharing information, recommendations, consultation, advice and receiving consensus and vetted feedback to incorporate into the decisions and planning, design, implementation and operational phases per component scope I as document in section B2 (Component Summary Tables) and the timelines included in Section A4 (Master Timeline).

## **Integration or alignment with legislative and executive authority**

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

- Applying current regulatory authority and requirements in the Medicaid Health Plan contract to provide Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan
- Considering adaptations to existing regulatory authority, as needed, to meet SIM Test goals.
- Assessing and communicating the need to changes to state laws and policy to support health care transformation related to SIM

- Collaborating with all applicable and required federal partners; the Center for Medicare and Medicare Innovation programs, State Plan Amendment and waivers as needed, Medicare participation in payment initiatives, collaborations with the Centers for Disease Control and Prevention and Health Resources and Services Administration

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

Please see sub-section 2 of C2, (Program Governance and Management Structure) for a list of key roles and responsibilities of the Program Management and Delivery Office. Additional contractors currently engaged with MDHHS in support of component planning, design and implementation are listed in the table C1.7.

Table C1.7 SIM Planning and Support Contractors.

Role	Responsibility
Bailit Health Purchasing	<ol style="list-style-type: none"> <li>1. Review, revise, and collaborate with the MDHHS Medical Services Administration toward finalization of policies and documentation related to program development;</li> <li>2. Consistent with the overall Medicaid Managed Care RFP approach, assist in the development and finalization of the SIM payment model requirements and documentation;</li> <li>3. Provide feedback to the MDHHS Medical Services Administration related to proposed accountable system of care payment arrangements, to include feedback on payment model methodologies, accountable care delivery system requirements, community organization requirements, data collection and reporting requirements, and governance requirements for: Shared Savings, Episode-based Payment, Global Capitation;</li> <li>4. Provide strategic advice to the MDHHS Medical Services Administration related to implementation of accountable systems of care and communication to Medicaid health plans.</li> </ol>
Institute for Healthcare Improvement (IHI)	<p>The project will begin with strategic collaboration with the Michigan SIM team to develop a plan that will be implemented during the first two years of implementation. MDHHS, existing quality improvement coaches in Michigan, and stakeholders within ASCs and CHIRs will be engaged as IHI prepares a two year plan that includes:</p> <ol style="list-style-type: none"> <li>1. Creation of ASC and CHIR Teams</li> <li>2. Individualized coaching relationships by which an IHI improvement advisor works with ASC and CHIR teams and stakeholders</li> <li>3. Learning sessions for year 1 and year 2 regional participants and state-level stakeholders</li> <li>4. Online virtual programming, tools, and technical assistance resources</li> <li>5. Guided tests of change</li> <li>6. Regular cross-sector affinity groups</li> <li>7. Peer mentoring</li> <li>8. Leadership Academy</li> <li>9. Train-the-trainer</li> </ol>

Michigan Public Health Institute	<ol style="list-style-type: none"> <li>1. Program Monitoring and Evaluation</li> <li>2. Population Health Planning</li> </ol>
Public Sector Consultants (PSC)	<p>PSC will be on contract to engage stakeholders to ensure that:</p> <ol style="list-style-type: none"> <li>1. All relevant parties are aware of and familiar with the MDHHS's SIM Strategic and Operational vision</li> <li>2. Those most critical to its success are fully engaged and providing productive input to implement the MDHHS's SIM Strategic and Operational vision, and</li> <li>3. The plan for engaging stakeholders is comprehensive and cohesive.</li> </ol>
Segal and Company	<ol style="list-style-type: none"> <li>1. Program design and implementation consultation on Patient-Centered Medical Home, accountable systems of care, community health innovation regions, and payment arrangements—particularly as they relate to SIM investment strategies for proving the business case for sustainability and multi-payer alignment.</li> <li>2. Provide Subject Matter Expert feedback on program requirements, implementation management, and strategically establishing requirements and targeting investments for greatest impact.</li> <li>3. Serve as the primary advisor regarding commercial and employer engagement strategies.</li> </ol>

## Recruitment and Training of Staff and Contractors

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

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

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

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

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

1. Defining a holistic SIM Test overview for both new staff and contractors brought in to support the effort and MDHHS employees whom are not directly impacted by SIM, but for whom general awareness of the effort will be highly beneficial.
2. Providing deep content domain-specific training for new team members. The training will be developed on an ongoing basis in recognition of the constant and significant evolution of the best content for the training. Training will be delivered in the most convenient format for users, whether that is written materials, shared electronic documents, webinars or other media.

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

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

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

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

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



## C2 – Stakeholder Engagement

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

The stakeholder engagement components of the SIM Test in Michigan will unfold through the duration of the grant period. This section provides an overview of the work to be completed by the State (a) with input through statewide meetings, an online survey, and regional meetings, and (b) through committees during the Operation, Evaluation, and Improvement stage. The work to be completed is intended to aid the implementation of the Model Test and ensure stakeholders are well-informed of the model components. As the Model Test evolves work will be done to create a new process for stakeholder engagement that will consist of activities including a hierarchical committee structure integrated into the overall governance and operating model of the initiative.

The MDHHS has contracted with Public Sector Consultants to support and facilitate the stakeholder engagement efforts outlined below.

### Pre-Implementation and Design (January 2016 – June 2016)

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

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

The design decisions and other recommendations coming out of the initial planning process were translated into shareable documents that could be widely disseminated. This information fed into a process during which interested stakeholders were invited, to varying degrees depending on their likely level of involvement in the Model Test, to offer feedback and input on the preliminary design decisions and next steps.

The State prepared for public roll out of design decisions and plans for the Model Test by hosting a meeting of key external stakeholders whose input and buy-in is critical to SIM’s ultimate success. Participants included representatives of providers (physicians, health systems, FQHCs), health improvement organizations, payers (public and commercial), local public health, and consumers. This key leadership summit was designed to



prepare for statewide webinars with a wider audience. The SIM program staff identified the information to share with external stakeholders, and used the summit to identify ideas and plans that would need clarification before sharing the information with additional external stakeholders. Following the summit, the SIM program staff and MDHHS leadership made additional decisions regarding the SIM components and how implementation may be altered depending on feedback and input from initial stakeholders. Implementation plans were then shared through three statewide webinars.

## **Introductory Statewide Webinars (April/May 2016)**

To kick-off its stakeholder engagement efforts, the State held a series of three webinars in April and May 2016 to provide an overview of the SIM Model Test and implementation decisions made by the State about model components and to allow stakeholders to ask questions about the Model Test. These webinars served to provide high-level, yet detailed information about the Model Test so that interested stakeholders could provide thoughtful input. The webinars included an Overview of the SIM Program, a presentation of Care Delivery (PCMH, ASC and Payment Reform) concepts and approach, and a presentation of Population Health (CHIR and CLN) activities and goals. Between 200 and 300 people representing a broad swath of Michigan SIM stakeholders registered for each webinar. Interest in the SIM Model Test is high, and stakeholders are eager to be engaged.

## **Statewide Stakeholder Survey (April/May 2016)**

Following the webinars, the State fielded an online survey of SIM stakeholders to obtain feedback and input on the SIM Model Components. The survey was designed to solicit public feedback on the Operational Plan as it was communicated (in short-form) through the webinars and posted on the SIM web page. Comments and questions gathered from public feedback were addressed and incorporated into this final version where feasible. SIM staff will use all of the input obtained to inform future communication with stakeholders about the Model Test and to consider alternative strategies when appropriate.

## **Regional Meetings with Model Test Participants (June – August 2016)**

The State intends to meet with Model Test participants in the regions where the CHIRs are to be implemented to discuss in greater depth the plans for implementing the model components, including performance measures, patient attribution models, PCMH accreditation requirements, CHIR functions, and HIT/HIE needs and requirements. Note that payment models and HIT/HIE elements and design decisions will be discussed as part of each of these meetings rather than in separate meetings.

At these meetings, the State will share the input it received through the online stakeholder survey and how it has addressed questions and concerns raised by Model Test participants. The state will seek additional input and, to the extent possible, agreement from these regional stakeholders on how to operationalize the model components.

## Statewide Summit to Share Final Decisions and Program Parameters (August – September 2016)

Following the meetings with targeted groups of stakeholders, the State will hold a summit to share final plans for implementing and launching the Model Test components. The summit will be used as the kick-off for the launch and implementation of the Model Test. At the summit, participants will learn more about the regions in which the ASC and CHIR models will be tested and details regarding the participating entities, patient attribution methodologies, performance measurement and tracking, and how HIT/HIE will be used to support the Model Test. Summit participants will also learn about opportunities for future stakeholder engagement, including the SIM committee structure. Summit participants will represent those organizations and providers that will have a key role in the success of the initiative. Most will be direct SIM participants (e.g., CHIR backbone organizations and partners, ASCs, healthcare providers, and payers in the regions where the model will be initially tested). Some will be representatives of state associations (e.g., Michigan State Medical Society, Michigan Health and Hospital Association, Michigan Primary Care Association, and the Michigan Association of Health Plans).

## Operate, Evaluate, and Improve

Beginning in the fall of 2016 the program will build towards a structure for continuous engagement of stakeholders both in, and outside of, the Model Test. The State will establish a high-level working group called the SIM Commission and a set of committees that will provide ongoing input into the operation of the PCMHs, ASCs, and CHIRs, as well as HIT/HIE needs and payment models. The SIM Commission and potential committees are described below. Final decisions on committee design and charges will be established as the areas for ongoing input and feedback become clearer.

The state will develop charters for the commission and each committee will be developed as an Implementation/Launch activity, at which time members will recruit committee members. Charters will include the committee's charge, primary questions for deliberation, and the process for arriving at consensus recommendations, how communication with other committees will be handled, and an initial schedule of meetings.

In general, committee members will be expected to communicate about the SIM initiative and what is being learned during implementation with others within their organizations and/or with stakeholders they represent. They will also be expected to use feedback and guidance from those conversations to help the state identify areas of agreement and buy-in on planned strategies and approaches from participating and non-participating stakeholders.

## SIM Commission

The SIM Commission will track progress of the initiative and advise the State leadership during the implementation of the components. The commission will offer guidance on overarching Model Test

decisions. It will also review consensus recommendations made by committees and, where differences exist, make recommendations to department leadership on how to resolve them.

The SIM Commission will include senior-level state planners from MDHHS, the Governor's office, key contractors, and executive leaders from participants in the Model Test as well as non-participants whose engagement and buy-in will be important for expanding the model(s) in the State. For example, representatives of state trade associations and commercial payers that have not yet agreed to participate. The group is likely to comprise about 20 people, and will meet quarterly.

## Care Delivery Committee

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

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

## Population Health Committee

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

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

process designed to ensure a diverse range of stakeholder representatives. The committee will meet bi-monthly.

## **HIT/HIE Committee**

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

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

## **Additional Stakeholder Communication Channels**

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

- The State of Michigan website can be found [here](#) or at: [http://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_64491---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491---,00.html)
- To get more information about registering for the SIM LISTSERV interested parties should send an email to: [SIM@mail.mihealth.org](mailto:SIM@mail.mihealth.org)

In addition, the SIM team is compiling a list of all Model Test participants and their contact information to ensure that relevant information can be shared with these stakeholders on a timely basis.

## **Semi-Annual Statewide Webinars**

Stakeholder interest in the SIM model test is high as evidenced by strong participation in the recent SIM webinars hosted by MDHHS. As the committees get underway and the state begins to learn from initial implementation of SIM activities, it will be important to maintain open lines of communication with participating and non-participating entities alike. The state intends to host webinars on a semi-annual basis to

share updates and progress related to the Model Test with a wide array of interested stakeholders. This will allow the state to keep non-participants informed in anticipation of spreading the initiative to additional regions, and also to answer questions about progress being made and next steps.

## Annual Statewide Stakeholder Surveys

The state also intends to conduct annual surveys of stakeholders when the Michigan SIM Operational Plan is drafted. This will allow stakeholders to learn of the state's plans for each coming year and to respond to and provide their own input into the plan. This approach worked well for the plan submitted in May 2016, as the SIM Team was able to identify areas that needed improvement and/or clarification and make adjustments to the plan prior to submission. This process has also set the team up well to engage in closer conversations with participating stakeholders about changes that may be needed to the plan in the future.

## Collaborative Learning Networks

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

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

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

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

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

## Stakeholders

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

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

### Participating Medicaid Health Plans

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

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

### Participating Accountable Systems of Care

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

- Jackson Health Network
- Affina Health Network
- Genesys Physician Hospital Organization
- Professional Medical Corporation

- McLaren Physician Partners
- University of Michigan Health System
- Northern Michigan Health Network
- Integrated Healthcare Associates
- Wexford/Crawford Physician Hospital Organization

### **Participating Backbone Organizations (CHIRs)**

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

- Center for Healthcare Research & Transformation (in Washtenaw)
- Health Improvement Organization (in Jackson)
- Muskegon Health Project
- Greater Flint Health Coalition
- Northern Michigan Public Health Alliance

## **Potential Additional Stakeholders for Inclusion in Committees and Broader Engagement Activities**

The following list of stakeholders provides a starting point for selection of organizations and individuals that might be engaged over the course of the Model Test. Many may be invited to provide input and counsel through participation in committees or through broader stakeholder engagement activities. Broader activities are likely to include forums held in different areas of the State to ensure input received is inclusive of the diverse geographic regions. They may also include webinars where information is shared with a large group of people at one time. Throughout the Model Test period, forums and webinars (as appropriate) should be held to inform stakeholders of progress and/or receive feedback. The following lists are not exhaustive and may include other entities.

### **Purchasers and Commercial Payors**

- Michigan Office of the State Employer
- Self-Insured Employers
- Organized Labor/Unions
- Michigan Association of Health Plans and its members (e.g., Priority Health, Molina, HAP)
- Blue Cross Blue Shield of Michigan
- Michigan County Health Plan Association
- Michigan Chamber of Commerce
- The Economic Alliance for Michigan
- Michigan Manufacturers Association
- Small Business Association of Michigan
- Michigan Education Special Services Association (MESSA)



- Detroit Regional Chamber of Commerce

### **Health Systems/ACOs**

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

### **Physician Organizations**

- Consortium of Independent Physician Associations
- Detroit Medical Center PHO LLC
- Greater Macomb PHO
- Henry Ford Medical Group
- Henry Ford Physician Network
- Huron Valley Physicians Association PC
- Integrated Health Associates Inc.
- McLaren Physician Hospital Organization
- MedNetOne Health Solutions
- Michigan Healthcare Professionals PC
- Northern Physicians Organization
- Oakland Physicians Network Services
- Oakland Southfield Physicians PC
- Olympia Medical Services PLLC

- Professional Medical Corp.
- The Physician Alliance LLC
- United Physicians Inc.
- United Outstanding Physicians LLC
- University of Michigan Faculty Group Practice
- Wayne State University Physician Group

### **Physicians/Clinical Leaders**

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

### **Community-based and Long-term Support Providers**

- Area Agencies on Aging Association of Michigan
- Health Care Association of Michigan
- Michigan Primary Care Association
- Michigan Association of Community Mental Health Boards
- Michigan Center for Rural Health
- Michigan Association for Local Public Health

- Paraprofessional Healthcare Institute
- Washtenaw Health Initiative
- Greater Flint Health Coalition
- Jackson County Health Improvement Organization

### **Consumer Advocacy Organizations**

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

### **HIT/HIE**

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

## C3 – Plan for Improving Population Health

The SIM Plan for Improving Population Health (PIPH) will be the cumulative synthesis of the learning generated by SIM Test regions in Michigan, with finalization in 2019. The PIPH will collate the lessons of the SIM regions; define how the SIM components will contribute to overall population health in Michigan beyond SIM, and enable post-SIM regions understand how to best apply the strategies of SIM in their own regional endeavors. The Plan will identify the evolving role of the Community Health Innovation Regions, Accountable Systems of Care, and Patient-Centered Medical Homes to improve overall population health in Michigan, and the specific opportunities for contribution to advance Michigan’s approach to the SIM Priority Populations.

The PIPH will utilize the SIM Test period to identify goals and objectives integral for Michigan to pursue to advance population health. The approach of the PIPH process is to ensure that the State Innovation Model engages with existing and ongoing efforts across Michigan, to engage partners in the development of the goals, objectives, and post-SIM approach. The Plan will utilize the work of existing committees and associations, and will not seek to make duplicative solicitation of stakeholders when alternative forums are available. Partners will include, but are not limited to:

- State Health Officials
- Health Care institutions such as hospitals
- Health care providers
- Community Based Organizations
- Legislators, local elected officials
- Local boards of health
- Departments of Transportation/Insurance/Parks, Agriculture, Energy, Education, etc.
- Payers
- Purchasers
- Economic Development/Planning Authorities

The SIM Plan for Improving Population Health will align with existing population health improvement strategies in Michigan, including the existing State Health Improvement Plan of Michigan (SHIP)<sup>5</sup>, Department of Health and Human Services Winnable Battles, and the Michigan Health and Wellness 4x4 Plan, in order to leverage the SIM process to further effect population health endeavors beyond the SIM Test period. The current State Health Needs Assessment (SHNA) and SHIP are in effect through 2017, with an

---

<sup>5</sup> [https://www.michigan.gov/documents/mdch/MDCH\\_SHIP\\_FINAL\\_8-16-12\\_400674\\_7.pdf](https://www.michigan.gov/documents/mdch/MDCH_SHIP_FINAL_8-16-12_400674_7.pdf)

<sup>6</sup> [https://www.michigan.gov/documents/healthymichigan/Michigan\\_Health\\_Wellness\\_4x4\\_Plan\\_387870\\_7.pdf](https://www.michigan.gov/documents/healthymichigan/Michigan_Health_Wellness_4x4_Plan_387870_7.pdf)

update scheduled for the 2017-2022 period. The current SHIP supports the Michigan Health and Wellness 4x4 Plan<sup>6</sup>, and presents further opportunity to leverage the DHHS strategy to advance the SIM health system transformation goals. The present focus of the State Health Improvement Plan has the following population health emphases:

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

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

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

## Healthy and Safe Community Environments

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

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

## Clinical and Community Preventative Services

A core component of the CHIR operations is the implementation of a clinical-community linkage strategy to enable community service referrals and integration within the clinical care setting. This requirement also

---

6

[https://www.michigan.gov/documents/healthymichigan/Michigan\\_Health\\_Wellness\\_4x4\\_Plan\\_387870\\_7.pdf](https://www.michigan.gov/documents/healthymichigan/Michigan_Health_Wellness_4x4_Plan_387870_7.pdf)

enhances the prioritization of SDOH information within the clinical care setting. These components align with two areas of the National Prevention Strategy:

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

## **Empowered People**

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

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

## **Elimination of Health Disparities**

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

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

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

As such, the below section outlines the three elements of the Plan to Improve Population Health as part of the SIM effort:

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

## Michigan's Health Improvement Plan

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

### State Health Improvement Plan

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

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

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

### State Health Assessment

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



Accreditation Board standards, as well as fulfill the routine update of the State Health Improvement Plan and identify new priority health issues for the State of Michigan.

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

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

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

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

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

assessment. Phases four and five involve identifying the strategic issues and formulating goals and strategies. The final phase, phase six, is the action cycle which involves implementation.

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

Table C3.1 State Health Assessment

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

## Plan for Improving Population Health

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

As the Michigan SIM has an inherent focus on overall population health, community development, and upstream investment through the Community Health Innovation Region, the PIPH interventions section will vary from standard interventions. The CHIR as an intervention itself will be the focus of the PIPH intervention selection, with an emphasis on necessary regional variation in the strategies and implementation of interventions based upon local conditions. During the SIM period, the PIPH will look to the lessons of the CHIR to best understand what State policies and actions can support regional population health improvement, and how the goals and objectives of the PIPH can remain flexible for local regions to best adapt their implementation of the PIPH to their local context.

The Michigan SIM priority populations and metrics noted in the Operational Plan align with the conditions of the CMMI to improve the health of the entire state population, improve the quality of health care across the state, and to reduce health care costs. The Michigan SIM goals and strategies outlined in this Operational

Plan and further described in this section of the PIPH align with the population health metrics developed by the CMMI/CDC team. Further, the PIPH addresses the core measures in this plan through its SIM Quality Utilization Outcomes, Cost, and CHIR Metrics measures set.

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

## Ongoing Population Health Initiatives

The State will continue to identify ongoing population health initiatives with complementarity to the vision for at-risk populations and the state's five winnable battles<sup>7</sup>. These initiatives include but are not limited to:

### **Nutrition, Physical Activity, and Obesity (NPAO) Program:**

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

### **Healthy Weight Partnership:**

The Michigan Healthy Weight Partnership was established for the purpose of overseeing the implementation and evaluation of Michigan's obesity state plan to address the epidemic of obesity. Michigan's plan is called "Michigan Healthy Eating and Physical Activity Plan: A Five Year Plan". Members include over 50 state, local, public and private organizations who assisted with the creation of the state plan and/or whose organizations are actively engaged in completing activities consistent with the state plan's objectives. The Michigan Healthy Weight Partnership is a state-wide partnership that is facilitated by the Michigan Nutrition, Physical Activity, and Obesity Prevention (NPAO) Program at the Michigan Department of Health and Human Services through funding from the Centers for Disease Control and Prevention (CDC) Division of Nutrition, Physical Activity and Obesity (DNPAO).

---

<sup>7</sup>[https://c.ymcdn.com/sites/www.mpcanet/resource/resmgr/Clinical\\_Conference\\_2015\\_/2015\\_Clinical\\_Conference\\_MDHH.pdf](https://c.ymcdn.com/sites/www.mpcanet/resource/resmgr/Clinical_Conference_2015_/2015_Clinical_Conference_MDHH.pdf)

**Prevent Block Grant:**

This initiative involves implementation of evidenced-based population strategies aimed to have collective impact on increasing healthy lifestyles by decreasing tobacco use and obesity (through increased physical activity and healthy eating) among high risk, vulnerable populations. The strategies will be implemented in two SIM Community Health Innovation Regions (CHIRs), one urban and one rural (TBD). Strategies of “Getting to the Heart of the Matter in Michigan” include: implementation of tobacco cessation interventions into routine clinical care; increasing access to healthy foods and places for physical activity; and conducting a media campaign to increase participation in “Getting to the Heart of the Matter in Michigan” activities.

**Diabetes Self-Management Education Certification Program:**

To increase availability and improve the quality of diabetes self-management education, the Michigan Department of Health and Human Services, Certification Program has developed review criteria based on national standards. The Certification Program staff provide consultation services related to the standards and certification process. Programs that meet criteria and are certified are eligible for Medicaid reimbursement.

**Michigan's Diabetes Prevention Program:**

Michigan's Diabetes Prevention Program collaborates strategically to increase the delivery of evidence-based prevention messaging and programs such as the National Diabetes Prevention Program to high risk populations to reduce diabetes risk. The National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes and is offered in many Michigan communities through delivery organizations.

**Michigan Partners on the PATH:**

Personal Action Toward Health (PATH) is a chronic disease self-management program that helps participants build the skills they need for the day-to-day management of a chronic disease. PATH is a six-week workshop and covers topics including healthy eating, relaxation techniques, problem solving, and communication skills.

**The Michigan Department of Health and Human Services Tobacco Section:**

The team is dedicated to changing the negative health and economic impact of tobacco by:

- Providing help and support for smokers who want to quit: Multiple resources are available including the Michigan Tobacco Quitline, which offers free provider referrals, free counseling, and free nicotine replacement therapy to those who qualify.
- Promoting smoke-free air spaces, both indoors and out of doors: Michigan has statewide smoke-free air laws that protect residents and visitors from exposure to secondhand tobacco smoke in public places. The most comprehensive one is Public Act 188 of 2009, Michigan's Smoke-Free Air Law, which protects residents and visitors in all the state's restaurants, bars and businesses, including

hotels and motels. Many landlords and rental housing management companies have adopted smoke-free policies for their residents. In fact, Michigan now leads the nation in the number of public housing commissions that have adopted smoke-free policies.

- Protecting youth from exposure to secondhand smoke: There are a number of activities across the state of Michigan related to this endeavor including Michigan State Board of Education policies on 24/7 Tobacco-Free Schools and a toolkit from the Board of Education for 24/7 Tobacco-Free Schools.
- Continuing to raise awareness about other tobacco products, both the old (such as spit tobacco) and the new, emerging products
- Educating and empowering population groups that bear a higher-than-average burden from tobacco use and secondhand smoke exposure: The Michigan Department of Health and Human Services Tobacco Program provides funding for the Michigan Multicultural Network (MCN), which works to promote awareness about the risks of tobacco use and its impact on the communities most disparately affected by tobacco use. The agencies that comprise the Network serve African Americans; American Indians; Arab Americans; Asian Americans; Chaldean Americans; Hispanics/Latinos; people who are lesbian, gay, bisexual, or transgender; and veterans.

As the Plan for Improving Population Health process is conducted throughout the SIM Test period, Michigan will continue to identify new and ongoing Federally-supported programs and initiatives underway in the state, existing demonstrations and waivers granted to the State by the Centers for Medicare and Medicaid Services, and other ongoing initiatives that have impact upon and alignment with the health system transformation activities of the SIM.

## **C4 – Health Care Delivery System Transformation Plan**

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

The SIM program will have multiple levels of provider integration within the program's plan for health care transformation. First, primary care providers may choose to integrate to create Patient-Centered Medical Homes. These Patient-Centered Medical Homes would be responsible for coordinating care with the broader network of health care providers who are involved in the delivery of care to their patient panel. Community Health Innovation Regions will integrate not only health care providers but also community entities and state agencies within a given region. Community Health Innovation Regions will be governing bodies, supported by a legal backbone.

### **Payments to providers from all payors are in fee-for-service alternatives that link payment to value**

The SIM program will work with Medicaid and other payors to increase the level of provider contracting using alternative payment models consistent with the LAN definitions, with a focus on moving providers into models that meet the requirements of LAN categories 3 and 4. The SIM alternative payment model strategy is discussed in more detail in section C5 (Payments and/or Service Delivery Model(s)).

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

The Patient-Centered Medical Home is the core pillar of the Michigan vision for health care transformation and the State aims to have every PCP meet the requirements of a PCMH who is accountable for quality and total cost of care.

### **Care is coordinated across all providers and settings**

Care will be coordinated across primary care providers within the Patient-Centered Medical Home. Patient-Centered Medical Homes will drive care coordination in several ways, including developing care plans to capture a comprehensive approach for maintaining a patient's health or managing a chronic condition, supporting transitions of care, and engaging supportive services where necessary. MHPs and other payors will continue to work with their providers to ensure care coordination through several mechanisms, including enabling systems, relationships and workflows across the care continuum; planning for transitions of care; and enabling clinical data interoperability.

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

Patients will be engaged via the Patient-Centered Medical Home which will be patients' primary touch point with the healthcare system. Primary care providers will be charged with patient education and engaging patients on chronic disease management. Core metrics for Patient-Centered Medical Homes include patient engagement measured by surveys and other tools along with care coordination activity monitoring and

reporting. MHPs and other payors will utilize similar metrics with providers with which they enter into alternative payment arrangements. Additional metric and measure information can be found in sections A3 (Core Metrics and Accountability Targets), C7 (Quality Measure Alignment) and C11 (Program Monitoring and Reporting). Patients experience will also be involved in other public outreach and collaborative engagement as described in Section C2 (Stakeholder Engagement).

### **Providers leverage the use of health information technology to improve quality**

Rollout of prioritized use cases is a primary mechanism for ensuring that providers will leverage the use of HIT to improve quality. The set of prioritized use cases are described in detail in Section C10 (Health Information Technology). One use case is AMR. AMR is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Another use case is an ADT service. ADT notification is widely regarded as a keystone to improving patient care coordination through health information exchange. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. Alerts are then sent to update physicians and care management teams on a patient's status, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions. ADT notifications also support the identification of patients who are frequent or high users of the health care system, which allows providers to steer these patients toward clinical and non-clinical interventions that may reduce unnecessary overutilization by preventing avoidable emergency department visits and hospital readmissions.

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

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

### **Providers perform at the top of their license and board certification**

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

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



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

### **Performance in quality and cost measures is consistently high**

The SIM program will align participating payors and providers on a common provider measures that includes quality, access, patient experience, outcomes, and utilization measures. Participating payors will provide data to build performance reports for Patient-Centered Medical Homes and Accountable Systems of Care based on standard performance metrics and measures. Quarterly performance reports with benchmarking of provider performance are planned. High-performing providers will potentially receive larger compensation in the form of shared savings.

Alternative Payment Models implemented under the SIM program's health care transformation strategy will directly incentivize providers to work towards cost avoidance and quality. Alternative payment models within Patient-Centered Medical Homes will encourage providers to deliver high-quality, efficient care in an appropriate treatment setting.

### **Population health measures are integrated into the delivery system**

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

Please see section C3 (Plan for Improving Population Health) and A3 (Core Metrics and Accountability Targets) for a full population health approach and measures, respectively. The Population Health Committee will review the metrics and identify which should be measured. The Population Health Committee will assess the feasibility of capturing and measuring these metrics, with potential sources of data including Behavioral Risk Factor Surveillance System oversamples and data from vital records.

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

- Individual (Race, Ethnicity, Language, Age, Gender (sexual orientation), etc.)

- Physical Environment (Neighborhood Safety, Home Hazards, Homelessness, Crowded Housing, etc.)
- Social (Income, Occupation, Incarceration History, Citizenship Status, Military Status, etc.)

### **Data is used to drive health system processes**

The SIM program team will define use cases to ensure that clinical and claims data is used to drive health system processes. Data will be used in three key ways to support health system processes: (1) SIM Performance Metrics and Reporting, (2) Care Coordination Enablement, (3) Population Health Toolset.

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

## C5 – Payment and/or Service Delivery Model(s)

The Project Summary (A1) provides an overview of Michigan's general SIM approach including payment and service delivery models. Through the Michigan SIM Model Test, the State is implementing two delivery system components – Patient-Centered Medical Homes (PCMH), and Community Health Innovation Regions (CHIRs). In addition, the State will leverage existing activities in the Medicare, Medicaid and commercial marketplace and encourage increasing use of alternative payment methodologies.

### Patient-Centered Medical Homes:

Through SIM, Michigan intends to maintain and expand the strong multi-payer advanced primary care program that the state built in partnership with CMS, Michigan Medicaid and three commercial plan partners. The State's PCMH model builds off of our collective experience with the current Michigan Primary Care Transformation model (MiPCT). The MiPCT now represents 350 practices, serves over 1.2 million patients (more than 12% of the state's population), and has over 400 Care Managers embedded within practices. The MiPCT model has operated with a capped number of PCMH practices.

The December 31, 2016 expiration of MiPCT and the January 1, 2017 start date of the SIM PCMH Initiative allows for seamless continuity of our participating PCMH practices and expansion of this model within the Community Health Innovation Regions. Transitioning from the MiPCT demonstration period to the PCMH Initiative also provides a natural opportunity for the State to update and adapt participating PCMH expectations, alter some components of the care model (including care coordination team composition and performance measurement), and refocus PCMH quality improvement and participation compliance supports (including the collaborative learning network, supplemental training, and verification processes for PCMH capability). From the overwhelming response of the Intent to Participate, it is anticipated that the SIM PCMH Initiative will be able to expand to include approximately 500 practices, representing an estimated 380,000 Medicaid beneficiaries.

Provider types eligible to participate in the SIM PCMH Initiative include family physicians, general practitioners, pediatricians, geriatricians, internal medicine physicians, obstetricians / gynecologists, nurse practitioners, physician assistants, and safety net providers (e.g. federally qualified health centers, rural health clinics, child and adolescent health centers, local public health departments, and Indian health services). Under SIM, the definition of Care Management and Care Team will expand to recognize the role that non-traditional providers such as certified Community Health Workers, pharmacists, or peer advocates may play in engaging patients and coordinating care. Leveraging the Health Information Technology infrastructure, and specific uses cases such as Active Care Relationship Service, the Health Provider Directory, Admit/Discharge/Transfer messaging, Common Key Service and Quality Measure Information C10 (Health Information Technology) all key care team members will be able to actively engage in the coordination of services to meet patients needs. Patients included in the SIM PCMH Initiative will represent a broad array of individuals (e.g., healthy individuals, those with single or multiple chronic diseases etc.). Michigan's SIM target populations (high utilizers of emergency department services, patients with multiple chronic diseases) will be prioritized within the attributed population by orienting performance measures and linking care management

payment to processes and outcomes associated with the needs of both patient groups. SIM is working toward models which effectively engage behavioral health and substance use services through integrated care in the future.

Certain Medicaid populations will be excluded from attribution based on participation in other delivery system reform efforts, for more information on qualifying populations please refer to Appendix D4 (Care Delivery Artifacts). The SIM PCMH model directly involves Medicaid Health Plans (MHPs) in the statewide PCMH model. Most individuals enrolled in a MHP will be eligible to be attributed to a PCMH based on their selection of a primary care provider within the MHP. For attributed Medicaid members, MHPs will make PMPM payments for SIM-designated PCMH care coordination and practice transformation activities. Both payments will be made based on the attributed members, and will be subject to monitoring by the PCMH operations contractor. For more information on the payment model please refer to Section B2 (Detailed SIM Component Narratives and Summary Tables) or Appendix D4 (Payment Comparison Matrix).

The SIM program team will work with commercial payors and Medicare to support increased adoption of the PCMH model within the state. A key step in aligning with Medicare will be the submission of Michigan's PCMH custom option approach to CMS in the second half of SIM year 2.

As part of the SIM initiative, the State will track the number of PCMH practices, the number of members attributed to such practices by line of business (e.g., Medicaid, Medicare, or Commercial as applicable), the total care coordination and transformation fees paid to PCMHs, and the total cost of care associated with members attributed to a PCMH. More detail on Michigan SIM reporting metrics are included in Tables A2.1 (Measures by Primary Driver) and A3.1 (SIM Core Metrics).

## **Community Health Innovation Region:**

As described previously, the State has selected five SIM test regions and lead entities for CHIRs in each SIM test region. The CHIRs, working closely with the ASCs, PCMHs, MHPs and other organizations in their regions, will develop a community health needs assessment and define population health goals and initiatives across the medical, behavioral and social support sectors in order to reach those goals. Through SIM, the State will provide funding support for both consolidation for existing health assessments and alignment of population health goals, as well as funds to support implementation of initiatives to meet those goals. Through SIM, the State will require the CHIR to provide a detailed work plan of how it plans to utilize funding, and the State will closely monitor and report on CHIRs implementation of SIM-funded initiatives.

## **Alternative Payment Methodologies (APM):**

As noted in Section A1 (Program Summary), Michigan will leverage language in its existing Medicaid Health Plan (MHP) contracts to require plans to increasing use APMs with accountable provider systems, with a specific focus on categories 3 (APMs built on fee-for-service architecture) and 4 (population-based payment) of the Health Care Payment Learning and Action Network (LAN) APM framework which involve a variety

of shared savings and shared risk arrangements with providers. SIM will specifically define and carry out the PCMH Initiative payment model, which will evolve into an advanced alternative payment model over time and involve a significant number of providers and beneficiaries. However, beyond the PCMH Initiative payment model the State will encourage health plans and providers to negotiate payment arrangements that meet their goals (which may or may not be the same across communities). The State will focus on aligning performance and outcome goals, health information technology strategies, and core care model functions across the various APMs to reduce administrative complexity for participating providers while simultaneously allowing health plans to develop unique payment constructs. The state will require MHPs to report on their use of these provider payment methods consistent with the APM categories and sub-categories defined through the LAN.

The State will first amend MHP contracts in October 2016 (for fiscal year 2017) to introduce a format and measurement methodology for health plan APMs, collect a baseline report of current health plan APM activity and learn more about health plan payment reform approaches and initiatives. Then, in October 2017 (for fiscal year 2018) the State will add specific APM threshold targets in terms of the amount of a health plan's population and payment that are required to be associated with an APM over the term of the Contract. The MHP Contract will continue to include specific APM reporting requirements consistent with the LAN APM framework, but reporting for fiscal year 2018 and beyond will be structured to allow the State to assess how MHPs are progressing to meet APM threshold targets and to provide APM reporting for the SIM Test.

By incentivizing the MHPs to meet these APM threshold targets, the State will further a goal of SIM to transform the health care delivery system in a way that allows providers to receive financial incentives for improved quality and cost outcomes. In addition, through SIM, the State will work to encourage commercial health plans to align with Medicaid and Medicare and set their own targets for increasing APMs with an emphasis of LAN categories 3 and 4.

The State will also encourage MHP and Commercial APM designs to include payment adjustments based on provider performance to specified thresholds on common measures. As noted in the Program Summary (A1) SIM will support collaborative efforts to align provider measures across Medicaid health plans and to the extent feasible, align provider metrics across commercial payers and Medicare to reduce administrative burden and reward a consistent set of provider behaviors and priorities. This collaborative measurement effort, which includes work from the Michigan Health Information Network Shared Services and the Michigan State Medical Society, is described in more detail in Section C7 (Quality Measure Alignment).

## C6 – Leveraging Regulatory Authority

The State will leverage current policy and mechanisms to support the implementation of the Care Delivery, Population Health components and other State Innovation Model drivers.

Policy levers promoting adoption of Information Technology, Payment Reform and Care Delivery platforms have been detailed under Section C10, C5 and C4, respectively. Additional broad policy and regulatory levers to support payment reform initiatives are outlined below. They are primarily (1) the Medicaid Health Plans in Michigan executing the Comprehensive Health Care Program (CHCP) contract in the service areas within the State of Michigan, (2) workforce capacity monitoring (section C9), (3) license and board certification, and (4) certificate of need.

### State of Michigan Medicaid Health Plan Contract

There are multiple requirements within the current Medicaid contract which advance the push towards Alternative Payment Models. The following categories include language from within the Medicaid contract supporting each area.

- Patient-Centered Medical Homes (PCMH) expansion to support Population Health improvement and innovation plans.
- Contractor must contract with primary care practices that are recognized as PCMHs by the National Committee for Quality Assurance or Blue Cross Blue Shield of Michigan's Provider Group Incentive Program or under other PCMH standards approved by Michigan Department of Health and Human Services (MDHHS).
- Contractor must report to MDHHS semi-annually on the number and percentage of Enrollees receiving services from PCMH designated practices (as described above), overall and for subpopulations in a manner determined by MDHHS.
- Contractor must promote within PCMH practices Enrollee engagement and responsibilities by undertaking person-centered initiatives that:
  - Improve access to behavioral health, dental care, community health workers, patient navigators, and health promotion and prevention programs delivered by community-based organizations, or social service programs from the clinical setting.
  - Increase the rate of completed person/family-centered care plans for Children's Special Health Care Services and children in foster care.
  - Increase the rate of person/family-centered care management plans for Enrollees with multiple co-morbid conditions, and
  - Increase the proportion of Healthy Michigan Enrollees who complete a health risk assessment within a specified time period.

## **Support of Care Managers**

- Contractor must report semi-annually on the percentage of primary care practices with embedded or shared care managers and which of those practices are supported through the Michigan Primary Care Transformation Demonstration
- Contractor must establish standardized work processes between contractor's care management staff and the embedded and shared care managers to promote coordination of services and to avoid duplication of services. Such work processes must include establishing a single point of contact between the health plan and an embedded care manager

## **Support for Community Health Innovation Regions**

- Contractors would be required to participate in community-based initiatives including Community Health Innovation Regions as these develop in the contractor's respective service area

## **Access to Care**

- Contractor must make available covered services 24 hours per day, 7 days per week when medically necessary.
- Contractor must assure Enrollees have access to emergency and urgent care services 24 hours per day, 7 days per week. All primary care providers within the network must have information on this system and must reinforce with their Enrollees the appropriate use of the health care delivery system.
- Contractor must require that physician office visits be available during regular and scheduled office hours.
  - Contractor must ensure that Enrollees have access to evening and weekend hours of operation in addition to scheduled daytime hours.
  - Contractor must provide notice to Enrollees of the hours and locations of service for their assigned primary care provider network providers' office hours.
- Contractor must make available direct contact with a qualified clinical staff person through a toll-free telephone number at all times, 24 hours per day, 7 days per week.
- Contractor must maintain MDHHS approved standards for monitor, and report to MDHHS.

## **Addressing Health Disparities**

- Contractors must recognize and support initiatives designed to address the social determinants of health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve health equity.
- Contractor must develop protocols for providing population health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings:
  - At adult and family shelters for Enrollees who are homeless
  - The Enrollee's home
  - The Enrollee's place of employment or school



- At foster home, group homes and other residential placements especially for children in the care or custody of MDHHS
- Contractor must implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

## License and Board Certification

Licensing and board certification standards ensure proper credentialing for SIM providers and provide baseline assurances that they meet State guidelines, regulations, and licensure requirements. Managed Care Plans participating in the Medicaid program will need to comply with the requirements of the Michigan Compiled Law 500.3528 regarding the credentialing and re-credentialing of providers within the Contractor's network. This includes specific language relating to ensuring that enrollees are licensed by the State and are qualified to perform their services throughout the life of the contract.

## Certificate of Need, Access to Care

Michigan's approach to its certificate of need and Access to Care programs balances cost, quality, and access issues, without undue political influence. These initiatives ensure the proper supply of health care providers to meet State demands. Such regulatory authority creates a mechanism to evaluate service delivery needs across the State and take into account new findings and demands that may emerge as a result of the Michigan SIM Test model. An independent 11-member commission develops the review standards, and updates them every 3 years on a rolling basis. Reviews are conducted by the evaluation section of the Department. The evaluation section and the commission are committed to ongoing process improvements designed to enhance the efficacy, efficiency and transparency of the process. Working with innovation model leadership, the certificate of need program can help address anti-competitive concerns by using established health policy considerations in evaluating any significant market changes.

## Public Act 107

On September 16, 2013, Governor Rick Snyder signed into law Michigan Public Act 107 of 2013 (commonly referred to as Michigan's Medicaid Expansion Statute), which directs the creation of the Healthy Michigan Plan. Public Act 107 provides greater insurance coverage to noted populations thereby providing better access to health services and further enabling SIM goals of better health care delivery, improved population health outcomes. The State of Michigan plans to make health care benefits available through the Healthy Michigan Plan. The Healthy Michigan Plan provides health care coverage for individuals who are age 19-64 years, have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for or are not enrolled in other Medicaid programs, are not pregnant at the time of application and are residents of the State of Michigan.

## Behavioral Health Waiver

Building off of Michigan's long standing commitment to community supports and inclusion and to focus on the capability to function and the opportunity to achieve for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual/Developmental Disabilities (I/DD) and Children with Severe Emotional Disturbances (SED). The State of Michigan is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver to combine under a single waiver authority all services and eligible populations served through its §1915(b), 1915(i) and its multiple §1915(c) waivers. Under this consolidated waiver authority, Michigan is seeking broad flexibility to develop quality, financing and integrated care (physical and behavioral health care) initiatives for all Specialty Service Populations on a statewide basis. Integrated care efforts remain a focus of the SIM initiative and further alignment with the Behavioral Health Waiver will be explored.

The noted regulatory authorities provide an opportunity for the SIM Initiative to leverage existing and emerging efforts to enable core objectives aimed at Care Delivery, Population Health components and other State Innovation Model drivers. In particular, the formal and long-standing regulatory authority of the State License and Board Certification Program and the Certificate of Need and Access to Care Program provide a formal means to support SIM by ensuring proper regulatory practices are in place. The noted Behavioral Health Waiver provides another leverage point to further support SIM efforts aimed at integration and policy alignment.

## C7 – Quality Measures Alignment

Michigan is currently working toward aligning all participating payors and providers on a common provider measures to assess provider performance.

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

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

### Background, History, and Next Steps for the PPQC

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

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

In addition to aligning on metrics overall, other efforts of the above body which are relevant to ongoing efforts on metric alignment include "Data Capture and Collection" and "Harmonization Financial Incentives & Pay for Performance." The effort on data capture and collection will focus on developing standards and to efficiently and accurately record, store, and transmit data necessary to calculate selected quality measures. Sources of data can include clinical supplemental data, insurance claims, laboratories, and others. This group will also work toward standardization of provider lists, credentialing, and performance reports, including the timeliness of data. Additionally, once quality measures are calculated, the group will identify ways that results and any identified gaps in care can be communicated back to providers in a meaningful and accessible way.

Michigan's core Model Test components, Population Health and Care Delivery, and related supporting component teams will be aligned with these activities through the continued membership of the Medical Services Administration, key Medicaid Health Plans, and participating PCMH and ASC providers in the PPQC.

## **C8 – SIM Alignment with State and Federal Initiatives**

The state is committed to ensuring that all of its health care efforts are working in coordination to effectively transform delivery of the health care system. This includes efforts which the state is participating in as part of a federal or state initiative. Below are a list of federal and state initiatives which the State Innovation Model (SIM) effort is aware of and will align with as is appropriate to ensure we build upon, and integrate with, where appropriate, existing initiatives and to ensure federal funding will not be used for duplicative activities, or to supplant current federal or state funding.

### **How the State will coordinate between SIM and CMS/DHHS/Federal and other CMMI Initiatives**

#### **1115(a) Medicaid Demonstrations**

On September 1, 2015, the Michigan Department of Health and Human Services (MDHHS) submitted a Section 1115 waiver amendment to the Centers for Medicare & Medicaid Services (CMS) in compliance with state law. The Michigan SIM model strives to align with Medicaid programs and the 1115 Demo. Michigan is a predominately managed care state and as such, has included a number of SIM elements within its latest contract requirements as a lever. The 1115 Demo follows and builds off this consistency. The State is seeking approval of this amendment in order to implement certain directives contained in the State law known as Public Act 107 of 2013 and in turn, continue to provide affordable and accessible health care coverage for approximately 600,000 Michigan citizens.

The state is seeking a waiver that would allow individuals who are between 100% and 133% of the federal poverty level and have had Healthy Michigan Plan coverage for 48 cumulative months to choose one of the following options:

1. Purchase private insurance through the federal Marketplace (with eligibility for advanced premium tax credits and cost sharing reductions), or
2. Remain in the Healthy Michigan Plan with increased cost-sharing up to 7% of income. This option also includes an increase in enrollee contributions to 3.5% of income (with the opportunity for reductions).

The individuals described above who do not choose one of these options will remain in the Healthy Michigan Plan under option 2.

### **Medicaid-led transformation efforts, such as Health Homes, Accountable Care Organizations, and Patient-Centered Medical Homes**

#### ***Health Homes***

Section 2703 of the Affordable Care Act provides a State option for health homes for enrollees with chronic conditions. Michigan's approach to the health homes initiative has manifested in the launch of the MI Care Team.

**MI Care Team** is a primary care health homes program that began July 1, 2016, and was created in accordance with Section 2703 of the Affordable Care Act. MI Care Team is a method of delivering care coordination and comprehensive care management in an integrated health care environment to improve health outcomes for beneficiaries in the program. MI Care Team health homes serve as the central point of contact for directing patient-centered care across all elements of the broader health care system. Participation is voluntary, and beneficiaries must consent to be enrolled in the program. Enrolled beneficiaries may opt-out at any time.

## **The Patient-Centered Medical Home**

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

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

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

In addition to delivering high-quality, efficient primary care PCMHs will be responsible for serving as the “quarterback” for primary care by coordinating across multiple providers and care settings to understand and holistically address the health needs of each patient.

## **Comprehensive Primary Care Plus Initiative**

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.). The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. On April 11, 2016, CMS announced the CPC+ initiative to transform and improve how primary care is delivered and paid. Because the program 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 options.

## **Duals integration**

MI Health Link is a new health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care, all in a single program designed to meet individual needs. MI Health Link aims to reduce the administrative burden for providers and simplify the navigation of benefits and services for this population.

Care coordination is also a key benefit of MI Health Link. The care coordinator will get to know the member and help create a personal care plan based on their goals. The care coordinator will connect the member to supports and services they need to be healthy and live where they want.

## **Medicare Advanced primary care program**

The demonstration program pays a monthly care management fee for beneficiaries receiving primary care from Advanced Primary Care (APC) practices. One example of the APC coordination is Regents of the University of Michigan project which will implement the Michigan Surgical and Health Optimization Program (MSHOP), which focuses on real-time risk stratification and peri-operative optimization for patients undergoing abdominal surgery. By the end of the three year demonstration approximately 1200 medical homes serving over 900,000 Medicare beneficiaries are expected to be participating.

## **Medicare Shared Savings Programs, including Pioneer ACOs**

The Detroit Medical Center's Michigan's Pioneer Accountable Care Organization (ACO) is based in Southfield, MI and aims to promote changes in the delivery of care from fragmented care to coordinated care systems as part of broader efforts to improve care integration, such as initiatives on medical homes and bundled payments, promote effective engagement with, and protections for, beneficiaries and develop close working partnerships with providers. The ACO generated an estimated savings of nearly \$17 million in its third performance year, making it the most successful Pioneer ACO in 2014 for benchmark savings improvement.

## **Other CMS-funded efforts**

The Michigan Public Health Institute (MPHI), in partnership with the MDHHS and local community agencies, implements the Michigan Pathways to Better Health (MPBH) initiative. MPBH supports the CMS goals of better health, better care, and lower cost through improvement, by assisting beneficiaries to address social service needs and link them to preventive health care services. Community Health Workers (CHWs) are trained and deployed to assist Medicaid and/or Medicare adult beneficiaries who have two or more chronic conditions and have health and social service needs (such as primary care, housing, food, and transportation). In other states, the model has improved health outcomes and lowered health care costs. The Pathways Community HUB conducts outreach, accepts referrals, determines client eligibility, and enrolls and assigns clients to a Care Coordination Agency (CCA).



## Health care innovation awards

The State of Michigan is working with multiple organizations on innovative health care initiatives. The below list is not all encompassing, but it does highlight many of the Federal collaborations that align with SIM.

- Altarum Institute, in partnership with United Physicians and Detroit Medical Center Physician Hospital Organization, received an award to reduce unnecessary imaging studies for beneficiaries in Southeastern Michigan.
- The Feinstein Institute for Medical Research received an award to develop a workforce that is capable of delivering effective treatments, using newly available technologies, to at-risk, high-cost patients with schizophrenia. This intervention is expected to improve patients' quality of life and lower cost by reducing hospitalizations.
- The Henry Ford Health System of Detroit, Michigan received an award for an innovative care model that encourages and supports patient mobility for patients at risk for hospital-acquired pressure ulcers and Ventilator-Associated Pneumonia (VAP) during acute inpatient hospitalizations; the goal is to reduce hospital acquired pressure ulcers and associated costs, VAP, improve patient satisfaction and decrease length of stay.
- The Michigan Public Health Institute, in partnership with the MDHHS and local community agencies, implements the MPBH initiative. MPBH supports the CMS goals of better health, better care, and lower cost by assisting beneficiaries to address social service needs and link them to preventative health care services.
- TransforMED received an award for a primary care redesign project across 15 communities to support care coordination among Patient-Centered Medical Homes (PCMH), specialty practices, and hospitals, creating "medical neighborhoods;" Over a three-year period, TransforMED's program will train an estimated 3,024 workers and create an estimated 22 jobs.
- The High Value Healthcare Collaborative (HVHC) received an award led by The Trustees of Dartmouth College to implement patient engagement and shared decision making processes and tools across its 15 member organizations for patients considering hip, knee, or spine surgery and complex patients with diabetes or congestive heart failure.
- The Altarum Institute project will test a service delivery model with multiple components that involves direct work with primary care providers and dentists and the development and enhancement of supporting health information technology components.
- Detroit Medical Center is receiving an award to test a proposal that would make primary care immediately available to individuals who arrive at 4 major inner city Emergency Departments for non-urgent care by establishing adjacent PCMH clinics. The goals of the project are to reduce emergency room service costs for the subset of emergency room patients with non-urgent care needs while concomitantly increasing access to PCMHs.

## **Bundled payment initiatives**

Numerous providers within Michigan are currently participating in bundled payment initiatives such as the Bundled Payments for Care Improvement initiative. We will support these initiatives to the extent that they align with our vision for payment reform and our broader vision for health care transformation.

## **Meaningful Use and HITECH**

SIM strives to align with Meaningful Use and HITECH goals by utilizing enabling infrastructure. MU and HITECH provided the springboard for greater standardization and SIM will leverage these improvements to further evolve the data sharing landscape to support overarching goals related to health care delivery, payment reform, and population health improvements.

The Medicaid Health Information Technology (HIT) office is deeply invested in leveraging the Electronic Health Record (EHR) incentive program to improve care, improve population health, and reduce costs through the widespread adoption and meaningful use of HIT and health information exchange.

One emerging opportunity is the substantial effort being made by the MDHHS to support Medicaid specialists who were ineligible for the regional extension center support under the HIT Act, and who have not yet met Meaningful Use. Outreach to specialists is currently underway and is expected to help further the spread of information about the value of Meaningful Use of EHRs. There are currently over 3,000 providers utilizing Meaningful Use in Michigan.

The Office of the National Coordinator for Health IT (ONC) has seven Health Information Technology for Economic and Clinical Health (HITECH) grantees in Michigan. As of 2013, over 900 students have completed the Community College Consortia HITECH training program. Over 4,000 providers are currently actively utilizing EHRs. Meaningful Use and HITECH will continue to be an essential part of SIM from an alignment, lever, and driver perspective. Michigan will continue to drive adoption of EHRs/technology to ensure seamless tracking and reporting of SIM data for all stakeholders.

## **Initiatives relating other agencies**

SIM is a multi-stakeholder initiative that will leverage efforts across diverse agencies and organizations as appropriate. Michigan has a number of initiatives ongoing. These initiatives include the following:

- The Agency for Healthcare Research and Quality funding initiative to train pre and post-doctoral students on how to be effective health services researchers. The Agency for Healthcare Research and Quality funds 18 institutions for this initiative, and the University of Michigan is one of those.
- The Administration for Children and Families and Health Resources and Services Administration grant program to award \$10M of Affordable Care Act funds for tribal, maternal, infant, and early child home visiting

- The Michigan Keystone ICU Project is a joint partnership between Johns Hopkins University and Michigan Health & Hospital Association to reduce the number of infections in Michigan intensive care units

## State Initiatives

Please refer to section C3 (Plan for Improving Population Health) for detailed information about the SIM alignment with state initiatives. The SIM team is committed to ensuring alignment through our population health improvement plan and other Model Test component implementations.

As SIM requirements continue to evolve and mature, the SIM Initiative will continue to evaluate alignment and coordination with Federal and State Initiatives. Alignment efforts will focus on consistency and limiting the burden on provider and payer base participants who may be involved in multiple initiatives.

## C9 – Workforce Capacity

Michigan's aging population and aging health care workforce, mixed with a maldistribution of health care providers and increased demand due to the health care reform highlights the need for solutions to increase access to care across the state. Numerous forecasts suggest that Michigan will need to make targeted, effective interventions in order to build and maintain a strong health care workforce. The below sections discuss efforts underway to assess and alleviate workforce capacity issues within the state. The State Innovation Model (SIM) will monitor the state of workforce capacity in Michigan to ensure the model components can be undertaken in line with related implementation plans.

### Current State of Healthcare Workforce in Michigan

Comprehensive data about the workforce is critical to addressing workforce shortages and maldistribution. Michigan has access the following data sources to inform health care workforce planning:

- **Area Health Resource File:** This is a county level database updated annually by the Health Resources and Services Administration (HRSA). Contains extensive health care practitioner data.
- **Health Professional Survey:** Michigan Department of Health and Human Services (MDHHS) works with Michigan's health care licensing authority to administer surveys tied to the license renewal application. Survey information is analyzed each year and provides data useful for workforce planning in Michigan.
- **Health Professional Shortage Area and Medically Underserved Area and Population Maps:** Maps reflect areas in Michigan that are designated as Health Professional Shortage Areas and Medically Underserved Areas and Populations. These maps illustrate the regions with greatest primary care needs across the entire state.
- **Safety Net Listing:** Listings and maps are maintained for primary care safety net delivery sites including Federally Qualified Health Centers, rural health clinics, free clinics, critical access hospitals, state funded and adolescent health centers, and other safety net sites.
- **County Health Ranking:** This data source ranks Michigan counties according to their summary measures of health outcomes and health factors. Data is provided to participants on access to care.
- **Statewide Vital Statistics, Population trends & Health care data:** This is a comprehensive, statewide web-based database maintained by MDHHS that includes community-specific health status data and marketplace resource data.
- **Michigan Behavioral Risk Factor Surveillance System:** This data source details the prevalence of health behaviors, medical conditions and preventative health care practices among Michigan adults by age, gender, race/ethnicity, education, household income and region.

The above data sources are evaluated, synthesized and combined to create an informative picture of Michigan's health care workforce needs and is reported in dashboards and various annual reports. Governor Snyder implemented dashboards to provide a quick assessment of the state's performance in many key areas. The Health and Wellness Dashboard tracks access to care metrics to measure progress on a statewide level. Local communities are able to join the effort by using the County Health Rankings, identifying local health

priorities, developing evidence-based programs and policies, and by evaluating the success of their efforts. Annual reports that describe Michigan's health status using some of the above data sources include the *Analysis of Advanced Practice Registered Nurses*. This report details trends of the nurse workforce, including perception and participation on an inter-professional team.

Health care workforce data and reports are shared and disseminated in various ways. The Michigan Primary Care Office (for more information on the Primary Care Office (PCO), see below) regularly reviews available data to identify and assess communities and populations with major disparities in health care access and regions in the state with a shortage of primary care providers. The PCO shares the needs assessment activities with partner organizations to support their community development activities. Additionally, the PCO collaborates with the Michigan Primary Care Association using the above data sources and reports around a detailed community development plan to improve Michigan communities.

Responsibility for the health care workforce is dispersed among various agencies and divisions across state government and many other private partners. The MDHHS and many other private partners maintain data repositories, conduct numerous assessments and prepare reports. The PCO is intended to bring these elements together. The SIM implementation accountability is located in the same administration as the PCO, and is strategically positioned to coordinate reform efforts with workforce analysis and planning. During year 1 of implementation, the SIM team will develop a scope of work, including analytical plans and milestones, for addressing workforce capacity projections given future needs based on delivery and payment reform.

### **Health workforce capacity programs / new workforce models**

Multiple efforts to coordinate workforce planning in Michigan have resulted in task forces and planning groups dedicated to developing a common vision among stakeholders and statewide plans. Michigan's health care community has been active and engaged in planning efforts to strengthen the supply of health care providers to adequately serve the needs of Michigan's residents. These efforts have been led by the Governor's office and implemented by the MDHHS within the Policy, Planning, and Legislative Services Administration.

The Michigan PCO is housed within the MDHHS Policy, Planning, and Legislative Services Administration. The Michigan PCO coordinates the availability of primary care services to Michigan's increasingly large, high-need population groups. The PCO and Michigan Primary Care Association work cooperatively to support the creation and expansion of health center access points in Michigan's underserved communities. Michigan actively participates in state and federal programs that offer incentives to health professionals for their service in underserved communities. The Michigan PCO supports the federal National Health Service Corps and administers programs including the Michigan State Loan Repayment Program, the Conrad State 30 program, and the National Interest Waiver Program.

The Michigan PCO holds quarterly Core Advisory Group meetings to gain input and recommendations of PCO partners around health care workforce related issues. This group consists of health care workforce associations, like the Michigan Primary Care Association, the Michigan Center for Rural Health, the Michigan

Area Health Education Center, representatives from Michigan colleges and universities with health care training programs and is open to other relevant stakeholders. The PCO Core Advisory Group has been instrumental in developing the policies and practices of the PCO and has guided the success of many PCO programs.

To further prepare Michigan's health care workforce for delivery system reforms such as care coordination as part of a team, the MDHHS received the Nurse Education, Practice, Quality, and Retention (NEPQR) grant from the HRSA. The National Center for Interprofessional Practice and Education selected a team from a Michigan academic institution as one of eight incubator sites in the nation. The team was recognized because of their large-scale inter-professional efforts like the NEPQR grant with the MDHHS. The incubator sites collaborate with each other to improve inter-professional education and collaborative practice within the state of Michigan and across the nation.

The MDHHS has also established an Office of Nursing Policy to focus specifically on nursing workforce issues. From this office, the Task Force on Nursing Practice was created in 2010 to address the nursing shortage. The Task Force on Nursing Practice was composed of representatives of the nursing practice, employers of nurses and representatives from the Michigan State Board of Nursing and other stakeholders. Recommendations were made to the Director of the MDHHS and other health care stakeholders to improve the nursing workforce.

The Michigan Center for Nursing was established by the MDHHS along with Michigan's health professions licensure program in 2003 to assist with nursing workforce related issues. Overarching goals of the Michigan Center for Nursing are to strengthen nursing education to meet the needs of the workforce and population and to survey the nursing workforce through the license renewal process. The Center for Health Professions (CHP) was also created to focus on workforce issues of all health care professionals and to increase system capacity to train more professionals by addressing bottlenecks. The goal of the CHP was to prepare professionals to work together to provide patient-centered care. The CHP led to the development of the Council of University Health Deans. The council provides a communications infrastructure for deans of health professional programs to facilitate inter-institutional communication regarding common challenges and prospective solutions.

### **Other targeted programs include**

- Michigan Community Health Worker Alliance (MiCHWA) is a statewide advocacy organization consisting of partners across payers, providers, health systems, government, and other associations. The goal is to ensure Community Health Workers (CHWs) are a certified and reimbursable workforce in Michigan's newly developed delivery system. MiCHWA has been in operation for approximately 5 years, and has made significant progress educating people about the CHW workforce, and advocating for ways to institutionalize the workforce into delivery and payment systems.
- Education 2 Practice: Education to Practice (E2P) is a clinical practice consulting service offered by the Michigan Health Council—a nonprofit organization near Lansing, Michigan. The group's mission

is to decrease everyone's inter-professional collaboration learning curve so they can achieve the Triple Aim plus improve the work life of clinicians and staff. The group has convened recurring workgroups involving 44 individuals from 23 organizations and taught over 200 preceptors, faculty, and other clinical education leaders how to apply core competencies at three regional conferences. Specific to workforce capacity the group emphasizes the importance of building health professional capacity. Examples include: supporting new members of the care team like Community Health Workers and serving as an affordable and effective sourcing tool to support the recruiting needs of employers in diverse settings and communities.

- The Michigan Area Health Education Center (MI-AHEC), established by Wayne State University, was established in 2010 to improve access to primary care for all Michigan residents, many of whom live in areas that have too few health professionals. Through recruitment and retention initiatives, as well as special clinical education programs, MI-AHEC seeks to expose disadvantaged students to health care opportunities, expand the number of underrepresented minorities in the health professions, and encourage students and health professionals to work in areas that need greater access to primary care providers. The national AHEC program was created by Congress in 1971.

SIM implementation will develop a plan during year 1 to coordinate the efforts of the PCO, MiCHWA, E2P, and MI-AHEC to monitor and project primary care workforce needs, as well as workforce needs in other primary healthcare areas. The effort will also include analysis of workforce needs relative to supporting and non-traditional workforce elements such as CHWs. The State has a general idea of the certification, licensure, and regulatory options available to expand the use of non-traditional healthcare workers, and will coordinate with key partners such as MiCHWA during year 1 to develop a plan that will set a foundation for this workforce within the SIM implementation calendar.

SIM will support this planning effort with policy and programmatic tests within the healthcare delivery and payment and population health initiatives being funded through the SIM grant. The PCMH initiative, specifically, will be giving providers the option to expand the use of CHWs at the provider organization or provider level as a member of their healthcare team. The CHIR initiative will be requiring local healthcare organizations and community organizations to partner in the development of clinical-community linkage initiatives, which may incorporate CHWs into the community and/or clinical setting depending on the assets and plans of local implementation. Implementation and planning efforts will be coordinated over the course of the 3 year SIM period through the Stakeholder Engagement committees established under SIM.

### **Legislative, Regulatory or Executive Actions on Health Care Workforce Issues**

SIM Executive Governance Team members are those executives within the State directly responsible for executing the State's vision of a redesigned health care system. The SIM Executive Governance Team establishes a vision for SIM that aligns with the broader State goals and external stakeholder interests. The composition of the SIM Executive Governance Team is a select sub-set of the Executive stakeholders leading office, agencies, and bureaus that are integral to the implementation and operationalization of SIM components in Michigan. This is an official governing body that convenes quarterly to review plans,



progress, issues, risks and outcomes and recommends/approves potential changes to the high-level scope and direction of the SIM initiative in Michigan.

FOR STAKEHOLDER ENGAGEMENT PLANS, PLEASE REFER TO THE SECTION C2 (STAKEHOLDER ENGAGEMENT).

## C10 – Health Information Technology

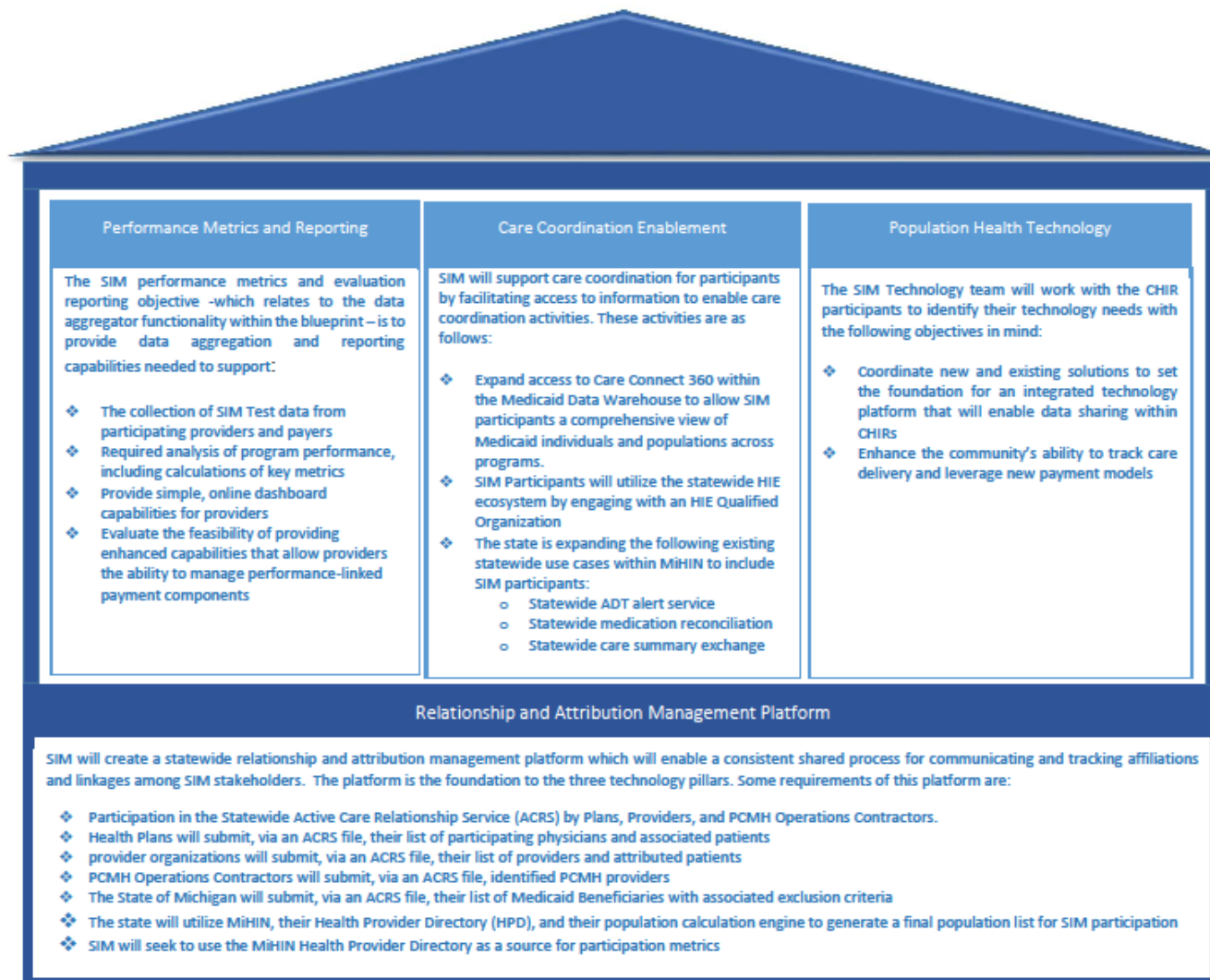
### Rationale

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

Core technology pillars will be implemented to support the healthcare transformation goals of the Michigan SIM Test. Figure C10.1 (SIM Relationship and Attribution Management Platform with Technology Pillars) provides an overview of the core technology pillars, as well as the Relationship and Attribution Management Platform. The technology pillars are:

- Performance Metrics and Reporting
- Care Coordination Enablement
- Population Health Technology

Figure C10.1 SIM Relationship and Attribution Management Platform with Technology Pillars



## **SIM Relationship and Attribution Management Platform**

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

There are building blocks, or foundational use cases, that are at the core of the relationship and attribution management platform. Once established, the relationship and management platform will enable the implementation and rollout of advanced supportive use cases. The implementation of the use cases will be facilitated by the MiHIN and the trusted data sharing organizations within the MiHIN network.

### **Foundational Use Cases**

#### **Statewide Active Care Relationship Service Use Case**

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

#### **Healthcare Provider Directory Service Use Case**

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

#### **Common Key Service Use Case**

The Common Key Service (CKS) use case is a statewide service that enhances patient matching to facilitate the exchange of health information across disparate data systems. The service assigns a unique key that is stored and attached to the patient in the State of Michigan's Master Person Index (MPI), and shared with all systems exchanging information about that patient. This reliable matching capability improves patient safety and data integrity in all use cases when information about a specific patient is shared. SIM will utilize the CKS to effectively identify, match, and track the SIM patient population.

## Supportive Use Cases

### Coordinate Care Coordinators Use Case

The Coordinating the Care Coordinators use case is a mechanism to formally enable care coordinator registration and population of a directory where this information can be electronically maintained and shared among other healthcare providers engaged in care coordination. This includes establishing defined roles and types of care coordinators to include in a directory, as well as creation of standardized rules of engagement for beneficiary interaction to support standard practices around electronically updating beneficiary interaction.

### Statewide Admission, Discharge, Transfer Service Use Case

The Statewide Admission, Discharge, Transfer (ADT) Notification Service use case is a statewide service that enables communication of alerts regarding patients' care transitions to every care team member interested in that patient, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions. This also allows providers to steer these patients toward clinical and non-clinical interventions that may reduce unnecessary overutilization by preventing avoidable Emergency Department (ED) visits and hospital readmissions.

### Care Summary Use Case

The Care Summary use case allows providers to share patient Care Summary information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities such as outpatient tertiary and skilled nursing facilities. Statewide coordination in sharing patient Care Summary information helps minimize Hospital Readmissions and Adverse Drug Events (ADEs), and helps maximize cost benefits. Additionally, this use case leverages the Active Care Relationship Service (ACRS) for notifying appropriate providers of changes to a patient's care status.

### SIM Quality Measures Use Case

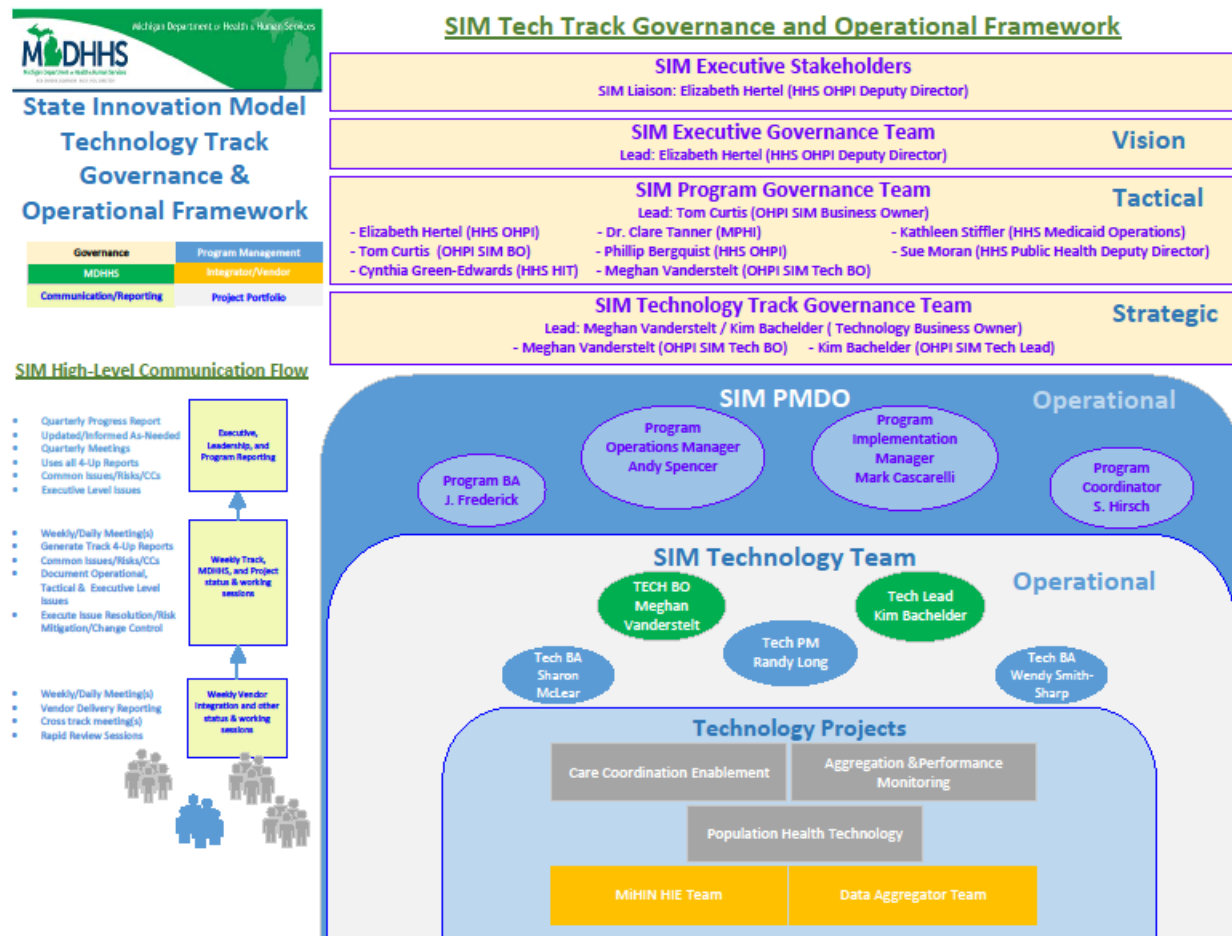
The SIM Quality Measures use case enables providers and payers to consolidate and standardize the electronic exchange of quality-related data and performance results. Providers gain the ability to send one supplemental clinical quality data file in one format to one location. SIM would leverage the growing infrastructure of Quality Metric Reporting to help collect data for the Quality component of SIM. Participating physicians and their Physician Organizations could provide necessary data to MiHIN, who would then route this data to the Data Aggregator for further processing.

## Governance

Healthcare Information Technology (HIT) will be governed by a subset of the overall SIM governance structure, as outlined in section C1 (SIM Governance, Management Structure, and Decision-making Authority). The SIM Technology Team manages the HIT/HIE requirements, implementations, integrations, and other SIM-dependent technology and interfaces. The Technology Team's primary goal is to implement the core Model Test component technological components while maintaining alignment and compliance to State and Federal standards and related initiatives. Additional alignment, communication, and idea flow with participants and stakeholders (both public and private) will be facilitated via the HIT/HIE Committee, which

is part of the overarching SIM Commission for public/private SIM-related engagement. Figure C10.2 (Technology Component Governance) depicts the high-level technology team and its overall composition and linkages the SIM Governance Structure.

Figure C10.2 Technology Component Governance



## SIM Technology Implementation Team

The SIM Technology Implementation Team is a chartered project managing the portfolio of technology initiatives that has been established to support implementation and operationalization of the SIM component initiatives – Care Delivery and Population Health.

The goals of the technology initiative portfolio are to:

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

## **SIM Commission and HIT/HIE Committee**

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

The HIT/HIE committee will provide recommendations and input on HIT/HIE decisions related to the design and operationalization of the core HIT/HIE elements supporting coordinated care delivery and Alternative Payment Models.

## **MiHIN Operation Advisory Committee**

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

## **Policy**

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

## **Medicaid contract HIT/HIE requirements and Medicaid integration efforts**

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

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

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



- Provider adoption of e-prescribing and e-portals in accordance with national and State laws and Office of the National Coordinator (ONC) regulations and standards for meaningful use.

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

## **Medicaid EHR Incentive Program**

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

Overarching goals of this program include:

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

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

## **Office of National Coordinator Interoperability Roadmap**

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

The four most important actions for public and private sector stakeholders to take to enable nationwide interoperability of electronic health information through health IT in the near term are: (1) establish a coordinated governance framework and process for nationwide health IT interoperability; (2) improve technical standards and implementation guidance for sharing and using a common clinical data set; (3)

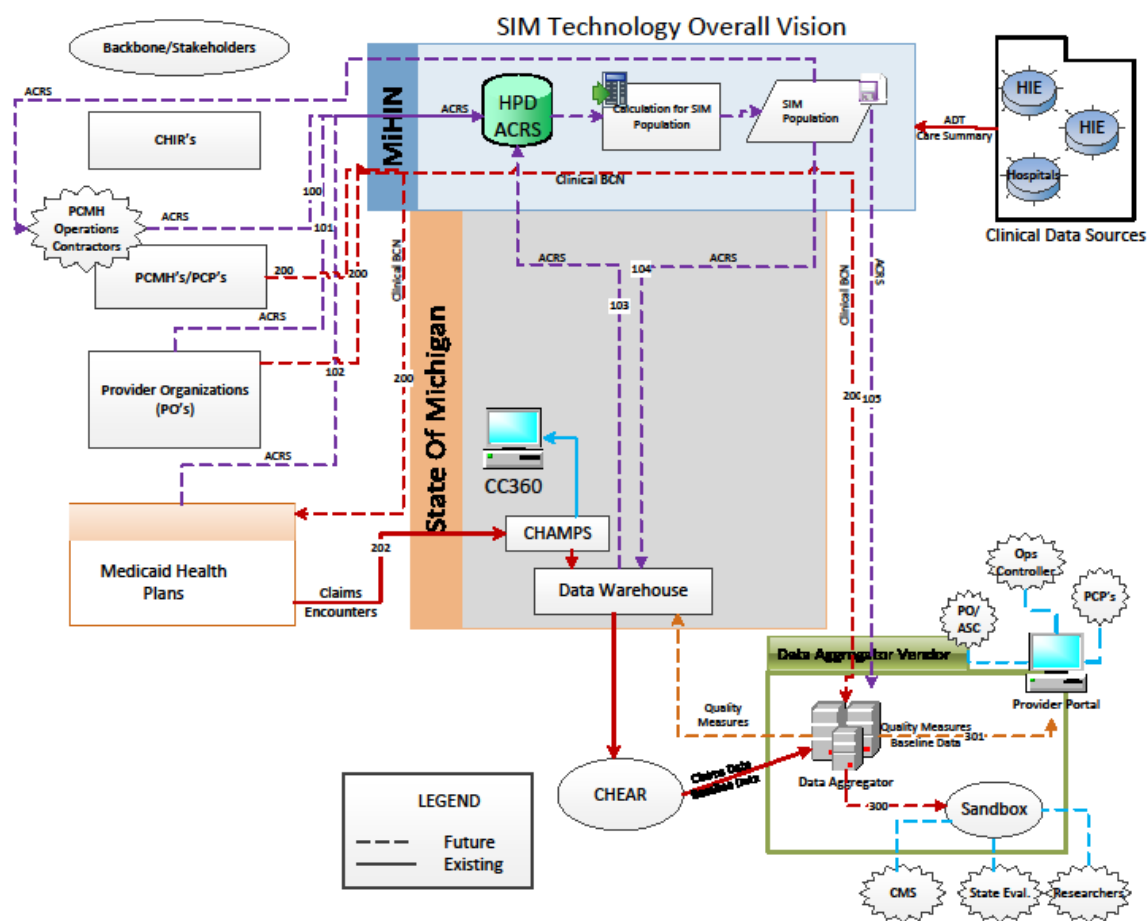
enhance incentives for sharing electronic health information according to common technical standards, starting with a common clinical data set; and (4) clarify privacy and security requirements that enable interoperability. The Model Test in Michigan will ensure that these actions are a cornerstone of our continued roadmap efforts.

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

## Infrastructure

The technological and architectural strategy outlined in Figure C10.3 (SIM Technology Overview) to support the SIM vision for health care transformation provides a baseline of data interoperability needed to successfully support the three core objectives: (1) enabling SIM program performance, comprehensive evaluation, and reporting; (2) supporting care coordination; and, (3) providing a population health monitoring toolset to support greater interoperability between health care and community entities. Detailed information about the technology contained in the SIM overall technology vision is described further in this section.

Figure C10.3 SIM Technology Overview



## Relationship and Attribution Management Platform

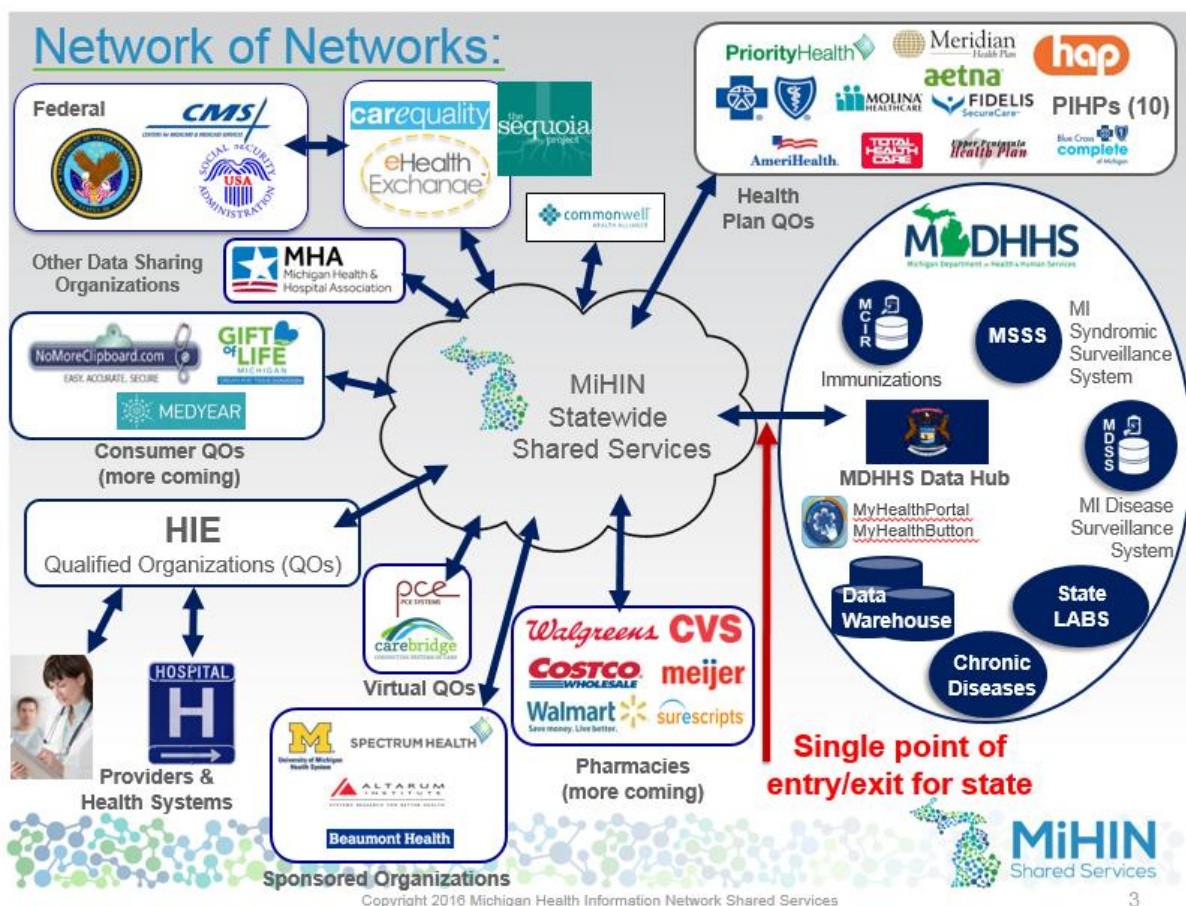
The Relationship and Attribution Management Platform is being implemented to support the identification and capture of relationships between patients/consumers and their healthcare delivery team members, to facilitate the active exchange of information between these identified individuals and organizations, and to provide an infrastructure that is necessary for health care delivery and payment reform. MiHIN, the State-Designated Entity (SDE) for health information exchange across Michigan, has been engaged in the Relationship and Attribution Management Platform project to leverage the widespread interoperability network established in the State of Michigan, along with the State's investment in MiHIN's tools and services to support the goals of this large undertaking.

Use Cases identified as foundational to the Relationship and Attribution Management Platform include:

- Active Care Relationship Service
- Health Provider Directory Service
- Common Key Service

The Relationship and Attribution Management Platform process leverages connectivity already established between MiHIN and multiple stakeholders throughout the State of Michigan, as detailed in Figure C10.4 (Michigan's Network of Networks) below. The many stakeholders and stakeholder types that participate in MiHIN are shown in Figure C10.4 (Michigan's Network of Networks) as well.

Figure C10.4 Michigan's Network of Networks



Achieving successful patient-provider attribution and using that attribution to successfully route data requires a number of Use Cases working cohesively. Healthcare providers must be identified and their electronic delivery preferences recorded, and active care relationships between patients and providers must be captured and tracked. Accurate patient matching is required to ensure correct data is routed to the appropriate providers, and tools need to be in place to help care coordinators stay aware of their patient's status. Finally, robust tools are necessary to send, receive, find and use patient healthcare information.

This connection between patients and their health care providers is referred to as 'attribution.' One definition of attribution is: "Assigning a provider or providers, who will be held accountable for a member based on an analysis of that member's claim data. The attributed provider is deemed responsible for the patient's cost and quality of care, regardless of which providers actually deliver the service."<sup>8</sup>

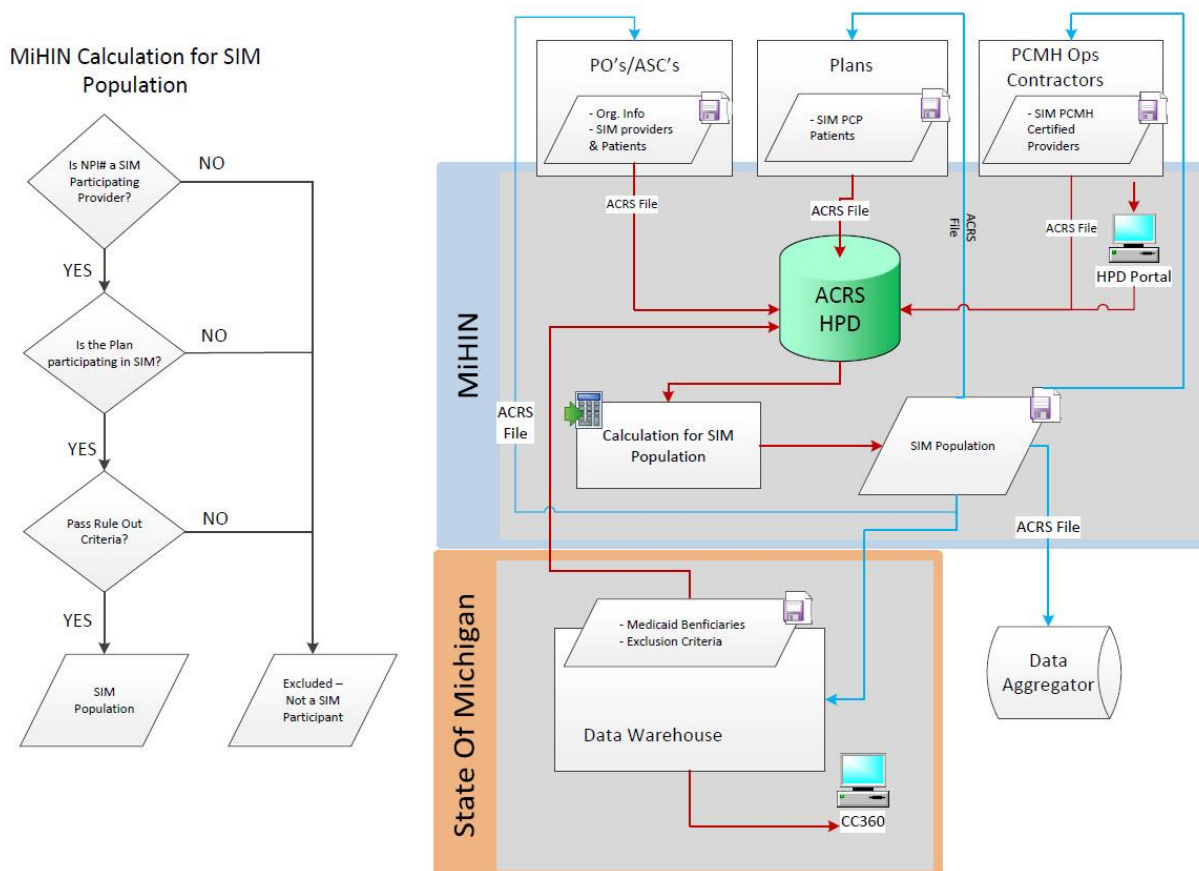
The Active Care Relationship Service (ACRS) keeps track of patient-provider attributions and acts as the basis of the Relationship and Attribution Management Platform process. ACRS allows the Relationship and Attribution Management Platform to match patients/consumers with their attributed care team members

<sup>8</sup> Panteely, Susan E. Whose patient is it? Patient attribution in ACOs. Milliman Healthcare Reform Briefing Paper. January 2011. <http://publications.milliman.com/publications/healthreform/pdfs/whose-patient-is-it.pdf>.

with a highly effective mechanism that supports sharing information between members of the extended healthcare delivery team, including the patient.

Figure C10.5 Detailed SIM Relationships and Attribution Management Platform

## SIM Relationships & Attribution Management Platform



With additional capabilities provided by ACRS, the Relationship and Attribution Management Platform has the ability to utilize resources beyond claims data to attribute patients with providers. This will be particularly important in support of the calculation of participation metrics of the SIM model test components.

Additional information on the specific Use Cases identified to support the Relationship and Attribution Management Platform is provided in the next section.

### Active Care Relationship Service

To achieve healthcare delivery and payment reform, alignment of patient-to-provider attribution approaches becomes increasingly critical, but so does the knowledge of how patients connect to health plans, how doctors link to Patient-Centered Medical Homes, and how practices link to contracting organizations that share risk with the health plan.



Successful alignment will enable the integration of best practices in care coordination, measurement of performance outcomes, and reallocation of financial (and other) resources.

Rationalizing the multiple attribution approaches means effectively harmonizing how performance evaluation and payment align with care coordination and population health management. This reduces duplication of effort, streamlines the evaluation process, and reduces the time delay before gaps in care can be closed.

To achieve this level of success, the scalable statewide Relationship and Attribution Management Platform will offer:

- An ability to leverage the existing ACRS process once it has been expanded to support linkages to include health plans and track participation in programs
- A mechanism for participating health plans to share retrospective attributions for each member. These lists will be used for comparison to ACRS entries and, when needed, will serve as a means to include providers initially unable to generate a complete ACRS record themselves
- A manual and automated process for provider organizations to update and maintain their affiliations with other organizations in the statewide health provider directory
- A manual and automated process for tracking existing practice units, certified Patient-Centered Medical Homes, and the specific providers or care givers linked to each practice unit in the statewide health provider directory

The existing MiHIN ACRS, with some modest modifications, can be leveraged almost as-is to incorporate traditional and newer attribution approaches.

One new requirement is for health plans to start sending their attributions to MiHIN. The benefit of this approach is that health plans, Medicaid, etc. can continue to utilize their existing attribution approaches and technology investments of choice, but still participate in a more comprehensive statewide approach aligned to support care coordination and population health.

In addition, provider organizations not yet able to assemble their own ACRS submissions can leverage the health plan assigned submissions to MiHIN to build an ACRS list as an entry to the program. These provider organizations can then send changes to their ACRS list as they develop more internal population health management capabilities.

In effect, using ACRS as a comprehensive statewide approach allows current attribution methods to continue without adding burdens to health plans, and simultaneously lowers barriers to entry for providers currently unable to accurately report their patient populations. By adopting ACRS as a common attribution model, Michigan will create a unified attribution method that benefits all stakeholders in our healthcare ecosystem.

## **Health Provider Directory (HPD) Service**

Multiple organizations track physicians and information on how to contact them such as name, address, specialty, national provider identifier, or specific credentialing information. The statewide Health Provider Directory (HPD) not only includes information contained in any traditional provider directory, from multiple

sources, but also includes the electronic service information required to know how and where health information is to be delivered electronically for each healthcare provider.

Health professionals now have electronic delivery endpoints such as Direct Secure Messaging (DSM) addresses or electronic medical records to which patient information can be sent. These endpoints for electronically sharing information with healthcare providers are collectively called Electronic Service Information (ESI), or in the new Fast Healthcare Interoperability Resources terminology, Endpoints. Health professionals need each other's ESI, electronic addresses, and endpoints to share information electronically.

The HPD is the most current directory in the state because it is updated monthly with information sent directly to MiHIN by providers to ensure they receive their patient data for all of their patients via ACRS. And unlike other provider directories, the HPD also tracks each individual provider and their multiple affiliations with various organizations. For example, in addition to a doctor's information, the HPD contains information about the practice unit (e.g. a Patient-Centered Medical Home) each doctor works at, plus the Physician Organization associated with that practice. The HPD also contains each hospital, its emergency department, and all the skilled nursing facilities in the state of Michigan. The HPD keeps track of specialties according to the national taxonomy along with historical information for providers. Finally, the HPD has information about health plans, and legal structures that affiliate providers.

Additional Modules utilizing the existing HPD are being considered to support the SIM needs. These modules would offer enhanced functionality based on roles and access rights that may include, but is not limited to, standardized views (i.e., dashboards, workflow, alerts) and user management. Requirements are being gathered to determine specific business needs.

### **Common Key Service Use Case**

One of the most important goals of sharing patient information electronically is to help doctors build complete, current pictures of their patients using health information from multiple sources. These sources can include other doctors or specialists, hospitals, clinics, pharmacies, skilled nursing facilities and any other healthcare settings where care is provided. Enabling doctors to gather the details to build these complete patient pictures requires accurate 'patient matching' to ensure electronic health information from outside sources is attached to the correct patient.

The Common Key Service (CKS) provides a consistent and reliable way to match patients with their electronic health information across multiple organizations, applications and services. The CKS uses multiple methods to link health information to individuals, such as:

- The CKS uses proven matching criteria to ensure that patient details (such as last name, date of birth, and phone number) positively and accurately identify the patient.
- The CKS connects with a Master Person Index (MPI) to manage information about patients and to eliminate duplicate entries with great accuracy.
- The CKS assigns a unique key that is stored and attached to the patient in the MPI and shared with all systems exchanging information about that patient. Each system can link their



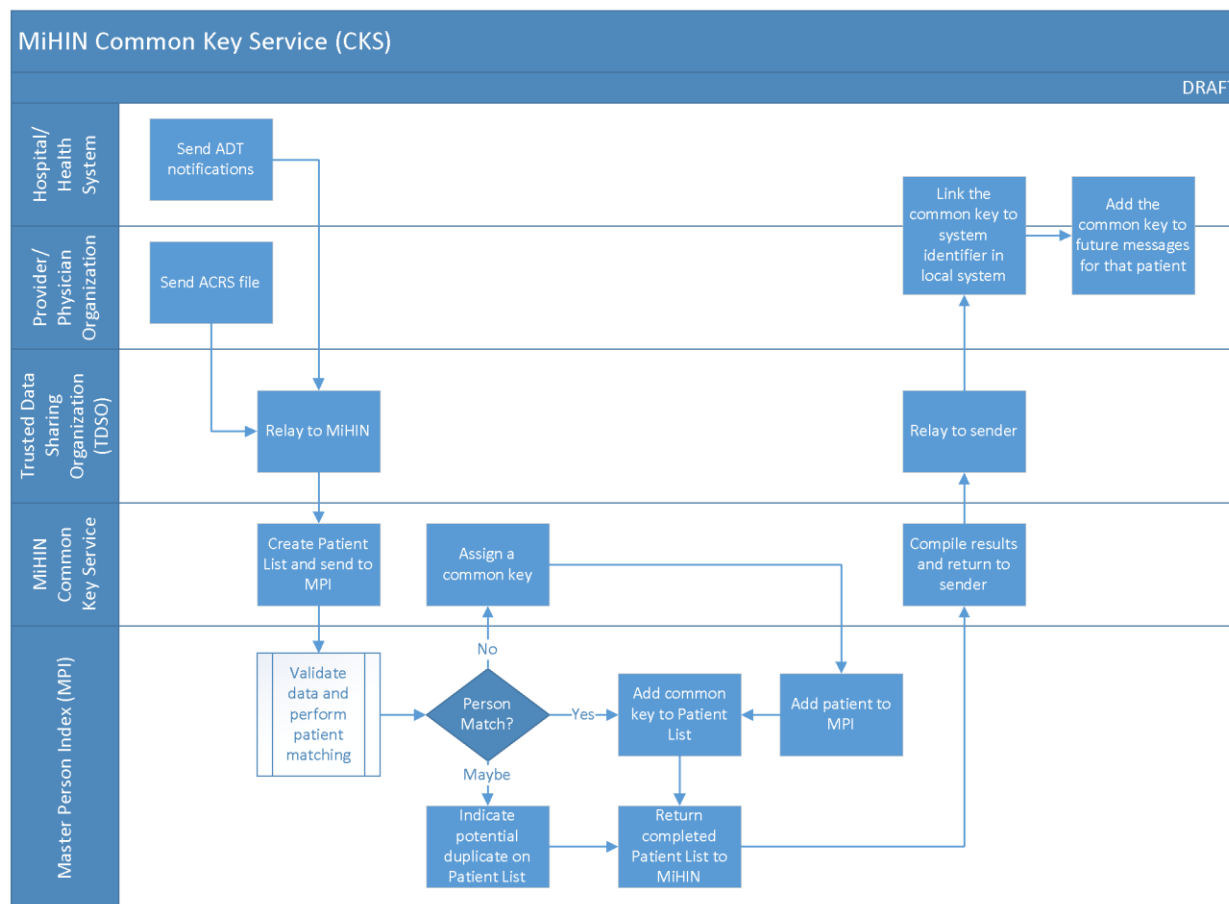
respective Medical Record Number to the same common key and then include the common key when exchanging information about the patient.

Essentially, the Common Key Service strengthens matching by providing a consistent and accurate detail (the individual patient's common key) that each system can rely on. This reliable matching capability improves patient safety and data integrity in all use cases when information is shared about a specific patient.

Over time, as CKS adoption grows throughout the state and more and more local systems link patients to a common key, it may no longer be necessary to include all of a patient's demographic information when exchanging their medical information, further improving the privacy and security of the information exchange as well by de-identifying the message.

Demonstration of how Common Key Service assignments take place are illustrated in Figure C10.6 (Example of Common Key Assignment using statewide ADT service).

Figure C10.6 Example of Common Key Assignment using statewide ADT service



1. Patient goes to the hospital which assigns MRN and generates an ADT message
2. ADT message is sent to MiHIN via Trusted Data Sharing Organization (TDSO) for normal routing to ADT receivers

3. MiHIN accumulates A03 inpatient ADT messages which do not have the common keys for a period of time (will be 100% of the time at first)
4. MiHIN assembles patient list file and processes it through the CKS
5. MiHIN sends a flat file of A31 messages with the common keys to the hospital to store within their system during testing, moving to real-time over time
6. Hospital can now add common key to future messages for that patient

## Performance Metrics and Reporting

The State Innovation Model Test seeks to test core elements of a transformed health system that will increase the efficiency of the health care delivery system, improve care coordination among health care providers and between health care providers and community-based services and supports, and focus on primary prevention interventions to improve population health. Collecting structured data from the Test participants will be crucial to understanding who is participating, and the outcomes of the test. The SIM data aggregator will provide a platform for this standardized collection and reporting.

### Data Aggregator Components

The role of the SIM data aggregator is defined as a centralized data aggregator with a public/private partnership that supports multi-payor and multi-participant reporting and analytical needs. The SIM data aggregator will be rolled out using a phased approach initially centered on (27) quality and (4) utilization measures with the potential to expand. The proposed solution is comprised of the following components:

- Quality Measures
- Utilization Measures
- Support Reporting Needs
- Portal
- Sandbox for Ad-Hoc Analysis

The SIM data aggregator will leverage the MiHIN ecosystem to pull and push the requested data. A process to evaluate the accuracy of the measure engine will compare results to benchmarks and utilize the use case method to find coding anomalies. Each measure must undergo a validation process. Detailed information about each component is provided below.

#### *Quality Measures*

The SIM data aggregator will calculate and report on all defined quality measures for the project. Quality measures are used to assess whether and to what degree patients are receiving consistent and appropriate care and management for their health status, demographics, and risk factors. Quality measures give users feedback on metrics such as percentages of well child visits for the pediatric population, rates of adult preventive screenings such as colonoscopies and mammograms, and counselling and treatment for tobacco cessation. Quality measures will be calculated and updated using all appropriate data sources, including claims, clinical, and eligibility information. All current, specified guidelines will be applied to measure the correct population (e.g. age, gender, and exclusion criteria for numerator and denominator selection). Where possible, HEDIS measure specifications will be used for both Quality and Utilization measures. Quality measures will be tested to ensure reliability and validity.

Table C10.1 Phase I Quality Measures

#	Metric/Measure	Definition
CQ1	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
CQ2	Cervical Cancer Screening	Percentage of women aged 21-64 years who, received one or more Pap tests to screen for cervical cancer
CQ3	Chlamydia Screening in Women	Percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period
CQ4	Comprehensive Diabetes Care: Blood Pressure Control	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had their most recent BP reading under 140/90 mm Hg.
CQ5	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
CQ6	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
CQ7	Comprehensive Diabetes Care: Eye Exam (retinal) performed	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.
CQ8	Adult BMI Assessment	Members age 18-74 who had an outpatient visit with a BMI documented during the measurement year or the year prior
CQ9	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90mmHg) during the measurement period
CQ10	Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
CQ11	Breast Cancer Screening	Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months
CQ13	Immunizations for Adolescents	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.

#	Metric/Measure	Definition
CQ15	Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday
CQ20	Well-Child Visits in the First 15 Months of Life	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: <ul style="list-style-type: none"> <li>•No well-child visits</li> <li>•One well-child visit</li> <li>•Two well-child visits</li> <li>•Three well-child visits</li> <li>•Four well-child visits</li> <li>•Five well-child visits</li> <li>•Six well-child visits</li> </ul>
CQ21	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.
CQ23	Adolescent Well-Care Visits	Members 12-21 years old in the measurement year that have had at least ONE “Well Care” visit (school physical, pap, post partum visit)
CQ26	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> <li>- Body mass index (BMI) percentile documentation</li> <li>- Counseling for nutrition</li> <li>- Counseling for physical activity</li> </ul>

### *Utilization Measures*

The SIM data aggregator will calculate and report on all defined utilization measures for the project. Utilization measures are used to provide insight into how patients are receiving care and whether they are receiving the appropriate care in the appropriate setting. These are a key driver for containing costs and improving patient experiences and outcomes over time. For example, analysis of the rate of Emergency Department visits for patients diagnosed with Asthma can lead to better management of chronic conditions through Primary Care and patient education. Calculation of Utilization measures such as Inpatient Admission, Readmission, and ED Visit rates will be done using medical claims and member eligibility for the selected population. Rules will be developed to ensure that the correct patients and encounters are included and excluded during measure calculation. Where possible, HEDIS measures specifications will be used for both Quality and Utilization measures. Utilization Measures will be tested to ensure reliability and validity.

Table C10.2 Phase I Utilization Measures

#	Metric/Measure	Definition
U29	Hospital admissions	Hospital admission rate per 1000 population
U30	All-cause readmissions	Number of acute inpatient hospital stays for patients aged 18 and older during the measurement year that

#	Metric/Measure	Definition
		were followed by an acute readmission for any diagnosis within 30 days.
U31	Emergency department visits	ED visits per 1000 population

### ***Support Reporting Needs***

Reporting to assess performance based on the SIM metrics will be provided by the SIM data aggregator. Dynamic dashboards and static reports will be available via central web-based portal hosted by the SIM data aggregator. Dashboards will include graphs and tables containing the SIM population, the quality and utilization measures described above, trends over time, and comparisons across the SIM population. Static reports containing participation and quality and utilization measures will be provided.

The SIM data aggregator will provide Ad Hoc custom reports not included on the portal to support the needs of the SIM leadership, PCMH operations contractor, collaborative learning network, and other committee requests.

### ***Portal***

The SIM data aggregator will host a secure portal where multiple levels of reporting are made available to users. Online, dynamic dashboards displaying the SIM metrics will be included so that users can evaluate performance. Static reports generated by the SIM data aggregator containing affiliated population and program participation as well as quality and utilization information will be available for download. Alternative Payment Model reports provided by other SIM sources will be provided as well. Access to reports will vary based on user and will be managed by the SIM data aggregator. The portal will provide a single point for users to access information related to participation and performance.

### ***Sandbox for ad-hoc analysis***

The goal of SIM analytical sandbox is to enable analysts, researchers and evaluators to conduct discovery and situational analytics. This platform is targeted for select analysts and “power users” to support the SIM Leadership, the Collaborative Learning Network and SIM Committee’s. The SIM analytic sandbox will also support evaluators, researchers and population health analytics.

Many of these analytic users have been building their own makeshift sandboxes, referred to as data shadow systems or “spreadmarts”. The intent of the SIM analytical sandbox is to provide the dedicated storage, processing resources and support analytic tools to eliminate the need for the data shadow systems.

The key components of the SIM analytical sandbox are:

- Business Analytics – supports the self-service Business Intelligence tools used for discovery and situational analysis
- Analytical Sandbox Platform - provides the processing, storage and networking capabilities

- Data Access and Delivery - enables the gathering and integration of data from a variety of data sources and data types
- Data Sources – sourced from within and outside the enterprise, it can be big data (unstructured) and transactional data (structured); e.g., extracts, feeds, messages, spreadsheets and documents.

The requirements of the SIM Analytic Sandbox will be defined during SIM implementation Year 1. However, detailed technical requirements and implementation activities are targeted to be completed in SIM Implementation Year 2.

## **Data Standards**

The underlying infrastructure will utilize prescribed data standards to support the components of the SIM data aggregator. The proposed data standards are comprised of the following:

- Data Interaction Process
- Data Format
- Data aggregation
- Data Storage
- Measure Engine / Report Development

Each of the proposed data standards are discussed in detail below.

### ***Data Interaction Process***

The SIM data aggregator will be responsible for receipt, evaluation, and conversion of all data used to support measure calculation and reporting for the project. This will include working with current and future data suppliers to define file formats for claims, clinical, membership, and provider information. The SIM data aggregator will assist with file transmission set-up and ongoing troubleshooting for all organizations submitting data. A standard supplier implementation and support plan will be in place through the life of the project. This will allow for consistent onboarding of new suppliers as the project expands. The SIM data aggregator will develop and apply standard data checks for all data, including those for format, content, and consistency. Additional, ad hoc data investigation will be performed when troubleshooting data issues as needed. The SIM data aggregator will dedicate staff to working with all new and existing data suppliers to maintain consistent data quality and address all data issues in a timely manner. The SIM data aggregator will leverage existing data supplier relationships, where possible, to ensure timely set up and ongoing receipt of all data types.

### ***Data Format***

The SIM data aggregator will receive files in the all payer claims database (APCD) format for eligibility, medical claims and pharmacy claims. In addition, the SIM data aggregator will receive supplemental clinical data and participation data from MiHIN to identify and attribute the SIM population.

### ***Data Aggregation***

The SIM data aggregator will aggregate and standardize membership, claims, and clinical information in support of the project. This will include assignment and utilization of consistent identifiers for patients and

providers across data sources, the calculation of measures using multiple inputs and levels of granularity (e.g., Inpatient Admission Rates), and the grouping of data in structures and formats designed for ease of reporting and extraction. Aggregation will be modular and repeatable – for example, recreation of rates based on receipt of additional data sources will be supported.

### ***Data Storage***

Storage units will be secure, not only from a data access perspective but physical location as well. Service SLA's will be established that follow SIM guidelines for up-time, support and data recovery. Storage will be easily scalable to allow for rapid growth.

### ***Measure Engine / Report Development***

Utilize solid, well tested development tools that will process large amounts of data rapidly in both batch and ad-hoc mode. Process needs to be easily expandable to handle new measure and reporting needs with quick turn-around and minimal performance degradation. Reusable code should be utilized to reduce time for code development, testing and code management.

## **Care Coordination Enablement**

The support of high visibility of patient movement within the healthcare ecosystem and provider performance, as well as facilitating the receipt of patient information/ notifications by the provider attribution care team to coordinate their ability to provide safe, effective and high quality care to the patient is crucial to the overall SIM vision. Advanced use cases identified to support this vision include:

- Coordinate Care Coordinators
- Statewide Admission-Discharge-Transfer Notification Service
- Care Summary
- SIM Quality Measures

The implementation of these use cases will leverage the Relationship and Attribution Management Platform in future SIM years. Detailed information about each advanced use case is provided below.

### **Coordinate Care Coordinators Use Case**

The number and types of individuals working or trying to work with patients continue to grow, ranging from nurses embedded in Patient-Centered Medical Homes, to discharge planners, to chronic disease programs, and now, more recently, community-based success coaches. This is especially true as payment models change, social services integrate programs with Medicaid, and penalties for readmissions reinforce the desire to coordinate care. Beneficiaries now receive calls from multiple, uncoordinated groups of individual care coordinators each asking for information and making requests that often lead to beneficiary confusion and frustration.

In addition, these care coordinators place additional burdens on Medicaid providers because the coordinators frequently need to talk to a physician and/or their staff to request additional information or clarification, and it is often unclear what can be shared. Medicaid beneficiaries have no idea how these individuals are connected to their doctor or their care, and most care coordinators are only aware of other individuals doing



care coordination when exasperated beneficiaries say “I already answered that” or “Didn’t you ask my doctor?”

Frequently, care coordinators do not know exactly with whom to speak so this process can be very labor intensive and unsatisfying for already busy and overworked providers receiving multiple, uncoordinated requests via multiple points of entry. Further, not only do care coordinators lack contact information for other coordinators, they do not operate under any standard or predetermined set of “rules of engagement.” Such a protocol would clarify expectations for each care coordinator’s role, place limits on given roles (what not to do), and establish basic common communication and follow up expectations around keeping other care coordinators informed.

The Coordinating the Care Coordinators use case is a mechanism to formally enable care coordinator registration and population of a directory where this information can be electronically maintained and shared among other healthcare providers engaged in care coordination. This includes creation of a formal Use Case for electronically accessing this information and determination of electronic service information. Another major element will include working with the Medicaid care coordinator community to establish defined roles and agreed-upon types of care coordinators to include in a directory. This will allow each care coordinator to quickly recognize the types of other coordinators working with a patient, and how to contact them manually or electronically via automated data sharing. Finally, once the individual care coordinators have been registered and types or roles identified, additional work with the Medicaid community will include development of standardized rules of engagement for beneficiary interaction. These rules of engagement will be automated mechanisms to support agreed-upon standard practices for each care coordinator to electronically update their latest interaction with the beneficiary and where possible ensure that duplicate work does not occur and unnecessary burdens on providers are removed.

### **Statewide Admission-Discharge-Transfer (ADT) Notification Use Case**

Admission, Discharge, Transfer (ADT) notifications are widely regarded as a keystone to improving patient care coordination through health information exchange. ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. Alerts are then sent to update physicians and care management teams on a patient’s status, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions.

ADT notifications also support the identification of patients who are frequent or high users of the healthcare system, which allows providers to steer these patients toward clinical and non-clinical interventions that may reduce unnecessary overutilization by preventing avoidable Emergency Department (ED) visits and hospital readmissions.

The Statewide Admission, Discharge, Transfer (ADT) Notification Service enables communication of alerts regarding patients’ care transitions to every care team member interested in that patient.

When a patient is admitted to a hospital, transferred, or discharged, an ADT message is created by the hospital’s Electronic Health Record (EHR) system. The hospital EHR system sends the ADT messages

through a “Trusted Data Sharing Organization” (TDSO) to MiHIN, which then looks up the patient and the providers on that patient’s care team using the Active Care Relationship Service (ACRS). MiHIN also looks up the providers in the statewide Health Provider Directory (HPD) to obtain the delivery preference for each of those providers and to determine the electronic endpoint and “transport” method by which the providers wish to receive ADT notifications (e.g. via Direct secure message, via HL7 over LLOP, etc.) for their patients.

Based on the provider’s delivery preferences, MiHIN notifies each provider having an active care relationship with a patient upon the following ADT events:

- Patient is admitted to the hospital for inpatient or emergency treatment
- Patient is discharged from the hospital
- Patient is transferred from one care setting to another (e.g., to a different location (unit, bed) within the hospital or to another facility outside of the hospital) and/or
- Patient’s demographic information is updated (e.g. name, insurance, next of kin, etc.) by a Participating Organization (PO)

### **Care Summary Use Case**

A Care Summary is the comprehensive evaluation of a patient’s treatment any time there is a change in therapy or Transition of Care (TOC) in an effort to avoid poor communication - particularly in regards to medication errors such as omissions, duplications, dosing errors, or drug interactions - as well as to observe compliance and adherence patterns.

The Care Summary process includes a review of care that has taken place by a provider and should occur at every transition of care. Hospital discharge is a transition of care when patients are at high risk of lack of appropriate follow-up or medication discrepancies as they transition from hospital to home. In particular, identifying and remedying medication discrepancies is important, as unaddressed discrepancies may contribute to drug-related problems, medication errors, and adverse drug events.

Several factors create difficulty for providers in managing patient care and improving patient safety including patient gaps in knowledge regarding medication details, next office visit dates, recommended changes in behavior and specifics of the care delivered, including names of providers.

The Care Summary Use Case allows providers to share patient Care Summary information at multiple points of care, including pharmacies, physician offices, hospitals, and transitional facilities such as outpatient tertiary and skilled nursing facilities. Statewide coordination in sharing patient Care Summary information helps minimize Hospital Readmissions and Adverse Drug Events (ADEs), and helps maximize cost benefits. Additionally, this Use Case leverages the MiHIN Active Care Relationship Service (ACRS) for notifying appropriate providers of changes to a patient’s care status.

## **SIM Quality Measures Use Case**

Quality measures are metrics of healthcare processes, health outcomes, or patient satisfaction. Sources of information used to calculate quality measures can include EHR systems, payer claims, lab results, medications, vital signs, symptoms, diagnoses, x-rays, etc. When properly utilized, quality measures can help transform healthcare delivery to improve care for patients and help transform healthcare payment to be quality-based instead of volume-based.

The burden of collecting, sending, and calculating the various quality measures is borne by physicians and payers (both government and commercial health plans). Due to a lack of standards, the electronic formats required by various payers and quality measure reporting programs can vary significantly, increasing the burden on physicians and Physician Organizations by adding a formatting step to the data submission process. Presently, each payer works with each physician or physician organization separately to gather the data necessary for each applicable quality measure, creating an inefficient point-to-point tangled web of redundancies, inconsistencies, and inefficiencies.

The SIM Quality Measures Use Case will enable providers and payers to consolidate and standardize the electronic exchange of quality-related data and performance results. Providers gain the ability to send one supplemental clinical data file in one format to one location.

The data is then separated and distributed to the appropriate health plans/payers based on membership attribution files provided by participating payers. The supplemental clinical data will also be distributed to the SIM Data Aggregator to calculate the SIM quality and utilization measures, which will be provided back to providers via a secure web-based portal.

Centralizing and standardizing this quality data flow will result in numerous benefits to all stakeholders:

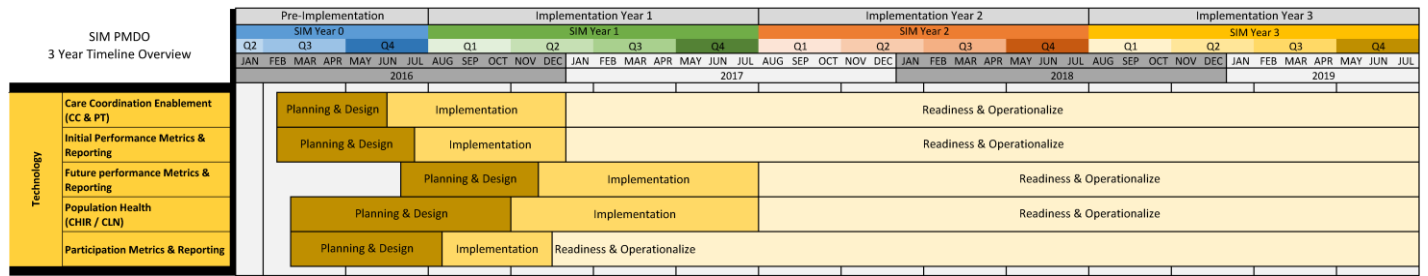
- Physician Organizations will enjoy a greatly reduced labor burden of running attribution and creating multiple custom formats and secure connections with different payers.
- Payers will get access to a greater quantity and quality of supplemental clinical data, often from sources they had not received data from in the past.
- Finally, providers will enjoy a centralized source from which they can view all-payer quality measure performance and receive actionable data which they can use to improve their quality scores and health of their patients.

## **Population Health Technology.**

The Technology Team and pertinent technology stakeholders will be involved in CHIR planning sessions to assist with education and technology solution design for regional technology needs as it relates to ongoing SIM participation needs.

## Technology Components

Figure C10.7 Technology Component Timeline



See Figure A4.1 or Appendix D3 for complete timeline

Figure C10.8 Technology Component Timeline-Related Activities

Component	Sub-Component	Activity
Performance Metrics and Reporting	Quality Metrics	Define Metrics
		Contracts and Agreements
		Development
		Testing
		Operational
	Reporting	Define Reports
		Define Presentation Area
	Participation / Relationship & Affiliation Management Plan	Define Participation Group
		Define Comparison Group
		WBS & Project Requirements Management
		ACRs File Submission Gap Analysis
		Development
		Testing
		Activation & Training
		Onboarding Support & Training
Care Coordination Enablement	CareConnect 360	Feasibility Study
		Design
		Development
		Testing
	HIE QO Engagement	Define Engagement Procedures
		Engage
	ADT/Care Summary/MedRec	Design
		Development
		Testing
Population Health Technology	Data Sharing	Implementation
		Analyze and Evaluate Solutions
	Care Delivery	Analyze and Evaluate Solutions

## Technical Assistance

Patient-Centered Medical Homes will receive practice transformation payments to support necessary technology and use case investments in practices. These payments will be made at a practice level for the first 24 months that a practice participates, and will be made upfront to enable early investments into transformation that will positively affect patient outcomes and satisfaction.

Along with the practice transformation payments, practices will receive support (e.g., from vendors, MCOs, others) in deciding how to invest practice transformation payments to make best use of the funds. Possible investment areas will include HIE / HIT systems, workflow management systems, training, and hiring new support staff.

Patient-Centered Medical Homes that are already receiving practice transformation reward, and care management support payment streams through participation in the Michigan Primary Care Transformation demonstration (MiPCT), will continue receiving these payments through the end of the demonstration project in December 2016. In January 2017, these practices will qualify to receive the new payment streams described above if they choose to participate in the Patient-Centered Medical Home model under SIM.

We will also leverage the use case factory approach to support development of and deliver technical assistance on new use cases developed for a statewide roll out over the next few years. With evolving needs, additional requirements for technical assistance will be determined based on participant feedback/learnings and incorporated within the existing HIE / HIT infrastructure.

## Summary

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

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

## C11 – Program Monitoring and Reporting

Michigan’s approach to program monitoring will support the initiative in achieving better health, better care, and lower cost by facilitating (a) timely and actionable identification of opportunities for improvement and course correction within the initiative, and (b) regular performance feedback to participants.

Monitoring activities can be summarized in three domains: monitoring for outcomes, monitoring for participation and processes, and monitoring for formative feedback and learning.

### Monitoring for Quality, Cost, and Health Outcomes

To accomplish outcomes monitoring, the SIM Initiative will leverage the initial quality and utilization metrics described in Section A3 (Core Metrics and Accountability Targets) of this document. The final measure set will be refined in collaboration with the Centers for Medicare & Medicaid Services, and SIM participant stakeholders over the course of the SIM Test period. A crosswalk between the CMMI recommended core measures and Michigan’s proposed initial measure set is provided in Table C11.1 (CMMI Recommendations and Michigan Proposed Metric Crosswalk) below.

#### Health Care

Claims and encounter data, supplemented by clinical data and survey measurement (for patient experience), will be the key sources for monitoring and reporting on performance on clinical quality, health care costs and utilization, patient experience, and use of care management processes (this may be ascertained through the reporting of HCPCS codes). It is expected that the SIM data aggregator – working in partnership with MiHIN, the PCMH contractor, and MDHHS staff – will collect and compile these data types.

Clinical quality data may be shared with the actuarial consultant for use in payment model calculations (cost data for calculating shared savings in Medicaid will be supplied through the Medicaid Data Warehouse). Relevant information on health care organizational performance will be summarized and presented to PCMHs periodically (likely quarterly) to support performance monitoring and continuous improvement within these organizations. (See Section C12: Data Collection, Sharing, and Evaluation.) Internal reports will be prepared on a quarterly basis to provide updates to SIM leadership on progress in achieving desired outcomes (see Accountability Targets in A3), and where possible, data will be stratified as to facilitate identification of racial/ethnic health disparities. In addition, program monitoring staff will regularly examine available data to assess for unintended consequences of implementation (e.g., adverse selection of patients by providers).

#### Population Health

Michigan’s set of common proposed population health metrics are detailed in Section A3; in general, performance data will be collected through the Behavioral Risk Factor Surveillance System (BRFSS). It is intended that individual CHIRs will also select population health-related outcomes and processes of particular local interest, and will monitor and report on these measures through an online platform.



To address the population health-related measures, evaluation contractors on behalf of SIM will regularly prepare reports for purposes of informing CHIRs and SIM leadership of progress in meeting accountability targets. Reports on measures may be updated less frequently for some of the population health outcomes given: (a) the longer time horizon for many interventions intended to address population health outcomes, and (b) the BRFSS administration schedule.

## Relevant Populations

Reporting using the state's entire population as the denominator is not feasible at present for many of the measures outlined in Section A3. However, Michigan will seek to expand the number of individuals included in the denominator to the greatest extent possible over the course of the Model Test. Inclusion of Medicare beneficiaries in the denominator is contingent on execution of a custom Medicare agreement with CMS. The State anticipates reporting, where possible, the population health measures outlined in A3 (Core Metrics and Accountability Targets) using the statewide population as the denominator.

Table C11.1 CMMI Recommendations and Michigan Proposed Metric Crosswalk

CMS Recommended Measure	Proposed Core Set Metrics
A. Hospital Readmission Rates	Plan all-cause readmissions
B. Emergency Department Visits	Emergency department visits
C. Patient Experience	Existing PCMH CAHPS surveying efforts
D. Diabetes Care	Comprehensive diabetes care composite <sup>9</sup>
E. Tobacco Use	
F. Obesity	Adult BMI assessment
G. Total Cost of Care PMPM	Standardized (Medicaid fee schedule) PMPM costs
H. Behavioral Health	

## Participation Monitoring

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

### Patient-Centered Medical Homes

Michigan will track the number of providers and provider organizations participating, including compliance with SIM-developed expectations. For PCMHs this will include, among other items, ensuring the maintenance of a specified ratio of SIM-eligible patients to care managers. Information compiled by operations personnel (for participation counts, staffing ratios, progress in achieving transformation objectives, and alignment with terms of participation), as well as encounter data compiled by the data aggregator (to track care management activity), will be used to develop scoreboard reports.

<sup>9</sup> HbA1C Poor Control rates may not be included initially depending on availability of clinical information.

## CHIR centralized social service navigation

The particular approach to monitoring of CHIR-supported clinical-community linkages for social service navigation will vary depending on the models adopted by each CHIR (e.g., Pathways Community Hubs). The State anticipates that, at a minimum, providers of navigation services will report on the number of individuals served, the services provided, and the extent to which individuals' needs were met. Michigan will make available a common platform for tracking and reporting on community navigation services provided to residents by CHIRs, while encouraging local innovation related to tracking and reporting (especially solutions that leverage Michigan's health information exchange infrastructure). Periodic "snapshots" of the platform(s) will be used for regular scoreboard reports.

## Other CHIR activities

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

## Monitoring for Formative Feedback and Learning

Michigan will use readiness assessments, reports from improvement coaches, CHIR specific evaluation contractor, and feedback through stakeholder committees (see Section C2: Stakeholder Engagement) to monitor the experience of participation (e.g., perceived level of burden, opportunities for improving model design, utility of SIM-provided supports, including HIT/HIE and CLN, etc.) as well as the development of skills and expertise for continuous improvement among Model Test organizations.

Table C11.2 SIM Monitoring

Domain	Primary Audiences	Key Resources	Frequency
<b><i>Population Health and CHIR</i></b>			
<b>Population Health Outcomes</b> <ul style="list-style-type: none"><li>• BRFSS</li><li>• CHIR-reported</li><li>• eQMs/claims and encounters</li></ul>	<ul style="list-style-type: none"><li>• SIM leadership</li><li>• CHIRs</li></ul>	<ul style="list-style-type: none"><li>• BRFSS</li><li>• Online tracking platform(s)</li><li>• Data aggregator</li></ul>	<ul style="list-style-type: none"><li>• CHIR-reported: Quarterly</li><li>• Others: Annual</li></ul>
<b>Navigation/Clinical-Community Linkages Services</b>	<ul style="list-style-type: none"><li>• SIM leadership</li><li>• CHIRs</li><li>• Payers</li></ul>	<ul style="list-style-type: none"><li>• Tracking platform(s)</li></ul>	Quarterly

<b>CHIR Capacity</b> <ul style="list-style-type: none"> <li>• Readiness assessment</li> <li>• Updates from coaches</li> </ul>	<ul style="list-style-type: none"> <li>• SIM leadership</li> <li>• CHIRs</li> </ul>	<ul style="list-style-type: none"> <li>• Provided through CLN contract, collected in a common database</li> </ul>	Semi-annual
<b>Other CHIR Activity &amp; Participation</b> <ul style="list-style-type: none"> <li>• Counts/tracking of CHIR participants, including ASCs</li> <li>• Development and execution of CHIR operational plans</li> <li>• Completion of CHNA</li> <li>• Fidelity to participation expectations</li> <li>• Feedback from participants</li> <li>• Lessons learned</li> </ul>	<ul style="list-style-type: none"> <li>• SIM leadership</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholder committees</li> <li>• CLN</li> <li>• Formative evaluation contractor</li> <li>• Online tracking platform(s)</li> </ul>	Quarterly
<b>Health Care Delivery and PCMH</b>			
<b>Health Care Processes and Outcomes</b> <ul style="list-style-type: none"> <li>• Clinical quality</li> <li>• Clinical processes (e.g., care management processes)</li> <li>• Utilization (including ED utilization analysis and population segmentation)</li> <li>• Disparities</li> </ul>	<ul style="list-style-type: none"> <li>• SIM leadership</li> <li>• Payers</li> <li>• Practices</li> </ul>	<ul style="list-style-type: none"> <li>• Data aggregator</li> <li>• MiHIN</li> </ul>	Bimonthly
<b>Health Care Costs</b>	<ul style="list-style-type: none"> <li>• SIM leadership</li> <li>• Practices</li> </ul>	<ul style="list-style-type: none"> <li>• Actuarial services</li> </ul>	TBD
<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>• SIM leadership</li> <li>• Payers</li> <li>• Practices</li> </ul>	<ul style="list-style-type: none"> <li>• CAHPS survey vendor(s)</li> </ul>	Annual
<b>Participation Counts</b> <ul style="list-style-type: none"> <li>• Providers</li> <li>• Practices</li> <li>• Patients</li> <li>• Payers, including use of Alternative Payment Models (by Learning and Action Network typology)</li> </ul>	<ul style="list-style-type: none"> <li>• SIM leadership</li> </ul>	<ul style="list-style-type: none"> <li>• PCMH operations contractor</li> <li>• Data aggregator</li> <li>• MiHIN</li> <li>• Medical Services Administration</li> </ul>	Quarterly (APM use may be measured less frequently in accordance with contract monitoring work of MSA)
<b>Other Participation Monitoring</b> <ul style="list-style-type: none"> <li>• Regular monitoring to ensure participation compliance</li> <li>• Progress in pursuing PCMH transformation objectives</li> <li>• Feedback from participants</li> <li>• Lessons learned</li> </ul>	<ul style="list-style-type: none"> <li>• SIM leadership</li> </ul>	<ul style="list-style-type: none"> <li>• PCMH operations contractor</li> <li>• Stakeholder committees</li> <li>• Collaborative learning network</li> <li>• Formative evaluation contractor</li> </ul>	Quarterly or Semi-annually

## C12 - Data Collection, Sharing, and Evaluation

The following sections describes the collection and sharing of data, and how the state is prepared to cooperate with the Center for Medicare and Medicaid Services as well as associated contractor's efforts to conduct the federal evaluation.

**Collecting, securing and providing the necessary Medicaid data, private payer data and/or Medicare data (E.G. Identifiers) in such a manner, including file specification, that the CMS and its contractors can perform the federal evaluation.**

The state will leverage existing assets for collecting, securing, sharing and providing the necessary data. Assets in the state which can be leveraged for this effort include the enterprise data warehouse within the Michigan Department of Health and Human Services which contains Medicaid claims and encounters, eligibility information, and provider tables, a new data aggregator which the state is developing over the duration of the SIM initiative.

To provide the necessary access to data needed by the federal evaluator and the Centers for Medicare & Medicaid Services the Michigan Department of Health and Human Services will enter into appropriate agreements with participants, including Medicaid payers, which would allow the transfer of data to take place.

**Providing data for all patients covered by the SIM program (public, and commercial), including baseline and historical data for three years prior to the project period**

Available data exists within the Department of Health and Human Services data warehouse and this data may be made available via a portal or other participant accessible repositories. Mechanisms for providing and presenting this data will be considered by relevant state bodies, including the HIE / HIT Committee and related sub-committees.

**Creating an identifier for those affected by the SIM program, regardless of payor, as well as sufficient data to identify a comparison group.**

The state is implementing a process to identify those that have required affiliations and linkages into the SIM Healthcare Ecosystem. The state will utilize MiHIN to gather the necessary data to determine the population affected by the SIM program (See C10 (Health Information Technology) for MiHIN and the Relationship & Affiliations Management Platform information). In order to determine the SIM population, based on criteria provided by the State, as well as comparison groups, MiHIN will gather data from health plans, PCMH Operations Contractors, POs, and SOM data warehouse and other potential sources identified during implementation and operationalization.

**Providing CMS and its contractor(s) with identifying and contact information for beneficiaries who receive services under the model to examine patient care experience under this initiative. The state will coordinate and facilitate and sampling and data collection on behalf of the centers for CMS among, but not limited to, state payors, private sector payors and health care providers.**

The Michigan Department of Health and Human Services is committed to working to ensure appropriate agreements are in place to provide data to evaluators from the Centers for Medicare & Medicaid Services. There is an expectation that appropriate agreements will be made between public and private payers and the Centers for Medicare and Medicaid Services and the federal evaluator to ensure information is shareable between stakeholders. The Michigan Department of Health and Human Services will assist with discussions to facilitate this. The Michigan Department of Health and Human Services and its contractors will also explore other options to meet evaluation needs.

**Cooperating with primary data collection efforts such as, but not limited to, survey, focus groups and key informant interviews**

The Michigan Department of Health and Human Services will use available resources, including the state evaluator, and regulatory levers to help the Center for Medicare and Medicaid Services undertake primary data collection efforts. The Michigan Department of Health and Human Services will be undertaking stakeholder engagement throughout the duration of the SIM effort, and this engagement may prove helpful for primary data collection efforts.

**Ensuring that the necessary legal mechanisms, authorities and/or agreements are in place to ensure timely delivery of data to the center for Medicare and Medicaid services and/or the center for Medicare and Medicaid services contractors**

Michigan does not have laws over and that supersede federal laws in regards to data sharing that are likely to prevent disclosure or protection of the type of data needed to evaluate its Model Test. The Health Insurance Portability and Accountability Act allows for research exemptions, and Michigan has developed Data Use Agreements with evaluation contractors in the past to allow for the analysis of records that contain protected health information.

**Cooperating with the federal evaluation contractor and the center for Medicare and Medicaid services for any other needs/requirements for the evaluation**

The Michigan Department of Health and Human Services will have the evaluation contractor coordinate the evaluation plan and data collection activities with program monitoring systems. The Michigan evaluation contractor will be involved in program monitoring, data collection and database design and development so that data collected will be useful for the evaluation. The evaluation contractor will be invited to relevant forums to ensure the evaluation contractor has an opportunity to stay up to date with program developments, and in fact provide formative input. The Michigan evaluation contractor will coordinate with the federal evaluator to provide data that the federal contractor may not have access to, and coordinate in order to streamline activity and reduce burden for participants.

**Agreeing not to receive additional reimbursement for providing data or other reasonable information to the center for Medicare and Medicaid services or another government entity or contractor**

The state will draft appropriate language in contracts and other necessary documents ensuring that it will not receive additional reimbursement for providing data or other reasonable information to the Centers for Medicare and Medicaid Services or another government entity or contractor.

## **C13 – Fraud and Abuse Prevention, Detection, and Correction**

New exposures that result from payment reform and funding methods under State Innovation Model (SIM) Test, as well as determining how existing fraud & abuse measures will be impacted by the health care transformation and SIM components. Michigan has a number of tools, processes and control measures in place to deter fraud and abuse in the Medicaid and other Michigan Department of Health and Human Services (MDHHS). We outline these measures and SIM-specific impacts and below.

### **New Exposures to Fraud & Abuse Under SIM**

To date, we have identified three potential new exposures to fraud and abuse as a result of the State Innovation Model program. First, health care costs could potentially be compromised if providers take unjustified action to bill services under claims codes not included in the Patient-Centered Medical Home / Accountable Systems of Care payment definition. Additionally, providers could inaccurately increase the severity of a patient's condition in order to obtain more reimbursements from the state. Lastly, providers could potentially withhold clinically necessary and appropriate care to patients within their panel in light of total cost of care accountability. We are continually assessing and will continue to identify other fraud & abuse exposures under SIM.

These potential exposures to fraud and abuse as a result of Alternative Payment Model implementation are not unique to Michigan. We will apply the appropriate controls and regulations necessary to ensure the delivery of high-quality care and improved patient experience to individuals. The SIM Test components will leverage best practices implemented by MDHHS and its Office of the Inspector General (OIG) to define strategies to mitigate fraud and abuse. The State will develop, as needed, additional SIM-specific safeguards, requirements and policy based on the Inspector General's guidance to ensure the integrity of the both the financial and evaluation of the Model Test in Michigan.

### **BARRIERS TO IMPLEMENTING SIM WITH EXISTING FRAUD & ABUSE MEASURES**

Michigan is committed to the successful implementation of the SIM Test components and will identify and seek to immediately resolve any policies that would inhibit the current implementation and operational plan.

### **MICHIGAN'S INITIATIVES TO MITIGATE FRAUD & ABUSE**

#### **Michigan Managed Care Plan Request for Proposal**

The Michigan Request for Proposal to provide Comprehensive Health Care Program (CHCP) services for Medicaid beneficiaries in the service areas within the State of Michigan mandates a number of measures for Medicaid health plans to implement for fraud & abuse. It includes policies and procedures for fraud, waste, and abuse as well as reporting noncompliance. Contractors are also subject to compliance and reviewing procedures. MDHHS can utilize a number of remedies and sanctions to deal with noncompliance.



In their educational materials for enrollees and providers, contractors will make their fraud, waste, and abuse policies transparent. The Request For Proposal mandates that in the collection of enrollment files, all stakeholders will appropriately identify and report fraud, waste and abuse. Contractors will also ensure compliance of the federal False Claim Act and the other provisions named in Section 1902(a)(68)(A) of the Social Security Act by integrating those provisions into employee handbooks and policies. Contractors will also employ a full time employee compliance officer who reports to senior management.

### **Medicaid health plan compliance review process**

The MDHHS requires quarterly submissions of program integrity metrics and criteria to ensure Medicaid Health Plans are compliant in regards to fraud, waste, and abuse. MDHHS collects the reports and refers to the OIG as necessary. Health plans are also required to submit an annual compliance plan. This report details how the health plans will comply with the policies procedures defined in 42 CFR 438.608. The compliance report will verify that contractors are utilizing effective fraud and abuse education / training, a compliance officer with accountability to management, and enforcement techniques for fraud and abuse standards. The compliance report submitted by health plans also has a requirement to show proof that no employee has a conflict of interest, which may hinder the contractual obligations to the State.

The content of the compliance report provides the State with a comprehensive picture as to how the health plans are curtailing fraud, waste, and abuse. Health plans are required to describe their data mining and algorithms efforts, or program integrity ideas that are applied to claims data, which may help to identify potential fraud, waste, and abuse. Additionally, plans provide a complete list of tips and grievances – complaints or referrals received by the plans from others relating to program integrity that require some sort of investigation. Health plan audits of their providers are performed on a scheduled or ad hoc basis. Lastly, plans submit their list for provider disenrollment separated for cause or on a voluntary basis.

### **Data sharing agreement**

The MDHHS also uses a standard Data Sharing Agreement. This agreement outlines the method for sharing data, the process for sharing data, the entities that are allowed to use the data and how, and procedures in the case of a security breach. The Data Sharing Agreement helps to protect against fraud and abuse in regards to personal health information and other sensitive data.

### **State employee code of conduct**

All MDHHS employees are governed by a code of conduct. Employees are given the MDHHS Employee handbook which references Civil Service Rule 2-8. This rule details prohibited activities that would prevent the high ethical conduct for employees.

### **Office of the Inspector General**

In addition to the above, the State OIG will work with the State's Medicaid Agency Managed Care division to review SIM requirements and model payment methods to identify potential gaps in Fraud and Abuse policies. The OIG will work to develop, if necessary, modifications and additions to existing policies and procedures related to SIM-related Medicaid and Population Health-related component and fiduciary integrity. The OIG

will also play a role in the evaluation of Community Health Innovation Region-based programs where Fraud & Abuse potential may exist.

## D. Appendix

### D1. State Innovation Model Acronyms and Abbreviations

Acronym	Description
ABAD	Aged, Blind and Disabled
ACO	Accountable Care Organization
ACRS	Active Care Relationship Service
ADE	Adverse Drug Events
ADT	Admission, Discharge and Transfer
AHEC	Area Health Education Center
APC	Advanced Primary Care
APM	Alternative Payment Method
ARRA	American Recovery and Reinvestment Act of 2009
ASC	Accountable Systems of Care
BIC	Business Integration Center
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCA	Care Coordination Agency
CEHRT	Certified Electronic Health Record Technology
CHAMPS	Community Health Automated Medicaid Processing System
CHAP	Children's Healthcare Access Program
CHCP	Comprehensive Health Care Program
CHIR	Community Health Innovation Regions
CHNA	Community Health Needs Assessment
CHP	Center for Health Professions
CHW	Community Health Workers
CJS	Cross-Jurisdictional Sharing
CKS	Common Key Service
CLAS	Culturally and Linguistically Appropriate Services
CLN	Collaborative Learning Network
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPC+	Comprehensive Primary Care Plus
DHHS	Department of Health and Human Services
DIFS	Department of Insurance and Financial Services
DNPAO	Division of Nutrition, Physical Activity and Obesity
DSM	Direct Secure Messaging
E2P	Education to Practice
EHR	Electronic Health Record
ESI	Electronic Service Information
FMAP	Federal Medical Assistance Percentages
FQHC	Federally Qualified Health Center
HHS	Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HPD	Health Provider Directory
HRSA	Health Resources and Services Administration
HVHC	High Value Healthcare Collaborative
ICSI	Institute for Clinical Systems Improvement
ICU	Intensive Care Unit

<b>Acronym</b>	<b>Description</b>
<b>IHI</b>	Institute for Healthcare Improvement
<b>LAN</b>	Health Care Payment Learning and Action Network
<b>LARA</b>	Licensing and Regulatory Affairs
<b>MAAP</b>	Mobilizing for Action through Planning and Partnerships
<b>MDC</b>	Michigan Data Collaborative
<b>MDHHS</b>	Michigan Department of Health and Human Services
<b>MHP</b>	Medicaid Health Plan
<b>Mi-AHEC</b>	Michigan Area Health Education Center
<b>Mi-CHWA</b>	Michigan Community Health Worker Alliance
<b>MiHIN</b>	Michigan Health Information Network
<b>MiPCT</b>	Michigan Primary Care Transformation Project
<b>MOA</b>	Memorandum of Agreement
<b>MOAC</b>	MiHIN Operations Advisory Committee
<b>MPBH</b>	Michigan Pathways to Better Health
<b>MPHI</b>	Michigan Public Health Institute
<b>MPI</b>	Master Person Index
<b>MSHOP</b>	Michigan Surgical and Health Optimization Program
<b>MSMS</b>	Michigan State Medical Society
<b>MSSP</b>	Medicare Shared Savings Program
<b>NCQA</b>	National Committee for Quality Assurance
<b>NEPQR</b>	Nurse Education, Practice, Quality, and Retention
<b>NHIM</b>	National Health Information Network
<b>NPAO</b>	Nutrition, Physical Activity, and Obesity
<b>OIG</b>	Office of the Inspector General
<b>OMH</b>	Office of Minority Health
<b>ONC</b>	Office of the National Coordinator
<b>PATH</b>	Personal Action Toward Health
<b>PCMH</b>	Patient-Centered Medical Home
<b>PCO</b>	Primary Care Office
<b>PGIP</b>	Physicians Group Incentive Program (BCBS)
<b>PHIP</b>	Population Health Improvement Plan
<b>PIPH</b>	Plan for Improving Population Health
<b>PMDO</b>	Project Management and Delivery Office
<b>PMPM</b>	Per Member Per Month
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SHIP</b>	State Health Improvement Plan
<b>SHNA</b>	State Health Needs Assessment
<b>SIM</b>	State Innovation Model
<b>SME</b>	Subject Matter Expert
<b>SPA</b>	State Plan Amendment
<b>TANF</b>	Temporary Assistance for Needy Families
<b>TCOC</b>	Total Cost of Care
<b>VAP</b>	Ventilator-Associated Pneumonia

## D2. Multi-Payor Engagement Plan

### Background and Current Conditions

The healthcare marketplace in the United States is extremely fragmented. Purchasers, employers, insurers and the government act as intermediaries. The ultimate goal is to provide quality healthcare at a reasonable cost. The inability to control the healthcare cost trend and not producing best in class quality has led the system to a “breaking point” whereby purchasers can no longer afford to pay for an inefficient and ineffective system. A clear goal to improving the current state is to reduce inefficiencies and align several aspects of the system to reduce duplication, increase transparency and build a sustainable healthcare marketplace. A primary driver of this transformation is Multi-Payer Alignment.

The SIM PCMH Initiative will leverage existing knowledge, administrative procedures and best practices from existing demonstration projects whenever possible. There are several significant federal, state and health plan PCMH initiatives and projects that the SIM PCMH Initiative can learn from to help improve the design and ultimate success of this project. These strategic initiatives include:

- Michigan Primary Care Transformation Project (MiPCT);
- BCBSM PCMH Initiative;
- Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration project sponsored by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA); and
- Comprehensive Primary Care (CPC) Initiative sponsored by CMS

Additional details regarding these initiatives can be found in the appendices of the full Multi-Payer Alignment Strategy.

### Potential Areas of Alignment

The SIM Leadership Team (SLT) with input from a Multi-Payer Alignment Team (MAT) and other key stakeholders have developed a grid of potential alignment categories that is cross tabulated by SIM strategic category (PCMH and CHIR) and also by payer category (Medicare, Medicaid, Commercial (Insured), Commercial (Self-Insured) and Self-Insured employers). A sample of the grid is below.

Patient-Centered Medical Homes (PCMHs)					
Alignment Categories	Medicare	Medicaid	Commercial Health Plans (Insured)	Commercial Health Plans (Self-Insured)	Self-Insured Employers
Performance Measures					
Data Content,					

Format & Transmission					
Risk Adjustment					
Attribution					
Metrics					
Payment Type					
Operations					
Contracting					
Collaborative Learning					
Research					
Key	Year 1	Year 2	Year 3		

## A Regional Phased Approach

The SIM implementation plan has outlined five (5) test regions for strategic implementation. The Multi-Payer Alignment strategy will outline the payers and employers in the test regions, then prioritize a list of “preferred partners” by region and phase of rollout. The prioritized payers will be entered into a grid to help identify payers across lines of coverage. A sample of the grid is below. Complete grids can be found in the appendices of the full Multi-Payer Alignment Strategy.

Table D2.1 SIM Five (5) Test Regions Identified for Phase 1 (Year 1)

Jackson County	Medicare	Medicaid	Commercial Health Plans (Insured)	Commercial Health Plans (Self-Insured)	Self-Insured Employers
<b>Payer #1</b>	Blue Cross Blue Shield of Michigan	Meridian Health Plan	Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan	Allegiance Health System
<b>Enrollment</b>	4,079	20,178	Not Available	Not Available	3,226 EE's (2015)
<b>Payer #2</b>	Blue Care Network of Michigan	UHC Community Plan	Blue Care Network of Michigan	Blue Care Network of Michigan	Consumers Energy
<b>Enrollment</b>	1,536	3,509	Not Available	Not Available	2,400 (2012)
<b>Payer # 3</b>	Priority Health	Aetna Better Health of MI	Priority Health	Priority Health	Michigan Department of Corrections
<b>Enrollment</b>	852	2,808	Not Available	Not Available	2,040 EE's (2012)

## Potential Barriers to Alignment

The SIM Leadership Team (SLT) and Multi-Payer Alignment Team (MAT) are tasked to identify potential barriers to alignment. Examples of potential barriers include existing similar program infrastructure and understanding:

- Michigan Primary Care Transformation Project (MiPCT);
- BCBSM PCMH Initiative;
- Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration project sponsored by the Centers for Medicare and Medicaid Services (CMS) in partnership with the Health Resources Services Administration (HRSA); and
- Comprehensive Primary Care (CPC) Initiative sponsored by CMS

In addition, existing health plan contracts and incentive programs, data availability, analytics, return on investment assumptions, and development of program specifics including the timing and complexity of items identified in the Alignment Categories have been identified as potential barriers. MAT has scheduled regular meetings and a first priority after identifying potential areas of alignment is to critically examine potential barriers to that alignment. Identified barriers will be included in the alignment prioritization process.

Currently identified risks include:

- The need to generate broad-based support and buy-in across multiple stakeholders (e.g., Medicare health plans, Medicaid health plans, commercial insurers, providers, provider organizations), many of whom have diverse priorities;
- Challenges with creating incentives that are sufficient to drive meaningful change in provider behavior and cost avoidance;
- Variations in existing programs with similar goals and objectives but different metrics, incentives and accountability;
- Competing programs that have been announced or are currently being communicated have to be compared, contrasted and aligned with SIM goals and objectives. timing of changes adds complexity and confusion;
- Fully identifying all areas of potential alignment;
- Fully identifying associated barriers to alignment; and
- Significant health information technology and infrastructure capability necessary to enable full achievement of PCMH and CHIR goals.

Through the SIM operational plan drafting process, the SLT and MAT reviewed these potential risks and proposed the following corresponding strategies for mitigation:

- Engage stakeholders at key points in strategy development and implementation via committees and teams;
- Invite payers to contribute strategies and feedback in areas including alignment categories, barriers to alignment, metrics, payment adjudication, etc.;
- Create incentives that directly impact provider behavior and ensure they are of sufficient magnitude to drive changes in provider behavior;



- Institute process metrics related to patient engagement and education to ensure PCMH and CHIR engagement is appropriately prioritized;
- Supply practice transformation payments to PCMHs or through CHIRs to support investment in high-value systems and processes;
- Create a Multi-Payer Alignment Team to identify, scrutinize and prioritize potential opportunities for alignment; and
- Make information technology and infrastructure decisions to reflect the various needs of the care delivery models, holistically.

## Specific Payer Strategies

### Medicare

The SIM leadership team and key stakeholders recently analyzed two approaches regarding Medicare alignment with SIM goals and objectives, both of which have downstream impact on the PCMH and CHIR tracks. CMS recently released guidelines for a CPC+ enhanced PCMH model. The model provides a five-year demonstration for Medicare's participation in a PCMH initiative. The model does not allow PCMHs to participate in CPC+ if they are Federally Qualified Health Centers (FQHCs), rural health centers or if they participate in another Medicare shared savings model. It also requires separate applications for participation by Medicaid for its fee-for-service population and by Medicaid health plans for the managed care population. Given the provider exclusion and lack of interest from the plans, combined with the complexities of implementing Track 2 of CPC+, the State and its stakeholders prefer to focus on a custom option for Medicare participation in the Michigan PCMH model.

The custom approach provides the greatest amount of flexibility in designing how payment reform and delivery system transformation are pursued in Michigan. The SIM Leadership Team (SLT) believes there will be an opportunity to continue to grow the size of Michigan's PCMH program, allowing for practice expansion (within a negotiated framework) over time.

The custom Medicare participation option would involve a set of negotiations between MDHHS/SIM and CMS to develop an agreement that incorporates a set of Medicare principles for participation in care delivery and payment models. Conversations are taking place throughout 2Q 2016.

The custom approach and application specifics will be driven by an analysis to identify and prioritize areas of alignment using the sample grid/tool below.

Medicare		
Alignment Category	PCMH	CHIR
Performance Measures		
Data Content, Format & Transmission		
Risk Adjustment		
Attribution		
Metrics		

<b>Payment Type</b>			
<b>Operations</b>			
<b>Contracting</b>			
<b>Collaborative Learning</b>			
<b>Research</b>			
<b>Key</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>

## Medicaid

The SIM implementation plan aims to leverage the buying power of Medicaid through its health plans and current requirements for Medicaid Health Plans (MHPs) to implement value-based purchasing arrangements. The SIM Leadership Team (SLT) proposes that MHP contracts are amended to add specific Alternate Payment Model (APM) threshold targets, which would include the following requirements:

- The amount of populations or premiums that are required to be associated with APM's as defined by the State and consistent with Learning and Action Network (LAN) categories over the term of the contract;
- A certain percentage of APMs must qualify in LAN categories 3B and 4 and require Medicaid Health Plans (MHP) to share savings/risk with providers; and
- Specific APM reporting requirements through which the MHPs share detailed information on these models with the State.

In addition, we propose tying the MHPs ability to receive any of the 1% performance withhold on the MHP's success in moving towards these payment models at agreed upon rates between the MHP and the State.

By incentivizing the MHPs to meet these APMs, the State will further the goal of SIM to transform the health care delivery system in a way that allows providers to receive financial incentives for improved quality and cost outcomes. MHPs will be able to contract with health systems and other providers that form ASC-like arrangements, and will have the ability to develop the relationships that work best for the providers and plans. MSA could provide best practice information and templates to MHPs to support plan efforts to implement these initiatives.

Medicaid alignment specifics will be driven by an analysis to identify and prioritize areas of alignment using the grid/tool below.

<b>Medicaid</b>		
<b>Alignment Category</b>	<b>PCMH</b>	<b>CHIR</b>
<b>Performance Measures</b>		
<b>Data Content, Format &amp; Transmission</b>		
<b>Risk Adjustment</b>		
<b>Attribution</b>		
<b>Metrics</b>		

Payment Type			
Operations			
Contracting			
Collaborative Learning			
Research			
Key	Year 1	Year 2	Year 3

### Commercial Health Plans (Self-Insured)

Commercial self-insured payers, including Blue Cross Blue Shield of MI, have various quality improvement and cost containment incentive-based strategies. BCBSM has actively participated in MiPCT and continues to have discussions with the SLT as the plan evolves. Discussions with currently participating commercial self-insured MiPCT payers are in process and are looking positive for continued participation. The initiative is interested in recruiting additional commercial payers and will be launching a formal payer engagement plan soon. Commercial payers representing both large and small employers will be asked to participate on the Multi-Payer Alignment Team (MAT). The plan is to maximize Commercial self-insured Multi-Payer Alignment through the use of key stakeholder input, the tools identified in the Multi-Payer Alignment Strategy and a formal process to identify, scrutinize and prioritize those strategies.

Alignment specifics will be driven by an analysis to identify and prioritize areas of alignment using the grid/tool below.

Commercial Health Plans (Self-Insured)			
Alignment Category	PCMH		CHIR
Performance Measures			
Data Content, Format & Transmission			
Risk Adjustment			
Attribution			
Metrics			
Payment Type			
Operations			
Contracting			
Collaborative Learning			
Research			
Key	Year 1	Year 2	Year 3

### Commercial Health Plans (Insured)

Commercial insured payers, including Blue Care Network of MI and Priority Health, have various quality improvement and cost containment incentive-based strategies. They have actively participated in MiPCT and continue to have discussions with the SLT as the plan evolves. Discussions with currently participating commercial insured MiPCT payers are in process and are looking positive for continued participation. The initiative is interested in recruiting additional commercial insured payers and will be launching a formal payer engagement plan soon. Commercial insured payers will be asked to participate on the MAT. The plan is to

maximize Commercial insured Multi-Payer Alignment through the use of key stakeholder input, the tools identified in the Multi-Payer Alignment Strategy and a formal process to identify, scrutinize and prioritize those strategies.

Alignment specifics will be driven by an analysis to identify and prioritize areas of alignment using the grid/tool below.

Commercial Health Plans (Insured)				
Alignment Category	PCMH			CHIR
Performance Measures				
Data Content, Format & Transmission				
Risk Adjustment				
Attribution				
Metrics				
Payment Type				
Operations				
Contracting				
Collaborative Learning				
Research				
Key	Year 1	Year 2	Year 3	

## Self-Insured Employers

Many self-insured employers in the State are participating in PCMH-related activities today. Typically, this participation involves paying for certain care management services through accredited PCMH offices through commercial payers. Self-insured employers have to agree to pay for the services, so the uptake on engagement has been slow. The SLT and MAT seek to maximize both the number of self-insured participants and the use of the services designed to improve the quality of care.

Self-insured employers will be asked to participate on the MAT. The plan is to maximize self-insured Multi-Payer Alignment through the use of key stakeholder input, the tools identified in the Multi-Payer Alignment Strategy and a formal process to identify, scrutinize and prioritize those strategies. In addition, a separate ROI focused communication tool will be developed for this particular audience. This is necessary as employers view health care spend through a different lens. In an environment of cost containment, the evidence regarding quality and cost improvement strategies will need to be communicated differently.

Specifically, self-insured employer alignment specifics will be driven by an analysis to identify and prioritize areas of alignment using the grid/tool below.

Self-Insured Employers			
Alignment Category	PCMH		CHIR
Performance Measures			
Data Content, Format & Transmission			
Risk Adjustment			
Attribution			
Metrics			
Payment Type			
Operations			
Contracting			
Collaborative Learning			
Research			
Key	Year 1	Year 2	Year 3

## SIM “Pillar” Strategies

### Patient-Centered Medical Home (PCMH)

Similar to other Michigan SIM components, the PCMH initiative is intended to be multi-payer in design including Medicare, Medicaid, Commercial health plan (Insured), Commercial health plan (Self-Insured) and Self-Insured Employers.

The SIM PCMH Initiative is designed to create a high degree of standardization for all of the alignment categories listed below and sub-elements including technical requirements, attribution, quality measures, payment streams, etc. All existing payers are involved in PCMH initiatives to date. The main initiative that crosses all payers is the MiPCT project. The SLT and key stakeholders have been in discussions to leverage the MiPCT program including learnings and operational components. The key will be to leverage the existing framework but still move the PCMH strategy forward to an advanced state.

The Multi-Payer Alignment Team (MAT), in its final state, will be comprised of members from each payer type. The team objective is to maximize multi-payer alignment through the use of key stakeholder input, the tools identified in the Multi-Payer Alignment Strategy and a formal process to identify, scrutinize and prioritize those strategies across the continuum of payers. The key to maximizing this alignment will be the thoughtful process of leveraging existing learnings and infrastructure while prioritizing and agreeing to the path forward.

Specifics will be driven by an analysis to identify and prioritize areas of alignment and specific components of alignment using the grid/tool below.

Patient-Centered Medical Homes (PCMHs)					
Alignment Categories	Medicare	Medicaid	Commercial Health Plans (Insured)	Commercial Health Plans (Self-Insured)	Self-Insured Employers
Performance Measures					
Data Content, Format & Transmission					
Risk Adjustment					
Attribution					
Metrics					
Payment Type					
Operations					
Contracting					
Collaborative Learning					
Research					
Key	Year 1	Year 2	Year 3		

### Community Health Innovation Regions (CHIR)

Community Health Innovation Regions (CHIRs) will be designed to leverage well-developed, existing capacity in communities to bring partners together in a local area to identify and address community health needs. When community health needs are identified, the CHIR and its infrastructure will support payers and providers in an effort to improve community health. Similar to other Michigan SIM components, the CHIR initiative is intended to be multi-payer in design including Medicare, Medicaid, Commercial health plan (Insured), Commercial health plan (Self-Insured) and Self-Insured Employers.

CHIRs will develop and implement linkages between healthcare, including payer partners, and community-based agencies to address social determinants of health. CHIRs will pursue local policy and build environment efforts and others services to encourage health and wellness. The SIM vision for the CHIRs is to achieve a high level of organization and sophistication in terms of governance, partnership, data collection and information sharing, and integrated service delivery. All of these objectives will be coordinated using a multi-payer, multi-provider approach to strategy deployment.

One main objective of CHIR support is a partnership with existing Accountable Systems of Care (ASCs). ASCs in turn may have contracts with multiple payers, hence the need for Multi-Payer Alignment. CHIRs will be structured to include a responsibility to transform the region's health system to allow it to better serve the needs of the specific community and put appropriate infrastructure in place to work differently. CHIRs will have the ability to contract with health systems and other providers to begin these transformations, by providing infrastructure support and funding for transformation initiatives that may include health systems as well as community-based organizations.

Specific CHIR related multi-payer strategies will be developed and refined in an approach similar to that of the PCMH and individual payer tracks. Initiatives will be driven by an analysis to identify and prioritize areas and specific components of alignment using the grid/tool below.

Community Health Innovation Regions (CHIRs)					
Alignment Categories	Medicare	Medicaid	Commercial Health Plans (Insured)	Commercial Health Plans (Self-Insured)	Self-Insured Employers
Performance Measures					
Data Content, Format & Transmission					
Risk Adjustment					
Attribution					
Metrics					
Payment Type					
Operations					
Contracting					
Collaborative Learning					
Research					
Key	Year 1	Year 2	Year 3		

## Timeline & the Path Forward

Macro-level and detailed timelines have been created to provide both a high-level perspective of project timing and a detailed level of planning associated with Multi-Payer Alignment. The initial focus of the Multi-Payer Alignment Strategy includes building the necessary infrastructure to support the efforts moving forward.

Table D2.2 – High-Level Perspective

	Initiative Year 1 2017	Initiative Year 2 2018	Initiative Year 3 2019
PCMH Medicaid	Interim payment model implementation	Payment model alignment (to the extent possible) with custom option	Payment model refinement and growth
PCMH Medicare	Interim chronic and transitional care management payments	Custom option payment model implementation	
PCMH Commercial	Sustain current commercial payer participation	Commercial payer participation growth	
Broad APMs	Collect Michigan’s APM baseline and establish goals	Progressively increase percentage of payment in APMs	

*Please note that timelines are approximate.*



### **D3. HIE/HIT Implementation Year 1 Timelines and Milestones**

The following SIM Technology timelines have been created in order to help meet and support the first year initiatives set forth by the SIM Model Test Project. The timelines are defined by activities and milestone objectives needed by SIM partners over the first implementation year.

The SIM PMDO has over accountability for the execution of all SIM timelines and implementation activities. The SIM PMDO team has established standard meeting cadence, documentation requirements and status reporting formats across the SIM program to improve cross component communication, issue and risk management and status reporting. The timelines below are directly managed and monitored by the SIM Technology Component Governance depicted in Figure 10.2.

The SIM Technology Project Manager is the primary liaison and coordination point with the SIM technology partners. Each SIM technology partner is also required to assign a project manager to ensure adherence to standard reporting requirements, develop and manage timelines specific to their responsibilities and communicate issues and risks. Individual weekly status meetings are held between the SIM Technology Project Manager and each technology partner's project manager to review progress, address issues and risks and update plans as necessary.

Interdependencies across technical partners are addressed during weekly cross track meetings. Current cross track meetings have been established for Participation Determination which covers the Relationship & Attribution Management Platform, Metrics and Reporting, Care Coordination, Population Health and State of Michigan Integration Points. During these meetings timelines, issues, risks and deliverables are reviewed by project managers, implementation leads and other team members as necessary. These meetings serve as the primary mechanism for managing cross dependencies and ensuring continued alignment between partners identified on the time lines bellow. Focused working meetings are held as needed to define requirements, designs, testing plans and testing results.

Issues, risks and action items not resolved in the cross track meetings are escalated to the SIM Technology Component Governance following the processes defined in section B3 – Risk Assessment and Mitigation Summary.

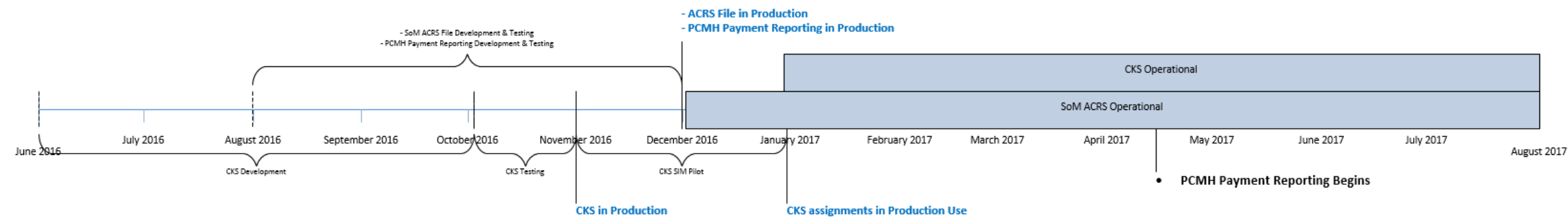
The timelines are defined by activities and milestone objectives needed by SIM partners over the first implementation year:

## State of Michigan Timeline

The SIM technology team is engaging the State of Michigan’s technology department to participate in the following use cases:

- Active Care Relationship Service (ACRS)
  - The State of Michigan will be providing to MiHIN a list of SIM eligible participants based on pre-defined exclusion criteria. This information will be used to determine the final SIM population.
- Common Key Service (CKS)

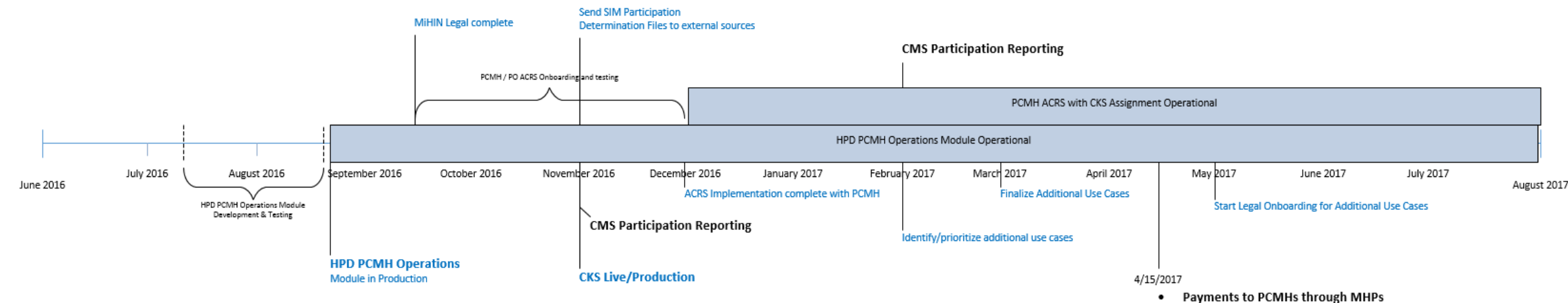
The State of Michigan is implementing the Common Key Service. The SIM technology team plans to utilize this service as ACRS files flow through the MiHIN.



## MiHIN Timeline

The SIM technology team is engaging the Michigan Health Information Network (MiHIN) to perform the following activities over the first SIM implementation year:

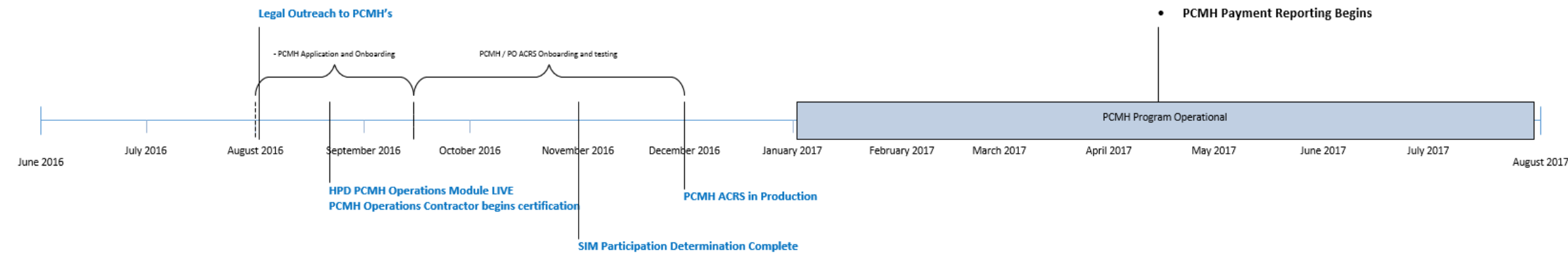
- Medicaid Health Plans and PCMH Legal and Technical Onboarding with the following use cases:
  - Active Care Relationship Service (ACRS)
    - Medicaid Health Plans will send, via ACRS, their list of providers and members. This information will be used by MiHIN during to help determine the final SIM population.
  - Common Key Service (CKS)
    - MiHIN will utilize the State of Michigan’s Common Key Service during the SIM Model Test.
- HPD PCMH Operations Module
  - Web-based solution allowing “Intent To Participate” providers the ability to complete an application for approval into the SIM Model Test.
- Participation Metrics and Reporting



## PCMH Operation Contractors Timeline

The SIM technology team is working with the PCMH Operations Contractors to perform the following activities over the first SIM implementation year:

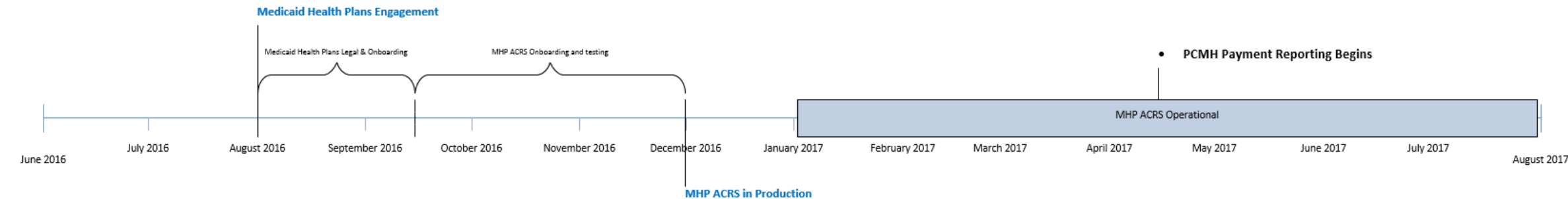
- Technology support for review and certification of applications for PCMH SIM Participation
  - PCMH Operations Contractors will be working with provider organizations and the SIM PCMH Track to approve and onboard those providers qualified to be a PCMH.
- Use of the MiHIN HPD PCMH Operations Module
  - MiHIN will provide a web-based solution that will allow the PCMH Operations Contractors the ability to manage provider organization's PCMH certification.
- ACRS Technology Onboarding for PCMH's.
  - PCMH Operations Contractors will work with PCMH certified provider organizations to ensure they are technically on-boarded per the ACRS use case.



# Medicaid Health Plans Timeline

The SIM technology team, in conjunction with the State of Michigan, is engaging the Medicaid Health Plans to participate in the following use cases and activities:

- Active Care Relationship (ACRS)
  - Medicaid Health Plans will send, via ACRS, their list of providers and members. This information will be used by MiHIN during to help determine the final SIM population.
- Common Key Service (CKS)
  - MiHIN will utilize the State of Michigan’s Common Key Service to ensure unique relationships are identified for the SIM Model Test.
- Technical Onboarding

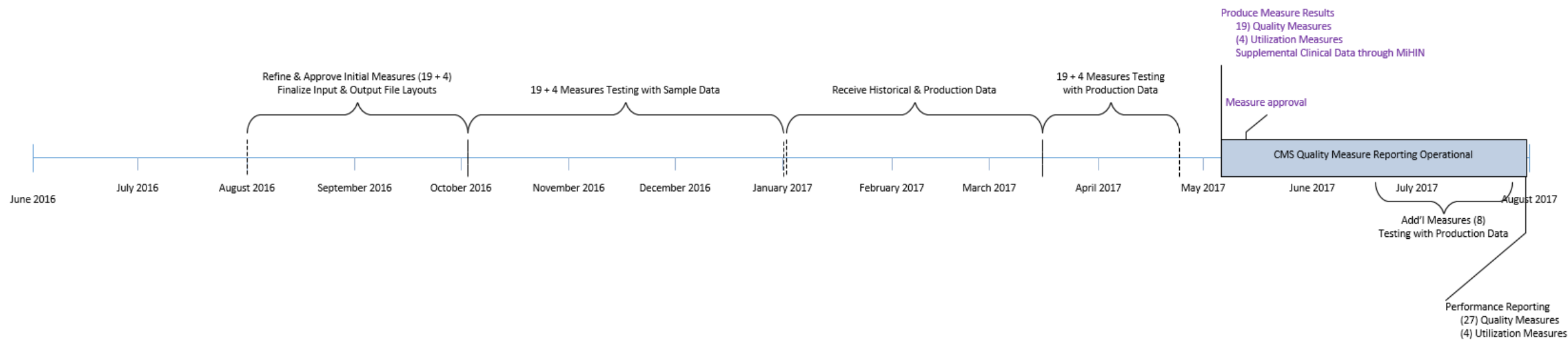


## Data Aggregator Timeline

The SIM technology team has engaged Michigan Data Collaborative (MDC) to consult in the development of quality metrics and develop the Data Aggregator timeline. The Data Aggregator timeline includes activities related to the following use cases:

- Active Care Relationship (ACRS)
  - The Data Aggregator will receive and ACRS file of the SIM population for quality metrics reporting.
- Common Key Service (CKS)
  - The Data Aggregator will participate in the Common Key Service.
- Quality Measures Specifications & Reporting

The SIM Model test requires the calculation and reporting of quality and utilization measures. The Data Aggregator will be responsible for this calculation and reporting.



## D4. Care Delivery Artifacts

### Practice Transformation Menu

#### PCMH Initiative Year One Practice Transformation Objective Menu

Subcategory	Activity
<b>Expanded Practice Access</b>	Adoption and use of telehealth services to increase patient access to remote specialty care consults or services.
<b>Expanded Practice Access</b>	Collection of patient experience and satisfaction data on access to care, development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs; and evidence of improvements made as a result of data collected.
<b>Population Management</b>	Manage medications to maximize efficiency, effectiveness and safety that could include one or more of the following: Integrate a pharmacist into the care team; and/or Conduct periodic, structured medication reviews.
<b>Population Management</b>	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.
<b>Beneficiary Engagement</b>	Use tools to assist patients in assessing their need for support for self-management (e.g. the Patient Activation Measure or How's My Health) and promote the use of processes and tools that engage patients for adherence to treatment plan.
<b>Beneficiary Engagement</b>	In support of improving patient access, performing additional activities that enable capture of patient reported outcomes (e.g., home blood pressure, blood glucose logs, food diaries, at-risk health factors such as tobacco or alcohol use, etc.) or patient activation measures through use of a technology solution, such as certified EHR technology, or patient registry; containing this data in a separate queue for care team member recognition and review.
<b>Beneficiary Engagement</b>	Integrate peer support into the care team to enhance care management activities such as providing patient self-management support, and/or leading patient support groups.
<b>Beneficiary Engagement</b>	Implement the use of group visits (sometimes called a cooperative healthcare clinic) for common chronic conditions (e.g., diabetes) specific to the PCMH Initiative.
<b>Beneficiary Engagement</b>	Access to an enhanced patient portal or personal health record (PHR)\ that provides up to date information related to relevant chronic disease health or blood pressure control, and includes interactive features allowing patients to enter health information and/or enables bidirectional communication about medication changes and adherence.



<b>Patient Safety and Practice Assessment</b>	Build the analytic capability required to manage total cost of care for the practice population that could include: Training appropriate staff on interpretation of cost and utilization information; and/or using available data regularly to analyze opportunities to reduce cost through improved care.
<b>Integrated Behavioral and Mental Health</b>	Develop a formal collaborative relationship with one or more behavioral health and/or substance abuse providers, enhance technology solution to capture additional data to promote implementation of shared integrated clinical decision making capabilities approach which could include: a combined/holistic health assessment, sharing health information, developing a shared treatment plan and goals, ensuring regular communication and coordinated workflows between clinicians in primary care and behavioral health; and conducting regular case reviews for at-risk or unstable patients and those who are not responding to treatment.

## Inclusion & Exclusion Criteria

### Michigan SIM Medicaid Patient Population Inclusion/Exclusion Listing

Benefit Plan Level

[https://www.michigan.gov/documents/mdch/Benefit\\_Plan\\_Table\\_293077\\_7.pdf](https://www.michigan.gov/documents/mdch/Benefit_Plan_Table_293077_7.pdf)

Scope of Coverage = Full Medicaid and Medicaid Managed Care only (Level of Care 7 & 11)

<b>Included</b>		<b>Excluded</b>	
BMP	Benefits Monitoring Program	APS	Ambulatory Prenatal Services
CSHCS-MC	Children's Special Health Care Services – Managed Care	CSHCS	Children's Special Health Care Services (FFS)
MA-HMP-MC	Healthy Michigan Plan – Managed Care	HHMICARE	Primary Care Health Homes
MA-MC	Medicaid – Managed Care	HHBH	Health Home Behavioral Health
MME-MC	Medicaid – Medicare Dually Eligible – Managed Care	Hospice	Hospice
TCMF	Targeted Case Management Flint	ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
		ICO-MC	Integrated Care - MI Health Link
		INCAR-ESO	Incarceration – Emergency Services Only
		INCAR-MA	Incarceration - MA
		INCAR-MA-E	Incarceration – MA Emergency Services Only
		MA	Full Fee-for-Service Medicaid

---

		MA-ESO	Medical Assistance Emergency Services Only
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only
		MA-HMP	Healthy Michigan Plan (FFS)
		MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only
		MA-HMP-INC	Healthy Michigan Plan Incarceration
		MICild - ESO	MICild Program – Emergency Services Only
		MI Choice-MC	MC Home and Community Based Services – Managed Care
		MOMS	Maternity Outpatient Medical Services
		NH	Nursing Home
		PACE	Program All-Inclusive Care for Elderly
		Plan First!	Family Planning Waiver
		QMB	Qualified Medicare Beneficiary – All Inclusive
		Spend-down	Medical Spend-down
		SPF	State Psychiatric Hospital
		QDWI	Qualified Disabled Working Individual
		SLMB	Specified Low Income Medicare Beneficiary
		ALMB	Additional Low Income Medicare Beneficiary

---

**Not Applicable for Inclusion/Exclusion Decisions**

*The following benefit plans are either not directly relevant to deciding whether or not a beneficiary can be included in the population (dental, mental health etc.) or represent services that are additions/enhancements to the standard Medicaid state plan benefit (waivers etc.).*

CSHCS-MH CSHCS Medical Home  
HK-Dental Healthy Kids Dental  
HK-EXP Full Fee-for-Service Healthy Kids Expansion  
HK-EXP-ESO Healthy Kids Expansion Emergency Services Only  
NEMT Non-Emergency Medical Transportation  
PIHP Prepaid Inpatient Health Plan  
PIHP-HMP PIHP Healthy Michigan Plan  
DHIP Foster Care and CPS Incentive Payment  
AUT Autism Related Services  
CWP Children's Home and Community Based Services Waiver  
HSW Habilitation Supports Waiver Program  
SED Children's Serious Emotional Disturbance Waiver Program  
SED-DHS Children's Serious Emotional Disturbance Waiver Program – DHS

## Payment Comparison Matrix

SIM PCMH Initiative Payment Model Matrix		
	Practice Transformation Payments	Care Coordination Payments
<b>Attribution Process</b>	Standard Process as outlined in Appendix D4. (Inclusion & Exclusion Criteria / Attribution Methodology)	Standard Process as outlined in Appendix D4. (Inclusion & Exclusion Criteria / Attribution Methodology)
<b>PMPM Rates</b>	TBD: Final rates to be set early September	TBD: Final rates to be set early September
<b>Payment Cycles</b>	Prospectively payed to practices, Determined Monthly, Paid no less than Quarterly.	Determined monthly, paid no less than quarterly.
<b>Tied to Performance</b>	Yes - Practices will be required to demonstrate achievement, or progress towards achievement as prescribed. P.T. assurance strategy is slated for design in SIM Implementation Year 1 - Q1	Yes - Practices will be required to consistently meet C.C. Measures: 1) % of attributed patient receiving CC Service 2) % of attributed patients receiving timely follow up after discharge
<b>Measurement</b>	Adequate progress towards Practice Transformation Objective as chosen by practice.	9 month "Grace Period" as performance data is collected
<b>Repayment Risk / Loss of Payment</b>	Yes - If practice does not complete stated P.T. Objective in the identified time frame, payments will be stopped.	Yes - If practice does not meet minimum threshold identified for the C.C. Measures, payments will be stopped.
<b>Performance Review Cycle</b>	Bi-Annually - by completing the brief practice transformation survey/self-reporting process	Monthly (Part of HIE/HIT and coding process)

---

--

**D5. Community Health Innovation Region (CHIR) Participation  
Guide and Local Operational Plan Template for Year One - DRAFT**