

REINVENTING  MICHIGAN'S HEALTH CARE SYSTEM
Blueprint for Health Innovation

Submitted to:
Center for Medicare and Medicaid Innovation
On:
January 24, 2014
By:
Governor Rick Snyder, State of Michigan



STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
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January 22, 2014

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Sebelius and Ms. Tavenner:

Thank you for the opportunity to participate in the Centers for Medicare and Medicaid Services State Innovation Model Design initiative. I am pleased to submit Michigan's State Health Care Innovation Plan, the Blueprint for Health Innovation.

Since receiving the State Innovation Model Design award from the Centers for Medicare and Medicaid in February 2013, the Michigan Department of Community Health has partnered with dozens of stakeholders across the state to develop the Blueprint for Health Innovation. The model proposed in the Blueprint is built on the following five foundational components:

1. Patient-centered medical homes providing access to high quality primary care;
2. Accountable systems of care responsible for improving systems of care to ensure delivery of the right care, by the right provider, at the right time, and in the right place;
3. Community health innovation regions building capacity within a community to improve overall population health;
4. Payers committed to paying for value rather than paying for volume; and
5. Infrastructure support that facilitates system improvements to reduce administrative and delivery system complexity.

Michigan is the comeback state, and we have already made great strides towards the reinvention of our health care system. We appreciate your consideration and look forward to working together to further this common goal.

Sincerely,

A handwritten signature in blue ink that reads 'Rick Snyder'.

Rick Snyder
Governor

Acknowledgements

In early 2013, the state of Michigan was granted the State Innovation Model Design award. Over the past several months, the State has partnered with various stakeholders from across the state to develop the Michigan Innovation Model. The model outlined in the following Blueprint for Health Innovation was developed with input and guidance from these stakeholders who warrant special recognition for their knowledge, experience, and commitment to this process.

These stakeholders were comprised of consumers/advocates, physicians, community supports/services, payers, hospital/health systems, government, business, safety net, and academic experts. With their dedication and support throughout this process, Michigan has created a model that encompasses better health, better care and lower costs for the entire population.

A very special thank you to all of the staff from the following organizations that made this work possible:



Population Health Partners, PLC

HEALTH MANAGEMENT ASSOCIATES

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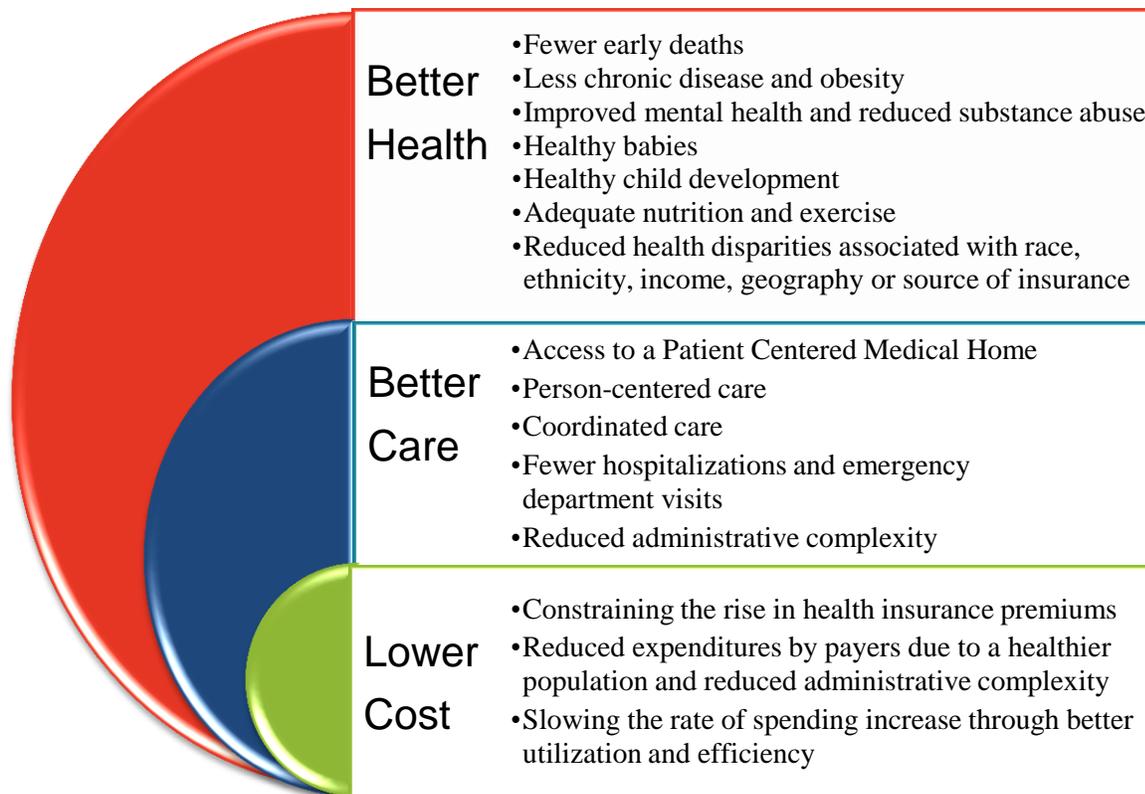
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Chapter A: Michigan’s Vision for Health System Reinvention

To build a stronger Michigan, we must build a healthier Michigan. My vision is for Michiganders to be 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. Health and wellness are important across the continuum of life from prenatal care, to providing children and adults with opportunities for nutritious food and physical activity, to the option of home-based long-term care for seniors who need it.

– Governor Rick Snyder

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



Critical Health Indicators in Michigan Compared to the United States Average

Better than Average

- Binge drinking
- Cholesterol testing
- Education attainment
- Human immunodeficiency virus/acquired immunodeficiency syndrome infection
- Injury mortality
- Insurance coverage
- Mammograms
- Childhood obesity
- Adult physical activity
- Teen birth rate

Worse than Average

- Cancer mortality
- Cardiovascular disease
- Chlamydia
- Cigarette smoking
- Diabetes
- Hypertension
- Infant mortality
- Unemployment
- Life expectancy
- Nutrition
- Adult obesity
- Pap tests
- Child physical activity
- Poverty
- Veterans' access to health care

The Current State of Health Care in Michigan

Michigan is in the process of rebounding from a recession that hit the industrial Midwest especially hard. Governor Snyder came into office in 2011 with the goal of reinventing Michigan. Health care is one of his top 10 priorities.¹ Governor Snyder recognizes that health and wellness are fundamental to the overall economic success of the State.

Michigan continues to grapple with obesity, diabetes, and heart disease. The rate of obesity has increased consistently among both adults and children, and is especially high among low income and minority groups.² Michigan faces challenges addressing health disparities with issues such as infant mortality and obesity-related chronic diseases disproportionately affecting Michigan's African American and Hispanic communities. According to the National Healthcare Quality Report, Michigan's overall health care quality is average³ and Michigan is underperforming on many of its Healthy People 2020 goals.⁴

Despite the State's challenges, health care innovation is already underway in Michigan. The Michigan Primary Care Transformation demonstration project is the largest multi-payer Patient Centered Medical Home demonstration in the country. Physician organizations across the State are recruiting specialists to enhance communication with primary care providers. Provider groups, health systems and other entities are participating in federal innovation initiatives. Hospitals are working to reduce admissions by following up with patients after discharge. The State of Michigan and the federal government are working collaboratively on a plan to coordinate care for individuals eligible for both Medicaid and Medicare. The Michigan Department of Community Health and providers across the state are preparing to serve 477,000 new Medicaid beneficiaries under the Healthy Michigan Plan to extend benefits to previously ineligible adults⁵ below 133% of the Federal Poverty Level. A detailed description of the Healthy Michigan Plan and its impacts is provided in chapter B. Community Mental Health Service Providers are working with the State of Michigan to design a Health Home model to

Michigan was ranked the 37th healthiest state in the country in 2012, compared to 33rd in 2011.

<http://www.americashealthrankings.org/MI/2012>

integrate primary care with behavioral health care for those with serious and persistent mental illness. Community coalitions and organizations are engaging stakeholders to improve health care delivery systems and address how environments affect healthy behavior. Michigan providers are increasingly exchanging electronic health information to streamline patient care. These are just a few examples of what health care providers, health insurance companies, citizens, businesses, communities, and government are already doing to promote health and well-being in Michigan.

Michigan is making great progress, but care continues to be fragmented, with payment systems that reward volume over value, and the performance of procedures over time spent thinking, educating, talking, and coordinating care. Michigan achieves the health outcomes that the current payment system rewards, and it can achieve better.

Working Together to Create a Better Future

The State Innovation Model initiative, funded by the Center for Medicare and Medicaid Innovation, provided an opportunity to continue the work of breaking down silos and bringing stakeholders together to innovate. Governor Snyder's commitment and support for building a stronger Michigan, along with the creative initiatives already occurring around the state, served as the starting point for stakeholder discussions and planning.

The Michigan Department of Community Health was tasked with forming a State Innovation Model advisory committee in April 2013. The committee consisted of representatives from payers, state agencies, business representatives, consumer groups, providers, community service entities, and academia. The advisory committee met on a monthly basis, serving as the primary conduit for the input of a wide variety of stakeholders in the design of an initial working concept of a redesigned service delivery system. Additional stakeholders were engaged through focus groups, work groups, public outreach meetings, key informant interviews, and the Michigan State Innovation Model web site.

The advisory committee focused first on providing detailed specifications for how an ideal health system – and the people within it – would function. They then considered what would make that vision a reality – including payment models that would support the reimagined delivery system. The Michigan Department of Community Health and other State officials carefully considered all of the stakeholder input throughout every part of the process, and crafted a to-be model of health care delivery and payment reform that embodies a "bottom-up, top enabled" approach in line with Governor Snyder's "Bureaucracy Busters" initiative. The result of the State Innovation Model Initiative is this document: Reinventing Michigan's Health Care System: Blueprint for Health Innovation.

Health System Design and Performance Objectives

The Blueprint is founded on the belief that Michigan can achieve better health and better care while containing costs. The advisory committee formulated six goals for Michigan's reinvented health system:

- Goal I.** Strengthen the primary care infrastructure to expand access for Michigan residents
- Goal II.** Provide care coordination to promote positive health and health care outcomes for individuals requiring intensive support services
- Goal III.** Build capacity within communities to improve population health

- Goal IV.** Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and in the right place
- Goal V.** Design system improvements to reduce administrative complexity
- Goal VI.** Design system improvements that contain health care costs and keep insurance premiums affordable for individuals/families and employers/businesses

Building on these goals, the advisory committee further specified Michigan’s reinvented health care system as possessing the following characteristics: accountability; person- and family-centered care; community-centered design; focus on prevention, wellness, and development; community integration; system-wide linkages; evidence-based approaches; and payment for value. Payment reform is recognized as one driver to an improved delivery system. These characteristics align with Michigan’s vision for health system reinvention.

Shortly after he came into office in 2011, Governor Snyder created the Michigan Health and Wellness dashboard to measure the State’s performance on several key areas of health, including access to health care, health behaviors and preventable hospital stays. Michigan’s Blueprint calls for monitoring a variety of metrics, including measurements from Governor Snyder’s dashboard, as part of a process for continuous improvement. The Blueprint also requires monitoring access to primary care, clinical quality, patient experience of care, and utilization – gathering information from the dashboards implemented throughout the Michigan Department of Community Health.

Proposed Delivery System Transformation

In order to strengthen primary care capacity and capabilities, and increase recruitment and retention of primary care providers, the advisory committee agreed that there must be ongoing support for existing Patient Centered Medical Homes. Furthermore, the advisory committee agreed that there must be transformation of additional primary care practices to Patient Centered Medical Homes, as well as an expansion of Michigan’s primary care workforce.

The Patient Centered Medical Home is the core of Michigan’s Blueprint for Health Innovation

Michigan’s Blueprint rests upon the Patient Centered Medical Home, but also goes beyond it. Primary care physicians, nurses, and practice staff cannot bear the entire burden of health reform.

Networks of primary care providers, specialists, and hospitals are developing capacity to integrate clinical care across settings, providing safer, more efficient, and less redundant (and therefore less expensive) care – as well as a better experience for patients. The Blueprint proposes to recognize these networks as formal entities called Accountable Systems of Care. Accountable Systems of Care will be responsible for ensuring high quality and person-centered care while lowering costs for a defined population. As formal entities that organize providers and are accountable for outcomes, Accountable Systems of Care will enter into contracts with payers that shift progressive amounts of financial benefit and risk to providers.

Infrastructure created at the community or regional level will support the efforts of all health care providers to improve the health of the populations they serve. Community Health Innovation Regions will form out of broad partnerships among stakeholders, to leverage Michigan’s Prosperity Regions and

contributions of health care, public health, community organizations, businesses, schools, higher education, economic development organizations, and local government to address issues that affect the health of the entire community. This collective impact model is based on the idea that complex problems are better solved through cross-sector coordination than the isolated interventions of individual organizations.⁶ Coordination cannot be sustained at the level needed through voluntary efforts, however, so Community Health Innovation Regions will be formal associations supported by ‘backbone’ organizations that have a small number of paid staff.

The Michigan Department of Community Health will support the success of Accountable Systems of Care and Community Health Innovation Regions through investments in health information technology infrastructure when needed, the development of a performance measurement and recognition committee, and the provision of technical assistance resources to spread best practices and promote success.

Health Information Technology

Patients and providers having access to relevant health information when they need it is critical for a safe, efficient, and coordinated health care system. Recognizing this, providers across the state are investing in electronic health records. Networks to facilitate exchange of health data between patients and providers in different settings have been encouraged through the Office of the National Coordinator for Health Information Technology’s State Health Information Exchange Cooperative Agreement Program. However, many are frustrated that change is not happening fast enough. To date, investment has been driven by incentive programs offered by Medicare, Medicaid, and commercial health insurers. Implementation of Michigan’s Blueprint will change the value proposition for investing in health information technology: when providers are paid for value rather than volume, the adoption of health information technology will become essential to meeting health, quality, and cost goals. Software vendors and health information exchange organizations will then be oriented to providing solutions that help providers reach those value targets.

While the public-private partnership led by Michigan Health Information Network Shared Services (the State-designated entity in the State Health Information Exchange Cooperative Agreement Program) continues to achieve greater coordination and useful exchange of health information, Michigan is finding creative ways to leverage mobile technology to improve health care delivery and services at many levels. The Southeastern Michigan Beacon Community pioneered Txt4Health diabetes management text alerts, and the MI Healthier Tomorrow 4x4 Wellness tool also offers a mobile link to motivational health and wellness messaging. Michigan Medicaid is scaling up a mobile application called “MyHealthButton” which allows beneficiaries to find real-time coverage information, nearby providers, and track payment arrangements. Interfaces with Women, Infants and Children Program benefit information and the 4x4 wellness tool engage consumers in taking an entire portfolio of services and health information with them wherever they go. Web portals into electronic health records will further integrate health care into Michiganders’ daily lives and take health information technology into the mainstream.

Michigan’s Blueprint for Health Innovation proposes a transformation that includes the following structural elements:

Patient Centered Medical Homes put the individual in charge of their health care: clinicians are more accessible, care teams engage patients with complex needs, and providers monitor their patient population to assure that everyone is getting the care they need.

In **Accountable Systems of Care**, providers are organized to communicate efficiently, coordinate patient care across multiple settings, and make joint investments in data analytics and technology. Through clinical integration – supported by formal governance and contractual relationships – providers co-create tools, workflows, protocols, and systematic processes to provide care that is accessible to patients and families, supports self-management, is coordinated, and incorporates evidence-based guidelines. As the capacities of an Accountable System of Care grow, the system can be held responsible for performance in terms of quality of care and the health outcomes of their assigned population. Health plans will continue to fulfill their current role in managing insurance risk, while contracting with Accountable Systems of Care to take on performance risk. Plans will collaborate with Accountable Systems of Care to provide wrap-around services and benefits; beneficiary outreach, engagement, education, and other member services; data analytics; and information on utilization outside of the Accountable System of Care.

In **Community Health Innovation Regions**, partners act cohesively with a broad-based vision for region-wide impact, to make the environment healthier and to connect health services with relevant community services. The process begins with a collaborative community health needs assessment that identifies key health concerns, illuminates root causes of poor health outcomes, and sets strategic priorities. Action plans are developed to organize and align contributions from all partners for collective impact.

Payment models are designed to incentivize value over volume – aligning the interests of patients, communities, primary care providers, specialists, hospitals, payers, and policy makers toward the aims of better population health, high quality health care, and lower cost. To do this, a staged approach to payment reform is proposed in which Patient Centered Medical Homes and Accountable Systems of Care are supported in moving away from fee-for-service and adding capacity for coordinated care and responsibility for outcomes.

A **statewide infrastructure** will be put in place to provide governance for the implementation of Michigan’s Blueprint and to respond to the needs of patients, providers, communities, and payers. State government must align policy, payment, and programming to reinforce the Blueprint elements and incentivize the desired outcomes. The State is a major purchaser of health care services for Medicaid beneficiaries and for its own employees. The State has an important role in guiding investment in shared infrastructure and promoting practice transformation through statewide data monitoring, evaluation and dissemination. It establishes systems to monitor and reward performance, and to disseminate information, including recognition of top performers.

Paying for Value

Payment for value involves movement from a volume-driven health care delivery system to one that pays for performance, as measured by the quality of health care, the health of the population, and efficiency. This shift has many challenges. As Michigan transitions to new ways of paying for health care, several considerations must be kept in mind:

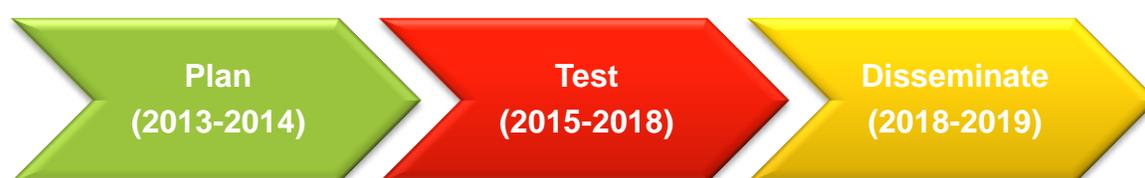
- Physicians and other providers cannot control all factors that lead to better outcomes
- Patients, through healthy behaviors, are also responsible for their own health
- Payment models work best – and save the most money – when expectations and administrative processes are aligned across payers
- Transparency of cost, quality, and health outcomes will promote good decision-making

Reforming the fee-for-service payment model is integral to the proposed health system reinvention. Michigan’s Blueprint promotes multi-payer alignment in testing innovative approaches to paying for value. The Blueprint proposes staging a continuum of health care reimbursement models that require increasing amounts of provider accountability. Benefit design elements that encourage patients to make healthy choices are desired, and a performance recognition program that makes information about provider quality and outcomes publicly available engages consumers in driving the demand for value-based payment models.

Payment Type	Description
Care Management Reimbursement	A fee-for-service adjustment or capitated payment for comprehensive and coordinated care management of an assigned panel of patients.
Shared Savings	A financial award based on a percent of aggregate total cost of care savings achieved during a specified performance period.
Pay-for-Performance	Incentives that reward providers for achieving target performance levels or specific outcomes over a defined period: this form of payment is designed to encourage health care providers to produce incremental improvements in performance on health outcomes over time.
Population-Specific Global Payment	Fixed prepayment made to an accountable provider organization or a health care system, which covers most or all of a patient’s care during a specified period: global payment for children with special health care needs is an example of how global payments have been used in Medicaid.
Partial Risk-Based Capitation	A payment method in which the accountable provider organization or a health care system receives a monthly per member per month payment for an assigned/enrolled group of patients to provide or arrange for a broad range of inpatient, outpatient, and/or diagnostics services (but not all the benefits and services that a health plan or payer may be obligated to provide). The Accountable System of Care may be at full risk or have limited risk for the total cost of services provided under as part of the capitation payment.

Implementing Michigan's Blueprint for Health Innovation

Michigan will test the Innovation Model in several communities before scaling it up across the state using a rapid-cycle improvement process to implement, evaluate, refine, and disseminate change. A rapid-cycle improvement process is one in which target measures and milestones are established, data is collected, progress is assessed, and improvements are incorporated into the system on an ongoing basis. Testing the models proposed as part of Michigan's Blueprint on a small scale allows the participants in the test sites to learn from the results and to make adjustments before making the change permanent. Also, smaller-scale tests minimize risks and provide the State with the opportunity for making adjustments to the Blueprint to avoid unintended consequences as the system reacts to changes over time. Michigan's proposed service delivery and payment models will be implemented on a test basis in select areas. As the models are refined, they will be scaled up to other communities and to other payers.



During the planning period, the State will:

- Submit a grant application for a test of the service delivery and payment models contained in the Blueprint to the Center for Medicare and Medicaid Innovation
- Establish multi-payer steering and performance recognition committees
- Engage providers, payers, patients, and others to develop multi-payer metrics
- Work with stakeholders to refine the models
- Select test sites and assess capacity using a methodology developed by project stakeholders and staff
- Identify technical assistance needs

During the test period, the State will:

- Continue investments into shared information exchange capabilities and data systems
- Invest in the education and training of health care teams
- Implement service delivery and payment models
- Refine the models based on participant feedback and rapid-cycle improvement processes
- Provide participants with performance feedback and technical assistance
- Identify needed policy change
- Evaluate outcomes

During the dissemination period:

- The elements of a high quality service delivery model will be spread to other geographies, populations, and systems
- All Michiganders will have a relationship with a Patient Centered Medical Home
- Health care payment in Michigan will drive value not volume

- Communities will have an infrastructure and sustainable funding that support effective collaboration to continuously improve local service and population health systems

Governor Snyder is committed to the vision, goals, and culture of a healthier Michigan. The provision of health care involves the interaction of multiple complex systems. The Blueprint provides a process for learning the way to a better system: testing and implementing change in ways that involve individuals and organizations to co-create this new system with tools and processes to continuously monitor and adjust performance.

Overview of the Blueprint for Health Innovation

Element	Approach
<p>Patient Centered Medical Home</p>	<ul style="list-style-type: none"> • Build upon current Michigan Primary Care Transformation demonstration project across the State, promoting interprofessional teams • Increase the number of providers and payers participating, while maintaining the support of existing payers • Include risk-adjusted monthly payments for care management in Medicaid contracts • Ensure Patient Centered Medical Homes achieve specified performance standards to retain designation • Align performance metrics, reporting, and incentives across multiple payers • Make Patient Centered Medical Homes the foundation for Accountable Systems of Care that provide common infrastructure investments and coordinated linkages to medical, behavioral, and community care providers
<p>Accountable System of Care</p>	<ul style="list-style-type: none"> • Build upon formal legal entities that: <ul style="list-style-type: none"> ○ Integrate providers and services to proactively manage and coordinate comprehensive care for a defined population ○ Support primary care providers to become Patient Centered Medical Homes, and support current Patient Centered Medical Homes to achieve greater capacity for improving health care while reducing cost ○ Are accountable to payers to improve quality while controlling costs • Test a graduated range of payment models that support Accountable Systems of Care to move on a continuum away from fee-for-service payments and toward payment for performance outcomes • Ensure Accountable Systems of Care achieve specified performance standards in order to participate • Engage in community-based population health strategies championed by Community Health Innovation Regions
<p>Community Health Innovation Region</p>	<ul style="list-style-type: none"> • Build upon formal entities, with a backbone infrastructure, that: <ul style="list-style-type: none"> ○ Engage cross-sector partners within a geographic region in population-level strategies to improve health and wellness ○ Partner with public health ○ Assure community assessments are conducted and set strategic priorities with the community ○ Engage and mobilize patients and community members in community-centered health and wellness strategies ○ Engage Accountable Systems of Care to create integration across clinical, behavioral, and social care services ○ Organize regions to take a “health-in-all-policies” approach • Demonstrate the added value of investments in Community Health Innovation Regions to reduce health risks in the community • Secure sustainable financing mechanisms for the backbone infrastructure and population-level activities

Overview of the Blueprint for Health Innovation

Element	Approach
Payment Reform	<ul style="list-style-type: none"> • Continue multi-payer participation in Patient Centered Medical Home transformation • Test payment models that: <ul style="list-style-type: none"> ○ Reward providers for improving outcomes in population health, health care quality, and cost ○ Offer Accountable Systems of Care flexibility to make the necessary investments in system redesign, including health information infrastructure ○ Provide the Accountable Systems of Care and Community Health Innovation Regions incentives to address environmental and social determinants of health • Test benefit designs that encourage desired behaviors among beneficiaries for: <ul style="list-style-type: none"> ○ Maintaining a long-term relationship with their Patient Centered Medical Home care team ○ Appropriate, value-based utilization of health care services ○ Healthy lifestyles • Test payment models that support providers to move on a continuum toward payment for performance outcomes, including: <ul style="list-style-type: none"> ○ <u>Shared savings with and without down-side risk</u>: financial reward or loss to an Accountable System of Care based on a percent of aggregate total cost of care savings achieved during a specified performance period ○ <u>Partial capitation</u>: monthly payment to an Accountable System of Care for enrolled patients to provide or arrange for a broad range of inpatient, outpatient, and diagnostic services (but not all the benefits and services that a health plan or payer may be obligated to provide) ○ <u>Global capitation</u>: fixed prepayment made to an Accountable System of Care that covers most or all care for a specific health condition, or a specific population, during a specified time period
Infrastructure	<ul style="list-style-type: none"> • The Policy and Planning Office of the Michigan Department of Community Health will work to align programming across governmental units, coordinate policy and funding levers, and provide overall accountability for the Blueprint for Health Innovation • Convene two multi-stakeholder entities: <ul style="list-style-type: none"> ○ <u>Innovation Model Steering Committee</u>: responsible for guidance on implementation, monitoring, and continuous improvement of the Blueprint for Health Innovation ○ <u>Innovation Model Performance Measurement and Recognition Committee</u>: responsible for developing and maintaining core performance measures that are acceptable to, and used by, multiple payers, providers, and consumers • Leverage and invest in Michigan’s existing health information exchange infrastructure that is responsible for data standardization, analytics, and public reporting in order to: <ul style="list-style-type: none"> ○ Inform patient decisions regarding health and health care choices ○ Ensure providers have data for clinical decision-making, care coordination, and population health management ○ Monitor progress, track performance, and inform policy decisions

¹State of Michigan. Reinventing Michigan.

http://www.michigan.gov/documents/snyder/ReinventingMichiganCard_368353_7.pdf.

² Michigan Department of Community Health. Overweight and Obesity in Michigan: Surveillance Update 2011.

http://www.michigan.gov/documents/mdch/Overweight_and_Obesity_in_Michigan_Surveillance_Update_2011_432811_7.pdf.

³ National Healthcare Quality Report. Michigan Dashboard on Health Care Quality Compared to All States. Agency for Healthcare Research and Quality, Department of Health and Human Services.

http://nhqrnet.ahrq.gov/inhqrdr/Michigan/snapshot/summary/All_Measures/All_Topics. Accessed January 21, 2014.

⁴ Michigan Department of Community Health. Comparison of Michigan Critical Health Indicators Report & Healthy People 2020 Targets.

https://www.michigan.gov/documents/mdch/CHI_HP2020_Comparison_2012_FINAL_387635_7.pdf. Published May 30, 2012. Accessed November 13, 2013.

⁵ Office of the Governor of Michigan. Gov. Snyder signs Healthy Michigan into law, bringing health care to

470,000 Michiganders. September 16, 2013. <http://www.michigan.gov/snyder/0,4668,7-277-57577-312514--00.html>. Accessed September 16, 2013.

⁶ Kania J, Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011;9.

http://www.ssireview.org/articles/entry/collective_impact. Accessed November 13, 2013.

Chapter B: Michigan's Health Care Environment

Michigan's reinvented health system will be built on the current one. This chapter provides contextual information about Michigan's population and health care coverage trends, health status, health care cost and quality performance trends, key drivers of health system performance, and current health information technology initiatives underway across the state. In addition, this chapter describes the innovative health care initiatives currently underway around the state, and establishes the building blocks for Michigan's Blueprint for Health Innovation.

B1. Michigan's Population and Health Care Coverage

Demographics

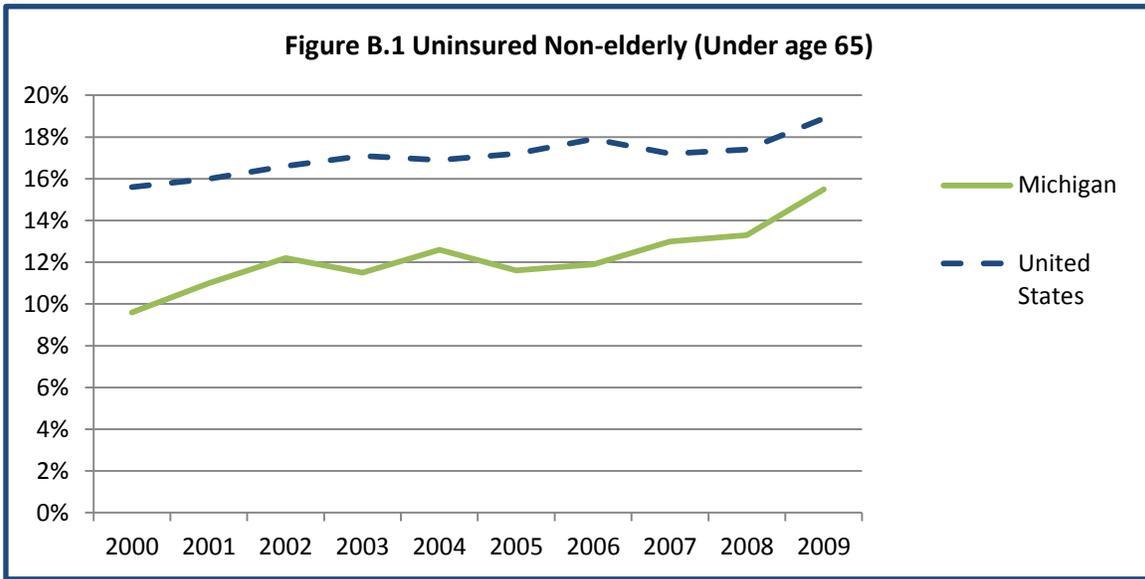
Michigan is the 9th most populous state in the United States, with an estimated 9,882,360 residents in 2012. The population is 76.2% White non-Hispanic, 14.3% Black or African American, 4.6% Hispanic or Latino, and 2.6% Asian.¹

According to the 2010 Census, Michigan was the only state with net loss of population over the preceding decade.² Michigan has historically been an urban state, with most of the population concentrated in a narrow band across the southern portion of the Lower Peninsula. Population loss has been greatest in the cities, and this has led to some unique challenges as Michigan struggles to improve population health in areas that do not have the resources to serve the people living in them. As people leave Michigan's biggest cities, their tax dollars leave with them. Shrinking revenue makes managing large cities extremely difficult. Flint's population fell by 2.4% between 2000 and 2010. In Pontiac, declining population has led to tax revenues falling by 40% since 2008. Detroit, once the fourth-largest city in the nation, is now ranked 18th.³ The 25% depopulation of Detroit has created "urban desert" areas that require innovative approaches to health care delivery.

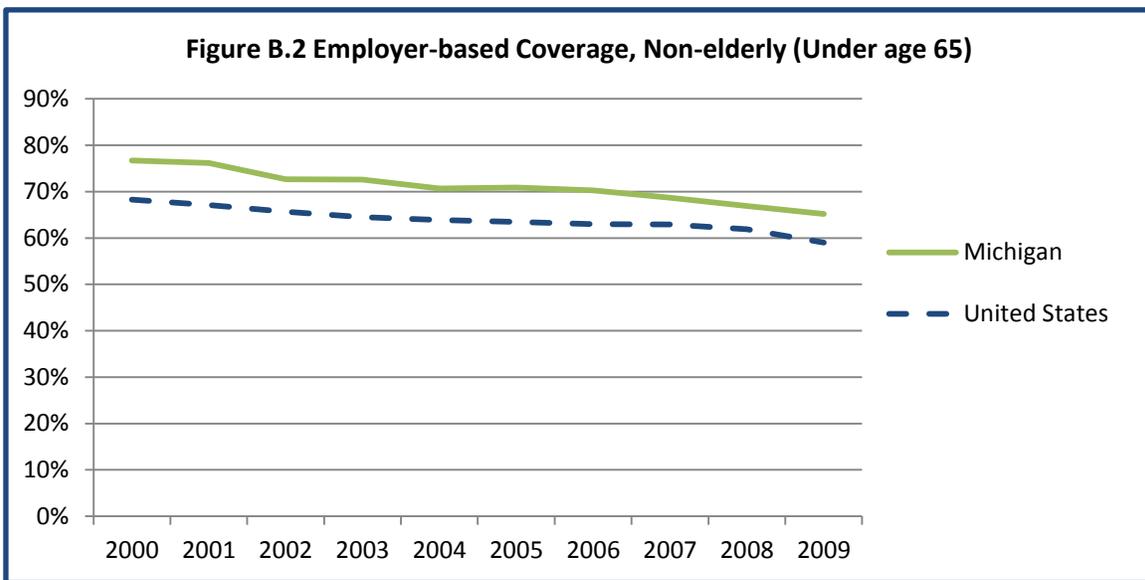
The downward trend in Michigan's population is made more troubling due to the fact that, in addition to a fertility rate consistently below the national average,⁴ much of the state's out-migration over the past several years has been among young adults.⁵ As a result, the proportion of people over age 55 has increased. The current percentage of the population at retirement age is 13.5% compared with 12.8% nationwide, and this is expected to increase rapidly as the "baby boom" generation ages. The barriers presented by the respective physical environments of both the urban and rural regions in Michigan, combined with other health status issues, are such that the long-term health status outlook for the over 55 age group could drive significant increases in health care costs.⁶

Insurance Coverage Trends

Overall, rates of commercial insurance coverage in Michigan have fallen over the past decade, such that the proportion of the population without any health care coverage has increased.⁷ Although uninsured rates have remained below the national average for decades, they have increased more rapidly than the national average in recent years as shown in figure B.1.⁸



Much of this increase can be attributed to declining rates of employer-sponsored coverage. High unemployment rates and an aging population have led to a decrease in such coverage both in Michigan and nationally as shown in figure B.2.⁹



Public Payers

Public Act 107, The Healthy Michigan Plan, was signed into law on September 17, 2013.¹⁰ It expands the Medicaid program to an estimated 477,000 low-income adults, providing an unprecedented level of healthcare coverage to a historically underserved demographic.

The Healthy Michigan Plan describes benefit design changes that promote value-based purchasing and healthy behaviors. By September 30, 2016, the pharmaceutical benefit will be designed that utilizes co-pays at levels that encourage the use of high-value, low-cost prescriptions (such as generics and 90-day supplies). Cost sharing is implemented as a tool to drive value-based purchasing and to promote healthy behaviors. Required cost sharing can be reduced by the contracted health plan if healthy behaviors are being addressed as attested to by the contracted health plan, based on uniform standards developed by the Department of Community Health in consultation with the contracted health plans. The uniform standards shall include healthy behaviors that must include, but are not limited to completing a Department of Community Health-approved annual health risk assessment to identify unhealthy behaviors. Cost sharing reductions are limited based on such things as enrollees' inappropriate usage of emergency departments. Additional policy levers contained in the Healthy Michigan Plan are described in chapter J.

The Healthy Michigan Plan is projected to increase the number of non-elderly Michigan residents enrolled in Medicaid/Children's Health Insurance Program from 1.4 million (2011 baseline) to just over 2 million by 2019.¹¹ In 2011, 55% percent of those who would be eligible for Medicaid or for subsidies to purchase health insurance were uninsured. The remaining 45% of those eligible for coverage under the Affordable Care Act had coverage through an employer, an individual policy, or another form of public insurance.¹²

Currently in Michigan, Medicaid covers principally pregnant women, low-income children, and the disabled.¹³ Medicaid covers pregnant women whose income is 185% of the federal poverty line; this, and other caregiver eligibility criteria results in a majority of current adult enrollees being women. However, men will comprise a slight majority in the expansion population.¹⁴ It is believed that nearly 77% of the expansion population does not have children and approximately two-thirds of the Health Insurance Marketplace target population is composed of childless adults. Non-disabled adults with no children are not currently eligible for full Medicaid coverage.¹⁵ The 2014 expansion will provide coverage for adults earning between 100 and 133% of the federal poverty line, \$15,282 for a single adult and about \$25,975 for a family of three.¹⁶ This will impact various age groups differently. In 2011, 41% of the expansion population was between 19 and 24 years old and 46.5% of exchange population was between 45 and 64 years old.¹⁷ Of those currently enrolled in Medicaid, racial and ethnic minorities comprise a disproportionate percentage. The expansion and exchange target populations more closely mirror the distribution in the overall population.¹⁸

Table B.1¹⁹ shows the projected health insurance coverage by coverage type for non-elderly Michigan residents following the expansion.

Table B.1 Projected Health Insurance Coverage for Non-Elderly Residents (Aged 0–64) with Medicaid Expansion

Coverage Type	2011 (baseline)		2014		2019	
	Uninsured	1,147,613	13.6%	864,300	10.3%	528,001
Employer	5,090,087	60.5%	5,010,780	59.6%	4,764,218	56.6%
Medicaid/Children’s Health Insurance Program	1,402,191	16.7%	1,729,693	20.6%	2,061,715	24.5%
Non-group & Other Public	772,844	9.2%	681,133	8.1%	504,984	6.0%
Exchange	--	NA	126,828	1.5%	553,816	6.6%
Total	8,412,735	100.0%	8,412,735	100.0%	8,412,735	100.0%

In 2011, approximately 1.7 million Michigan residents were enrolled in Medicare,²⁰ constituting 16.2% of the population.²¹ As of January 2013, 467,000 seniors in Michigan were enrolled in a Medicare Advantage plan, up from 425,389 in 2012. This constitutes over 25% of total Medicare beneficiaries.²²

Insurance Market Trends

There are 24 licensed health plans active in the commercial market, with 13 offering Medicaid plans. Fourteen (14) carriers offer Medicare Advantage plans and four offer Medicare Supplement insurance plans. Among the licensed health plans in Michigan, nine are for-profit companies and 15 are non-profit.²³ The commercial insurance market in Michigan is highly concentrated, with about 80% of statewide commercial enrollment accruing to three insurers.²⁴ At an estimated 70% share of the commercial market, Blue Cross Blue Shield of Michigan is foremost among these due to its penetration of the large group market.²⁵

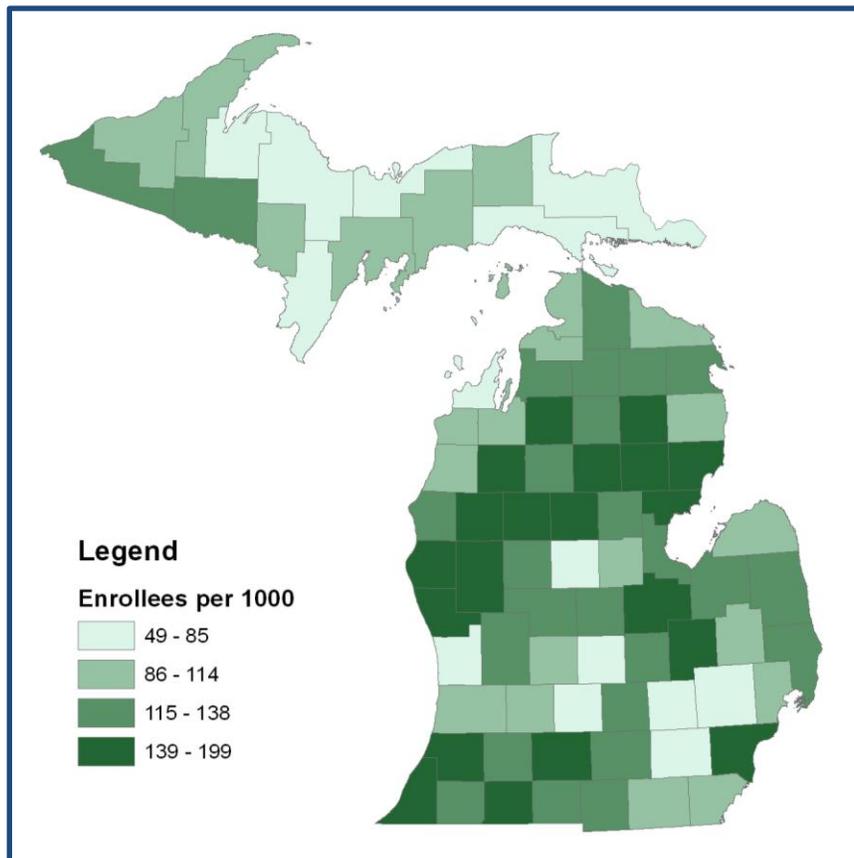
Until 2013, Blue Cross Blue Shield of Michigan had a unique status in the State, codified by the legislature in the Nonprofit Health Care Corporation Reform Act of 1980, as a tax-exempt non-profit and the insurer of last resort for the State. The “guaranteed issue” provisions in the Affordable Care Act rendered the insurer of last resort requirement unnecessary for the State, and Blue Cross Blue Shield of Michigan pursued changes to its business model. As of 2014, Blue Cross Blue Shield of Michigan will become a conventional commercial non-profit mutual insurer, owned by its members and required to pay state and local taxes, according to the provisions of Michigan Senate Bills 1293 and 1294. However, since Blue Cross Blue Shield of Michigan’s dominance of the commercial market was established with explicit support from the State, significant negotiations were made in order for this transition to be equitable.

As of October 2013, there were approximately 1.25 million Medicaid beneficiaries enrolled in 13 Medicaid health plans, out of approximately 1.8 million total Medicaid beneficiaries in the state.²⁶ In 2011, the Michigan Department of Community Health obtained an amendment to the 1915(b) managed care program waiver to allow voluntary enrollment of persons with Medicaid and Medicare (“dual eligibles”) into the Medicaid health plans and beginning in 2011, about 30,000 children with special health care needs were transitioned to managed care.²⁷ The mandatory managed care population

historically included families with children receiving assistance under the Financial Independence Program, persons receiving Medicaid for caretaker relatives and families with dependent children who do not receive Financial Independence Program assistance, and persons receiving Medicaid for the aged, blind, or disabled.

Michigan's Medicaid health plans are financially solvent and cover significant portions of the population in both the urban and rural areas of the state. In addition, the Healthy Michigan Plan enrolls beneficiaries in these health plans.²⁸ The map below (figure B.3) depicts overall Medicaid health plan enrollment per 1,000 residents by county as of July 2013.²⁹

Figure B.3 Medicaid Managed Care Enrollees per 1,000 Residents



B2. Population Health Status

Adults

In 2012, an estimated 17.8% of Michigan residents were in fair or poor health.³⁰ The state ranks fairly well on some health indicators; however, the extent to which residents engage in healthy behaviors is generally variable, and large disparities exist in overall health outcomes.³¹ Racial and ethnic minority

populations in Michigan experience poorer outcomes than the general population for many health conditions, challenging the state to identify new and innovative strategies to address these disparities.³²

Michigan has the fifth-highest adult obesity rate in the country.³³ Obesity affects more than two-thirds of adults, and is a risk factor for heart disease, Type 2 diabetes, and many types of cancer.³⁴ Obesity-related health costs totaled \$3.1 billion statewide in 2008, a figure that is expected to increase to \$12.5 billion statewide by 2018.³⁵ While a large proportion of all adults in the state are obese, disparities are pronounced. Issues with obesity-related chronic diseases are disproportionately felt in the African American and Hispanic communities; 55.4% of Black, non-Hispanic women and 32.5% of Hispanic women are obese compared to 29.2% of White, non-Hispanic women.³⁶

Heart disease is the leading cause of death in Michigan, followed by cancer; Type 2 diabetes is the sixth leading cause of death at a rate of 24.5 per 100,000. The prevalence of these diseases is particularly high in Michigan when compared to the national average.³⁷ Significant racial disparities exist based on the prevalence and mortality rates in the state for each of these diseases. African Americans experience the highest mortality from heart disease and cancer and, along with American Indians, have the lowest life expectancy. African American women have high death rates for heart disease (242 per 100,000) compared to Caucasian and Hispanic women (at 155 and 105 per 100,000 respectively).³⁸ The incidence of cervical cancer is also higher for African American women than any other racial group.³⁹

Chronic obstructive pulmonary disease is the third leading cause of death in Michigan, killing more than 5,000 people each year. Chronic obstructive pulmonary disease impacts low income and minority groups at a higher rate than the rest of the population.⁴⁰ It is largely preventable: smoking is the leading cause of chronic obstructive pulmonary disease.⁴¹ A greater percentage of adults in Michigan smoke compared to adults nationwide (23.3% compared to 19%).⁴² People with lower levels of income and education are more likely to smoke than those with higher levels of income and education.⁴³ As a state, Michigan spends an estimated \$3.4 billion annually on health care costs related to smoking, and Medicaid pays about one-third of those costs.⁴⁴

Among adults with current asthma – 686,000 – an estimated 28.1% have also been diagnosed with chronic obstructive pulmonary disease, making adults with current asthma nearly five times more likely to have chronic obstructive pulmonary disease than adults without asthma.⁴⁵ There are more than 16,000 asthma hospitalizations in Michigan each year (16 hospitalizations per 10,000 people) with the rate for Blacks four times that for Whites. This disparity has been increasing over time.⁴⁶ A similar disparity exists for asthma-related deaths. Although most asthma deaths are considered preventable, there are roughly 130 asthma-related deaths in Michigan each year. Blacks are four times as likely as Whites to die from asthma.⁴⁷

Behavioral health is an important issue in Michigan as well. Thirteen percent (13%) of adults in Michigan reported poor mental health status in 2012. Those with serious mental illness account for about 3.5% of the state's population, an estimated 350,000 adults. There are strong associations between poor mental health, low education, and low income, suggesting that this population is particularly vulnerable.⁴⁸

Children

Children are an especially vulnerable population. Michigan has engaged in a number of initiatives aimed at addressing children's health issues and health disparities, but significant challenges remain.

In 2011, 32.6% of Michigan children aged 10-17 were considered overweight or obese.⁴⁹ Among children with private insurance, 28.1% are overweight or obese while among children with public insurance, 40.7% are overweight or obese.⁵⁰

The statewide infant mortality rate was 7.1 per 1,000 live births in 2010, compared to 6.7 per 1,000 nationally.⁵¹ On average, African American infants experience a much higher mortality rate than Caucasian and Hispanic infants (14.7/1,000 compared to 5.9/1,000 and 7.1/1,000).⁵² Rates of low birth weight (< 5.5 pounds), which are highly predictive of infant mortality, also vary greatly along racial lines and have remained largely stagnant over the past several years.⁵³ In 2011, rates of low birth weight among Whites and Hispanics were 6.9%, and 14.0% among Blacks in Michigan.⁵⁴ Infants born with very low birth weight (< 3.5 pounds) have significantly higher mortality rates, with an infant death rate of 240.9 per 1,000 live births compared to a rate of 2.3 for low birth weight infants in 2010.⁵⁵

Although asthma can affect people of all ages, in most cases it begins during childhood. In 2012, an estimated 14.4% of children in Michigan aged 0-17 years had been told by a doctor that they had asthma, and 9.5% currently had asthma.⁵⁶ There are significant disparities in the asthma burden among different racial and socioeconomic populations in Michigan. An estimated 13.2% of White non-Hispanic children had lifetime asthma, compared to 15.1% of Black children, 16.6% of Hispanic children, and 22.1% of children among other demographics.⁵⁷ The prevalence of both lifetime and current asthma increased with age and decreased with higher household income. Children living in low income areas were hospitalized for asthma 3.3 times as often as children living in high income areas.⁵⁸ Additionally, boys were hospitalized for asthma at a rate 61% higher than girls.⁵⁹

B3. Health Care Cost Performance Trends

Across the nation, the rate of growth of health care costs is widely regarded as unsustainable.⁶⁰ As the growth in health care spending outpaces that of inflation and income, health care services will consume a greater portion of individual, community, and state resources, and become increasingly less affordable for payers, consumers, and businesses.

Private Health Care Spending

Insurance premiums in Michigan increased by 28% for individuals and 39% for families from 2003 to 2010, so that average premiums were about \$393 per month for individuals and \$1,096 per month for families.⁶¹ Michigan's average deductibles have also increased over time and according to a 2010 survey, one-third of those with health insurance in Michigan felt their out-of-pocket costs were too high.⁶²

Rising health care costs often result in families deciding to cut back on health care. Data from the Centers for Disease Control and Prevention⁶³ show that nationally, health care costs impose a significant burden on families. The 2012 Michigan Behavioral Risk Factor Survey found that 15.1% of Michigan residents

reported cutting back on medical care in the past 12 months due to cost, and that this percentage increases to 32% among those with incomes under \$20,000 per year.⁶⁴ These cutbacks can take various forms, according to national surveys, including relying on home remedies and over-the-counter drugs rather than visiting a doctor (33%), skipping dental care (31%), and postponing getting health care they needed (28%). Seventeen percent (17%) of those surveyed said they experienced serious financial problems due to family medical bills, with 11% using up all or most of their savings, and 7% reporting being unable to pay for basic necessities like food, heat, or housing. Beyond actual financial hardship due to medical care, 4 in 10 Americans (40%) report that they are “very worried” about having to pay more for their health care or health insurance.⁶⁵ The financial burden of medical costs was so great that, from 2001 to 2007, the primary cause of individual bankruptcies in the United States was unpaid medical bills.⁶⁶

These trends have affected employer-sponsored health care, raising costs for employers and employees alike. Increases in health insurance premiums consistently outpace inflation and growth of workers’ earnings. Nationally, premium increases have been between 3 and 13% per year since 2000; inflation and changes in workers’ earnings are typically in the 2 to 4% range.⁶⁷ This means that workers may have to spend more of their income each year on health care to maintain coverage. Nationally, average annual worker and employer contributions to total premiums have increased since 1999, with the worker contribution for family coverage increasing from \$1,543 in 1999 to \$4,129 in 2011.⁶⁸ In Michigan, the growth rate in employee share of health care costs was three times the national rate, going from 16% of premiums in 2002 to 24% in 2012.⁶⁹ As health care costs increase, it becomes increasingly difficult for families and businesses to purchase coverage because the price of coverage (the premium) typically increases. Employers, as purchasers of insurance, may also decide to increase the amount covered workers must pay to visit the doctor or go to the hospital (the cost sharing), which can put pressure on family budgets when family members become ill.

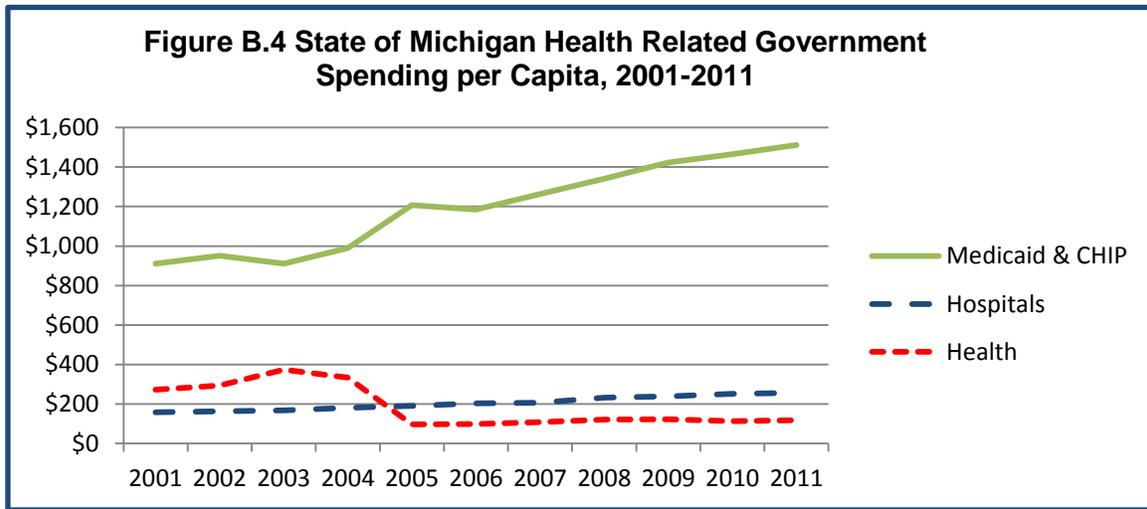
Government Health Care Spending

Categories of spending on health and health care in Michigan include medical services (Medicaid), behavioral health, public health, maternal and child health, services to the aging, crime victim services, information technology, various one-time only programs, and administrative overhead. Funding for public health initiatives in Michigan comes from the Federal government (63%), General Fund (21%), and local or private funds (11%). State restricted funds account for about 5% of public health revenues. The Federal share of Medicaid spending (the Federal Medical Assistance Percentage) was 66.4% as of fiscal year 2013.⁷⁰

Figure B.4⁷¹ shows State of Michigan expenditures on Medicaid, the Children’s Health Insurance Plan, public health, and public hospitals as compiled by the State Government Finances division of the Census Bureau. The “Health” category consists of “outpatient health services, other than hospital care, including: public health administration, research and education, categorical health programs, treatment and immunization clinics, nursing, environmental health activities such as air and water pollution control, ambulance service if provided separately from fire protection services, and other general public health activities such as mosquito abatement.” School health services provided by health agencies (rather than school agencies) are included here as well.⁷²

“Hospitals” spending refers to the “financing, construction, acquisition, maintenance or operation of hospital facilities, provision of hospital care, and support of public or private hospitals.” This includes facilities administered directly by the State and support for hospital services in privately owned hospitals or provided by local governments. Nursing homes are not included under this category unless they are directly associated with a government hospital.⁷³

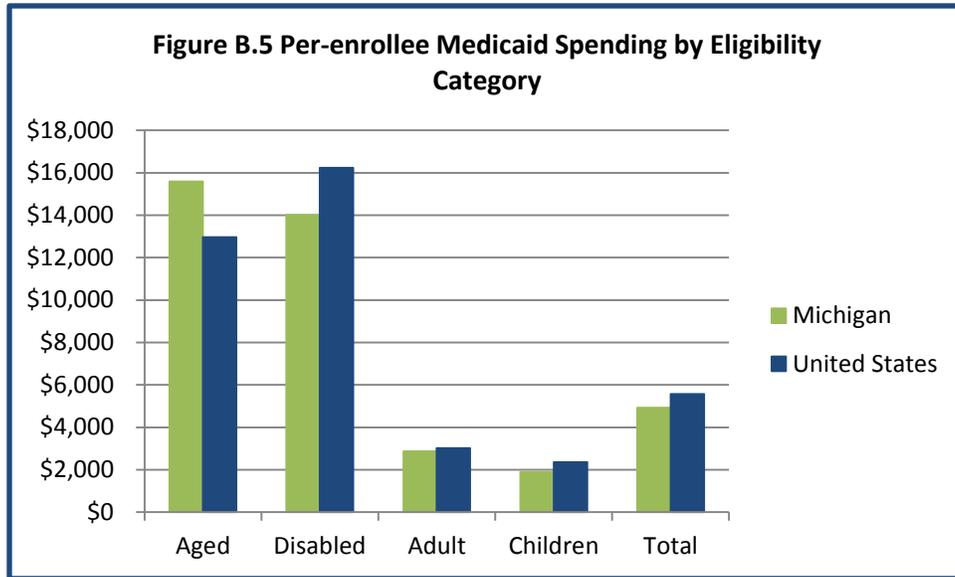
Figure B.4 shows that as a state, we spend an increasing amount on medical care, but spending on improving population health fell with the recession of 2003, and has remained flat since then.



Medicaid spending comprised 73.3% of the overall \$15 billion gross budget of the Michigan Department of Community Health in fiscal year 2012-2013, and 50.9% of the General Fund appropriations to the department.⁷⁴ The combined budgets of public health, maternal and child health, aging, crime victim services, information technology, one-time-only programs, and administration totaled 5.8% of the department’s gross appropriations, and 5.4% of general fund dollars. Behavioral health spending by the Michigan Department of Community Health amounted to about \$3,500 per person with serious mental illness in fiscal year 2013, accounting for \$3.1 billion of gross appropriations and \$1.2 billion, or 43.7%, of General Fund appropriations to the department.⁷⁵

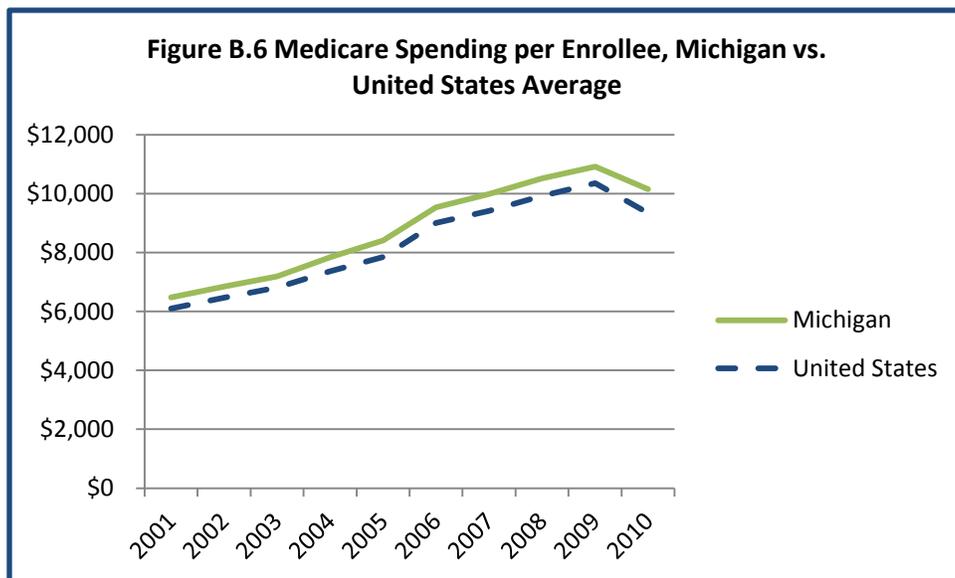
Medicaid Cost Trends

The upward trends in health insurance premiums are paralleled in Michigan’s Medicaid and Children’s Health Insurance Program spending, which have increased over 65% between 2001 and 2011. This increase is due in large part to rising enrollment, which increased by 69% from 2001 to 2010 compared to a 47% increase nationally.⁷⁶ High levels of per-enrollee spending for aged Medicaid beneficiaries, shown in figure B.5,⁷⁷ are likely a factor as well.



Medicare Cost Trends

Overall, per-enrollee Medicare spending in Michigan (\$10,152) was somewhat higher than the national average in 2010 (\$9,347).⁷⁸ This is depicted in figure B.6.⁷⁹



Medicare spending is distributed irregularly across the state; all but one hospital service area in southeast Michigan place above the 90th percentile nationally in terms of spending per enrollee (\$11,033), while those in the western portion of the Lower Peninsula fall below the national average.⁸⁰

Public Health Services

The state's population is served by 45 local health departments.⁸¹ Due to many counties' low population density, some local health departments serve multiple counties. These multi-county departments each

contain between two and 10 counties and can deliver services more efficiently in rural areas. Local health departments provide the following mandated local public health services: immunizations; infectious disease control; prevention and control of sexually transmitted infections; hearing screening; vision services; on-site sewage management; food safety and protection; and public and private water supply regulation. In addition to these mandated public health services, local health departments can elect to carry out other programs and services in response to identified community health needs, such as clinical services for family planning, maternal and child health services, special health care services for children, nutrition programs, and health education.⁸² Even as health care costs continue to increase for individuals and families, local government funding for health care services is facing historic shortfalls, which has led to cuts in health and hospital spending by local governments (including counties, cities, townships, and villages) in Michigan by an average of 5.3% from 2000 to 2011.⁸³

Behavioral Health Services

Michigan's Community Mental Health Service Programs – as defined by Michigan's Mental Health Code⁸⁴ – provide public behavioral health care services in the state that are funded by federal (53%), state general fund (39%), state restricted funds (2%) and local or private revenues (6%).⁸⁵ Federal funding for Community Mental Health Service Programs comes in the form of Medicaid funding through a network of Prepaid Inpatient Health Plans as defined by the Federal government.⁸⁶ State spending for the Community Mental Health system is determined by contract between each respective Community Mental Health Service Program and the Michigan Department of Community Health.

Within their defined geographic service area, Community Health Service programs must provide services “to individuals with serious mental illness, serious emotional disturbances or developmental disabilities.” Additionally, the Michigan Department of Community Health contracts directly with Community Mental Health Services Programs to provide services for children through the Children with Serious Emotional Disturbances Waiver and Children's Waiver.

As of January 2014, there will be 10 Prepaid Inpatient Health Plans in Michigan providing behavioral health services to Medicaid recipients. Before 2014, there were 18 Prepaid Inpatient Health Plans, including 8 “stand-alone” Community Mental Health Service Programs. Prepaid Inpatient Health Plans contract with Community Mental Health Services Programs to provide services under two waiver programs (the Medicaid Managed Specialty Supports and Services and the Habilitation Supports waivers).⁸⁷ Specialty care is prioritized for individuals with developmental disabilities and serious and persistent mental illnesses who meet eligibility criteria.⁸⁸

B4. Quality Performance of Michigan's Health Care System

Access to Care

Access to Primary Care

Primary care is the foundation of the health care system. In areas where primary care is strong, patients have better health outcomes and are more satisfied, while health disparities and health care costs are lower.⁸⁹ In 2012, 15.8% of adults in Michigan reported having no personal health care provider.⁹⁰ Among

the uninsured in the state, this figure jumps to 47.8%. Thirteen (13) percent of Michigan adults reported they could not see a doctor in the last 12 months due to cost.⁹¹ It is expected that the Healthy Michigan Plan and the Health Insurance Marketplace will address much of the cost barrier to accessing health care appropriately.

Whether Michigan will have a sufficient health care workforce to provide care for the newly insured – as well as Michigan’s aging population – is of concern, and the evidence is mixed. A survey of primary care providers conducted by the Center for Healthcare Research and Transformation indicated that the majority of primary care providers will have capacity to take on new Medicaid patients under the Healthy Michigan Plan. The survey found that 81% of primary care providers anticipate expanding their practices to include newly insured patients. Of those providers, 90% of pediatricians, 78% of internal medicine practitioners, and 76% of family physicians reported that they will have capacity to accept additional patients.⁹²

On the other hand, projections going forward estimate that between now and 2020, the growth in the demand for primary care physicians in Michigan may outpace growth in the supply of primary care physicians, leading to a shortage by 2020.⁹³ The extent of this shortage is expected to be about 7% of the number of physicians required to meet the forecasted demand for primary services in 2020. Further, increasing numbers of physicians are leaving primary care practice, while the number of new physician, physician assistant, and nurse practitioner graduates who are entering the primary care workforce is declining. Among physicians in the United States who spend the majority of their time in direct patient care, slightly more than one-third are working in primary care. Thirty-six percent (36%) of physicians nationwide and 35% of physicians in Michigan are practicing in a primary care field, which is substantially lower than in other developed countries (over 50% on average).⁹⁴

Some regions of the State already have a shortage of health care providers. The Health Research and Services Administration designation criteria for Health Professional Shortage Areas incorporate the number of providers per capita, poverty rate, and proximity to a source of care. These designations are determined separately for primary care, dental care, and behavioral health care.⁹⁵ Currently, there are 225 primary care Health Professional Shortage Areas in Michigan. It would take 203 primary care practitioners to remove the Health Professional Shortage Areas designations statewide.⁹⁶ In order to help serve these areas, 32 Federally Qualified Health Centers are currently serving 170 delivery sites, caring for 600,000 patients annually. Further, there are 172 Medicare Certified Rural Health Clinics in the state.⁹⁷ Health centers serve about 15% of the uninsured, 16% of the Medicaid population, and fewer than 2% of the privately insured in 2010.⁹⁸

Access to Behavioral Health Services

There are 141 Behavioral Health Professional Shortage Areas in Michigan, requiring 58 behavioral health practitioners across the state to remove the designations.⁹⁹

In the commercial insurance market, mental health services are an essential benefit of exchange-eligible insurance plans in Michigan,¹⁰⁰ and the prohibition on pre-existing condition exclusions under the Affordable Care Act includes mental health conditions.¹⁰¹ Medicare helps to pay for inpatient care under Part A, and outpatient mental health services under Part B, “including visits with a psychiatrist or other doctor, visits with a clinical psychologist or clinical social worker, and lab tests” as well as partial

hospitalization services. Medicare Part D also covers some medications to treat mental health conditions.¹⁰²

Michigan Medicaid benchmark health plan benefits include 20 visits to providers within a health plans' provider network. For Medicaid enrollees with more intensive behavioral health care needs, the state contracts with the ten Prepaid Inpatient Health Plans across the state.

The Community Mental Health system served approximately 233,000 residents in 2011 across 46 Community Mental Health Service Programs located throughout the state. In 2011, there were 144,668 adult consumers; 39,748 MI Child consumers; 28,521 consumers with developmental disability; 12,752 dual diagnosis; and 5,870 consumers who received treatment for substance abuse.¹⁰³

Demand for Community Mental Health services has exceeded supply in recent years, with a majority of Community Mental Health providers maintaining waiting lists for General Fund services. When there is a waiting list for these services, Community Mental Health service providers prioritize services to those with serious behavioral health care needs as required by the contract with the Department of Community Health. The priority population also includes “applicants eligible for or enrolled in Medicaid, the Adult Benefit Waiver, the MiChild program, or individuals who qualify for Medicaid through the “Medically Needy” pathway (i.e., spend-down beneficiaries).”¹⁰⁴

Since those with severe mental health needs are prioritized for General Fund services, persons with mild-to-moderate behavioral health needs who do not qualify for Medicaid may go without adequate access to care. A 2011 study by the Anderson Economic Group estimated that in 2009, approximately 85,000 children and 155,000 adults in Michigan had some form of mental illness and would have benefited from access to treatment.¹⁰⁵

This group includes, among others, those with substance use disorders, as Michigan was recently ranked 39th of 45 states in per-capita spending on substance use disorder treatment.¹⁰⁶ Compliance with the Mental Health Parity and Addiction Equity Act will help address this problem, and in the Healthy Michigan Plan, the State “is planning to significantly enhance services provided to beneficiaries in need of substance use disorder services. Services for substance use disorders will be provided in the same manner and in coordination with the mental health services and supports. All services will be identified and provided to best meet the needs of the beneficiary through person-centered planning.”¹⁰⁷

Quality of Care

Clinical Quality

Health care quality in Michigan scored as ‘Average’ relative to other states according to the 2011 National Healthcare Quality Report.¹⁰⁸ This report classifies state performance relative to the performance of other states. All National Healthcare Quality Report measures available were grouped into summary measures that included overall health care quality, types of care (preventive, acute, chronic), settings of care (hospital, ambulatory, nursing home, home health), care by clinical area (cancer, diabetes, heart disease, maternal and child health, respiratory diseases), and clinical preventive services.

As of 2011, differences in quality of care between patients in Michigan with private insurance and those with coverage through Medicare and Medicaid were within the ‘average’ range nationally.¹⁰⁹ The Agency for Healthcare Research and Quality Inpatient Quality Indicators and Patient Safety Indicators used to assess this performance refer to inpatient deaths and potentially avoidable complications. Compared to the United States, the performance in quality of care for both privately-insured and Medicare hospitalizations is in the very strong range. Quality of care for Michigan Medicaid hospitalizations is in the average range.¹¹⁰

Michigan’s chronic care quality performance was also in the ‘average’ range nationally. This includes ‘strong’ quality performance for heart disease measures and ‘average’ quality performance for diabetes and cancer measures compared to other states.¹¹¹

In Michigan in 2012, 68.5% of adults with commercial insurance had adequate control (<140/90) of their hypertension, compared to 63.3% of adults on Medicaid and 71.6% of adults on Medicare.¹¹² Among those with depression who had a depression screening with commercial insurance, 71.6% had effective acute phase treatment and 53.9% had effective continuation phase treatment and these rates were higher for those with Medicare (78.0% and 65.2%).¹¹³ Among adults with diabetes with commercial insurance, 65.1% had glycosylated hemoglobin control < 8.0%, compared to 55.1% of those on Medicaid.¹¹⁴

Experience of Care

The Hospital Consumer Assessment of Healthcare Providers and Systems survey is the first national, standardized, public reported survey of patients’ perspectives of hospital care. The survey is administered to a random sample of adult patients across medical conditions and health plans between 48 hours and six weeks after discharge. Michigan also received above-average consumer satisfaction scores according to the National Committee for Quality Assurance as described in table B.2.¹¹⁵

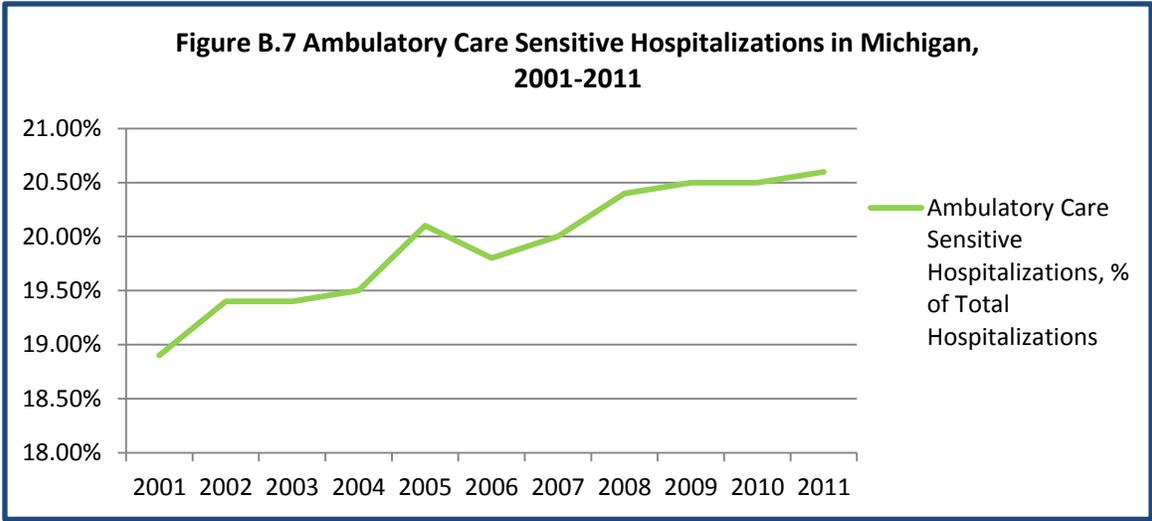
Michigan’s Quality Strengths and Weaknesses	
Strengths	Weaknesses
• Binge drinking	• Cancer mortality
• Cholesterol testing	• Cardiovascular disease
• Education attainment	• Chlamydia
• Human immunodeficiency virus/acquired immunodeficiency syndrome	• Cigarette smoking
• Injury mortality	• Diabetes
• Insurance coverage	• Hypertension
• Mammograms	• Infant mortality
• Childhood obesity	• Unemployment
• Adult physical activity	• Life expectancy
• Teen birth rate	• Nutrition
	• Adult obesity
	• Pap tests
	• Child physical activity
	• Poverty
	• Veterans access to health care

The Michigan Department of Community Health assesses the perceptions and experiences of members enrolled in Medicaid health plans as part of its process for evaluating the quality of health care services provided to adult members in the Michigan Department of Community Health Medicaid Program using the Consumer Assessment of Healthcare Providers and Systems Health Plan Survey.¹¹⁶ The survey found that the Medicaid Program scored significantly higher in 2013 than in 2012 on three measures: Rating of Personal Doctor, How Well Doctors Communicate, and Customer Service. Compared to national scores, the program scored highly on: Getting Needed Care, Getting Care Quickly, and How Well Doctors Communicate.

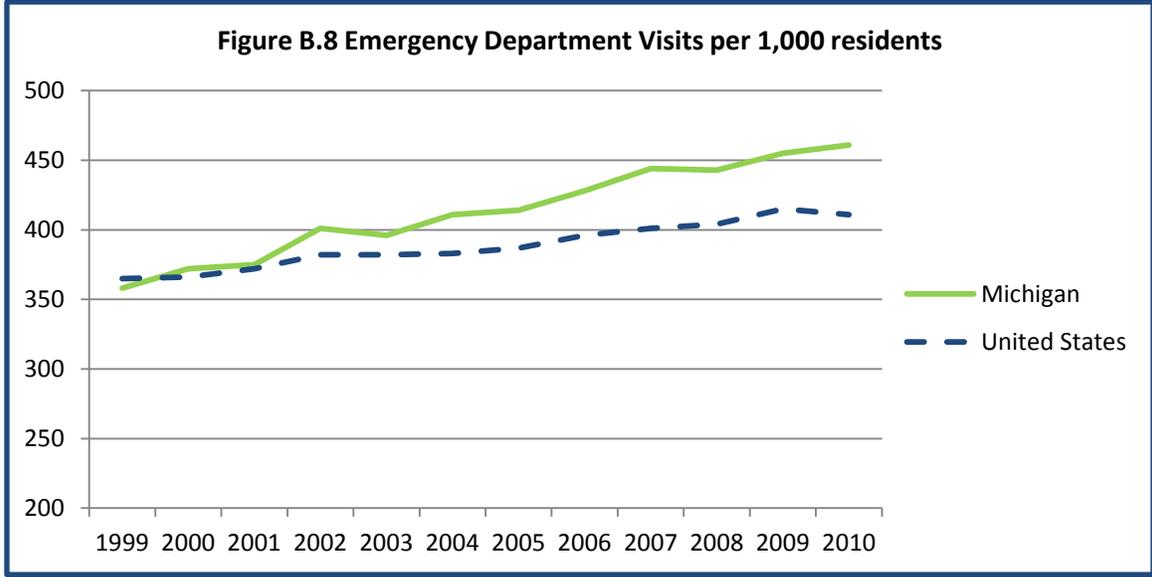
Table B.2 Michigan Hospital Consumer Assessment of Healthcare Providers and Systems Scores		
Experience with Hospital Scores, 2011-2012	Michigan (%)	U.S. (%)
Communication with nurses	79	78
Communication with doctors	80	81
Responsiveness of hospital staff	70	67
Pain management	71	71
Communication about medicines	64	63
Cleanliness of hospital environment	72	73
Quietness of hospital environment	58	60
Discharge information	87	84
Overall hospital rating	71	70
Would recommend the hospital	71	71

Utilization

In a well-functioning health care delivery system, patients receive the right care from the right provider at the right time and in the right place. As such, rates of inappropriate utilization measure the quality of care coordination efforts as well as the efficacy of existing systems of care. Importantly, over 20% of all hospitalizations in Michigan are ambulatory care sensitive – as seen in figure B.7.¹¹⁷ This means that many of these hospitalizations could potentially be prevented by interventions in a primary care setting.¹¹⁸ Leading causes for ambulatory care sensitive hospitalizations in the state include chronic obstructive pulmonary disease (9.8%), asthma (5.8%), and diabetes (5.1%).¹¹⁹



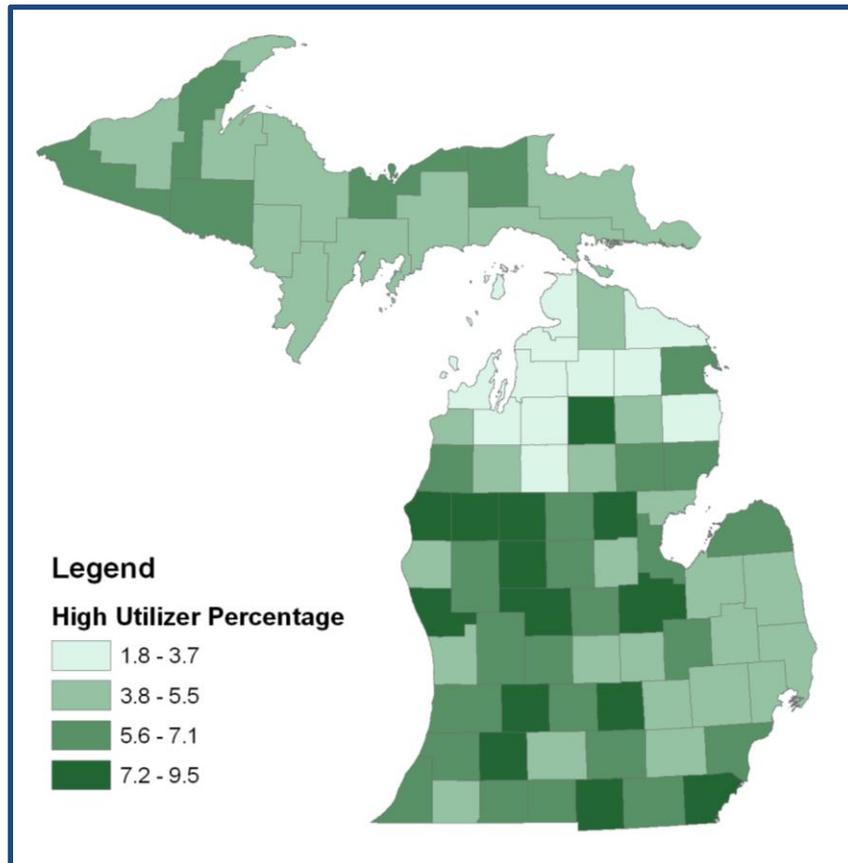
Additionally, increases in the number of emergency department visits per capita have outpaced the national average in recent years, depicted in figure B.8.¹²⁰ Further, there are significant disparities in rates of emergency department use for ambulatory care sensitive conditions. Of the approximately 2.3 million children in Michigan, 9.5% had two or more emergency department or urgent care visits for asthma in the last year and 3% had a hospitalization for asthma.¹²¹ Emergency department use rates are 2.7 times higher among African American children than among Caucasian children and are 2.2 times higher in urban areas than in rural areas.¹²²



As in other states, these costs are disproportionately attributable to a relatively small group of “high utilizers.”¹²³ High utilizers are defined as having five or more emergency department visits within a 12 month period. Analysis of Medicaid data revealed that from January 2011 to March 2013, this small group of high utilizers accounted for 44.8% of all emergency department visits by Medicaid beneficiaries

in some areas. The geographic distribution of emergency department high utilizers in Michigan Medicaid is shown below in figure B.9¹²⁴.

Figure B.9 Percentage of Medicaid Beneficiaries with 5+ Emergency Department Visits within a 12 Month Period

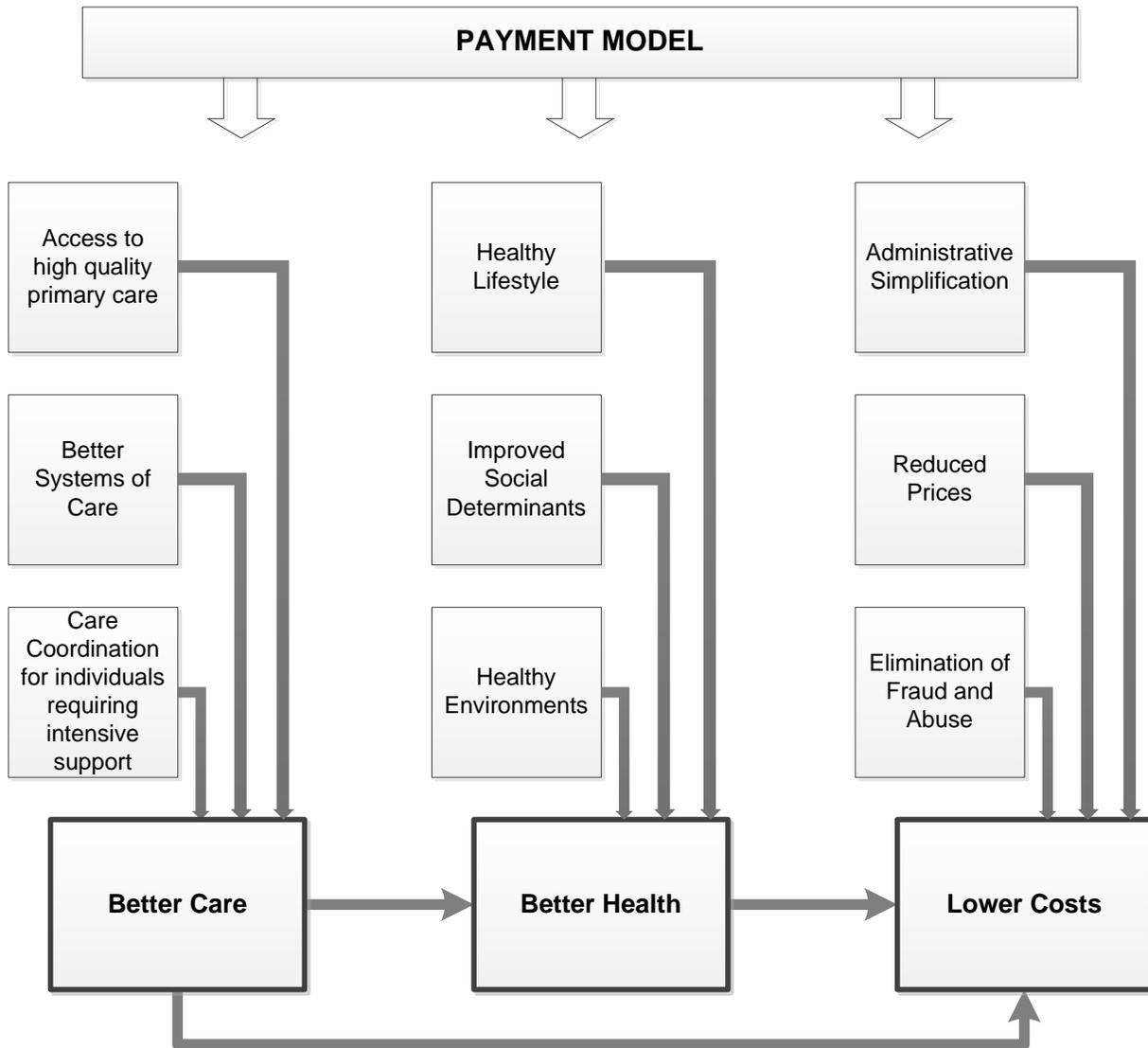


High emergency department utilization is both an urban and a rural phenomenon with 6.2% of the Michigan Medicaid population having at least 5 emergency department visits in a 12-month period statewide. The proportion of high utilizers ranges from 1.8% to 9.5% by county.¹²⁵

B5. Key Drivers of Performance

Michigan's driver diagram - presented in full in appendix 1.1 - identifies the drivers of cost, quality, and health outcomes in figure B.10, below. This section presents some of the more prominent efforts to address a few of these drivers. These efforts to address these drivers have been somewhat siloed, with little coordination between both private and public efforts to improve health care delivery, and efforts to improve population health.

Figure B.10 Driver Diagram



Better Care through Delivery System Change

Primary Care Improvements

Michigan Primary Care Transformation Program

The Michigan Primary Care Transformation program is a three-year multi-payer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship. The program grew out of the Patient Centered Medical Home initiative led by Blue Cross Blue Shield of Michigan, and is now the largest Patient Centered Medical Home demonstration project in the country.

Assistance and support for practice transformation takes place through a collaborative network of physician/physician hospital organizations and shared learning opportunities facilitated by the Michigan Primary Care Practice Transformation program administrative staff and the Care Management Resource Center, based at the University of Michigan. The Michigan Department of Community Health provides oversight and leadership for this program.

The Michigan Primary Care Transformation program model requires primary care practices to be affiliated with provider organizations to become designated as Patient Centered Medical Homes. The model requires designation through Blue Cross Blue Shield of Michigan or the National Committee for Quality Assurance (level 2/3). See appendix 2.4 for a crosswalk of the Blue Cross Blue Shield of Michigan and National Committee for Quality Assurance's designation criteria. A recent peer-reviewed article validates the Blue Cross Blue Shield of Michigan designation criteria,¹²⁶ and additional research demonstrates that this Patient Centered Medical Home model contributes to improved health outcomes and cost savings.¹²⁷

This model emphasizes population management through practice infrastructure investment and coordinated care, as described in greater detail in chapter E. Focus areas for transformation under the demonstration include care management, self-management support, care coordination and linkages to community services. The project is working toward a common incentive model across health plans, and provides clinical models, resources and supports aimed at avoiding emergency department and inpatient use for ambulatory care sensitive conditions, reducing fragmentation of care among providers, and involving the patient in decision-making.

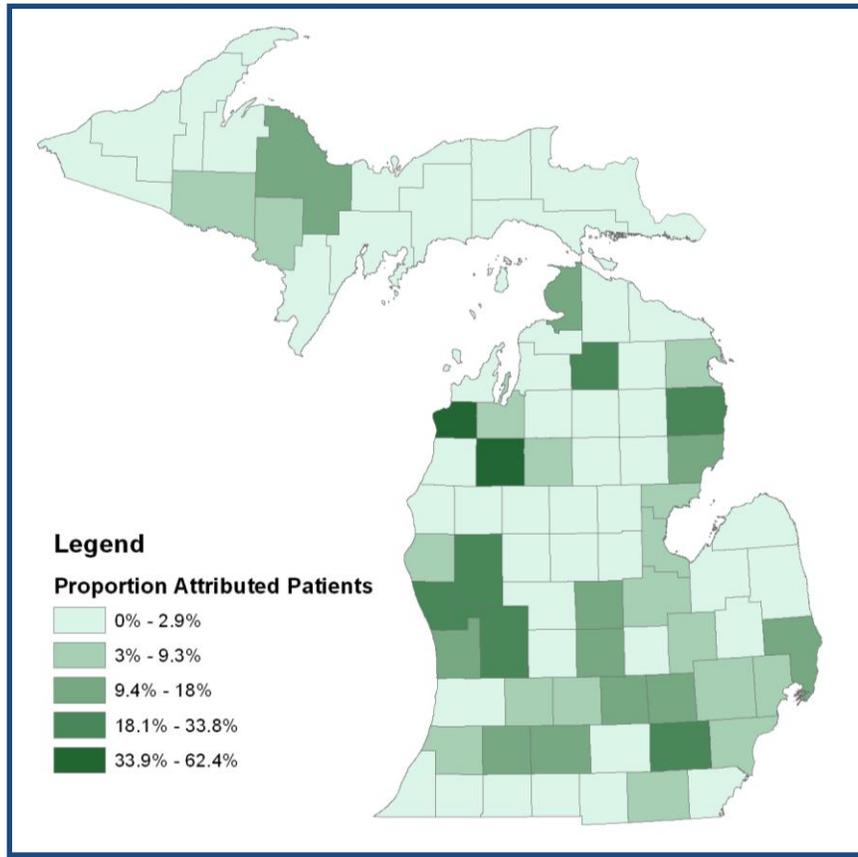
The Michigan Primary Care Transformation program has made substantial progress in developing and implementing the necessary support infrastructure and services for primary care practices and provider organizations.¹²⁸

- As of October 2013, 362 Michigan Patient Centered Medical Homes were participating in the multi-payer demonstration, covering 1,175,288 beneficiaries, 1,844 providers, and 35 physician organizations
- Five payers participate in the multi-payer project: Blue Cross Blue Shield of Michigan (461,577 beneficiaries, 39%) Blue Care Network (224,629, 19%), Medicare (197,554, 17%), Medicaid (185,499, 16%), and Priority Health (106,029, 9%)
- Four hundred and twenty-four Care Managers and Complex Care Managers have been hired, trained, and embedded in primary care medical home practice teams
- Three-hundred-sixty-two (362) practices have electronic health records in place with demonstrated all-patient electronic registry functionality to manage population health
- Nearly all practices have a clinical decision-maker available 24 hours / 7 days per week
- Two-hundred-eighty-four (284) practices receive daily electronic notifications of patient hospital admissions, discharges, and transfers – and all utilize Care Managers to provide transition care
- Project leadership has created a compendium of best practices in the following areas: advanced care planning, palliative care, and utilizing the recommendations of the American Board of Internal Medicine's 'Choosing Wisely' campaign that are spread through learning collaboratives, meetings, and webinars

- The Michigan Data Collaborative has been established at the University of Michigan to accept and standardize claims/encounters and eligibility history data for all participating beneficiaries
- Data are utilized to disseminate and monitor key quality, utilization, and standardized cost information

Michigan Primary Care Transformation coverage is depicted in Figure B.11 below, which shows that Patient Centered Medical Homes participating in the demonstration are spread across the state, but do not cover all populations equally. There are many areas in which populations do not have ready access to a Patient Centered Medical Home. However, Blue Cross Blue Shield of Michigan – a key participant in Michigan’s multi-payer demonstration program – continues to expand its Patient Centered Medical Home program. To date, Blue Cross Blue Shield of Michigan has designated 1,240 Patient Centered Medical Home practices according to its validated designation criteria that it has developed internally.

Figure B.11 Michigan Primary Care Transformation Statewide Coverage



Michigan Quality Improvement Network

The Michigan Quality Improvement Network utilizes quality improvement and system redesign methodology to improve community health centers’ performance outcomes in quality of care delivery, patient experience, and cost containment. The Network utilizes the Michigan Primary Care Association’s data repository to aggregate practice management, electronic health record, registry, and other data, which are translated into meaningful information that can be used by providers and quality improvement staff to drive improvements in the health centers. Several of the Michigan Primary Care Association’s 35

members are working on the National Committee for Quality Assurance’s Medical Home designation.¹²⁹ In addition, Michigan’s Federally Qualified Health Centers participating in the Quality Improvement Network are utilizing electronic health record systems.¹³⁰

Support for Patient Centered Medical Homes

In addition to Blue Cross Blue Shield of Michigan’s support for Patient Centered Medical Homes, other payers also support practice transformation. For instance, Priority Health has supported Patient Centered Medical Home development for 15 years. It recognizes the National Committee for Quality Assurance accreditation, and also participates in the Michigan Primary Care Transformation program.

Systems of Care

A system of care, or an organized delivery system, is a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.¹³¹

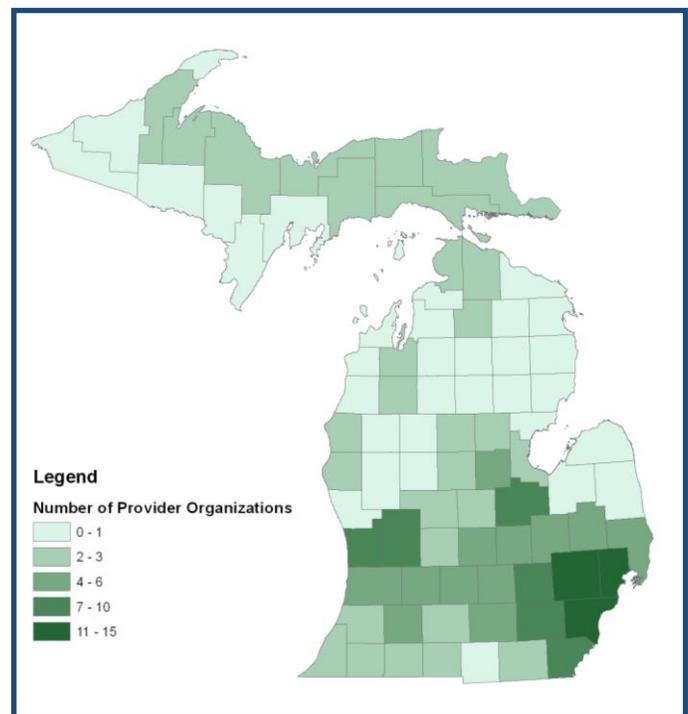
In recent years, significant hospital and health system consolidation has occurred both nationally¹³² and within Michigan.¹³³ Although consolidation of hospitals and ambulatory practices is occurring, Michigan health care is not currently dominated by large health systems. Michigan has 134 community hospitals – facilities that provide both inpatient and outpatient care and operate an emergency department – of which, 35 are critical access hospitals, 14 are public hospitals, 47 are teaching hospitals, and 18 are long-term acute care hospitals. The most recently available data indicates that of the estimated 3,500 primary care practices in the state as of 2005, about 85% were solo or small practices with one to three physicians, and 15% were larger group practices with four or more physicians.¹³⁴ There is some evidence that physician consolidation has also been increasing since then.¹³⁵

Physician Organizations

The predominance of independent practices in Michigan is one reason that Blue Cross Blue Shield of Michigan requires physician organization participation for providers who want to participate in its Physician Group Incentive Program. This program includes 40 physician organizations representing 15,500 primary care and specialty physicians. Blue Cross Blue Shield of Michigan encourages physician organizations to work on initiatives that may include: practice transformation, standardization of treatment for specific conditions, implementing processes to track needed services and follow-up, or accelerating the adoption of health information technology.

As depicted in figure B.12, physician organizations cover most of the state. In a 2011

Figure B.12 Physician Organization Coverage



survey, physician organizations participating in the Michigan Primary Care Transformation program reported providing the following functions:

- Administrative support
 - Contracting
 - Reporting
 - Credentialing
- Training
- Quality improvement
- Utilization management
- Data management
- Information technology implementation & support
 - Registry
 - Electronic prescribing
 - Electronic health records
 - Health information exchange

As part of the Michigan Primary Care Transformation program, physician organizations are hiring Care Managers and embedding them in Patient Centered Medical Homes. Physician organizations are also creating relationships with specialists.

Organized Systems of Care

Blue Cross Blue Shield of Michigan is working with physician organizations and hospitals across the state to develop Organized Systems of Care. Similar to an Accountable Care Organization, an Organized System of Care is a community of caregivers that is responsible for a specific patient population, which Blue Cross Blue Shield of Michigan is developing. The Organized Systems of Care are responsible for the care and treatment provided to a patient population attributed to the community's primary care physicians. They are expanding Blue Cross Blue Shield of Michigan's Patient Centered Medical Home model to include hospitals, specialists, and other providers within the community of caregivers.

Accountable Care Organizations

Accountable Care Organizations are groups of doctors, hospitals, and other health care providers who come together in a formal arrangement to give coordinated high quality care to the patients they serve and share accountability for outcomes.

The Centers for Medicare and Medicaid Services established the Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Michigan has seven Accountable Care Organizations participating in the Medicare Shared Savings Program including: Accountable Healthcare Alliance, Oakwood Accountable Care Organization, Partners in Care, Physician Organization of Michigan, ProMedica Physician Group Inc., Southeast Michigan Accountable Care Inc., and the University of Michigan Health System.

The Pioneer Accountable Care Organization model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It allows these provider groups to move more rapidly from a shared savings payment model to a population-based

payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. Two Pioneer Accountable Care Organizations cover urban populations in Genesee County and Detroit. Genesys Physician Hospital Organization includes the Genesys Health System, 160 primary care physicians, and 400 specialist physicians. Michigan Pioneer Accountable Care Organization is a partnership of the Detroit Medical Center and its physicians, serving 13,000 Medicare beneficiaries.

Michigan Surgical Quality Collaborative

The Michigan Surgical Quality Collaborative was founded in 2005 with support from Blue Cross Blue Shield of Michigan and Blue Care Network to organize systems of care around surgical services, and has 52 member hospitals. Each member hospital collects and reports surgical outcomes data to a data coordinating center at the University of Michigan. Hospitals and surgeons receive quality reports and participate in quality improvement meetings. To date, collected data has been analyzed to identify best practices. Additional uses currently being tested include an application to provide personalized surgical risk assessment for decision-making, and identify patients who would benefit from pre-operative health improvement services.

Care Coordination

Care coordination is defined as the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services.¹³⁶ It is particularly important for those with complex social or medical needs, such as those with behavioral health care needs, those with comorbid chronic conditions, and the frail elderly.¹³⁷ Moderate and complex care management is a central feature of the Michigan Primary Care Transformation program.

Until recently, care coordination was an uncompensated activity in fee-for-service payment systems, and therefore was an activity performed by managed care organizations or available to certain populations only. For example, Medicaid mental health and developmental disability services are required to be coordinated with other community agencies (including Medicaid health plans, family courts, local health departments, MiChoice waiver providers, school-based services providers, and the county Department of Human Services). They are provided according to an individual, person-centered written plan of service. Similarly, the MiChoice Home and Community Based Waiver program provides supports coordination; a service designed to inform, assist, and coordinate a variety of home care and other community-based services needed by elderly and other adults with disabilities aged 18 years and older who meet nursing facility levels of care criteria and who are enrolled in MiChoice.

There are many efforts to improve transition care when a person moves from one care setting to another, such as from hospital to home. In order to improve care and reduce costs, the Michigan State Action on Avoidable Rehospitalizations project, which concluded in June, aimed to reduce the number of patients who experience unplanned, related readmissions within 30 days of discharge, and to increase patient and family satisfaction with transitions and coordination of care. The project is transitioning to a statewide collaborative. The Michigan Health and Hospital Association's Keystone Center has convened the Michigan Care Transitions Coordinating Team, a group of key stakeholders tasked with providing strategic direction for care transitions work in the state.

Individuals dually eligible for Medicare and Medicaid are a particularly vulnerable population, for whom the health care delivery system has been largely uncoordinated. Michigan was selected as one of fifteen states to design new approaches to better coordinate care for individuals who are dually eligible for Medicare and Medicaid. In the demonstration, services and supports for persons who are dually eligible will be delivered by newly created Integrated Care Organizations and currently existing Prepaid Inpatient Health Plans. Integrated Care Organizations will be responsible for the provision of all physical health, long term care, and pharmacy services, while Prepaid Inpatient Health Plans will be expected to cover behavioral health and habilitative services for people with developmental disabilities, mental illness, or substance abuse issues. The Integrated Care Team will be connected through the Care Bridge, a care coordination model developed to integrate long term care, physical and behavioral health care services and establish communication linkages. The Care Bridge includes an electronic platform that supports individualized patient-centered care plans. The Integrated Care Team works collaboratively with the person to ensure the care plan is carried out according to the person's preferences.

In addition, Michigan is developing a pilot Medicaid Health Homes under the Affordable Care Act Section 2703 designation to provide “a comprehensive system of care coordination”¹³⁸ for beneficiaries with a serious and persistent mental health condition who also have co-occurring chronic medical conditions and high rates of hospital and emergency department utilization.¹³⁹ The program will focus on integrating behavioral health, medical care, and care coordination services for this population.

The Pathways Community Hub model – operating in three Michigan cities – has received a Healthcare Innovation Award from the Center for Medicare and Medicaid Innovation to integrate between health care settings and community services. The Michigan Pathways to Better Health project connects at risk individuals to community health workers who work with the Hub's registered nurse and clinical social worker to coordinate access to health care and social services. These at-risk individuals have multiple chronic conditions and complex social and medical needs. The Pathways Community Hub is described in more detail in appendix 2.1.

Better Health

Michigan's Blueprint for Health Innovation Driver Diagram follows the work of the *County Health Rankings & Roadmaps*, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute,¹⁴⁰ which tracks four factors that influence health outcomes (a fifth set of factors that influence health - genetics and biology - is not included in the *Rankings*). The following factors are discussed in more detail below:

- Health behaviors
- Clinical care
- Social and economic factors
- Physical environment

Improving clinical care is a factor of the *Rankings* and was addressed in section B.4 above.

Health Behaviors

Almost 80% of Michigan adults do not consume adequate amounts of fruits and vegetables.¹⁴¹ In 2009, the prevalence of inadequate physical activity among Michigan adults was 48%. This represents a decrease of 7.2% since 2001. Adults who are obese are significantly more likely to report engaging in

either inadequate or no-leisure time physical activity compared with adults with a body mass index that is normal or overweight.¹⁴²

The prevalence of obesity among youth has gradually increased over the past ten years, in both Michigan and the United States, with one-third of children in Michigan being obese.¹⁴³ African American (17.3%) and Hispanic (15.9%) youth have a higher prevalence of obesity than Caucasian (13.1%) youth.¹⁴⁴ Eighty (80) percent of youth do not consume adequate (5 or more) servings of fruits and vegetables per day, and 28% drink at least one pop or soda per day.¹⁴⁵

Only 31% of youth participated in physical education classes on a daily basis, and only 47% of youth are physically active for at least 60 minutes per day on five or more days per week. On an average school day, approximately 30% of youth spent 3 or more hours watching television, while 23% of youth used computer or video games for 3 or more hours. African American youth have the highest prevalence of excessive television viewing (48%) and computer or video game use (28%).¹⁴⁶

There are significant disparities in health behaviors across urban, suburban, and rural regions of the State. For example, Detroit has one of the highest prevalence rates of obesity (38.1%) compared to other Michigan cities. Over a half million Detroit residents live in areas that have an imbalance of unhealthy food options.¹⁴⁷ Holding other key factors constant, Detroit residents are statistically more likely to suffer or die prematurely from a diet-related disease. More than half of households with children under the age of 18 participate in Michigan's Food Assistance Program.

As described above, Michigan's rate of smoking is above the national average. Smoking is primarily initiated during adolescence and, in fact, 88% of adult smokers who smoke daily report that they started smoking by the age of 18 years.¹⁴⁸ Fourteen (14) percent of high school students smoke, with 15,200 kids under the age of 18 becoming new daily smokers each year. Seven hundred sixteen thousand (716,000) kids are exposed to secondhand smoke at home. Fourteen thousand five hundred (14,500) adults die each year due to smoking and 298,000 kids who are currently under the age of 18 will ultimately die prematurely from smoking.¹⁴⁹ The Michigan Smoke-Free Air Law went into effect on May 1, 2010 and banned smoking in bars, restaurants, and most workplaces. A study conducted in six regions of the state and 13 cities before and after the law passed showed a 93% reduction in the level of secondhand smoke air pollutants in 77 restaurants after the law went into effect. A more comprehensive evaluation of the impact of the law is due to be released in the near future.¹⁵⁰

Socioeconomic Determinants of Health

Michigan faces numerous socioeconomic challenges. With an 8.9% unemployment rate statewide,¹⁵¹ 20% of residents are living in poverty¹⁵² and receive nutrition assistance.¹⁵³ Michigan's food insecurity rate is 17.9% and nearly 1 in 4 Michigan children (24.8%) live in a food insecure household.¹⁵⁴

Since 2005, Michigan has lost more residents with college degrees than it has gained. Michigan ranked 47th nationally in net migration among those with a bachelor's degree or higher in 2010.¹⁵⁵ Although the state's 'brain drain' was mediated significantly in 2011, net migration among younger degree holders remains negative.¹⁵⁶ This trend has significantly impacted income levels in the state. Wage income

comprises less than half of overall per capita income, the growth rate of which has lagged behind the national average for 8 of the last 10 years.¹⁵⁷

Further, to the extent that exceptions to these economic trends have been observed, they have been largely driven by gains in relatively affluent areas, while areas with lower socioeconomic status have not seen improvement.¹⁵⁸ Economic disparities also tend to fall along racial lines. A 2012 study found that in Michigan, 21% of white households were asset poor compared to 47% of households of color, meaning that if the ‘average’ household of color were to lose its primary source of income, it would fall below the poverty line within three months. In addition, 33% of white households were liquid asset poor compared to a staggering 68% of households of color (“A household is considered liquid asset poor if it does not have sufficient liquid assets (for instance, bank accounts and other financial assets) to live at the poverty level for three months in the absence of income”).¹⁵⁹

In Detroit, 34.5% of residents live in poverty.¹⁶⁰ Detroit is also among country’s most violent cities. Detroit has a violent crime rate four and a half times the national rate, and four times the Michigan rate. The death rate for Detroit children 1 to 14 years of age was nearly 6.5 times the state rate. For adolescents and young adults, Detroit’s death rate was 2.2 times the state rate. Males represented 80% of the deaths of Detroiters age 15 to 24.¹⁶¹ Flint, Michigan joins Detroit among the country’s most violent cities. Within the city of Flint, the homicide rate per 100,000 is 16.3 compared to 7 statewide and the violent crime rate (per 100,000) is 908 compared to 497 statewide.¹⁶²

These socioeconomic trends have had important consequences for health status and for the overall low ranking (37th) the United Health Foundation gives Michigan for determinants of health.¹⁶³

Efforts to address social determinants exist across the state and a comprehensive review is beyond the scope of this chapter. However, three of Governor Snyder’s initiatives – the Regional Prosperity Initiative, Early Childhood Education, and Pathways to Potential – emphasize the integration, coordination, and collaboration that are mainstays of Michigan’s Blueprint.

Regional Prosperity Initiative

In order for the public, private, and nonprofit sectors to work in partnership toward a common goal of economic prosperity in Michigan, Governor Snyder has created the Regional Prosperity Initiative, which reorganizes the current coordination of state services. The impetus for the Regional Prosperity Initiative was clear: “The absence of a common economic vision and coordination of services for our regional economies creates both redundancies and gaps. This causes confusion for local, state, federal, private and nonprofit partners seeking to support a region.”¹⁶⁴ In order to harmonize state-level services and initiatives, 10 economic development regions were established: Upper Peninsula, Northwest, Northeast, West Michigan, East Central Michigan, East Michigan, South Central, Southwest, Southeast, and Detroit Metro. These are depicted in figure B.13.

Unfortunately, these programs and services are often uncoordinated, difficult to find, and fail to adequately serve children and families.

In 2011, Governor Rick Snyder took bold steps by calling for an integrated, coordinated system of early learning and development in Michigan, and creating the Office of Great Start, located in the Michigan Department of Education. The creation of this office included a charge to lead efforts to coordinate and integrate Michigan's investments in children from before birth through age eight. The Office of Great Start has spent the past year engaging stakeholders across the state about the best ways to improve Michigan's early childhood system. Recommendations include: build leadership within the system, support parents' critical role in their children's early learning and development, assure quality and accountability, ensure coordination and collaboration, use funding efficiently to maximize impact, and expand access to quality programs.

Pathways to Potential

Pathways to Potential is a new business model implemented by Michigan Department of Human Services focusing on three core principles: 1) place workers in the community, where people are already looking for help; 2) use a network approach with Department of Human Services staff serving as connectors; 3) leverage partnerships with communities to integrate services toward shared outcomes. By the end of the 2012-2013 school year, Department of Human Services' staff was in 124 schools in four core cities of Flint, Pontiac, Saginaw, and Detroit. With the start of the new school year, Pathways will be expanding to other areas with workers in 150 schools – many of which also have school-based health centers. The Pathways to Potential model uses a networking approach to help clients find solutions to the barriers they face. The model reflects the understanding that accessing public benefits is just one piece of a long pathway that people must take to reach their healthiest and fullest potential.

Environmental Factors Impacting Health

Sustaining Michigan's environmental quality is important for improving population health. The built environment in rural and metropolitan parts of the state may play a role in low rates of exercise. Children living in a neighborhood without access to sidewalks, walking paths, parks/playgrounds, or recreation/community centers were 20-45% more likely to become overweight or obese compared to kids with access to these features.¹⁶⁵ In urban areas, high crime rates¹⁶⁶ likely deter many from even walking outside their homes despite a high degree of 'walkability,'¹⁶⁷ and children residing in neighborhoods deemed unsafe are 30-60% more likely to be overweight or obese than children living in safer areas.¹⁶⁸

Local Health Alliances

An environmental scan conducted as part of the State Innovation Model planning process reveals that there are local initiatives in which partners are getting out of their silos and forming relationships across sectors to work together to address environmental, behavioral, and socioeconomic drivers of population health. Referred to as the Collective Impact model, these partnerships have the following features in common:

- Common agenda
- Shared measurement
- Continuous communication
- Mutually reinforcing activities across all participants that amplify impact

- A backbone organization to provide centralized infrastructure, dedicated staff, and structured processes

While these initiatives exist, a lack of sustainable funding and resulting reliance on volunteer efforts, can limit their viability and effectiveness over the long run.

Michigan Department of Community Health Chronic Disease and Injury Programs

Federal dollars primarily from the Centers for Disease Control and Prevention as well as some state funds support numerous health promotion and injury prevention programs as well as chronic disease control programs. Prevention programs address tobacco use, prediabetes, healthy eating, physical activity, unintentional injury, violence, and services that address the needs of people with disabilities. Chronic disease control programs address arthritis, asthma, cancer, diabetes, heart disease, human immunodeficiency virus/acquired immunodeficiency syndrome, kidney disease, obesity, and chronic disease self-management. All programs work to improve state, county and community population health through training and technical assistance, public and professional education about evidence-based programs and strategies, surveillance and evaluation, and dissemination of information to convey the burden of risk factors and/or disease and to inform policy.¹⁶⁹ State chronic disease programs also are responding to the Centers for Disease Control and Prevention's initiative based on recommendations outlined in the National Prevention Strategy of the Office of the U.S. Surgeon General.¹⁷⁰ This initiative promotes coordination across categorical programs, focusing on the following broad domain areas: Environmental Approaches (e.g., cross-program strategies to support and reinforce healthy behaviors), Health System Change Interventions (e.g., process and/or outcome improvements for risk reduction and disease management promoted within healthcare settings), and Strategies to Improve Community-Clinical Linkages (e.g., strategies to assure attention to the social determinants of health).¹⁷¹ All these strategies contribute to the goal of this Blueprint for a community-integrated health care system.

Payment Model Innovations to Lower Costs Trends

A key premise of Michigan's Blueprint is that paying providers for volume of service rather than value promotes fragmentation and denies providers the flexibility to innovate care delivery. Paying for volume over value can also lead to price distortions and even fraud.¹⁷²

As in most states, provider payments in Michigan are predominantly fee-for-service. Even in managed care plans, providers are typically compensated on a fee-for-service basis, although a much larger proportion of provider payments are made on a capitated basis in Michigan than in most other states, at approximately 24% of total payments by all health plans in the state. Capitation rates in the state reached as much as 45% of Medicaid payments as of 2006, but have been declining every year since. The distribution of capitation arrangements is irregular, with some health plans not participating in any capitated payment arrangements and others, including the third largest health maintenance organization in the state, rendering more than 30% of all provider payments on a capitated basis.¹⁷³

While fee-for-service remains the most common provider payment method in Michigan, several payment model innovations are currently being pilot tested across the state.¹⁷⁴

Medicare Accountable Care Organizations

As described above, Michigan has seven Accountable Care Organizations participating in the Medicare Shared Savings Program, and two participating in the Pioneer program. The Shared Savings program will reward organizations that lower their growth in health care costs while meeting performance standards on quality of care and patient experience. The Pioneer model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Services Program. It is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the Accountable Care Organization, and achieve cost savings for Medicare, employers, and patients.

Physician Group Incentive Program

The Physician Group Incentive Program is a Blue Cross Blue Shield of Michigan program that has supported and facilitated practice transformation using a wide variety of initiatives to reward physician organizations for improved performance in health care delivery.¹⁷⁵ Program participants, including both primary care physicians and specialists, collaborate on initiatives designed to improve the health care system in the state. Each initiative offers incentives based on clearly defined metrics to measure performance improvement and program participation. As of February 2012, the program includes 40 physician organizations from across the state, representing nearly 15,500 primary care and specialty physicians who are providing care to nearly two million Blue Cross Blue Shield of Michigan members.¹⁷⁶

Bundled Payments

There are two bundled payment models being tested in Michigan. First, several health systems across Michigan are participating in the Bundled Payments for Care Improvement initiative launched in January 2013. The initiative includes organizations entering into new payment arrangements with Medicare that involve “financial and performance accountability for episodes of care.” According to the Centers for Medicare & Medicaid Services, “the Bundled Payments initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care.”¹⁷⁷

In addition, the Michigan Value Collaborative, a quality initiative led by Blue Cross Blue Shield of Michigan and inclusive of more than 50 hospitals, “is the first statewide episodic bundled payment initiative in Michigan.”¹⁷⁸

B6. Special Needs Populations

Care coordination and care management services are most effective when well-targeted to patients who can most benefit: those, who when they receive appropriate services, achieve better outcomes at lower cost. The Blueprint for Health Innovation will focus services on at-risk populations in need of more intensive services.

Maternal and Child Health

Low birth weight infants are more likely to experience physical and developmental health problems or die during the first year of life than are infants of normal weight. Rates of low birth weight have remained

stubbornly above 8% in Michigan and nationally. A growing body of research also finds that poverty during early childhood causes health problems through neurochemical changes in the way the brain reacts to stress.¹⁷⁹ Given the large health status disparities for both adults and children discussed above, mothers and children in poverty are a critically important population for Michigan’s Blueprint to address. These efforts will complement several existing activities led by the Department of Community Health and the Office of Great Start.¹⁸⁰

Children’s Special Health Care Services

The Children’s Special Health Care Services “provides Medicaid eligibility to children up to age 20 with a qualifying medical condition (or individuals 21 and older with cystic fibrosis or certain hereditary blood coagulation disorders).”¹⁸¹ Since October 2012,¹⁸² approximately 14,000 children eligible for Children’s Special Health Care Services have been moved to one of 12 managed care plans which meet certain core competencies and are contractually obligated to maintain continuity of care and network availability.¹⁸³

Aged, Blind, and Disabled

In fiscal year 2011, Medicaid recipients in the Aged, Blind, and Disabled category totaled approximately 49,933 children under age 18 and 279,067 adults over age 19. Spending for this group amounted to nearly \$6 billion dollars, comprising almost half of overall Medicaid outlays.¹⁸⁴

Multiple Chronic Conditions

According to the United States Department of Health and Human Services, as an individual’s number of chronic conditions increases, the individual’s risk for hospitalizations that can be avoided increases. Having multiple chronic conditions contributes to frailty and disability. Moreover, increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall increase in spending in the traditional Medicare program. The privately insured population also has significant presence of costly multiple chronic diseases. Analysis of data from Blue Cross Blue Shield of Michigan shows that while 9% of adults aged 18-64 had two or more chronic diseases in 2008, they accounted for 30% of spending for that population.¹⁸⁵

Nationally, rates of adults with two or more chronic conditions are on the rise: from 21.8% in 2001 to 26.0% in 2010.¹⁸⁶ The Centers for Medicare and Medicaid Services report that 69.5% of Michigan Medicare beneficiaries are reported to have two or more chronic diseases.¹⁸⁷ According to United Health Foundation rankings, Michigan ranked 46th in the country on its metric of multiple chronic conditions, with 39.3% of adults age 65 and older who report having four or more of the following conditions: stroke, asthma, osteoporosis, cancer, atrial fibrillation, Alzheimer’s disease, chronic obstructive pulmonary disease, depression, chronic kidney disease, heart failure, diabetes, arthritis, ischemic heart disease, high cholesterol, or high blood pressure.¹⁸⁸

Chronic disease is also a significant issue for Prepaid Inpatient Health Plan consumers according to a 2012 study which found that among a sample of patients with some permutation of two selected chronic conditions, “compared to consumers without any of these conditions, those with both conditions are 18 percent more likely to use ambulatory services, 35 percent more likely to have an ER visit, and 1.3 times more likely to be admitted to a hospital for physical health services.”¹⁸⁹

Medicaid High Utilizers of Emergency Department Services

Spending on health care for high utilizers of services is described in section B.3 above. Examination of Medicaid data reveals that the most common primary diagnoses for high utilizer emergency department visits are related to pain (e.g. abdominal pain, chest pain, back problems and headaches). Analyses of secondary diagnoses, however, show high rates of comorbid mental health conditions and chronic physical health problems (e.g. hypertension, diabetes, asthma) that complicate care among these high utilizers.¹⁹⁰ This, coupled with the access issues for those with mild-to-moderate behavioral health needs described in section B.4, suggests that addressing these underlying diagnoses through primary care and behavioral health care would better meet the needs of this population while saving costs. This is addressed in part by the Healthy Michigan Plan, which emphasizes “prevention, wellness and chronic disease management (including caretaker education and support services), health coaching, relapse prevention and care coordination.”¹⁹¹

Dually Eligible Medicare & Medicaid Beneficiaries

Individuals who are dually eligible for Medicare and Medicaid (263,000 enrollees) make up about 5% of Medicare beneficiaries¹⁹² and 3% of the state’s population.¹⁹³ These dual-eligibles have a greater need for health services and long-term services and supports than beneficiaries who have only Medicare or Medicaid coverage. This population accounts for 25% of total Medicare expenditures and 28% of total Medicaid expenditures.¹⁹⁴ In 2010, Michigan spent over \$3.7 billion for Medicaid services and greater than \$4 billion for Medicare services on the dual-eligible population.¹⁹⁵

Excluding home- and community-based services specific to the Habilitation Supports Waiver, Medicaid spending in 2008 for long-term care was \$187.5 million per month while Medicare spending was \$43.6 million per month among dual-eligible beneficiaries. These expenditures include nursing facilities, hospice, MiChoice waiver services and Michigan’s adult home help program.¹⁹⁶

Michigan Medicaid spent over \$843.6 million on behavioral health and developmental disability services for full-benefit duals in 2008. Most of these funds are delivered through capitation payments to prepaid inpatient health plans. Of that amount, \$225.7 million covered services for people with serious mental illness, \$617.4 million for people with an intellectual/developmental disability, and \$2.3 million for those with substance use disorders.¹⁹⁷ For the intellectually/developmentally disabled population, \$356.8 million was spent for those enrolled in the Habilitation Supports Waiver, which served 5,500 individuals who are dual-eligible. An additional \$260.6 million was spent on services and supports for persons who have an intellectual/developmental disability and are not enrolled in the Habilitation Supports Waiver.¹⁹⁸

The Integrated Care Demonstration and the Behavioral Health Home pilot program described in the care coordination portion of section B5 above are two initiatives are underway that specifically address this population.

B7. Health Information Technology

Health Information Exchange

Michigan's formal health information exchange efforts began in 2005, when the state convened six work groups to create a comprehensive plan for determining the best approach for achieving meaningful, statewide health information exchange. The "Michigan Health Information Network Conduit to Care Report"¹⁹⁹ laid out the framework for what would become the Michigan approach to health information exchange. Legislation in 2006 created the Health Information Technology Commission, an advisory committee to the Michigan Department of Community Health, with the mission of facilitating and promoting the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in Michigan. The Michigan Department of Community Health has a Health Information Technology Coordinator who supports the work of the Health Information Technology Commission.

Federal funding opportunities are facilitating further development of health information exchange. Michigan partners with the Office of the National Coordinator for Health Information Technology in the State Health Information Exchange Cooperative Agreement Program. The Michigan Health Information Network Shared Services organization is the non-profit State Designated Entity currently funded through this agreement. Michigan Health Information Network Shared Services' strategic plan describes the incremental approach for advancing appropriate and secure health information exchange, implements a model that encourages public private partnerships and develops a scalable, open technology approach that complements the activities of sub-state health information exchange entities. Michigan Health Information Network Shared Services has been charged by the State of Michigan to establish the roadmap, legal infrastructure, operations, and required technological capabilities to ensure the systematic evolution of statewide data exchange. It was tasked with undertaking activities and staging technology to ensure a widespread and secure statewide information sharing capability where the people, processes, and technology enable better health and optimal health care.

Michigan's Blueprint will leverage a variety of the services developed in this approach such as results delivery, public health reporting, care coordination and patient safety, quality and administrative reporting, patient engagement, and access to the National Health Information Exchange (eHealth Exchange). Another vital Michigan Health Information Network Shared Services function is to uphold the legal framework for establishing the trust relationships for organizations within and outside the State of Michigan to exchange data in contractually required ways. In February, 2013, Michigan was designated an Office of the National Coordinator Capacity Building "Bright Spot" for its strategic approach to making health information exchange affordable throughout the state.

Michigan Health Information Network Shared Services is viewed as a network of networks. Local providers connect to sub-state health information exchanges. These sub-state health information exchanges connect to Michigan Health Information Network Shared Services, which interfaces with State of Michigan systems, the National Health Information Exchange (eHealth Exchange), and offers support services. This model promotes common data sharing use cases, broad stakeholder participation, transparency, and helps to promote the use of national standards. In addition, this approach to health information exchange ensures that business needs and market pressures inform the design and delivery of

health information services. Michigan Health Information Network Shared Services and qualified organizations seek out ways to provide value to providers, payers, and consumers.

The state benefits from this approach to data exchange because it streamlines development activities and normalizes data exchange through a collaborative, stakeholder-driven approach. The Michigan Department of Community Health is a member of the Michigan Health Information Network Shared Services' Board of Directors and participates in various workgroups. Early projects involving submissions to Michigan's public health surveillance systems to satisfy Meaningful Use requirements, and admission-transfer-discharge notifications are helping providers to see value in health information exchange.

Data analysis is an important tool in many aspects of the transformed health system. Michigan, like most states, faces many barriers regarding the useful analysis of health care data. Chief among these is the need for a robust data set and systems describing providers, patients, and encounters. The State Medicaid Agency has been ahead of the curve in anticipating the need for data and has already started using Medicaid population and claims data combined with Health and Human Services information in the Michigan Department of Community Health Data Warehouse to evaluate and improve interventions. The Medicaid Health Information Technology office has plans to capitalize on the public health Meaningful Use reporting measures in order to expand the data warehouse with interfaces to the Michigan Care Improvement Registry, Michigan Disease Surveillance System, Michigan Syndromic Surveillance System, newborn screening and cancer registries. This approach lines up with the State approach to data exchange, using Michigan Health Information Network Shared Services as the backbone infrastructure to help disparate health information exchanges and data sources automate and standardize reporting. In order to help providers and consumers enjoy some of the benefits of health information technology and health information exchange, bidirectional communications are a priority for health information exchanges. For example, the State immunization registry is working with Michigan Health Information Network Shared Services to provide the ability for providers to request the immunization history of a patient in real-time.

Meaningful Use of Health Information Technology

According to the State Health Information Technology Coordinator, the office-based provider adoption of basic electronic health records among all providers in Michigan is 38%, while among primary care providers it is 51%.²⁰⁰ The hospital adoption of electronic health records among hospitals is 74% and among rural and small hospitals is 59% and 54%, respectively.

The Michigan Center for Effective IT Adoption is Michigan's federally designated Regional Extension Center. It serves as a support and resource center to assist providers in electronic health record implementation and health information technology needs by offering subsidized consulting services to physician offices. Currently, 3,735 providers are enrolled with the Michigan Center for Effective IT Adoption; 3,254 of them are active electronic health record users, and 2,059 providers have received Meaningful Use incentive payments.²⁰¹

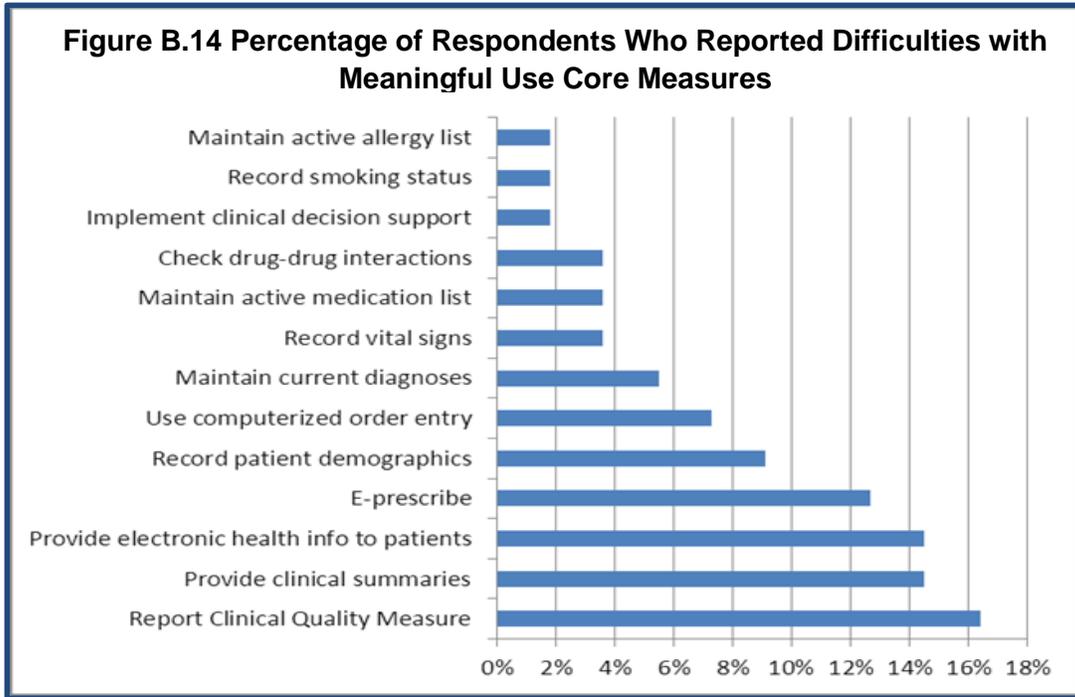
Michigan has not seen the same rate of electronic health record adoption in comparison to other states, perhaps due in part to a carefully managed rollout of the Medicaid Electronic Health Records Incentive Program which includes pre-auditing participant eligibility. In 2010-2011, Michigan ranked forty-second

in the nation for electronic health record adoption for office-based family physicians at 54%, with family practices adopting electronic health records at a greater rate than specialty providers.²⁰² Preliminary data from 2012 demonstrates that Michigan did make gains, advancing to 66.1% of office-based physicians adopting electronic health records. However, 73.3% of physicians intended to participate in the Medicare or Medicaid Electronic Health Records Incentive program, although only 21.5% had computerized systems capable of meeting the 13 core measures related to the electronic health record system.

A recent survey²⁰³ conducted for the Michigan Department of Community Health identified the barriers and challenges preventing meaningful use of an electronic health record system by Medicaid providers. Interview respondents were providers who were registered for the Medicaid Electronic Health Record Adoption, Implementation, and Use Incentive, but who had not yet applied for the Meaningful Use incentive. While this was a Medicaid specific study, the identified barriers are common among most small and/or rural providers. Major reasons for delaying attestation of Meaningful Use include:

- Difficulties with electronic health record vendor and/or electronic health record system
- Difficulty with workflow to accomplish the core functions
- Attestation complexity
- Staff training and resistance
- Timing of attestation
- Costs
- Insufficient patient volumes

Difficulties with the electronic health record vendor and/or electronic health record system was the most common problem (49%) reported by practices participating in the study. Of great concern, almost half of the respondents indicated struggles with at least one, and sometimes several specific core measures that have kept them from applying for Stage 1 Meaningful Use incentives.²⁰⁴ Figure B.14 shows other difficulties reported with meaningful use of electronic health records.



Just under 44% of the interviewed Medicaid primary care providers had worked with the Michigan Center for Effective IT Adoption, Michigan’s Regional Extension Center. Those providers who had used the Michigan Center for Effective IT Adoption assistance had positive things to say about the support they received. This suggests that the practice transformation activities provided by the Regional Extension Center have created an appetite and a market for helping providers realize the benefits of health information technology. Michigan’s Regional Extension Center program is carried out by several regional contractors who each bring a unique perspective and sustainability goals that leverage the incentive program funding into broader provider health information technology assistance efforts, which will help electronic health records penetrate into practices beyond the incentive programs’ eligible providers.

Another major challenge facing Michigan providers for future Meaningful Use compliance is the lack of interoperability and the emergent status of sub-state Health Information Exchanges. Promised interoperability deliverables have been slow to appear and many providers are not yet seeing the benefit in belonging to a health information exchange. Even though Michigan’s participation in the Federal Communications Commission’s Rural Broadband Initiative has extended broadband capacity to virtually every populated area of the state,²⁰⁵ provider awareness of available connectivity remains a challenge. However, Meaningful Use requirements and Michigan’s approach to data exchange are providing multiple incentives to provider participation in health information exchange. Unfortunately, many providers are piecing together interoperability with individual laboratories and hospital systems on their own, minimizing the value of connecting to a sub-state health information exchange. Finally, many providers have found themselves using different electronic systems without interoperability in order to meet different regulatory or other incentive requirements (such as Patient Centered Medical Homes or the Michigan Primary Care Transformation program), resulting in duplicative staff efforts and mistrust of

health information exchange organizations. Better alignment in data standards and connectivity promoted by the Blueprint will make meaningful exchange of information much easier.

Other barriers and challenges to achieving Meaningful Use designation, especially as Meaningful Use standards move into Stage 2 include:

- Patient engagement, including implementation of patient portals and patient education
- Cost of upgrading electronic health record systems and required functionality
- Staff training
- Lack of resources, as providers must also focus on Patient Centered Medical Homes, the Physician Quality Reporting System, International Statistical Classification of Diseases and Related Health Problems Revision 10
- Lack of information technology support for smaller/rural practices
- Lack of assistance

A recent study²⁰⁶ from the RAND Corporation demonstrated that dissatisfaction with electronic health record systems was more pronounced among older physicians and those lacking support to enter data and manage information flow. Sixty-eight (68) percent of respondents to a survey conducted with clients currently using Michigan Center for Effective IT Adoption assistance believed their practice would need assistance to achieve Stage 2 Meaningful Use.

One emerging opportunity is the substantial effort being made by the Michigan Department of Community Health to support Medicaid specialists who were ineligible for the regional extension center support under the Health Information Technology 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 electronic health records.

The Medicaid Health Information Technology office is deeply invested in leveraging the electronic health record incentive program to improve care, improve population health, and reduce costs through the widespread adoption and meaningful use of health information technology and health information exchange. In fiscal year 2014, an innovative consumer engagement effort will solicit input from separate stakeholder groups - providers and provider organizations, government agencies, consumers and advocacy groups, and information systems or health information exchanges - to collect more nuanced information about barriers and opportunities for further adoption of health information technology. Information will be used to develop ways to engage non-eligible providers, and enhance health information exchange beyond Medicare and Medicaid providers to hasten the “tipping point” needed to realize true return on investment.

Consumers could be a powerful demand driver. Michigan Medicaid partnered with its Medicaid Management Information Systems vendor to create a mobile Medicaid ‘blue button app’ to help consumers take advantage of health information technology. The application interfaces with Children’s Special Health Care Services data, Special Supplemental Nutrition Program for Women, Infants, and Children’s data, and Medicaid Management Information Systems to offer consumers real-time information about providers, eligibility, claims and payments, and benefits. In addition, the application interfaces with the Michigan 4x4 wellness promotion web site, providing information about 4 important

wellness categories, and allows users to log personal information. Next steps include the development of push alerts from providers about appointments and interfaces with web portals.

B8. Current Federally Supported Initiatives Underway in Michigan

See appendix 2.1 for descriptions of these initiatives.

Table B.3 Current Federally-Supported Program Initiatives Under Way in the State
Michigan Pathways to Better Health
Michigan Health Information Network Shared Services
Michigan Quality Improvement Network
Bundled Payment for Care Improvement Initiative
Medicare Accountable Care Organizations
Federally Qualified Health Center Advanced Primary Care Practice
Beacon Community
Michigan Center for Effective IT Adoption
Oral Health Disease Prevention Program
Office of Services to the Aging
Health Research Services and Administration initiatives
Implementing Evidence-Based Prevention Practices in Schools

B9. Other Demonstrations and Waivers

See appendices 2.2 and 2.3 for descriptions of these demonstrations, waivers, and other initiatives.

Table B.4 Existing Demonstrations and Waivers Granted to the State by the Centers for Medicare & Medicaid Services
Comprehensive Healthcare Program
Managed Specialty Program and Services Program
Home and Community-Based Services Waiver <ul style="list-style-type: none"> • 1915 (c) MI Habilitation Supports • MI Choice Waiver Program • 1915 (c) MI Children's Waiver Program
1115 Demonstration Waivers <ul style="list-style-type: none"> • Michigan Adult Benefit Waiver • 1115 FP- Plan First! Family Planning Demonstration
Multi-payer Advanced Primary Care Practice Demonstration
Integrated Care for People Eligible for Medicare and Medicaid
Healthy Michigan Plan

Table B.5 Other Relevant Initiatives
Comprehensive Community-Based Approach to Reducing Inappropriate Imaging
Navigator Grants
Mobility: the 6th Vital Sign
Community-Based Care Transitions Programs
Michigan Medicare/Medicaid Assistance
The Program of All-Inclusive Care for the Elderly
Partnerships with Other CMS Innovation
Mental Health Transformation Incentive Grant
Child Mental Health Initiative
Michigan's Linking Actions for Unmet Needs in Children's Health
The Respecting, Engaging, Supporting, Protecting, Empowering, Connecting, and Teaching Project
Neighborhood Service Organization Bridges Program
Southwest Counseling Solutions
Washtenaw Community Health Organizations

Summary

This chapter has described Michigan as having an aging population – slightly more pronounced than other states due to outmigration and lower birth rates – and rebounding from a prolonged recession that affected the industrial Midwest especially hard. Loss of employment has coincided with reductions in employer-sponsored health care. In addition, the health care delivery system in Michigan has largely been fragmented, as in most other states across the country. Michigan has room to improve the overall health status of its citizens, as it lags behind most other states on many indicators. Michigan has particularly high rates of chronic disease and obesity and marked disparities in indicators such as low birth weight and infant mortality.

In terms of the health care delivery system, Michigan has much to be proud of:

- Comprehensive statewide Patient Centered Medical Home Transformation
- Providers organizing to improve clinical integration and quality of care
- A unique approach to Medicaid expansion through the Healthy Michigan plan
- Efforts to integrate behavioral health care with physical health care
- State government with a focus on transparency and the power of data and information to drive improvement
- Engaged communities acting together to improve population health

Nevertheless, fragmentation of health care services remains a problem - driven in part by a predominantly fee-for-service payment system. Michigan has both the need to do more and the capacity to do more to improve population health, quality of care, and contain health care costs. This is the reason the State Innovation Model opportunity was embraced by a broad cross-section of stakeholders. Chapter C further describes the involvement of providers, payers, consumers/patients, public health, human services

agencies, business groups, state agency representatives, consultants, and university researchers in developing Michigan's Blueprint. Michigan's innovative integrated health system will have a well-designed learning system to addresses both clinical and non-clinical factors, with new payment systems, investments in system redesign, and ample support for transforming the system.

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Chapter C: Stakeholder Engagement and Design Deliberations

Michigan's Innovation Model management team recognized that to achieve Governor Snyder's vision for health care reinvention in Michigan, broad stakeholder engagement would be necessary to inform delivery system and payment model redesign, as well as for drafting Michigan's Blueprint for Health Innovation. Understanding the current environment and the perspectives of all stakeholders is a top priority, in order to ensure meaningful participation in health system innovation.

C1. Project Governance

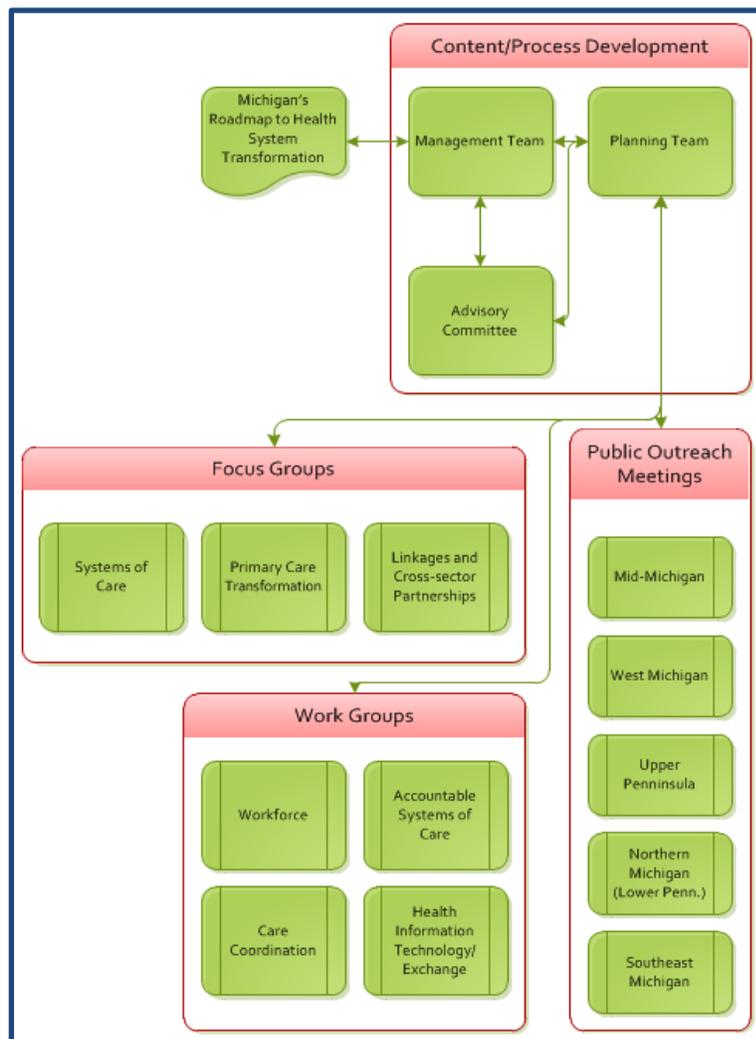
Michigan's Innovation Model governance and feedback structure (figure C.1) maximizes the flow of information from and among stakeholders to the appropriate content development and decision-making staff. Three teams allowed for meaningful and ongoing statewide stakeholder engagement for the necessary public and private sector buy-in. It also facilitated a collaborative and open planning process, and helped ensure alignment with ongoing initiatives in Michigan. These three teams were supplemented with outside stakeholder feedback through focus groups, work groups, public outreach events, and targeted interviews. The three main Innovation Model project governance teams are:

- Management team: deputies, bureau directors, and managers from the Department of Community Health, as well as state government representatives from the governor's office and the Office of the State Employer – the management team held thirteen independent meetings, as well as attended advisory committee meetings and some public outreach sessions (See appendix 3.1 for full member list)
- Planning team: Department of Community Health employees and contractors that met weekly and as needed throughout the project period (See appendix 3.2 for a full list of planning team members)
- Advisory committee: executives and high-level staff from 32 organizations consisting of many different types of stakeholders such as consumers, physicians, community supports and services, hospitals and health systems, payers, government, business, safety net, and universities that met seven times from April through December (See appendix 3.3, 3.4, and 3.5 for a member list, the Advisory Committee Charter, and meeting summaries and deliverables)

Team Functions

At the outset of the project, the management team recruited key private sector stakeholders for the advisory committee and implemented the project governance. Subsequently, management team leadership met monthly with Department of Community Health executive staff and representatives from Governor Snyder's office to provide updates and ensure the Blueprint was consistent with the governor's vision for Michigan.

Figure C.1: Michigan State Innovation Model Project Governance and Feedback Loops



The management team guides the activities of the advisory committee and planning team. The management team met regularly with the advisory committee and carefully considered the input provided in person and from work group meetings. Members also served on project focus groups and work groups.

The planning team is the working body of the management team and is responsible for carrying out the daily activities of the project. This includes process development, fostering collaboration among stakeholders (i.e. meeting facilitation, public outreach), and project management activities.

The advisory committee provided necessary input into the model design process through the identification of Michigan’s goals for health system innovation, characteristics of transformed service delivery and payment models, creation of model design specifications, and feedback on the Innovation Model itself.

Members served on focus groups and work groups, and were instrumental in identifying additional subject matter experts to inform the design process.

C2. Stakeholder Engagement

As evidenced by the innovation seen in chapter B, Michigan’s health system stakeholders are highly interested in innovation and transformation, and the input of the advisory committee was essential to the successful formation of Michigan’s Blueprint. The first several meetings of the advisory committee and management team were focused on health care delivery system reform. Both teams considered and agreed on six goals for the Blueprint, and identified several characteristics they believed would be important to Michigan’s Innovation Model.

Advisory committee meetings focused on how the model characteristics should be applied in order to achieve the goals. During the meetings, stakeholders discussed Section 2703 health homes (as described in the Affordable Care Act), commercial payer Patient Centered Medical Home models, and the Michigan Primary Care Transformation demonstration project as they worked to identify ways to strengthen the primary care infrastructure and expand access in a way that will engage multiple payers.

The advisory committee also discussed the various accountable care organization models that currently exist, including those sponsored by Medicare and commercial payers in the state. The importance of patient and physician participation in an integrated model that could be supported by multiple payers was firmly established. As Michigan's Accountable System of Care model was taking shape, much practical discussion revolved around ways to leverage current initiatives, and ensure that the model demonstrated the characteristic of reduced administrative complexity.

Several advisory committee members representing health plans and providers voiced concerns over the creation of the Accountable Systems of Care described in chapter E. They felt that it may actually add a layer of administrative complexity. They felt that the proposed Accountable Systems of Care would carry out the same functions that Medicaid Health Plans are currently performing in Michigan, and would only be adding a new layer of bureaucracy for payers and providers. Moreover, it was felt that many communities in Michigan would not be served under the new Accountable Systems of Care. These advisory committee members were also concerned over what they saw as an absence of robust discussion around managing financial risk during the early conversations regarding Accountable Systems of Care, as managing risk is a major function that separates health plans from other types of health care organizations.

To address these concerns, advisory committee members recommended a test that supports pilot projects involving Michigan's managed care plans and community-based comprehensive care models (Federally Qualified Health Centers) that could demonstrate the following key points:

- Uses "all participating payers' data"
- Focuses on providers' patients enrolled in participating plans
- Does not involve development of another payer structure
- Incentivizes major improvements within and without the four walls of the practice

The project teams understood the concerns voiced by these members and recognize that Michigan has a mature managed care system on which to build future innovation. The Blueprint is not intended to displace or minimize the roles of Medicaid Health Plans and recognizes the value they add through their emphasis on finding and engaging hard to reach patients, managing benefits, innovative care management, the use of analytic tools (i.e. predictive modeling), and managing financial risk. The Blueprint was crafted to address the concerns voiced by these advisory committee members and will serve as a catalyst for Medicaid Health Plans to engage in innovative, value-based reimbursement strategies.

Experts in collective impact initiatives informed discussion on regionally-based infrastructure that supports cross-sector partnerships and the integration of health-in-all-policies into community life. Participants understood that the major determinants impacting Michigan's health status were outside of

the health care delivery system. Advisory committee members were interested in the possibilities for reducing disparities by making Michigan's Innovation Model community-centered and community-integrated, and they strove to identify a sustainable payment mechanism for Community Health Innovation Regions. An expert in systems change and community organizing was engaged to address large-scale health system transformation.

To prepare advisory committee members for a discussion of payment reform that would move health care expenditures in the state further along from volume-based to value-based, the planning team engaged Harold Miller of the Center for Healthcare Quality and Payment Reform, and Tony Rodgers of Health Management Associates. Several potential payment models and important issues to consider in the selection of payment models were discussed in a webinar prior to an in-person advisory committee meeting. The webinar was well-attended by advisory committee members, and was recorded for subsequent viewing. The following options were presented and discussed:

- New fee codes for unreimbursed primary care services (e.g., phone calls with patients, nurse care managers)
- Monthly care management payment to primary care physicians to cover unreimbursed services
- Shared savings models
- Primary care physician care management payment plus pay-for-performance based on utilization
- Primary care bundle plus pay-for-performance based on utilization
- Partial global payment (outpatient services)
- Risk-adjusted global payment

This was followed at the next in-person advisory committee meeting by a reactor panel of committee members most familiar with payment models. They discussed the practical applications of the models put forth in the webinar, and considered how best to achieve payment for value as Michigan's Blueprint rolls out. Consensus was not reached on a specific payment strategy that should be used to support the entire Innovation Model, but several themes emerged which informed the incremental approach proposed in this Blueprint. The principles for payment reform are:

- Flexibility for providers to innovate and change the way care is delivered
- Accountability for costs and quality/outcomes related to care shared as appropriate among participants
- Adequate payment to cover lowest achievable costs
- Protection for the provider from risk due to things they cannot control

These discussions around service delivery and payment transformation led to an Innovation Model Working Concept and Blueprint that includes the following elements:

- Patient Centered Medical Homes
- Accountable Systems of Care
- Community Health Innovation Regions
- Centralized health information and process improvement infrastructure and systems
- Pay-for-value payment models

Feedback regarding the original Working Concept was also solicited through targeted engagement of experts on focus groups and work groups, as well as broader public comment through five regional public outreach meetings. The majority of comments focused around practical implications of implementing the service delivery model.

All of the discussion and input received from stakeholders were considered in Michigan's Blueprint. See chapter E for a full discussion of the proposed service delivery and payment models.

Focus Groups

Concurrent to management team and advisory committee feedback, focus groups were conducted in June to seek out more information about Michigan innovations underway in three key areas. Management team and advisory committee members nominated participants for discussions around systems of care, cross-sector partnerships, and primary care transformation. This allowed additional stakeholders to discuss current initiatives in Michigan that address the Innovation Model characteristics and align with the goals articulated by the advisory committee. Stakeholders were also able to discuss barriers and opportunities for innovation. The full participant lists are available as appendices 3.6, 3.7, and 3.8.

Work Groups

Four work groups were convened to examine the Working Concept and provide recommendations for addressing specific issues in the Innovation Model. Members of the advisory committee and management team volunteered for work groups relevant to their expertise, and recommended additional experts from around Michigan to participate. Each work group held three or more two-hour meetings. The topics discussed by the work groups were:

- **Health Information Technology – Health Information Exchange:** The work group discussed design considerations and investments needed for health information technology/health information exchange, data infrastructure, and governance policies to support a transparent, accountable, community-integrated health system (See appendices 3.9 and 3.10 for the work group member list and charter)
- **Workforce:** The work group provided recommendations related to policy, education, and training to strengthen Michigan's primary care workforce (See appendices 3.11 and 3.12 for the work group member list and charter)
- **Care Coordination:** The work group debated how care coordination should be integrated into the care processes of the proposed service delivery model to serve clinically complex and vulnerable populations (See appendices 3.13 and 3.14 for the work group member list and charter)
- **Accountable Systems of Care:** The work group provided recommendations on contractual structures, payment models, and risk sharing among providers and payers in the context of the Accountable Systems of Care concept described in the Blueprint for Health Innovation (See appendices 3.15 and 3.16 for the work group member list and charter)

Public Outreach Meetings

Five public outreach events were conducted throughout September and October, 2013 in different regions of the state to solicit feedback from stakeholders on the proposed model design, and to identify additional regional examples of innovation and cross-sector collaboration that could provide guidance in the development of the Blueprint. These were hosted by community organizations who volunteered accommodations in their region. Regions included mid-Michigan, west Michigan, southeastern Michigan, the Upper Peninsula, and northern Michigan (Lower Peninsula). These events were targeted to the broadest cross-section of the community. Attendance was not limited in any way. Feedback was solicited during the events, but participants were also invited to offer feedback electronically after the events through the use of a forum on the project web site and via email. Figure C.2 shows the geographic distribution of these events.

Figure C.2 Public Outreach Meeting Locations



Key Informant Interviews

When complicated issues surfaced, targeted key informant interviews were used to inform the process. These interviews provided insight on critical operational details of existing programs aimed at improving care and lowering costs. Interviewees were government officials, key stakeholders, or representatives of interested groups such as the following:

- Michigan Center for Clinical Systems Improvement
- West Michigan Community Mental Health
- Center for Health Research & Transformation
- Greater Flint Health Coalition
- Children's Healthcare Access Program
- Federally Qualified Health Center in Alcona
- Blue Cross Blue Shield of Michigan

Michigan State Innovation Model Website and Additional Feedback

In addition to the individuals that were involved in key informant interviews, many organizations provided feedback following focus groups, work groups, and public outreach events. In anticipation of this, a web site was created to allow the general public to learn about the State Innovation Model initiative in Michigan and collect input: <https://public.mphi.org/sites/sim/Pages/default.aspx>. The web site explains the purpose of the initiative, gives instructions on how to participate, answers frequently asked questions, and provides contact information and additional resources. Additionally, links were provided to other web sites where more information could be found on health care model design and other states' initiatives. The State Innovation Model public web site is updated frequently to keep up with progress on Michigan's Blueprint, and provides announcements and information on upcoming events.

The advisory committee, management team, and planning team have dedicated pages to facilitate remote collaboration. These pages contain all deliverables from the model design process. Members have access to discussion boards, meeting agendas and summaries, project deliverables, background information, and other useful resources. The planning team page also contains working documents and other resources collected over the course of the project. The planning team page allows members to effectively collaborate by sharing ideas, data, and other documents and resources remotely without concern as to completeness or relevance to the management team or advisory committee.

Many organizations (including some represented on the advisory committee) chose to provide feedback or information relevant to the planning process through the web site and other avenues outside of the regular model design meetings. This feedback generally centered on how the role of specific initiatives or organizations could fit into the Working Concept, comments on areas of the Working Concept pertaining to the organization's area of expertise, concerns with preliminary roles identified in the Working Concept, and general feedback on the model design. These organizations included community-based organizations, purchasers, businesses, universities, provider organizations, and health plans, among others, of which the following is an abbreviated but representative list: School-Community Health Alliance of Michigan, the Michigan State Alliance of Young Men's Christian Associations, Pathways to Healthy Living, NorthCare, Wayne State School of Medicine, Michigan Community Health Worker Alliance, Michigan Association of Health Plans, Michigan Primary Care Association, Michigan Surgical Quality Collaborative, Sparrow Physicians Health Network, Automotive Industry Action Group, Michigan State Medical Society, United Auto Workers Retiree Trust, Kelly Services, Detroit Regional Chamber of Commerce, Medical Benefits and Strategy for the University of Michigan, Automotive Industry Action Group-Payment Reform Ad-hoc Team, and the Physician Group Incentive Program. Discussions around the Innovation Model continue as the Blueprint evolves.

State Innovation Model Newsletters

As part of the communication plan, the planning team created a weekly/as needed electronic newsletter that augments both advisory committee and management team member awareness of action items, educational resources and opportunities, and news and upcoming events related to the project. The newsletter contains links that take stakeholders to specific project web pages, where members can sign in and access multiple documents or view the public facing State Innovation Model web page. Contact information is also included in every newsletter in order for stakeholders to easily communicate with the project team.

C3. Design Deliberations

Meaningful stakeholder engagement was incorporated throughout the model design process and is reflected throughout Michigan's Blueprint. Appendix 3.17 gives additional accounting of stakeholder engagement and design deliberations as it pertains to the topics enumerated in the Notice of Award.

Summary

Stakeholder input was integral to the Michigan Innovation Model initiative and remains a priority throughout the model design and implementation. The management team led by the Michigan Department of Community Health, instituted project governance and feedback structures that allowed the flow of information from and among stakeholders to promote meaningful input during the model design phase. These stakeholders included an advisory committee comprised of consumers, physicians, community supports and services, hospitals and health systems, payers, government, business, safety net, and universities. Additional stakeholders from health care sectors across Michigan were able to provide feedback through a series of focus groups, work groups, interviews, and public outreach meetings. Regular meetings of management team staff with representatives from Governor Snyder's office ensured the Blueprint remained true to the governor's vision for Michigan.

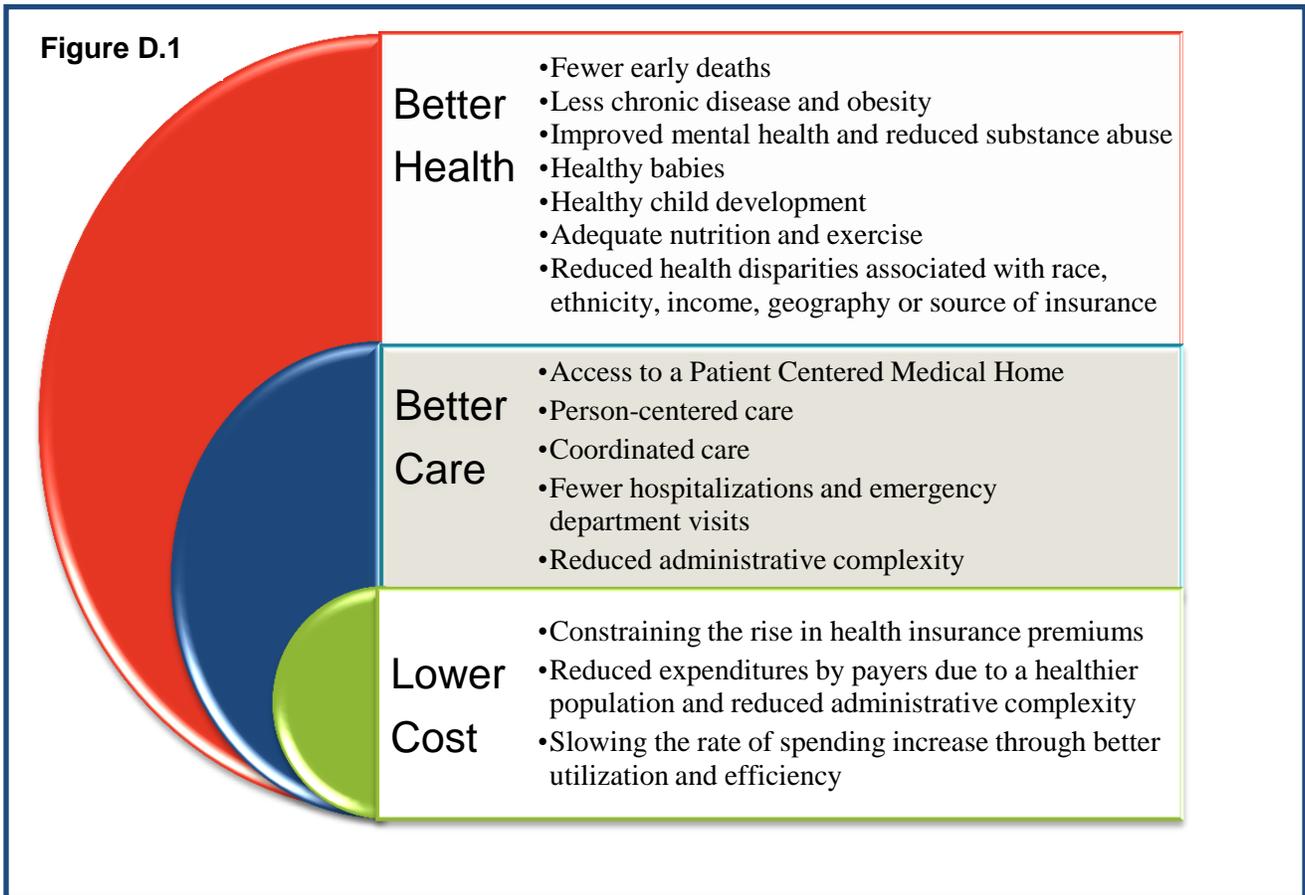
Chapter D: Health System Design and Performance Objectives

Governor Snyder expressed his vision for reinventing the health care system in Michigan in his address to the State on Health and Wellness on September 14, 2011, in which he stated:

My vision is for Michiganders to be 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. Health and wellness are important across the continuum of life from prenatal care, to providing children and adults with opportunities for nutritious food and physical activity, to the option of home-based long-term care for seniors who need it.

– Governor Rick Snyder

The governor went on to highlight aspects of an improved health care system in his message, and created a dashboard on the State’s web site to track Michigan’s progress. Figure D.1 depicts the aims of health care reinvention in Michigan as reflected on the State’s dashboard and expressed priorities.



D1. Measuring Progress

Governor Snyder and the Michigan Department of Community Health believe in dashboards as a way to assess and communicate progress. Therefore, the overall impact of Michigan's Blueprint will be measured by monitoring indicators that align with the aims these dashboards monitor. Another critical factor in improving Michigan's overall population health will be the reduction of racial and geographic disparities. Monitoring outcomes along these lines will help evaluate whether Michigan's Blueprint is helping to improve health statewide. As will be described in chapter E, the Blueprint calls for establishing a performance measurement and recognition committee that will involve all stakeholders who are expected to use the metrics (providers, payers, consumers/patients, community agencies) in the creation, evaluation, and application of performance indicators. This committee is expected to further refine planned metrics – prioritizing those that are acceptable and useful to stakeholders, and ensuring that metrics keep up with evolving guidelines. Michigan will also conduct a self-evaluation of the testing process. Additional measures and methods to assess the success of the Innovation Model test are described in chapter I.

Better Health

Within five years, Michigan aims to achieve improvements in selected indicators of population health taken from the Health and Wellness Dashboard, such as:¹

- Reduce rates of infant mortality to 6.5 per 1,000 live births (Baseline = 7.4 per 1,000 live births)
- Reduce adult obesity by 5% (Baseline = 31.1%)
- Reduce adolescent obesity by 10% (Baseline = 12.1%)
- Increase adequate physical activity for adults by 20% (Baseline = 19.7%)
- Increase adequate daily consumption of fruits and vegetables by 20% (Baseline = 17.8%)
- Reduce excessive alcohol consumption by 10% (Baseline = 6.1%)
- Reduce teen birthrates by 5% (Baseline = 30.1 per 1,000 women ages 15-19)
- Increase reported recent dental visits by 5% (Baseline = 68.0%)
- Increase childhood immunization status rates by 5% (Baseline = 87%)
- Reduce proportion of adult cigarette smokers by 15% (Baseline = 23.3%)
- Reduce chlamydia prevalence by 10% (per 100,000 population)

Movement on some of the above metrics will require focused attention to health disparities. Long-term, the Blueprint will also enable Michigan to reduce overall morbidity (poor health) towards national benchmarks, such as those described by the Robert Wood Johnson Foundation's County Health Rankings:²

- Percent of adults reporting fair or poor health reduced from 14% to 10%
- Average number of physically unhealthy days in last 30 from 3.5 to 2.6
- Average number of mentally unhealthy days in last 30 from 3.7 to 2.3

Each Community Health Innovation Region described in chapter E will work in collaboration with the provider community to identify the major drivers that impact these and other measures in their local population. Such measures are likely to align with several of Michigan's Healthy People 2020 objectives, such as reducing rates of low birth weight, uncontrolled hypertension, and diabetes incidence.³

Community interventions that improve population health should also reduce overall health care costs by preventing the chronic conditions most responsible for high per capita spending.

Better Care

Progress in the area of better care will be measured by indicators in the following domains:

- Access to primary care
- Improved quality of care
- More appropriate utilization
- Improved experience of care

Access to Primary Care

Over five years, the Blueprint will increase participation in multi-payer Patient Centered Medical Home programming. This will result in the following:

- An increase in the number of practices fulfilling Patient-Centered Medical Home functions from 375 to 1,500 in 2015 and 3,000 in 2019, out of an estimated 3,500 primary care practices
- An increase in beneficiaries served by a Patient Centered Medical Home from 900,000 to 8,000,000 (roughly 80% of the population)
- An increase in the percentage of Medicaid managed care beneficiaries assigned to a multi-payer Patient Centered Medical Home from approximately 15% of all Medicaid managed care beneficiaries to 80%

To mitigate the impact of a looming physician shortage in the State (currently at 117.4 primary care physicians per 100,000 population),⁴ the Blueprint will increase the proportion of primary care providers working within an interprofessional care team over 5 years (these teams are further described in chapter G). To evaluate the effectiveness of these teams, the Blueprint will incorporate questions assessing their activities into provider surveys that are planned as part of the self-evaluation in chapter I. In a 2013 survey of licensed nurses in Michigan, 14% of registered nurses and 6% of licensed practical nurses reported participating in all of the identified core activities of an interdisciplinary care team.⁵ A description of these core activities of an interdisciplinary care team can be found in the Care Coordination Measures Atlas.⁶

The success of Michigan's Blueprint in improving access to high quality care through investments in Patient Centered Medical Homes and interprofessional care teams should be revealed in state and regional survey data that show:

- A decrease in the number of Michigan residents reporting no personal health care provider from 15.8% to 10% over 5 years⁷

Clinical Quality

The Michigan Innovation Model described in the Blueprint will create a performance measurement and recognition committee to review and align performance metrics currently reported by providers to various groups (so that data are reported once and used often). Community Health Innovation Regions will also provide input to, and draw from, the common metrics during the process of conducting community health needs assessments and setting strategic priorities. The performance measurement and recognition committee will begin by leveraging ongoing efforts in Michigan and nationally to crosswalk and streamline indicators. In particular, the Michigan Quality Improvement Consortium, consisting of physicians, health plan administrators, researchers, quality improvement experts, and specialist societies,

has resources that can be leveraged quickly in this endeavor. These measures also align with the Michigan Primary Care Transformation demonstration project. Efforts are also underway at the federal level to align the Physician Quality Reporting System and the Medicare and Medicaid Electronic Health Records Incentive Program Meaningful Use requirements.

While the performance measurement and recognition committee will establish the final set of metrics, they will likely include a subset of the following as tracked by the Michigan Quality Improvement Consortium or pursuant to Meaningful Use requirements⁸, unless otherwise noted. These metrics have been selected to cover both adults and children, as well as to reflect the quality of both preventive care and disease management. The Blueprint for Health Innovation aims for a 10% improvement over five years from baseline levels.

Adult Quality Metrics:

- Controlling high blood pressure at <140/90 (Baseline = 63.25% Medicaid, 68.47% commercial, 71.62% Medicare)
- Tobacco use and advice to quit (Baseline = 79.04% Medicaid, 82.94% commercial)
- Depression screening, effective acute care and continuation care (Baseline = 77.96% Medicare, 71.57% commercial; 65.22% Medicare, 53.86% commercial)
- Body mass index assessment of healthy weight (Baseline = 73.36% Medicaid, 82.59% Medicare, 77.82% commercial)
- Comprehensive diabetes care at glycated hemoglobin <8.0% (Baseline = 55.1% Medicaid, 65.06% commercial)
- Timeliness of prenatal care (Baseline = 90.13% Medicaid, 95.82% commercial)
- Breast cancer screening (Baseline = 57.84% Medicaid, 77.17% commercial)
- Cervical cancer screening (Baseline = 75.82% Medicaid, 83.64% commercial)
- Chlamydia screening (Baseline = 70.37% Medicaid, 51.89% commercial)
- Influenza vaccination rate in adults age 65 and older (Baseline = 67.5%)
- Complete lipid profile and low-density lipoprotein control <100 (no baseline available)⁹

Child and Adolescent Quality Metrics:

- Immunization for adolescents [Combination 3] (Baseline = 76.07% Medicaid, 74.06% commercial)
- Well-child visits in first 15 months of life, third-sixth years, and adolescent well-care visit (Baseline = 75.97% Medicaid, 80.84% commercial; 79.31% Medicaid, 79.55% commercial; 62.92% Medicaid, 45.66% commercial)
- Chlamydia screening for adolescents (Baseline = 62.83% Medicaid, 47.3% commercial)
- Weight assessment and counseling for nutrition and physical activity (Baseline = 62.67% Medicaid, 61.64% commercial; 58.79% Medicaid, 59.86% commercial; 47.32% Medicaid, 52.49% commercial)

Experience of Care

Efforts are underway in Michigan to adopt a common patient experience survey that can be aggregated at the practice, Accountable System of Care, and payer levels. The Michigan Patient Experience of Care Work Group is about to begin a collaborative effort to implement the Consumer Assessment of Health Care Providers and Systems Clinician and Group Survey with the expanded Patient Centered Medical Homes item set, with voluntary participation from physician organizations in the state.¹⁰ The Michigan

Primary Care Transformation demonstration project will also implement this survey as part of its evaluation plan. This survey will include child and adult versions, and will be conducted statewide with both Michigan Primary Care Transformation demonstration project beneficiaries and a comparison sample. The results of this survey will provide baseline experience of care information for multiple payers. The multi-stakeholder work group will make final recommendations on a common survey for tracking patient experience in Michigan going forward.

Utilization

Utilization metrics will be tracked to measure the extent to which Michigan’s health system is doing a better job of coordinating care for individuals with complex needs, and also providing the right care, in the right place, at the right time, and by the right provider. Reducing inappropriate utilization is one of the primary mechanisms by which the Blueprint will lower health care costs. The Healthy Michigan Plan, described in detail in chapter B, requires tracking non-urgent emergency department utilization, and the extent to which emergency departments are used inappropriately. Implementing the Blueprint will dramatically decrease the following:

- Preventable emergency department visits (Baseline unavailable)¹¹
- Percent of hospitalizations for ambulatory care sensitive conditions (Baseline=20%)¹²
- Rates of 30-day hospital readmissions (Baseline=16.1%)¹³
- Number of inpatient days during the last six months of life for Medicare patients (Baseline=10.5)¹⁴

Lower Cost

As part of the Healthy Michigan Plan described in chapter B, the Michigan Department of Community Health is required to “pursue a range of innovations and initiatives to improve the effectiveness of the medical assistance program and to lower overall health care costs” which must include “minimum measures and data sets required to effectively measure the medical assistance program’s return on investment to taxpayers.” The Blueprint should reduce per member per month cost growth over five years such that per member per month Medicare and Medicaid expenditures are 10% less than what they would be if the Blueprint were not implemented.

D2. Goals and Characteristics of Michigan’s Future Health System

The Michigan Innovation Model management team adopted six goals recommended by the advisory committee, as follows:

- Goal I.** Strengthen the primary care infrastructure to expand access for Michigan residents
- Goal II.** Provide care coordination to promote positive health and health care outcomes for individuals requiring intensive support services
- Goal III.** Build capacity within communities to improve population health
- Goal IV.** Improve systems of care to ensure delivery of the right care, by the right provider, at the right time, and in the right place
- Goal V.** Design system improvements to reduce administrative complexity
- Goal VI.** Design system improvements that contain health care costs and keep insurance premiums affordable for individuals/families and employers/businesses

The advisory committee further specified Michigan’s reinvented health care system as possessing the following characteristics: accountability; person- and family-centered care; community-centered design; focus on prevention, wellness, and development; community integration; system-wide linkages; evidence-based approaches; and payment for value. These characteristics are defined in detail as follows.

Accountability

Accountability incorporates transparent and uniform procedures and processes that require all stakeholders within the model to take some level of responsibility for their actions, or conversely, for their inaction. In order to achieve an integrated, community-based health care system, individual stakeholders must take on a fair and reasonable portion of responsibility for outcomes. Within Michigan’s community integrated health system model, stakeholders would include but not be limited to, health care providers, social service providers, community organizations, payers, employers, patients, and community members.

Person- and Family-centered Care

Person- and family-centered care refers to orientating the delivery of health care and supportive services to an individual’s expressed needs, goals, preferences, cultural traditions, family situation, and values. It places the person and the family at the center of the care team, engaging them in decisions about managing their health and health care. The experience of care is evaluated from their perspective. Services and supports are delivered in a manner that is sensitive to the needs and preferences of the individual receiving the care and, when appropriate, their family.

Community-centered Design

Community-centered design requires the involvement of all stakeholders within a community in the identification of priorities, interventions, and strategies to maintain and improve the health of the community’s residents. This approach emphasizes engaging the community in decision-making, and assures community influence in health policy and the design of the health care delivery system. At the same time, the State should seek to provide a framework for the delivery of services that leads to a consistent experience of care across the state.

Focus on Prevention and Wellness

Focusing on prevention and wellness is a proactive approach to improving health status across the lifespan by addressing root causes of poor health. A focus on prevention and wellness requires the implementation of strategies in the community and/or clinical settings that are designed to prevent illness and disease, and promote health and well-being. This focus represents a shift from episodic sick care to prevention and wellness promotion, often through population-based strategies.

Community Integration

A community-integrated health system is a multi-sectoral approach at a regional or local level that recognizes the role that communities can and must play in promoting health and preventing disease. A community-integrated system places the health care delivery system in the broader system of environmental, social, and community health. Medical care is part of a network of community resources, services, and policies that can and should be used to improve the health of a community.

System-wide Linkages

System-wide linkages create seamless, “no wrong door” access to services that promote health by creating connections between and among community services and resources, public health, behavioral health, long-term care, and medical care.

Evidence-based Approaches

An evidence-based approach integrates the best available research evidence pertaining to specific conditions, practitioner expertise, and other available resources providing comparative information, and the characteristics, needs, values, and preferences of those who will be affected by the intervention in the design of care delivery. In clinical care, evidence-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care. Evidence is constantly evaluated and revised, based on research and sharing of anecdotal observations and lessons learned via a continuous quality improvement process. In public health, science-based interventions are integrated with community preferences for improving population health.

Payment for Value

Payment for value is the movement away from a fee-for-service payment model to a payment model that focuses on quality and good outcomes. Paying for value requires linking financial and other incentives to the delivery of evidence-based care and interventions. In a value-based, community-integrated system, incentives are aligned to foster stewardship of resources, promote the best health of the population, and to assure long-term sustainability of a high-performance health system. Paying for value means paying for those interventions and services that yield the best outcomes for patients and communities over time.

Summary

Michigan defines successful health innovation as making progress on the aims of improved population health, better care, and lower cost – with the added commitment to ensuring that improvements in health and health care are felt across all populations, reducing disparities related to race, ethnicity, income, geography, and source of health insurance. A multi-stakeholder body will be convened to develop core performance metrics that will be used for monitoring progress at multiple levels. In this chapter, we proposed an initial comprehensive set of metrics and specific aims to measure Michigan’s progress. The Blueprint’s service delivery and payment model design elements are described in detail in chapter E. A driver diagram which outlines the mechanisms by which the service delivery design elements address both the aims for health care transformation and the goals of the Blueprint is included in appendix 1.1.

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Chapter E: Delivery System Transformation and Payment Models

Taking into account Governor Snyder’s vision, and the goals and model characteristics articulated by the Innovation Model advisory committee, service delivery and payment model transformations were designed to achieve better health, better care, and lower cost. Specifically, Michigan’s Blueprint for Health Innovation is designed to:

- Advance the strategic vision of Governor Snyder and the Michigan Department of Community Health for **“Michiganders to be 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”**
- Continuously engage diverse stakeholders to achieve broad commitment to common metrics, processes, and administrative requirements that will add to value and minimize administrative complexity
- Support Michigan’s health care providers in creating a community-integrated system of care that breaks down silos across the health system
- Create a shared commitment among all health system stakeholders to accept accountability for improving health care outcomes and controlling costs
- Prepare for the increase in demand for services which will result from expansion of the Medicaid population with the passage of the Healthy Michigan Plan, an aging population, and an epidemic of chronic disease
- Enhance infrastructure that supports performance transparency, informed choices, ongoing learning, and continuous improvement
- Build upon and align with existing health care delivery system and population health improvement initiatives in Michigan

Michigan’s proposed health system model is designed, above all, to be person and family-centered – an orientation to the delivery of health care and supportive services that considers the individual’s needs, goals, values and preferences – and includes the following five elements:

- Patient Centered Medical Homes
- Accountable Systems of Care
- Community Health Innovation Regions
- Centralized health information and process improvement infrastructure and systems
- Pay-for-value payment models

The model elements presented below will be evaluated by pilot tests in 3 Michigan communities, described in greater detail in chapter J. Best practices established during this phase will then be scaled statewide.

E1. Patient Centered Medical Homes: The Foundation for Michigan's Transformed Health Care System

Michigan's proposed innovative delivery and payment models focus on health system reinvention that is person- and family-centered, and improving outcomes in health, health care and lowering cost trends. The Patient Centered Medical Home is the first element of Michigan's health system transformation. The Patient Centered Medical Home model helps to reach the goal of strengthening the primary care infrastructure to expand access for Michigan residents. Research conducted by Barbara Starfield and colleagues¹ demonstrates that primary care delivers better health care outcomes, is less expensive than current care delivery, and reduces health disparities. Recognizing the value of primary care in a high-performance health care delivery system, the advisory committee came to the consensus that widely accessible primary care should be the fundamental building block of the health care delivery system in Michigan.

Michigan's Patient Centered Medical Home model builds on the Michigan Primary Care Transformation demonstration project, which has been widely adopted and is being scaled up across the state as a cornerstone of health system transformation. Michigan's Blueprint for Innovation will leverage the Michigan Primary Care Transformation program to meet the goal of strengthening primary care infrastructure to expand access to care for Michigan residents and to ensure that patients get high quality health care services. In Michigan's innovation model, the individual's first contact with the health care delivery system will be a Patient Centered Medical Home, which offers enhanced access to a trusted interprofessional health care team (described in detail in chapter G). Care will be person-centered: engaging individuals as partners in their health and health care planning, and will be tailored to the needs and preferences of the individual. Patients will have an ongoing relationship with their Patient Centered Medical Home, which will be responsible for coordinating care across the health system. The primary care team will work to engage and help motivate patients to take greater responsibility for their health and health care.

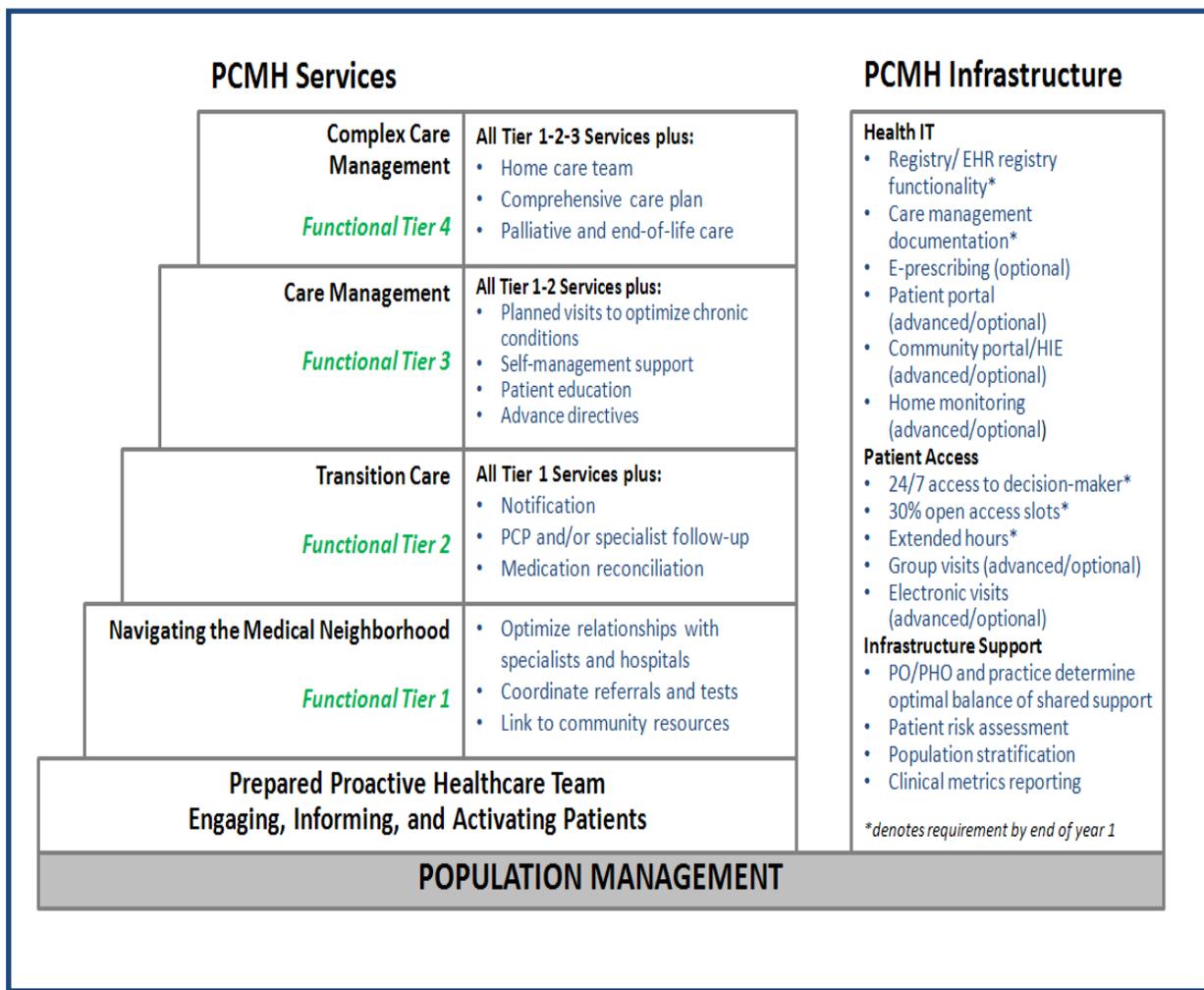
These enhanced capabilities of Michigan's Patient Centered Medical Home require health information, learning, and quality improvement infrastructure and systems, as well as payment mechanisms that encourage providers to adopt and sustain the model. The Patient Centered Medical Home will utilize confidential and secure health information systems that make relevant data accessible at the point of care, and provide support for population management activities such as preventive and chronic disease care. The development of health information systems that providers and patients can use to access relevant, timely health information for use in decision-making is an increasingly important tool for consumer engagement in health. Implementation of the Blueprint will include developing learning systems that inform workforce training and consumer engagement strategies.

Care in the Patient Centered Medical Home will be based on evolving evidence for best practices, and will engage innovative patient engagement tools such as patient portals, mobile applications and risk calculators for wise health care decision-making. Primary care practices will employ rapid-cycle improvement processes to continually improve care delivery. Patient input is central to this improvement process to maintain the focus on the individual and ensure accountability to Michigan's innovation goals. Patient satisfaction surveys will collect measures of patient experience, which will be incorporated into provider performance measures tied to incentives. In addition, patients will be active members of quality

improvement teams and will be key partners in guiding clinical care transformation in a manner that places the patient at the center of care.

The Patient Centered Medical Home, with enhanced access, patient engagement strategies, and accountability for improved quality and cost outcomes, is the foundation of Michigan’s high-performing, integrated health care delivery system of the future. The Patient Centered Medical Home will continue to be based on the Michigan Primary Care Transformation program as described in chapter B and depicted in figure E.1, below. The proposed Patient Centered Medical Home payment model is based on the current model used in Michigan, with a few refinements, as presented later in this chapter.

Figure E.1. Michigan Primary Care Transformation Model of Care



The Innovation Model is designed to strengthen the primary care infrastructure by building on the Michigan Primary Care Transformation demonstration in the following ways:

- I. Expand the Michigan Primary Care Transformation program to additional practices, providers, payers, and patients/beneficiaries

- a. Participation of Medicaid health plans will be required, and new payers will be encouraged to join as new delivery and payment models support transformation to Patient Centered Medical Homes for all settings that provide primary care
 - b. Eligibility rules will allow safety net providers to participate in the pilot tests; and Accountable Systems of Care will reach out to safety net providers to meet requirements to serve Medicaid beneficiaries
- II. Enhance interprofessional, team-based care (as described in chapter G) to:
- a. Provide comprehensive and coordinated care including medical, behavioral, and social care services, for better health and health care outcomes, while reducing workload on primary care physicians
 - b. Create person-centered care plans for individuals with complex care needs in a process that is directed by the individual, and is based on achieving outcomes in pursuit of the individual's own preferences and goals
- III. Expand access to care across all Patient Centered Medical Homes as follows:
- a. Expand office hours, provide virtual visits, and offer open scheduling for enhanced access to care in all Patient Centered Medical Homes
 - b. Employ strategies to maximize primary care access for the underserved, including:
 - i. Delivering care in the right place, utilizing existing safety net settings including: Federally Qualified Health Centers, rural health clinics, school-based clinics, free clinics, and community mental health services providers
 - ii. Offering critical 'enabling services' such as translation, transportation, case management, and health education
- IV. Expand and organize relationships and linkages to community service providers, including Michigan's dual eligible demonstration project, maternal and child health programming, community-based supports coordination, and social service agencies
- V. Utilize strategies and technology to increase access to care and to engage patients in taking greater responsibility for their health and health care, for example:
- a. Patient engagement tools (e.g., risk calculator for surgical procedures)
 - b. Patient engagement personal technology devices (e.g., interactive mobile health technologies to improve medication adherence)
 - c. Tele-visits, such as behavioral health visits
 - d. E-visits for care that can be delivered through a virtual encounter
 - e. Consumer educational web sites to encourage access to health information and support for informed decision-making
 - f. Patient portals (for patients to communicate with their Patient Centered Medical Home)

The Michigan Primary Care Transformation program will continue to adapt in order to effectively respond to the changing health care environment – with the performance measurement and recognition committee providing recommendations that ensure that the program improves outcomes, including a positive experience of care for patients and providers. In order to expand the Patient Centered Medical Home in these ways without stressing an already fragile primary care infrastructure, as described in chapter B, it is necessary to implement other elements of Michigan's service delivery model. These include Accountable Systems of Care, Community Health Innovation Regions, enhanced health information exchange, and access to multi-payer claims and clinical data.

E2. Accountable Systems of Care

The second element in the proposed service delivery model is the Accountable System of Care. This element of the transformed health system, defined and developed during the planning process, grew out of the natural integration of clinical providers working together to improve health care in local health systems across Michigan. As discussed in chapter B, provider organizations have built sophisticated support infrastructure through the Michigan Primary Care Transformation program, which has become a platform for transformation for primary care practices in Michigan. In the safety net, the Michigan Primary Care Association has provided support for its members to achieve recognition as Patient Centered Medical Homes. In addition, health plans have provided support services to their providers to improve health care outcomes. The Accountable System of Care will build upon the collective hard work of these entities to transform the primary care system, and will grow out of the capabilities that are now embedded in the Michigan health care system.

The role of the Accountable System of Care in Michigan's health system transformation is to improve health system performance by organizing care providers within an integrated network that ensures patients have access to the right care, by the right provider, at the right time, and in the right place, a goal of the Innovation Model advisory committee. A Michigan Accountable System of Care is a legal entity with infrastructure that organizes and supports a network of providers who are accountable to work together in a coordinated manner to proactively manage comprehensive medical, behavioral, and social care services for a defined population. Providers in an Accountable System of Care include Patient Centered Medical Homes that serve children and adults with complex clinical care management services. Accountable Systems of Care will provide the structural support for person-centered care systems that coordinate care to promote positive health and healthcare outcomes for individuals requiring intensive support services, another goal of the State Innovation Model advisory committee. Accountable Systems of Care will have referral relationships for required specialty care services, acute care hospitals and diagnostic services, and required community services. They will create strong community linkages to provide access to needed social services.

The distinguishing feature of this provider network is that – through new payment mechanisms – the providers are held financially accountable for performance outcomes of a defined population. As clinical integration increases and networks build needed support infrastructure, the capacity of the Accountable System of Care will also increase to bear progressively greater financial risk for performance outcomes in quality and cost across the defined population. It is important to point out that providers in an Accountable System of Care will not bear insurance risk, which remains in the domain of licensed insurance entities regulated by the Michigan Department of Insurance and Financial Services.

Accountable Systems of Care share some features with an Accountable Care Organization, in particular, 1) the population-based approach to care for patients whether or not they seek care, 2) a focus on accountability to demonstrate improved performance, and 3) payment based on outcomes. Important distinctions that are central to Accountable Systems of Care include the following: 1) prospective assignment and enrollment of the defined population, 2) required inclusion of Medicaid

While there are differences, the Accountable System of Care is sufficiently consistent with the definition of an Accountable Care Organization that Medicare should be able to participate in payment models for Accountable Systems of Care.

beneficiaries, 3) relevant stakeholder involvement in improving the system design and ongoing input into performance metrics that are tied to incentives, 3) engagement in population-level strategies that improve health care outcomes, 4) learning systems and reinforcing feedback loops embedded in the design to assure patient and provider input for ongoing improvement of the system, and 5) a network comprised of a diverse mix of providers that can address broad determinants of health: medical, behavioral, and social care needs. Each of these distinguishing features will be discussed in greater depth in this chapter.

A distinguishing feature of the Accountable System of Care is the diverse mix of providers that comprise the network. While many provider networks focus on medical services, providers in the Accountable System of Care are accountable to address not just medical, but also behavioral and social care needs of the defined population. During the Innovation Model planning process, the advisory committee strongly supported the value of addressing the comprehensive needs of the patient based on a growing body of evidence that suggests that nonclinical determinants of health have a strong impact in achieving better health care outcomes.² For example, a diabetic patient with depression may not improve without addressing this behavioral health concern.

“It has long been recognized that primary care practices that have transformed themselves according to the attributes of the Patient Centered Medical Home would not by themselves be able to transform the broader health care system.”³ The integration that is needed for a high-performing health system requires breaking down silos and working together across the health system. As such, providers in the Accountable System of Care may include the following: Patient Centered Medical Homes, specialists, behavioral health providers, hospitals/health systems, and all other providers and facilities needed to provide comprehensive, coordinated care for the defined population.

The Accountable System of Care also includes infrastructure that links the delivery system to public health and community agencies. In general, however, the social care coordination infrastructure that links the Patient Centered Medical Home with social agencies will be a community resource and shared among many Accountable Systems of Care in a region, such as the Pathways Community Hub model that is being implemented in three communities in Michigan and the school-based Pathways to Potential centers staffed by Department of Human Services described in chapter B. In these examples, Accountable Systems of Care would contract with these care coordination systems to create seamless linkages across the health care system, community resources, and social services. When integrated with behavioral health services, the Patient Centered Medical Home reaches beyond its traditional boundaries to behavioral health, and when coupled with social care services, the Accountable System of Care can provide comprehensive, coordinated care for better health and health care outcomes.

There are two levels of Accountable Systems of Care to address readiness to bear financial risk.
Level I: financial, clinical, and operational ability to manage shared savings with upside risk
Level II: capability to manage shared risk payment arrangements including partial and global capitation reimbursement

Successful implementation of Accountable Systems of Care requires consideration of several key aspects of accountability and integration, including:

- Patient engagement in the design of care systems and assuring data transparency

- The set of functions for which the Accountable System of Care is responsible
- The population for which the providers will be held accountable
- Levels of integration and network adequacy
- Administrative capacity
- Governance

Key Functions of an Accountable System of Care

The guidelines for Michigan Accountable System of Care will not be overly complex or prescriptive in how providers organize themselves to achieve performance outcomes; rather, they provide a flexible framework for successfully advancing the aims of better care, improved population health, and lower cost. The following are the functions of the Michigan Accountable System of Care:

- I. Negotiate contracts with payers in which providers share responsibility for performance outcomes
- II. Champion a practice culture of continuous quality improvement as described in chapter I through the following:
 - a. Employing rapid-cycle improvement processes for quality improvement and reinforcing feedback loops for accountability to system improvements, better communication, and sustainability of transformation efforts
 - b. Ensuring the availability of high quality technical assistance support infrastructure, including well-trained practice transformation coaching
 - c. Facilitating learning collaborations
- III. Create effective and efficient systems of care to enhance access, coordinate care across providers and settings, and optimize utilization patterns, including:
 - a. Expanded practice teams such that members of the teams work at the top of their license for optimal use of staff resources
 - b. Pool resources to assist Patient Centered Medical Homes to meet enhanced access requirements (for instance, through an after-hours clinic that serves patients of all primary care providers in the Accountable System of Care)
 - c. Incorporate tools, workflows, protocols, systematic processes, and evidence-based clinical guidelines that improve efficient and effective care delivery and optimize provider referral patterns
 - d. Design, implement, and continually improve systems of care for complex patients including targeting of patients, optimal interventions, and tracking systems
 - e. Develop efficient and effective linkages across multiple health care settings, public health, and community resources
- IV. Implement and optimize health information systems across the networks that ensure the following:
 - a. Robust population management with the ability to aggregate data on all patients across settings, segment and target populations that require care management or other services, and ensure quality of care and reduce disparities
 - b. Seamless care coordination with health information exchange across the network, notifications to the primary care provider when patients are admitted, discharged, or transferred to a facility

- c. Optimal care management with the ability to create a proactive care plan to meet patient's needs; appropriately share the common patient-centered care plan with the patient's care team; and document care management services
- d. Patient access to their own data and the ability to communicate electronically with care providers to facilitate engagement in care

Defining the Population of an Accountable System of Care

Accountable Systems of Care will need to have enough patients to make quality measurement statistically meaningful, and to mitigate risk across the population as a whole. The minimum patient population varies according to the payment model, and will be greater for those systems that bear greater financial risk. This will be discussed further in the Payment for Value section of this chapter.

Michigan's Blueprint does not propose creating Accountable Systems of Care to replace programs and demonstration projects that target certain special populations and already provide the needed care coordination services for those individuals, or are testing other integration approaches. However, the Accountable System of Care is designed to draw from the service providers for those programs, integrate lessons learned into the Innovation Model, and reduce the bifurcation between safety net and private care settings for larger populations. Populations who would not be included in the population of an Accountable System of Care during the testing phase include: those with nursing home level of care needs who participate in the MiChoice waiver, people with serious and persistent mental illness and developmental disabilities covered through contracts with the Prepaid Inpatient Health Plans, and children with serious emotional disturbance covered by Medicaid waivers.

As noted above, providers in an Accountable System of Care will be held financially accountable for performance outcomes in quality and cost for a defined population. During the advisory committee meetings, stakeholders agreed that the population for which providers are accountable must be clearly defined from the start. All payers will adopt an enrollment process that supports this ideal.

The process for assignment and affiliation of beneficiaries to primary care practices or Patient Centered Medical Homes that will be applied in Michigan's Medicaid program are as follows:

- Step I.** Beneficiaries who do not choose a primary care provider or Patient Centered Medical Home will be assigned one by the Health Plan
- Step II.** Each primary care practice or Patient Centered Medical Home will be affiliated with a specific Accountable System of Care
- Step III.** The Medicaid beneficiaries will be affiliated with their primary care provider or Patient Centered Medical Home's Accountable System of Care
- Step IV.** Therefore, the Accountable System of Care's defined population will include the Medicaid beneficiaries that are enrolled with their network of participating primary care providers and Patient Centered Medical Homes
- Step V.** Patients must be informed and agree to the arrangement

Assignment or affiliation of Medicaid beneficiaries to the Accountable System of Care will be based on the beneficiaries' selection or auto assignment to a primary care practice or Patient Centered Medical Home that is affiliated with an Accountable System of Care. But this must be balanced with the

preference for patients to have choices about where they seek care. To provide as much choice to the patient as possible and enable providers to manage risk, rules must be established that govern beneficiaries' ability to change providers and Accountable Systems of Care outside of regularly established enrollment windows. It is the responsibility of the Accountable System of Care to attempt to expeditiously resolve patient complaints and issues to try to avoid patients leaving the network.

Frequently safety net settings (including Federally Qualified Health Centers and community mental health services providers) have not been incorporated into Michigan's developing Accountable Care Organizations (as discussed in chapter B) or provider organization networks. This is, in part, because these organizations are responding to requirements of payment programs of Medicare and commercial insurers rather than Medicaid, which provides coverage for beneficiaries served by safety net settings.

These safety net settings remain an important part of serving vulnerable populations in Michigan that support Michigan's population health goals. They have developed methods of targeting high-risk populations, patient engagement, addressing social determinants, cultural competence, and have built trust with vulnerable populations and within the communities where they reside. To ensure this vulnerable population receives care through new delivery systems that are accountable to performance outcomes, the Accountable System of Care will be required to demonstrate that beneficiaries of Medicaid and Children's Health Insurance Program are represented proportionately to the region that the Accountable System of Care serves. They will be encouraged to achieve this by including existing safety-net settings in their provider networks.

Levels of Integration

An Accountable System of Care will organize and support providers who work together in a coordinated manner to proactively manage comprehensive care services for a defined population. The proposed Innovation Model is designed around a fundamental principle expressed by the Innovation Model advisory committee: providers cannot be held responsible for outcomes beyond their capacity to manage to achieve those outcomes. Recognizing the need to build the necessary infrastructure support and system capacity to take on financial risk, and to give providers the best chance for success, the model of an Accountable System of Care includes two levels of clinical integration based on their readiness to bear financial risk.

Level I Accountable Systems of Care will have the financial, clinical, and operational ability to manage shared savings (based on total cost of care) with upside risk, pay-for-performance incentives, and care management reimbursement with continuity of care adjustments for a population of assigned or enrolled beneficiaries.

Level II Accountable Systems of Care will have the financial, clinical, and operational capability to manage shared risk payment arrangements including partial and global capitation reimbursement options for a population of assigned or enrolled health plan beneficiaries that will be described in detail in the Payment for Value section of this chapter. Accountable Systems of Care that contract for shared risk arrangement are responsible for providing or arranging for all the services that are included as part of the global or partial capitation payment from the payer. Level II Accountable Systems of Care are highly integrated with sophisticated health care analytic systems for monitoring performance against established

targets. Level II Accountable Systems of Care must have mature continuous improvement processes and demonstrate consistent improvement in long-term health status of their beneficiary population that reduces cost and improves the quality of life of their patients.

Table E.1 shows components of the proposed requirements for Accountable Systems of Care.

Table E.1 Proposed Requirements for Accountable Systems of Care		
Organizational Requirements	Level I	Level II
Formal Governance Structure	Board composed of: <ul style="list-style-type: none"> Accountable Systems of Care participating providers Consumer representation 	Board composed of: <ul style="list-style-type: none"> Accountable Systems of Care participating providers, Consumer representation
Clinical Integration	Accountable Systems of Care with contracted or employed providers, behavioral health, plus strong community linkages	Full clinical integration across all networked services
Financial Integration	Must have a method for distributing shared savings equitably	Full financial integration for upside and downside financial risks
Financial Reserves	Recommended but not required	Required based on number of beneficiaries and level of financial risk
Minimum Number of Beneficiaries	10,000 recommended	20,000 recommended
Claims Payment Capability	Not Required	Required
Downside Medical Cost Risk	No	Yes
Integrated Electronic Health Record with Health Information Exchange Interface and Continuity of Care Record Exchange Capability	Recommended	Recommended
Grievance and Appeal Process	Yes	Yes

Table E.1 Proposed Requirements for Accountable Systems of Care		
Organizational Requirements	Level I	Level II
Risk-based Payment Models Options	<ul style="list-style-type: none"> Care management payments with annual continuity of care adjustments Shared savings with upside risk 	<ul style="list-style-type: none"> Care management payments with annual continuity of care adjustments Shared savings with upside and downside risk Partial capitation Global capitation
Pay-for-Performance	Incentive Only	Incentive and risk of loss
Beneficiary Lock in	No	Yes
Scope of Network	Primary care and other specialty services provided by referral	Integrated primary care, behavioral health, clinical specialty, hospital acute care services, and required community based support services
Experience with Shared Savings Risk	Not required	Required

Network Adequacy

Having an adequate and effective network of providers will be essential for the success of an Accountable System of Care. A strong primary care infrastructure is foundational. In order to demonstrate the capability of this infrastructure, Accountable Systems of Care should have a preponderance of primary care providers designated as Patient Centered Medical Homes. As Accountable Systems of Care provide support for practice transformation to practices that are working toward Patient Centered Medical Home designation, the proportion of practices that are recognized as Patient Centered Medical Homes must increase.

In addition to primary care, network adequacy requires integration of behavioral health care providers in order to address behavioral health concerns. Accountable Systems of Care must demonstrate capacity to provide supports coordination and/or navigation for complex care patients, and have strong linkages in place for patients who require special intervention and community support to reduce overuse of high cost acute care services. The Accountable System of Care will provide complex care coordination using care teams with care managers that provide wrap-around services that include behavioral health and community services in order to reduce emergency department visits and risk of hospitalization. Care teams provide structured processes for meeting the needs of the complex patient, and provide the platform for linking to community health services that address social care needs. Person-centered care plans will be used to create partnerships between providers and patients, with individual choices and values guiding the decisions about care. One way for the Accountable System of Care to link its complex care coordination infrastructures to social care services is by working with the Community Health Innovation Region to establish a Pathways Community Hub and/or to integrate with Pathways to Potential in the school. In fact, an Accountable System of Care must demonstrate commitment to working with community partners meaningfully engaging with the Community Health Innovation Region.

Both Levels of Accountable Systems of Care must have capacity for providing or arranging for required specialty care services and have referral relationships with acute care hospitals and diagnostic services and required community services. To achieve Level II, the Accountable System of Care must create formal relationships with specialists and hospitals, to assure the functions listed above. The participants are all held accountable for performance outcomes along with primary care.

Because the population of an Accountable System of Care is defined by the population enrolled via the primary care practices, primary care providers can only participate in one Accountable System of Care, while specialists and hospitals can participate in more than one. This requirement is consistent with Medicare Accountable Care Organizations⁴ and Blue Cross Blue Shield of Michigan's Organized System of Care program⁵ described in Chapter B.

Administrative Capacity

The Accountable System of Care will contract with payers such that providers are held accountable for performance outcomes. These contracts must cover assignment of beneficiaries; specific, delegated responsibilities; defined services; and reimbursement methods. One of the primary responsibilities of an Accountable System of Care will be the integration and equitable distribution of shared savings and financial risk across the provider network. In order to share performance accountability with providers, these contracts will include financial arrangements such as shared savings, pay-for-performance incentives, partial capitation, or global capitation, which are further explained in the payment for value section.

The Accountable System of Care must have accounting and financial systems to account for and equitably distribute performance rewards and attribute losses to participating providers based on the contribution to achieving the required outcomes. Accountable Systems of Care must have financial systems that can manage the distribution of care management payments, other grants and incentives passed on from payers (such as Meaningful Use incentive payments for electronic health record adoption), and pay-for-performance incentives. The Accountable System of Care must be able to provide timely and accurate accounts payable and service reimbursements in a transparent and well-organized business process.

In addition to financial capacity, sharing accountability for performance outcomes requires investment in the health information technology and analytical capacity, all the clinical protocols to manage comprehensive patient care, and the ability to organize providers. This is related to the next capacity: governance.

Governance of Accountable Systems of Care

Michigan's Innovation Model advisory committee members felt strongly that, during this period of health system transformation, Accountable Systems of Care should not add unnecessary administrative burdens by way of prescriptive governance requirements. Required functions of the governing bodies of Accountable Systems of Care should add value beyond those functions of existing organizational structures (such as provider organizations and health plans). Even so, it is important to note that effective governance models are crucial if the Accountable System of Care will deliver on better health, health

care, and lower costs through improvements in delivery and payment models. As such, the governance structure will need to do the following:

- I. Negotiate contracts between providers and payers for new model of care and payment mechanisms; and make decisions about distribution of payments
- II. Provide strong leadership and organizational oversight for improving system operations
 - a. Ensure that patient/consumers have access to the best care possible at the lowest possible cost
 - b. Track and hold providers accountable to performance outcomes in the Accountable System of Care
 - c. Ensure providers have the needed care coordination, quality improvement, and health information systems and infrastructure to improve performance outcomes
- III. Work with cross-sector partners at the community level to achieve integration across the health care delivery system, public health and community resources; and improve population health through engaged membership in a collective impact consortium at the community level

Accountable Systems of Care will support primary care practice transformation, embed quality improvement processes, and offer pooled resources, such as shared care managers, for economies of scale. Given the governance requirements enumerated above, decision-making by the Accountable System of Care will need to be responsive to providers and patients. Specifically, governance will assure the following engagement functions:

- Engage and organize providers to lead health system improvement efforts across the network
- Engage patients and community members in designing and continually improving the patient-centered systems of care

Also, the Accountable Systems of Care must participate in governance at the central level – with meaningful input into metrics and program policy in the Innovation Model Steering Committee and the performance measurement and recognition committee. Accountable Systems of Care will represent their provider network by working with the Steering Committee to reduce administrative complexity by creating common processes and policies across all payers. Systems will be put in place to eliminate waste, reduce administrative complexity, and enhance the experience of health care delivery for the patient and the provider.⁶

Finally, Accountable Systems of Care are located in geographic communities and serve an important role in the promotion of population health. As part of a community-integrated health system, the Accountable System of Care will work with cross-sector partners such as public health, community agencies, government officials, philanthropy, business interests, non-profits and community members to address population-level health priorities and to reduce health risks in the community in which it is located. In this model, Accountable Systems of Care will be key participants in creating a community-integrated health system as engaged partners in the Community Health Innovation Regions described below.

Role of Medicaid Health Plans in an Accountable System of Care

Medicaid managed care has been the dominant delivery system for Michigan’s Medicaid beneficiaries since 1997. Today approximately 70% of the state’s 1.8 million Medicaid beneficiaries are enrolled in one of thirteen contracted Medicaid health plans. Michigan’s Blueprint recognizes the value that managed care brings to health care now and into the future. Active collaboration between Medicaid Health Plans

and Accountable Systems of Care will be necessary to avoid duplication of effort and complement existing managed care infrastructure to achieve optimal outcomes. In some circumstances, health plans may meet all the requirements and therefore could serve as Accountable Systems of Care.

Medicaid Health Plans have the following key roles and expertise:

- Contract with Accountable Systems of Care and other service providers
- Develop value-based pay-for-performance outcome payments and other reimbursement approaches that move away from fee-for-service
- Reconcile shared savings allocations and accuracy of other shared risk and reward reimbursement methods
- Develop efficient business and operational processes with Accountable Systems of Care to reduce administrative cost and complexity
- Provide member services including a beneficiary call center, eligibility information, and provider selection assistance
- Manage beneficiary provider assignments including primary care provider and medical home panel assignments
- Claims payable operations, third party payer benefits coordination, provider and beneficiary grievance and appeals
- Provider wrap-around services and benefits that are not delegated to the Accountable Systems of Care
- Provide beneficiary outreach and education support in collaboration with the Accountable Systems of Care
- Collect encounter and claims data, perform analysis, and develop quality, population health, and cost performance reports for each Accountable System of Care as part of multi-payer performance reporting
- Provide Accountable System of Care beneficiary information from out of network services and utilization
- Work collaboratively with the Accountable System of Care to provide support for patient self-care management and patient personal health record and patient portals for beneficiaries
- Work with Accountable System of Care on beneficiary retention and assuring continuous enrollment
- Work collaboratively with Community Health Innovation Regions and community stakeholders to address the social and economic determinants of health
- Identify potential barriers for patients receiving appropriate access to care, including working with Accountable System of Care to identify and eliminate patient challenges when receiving health care
- Evaluate patient experience with the network and health system and support physician-patient communication to improve patient satisfaction and outcomes; assure patient appointments are provided in a timely manner
- Collaborate with the Accountable System of Care to create an environment that promotes quality improvement and continuous improvement in all aspects of care, population health management and cost containment

- Provide tools and strategies that encourage patients to take a more active role in the self-care management of their health

Michigan's Medicaid Health Plans are expected to benefit in the long-term from the implementation of the Blueprint through new delivery and payment mechanisms that improve performance outcomes and reduce costs. With a focus on broad investment in Patient Centered Medical Homes, supportive Accountable Systems of Care, and organizing community engagement in community risk reduction and health improvement, the transformed health system recognizes the important role the Medicaid Health Plans play in improving quality, access to care, population health, and cost containment.

E3. Community Health Innovation Region

The third element of the Innovation Model is the Community Health Innovation Region. While Accountable Systems of Care will provide a structure for clinical integration and provider accountability, Michigan stakeholders strongly support the development of a community-based organizing mechanism composed of partners from many different fields in the community 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 are needed across the health system and beyond. To be effective and sustained over time, these partnerships will take a collective impact approach,⁷ with a long-term commitment to a common agenda, shared measures, and effective strategies for engaging the community in improving health and the health care delivery system while containing costs.

The Innovation Model advisory committee members included representatives of innovative health coalitions and public health practitioners who are working to build capacity to improve health in the community through population-level strategies, and by making seamless connections across the health care delivery system, community services, and public health. These stakeholder groups agreed with physicians within the advisory committee that public health and other social services were critically necessary to achieve quality and cost targets. This led to the recommendation that community partnerships be a central element of the system as a whole.

The Community Health Innovation Region can be described as a consortium, composed of a broad partnership of community organizations, government agencies, business entities, health care providers from Accountable Systems of Care, payers, and individuals (including those from vulnerable populations) that come together with the common aim of raising the community’s capacity for improving population health. The Community Health Innovation Region will build on existing community partnerships in Michigan that are working collaboratively for a collective impact on health outcomes. It can leverage Prosperity Region initiatives (described in chapter B) that provide greater efficiency and consolidation of resources. Community Health Innovation Regions must demonstrate that they have a broad base of financial support from their local partners (such as health plans, businesses, Community Benefit funding, and philanthropy).

To sustain these partnerships, a Community Health Innovation Region will have a formal backbone organization that functions as the governing body, and serves as the fiduciary. Core infrastructure and staff will be needed for logistical support, management, and quality improvement processes.⁸ The role of this backbone organization will be to convene stakeholders to improve health outcomes, and create greater integration across the health system, thereby reducing sources of health risk, and strengthening assets that protect and promote health in the community. The Community Health Innovation Region will work with health systems, public health departments, and community stakeholders to conduct community health needs assessments and to identify and implement strategies that address community priorities. Additionally, the backbone organization and its stakeholders will work to establish greater integration across the health system and organized entry points for access to care with links to coordinated community services.

Cross-sector Partners in the Community Health Innovation Region

- Consumers/Community representatives
- Local public health agencies
- Community mental health service providers
- Department of Human Services
- Local health plans
- Representatives from Accountable Systems of Care
- Health system leadership
- Veterans groups
- Faith-based organizations
- Nonprofit organizations
- Philanthropic organizations
- Community support infrastructure and services
- Government entities
- Elementary, secondary, and higher education institutions
- Business leaders
- Chambers of Commerce
- Economic development entities
- Community and economic development and investment

Community Health Innovation Regions will perform the following functions:

- I. Act as a convener of cross-sector stakeholders, including facilitating partnerships among stakeholders that are competing in a market-based health system
 - a. Governed by a Board of Directors and by-laws
 - b. Convene diverse stakeholders
 - c. Engage and sustain the commitment of leadership from local government, purchasers, payers, providers, community, and public health
 - d. Facilitate a process to develop and define a common agenda and community health improvement goals
 - e. Facilitate a process to develop and define how to measure improvements

- f. Assure accountability to improvement goals
- II. Provide backbone organizational body for governance and a staff that carries out the day-to-day organizational and administrative functions
- III. Coordinate activities with state and local public health
- IV. Develop a systematic approach to community-wide public engagement, education, and mobilization for ongoing input into improvements in the health care delivery system and community-centered population level strategies, with special emphasis on vulnerable populations
- V. Develop a core set of community performance measures with input from community members, collaborating with the state-level Performance and Recognition Committee
- VI. Maintain a public community dashboard that provides community specific measures, target performance, and compares level of improvement against target performance goals
- VII. Ensure a community needs assessment is completed including development of strategic priorities for health improvement in the community
- VIII. Develop and effectively champion strategic interventions to drive improvements in health and health care; examples of strategic interventions include:
 - a. Coordination of health care services with human services (e.g., implement Pathways Hub model or leverage Pathways to Potential Family Resource Centers, as described in chapter B)
 - b. Integration of medicine, public health, and community resources in addressing health priorities (e.g., a community-wide approach to childhood obesity)
 - c. Public reporting of performance measures in health care delivery and at the community level
 - d. Local approaches or policies that create healthy environments
 - e. Develop community-level, culturally appropriate health literacy and consumer engagement strategies
- IX. Champion the need to achieve greater balance in investments in health care and other social determinants of health and marshal available resources within the community (financial, knowledge/skills, leadership, manpower, etc.) to achieve collective impact in community-based strategies that improve health and health care, including:
 - a. Community benefit dollars (as required by IRS)
 - b. Community investment/development funds (as required by the Community Reinvestment Act)
 - c. Philanthropic funding
 - d. Federal, state and local funding (e.g., Metropolitan Planning Organizations investing transportation dollars in a healthy built environment)
 - e. Community trust funds
 - f. Funding streams that represent a shared savings from a high-performance health system
 - g. Expanding billing for services by local public health departments
 - h. Comprehensive payment reform that pays for value

Over time, the Community Health Innovation Region will demonstrate value by improving health outcomes and reducing health risks. As these community partnerships demonstrate the ability to collaborate across partners, engage leadership in the community, and demonstrate improved health outcomes, they will garner broad-based support and funding from stakeholders. A demonstrated return on investment will enable the Community Health Innovation Region to secure sustainable funding sources.

E4. Payment for Value

Value-based payment entails financially rewarding or penalizing health care providers based on achievement of target performance levels instead of volume (number) of services provided. The goals of payment reform are:

- Create sustainable multi-payer payment methods
- Move away from fee-for-service payment
- Align payment methods to reward improved health outcomes and lower health care costs
- Stimulate care and technology innovation in the delivery of care and in patient engagement strategies
- Provide financial incentives to invest in health information technology and continuous improvement infrastructure
- Align communities with the overall goal of population health improvement, wellness, community health risk reduction, and cost containment to keep premiums affordable and Medicaid and Medicare financially sustainable

Paying for value will require payers and providers to make changes to their business models. Accountable Systems of Care provide the structure to support the evolution of new value-based payment and reimbursement methods. Individual or small group practices cannot bear performance risk for patients beyond the services that they provide. Michigan's Blueprint requires Medicaid Health Plans and other participating payers to contract with Accountable Systems of Care, which assign patients to their affiliated primary care practices or Patient Centered Medical Homes. The example set by Medicare's Accountable Care Organizations informs the way Michigan will move the preponderance of health care payments away from fee-for-service and into value-based models. In order to offer shared savings with upside and downside risk and quality performance requirements for a defined attributed population of patients, it was necessary for Medicare to create Accountable Care Organizations.⁹ Michigan's Accountable Systems of Care organizational framework is based on the same set of financial and clinical integration principles for organizing providers to improve quality and reduce cost, with some additional roles that go beyond Medicare Accountable Care Organizations.

The underlying business model of Michigan's health care system will move from expanding acute care, high-cost specialty care, and diagnostic services, to a business model based on prevention, primary care, and effective care management. Accountable Systems of Care will achieve financial success by improving quality and population health performance and reducing health care cost. Accountable Systems of Care will grow their economic potential by increasing the market share of affiliated patients assigned to their primary care providers and Patient Centered Medical Homes. Hospitals and specialists will affiliate with multiple Accountable Systems of Care to assure that they are part of the networks of service providers in a given region, but will align with the more efficient and effective Accountable Systems of Care when at financial risk for improved performance.

The payment reform strategy is based on balancing risk and reward for improved value-based outcome performance. The level of financial risk and amount of financial reward embedded in the payment method will be appropriate to the capacity of the Accountable System of Care to effectively manage the performance risk. At the same time, Michigan's payment reforms will incentivize the continuous

development of Accountable Systems of Care capability and capacity to manage performance risk for long-term population health and health care cost containment. Payment methods that are based on balanced risk and reward, instead of fee-for-service methods that create constant pressure to increase provider fee-for-service reimbursement rates, will reduce cost shifting and price inflation. The payment methods will provide an incentive for the Accountable System of Care to negotiate with providers on their service pricing and cost structure. Accountable Systems of Care will seek to manage and impact a larger population of beneficiaries, including high-risk beneficiaries. This is because it is through successful management of the high-risk beneficiaries where the most savings are possible.

Accountable Systems of Care balance coordinated, integrated care systems with market-based competition. In this model, Accountable Systems of Care will compete in many service regions for multi-payer contracts. Payers can contract with multiple Accountable Systems of Care in the same region, but over time, payers will direct their business and their patients to those that achieve higher performance levels. This will create market pressure on all Accountable Systems of Care to continuously improve their cost and quality performance. At Level II, in particular, with capitation payment models, there will be embedded incentives to contain cost and reduce unnecessary utilization. Likewise, moving away from fee-for service to capitated payment mechanisms will reduce the fraud and abuse that are seen with fee-for-service payments.

The underlying business model of Michigan's health care system will move from expanding acute care, high-cost specialty care, and diagnostic services, to a business model based on prevention, primary care, and effective care management. Accountable Systems of Care will achieve financial success by improving quality and population health performance and reducing health care cost. Accountable Systems of Care will grow their economic potential by increasing the market share of affiliated patients assigned to their primary care providers and Patient Centered Medical Homes. Hospitals and specialists will affiliate with multiple Accountable Systems of Care to assure that they are part of the networks of service providers in a given region, but will align with the more efficient and effective Accountable Systems of Care when at financial risk for improved performance.

Michigan's multi-payer value-based payment methods are based on the following general principles:

- Performance is evaluated relative to risk-adjusted estimates of the cost of care for a specific patient panel
- Top performing Accountable Systems of Care and their affiliated providers are rewarded financially based on their relative contribution to the outcome
- All conditions of base payment, rewards, penalties, and any non-economic rewards are set out in advance by contract or by program policy
- Performance results and rewards are transparent
- Patients are informed of how financial rewards are earned and allocated
- Penalties for non-performance are appealable and based on auditable information
- Distribution of financial rewards and penalties occur within a set period of time

Implementation of Payment Reform

As described above, not all Accountable Systems of Care will have the capacity to bear downside financial risk for performance initially. To account for this, Level I and Level II payment models are

proposed with graduated levels of risk, corresponding to the categories described under Accountable Systems of Care. The payment models offered will be designed such that it is beneficial for Level I Accountable Systems of Care to move to Level II when they are ready.

Michigan's Blueprint includes expansion of existing payment reforms that are already implemented as part of other federal initiatives. This includes Patient Centered Medical Home care management payments, pay-for-performance incentives, and shared savings. These payment reforms provide the foundation for further Michigan payment reform evolution. Previous Center for Medicare and Medicaid Innovation initiatives validated the value and impact of these payment reforms. Expanding them will drive delivery system performance improvement that support continued increase in Patient Centered Medical Home capacity and development of the Accountable System of Care delivery system model.

Because the Level I payment model still has fee-for-service components, it is essential to include incentives that promote a high-performance health system. Therefore, to qualify for enhanced care management payments, shared savings, or incentives, Patient Centered Medical Homes and Accountable Systems of Care must meet base performance thresholds in quality, utilization, and population-level metrics.

Level II payment reforms represent the next generation of Michigan payment methods. They will be part of Innovation Model testing, evaluation, and validation. These payment reforms have been used by other states and private payers. Testing Level II risk-based payments on a smaller scale in the Michigan health care environment as described in chapter J will determine the effectiveness and appropriate application of these types of payment reforms prior to considering statewide adoption. Testing Level II payment reforms will provide the evidence and performance data to develop necessary policy and regulatory changes to effectively implement these next generation payment reforms in Michigan.

Table E.2 summarizes the payment model for each element of the delivery system and payment reform stages. Additionally, the table depicts how Accountable System of Care payments will be staged based on the capacity of the Accountable System of Care. Following the table are detailed descriptions of each of the proposed payment reforms. Topics are described in the order in which they appear in the table.

Table E.2 Proposed Payment Models for each Model Element

Model Element	Payment Options
Patient	<ul style="list-style-type: none"> • Co-pay and deductible reductions for optimal utilization • Incentives for healthy behaviors and health improvement • Continuity of care adjuster for long-term relationship with provider
Patient Centered Medical Home	<ul style="list-style-type: none"> • Care management payments (risk-adjusted per member per month) • Practice transformation payments • Pay-for-performance outcome incentives
Accountable System of Care: Level I	<ul style="list-style-type: none"> • Care management and practice transformation payments to the Patient Centered Medical Homes (as above) • Pay-for-performance outcome incentives • Shared savings upside risk (a percentage of shared savings returned to the Accountable System of Care) • Continuity of care adjuster
Accountable System of Care: Level II	<ul style="list-style-type: none"> • Care management payments (risk-adjusted per member per month payments) • Continuity of care adjuster • Shared savings with upside and downside risk (potential for increased shared savings payments with risk of loss) • Risk-adjusted partial capitation for assigned population and scope of service • Risk-adjusted global payment for specific high cost conditions
Community Health Innovation Region	<ul style="list-style-type: none"> • Local stakeholder investments (business, philanthropy) • Leverage public and private funding streams • Identify and test sustainable funding mechanisms, such as: <ul style="list-style-type: none"> ○ Social impact bonds ○ Community health improvement trust ○ Community benefit dollars

Patient Incentives for Healthy Behavior

Patient responsibility is an important attribute in Michigan’s transformed health system. As coverage expands, and patients who have been uninsured and without coverage seek health care, it is important that patients take personal responsibility for choosing a primary care provider or Patient Centered Medical Home, and that they commit to healthy behaviors. Michigan’s Blueprint strategy is to incentivize patients, where appropriate, to take on such commitments. Patients need to have support for improving their health and engaging in health care decisions. They also need healthy environments that support healthy lifestyles. The health system is designed to be person-centered and provide support to the individual and their family for taking greater responsibility for their health and health care decisions. The Patient Centered Medical Home will take an active role in educating and supporting patients in self-care management and coaching their patients on health behaviors. The Community Health Innovation Regions will address the nonclinical factors that impede improvements in health such as strategies that ensure a healthy built environment.

The Healthy Michigan Plan provides for coverage expansion under the Patient Protection and Affordable Care Act and incorporates the use of patient incentives as a way to reinforce and reward patients that are committed to improving their health and wellbeing, which in the long run reduces health care costs and

improves productivity and quality of life. It also reduces a portion of co-payments or deductible obligations of patients who demonstrate they are committed to healthy behaviors. Michigan Medicaid will work with other stakeholders to determine these incentives, which may be drawn from, and will in turn inform other payers' approaches to patient incentives. Michigan will innovate, test, and incorporate other financial and non-financial incentives as part of the overall strategy to engage patients, families, and communities in improving the health of Michiganders.

Care Management Payment

Care management payment is a pre-paid per member per month reimbursement methodology. Care management payments provide the necessary upfront financial resources for providers to carry out the substantial work of developing the care coordination system in the Patient Centered Medical Home for managing and coordinating care of a panel of patients. As such, the care management payment covers the workflow changes, data system, and invests in the staffing and data/information system resources necessary for the Patient Centered Medical Home to develop a care plan that meets a patient's unique needs and preferences. Primary health care services continue to be reimbursed through fee-for-service payments. The Blueprint builds on the Michigan Primary Care Transformation program care management reimbursement methodology that is employed for well-designed care management services that have demonstrated added value with better outcomes and cost containment.

Risk Adjustment

Risk adjustment of payments modifies revenue to providers based on the health status of their assigned population relative to the average health status of the entire population. Michigan will evaluate multiple models for risk adjustment before implementing a specific method, and will seek to constantly evaluate and calibrate risk adjustment in order to appropriately reward providers for serving patients at high risk. Current models of risk adjustment in Michigan are based on diagnostic groupers. This method of risk adjustment does not recognize the contributions that social determinants make to health status as well as health care utilization and thus spending. Accounting for the impact of social determinants of health is necessary in order to compensate practices who provide 'enabling services' or are otherwise exceptional at reaching socially/economically vulnerable populations.

Care management payments will be risk-adjusted based on the level of patient acuity and therefore the need for increased level of services from the Patient Centered Medical Home. Risk adjustment allows the Patient Centered Medical Home to provide the resources required for managing high-acuity complex cases without sacrificing resources available to low-risk patients. Risk adjusting care management payments will also incentivize Patient Centered Medical Home to manage patients with higher acuity and complexity. As part of the overall payment reform strategy, the Michigan Innovation Model Steering Committee will develop, update, and test a method for multi-payer risk adjustment of care management payment to assure confidence in the risk adjustment calculation.

Pay-for-performance

Pay-for-performance is a system of payment that rewards health plans and/or providers for achieving or exceeding pre-established benchmarks for quality of care, health results, and/or efficiency. Pay-for-performance is most often used to encourage providers to follow recommended guidelines or meet treatment goals for high-cost conditions like heart disease, preventive care such as immunizations, or avoiding an adverse or avoidable acute care event such as hospital readmissions. Many pay-for-

performance programs are designed to address health care underuse (e.g., inadequate preventive care) and overuse (e.g., unnecessary medical tests). Medicaid Health Plans currently receive performance payments based on plan-wide Health Care Effectiveness Data and Information Set scores. The Michigan Patient Centered Medical Home will continue to be based on the Michigan Primary Care Transformation demonstration, and therefore will continue with pay-for-performance payment mechanisms that use a common core set of clinical and utilization metrics that guide performance payments to physician organizations (80% of which are required to be re-distributed to the practice). The Accountable System of Care will align these measures, reducing the administrative burden on providers.

Shared Savings

Shared savings is a financial reward shared between the health plan/payer and contracted Accountable System of Care. The contracted Accountable System of Care is eligible to receive a percent of total savings based on a reduction of the total cost of care of their attributed patient population based on benchmarks defined in the contract. There is a quality performance requirement that must first be met to qualify for the shared saving award. The total amount of savings earned in the performance period (usually one year) may vary based on a number of factors, including cost trend used, baseline for total cost of care, number of beneficiaries in the pool, and percentage retained by the payer.

Shared savings is a transitional payment mechanism in the Blueprint. Shared savings with upside risk is only an initial payment method for those Accountable Systems of Care that chose Level I as a transitional step. Upside risk refers to a payment mechanisms in which a share of savings is a distributed to providers, who do not receive a bonus if no savings are realized, but face no financial penalty for failing to meet targets. As an Accountable System of Care matures, it will be able to manage a higher level of financial risk for a greater share of the savings. Level II Accountable Systems of Care demonstrate the ability to manage shared saving with downside risk, where participants face losses if costs are higher than the total cost-of-care target.

Table E.3 shows components of the shared savings methodology with recommended specifications.

Table E.3 Proposed Shared Savings Methodologies

Components for Determining Shared Savings	Shared Saving with Upside Risk Only	Shared Savings with Downside Risk
Minimum Population:	10,000	20,000
Total Cost of Care	Not including out of state costs stop loss at \$200,000	Including out of state stop loss at \$500,000
Shared Savings Risk Corridor	None	95% -105%
Shared Saving Breakdown	Accountable System of Care 40% Payer 60%	Accountable System of Care 70% Payer 30%
Shared Risk Penalty	None	Accountable System of Care 70% Payer 30%
Annual Cost Trend Factor	Regional adjusted base of 3.2%	Statewide adjusted base of 3.2%
Shared Saving Payout	Based on 12 months of continuous beneficiary affiliation with Accountable System of Care	Based on 12 months of continuous affiliation with Accountable System of Care

Continuity of Care Adjustment

The continuity of care adjuster is proposed as a scheduled payment adjustment uplift that rewards primary care providers and Patient Centered Medical Homes who maintain continuous and long-term relationships with patients. Patients that have a continuous long-term relationship with the same provider become less costly and more adherent to care management and treatment than those that have only a brief or episodic relationship with their primary health care provider.¹⁰ The continuity of care adjuster recognizes and financially rewards Patient Centered Medical Homes that show evidence of continuity with their panel of assigned patients. The continuity of care adjuster increases reimbursement over time to encourage long-term relationships. The continuity of care adjustment can be applied to the “Evaluation and Management” claims code for fee-for-service, or applied to the care management per member per month payment for Patient Centered Medical Homes. To earn a continuity of care adjustment, the primary care provider must have the patient as part of their panel for the previous 12-month period, and have provided at least one preventive or medical visit during the previous year. Patient Centered Medical Homes must also have a care management or wellness plan for each patient in their assigned panel. There should be evidence that the care management plan has been discussed with the patient to qualify for the continuity of care adjustment.

Table E.4 summarizes how the continuity of care adjustment will be implemented as part of Michigan’s overall payment reform strategy, with recommended specifications.

Table E.4 Continuity of Care Adjustment		
Component	Primary Care Provider	Patient Centered Medical Home
Adjustment scheduled for every 12 months of continuous relationship	Adjustment to E & M code for qualifying patients: First Year: 5% Second Year: 10% Third Year: 15% Fourth Year and beyond: 20%	Adjustment to care management per member per month or uplift payment for qualifying patients: First Year: 5% Second Year: 10% Third Year : 15% Fourth Year and beyond: 20%
Qualification Events	One (1) preventive visit or evidence of medical management of patient during the previous 12-month period	Updated care management plan and either 1 preventive visit or medical management of episode of care during the previous 12 months
Disqualifying Events	Failure to meet quality of care minimums	Failure to meet quality of care minimums, no evidence of care plan, poor patient experience scores

Partial Capitation

Partial capitation¹¹ is a payment option under which an Accountable System of Care takes financial risk for a defined set of services covered by a health plan, while some services remain fee-for-service. For example, partial capitation may pay only for primary care services, but not specialty or hospital care. Alternatively, specialty care could be paid on a partial capitation basis, with primary care paid fee-for-service. In the Accountable System of Care, partial capitation could be introduced such that providers would be placed at financial risk for some but not all services. To be eligible for partial capitation, the Accountable System of Care must be at Level II and have demonstrated the ability to successfully manage shared savings downside risk. Partial or global capitation requires health system integration at a level for the Accountable System of Care to be able to manage care, utilization, and cost of services across the delivery system.

Table E.5 below shows recommended requirements for partial capitation based payments methods.

Table E.5 Partial Capitation	
Component	Requirement
Accountable System of Care Level	Accountable System of Care Level II
Scope of Service	Based on health plan primary care, specialty, and acute care benefits
Payment Amount	Based on the total cost of care for similar population within Michigan adjusted for 90% of annual cost
Population Minimum	20,000
Stop Loss Protection	\$500,000
Performance Minimum Withhold	Must meet quality and population health performance to qualify for receiving performance withhold
Risk Adjustment	Prospective risk adjustment based on health assessment and acuity
Performance Incentive	Performance incentive based on quality and population outcomes
Community Linkages	Must have evidence of linkages with community resources and services.
Community Engagement	Must have relationship with Community Health Innovation Region
Contract Period	Minimum of one year

Although, to date, the Centers for Medicare and Medicaid Services have not taken advantage of paying partial capitation to Accountable Care Organizations for Medicare beneficiaries, the Affordable Care Act does authorize the Centers for Medicare and Medicaid Services, at its own discretion, to utilize partial capitation for part A and/or part B services to Medicare beneficiaries assigned for that year. The Affordable Care Act states that, under the partial capitation model, the Centers for Medicare and Medicaid Services should establish the partial capitation payment in a manner that does not result in spending more for provided services for such beneficiaries than would otherwise be expended had the model not been implemented. The Affordable Care Act requires that Centers for Medicare and Medicaid Services establish criteria that Accountable Care Organizations must meet to qualify for partial capitation. The criteria must include a determination that an Accountable Care Organization is capable of bearing financial risk, as determined to be appropriate, for the type of beneficiaries assigned. In order to implement the Blueprint, the Policy and Planning Office will work with Medicaid and other payers to define the qualifying criteria for a Level I and Level II Accountable System of Care and negotiate with Centers for Medicare and Medicaid Services to pay Accountable Systems of Care using Michigan’s partial capitation model.

A partial capitation payment model for Accountable Systems of Care could be structured in a way that would address the problems often mentioned by provider organizations about the current Centers for Medicare and Medicaid Services shared savings model. It is believed that a partially capitated model could help Centers for Medicare and Medicaid Services achieve greater cost savings for the Medicare program than shared savings, and do so without requiring changes in the benefit structure for Medicare beneficiaries. Moreover, this could be done in a way that uses the same types of methodologies for risk adjustment, quality measurement, etc. that will be used in the shared savings approach, thereby

minimizing the extent to which Centers for Medicare and Medicaid Services or other payers need to develop new regulations, data systems, etc. to implement the partial capitation model.

Partial capitation payments are designed to incentivize Accountable Systems of Care and their providers to:

- Promote cost-effective prevention, early intervention, care management and cross-sector care coordination
- Innovate patient-centered care approaches, apply new health information technology solutions, engage patients and utilize self-care management tools, and eliminate non-value-added services and processes
- Use health data to improve clinical and patient decision making
- Reduce excess health care system utilization and unjustified or unnecessary cost
- Integrate home- and community-based resources and services
- Eliminate avoidable or unnecessary acute care and specialty service utilization and cost

Global Payment for High Cost Complex Conditions

Global payments also are known as risk-adjusted global budget or risk-based global capitation. Health economists and others are increasingly examining global payments as an important strategy to slow growth of health care expenditures.¹² A 2008 *New England Journal of Medicine* article examining health care cost control options concluded, “The most potent version of payment reform is budget-based capitation, or a global payment to cover all health care needs of a population of patients.”¹³

A global payment is a fixed prepayment made to an Accountable System of Care that covers most or all of a patient’s care during a specified period for a specific high-cost chronic condition and for specific services. Global payment rates are based on the equivalent fee-for-service costs of the specified services and population covered. Global payments are usually paid monthly based on the number of patients that have the qualifying condition. Unlike fee-for-service, which pays for each service or procedure after they are performed, a global payment is pre-paid, and includes all the required services, equipment, and procedures in the global payment. The Blueprint anticipates the use of global payment for the management of specific high cost and complex conditions. Global payments can cover the primary care, specialty, diagnostic tests, hospital, and sub-acute services specific to the treatment of the condition. The health plans and other payers will contract with Accountable Systems of Care when there are enough patients that have a qualifying condition. The Accountable System of Care is at risk for costs above the global payment. Global payments are appropriately risk-adjusted to reflect the levels of health risk segmentation or acuity levels in the assigned patient group. Global payment provides an incentive for providers to coordinate, engage the patient in the care process, and deliver care efficiently and effectively to hold down unnecessary health care costs.

Some similarities exist between global and episode-of-care payments. In both cases, payment is provided for a defined set of care procedures and services over a specified period. The major difference is that global payments are made for a long period on behalf of a group of patients who have chronic conditions that must be managed through their life span (e.g. Human Immunodeficiency Virus). Bundled- or episode-of-care payments are primarily for a specific medical condition and specific period of treatment with a set beginning and end. Global payment is also similar to risk-based partial capitation, but partial

capitation is used to pay for a group of beneficiaries, not for specific conditions. Global payment methodologies usually are based on an actuarial estimate of the amount of equivalent fee-for-service costs and utilization, plus any adjustments necessary to treat a specific condition. Global payment can also be based on a specific total budget or on a negotiated global rate. The downside financial risk for the Accountable System of Care is that if the cost is above the global payment reimbursement, they are responsible for the difference. Recommendations for Michigan’s global payment requirements are described in the table E.6 below.

Table E.6 Global Payment Recommendations	
Component	Requirements
Accountable System Level	Accountable System of Care Level II
Scope of Services	Primary care, specialty, and condition specific hospitalization and other services
Minimum Population	5,000 affiliated beneficiaries
Payment Method	Global payment based in discount against estimated total cost of care for population with similar conditions
Stop Loss Protection	500,000
Performance Withhold	10% performance withhold for minimum level of quality, patient experience, and population health performance
Performance Incentive	10% quality and population performance incentive based on performance target levels.
Community Linkage	Evidence of appropriate linkages to community resources
Community Engagement	Evidence of engagement with Community Health Innovation Region
Contract Period	Minimum one year

Global payments are designed to incentivize Accountable Systems of Care and their providers to:

- Promote cost-effective prevention, early intervention, care management and cross-sector care coordination
- Innovate patient-centered care approaches, apply new health information technology solutions, engage patients and utilize self-care management tools, and eliminate non-value-added services and processes
- Use health data to improve clinical and patient decision making
- Reduce excess health care system utilization and unjustified or unnecessary cost
- Integrate home- and community-based resources and services
- Eliminate avoidable or unnecessary acute care and specialty service utilization and cost

These goals are accomplished by holding providers in the Accountable System of Care mutually accountable and responsible for patient experience, quality, and population health outcomes. With global payments, the financial success of the Accountable System of Care is achieved by eliminating waste and controlling unnecessary utilization and costs. Such payments also provide the revenues necessary to invest in health information technology, performance analytics, care management infrastructure, and

Patient Centered Medical Home capacity and capability, as well as primary care capacity and geographic distribution. Global payments incentivize health improvement rather than sick care.

Sustainable Funding for the Community Health Innovation Region

The Community Health Innovation Region requires sustainable funding to support its essential functions including ongoing funding for the backbone infrastructure, community engagement, community assessment, strategic planning, and execution of strategic priorities. To assure sustainability and demonstrate that local stakeholders are committed, Community Health Innovation Regions must secure financial support from a broad base of local funding sources, for example, Community Benefit funding, health plans, business, and philanthropy. The Community Health Innovation Regions must also demonstrate an ability to leverage public and private funding streams to support ongoing operations and population strategies. With a demonstrated return on investment, Community Health Innovation Regions could secure other sustainable funding sources. New payment mechanisms will be tested including community health trusts and social impact bonds.

A community trust fund is created by a pre-payment by the relevant stakeholders (such as payers, health systems, business) for improving community health and reducing community health risk factors that increase health care cost and impact the quality of life and productivity of Michiganders. The community trust, funded based on the number of covered beneficiaries that live a region, is accountable for public reporting of spending and outcomes achieved. If Michigan were to adopt Medical Loss Ratio requirements for Medicaid contracted health plans, payments to the community trust by those plans would be considered medical costs rather than administrative expenses.

Social Impact Bonds are a public-private form of financing in which private investors finance the upfront costs of social programs, and are repaid if the programs demonstrate savings. Michigan was selected to receive technical assistance from the Social Impact Bond Technical Assistance Lab at Harvard Kennedy School to explore the use of Social Impact Bonds.¹⁴ Social Impact Bonds can be incorporated into pilot testing for the Innovation Model to test sustainable funding streams for the Community Health Innovation Regions.

E5. Health Information and Process Improvement Infrastructure

Most infrastructure and process improvement investments will be made at local levels (for instance as Accountable Systems of Care implement network-wide electronic health records, enroll in health information exchange organizations, and engage practice coaches or quality improvement consultants). There are three areas of infrastructure investment that are recommended to be made at a central level in order to implement the Blueprint. These relate to the Policy and Planning Office Innovation Model Steering Committee, performance measurement and recognition committee, and central health information technology.

Policy and Planning Office

The Policy and Planning Office within the Michigan Department of Community Health will oversee the implementation of the Blueprint. In doing so, it will: 1) coordinate the many state policy levers that will

drive participation in the Model as well as the infrastructure investments to support it, and 2) provide overall accountability for implementation and evaluation of the Blueprint.

The Michigan Department of Community Health oversees the following areas, which will facilitate the coordination of different agencies necessary to implement the Blueprint.

- **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
- **Public Health 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 Community Health Innovation Regions
- **Behavioral Health and Developmental Disabilities Administration**
Directs delivery of publicly funded mental health, developmental disabilities, and substance abuse services
- **Office of Services to the Aging**
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 related to model implementation

In addition, the Policy and Planning Office will coordinate programming with the Office of the State Employer, Department of Human Services, Department of Education, and the Department of Corrections. The Office will participate in existing Departmental collaborations with the Departments of Agricultural and Natural Resources, Environmental Quality, and Transportation to promote a “health-in-all-policies” approach to health system improvement.

Key administrative functions of the Policy and Planning Office for implementing the Blueprint will include:

- Assuring that adequate resources and support are available for health system transformation.
- Conducting tests of the proposed models in a culture of continuous learning, including rapid-cycle evaluation and improvement action
- Monitoring Blueprint implementation and outcomes, and evaluating and disseminating models that work
- Implementing dashboards with transparent performance measures and quality rankings
- Supply technical assistance and expertise in identified areas that need improvement
- Encouraging health care innovation, such as application of remote and mobile technologies, telecommunication, care management and coordination processes, integrated use of electronic health records and personal health record systems that improve communication and coordination, and enhance patient engagement and reduce administrative cost and burden.

In performing these functions, the Office will harness resources within Michigan businesses, Michigan's research universities, and non-profit organizations with a track record for promoting system transformation.

Steering Committee

The Policy and Planning Office will convene a multi-stakeholder Steering Committee to guide implementation of the Blueprint. This Innovation Model Steering Committee will include stakeholders such as consumers, purchasers, payers, providers, State and local government, philanthropy, and community members. This will assure that the system is designed with the knowledge and experience of those who work on the front lines, facilitate ownership for the new models of care, and accelerate statewide deployment and sustainability. The process of continuous learning will encourage ongoing transformation that ensures that the Blueprint is updated to address changes in priorities and needs at the local level, as well as to support ongoing innovation and drive alignment across payers and health systems. The Office retains ultimate responsibility for implementing the Blueprint.

Performance Measurement and Recognition Committee

In addition to the Innovation Model Steering Committee, the Policy and Planning Office will establish and maintain a permanent multi-stakeholder performance measurement and recognition committee that engages key stakeholders in the design, monitoring, refinement, and reporting of common performance metrics. Michigan stakeholders strongly support developing a core set of common performance measures to reduce the administrative burden on providers who are currently accountable to varying performance outcomes, increasing administrative complexity, and mixed and diluted performance incentives and signals. Stakeholders also support information transparency to assist consumers, payers, purchasers, and providers to make better choices.

Performance measures are key to the success of large-scale health system transformation under the following conditions:¹⁵

- There is active participation of all relevant stakeholder groups to set the core measures
- There are incentives for acting on feedback from reported measures
- The feedback from measures is timely so as to impact provider behavior
- The measures are applied consistently across the system
- There is confidence in the validity of the measures selected
- The stakeholders can influence the measures over time as they are revised and improved

Measures will include both health care delivery and population level performance measures, and will recognize and reward achievements in areas such as infrastructure development, clinical quality, cost of care, coordination of care, and patient experience of care. The process of developing and updating the measures will be transparent, and will generate broad confidence among providers who are accountable to the measures.

This committee will be comprised of relevant stakeholders from private and public sectors, including representatives from Accountable Systems of Care, Community Health Innovation Regions, purchasers, payers, providers, State and local government, and health care consumers. The over-riding charge of this

committee will be to develop, implement, evaluate, and update a core set of performance measures to be used for the performance incentive payment component of Michigan’s Blueprint for Health Innovation.

Additional duties of this committee will be to review recognition criteria relating to defining and designating Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions, always working towards increasing alignment and decreasing administrative complexity.

Core Data Infrastructure

Michigan has invested in projects that will support a high quality information and improvement infrastructure. However, additional investments are required to enhance connectivity, usability, and efficiency of health information exchange for care coordination, as well as aggregation of claims and clinical data to support measurement of the value of care at the provider, practice, Accountable System of Care, and community levels.

Infrastructure that will be enhanced includes:

- Health information exchange and the State of Michigan Data Hub – especially Michigan’s shared services infrastructure including a health provider directory to track provider affiliations to Patient Centered Medical Homes and Accountable Systems of Care
- Collection and aggregation of cost and quality data from multiple payers and sources
- Mechanisms to prominently display progress towards overall Innovation Model goals
- Mechanisms to provide ratings and non-financial rewards to top-performing Accountable Systems of Care and Community Health Innovation Regions

The first two items are further described in chapter F. In regards to the third and fourth, it is believed that there are a number of non-financial rewards that will drive patients, providers, purchasers, and plans to choose value over volume in health care. Specifically, Michigan’s core data infrastructure will be leveraged in support of:

- Public reporting of provider and delivery system performance
- Public recognition programs that include profiling and performance rating of Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions

Summary

This chapter has described Michigan’s proposed service delivery and payment models to achieve the aims of population health, better care, and lower cost.

Patient Centered Medical Homes address patient needs: clinicians are more accessible, care teams engage patients to work together on their health, and they monitor their patient population to assure that everyone is getting the care they need.

In **Accountable Systems of Care**, providers organize so that they can communicate effectively; coordinate patient care across multiple settings, and make more efficient investments in the data analytics and technology to improve care. Through clinical integration – with formal governance and contractual relationships – providers co-create tools, workflows, protocols, and systematic processes, to provide care

that is accessible to patients and families, that supports self-management, is coordinated, and incorporates evidence-based guidelines. Managing the health of a population requires investments in health information technology, data systems, and analytics. As these capacities are strengthened within an Accountable System of Care, the system can be held responsible for performance in terms of quality of care and the health outcomes of their assigned population.

In **Community Health Innovation Regions**, partners act cohesively for community-wide impact to make the environment healthier and to connect health services with related community services. The process begins with a collaborative community health needs assessment that identifies key health concerns, root causes of poor health outcomes, and sets strategic priorities. Action plans are developed that organize and align contributions from all partners in order for collective impact.

Payment models are designed to incentivize value over volume – aligning the interests of patients, communities, primary care providers, specialists, hospitals, payers, and policy makers towards universal aims of population health, high quality health care, at an affordable cost. To do this, a staged approach to payment reform is proposed in which Patient Centered Medical Homes and Accountable Systems of Care are encouraged to move away from fee-for-service and add capacity for coordinated care and responsibility for outcomes.

Statewide infrastructure responds to patients, providers, communities and payers, and in turn, provides governance for the implementation of the model. State government must align policy, payment, and programming to reinforce the model elements and incentivize the desired outcomes. The state is a major purchaser of health care services for Medicaid beneficiaries, and for its own employees. The state has an important role in guiding investment in shared infrastructure and promoting practice transformation through statewide data monitoring, evaluation and dissemination. It establishes systems to monitor and reward performance, and disseminate information, including recognition of top performers.

The foundations are in place in Michigan to have a system of care that meets the vision and goals put forth by the State Innovation Model advisory committee. However, multi-payer payment models and other levers must be put in place to align behavior and organizational capacity to meet the goals of high quality, accessible, coordinated care that is integrated with community systems for population health. These will ensure that Michigan's system simultaneously improves population health and experience of care while reducing waste, unnecessary administrative complexity, and cost.

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Chapter F: Health Information Technology and Michigan's Blueprint for Health Innovation

F1. Technological Foundation of Health Information Exchange

Michigan's Blueprint for Health Innovation builds on Centers for Medicare and Medicaid Services and Office of the National Coordinator for Health Information Technology initiatives like the Medicare and Medicaid Electronic Health Record and Meaningful Use incentive programs, the Michigan Medicaid Health Information Technology State Plan, the Michigan Health Information Exchange Cooperative Agreement Program, the Regional Extension Center, the Beacon community, and current investments in health information exchange in order to achieve person-centered, community-based coordinated care that will contain costs. This approach allows flexibility for developments in the system over time as part of the continuous improvement process. Many functions and capabilities envisioned in the Innovation Model are dependent upon technology, and the Blueprint will support leveraging the current system while addressing gaps and barriers that prevent appropriate health information exchange. Patient Centered Medical Homes will be required to manage their assigned populations and are primarily responsible for maintaining patient registries. Accountable Systems of Care will need to ensure that the participating providers are exchanging information necessary for coordinating care and managing utilization, as well as for complex case management. Accountable Systems of Care must have sophisticated data systems and on all their enrolled patients in order to manage risk. Community Health Innovation Regions will be asked to maintain community resource information to further the community integration of health care, and to perform community needs assessments.

To date, a key driver of investment in electronic health records and health information exchange has been the need to meet Meaningful Use program requirements in order to qualify for incentive payments. The stage two rules for Meaningful Use will increase requirements that health information technology vendors must follow. The State does not intend to place additional rules on providers to dictate how they must store or exchange data. Rather, the Innovation Model introduces a value proposition: if providers are paid for value, those who are successful will adopt the health information technology that helps them meet health, quality, and cost goals. Software vendors and health information exchange organizations will then be oriented to providing solutions help providers reach those value targets.

However, this value proposition may be insufficient to ensure that vendors are responsive to provider's needs. The lack of standards in electronic health records means that once a provider has chosen a particular solution, their options for upgrades and for health information exchange may be limited. Moreover, the premise behind the creation of Michigan Health Information Network Shared Services is still true – it is more efficient to build core infrastructure at a central level instead of multiple times to meet similar needs. The Blueprint includes a governance structure that employs a rapid-cycle improvement process to identify barriers to health information exchange as experienced by providers on the front lines. Once surfaced, the Policy and Planning Office can leverage partnerships in the public and private sector, as well as the state-designated entity for health information exchange (Michigan Health

Information Network Shared Services), and other policy levers, to provide solutions. The Policy and Planning Office may also pursue technical assistance resources to assist Accountable Systems of Care and Community Health Innovation Regions to share and learn about optimal information technology solutions.

When developing goals for the Blueprint for Health Innovation and describing the characteristics of the transformed service delivery and payment models, the health information technology infrastructure was often discussed as a vital component. Care coordination for medically complex individuals and accountability are both believed to rest on the further adoption of electronic health records and health information exchange. An electronic common care platform is being implemented for the Integrated Care for Persons Dually Eligible for Medicare and Medicaid demonstration project, which may provide examples for other communities developing systems to effectively deliver the right care, at the right time, in the right place and by the right provider. Addressing inappropriate utilization will also require the ability to examine an individual's interactions with multiple providers, facilitated by health information exchange. The evidence base for all innovation can be disseminated most efficiently through new electronic media options, including clinical decision support modules for electronic health records. The primary care workforce will be supported by efficient electronic health record or practice management systems, which can streamline administrative functions such as billing and insurance-related tasks. Information systems can also automate reporting of quality measures and outcomes for payment incentives, and the reporting of reportable conditions that will strengthen the capacity of public health.

In order to achieve these goals, there are three areas of investment that need to be addressed, to be further refined during the next few months of planning.

- Further development of statewide health provider directory and attribution services that:
 - Describe the demographic profile of the provider and practice
 - Allows for the association of providers to practice units and Accountable Systems of Care
 - Helps providers make referrals and follow up on results, including non-traditional providers
- Further development of a statewide identity management service that:
 - Describes the demographic profile of the person
 - Allows for the attribution of persons to primary care providers and Accountable Systems of Care
 - Provides a source of truth for linking disparate data source records to an individual
- Standardized reporting of cost, quality, and outcome data that allows for robust data analysis and that will support a performance recognition program

Barriers to Robust Health Information Exchange

Michigan has an active and engaged community working collaboratively to realize the promise of robust health information exchange. Much of the discussion of how health information technology and information exchange would support the Innovation Model revolved around enabling the right data to be shared at the right place and time. The usefulness of electronic information exchange between providers is an underlying assumption when discussing coordinated care for individuals. Without a full picture of the individual's current health status, treatments, and environment, it is impossible to reach the best decisions regarding acute care, health management, services and supports coordination, or ongoing prevention and wellness.

Results from medical tests, recommendations, and referrals are all data elements that need to be effectively shared in order to achieve better care and health outcomes. Effective sharing means that the right information is available to the right person at the right time. The Centers for Medicare and Medicaid Services Electronic Health Records Incentive program is increasing the use of electronic health records by providers throughout the state. This adoption is resulting in a great deal of information being captured and stored digitally; however, there are still many barriers to the seamless flow of that information. These barriers fall into several different categories. The Blueprint addresses those barriers by coordinating the many health information technology and exchange activities in the State, in order to more rapidly spread lessons learned and benefit all residents.

The lack of uniformly adopted standards for electronic health information storage and exchange was identified as a major barrier. The proliferation of electronic health record systems that are not able to communicate with each other has opened up a market for business to help move information, called health information exchanges. This arrangement has become quite complex, as these entities do not have a common approach to data segmentation, privacy, and security. State-level standards for data and data exchange were often cited as a necessary requirement to facilitate the best health care and to improve data analytics. The Blueprint calls for collaborative decision-making about the adoption of standards, including those adopted by the United States Department of Health and Human Services for Administrative Simplification, and the Meaningful Use of Electronic Health Records.

Performance targets and quality measures also need to be standardized in order to reduce administrative complexity and to realize cost savings in the transformed health system. The Performance and Recognition Committee that will be created by the Policy and Planning Office will reduce the burden on providers by streamlining the reporting of these indicators. This group will likely need to form a subcommittee to look at the data standards and formats of this reporting to maximize the potential of this data collection. Coordinating Innovation Model testing with this process will provide greater insight into the best ways to collect and disseminate information that will bring maximum benefits to the people of Michigan through the improvement in care delivery and the reduction of administrative costs.

Under the Centers for Medicare and Medicaid Services Electronic Health Records Incentive Program, eligible providers in Michigan have received over \$180,000,000 toward installing electronic health record systems. However, individual practices bear the cost of implementing electronic health records, and patient demand may not be present. There is a cost to changing practice flow, even when the changes do lead to greater efficiencies. The immaturity of the electronic health record market and health information exchange means that many practices do not realize these efficiencies or a return on investment in the expected timeframe. During the advisory committee meetings and the health information technology-health information exchange work group meetings, stakeholders shared stories about the disillusionment among providers who dislike their systems. Many felt that providers have invested a great deal of time and money into customizing a system for their practice only to find that the system is therefore too unique to be upgraded to keep pace with changing needs, or to communicate with other systems. The State Innovation Model is an opportunity to build off of existing health information technology federal funding from the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for

Health Information Technology to further promote and support Michigan’s electronic data sharing plan at the provider level.

In order to have effective health information exchange in Michigan, questions about who owns the information, where it is stored, how protected it is, who can see it, who can amend it, and what to do to correct it all need to be addressed. The Policy and Planning Office will work with the Health Information Technology Office, the Health Information Technology Commission, Security Office, and legal counsel to ensure the best governance of data being exchanged to support the transformed service delivery and payment models.

F2. Coordinating Health Information Infrastructure Activities

Stakeholder collaborations described in chapter B have already started coordinating health information exchange activities. The activities of Michigan Health Information Network Shared Services, as well as other initiatives funded by the American Reinvestment and Recovery Act of 2009, are overseen by the Health Information Technology Coordinator. This office was created in the Department of Community Health in the same legislation that created the Health Information Technology Commission in 2006. The Health Information Technology Commission is an advisory committee to the Michigan Department of Community Health and the Michigan legislature, and its mission is to facilitate and promote the design, implementation, operation, and maintenance of an interoperable health care information infrastructure in Michigan. Each of the 13 gubernatorial appointed commissioners represents a different type of health system stakeholder, including the Department of Community Health and the Department of Technology, Management, & Budget. Staff from Medicaid and representatives of the many federally-funded and state partnership projects participate in the meetings and provide status updates on a regular basis. These meetings are public, and provide an opportunity for many different voices to contribute to the development of health information exchange in Michigan.

Implementing Michigan’s Blueprint will strengthen the voice of the front-line user of health information technology. Management of Blueprint implementation will be housed within the Policy and Planning Office, and will work with the Health Information Technology Office and Medicaid Health Information Technology Department. The Blueprint for Health Innovation calls for a rapid-cycle innovation approach in which providers, patients, and other stakeholders are engaged in a culture of learning. The evaluation plan described in chapter I relies on feedback loops that capture local learning and communicate it to planners in Accountable Systems of Care, Community Health Innovation Regions, and the Innovation Model Steering Committee.

The Medicaid Health Information Technology Office also convenes stakeholders involved in promoting electronic health record adoption, Meaningful Use, and health information exchange on a monthly basis. This is an informal, information-sharing opportunity for representatives from the Regional Extension Center, Southeastern Michigan Beacon Community, Michigan Health Information Network Shared Services, Medicaid electronic health record incentive program staff, state information technology systems personnel, evaluation contractors and other interested parties. Participants discuss current activities, and collaborate to solve issues or share lessons learned. Together with the Health Information Technology

Commission and the Michigan Health Information Network Shared Services' workgroups, this standing collaboration helps coordinate the health information infrastructure activities within the state.

Michigan's information exchange strategy includes multiple health information exchanges - regional, specialized, profit and nonprofit - with the state-designated entity, Michigan Health Information Network Shared Services providing shared services that allow them to work together. The Michigan approach to data exchange leverages Michigan Health Information Network Shared Services to advance the use of health information technology and health information exchange. This approach also allows for competition and innovation beyond what would be possible in a state-controlled, public utility model. The Innovation Model Steering Committee will coordinate with this structure already in place.

F3. Reaching All Providers

Michigan's progress toward health information technology adoption and health information exchange is well underway. Technical assistance and some financial incentives may be deemed necessary to accelerate testing of Michigan's Blueprint.

Rural Providers

Although Michigan is an urban state, the promise of health information exchange in enhancing rural practices has not been neglected. Michigan Health Information Network Shared Services took the lead through a capacity-building grant project and helped expand the services and geographic coverage of operational sub-state health information exchange entities to ensure that every provider has access to at least one option for health information exchange. Michigan also participated in the Federal Communication Commission's Rural Broadband Initiative to extend miles of fiber optic cable through rural areas. Local public health, schools, or other providers of health care services who qualify can now connect to reliable internet services, but some challenges remain. It is difficult for internet service providers to be self-sustaining in rural areas because the market is not yet very strong, which creates last-mile issues. The Healthcare Connect Fund is available to help rural providers pay for connectivity, and the Healthy Michigan Medicaid expansion plan allows for the provision of services via telehealth, with the goal of increasing health information exchange in rural areas in the next few years.

Small Practices

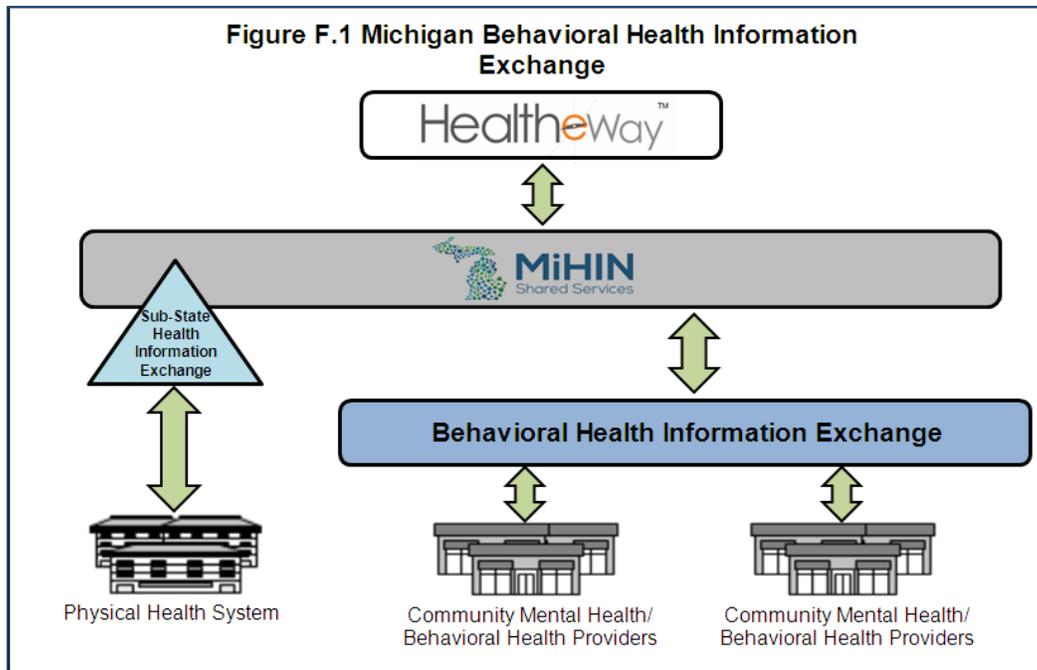
As the promise of administrative simplification, clinical decision support, and care coordination is fulfilled as the technology matures, small providers will become more interested in adopting health information technology. The Regional Extension Center's activities have begun to open a market for groups who can assist with electronic health record implementation and practice transformation, which is also necessary for other federal eHealth mandates for administrative simplification. As Accountable Systems of Care are incentivized to incorporate small practices within their network, they will want to help the practices implement technology that supports collaboration within the system. Many physician organizations and health systems have built relationships with the Regional Extension Center – who could continue to assist the Accountable System of Care with electronic health record implementation and optimization in small practices. Existing programs provide financial support for infrastructure investment at the practice level, including Patient Centered Medical Home payments and Meaningful Use incentives.

Behavioral Health Providers

The Michigan approach to data exchange opens up a path for innovative approaches. Michigan Health Information Network Shared Services has convened a privacy work group to examine consent issues that will help facilitate appropriate information exchange between physical and behavioral health care providers. A virtual qualified organization (an entity with a legal agreement to exchange data through Michigan Health Information Network Shared Services) has launched a behavioral health gateway service specific to behavioral health information in order to streamline the realignment of complicated privacy, security, and governance issues surrounding this type of information.

While the inclusion of behavioral health and substance abuse information would improve care, the unresolved policy issues remain a challenge. Michigan has very stringent laws protecting mental health information (as well as some other health conditions), and there are additional federal protections for most types of substance abuse health information. All providers are required to comply with the Health Insurance Portability and Accountability Act of 1996. However, the Health Insurance Portability and Accountability Act generally excludes psychotherapy notes without authorization (45 C.F.R. § 164.508(a)(2)). The Federal Substance Abuse Confidentiality Regulations also add restrictions to the sharing of health information regarding treatment related to substance abuse (42 C.F.R. Part 2). In addition, Michigan laws governing mental health records and substance abuse treatment are also more stringent than the Health Insurance Portability and Accountability Act. As a result, the electronic exchange of certain types of health information must meet additional consent requirements (such as pen-on-paper signatures). In order to address the policy and technical issues, the Michigan Health Information Network Shared Services privacy workgroup is collaborating with the Mental Health Diversion Council and numerous other stakeholders to develop a “universal consent form” for the electronic exchange of behavioral health information that addresses all of the state and federal legal requirements.

Michigan is also requesting federal financial participation to build a Behavioral Health Gateway Service into the Medicaid Enterprise to enable the secure exchange of information between Community Mental Health programs, Medicaid Health Plans and community hospitals. This will bring the behavioral health community into the state infrastructure for information exchange. Other initiatives, such as the Integrated Care for Persons Dually Eligible for Medicare and Medicaid Demonstration Project and groups discussing behavioral health homes are testing innovative new ways to help behavioral health providers utilize health information exchange. Figure F.1 shows how protected information can be safeguarded through a restricted gateway and shared appropriately.



F4. Medicaid Management Information Systems Impacts

Michigan has been investing in the expanded concept of the Medicaid Enterprise by leveraging the Medicaid Information Technology Architecture in order to move ahead with infrastructure critical to innovations in care delivery, quality improvement, and cost savings. The Community Health Automated Medicaid Claims Processing System is integrated into the Medicaid Enterprise. Much of the state’s progress in the Medicaid Information Technology Architecture maturity model mirrors what is needed for Michigan’s Blueprint. Changes to provider enrollment and management, member management, case management, and claims adjudication may be needed to accommodate negotiated changes to the payment models, but in general, Michigan’s Blueprint implementation needs dovetail with Medicaid Information Technology Architecture changes and other functionality enhancements.

F5. Cost Allocation Plan

Capital investments into Michigan infrastructure are usually a combination of general fund appropriations, grants, and federal financial participation. Ongoing costs are paid on a service level agreement plan where users pay for a proportional share of the costs based on transaction volume. Costs to implement Michigan’s Blueprint for Health Innovation will be allocated in three ways: 1) to the Accountable Systems of Care and participating practices for the adoption of health information technology and health information exchange, 2) using existing funding streams that support central Medicaid Management Information System functions, and 3) utilizing grant funds to support investments that are necessary and specific to the Blueprint.

In regards to expenditures made at the Accountable System of Care level on health information technology, these are expected to be borne by the individual Accountable System of Care. The proposed payment models alter the value proposition for investment in health information technology and health information exchange. Accountable Systems of Care will financially benefit from technology that improves efficiency and lowers the costs to providing care, and will make the investments that have the most value.

The other types of cost are those which are incurred as part of Michigan's model for health information exchange and enhancements to the Medicaid Enterprise. Examples include enhancements to the Enterprise Data Warehouse that are funded by Centers for Medicare and Medicaid Services through federal financial participation in design, development and implementation activities and ongoing maintenance. Funding for infrastructure investments will only be allocated if modifications are specifically designed to meet Blueprint requirements.

Some infrastructure investments, including those mentioned above, may be required specifically to accelerate testing innovations in the Blueprint. These one-time costs will be paid for using State Innovation Model testing grant funding (if successful). Community Health Innovation Regions will also be testing new funding partnerships for information systems that promote community health.

The following table illustrates the many interdependent impacts of health information technology and health information exchange on health system transformation envisioned in Michigan's Blueprint. In some cases, the Blueprint is dependent on decision points that will occur as health information exchange matures in the state. In others, investments made to accelerate testing of the Innovation Model will help develop health information exchange throughout Michigan.

Table F.1 Health Information Technology in the Reinvented Health System

Model Component	Role	Technology Supports	How Michigan Blueprint Addresses
Patient/ Consumer	<ul style="list-style-type: none"> • Shared decision-making • Value-based health choices • Engaged in care and receive health education • Self-care management • Demand secure, appropriate exchange of personal health information 	<p><i>Secure, trusted, easy-to-use</i></p> <ul style="list-style-type: none"> • Electronic personal health record • Patient portal to view personal health information stored in provider systems • Patient decision support tools (possibly mobile) • Health education applications (possibly mobile) • Online scheduling and communication with providers • Cost, quality and performance data available to the consumer 	<ul style="list-style-type: none"> • Market-driven choice of personal health record technology • Leverage Meaningful Use patient portal requirements • Consumer engagement strategies/leverage Medicaid mobile Blue Button engagement tool • Leverage patient-driven data sharing – Mi-Way consumer directory service in development for the Medicaid Enterprise • Provider performance dashboards available beginning in 2015 • Data sharing consent outreach and education provided by State implementation staff
Patient Centered Medical Home	<ul style="list-style-type: none"> • Care management • Care coordination • Care planning • Shared decision-making • Use of best evidence in clinical decision-making • Meet quality and performance targets • Community linkages 	<ul style="list-style-type: none"> • Electronic health records • Care management documentation templates • Health information exchange interface • Clinical decision support integrated into electronic health record system • Quality reporting tools • Patient registry and analytics • Interface with community resource database where available 	<ul style="list-style-type: none"> • Pursue incentive payments and Meaningful Use requirements to encourage adoption of electronic health records system and health information exchange, supported by Accountable Systems of Care • Deploy enterprise identity management • Collaborative, statewide, multi-payer approach to standardizing reporting • Prospective payments for infrastructure investments

Table F.1 Health Information Technology in the Reinvented Health System

Model Component	Role	Technology Supports	How Michigan Blueprint Addresses
<p>Accountable Systems of Care</p>	<ul style="list-style-type: none"> • Care management/coordination support • Health information technology and practice optimization assistance • Support health information exchange interfaces with provider electronic health records • Performance data reporting • Support community linkages • Support patient portals and electronic personal health record 	<ul style="list-style-type: none"> • Health information exchange • Enterprise patient registry and analytics • Performance database and analytical tools • Quality improvement data analytics • Interface with community resource database where available • Tools to securely report standard quality and performance metrics 	<ul style="list-style-type: none"> • Legal agreements facilitating integration and information exchange • Accountable System of Care entities will leverage all financial supports of electronic health record and health information exchange deployment within the Accountable System of Care network, including incentives available for Medicaid providers • Collaborative, statewide, multi-payer approach to data sharing, and standardized performance and quality metrics and reporting • Meaningful Use clinical quality measure database populated by 2016 • Community performance dashboards • Admit/discharge/transfer messages available across networks in test regions by 2016 • Statewide Provider Directory Services supporting coordination within Accountable Systems of Care and among them • Michigan’s Blueprint performance dashboards • Development of health information technology selection and implementation assistance • Health care data transparency policies • Telehealth supported

Table F.1 Health Information Technology in the Reinvented Health System

Model Component	Role	Technology Supports	How Michigan Blueprint Addresses
<p>Managed Care Organization</p>	<ul style="list-style-type: none"> • Provide patient panel information • Provide health education information • Collect encounter, quality, and population health data • Provide relevant health information to patient portal • Provide clinical best practice information • Provide out-of-network information • Formulary medication management • Support complex care management • Provider reimbursement, incentives and/or shared savings 	<ul style="list-style-type: none"> • Electronic patient panel/roster exchange • Patient portal support • Collect encounter data and performance analysis • Information exchange • Provide health education web site and internet self-care resources • Enterprise provider directory • Enterprise patient registry and analytics • Patient and beneficiary information and customer relations • Provider reimbursement systems • Link community resource database where applicable 	<ul style="list-style-type: none"> • Organizations will financially support electronic health record deployment and health information exchange • Leverage Healthy Michigan collaborations promoting value-based decision-making and standardized performance metrics • Collaborative, statewide, multi-payer approach to data sharing, and standardized performance and quality metrics and reporting • Meaningful Use clinical quality measure database populated by 2016 • Admit/discharge/transfer messages available across networks in test regions by 2016 • Statewide Provider Directory Services supporting coordination within Accountable Systems of Care and among them • Michigan’s Blueprint performance dashboards • Health care data transparency policies
<p>Community Health Innovation Region</p>	<ul style="list-style-type: none"> • Create systems and enhance communications for coordinating health care and community services • Community assessment • Community health campaigns and initiatives 	<ul style="list-style-type: none"> • Community resource database • Community-level health data analysis and reporting 	<ul style="list-style-type: none"> • Allow for a variety of community-based approaches to technology supports • Patient Centered Medical Homes, Accountable Systems of Care and Managed Care Organizations contribute to community resource database as agreed • Michigan’s Blueprint performance dashboards • Health care data transparency policies

Table F.1 Health Information Technology in the Reinvented Health System

Model Component	Role	Technology Supports	How Michigan Blueprint Addresses
Central Infrastructure	<ul style="list-style-type: none"> • Support statewide health information exchange • Support multi-payer encounter and claims data collection • Public reporting of performance • Population health data set • Support Blueprint implementation 	<ul style="list-style-type: none"> • Enterprise identity management • Enterprise Provider Index • Medicaid Enterprise claims information • Enterprise Data Warehouse • Meaningful Use clinical quality data repository • Data analytics and reporting • Disease surveillance • Health care data transparency policies • Michigan’s Blueprint • Michigan’s Blueprint test dashboards 	<ul style="list-style-type: none"> • Leverage Michigan approach to data exchange • Leverage existing data aggregation such as the Michigan Data Collaborative • Leverage federal financial participation in Medicaid Enterprise infrastructure • Collaboratively develop data standards, performance metrics and streamlined reporting • Collaboratively develop health care data transparency approach • Collaboratively develop business associate agreements, data use and data sharing agreements • Develop and execute plan to align payment models across payers, standardize performance measures, and simplify administrative policies • Use stakeholder feedback loops to prioritize initiatives • Use rapid-cycle evaluations to enhance existing tools and initiatives to continually evaluate data aggregation and analytics needs and capacities

Chapter G: Strategies for Improving the Effectiveness and Efficiency of the Health Care Workforce

Stakeholders engaged in designing the Michigan Innovation Model recognized the need to ensure that as part of Michigan’s Blueprint for Health Innovation, Michigan’s health care workforce is ready to respond to projected increases in demand for health care services and can maximize performance outcomes in quality, patient experience, and cost. The success of the Blueprint depends upon a workforce that is trained to deliver coordinated, comprehensive, and high quality health care in the context of an increase in demand for health care services under the Healthy Michigan Plan described in chapter B. This chapter presents strategies that Michigan will implement to improve the effectiveness and efficiency of a health care workforce that is accountable for better health and health care at lower costs.

A foundational element of the Blueprint is the Michigan Patient Centered Medical Home. As such, improving the effectiveness and efficiency of Michigan’s workforce to support this model of care is a primary strategy in Michigan’s Blueprint, as described in chapter E. The Blueprint builds on the Michigan Primary Care Transformation demonstration project (as described in chapter E), which has led to the expansion of Patient Centered Medical Homes throughout the state with five participating payers and 362 participating Patient Centered Medical Homes. Building on the successes and lessons learned from the Michigan Primary Care Transformation project, the Blueprint will support Patient Centered Medical Home transformation, with interprofessional teams that build capacity to meet the increase in demand for services, provide the right care in the right setting, provide enabling services (e.g., translation services and transportation), and better coordinate high quality, person-centered care across the health system including behavioral health and social care services.

G1. Health Care Teams

The Patient Centered Medical Home is an interprofessional team-based model of care that recognizes the need for new roles and responsibilities for health care workers, especially in caring for individuals with complex care needs. Patient Centered Medical Home teams are comprised of a group of providers that work together with complementary skills and hold themselves mutually accountable to providing comprehensive person-centered care. Teams are comprised of “at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care [and] all members are enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.”¹ Primary care practices will be supported in the development and execution of health care teams that are person-centered, embed core competencies, and best utilize team members’ skills, as described below.

Person-centered Care

Health care teams must be person-centered, considering the needs and preferences of the person. The composition and operation of a health care team, therefore, depends on the needs of the patient. A health care team may include primary and specialty medical providers, physician assistants, nurse practitioners and other nursing service providers, behavioral health providers, community health workers, social workers, patient navigators, long-term care and home health providers, social support service providers, pharmacists, and other service providers. Ethnic and language considerations, as well as social and behavioral health needs should be considered when organizing the team that is best able to serve the person and family. While a health care team may be interprofessional or inter-disciplinary, the team that is right for a particular patient may be structured to include members who are not typically thought of as part of a profession or discipline. It is critical that the health care team include the health care professionals and other service providers that can best meet the needs of the patient, and that all team members truly consider and respect the contribution of each person on the team. Most importantly, patients – and when appropriate, their families – are members of the team and will be included as partners in informed decision-making, taking on as much responsibility for their health and health care as possible. Team members will be trained in self-management and educational support to engage patients in their health and health care.

Core Competencies for Interprofessional Collaborative Practice

The Interprofessional Education Collaborative is a working group formed by the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools of Public Health. The initial working group produced a statement on interprofessional education collaboration in March 2009, committing members to developing a common vision for how the respective professions could combine their unique abilities to deliver patient-centered team-based care, promote efforts to reform health care delivery and financing in line with that vision, and foster meaningful interprofessional learning experiences to support team-based care. A framework of activities to support these goals was drafted in June 2009, including the identification of core competencies for interprofessional collaborative practice, current educational experiences, and curricular models.

The Interprofessional Education Collaborative has identified four domains for interprofessional collaborative practice competencies based upon a set of core principles for team-based health care that have been identified by the Institute of Medicine.²

- **Values/ethics for interprofessional practice**, including placing the interests of patients and populations at the center of interprofessional health care delivery, developing trusting relationships with patients, families, and other team members, and maintaining competence in one's own profession appropriate to scope-of-practice
- **Roles/responsibilities**, including communicating one's roles and responsibilities clearly to patients, families, and other professionals; communicating with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention; and using unique and complementary abilities of all members of the team to optimize patient care

- **Interprofessional communication**, including choosing effective communication tools and techniques (e.g., information systems and communication technologies to facilitate discussions and interactions that enhance team function); listening actively, and encouraging ideas and opinions of other team members; giving timely, sensitive, instructive feedback to others about their performance on the team; and responding respectfully as a team member to feedback from others
- **Teams and teamwork**, including engaging other health professionals in shared patient-centered problem solving; applying leadership practices that support collaborative practice and team effectiveness; and using available evidence to inform effective teamwork and team-based practices

Maximizing Use of Team Members' Skills

The use of health care teams can increase primary care capacity if all members of the team are supported in practicing at the highest competency level of their license or training. Physicians are too often responsible for patient care tasks that other team members could perform, and a more efficient division of care responsibilities can help increase access to primary care.³ Sharing responsibilities requires empowering all team members (such as physicians assistants, nurse practitioners and other nurses, pharmacists, social workers, medical assistants, patient navigators, health coaches, and community health workers) to handle a wider range of patient care responsibilities within their training and skill level.⁴ There is a need to identify and remove barriers that prevent team members from practicing to the full extent of their training and license in order to improve patient outcomes, recognizing that the obstacles may be different for different members of the team. Barriers to interprofessional team based care could derive from state laws and regulations, case law, and insurers' benefit structures. Should such barriers surface the Policy and Planning Office can leverage its position and partnerships to recommend and promote solutions. There were multiple bills introduced during the 2013 legislative session to revise current licensing regulations. As part of the Innovation Model test, Michigan's Blueprint will include identification and elimination of potential barriers that prevent health team members from practicing at the highest competency level of their license and training. By redefining some of the scope and standards of practice for medical professionals, Michigan could increase primary care capacity.

Training and Technical Assistance for Health Care Teams

Michigan is emerging as a national leader in interprofessional education and practice under the Michigan Department of Community Health's leadership by working with higher education institutions, non-profits, and care facilities on several initiatives. The Michigan Health Council's "Education 2 Practice" initiative regularly convenes health care stakeholders to lay the groundwork for implementing interprofessional education and care at a systems level in Michigan, and has developed the "Education 2 Practice Tool Kit," a resource for educators and health professionals to use when integrating interprofessional education and care into their work.

Several Michigan universities have incorporated team-based education into their health profession education curricula, which will result in a future workforce better prepared for interprofessional practice.

- Ferris State University Interprofessional Wellness Clinic brings optometry, nursing, and pharmacy students together to provide team-based care for patients with diabetes, high blood pressure, high cholesterol, and other conditions

- Michigan State University and Ferris State University have partnered to develop and offer a faculty development series on interprofessional education, with the aim to provide both a theoretical and practical understanding of interprofessional education and collaborative care
- The University of Michigan School of Dentistry Interprofessional Clinical Immersion Experience seeks to improve learning, patient care, and organizational efficiency using an interprofessional education model for primary health care
- The West Michigan Interprofessional Education Initiative is a regional inter-institutional collaborative partnership between Grand Valley State University, Michigan State University, and Grand Rapids Medical Education Partners – the initiative has incorporated a model of interprofessional education
- Wayne State University led the Interprofessional Team Home Visit Program Fostering a Collaborative Approach to Patient Care among students from a wide range of disciplines, including: medicine, pharmacy, social work, occupational and physical therapy, physician assistant, and nursing

Stakeholders report that while Michigan’s universities incorporate team-based care in the curriculum, students conducting clinical rotations do not experience it in practice. The Blueprint provides for training be provided on the principles and competencies required for team-based care to support implementation of the Innovation Model. The Education 2 Practice Tool Kit will be made available to serve as a model for efforts to support primary care practices in the implementation of interprofessional practice.

Payment Models for Team-based Care

Current fee-for-service payment models do not encourage team-based care, as only visits with certain ‘billable’ providers are reimbursed. Changes in reimbursement could encourage delivery of care by interprofessional teams. This includes reimbursing team members for traditionally unpaid services, such as paying for the time providers take to respond to patient inquiries outside of an office visit (e.g., e-mail or phone calls). Payment models described in chapter E give providers flexibility to implement team-based care to the extent it results in better care at lower cost.

G2. Community Health Workers

Michigan’s Blueprint includes support for greater use of community health workers, who are important members of the health care team. Community health workers are trusted members of the community they serve, making them ideal for delivering information, building relationships, and coordinating care for at-risk residents. The American Public Health Association defines a community health worker as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the community health worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.”⁵

Strong evidence exists to support the use of community health workers to provide health promotion and education and facilitate access to services. In Michigan, the use of community health workers in a variety of programs and initiatives has been tied to increased access to primary care and specialty services,⁶ improvements in prenatal care and birth outcomes,⁷ improved adherence to blood glucose testing and decreased blood glucose levels,⁸ and decreased depressive symptoms.⁹ One study found that the use of community health workers to improve children's asthma-related health led to improved lung function, decreased frequency of asthma symptoms, and decreased unscheduled health visits among children.¹⁰ Estimated health care cost savings associated with the use of community health workers ranges from \$2.28 to \$4.00 for every \$1.00 spent.^{11,12,13} Thus, community health workers are not only likely to contribute to better health outcomes, but also to contribute to improvements in utilization of health care services as well.

Community health workers are currently being incorporated in multiple settings in Michigan. One setting is the Pathways Community HUB described in appendix 2.1. The Innovation Model test will allow Michigan to assess the extent to which community health workers improve patient engagement and self-management, access to health care, and coordination of services.

There is work currently underway to define core competencies and qualifications for community health workers, identify a curriculum for use as the certification competency standard for community health workers in Michigan, and set a course of action relative to state licensure or certification. The Michigan Community Health Worker Alliance has adopted the American Public Health Association's community health worker definition of community health workers, and adopted several core competencies and roles that serve to further define and standardize expectations for the vocation:

Core competencies

- Advocacy and outreach
- Community and personal strategies
- Teaching and capacity building
- Legal and ethical responsibilities
- Coordination, documentation, and reporting
- Communication skills and cultural competence
- Health promotion
- Practice (internship)

Roles

- Outreach and community mobilization
- Community/cultural liaison
- Case management and care coordination
- Home-based support
- Health promotion and health coaching
- System navigation
- Participatory research

The Michigan Community Health Worker Alliance has also convened working groups to determine a course of action relative to state licensure or certification. Based on the working groups' recommendations, the Michigan Community Health Worker Alliance has endorsed the use of the Minnesota community health worker curriculum as the certification competency standard for community health workers in Michigan, and has endorsed the development of a system for community health worker certification in Michigan.

The Policy and Planning Office will convene stakeholders to address issues related to regulation of community health workers. A potential option is through the development of a registry that would include those individuals who have completed an agreed upon community health worker curriculum. A registry would allow Michigan to achieve a standard for entry into the community health worker vocation. Some professions, such as respiratory therapists, are not regulated and/or certified in Michigan, but are certified by a national organization. If a national community health worker certification is established, Michigan could consider leveraging that certification in the development of a registry, or use a national registry if one is available.

G3. Graduate Medical Education

New medical schools and expanded campuses in Michigan hold out the promise of increasing the supply of physicians in Michigan. However, a challenge remains in the limited number of graduate medical education dollars to fund residency programs, which are all allocated to hospital-based residencies. Additionally, as described in chapter B, the ratio of primary care physicians to specialists graduating from medical schools in the United States of America is more heavily weighted toward specialists than is typical in countries with better health status and lower costs.¹⁴ The Policy and Planning Office will work with the executive staff of Michigan Department of Community Health, the Executive Office, and the legislature on potential ways to restructure graduate medical education allocations away from hospitals and to community-based entities that offer resident rotations. The Policy and Planning office will also consider developing recommendations and specific guidelines for loan forgiveness and repayment programs to encourage prospective students to choose health professions with current or anticipated shortages or current students to select primary care specialties.

G4. Workforce Assessment and Planning

A better understanding of supply and demand for health care will be critical if Michigan is to meet the needs for health care in the future. This information will help communities identify the number and type of practitioners available to build health teams for delivery of care, and will help academic institutions and technical assistance resources know what type of practitioners to prepare and to whom they should be providing technical assistance.

The Michigan Department of Community Health commissions an annual survey of licensed providers to gain a deeper understanding of the activities and plans of active practitioners in Michigan. Respondents are asked about their long-term plans to continue to practice, which helps to inform policy and planning. In addition, Michigan Medicaid and Michigan Health Information Network Shared Services have been

working to create interfaces between multiple data sources within the State and without to develop robust provider directory services. This will allow the State of Michigan and the Michigan Health Information Network Shared Services community to support workforce planning by providing geographic data to show where particular services are offered and where they are needed.

Summary

In conclusion, as part of Michigan's Blueprint, the following activities will support implementation of Michigan's proposed service delivery and payment models described in chapter E.

- Technical assistance, tools and learning systems to support interprofessional teams
- Reviewing Graduate Medical Education funding and developing recommendations for leveraging these dollars to address shortages and suboptimal distribution of primary care physicians in Michigan – using data to test the effectiveness of this approach towards increasing primary care providers in underserved areas
- Consideration of the need for additional policy to enable all team members to practice at the highest competency level of their license and training
- Support for efforts to define the roles and skill sets of community health workers that will enable better care at lower cost – this may include development of a registry within the Health Professions Licensing Division in the Bureau of Health Care Services, at the Department of Licensing and Regulatory Affairs

¹ American Medical Association. The Structure and Function of Interprofessional Health Care Teams. AMA House of Delegates. <http://www.ama-assn.org/resources/doc/hod/ama-policies-principles-for-health-care-teams.pdf>.

² Interprofessional Education Collaborative Expert Panel. Core Competencies for Interprofessional Collaborative Practice: Report of an expert panel. 2011. <http://www.aacn.nche.edu/education-resources/ipcreport.pdf>.

³ Ghorob A, Bodenheimer T. Sharing the care to improve access to primary care. *New England Journal of Medicine*. 2012; 366(21):1955-7.

⁴ Bodenheimer T, Smith M. Primary Care: Proposed Solutions to the Physician Shortage without Training More Physicians. *Health Affairs*. 2013;32(11):1881-6.

⁵ American Public Health Association. Community Health Workers.

<http://www.apha.org/membergroups/sections/aphasections/chw/>. Accessed October 29, 2013.

⁶ Agency for Health care Research and Quality. Michigan's Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism.

<http://innovations.ahrq.gov/popup.aspx?id=2134&type=1&isUpdated=True&isArchived=False&name=print>. Accessed October 29, 2013.

⁷ Coughlin RL, Kushman EK, Copeland GE, Wilson ML. Pregnancy and Birth Outcome Improvements for American Indians in the Healthy Start Project of the Inter-Tribal Council of Michigan, 1998–2008. *Maternal Child Health Journal*. 2012. http://prime.mihealth.org/files/NA_HSP_work_in_MI.pdf. Accessed October 29, 2013.

⁸ Spencer MS, Rosland A, Kieffer EC, et al. Effectiveness of a community health worker Intervention Among African American and Latino Adults With Type 2 Diabetes: A Randomized Controlled Trial. *American Journal of Public Health*. 2011;101:2253-2260.

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- ⁹ Roman LA, Gardiner JC, Lindsay JK, et al. Alleviating perinatal depressive symptoms and stress: a nurse-community health worker randomized trial. *Women's Mental Health*. 2009;12:379-391.
- ¹⁰ Parker E, Israel BA, Robins TG, et al. Evaluation of Community Action Against Asthma: A community health worker Intervention to Improve Children's Asthma-Related Health by Reducing Household Environmental Triggers for Asthma. *Health Education & Behavior*. 2008;35:376-395.
- ¹¹ Johnson D, Saavedra P, Sun E, et al. Community Health Workers and Medicaid Managed Care in New Mexico. *Journal of Community Health*. 2012;37:563-571.
- ¹² Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. *Journal of Health Care for the Poor and Underserved*. 2006;17(1):6-15.
- ¹³ Felix HC, Mays GP, Steward MK, Cottoms N, Olson M. Medicaid savings resulted when community health workers matched those with needs to home and community care. *Health Affairs*. 2011;30(7):1366-1374.
- ¹⁴ Michigan Department of Community Health. Survey of Physicians 2012. Michigan Department of Community Health web site. http://www.michigan.gov/documents/health_careworkforcecenter/Survey_of_Physicians_Final_Report_2012_418612_7.pdf

Chapter H: Financial Analysis

H1. Health Care Costs and Savings Potential

Evidence is mounting that much of the United States of America's huge health care expenditure is unnecessary and unproductive. *Health Affairs* journal examined several sources and estimated that in 2011, 21% to 47% of health care spending nationwide was wasted.¹ Other research has resulted in even higher estimates, finding that waste constitutes more than half of all health care spending in the United States.² This chapter presents data on actual health care costs for Medicare and Medicaid in Michigan, with analysis of areas where Michigan has the greatest potential to achieve cost savings. Cost estimates for commercially insured populations will be collected as part of the payer engagement process. The results presented below indicate the potential for cost avoidance in the areas of hospitalization, emergency department visits, specialty services, and radiology by implementing the Blueprint.

Methods

Michigan Department of Community Health contracted with the actuarial firm, Milliman, to provide estimates of Medicaid and Medicare base year and three subsequent year cost trends assuming the absence of Michigan's Blueprint for Health Innovation.

Additionally, Milliman examined the following potentially avoidable costs:

- Claims identified as potentially avoidable by the Prevention Quality Indicators
- Claims identified as potentially avoidable by the Pediatric Quality Indicators
- Readmissions within 30 days of inpatient stay
- Claims identified as potentially unnecessary use of imaging following low back pain
- Claims identified as potentially avoidable by the New York University Emergency Department Algorithm

For purposes of summarizing Medicare expenditures, Milliman used the Medicare 5% sample data for Michigan. Prescription drug data were not available for the Medicare population. Limitations in the claims data also led to the exclusion of the following Medicaid and Medicare expenditures/populations:

- Behavioral health claims (mental health and substance abuse services)
- State of Michigan Medicaid program hospital reimbursement adjustment payments, graduate medical education payments, and program specialty network access fee payments
- Projected enrollment and expenditure information for the Healthy Michigan expansion population
- Administrative costs for health plans and the State
- Adult benefit waiver participants
- MiChild population, Michigan's Children's Health Insurance Program
- Pharmacy rebates
- Medicare Part A and Part B premium rates and Part D clawback payments
- Applicable taxes and fees
- Patient Centered Medical Home fees associated with Michigan Primary Care Transformation program

Table H.1 Current Per Capita Cost And Projected Future Per Capita Cost in Final Test Year Without the Innovation Model
(per member month)

Health Care Expenditures Categories of Services	Medicaid								Medicare			
	Adult Population = 392,000		Child Population = 953,000		Dually-eligible Population = 232,000		Disabled/Elderly (without Duals) Population = 204,000		Dually-eligible Population = 232,000		Fee-for-service Total Population = 1,071,000	
	Cost 2014	Estimated 2017	Cost 2014	Estimated 2017	Cost 2014	Estimated 2017	Cost 2014	Estimated 2017	Cost 2014	Estimated 2017	Cost 2014	Estimated 2017
Inpatient Hospital	49	49	29	29	5	5	227	230	516	547	359	381
Outpatient Hospital (total)	22	23	7	8	33	36	78	84	182	223	164	201
Emergency Department (subtotal)	17	17	7	8	0	0	29	31	49	60	24	29
Professional Primary Care	41	45	26	28	5	5	85	94	94	102	61	67
Professional Specialty Care				combined with above					169	185	162	177
Imaging/X-Ray	5	5	1	1	0	0	9	10	22	24	22	24
Laboratory	8	9	2	2	0	0	12	13	15	16	13	14
Durable Med. Equip.	1	1	1	1	2	2	12	14	45	49	25	27
Dialysis	0	0	-	-	0	0	1	1	44	48	16	18
Professional Other	2	2	3	3	1	1	9	10	10	11	14	15
Skilled Nursing	0	0	0	0	405	411	49	49	98	108	85	95
Home Health	-	-	1	1	0	0	10	11	126	155	81	100
Home and Community-Based	0	0	0	0	42	46	13	15	1	1	0	0
Other	15	17	23	25	5	5	43	48	29	31	15	17
Subtotal	\$ 161	\$ 168	\$ 99	\$ 104	\$ 499	\$ 513	\$ 577	\$ 611	\$ 1,399	\$ 1,562	\$ 1,042	\$ 1,165
Prescription Drugs (Outpatient)	41	46	30	33	7	8	264	294	-	-	-	-
Total	\$ 202	\$ 214	\$ 129	\$ 137	\$ 506	\$ 521	\$ 841	\$ 905	\$1,399	\$ 1,562	\$ 1,042	\$ 1,165

Note: due to each number being rounded, numbers presented throughout this table may not add up precisely to the totals provided.

Results

Baseline and Cost Trends without Implementing the Blueprint

Cost estimates for Medicaid and Medicare populations are presented for four Medicaid populations (children, adults, dual-eligible, and disabled) and two Medicare fee-for-service populations (dual and non-dual) in table H.1. Data are presented as estimated for the baseline (2014) and final year (2017) of the testing period as predicted based on current trends and no change in service delivery and payment models. Per member per month costs vary from \$129 for child beneficiaries of Medicaid to \$1,399 in non-prescription Medicare costs for dually Medicare-Medicaid eligible beneficiaries.

Avoidable Hospitalizations and Emergency Department Visits

Analysis revealed that avoidable emergency department and hospital stays account for 14% of total health care costs for Medicare and Medicaid (excluding prescriptions) as presented in table H.2.

These are conservative estimates, based only on analysis of potentially avoidable emergency department visits using the New York University algorithm; and hospitalizations, considering both unplanned readmissions and the Prevention Quality Indicators.

Unnecessary Procedures

There are a number of common tests and procedures that have been found to be medically unnecessary and therefore

wasteful – and even potentially harmful. For example, recent surveys have found that among adults with no history of heart disease or heart disease symptoms, 39% had undergone an echocardiogram during the preceding 5 years, with 12% having an exercise stress test during that period. The average cost of these tests was \$50 and at least \$200, respectively.³

These tests are classified as wasteful for those at low risk for heart disease, according to the *Choosing Wisely*® campaign led by the American Board of Internal Medicine.⁴ *Choosing Wisely* is an initiative of the American Board of Internal Medicine Foundation, focused on encouraging physicians, patients and other health care stakeholders to think and talk about medical tests and procedures that may be unnecessary or harmful. Leading specialty societies have participated by creating lists of “Things Physicians and Patients Should Question” — evidence-based recommendations that should be discussed between a patient and their health care provider to help the patient make wise decisions about the most appropriate care based on that patient’s individual situation. More than 50 specialty societies have now joined the campaign, and 30+ societies will announce new lists in late 2013 and early 2014. Consumer Reports and other consumer-focused organizations are developing and disseminating materials to help

Table H.2 Percent of Non-prescription Costs Identified as ‘Avoidable’ Hospitalizations or Emergency Department Visits

Population Category	Per Member Per Month	Percent of Costs
Medicaid Adult	\$24.53	15%
Medicaid Child	\$22.65	23%
Medicaid Elderly/Disabled (Non-Dual)	\$129.84	22%
Medicare Duals	\$167.52	12%
Medicare Fee-For-Service	\$106.19	10%
Total	\$450.73	14%

patients engage their physicians in these conversations and ask questions about what tests and procedures are right for them.⁵ Examples of practices targeted by the *Choosing Wisely* campaign include annual check-ups for healthy adults, imaging studies for low back pain, and over-prescription of antibiotics.

Another area of potential savings is redundant testing. It is estimated that eliminating redundant tests would have saved an additional \$8 billion nationally (2.7 percent of total inpatient costs).⁶ Researchers have found that unnecessary imaging for stroke patients, for example, has increased dramatically in recent years.⁷ Another study found that more than 41% of abdominal imaging constituted repeated tests.⁸ One initiative underway in Michigan to address imaging overutilization has set targets to reduce computed tomography volume by 17.4 percent and magnetic resonance imaging volume by 13.4 percent over three years, ultimately resulting in a 17% reduction in imaging costs. This initiative is described further in appendix 2.

In Michigan, the Value Partnerships initiative of Blue Cross Blue Shield of Michigan has resulted in savings in several domains, including \$27 million statewide through appropriate use of radiology services.⁹ Estimating the extent of redundant testing is fraught with methodological uncertainty – specifically, it is unknown what percent of repeated tests were actually unnecessary. Nevertheless, Michigan Medicaid has begun to examine repeated tests to establish a baseline and develop a methodology to determine unnecessary redundancy.

Administrative Complexity

Estimates of overall administrative expenses in health care nationwide suggest that operations waste amounts to \$107 to \$389 billion per year nationally (between 19% and 30.7% of total health care waste).¹⁰ The cost of time spent by providers interacting with health insurance companies amounts to \$23 billion to \$31 billion annually.¹¹ Studies have also shown that on average, hospital nurses spend only 30 percent of their time directly caring for patients.¹² These costs are driven up by administrative procedures that are unnecessarily complex or duplicative, especially since different payers may make different demands for documentation, pre-authorizations, and billing procedures for similar encounters. According to the National Institutes of Health, between \$63 and \$75 billion could be saved by public and private insurers in billing expenses alone by reducing complexity.¹³ Michigan’s Blueprint for Health Innovation addresses administrative complexity by moving away from fee-for-service payment (and the complexity around billing codes and rejected claims associated with fee-for-service) and by promoting infrastructure including a health care cost and quality database and consistent performance metrics that include multiple payers.

Additional Cost Drivers

Hospital charges in Michigan vary widely, but are below the national average. Michigan’s Medicare hospital billing costs were the tenth lowest average in the country in fiscal year 2011.¹⁴ Yet between October 2012 and October 2013, prices for medical care in the Detroit-Ann Arbor-Flint area rose by 4.9% according to the Bureau of Labor Statistics.¹⁵

Analysis of Michigan data, supplemented with national studies, estimate waste in the system on the order of:

- Hospitalizations and emergency department visits that could have been avoided through better ambulatory care, early intervention, prevention, and coordinated care: 4.5-20.6%¹⁶
- Unnecessary procedures: 17.0-28.0%¹⁷
- Redundant testing: 2.4-2.7%¹⁸

Moving away from fee for service and towards coordinated care provided by Accountable Systems of Care directly addresses all these areas.

Another cost driver in Michigan as depicted in the driver diagram (Appendix 1) is the poor health of Michigan’s population. As mentioned in chapter B, Michigan ranks 37th nationally in the health of its population according to a prominent source.¹⁹ As described in chapter B, this is in part due to high rates of chronic disease and obesity, as well as significant health disparities particularly affecting Michigan’s African American population. This characteristic of Michigan is the reason that stakeholders in the model design process advocated for community level interventions to address population health. These interventions are expected to have a significant return on investment; for instance, one study estimated that 10.3% of Michigan’s overall health care costs are attributable to the state’s epidemic of obesity.²⁰

Michigan’s service delivery and payment models are designed to provide care in appropriate settings, improve coordination, eliminate waste, reward value-based outcomes, and reduce administrative complexity. At a minimum Michigan will be able to achieve a 10% reduction in per member per month Medicare and Medicaid costs from current levels while improving the overall quality of care and health of the population.

H2. Estimated Blueprint Implementation Costs

Costs are estimated based on four levels of expenditures: 1) central infrastructure, 2) Patient Centered Medical Home, 3) Accountable System of Care, and 4) Community Health Innovation Region. Costs here are very high-level and based on extrapolation from the Michigan Primary Care Transformation program. They will be specified based on the actual State Innovation Model test proposal. The model test will aim to recruit 100,000 Medicaid beneficiaries and 50,000 Medicare beneficiaries, plus commercial members.

Infrastructure Costs

Infrastructure costs are presented for the three time periods: planning, testing, and implementation in tables H.3 – H.5 below.

Table H.3 Innovation Model Testing Costs – Planning Phase		
Cost Category	Expenditure Description	Total First Year Cost
Model test staff	Project team includes Project Director, Senior Business Analyst, Stakeholder Communication and Support Specialist, Project Manager, Research Analyst, Data Reporting Specialist	\$480,000
Technical consultant support	Business process development, payment operations, performance reporting system development, provider model test contracting	\$450,000

Table H.3 Innovation Model Testing Costs – Planning Phase		
Cost Category	Expenditure Description	Total First Year Cost
Demonstration recruitment consultant	Recruitment, beneficiary and provider materials and outreach	\$190,000
Training specialist	Model test provider training program	\$250,000
Actuarial consultant	Actuarial analysis, cost targets and trends and model health care cost reporting system	\$350,000
Community engagement consultant	Community Health Innovation Region consultant: development and evaluation and training program	\$200,000
Total Model Pre-Implementation Start Up Cost		1,920,000

Table H.4 Model Test Annual Project Management. Rapid Cycle Evaluation and Improvement, and Reporting Cost		
Cost Category	Expenses Covered	Estimated Amount
Model Test Staff	See Above	\$480,000
Rapid Cycle Evaluation and Improvement Support	Multiple cycles of rapid cycle evaluation and performance improvement	\$500,000
Model Test Operations	Contract management, payment, encounter data and operations systems required for model test operations	\$1,500,000
Provider Participation Reimbursement	Payment for cost associated with provider participating in the model test to cover extra reporting requirements and tasks associated with model testing	\$500,000
Data Reporting and Management	Beneficiary tracking, provider tracking and performance reporting and analytics	\$750,000
Patient Survey and focus group cost	Beneficiary and provider survey cost	\$350,000
Total Annual Model Test Management and Support Costs		4,080,000

Table H.3 presents estimated ongoing annual infrastructure costs for the future state when the Innovation Model is implemented. The largest expenditure is for a multi-payer claims and clinical database.

Table H.5. Annual Central Infrastructure Costs – Deployment Phase		
Cost Category	Expenses covered	Estimated Amount
Administration, monitoring	Staff – 3 Full Time Equivalents (Manager, Specialist, Assistant), including salary, benefits, travel and supplies, contractor support	\$500,000
Performance Measurement and	Meeting costs for committee, data analysis and dashboard production	\$450,000

Table H.5. Annual Central Infrastructure Costs – Deployment Phase		
Cost Category	Expenses covered	Estimated Amount
Recognition		
Communications	Website hosting and content updates, newsletter	\$50,000
Training and technical assistance	Medical consultants, health systems design expertise, health economist, learning collaborative, and webinars, annual symposia	1,000,000
Multi-payer claims/clinical database	Ongoing operational expenses for data standardization, processing, metric calculations, reporting, creation of data marts and portals for users	5,000,000
TOTAL		7,000,000

Patient Centered Medical Home Funding Model

Patient Centered Medical Home costs will continue to be calculated based on the Michigan Primary Care Transformation model – although these may be updated as more evaluation results are made available.

Currently, funding is contributed by participating payers as follows:

- Care Management support (hiring, training and embedding Care Managers in practices, including care management documentation software): \$3 - \$4.50 per member per month (based on payer acuity mix) covers approximately two nurse Care Managers per 5,000 beneficiaries
- Practice transformation support (training and coaching of the interprofessional team, software upgrades and licensing): \$1.50-\$2 per member per month
- Performance incentives (distributed to physician organizations and shared with member practices, based on performance across all participating members): Average of \$3 per member per month
- Administration (covers centralized project management, technical assistance, administration, and the multi-payer database –this would be absorbed in the costs presented above for central infrastructure): \$.26 per member per month

Given Michigan’s goal of 150,000 beneficiaries, expected Patient Centered Medical Home costs are \$726,000 for Medicaid, plus \$463,000 for Medicare.

Accountable Systems of Care Costs

Accountable Systems of Care will have expenses in the categories listed in table H.6. Estimates of the costs to form an Accountable Care Organization vary dramatically, with high-end estimates of \$5-12 million provided in a study funded by the American Hospital Association.²¹ Because there are existing entities that have developed some capacity to become Accountable Systems of Care, it is not anticipated that all startup costs must be covered by new payment models. Medicare and Medicaid’s ongoing participation in Accountable Systems of Care development along with existing programs is anticipated to be a needed and helpful catalyst to the movement towards clinical integration. Existing funding streams include Blue Cross Blue Shield’s Physician Group Incentive Program (which requires Physician Organization participation), Blue Cross Blue Shield’s Organized Systems of Care Program, Meaningful Use incentives, Patient Centered Medical Home payments described above, Health Resources and Services Administration grants, and community benefit requirements of non-profit hospitals, among

others. Moreover, the American Hospital Association cost estimates are far above those provided by Centers for Medicare and Medicaid Services in the initial Federal Rule on Accountable Care Organizations. For planning purposes, costs for the Accountable System of Care that will be funded by the new payment models (shared savings, partial capitation and global capitation) are estimated at \$3-5 million per Accountable System of Care per year.

Table H.6 Accountable Systems of Care Cost Categories

Budget categories	Payment model	
	Leverages existing sources	New payment model
Fees to the sub-state health information exchange	√	√
Data & analytics: staffing, database, software	√	√
Training and practice coaching: staffing, consultation, materials, web site	√	√
Interprofessional team implementation: shared resources beyond the Medical Home		√
Governance: planning, contracting, management	√	√
Community participation (Community Health Innovation Region)		√

Community Health Innovation Regions

Funding requirements for the Community Health Innovation Region will vary depending on the initiatives adopted, and existing resources. Staffing and skeletal infrastructure for the backbone organization is estimated at \$600,000 for staffing and office costs, data collection, convening functions, and communications – including web sites and materials. Other expenses of the Community Health Innovation Region are dependent on community needs. Experience with the Pathways Community Hub shows that implementing a Hub that employs 20 community health workers costs approximately \$1.2 million annually.

Table H.7 Community Health Innovation Region Cost Categories

Budget Categories	Payment Model	
	Existing Sources	New Investments
Backbone organization staff , supplies, travel		√
Community Health Needs Assessments	√	
Convening, strategic planning	√	√
Community outcomes data monitoring and a community resource database	√	√
Communications (web site, etc.)	√	√
Community linkages: shared resources linking health care and community services (such as Pathways Community Hub or other model)		√
Other health programming for collective impact	√	√

Table H.7 describes the costs of a Community Health Innovation Region and sources of funding. As with Accountable Systems of Care, there currently exist entities that provide some of the functions of a Community Health Innovation Region. A key aspect of the funding model for the Community Health Innovation Region is that existing participating entities align their investments in order to have greater impact. Moreover, grant making entities in the state will work together (convened by the Michigan Department of Community Health Policy and Planning Office) to align funding streams in ways that encourage collaboration. An example is occurring now in which Michigan Department of Community Health seeks to coordinate Home Visiting funding streams to reduce the fragmentation and duplication of programs at the community level. The Policy and Planning Office will also reach out to foundations as funding partners with shared goals to bring even greater alignment.

Significantly, funding is expected to come from within the communities as well as from state and other sources. The concept of the Community Health Innovation Region is that local partners must have a vested interest in success to assure long-term sustainability. Both Accountable Systems of Care and payers have an interest in reducing their risk through support of effective population health risk reduction strategies. Accountable Systems of Care benefit from the collective efforts of Community Health Innovation Regions that improve health outcomes, reduce risk, and facilitate integration across the health system. For example, the Pathways Community Hub model may be a shared resource that multiple Accountable Systems of Care, health systems, payers, and others could support in order to link high-risk patients to appropriate community services and thereby reduce costs.

Summary

Preliminary actuarial analysis provided by Milliman identifies savings opportunities in the areas of ambulatory care sensitive emergency department visits, ambulatory care sensitive hospitalizations, and readmissions. A true clinically integrated network of providers such as a Level II Accountable System of Care should dramatically reduce those visits. By also focusing on unnecessary procedures, redundant tests, administrative costs, and population health improvement, as well as avoidable hospital and emergency department visits, Michigan will be able to achieve a 10% total reduction in health care expenditures from projected costs.

¹Health Affairs. Reducing Waste in Health Care. Health Policy Briefs. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82. Published December 13, 2012. Accessed March 25, 2013.

²PricewaterhouseCoopers. The price of excess: Identifying waste in healthcare spending. PricewaterhouseCoopers Health Research Institute. 2008. <http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml>. Accessed May 4, 2013.

³Choosing Wisely. EKGs and exercise stress tests. <http://www.choosingwisely.org/doctor-patient-lists/ekgs-and-exercise-stress-tests/>. Published April 2012. Accessed June 8, 2013.

⁴Choosing Wisely. <http://www.choosingwisely.org/>. Accessed June 8, 2013.

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- ⁵ *Choosing Wisely* Partners are available here: <http://www.choosingwisely.org/partners/choosing-wisely-consumer-partners/>
- ⁶ Jha AK, Chan DC, Ridgway AB, Franz C, Bates DW. Improving Safety And Eliminating Redundant Tests: Cutting Costs In U.S. Hospitals. *Health Affairs*. 2009;28(5): 1475-1484. <http://content.healthaffairs.org/content/28/5/1475.full>.
- ⁷ Burke JF, Kerber KA, Iwashyna TJ, Morgenstern LB. Wide variation and rising utilization of stroke magnetic resonance imaging: data from 11 states. *Annals of Neurology*. 2012;71(2):179-85. <http://www.ncbi.nlm.nih.gov/pubmed/22367989>.
- ⁸ Ip IK, Morele KJ, Prevedello LM, Khorasani R. Repeat Abdominal Imaging Examinations in a Tertiary Care Hospital. *The American Journal of Medicine*. 2012;125:155-161.
- ⁹ Reinheimer D. Talk with your doctor about choosing wisely. Value Partnerships. <http://www.valuepartnerships.com/2013/06/talk-with-your-doctor-about-choosing-wisely/>. Published June 5, 2013. Accessed June 10, 2013.
- ¹⁰ Berwick, DM & Hackbarth AD. “Eliminating waste in US health care.” *JAMA*. 2012;307(14):1513-1516.
- ¹¹ Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T, Levinson W. What Does It Cost Physician Practices To Interact With Health Insurance Plans? *Health Affairs*. 2009;4(28).
- ¹² Smith M, Saunders R, Stuckhardt L, McGinnis JM. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. *National Academies Press*. 2013.
- ¹³ Yong PL, Saunders RS, Olsen L. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. *National Academies Press*. 2010:148-150.
- ¹⁴ Governing. Average Hospital Cost By State. <http://www.governing.com/gov-data/health/average-medical-hospital-costs-by-state-map.html>. Published May 2013. Accessed July 19, 2013.
- ¹⁵ Bureau of Labor Statistics. Consumer Price Index, Detroit-Ann Arbor-Flint. <http://www.bls.gov/ro5/cpidet.htm>. Published October 2013. Accessed November 14, 2013.
- ¹⁶ Michigan Department of Community Health. Ambulatory Care Sensitive Hospitalizations. <http://www.mdch.state.mi.us/pha/osr/CHI/HOSP/FRAME.HTML>. Accessed November 13, 2013.
- ¹⁷ See 8
- ¹⁸ See 5
- ¹⁹ America’s Health Rankings. State Overview: Michigan. <http://www.americashealthrankings.org/MI/2012>. Accessed November 13, 2013.
- ²⁰ Trogdon JG, Finkelstein EA, Feagan CW, Cohen JW. State- and Payer-Specific Estimates of annual Medical Expenditures attributable to Obesity. *Obesity*. (2012) 20,214–220. <http://www.healthpolicysolutions.org/wp-content/uploads/2012/03/State-by-State-Obesity-Costs.pdf>. Accessed July 19, 2013.
- ²¹ American Hospital Association. The Work Ahead: Activities and Costs to Develop an Accountable Care Organization. <http://www.aha.org/content/11/11apr-aco-workahead.pdf>. Published April 2011. Accessed August 8, 2013.

Chapter I: Evaluation Plans

As described more fully in Chapter J, service delivery and payment model elements will be evaluated in three regions during a three-year test period. There are two aspects to evaluation of Michigan’s Blueprint for Health Innovation. Michigan’s Blueprint for Health Innovation will help create a learning health system through:

- I. A learning culture which will serve as the foundation of health care system transformation which will:
 - a. Provide for ongoing monitoring of progress in continuous learning cycles that occur at local, regional, and state levels
 - b. Evaluate the effectiveness of specific programs and Innovation Model components
 - c. Provide evidence to support decision-making around scaling the Innovation Model to serve additional populations in Michigan
- II. A summative evaluation to be conducted by the Centers for Medicare and Medicaid Services to assess:
 - a. The overall impact of Michigan’s Blueprint on better health, improved care delivery, and cost containment – especially in relation to Medicaid, Medicare, and Children’s Health Insurance Program beneficiaries
 - b. Elements of Michigan’s model that should be disseminated to other states

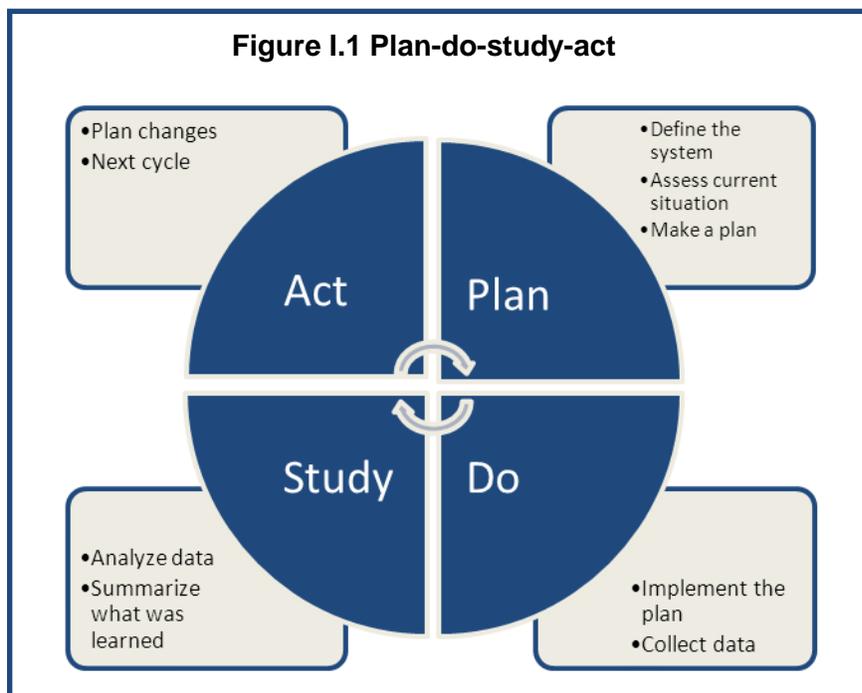
The Michigan Department of Community Health has relationships with numerous entities that provide high quality evaluation services. A lead evaluator and additional entities for specific tasks will be contracted to continuously monitor the implementation of the Blueprint and its impacts. If testing funding is approved, the Michigan Department of Community Health and its evaluator(s) will also develop relationships with the evaluators chosen by the Center for Medicare and Medicaid Innovation to collaborate around methodology and data collection. The Michigan self-evaluation staff/contractors – in consultation with the federal evaluation staff/contractors – will develop a comprehensive self-evaluation plan and identify data sources for ongoing internal and formal external evaluations. The evaluation plan will build on the components described below, and be updated each year to accommodate changes in Michigan’s Innovation Model.

I1. Self-evaluation

Michigan’s self-evaluation plan will be based on rapid-cycle improvement processes. Rapid-cycle improvement processes identify, implement, and measure changes in small tests-of-change that keep a focus on targeted improvements by answering the following three questions:

1. What are we trying to accomplish?
2. How will we know that the change is an improvement?
3. What change can we make that will result in an improvement?¹

When employing a rapid-cycle improvement process, the plan-do-study-act-cycle is a useful learning methodology in which changes are tested over short periods of time to learn what works, and in what



conditions, and to demonstrate that change is possible and worthwhile. Target measures and milestones are established, data are collected, progress is assessed, and improvements are incorporated. Testing the State Innovation Model on a small scale allows the participants in the test sites to learn from unexpected results and to make adjustments before

making the change permanent. Also, smaller-scale tests minimize risks and provide the opportunity for making adjustments in the Michigan Innovation Model to avoid unintended consequences as the system reacts to changes over time.

The self-evaluation plan will also track milestone achievement as presented in chapter J. Progress will be assessed in a proactive manner to include risk analysis and mitigation. When challenges are identified, root cause analysis will be conducted and an improvement plan will be developed. This process will be conducted at all levels: the Performance and Recognition Committee, Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions. Technical assistance will be provided to participating entities to ensure that effective, timely improvement strategies are developed. Feedback loops will be incorporated at all levels to break down silos, strengthen communication, and embed accountability into the improvement process. The feedback loops and involvement of state evaluators will ensure that lessons learned within the Performance Measurement and Recognition Committee, Accountable Systems of Care, and Community Health Innovation Regions are sustained and disseminated throughout the test sites.

Each year, evaluation goals will be updated based on the specific milestones to be achieved in a given year. The self-evaluation seeks to identify the impact of specific model elements on each aim – improving health, improving care delivery, and cost containment - as well as the extent to which specific program components contributed to achieving the goals. Examples of possible evaluation questions that relate to anticipated milestones for each year are listed in table I.1. The evaluation plan will be updated each year to propose a specific methodology to answer the self-evaluation questions.

Table I.1 Relationship of Evaluation Questions to Health Innovation Plan Milestones

Year	Milestone	Example Self-evaluation Question
2015	State hires staff/contractors to provide technical assistance to Accountable Systems of Care and Community Health Innovation Regions	Are state-supported technical assistance offerings: a) sufficient, b) high quality, c) complementary to expertise of the Accountable Systems of Care and Community Health Innovation Regions?
2015	Performance Measurement and Recognition Committee establishes core metrics	Are core metrics: 1) implemented across multiple payers, 2) acceptable to providers?
2015	Level I and II Accountable System of Care established	Are criteria: 1) reflective of actual capacity to bear progressive amounts of risk, 2) achievable?
2015	Accountable Systems of Care have health information exchange capabilities	Do health information exchanges provide useable services to meet the needs of Accountable Systems of Care?
2015	Accountable Systems of Care establish role in Community Health Innovation Region	How do Accountable Systems of Care engage in Community Health Innovation Regions? What benefits do Accountable Systems of Care expect from participation?
2015	Community Health Innovation Regions implemented according to the Blueprint	Do Community Health Innovation Regions: 1) engage patients and communities, 2) obtain non-grant funding, 3) mobilize community resources and action efficiently towards a common purpose?
2016	Performance recognition plan implemented	Does a performance recognition plan influence the behavior of consumers, providers, and payers?
2016	Additional payers make decision to adopt new payment systems	How many new payers participate in the payment model? How many beneficiaries are covered?
2016	Level I Accountable System of Care demonstrates capacity enhancements to achieve Level II and move from shared savings to a capitation payment model	Do the graduated payment models provide incentives for providers to participate and subsequently move to share more risk?
2017	Accountable Systems of Care demonstrate achievement of quality standards and cost containment	Do Accountable Systems of Care lower Medicaid, Medicare, and commercial insurance cost trends? Do Accountable Systems of Care improve quality of care and health outcomes?
2017	Community Health Innovation Regions demonstrate added value	How do Community Health Innovation Regions demonstrate added value? What are the key characteristics of well-functioning Community Health Innovation Regions? Do population health indicators show greater improvement in regions with those characteristics?

12. Metrics

The self-evaluation plan will include both qualitative and quantitative data collection methods. Participant feedback will be measured in a combination of ways: quarterly reporting, surveys, feedback forums, interviews, and focus groups.

Michigan’s self-evaluation plan will track quantitative metrics related to the aims and drivers depicted in Michigan’s driver diagram (appendix 1.1). Possible quantitative measures are summarized in table I.2 below. The table also summarizes the potential source of each type of data, anticipated frequency of data collection, and the unit(s) at which data are available to authorized users. To enable accurate assessment of progress, comparison region(s) will be selected that match test regions on a set of characteristics, including baseline metrics. Where feasible, metrics will be tracked for demonstration regions, comparison regions, and the state as a whole.

The final set of metrics will be determined during the model test planning phase, once the evaluation contractor(s) and model test participants are selected. The evaluation contractor will review existing measures and propose a plan to collect data using mechanisms such as patient and provider/staff surveys, qualitative data collection, existing data sources, as well as the reporting requirements of Accountable Systems of Care and Community Health Innovation Regions. Additionally, in regard to collection of clinical quality metrics, several pilot tests of electronic data submission are underway or planned for the near future to satisfy requirements of the Meaningful Use of Electronic Health Records from the Centers for Medicare and Medicaid Services. Data collection methods will be finalized based on the results of these tests, and with input from the participating Accountable Systems of Care.

The Blueprint calls for Community Health Innovation Regions to develop and track a core set of community performance measures with input from community members; and to maintain a public community dashboard that provides community-specific measures, target performance, and compares the level of improvement against target performance goals. Outcome metrics – specifically in regards to social determinants and the environment – will be chosen based on the focus areas of the Community Health Innovation Regions.

Table I.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Aim I. Better Health Outcomes*			
Infant mortality	Michigan Department of Community Health Division for Vital Records & Health Statistics	By county and for selected cities	Annual
Adolescent obesity	Centers for Disease Control and Prevention High School Youth Risk Behavior Survey	State	Biennial
Adult obesity	Michigan Behavioral Risk Factor Survey	Local Health Department, County, State	Biennial

Table 1.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Adults reporting fair/poor health	As above	As above	Biennial
# Physically unhealthy days in last 30	As above	As above	Biennial
# Mentally unhealthy days in last 30	As above	As above	Biennial
Percent low birth weight babies	As above	As above	Annual
Sexually transmitted disease – chlamydia	As above	As above	Biennial
Additional metrics will be added once specific populations and conditions are identified	To be determined		
Driver: Healthy Behavior[±]			
Adequate physical activity for adults	Michigan Behavioral Risk Factor Survey	Local Health Department, County, State	Biennial
Adequate daily consumption of fruits and vegetables	As above	As above	Biennial
Excessive alcohol consumption	As above	As above	Biennial
Adult cigarette smokers	As above	As above	Biennial
Additional metrics will be added once specific populations and conditions are identified	As above	As above	Biennial
Driver: Environment			
Farmer’s Markets per Capita	United States Department of Agriculture Agricultural Marketing Service	County and selected cities	Annual
Air Quality (lead, particulates, etc.)	Michigan Department of Environmental Quality Air Quality Monitoring	Select cities and monitoring sites	Annual
Driver: Social Determinants			
Teen birthrates	Michigan Department of Community Health Division for Vital Records & Health Statistics	Local Health Department, County, State	Annual
To be determined	Driver: Community Capacity		

Table 1.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Community Health Innovation Region capacity (domains to be determined)	State Innovation Model project database	Region	Annual
Community outputs, including policy changes	Quarterly reporting requirements	Region	Quarter
Aim II: Better Care/ Access to High Quality Primary Care			
Residents reporting no personal health care provider	Michigan Behavioral Risk Factor Survey	Local Health Department, County, State	Biennial
Number of primary care providers per capita	To be determined		
Primary Care Provider panel size	Provider/staff survey	Individual, practice, Accountable System, Region	Annual
Number of practices participating in multi-payer Patient Centered Medical Homes payment model	State Innovation Model database	Practice, Region, Accountable System, State	Monthly
Number of beneficiaries served by Patient Centered Medical Homes participating in multi-payer payment model	Patient enrollment database	Individual, practice, Accountable System, Region, payer, State	Monthly
Percent of Medicaid beneficiaries served by Patient Centered Medical Homes participating in multi-payer payment model	Patient enrollment database	Individual, practice, Accountable System, Region, State	Monthly
Aim II: Better Care/Clinical Quality			
Recent dental visits	Michigan Behavioral Risk Factor Survey	Local Health Department, County, State	Biennial
Controlling high blood pressure at <140/90	To be determined		
Tobacco use and advice to quit	To be determined		
Depression screening, effective acute care and continuation care	To be determined		
Body Mass Index assessment of healthy weight	To be determined		
Comprehensive diabetes care at glycated hemoglobin <8.0%	To be determined		
Timeliness of pre-natal care	To be determined		

Table I.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Breast cancer screening	Michigan Data Collaborative	Individual, provider, practice, Accountable System, Region	Bi-monthly
Cervical cancer screening	As above	As above	Bi-monthly
Chlamydia screening	As above	As above	Bi-monthly
Influenza vaccination rate in adults age 65 and older	To be determined		
Complete lipid profile and low-density lipoprotein control <100	To be determined		
Childhood immunization status (Combination 3)	Michigan Data Collaborative	Individual, provider, practice, Accountable System, Region	Bi-Monthly
Immunization for adolescents (Combination 1)	As above	As above	Bi-monthly
Well-child visits (first 15 months of life, third-sixth years, adolescent well-care visit)	As above	As above	Bi-monthly
Chlamydia screening for adolescents	As above	As above	Bi-monthly
Weight assessment and counseling for nutrition and physical activity	To be determined		
Aim II: Better Care/Experience of Care			
Consumer Assessment of Health Care Providers and Systems – Patient Centered Medical Home version (adult and child)	Patient Survey	Individual, provider, practice, Accountable System, Region	Annual
Provider/practice staff work-life experience	Provider/Staff Survey	As above	Annual
Aim II: Better Care/Utilization			
Preventable emergency department visits	Michigan Data Collaborative	Individual, provider, practice, Accountable System, Region	Bi-monthly

Table 1.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Percent of hospitalizations for ambulatory care-sensitive conditions	As above	As above	Bi-monthly
Rates of 30-day hospital readmissions	As above	As above	Bi-monthly
Number of inpatient days during the last six months of life for Medicare patients	As above	As above	Bi-monthly
Driver: Patient Centered Medical Home Capacity			
Patient Centered Medical Home capacity on 13 designation domains	Patient Centered Medical Home Scoring data	Practice, Accountable System, Region	Annual
Proportion of primary care providers working within an interprofessional team	Provider/staff survey	Individual, practice, Accountable System, Region	Annual
Practice adaptive reserve*	As above	As above	Annual
Driver: Systems of Care			
Proportion of people in test communities enrolled in an Accountable System of Care	Patient enrollment database	Individual, practice, Accountable System, Region	Monthly
Accountable System of Care capacity (domains to be determined)	State Innovation Model project database	Accountable System, Region	Annual
Driver: Care Coordination			
Coordinated care - specific metrics to be determined	Patient/provider surveys, and quarterly reporting requirements	Individual, practice, Accountable System, Region	Varies
Aim III: Cost Containment			
Medicaid Cost Trend	Michigan Data Collaborative	Individual, provider, practice, Accountable System, Region	Bi-monthly
Medicare Cost Trend	As above	As above	Bi-monthly
Private Payer Cost Trend(s)	As above	As above	Bi-monthly

Table I.2 Potential Measurement Domains and Metrics

Measurement Domain/Metric	Source	Unit(s) at which available	Timing
Cost trends by type (e.g., hospital inpatient, emergency department, primary care, ambulatory specialty care, laboratory and radiology, pharmacy)	As above	As above	Bi-monthly
Driver: Administrative Complexity			
Number of payers using core metrics	State Innovation Model implementation tracking	State	Ongoing
Additional common forms and processes adopted	State Innovation Model implementation tracking	State	Ongoing
Complexity of Accountable System of Care implementation	Provider/staff survey	Individual, practice, Accountable System, Region	Annual

* These metrics will be compared by race/ethnicity, region, and income to assess health disparities.

‡ Adaptive reserve is a term used to summarize an organization’s capacity for change. It encompasses concepts of facilitative leadership, teamwork, work environment, and culture of learning. The provider staff survey will include measurement domains used in a similar survey conducted statewide among participants in the Michigan Primary Care Transformation demonstration project, which incorporated items from the following surveys: Minimizing Errors/Maximizing Outcomes (MEMO) provider survey; TransforMed Clinician and Staff Questionnaire; Agency for Healthcare Research and Quality TeamSTEPPS Teamwork Perceptions Questionnaire; CASE – Michigan Public Health Institute-created survey with items from a variety of sources including, but not limited to the above.

¹ Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Chapter J: Roadmap for Health System Transformation

Governor Snyder is strongly committed to transforming the health care system in Michigan to improve the health and health care of all Michiganders, while working to control costs, ensure high quality person-centered care, and eliminate health disparities. The Blueprint builds on current transformation initiatives, and with input from engaged stakeholders, the Michigan Innovation Model was designed to transform, rather than replace, service delivery and payment models to achieve better health and better care with cost containment. State-level governance in the Department of Community Health is accountable for effective execution of Michigan’s Blueprint. This chapter lays out a timeline of milestones and opportunities on the road to transforming the health system in Michigan.

The Blueprint advances a service delivery model and payment mechanisms that coordinate care delivered by Patient Centered Medical Homes through formal entities called Accountable Systems of Care. The model is also designed to reduce health risks in Michigan communities through Community Health Innovation Regions. Community Health Innovation Regions are consortia that break down silos across the health system – bringing health care, behavioral health, public health, business, local government, and community organizations together to align resources and implement effective strategies that improve the health of the community. Community Health Innovation Regions can leverage Prosperity Region initiatives (described in chapter B) that provide greater efficiency and consolidation of resources.

Michigan’s proposed service delivery and payment models will first be piloted in test regions, which will be selected using a methodology to be developed by the Office of Policy and Planning Innovation Model Steering Committee. This methodology will be designed to facilitate the model test, with attention to: organizational and community capacity to implement the service delivery and payment model elements, inclusion of rural and urban areas, alignment with other reform initiatives, suitable comparison regions, and local needs. This will allow the state to monitor progress and conduct a continuous quality improvement process to refine the Innovation Model before disseminating it across Michigan. Successful model elements will then be scaled up statewide and to other payers.

J1. Timeline for Transformation

Figure J.1 depicts an overview of Michigan's timeline for service delivery and payment transformation, which is presented in detail in table J.2 at the end of the chapter. There are three phases of innovation:



Michigan's Blueprint moves progressively from the current state of Michigan's health and health care system to the new service delivery and payment model. As described in chapter B, the current state includes multiple reform efforts already underway, including Patient Centered Medical Homes, and preparations for a demonstration to integrate care for those dually eligible for Medicaid and Medicare. The testing phase will therefore focus on implementing Accountable Systems of Care and Community Health Innovation Regions with associated payment models, and aligning these with existing reform efforts.

Planning for the testing phase has already begun and will accelerate immediately upon submission of the Blueprint and will inform a model test application to be submitted to the Centers for Medicare and Medicaid Services early in 2014. Michigan will be ready to implement a test of the Innovation Model towards the end of 2014. During the planning phase, major milestones will include finalizing the service delivery and payment models for Accountable Systems of Care, obtaining agreements from an initial set of payers to implement the Innovation Model, and seeking the necessary approvals from the Centers for Medicare and Medicaid Services to begin testing.

Michigan will use an improvement methodology that recognizes the value of testing proposed changes on a small scale before widespread dissemination. This minimizes risks and provides the opportunity for making adjustments in the models as the system reacts to changes over time.¹ The testing phase will be utilized to continually study and refine the models in preparation for statewide rollout by the end of the five-year period. By the end of the test phase, the preponderance of the population in the regions where the models are being tested will have an established relationship with a Patient Centered Medical Home, and will be enrolled in a non-fee-for-service-payment model. The Policy and Planning Office will collaborate with payers and other stakeholders including government, providers, purchasers, and consumers to expand successful elements of the model by offering opportunities for eligible networks to form Accountable Systems of Care across Michigan. Likewise, the Community Health Innovation Regions are expected to demonstrate added value by improving health and wellness, reducing health risks in the community, linking patients to behavioral and social care services, and contributing to lower health care costs. By the end of the dissemination phase, a preponderance of the population in Michigan will be enrolled in a non-fee-for-service payment model, and will be benefitting from the population-level strategies of their Community Health Innovation Region.

Michigan's Blueprint milestones are grouped into general categories as follows: governance, Accountable Systems of Care and Patient Centered Medical Homes, Community Health Innovation Regions, data systems and health information technology, learning systems, stakeholder engagement, populations covered, and policy.

J2. Governance of Michigan's Blueprint for Health Innovation

Michigan Department of Community Health

The Michigan Department of Community Health retains ultimate responsibility for implementing Michigan's Blueprint for Health Innovation, which will be accomplished through its Policy and Planning Office. Throughout the execution of the Blueprint, the Policy and Planning Office will ensure that key administrative functions critical to the long-term success of Michigan's plan are performed, including:

- Engaging broad stakeholders including businesses, payers, Medicaid Health Plans, consumers, providers, physician organizations, state and local government, philanthropy, community leaders, agencies, and non-profits in active participation in the Innovation Model Steering and Performance and Recognition Committees
- Ensuring adequate resources and supports are available for health system transformation
- Fostering a culture of continuous learning: implementing dashboards, monitoring the Blueprint test implementation and outcomes, and evaluating and disseminating models that work
- Coordinating the many state policy levers that will support execution and drive participation in the Innovation Model
- Align resources within the State's businesses, research universities, and non-profit organizations with a track record for promoting system transformation
- Working with the Health Information Technology Coordinator to prioritize health information technology and health information exchange investments that improve communication and coordination, enhance patient engagement, and reduce administrative burden and associated costs

During the planning phase, the Policy and Planning Office will create and implement a process to establish the Steering Committee as well as the Performance Measurement and Recognition Committee. It will also engage project management staff and contractors, and finalize the geographic pilot test communities.

Steering Committee

Early in the planning phase, the Michigan Department of Community Health will convene a multi-stakeholder body that will guide implementation of Michigan's Blueprint. Broad stakeholder representation assures that the health system is designed with the knowledge and experience of those who live and/or work on the front line of the health system; it facilitates ownership of the new model of care; and accelerates statewide deployment and sustainability.

The Steering Committee will play a key role in the rapid-cycle evaluation and improvement processes which will be employed to evaluate progress in relation to milestones and outcomes against target performance measures (described in chapter D). By doing so, it will ensure that the Blueprint is updated

to address changes in priorities, respond to needs at the local level, support ongoing innovation, and drive alignment across payers and health systems. By the end of 2014, the Steering Committee will finalize details of the payment models described in chapter E. During the testing phase, the Steering Committee will support health plan efforts to design health benefits that encourage patients to seek care from Patient Centered Medical Homes and Accountable Systems of Care, and engage patients in informed decision-making to use health care services wisely.

Project Management

To support the day-to-day administrative functions, the Policy and Planning Office will retain project management support staff and subcontractors. Project management staff will be accountable for:

- Providing administrative support for the Steering Committee
- Engaging all relevant stakeholders in health system transformation
- Creating learning systems and collaborating with evaluators in rapid-cycle improvement processes, monitoring Blueprint implementation, and helping the Steering Committee make appropriate adjustments based on outcomes
- Providing relevant data and information to the Steering Committee for decision-making
- Developing a plan to provide technical assistance; identifying and organizing technical assistance and learning supports for the design and payment test sites
- Disseminating information about models that work
- Implementing dashboards with transparent performance measures and quality rankings

Performance Measurement and Recognition Committee

Early in the planning phase, the Michigan Department of Community Health will also establish and maintain a multi-stakeholder Performance Measurement and Recognition Committee that engages key stakeholders in the design, monitoring, adjustment, and reporting of common performance and patient experience metrics. Michigan stakeholders strongly support the development of a core set of common performance measures. When core measures are applied consistently across the system, incentives will be aligned for providers to improve performance outcomes. In addition, a core set of measures will reduce the administrative burden on providers who are currently accountable to varying performance outcomes and who struggle with increasing administrative complexity. Stakeholders also support information transparency to assist consumers, payers, purchasers and providers to make better choices.

Performance measures are key to the success of large-scale health system transformation under the following conditions:²

- There is active participation of all relevant stakeholder groups to set the core measures
- There are incentives for acting on feedback from reported measures
- The feedback from measures is timely so as to impact provider behavior
- The measures are applied consistently across the system
- There is confidence in the validity of the measures selected
- Stakeholders can influence the revision and improvement of measures over time

The Performance Measurement and Recognition Committee will ensure that these conditions are met. To begin, the Committee will be comprised of relevant stakeholders from private and public sectors,

Global capitation models will focus on the priorities of Governor Snyder, the legislature, and Michigan Department of Community Health, including:

- Adolescent, at-risk pregnancies
- Individuals with a pattern of high utilization of emergency department services

including representatives from Accountable Systems of Care, Community Health Innovation Regions, purchasers, payers, Medicaid Health Plans, physician organizations, providers, state and local government, and health care consumers. The over-riding charge of this body will be to develop, implement, evaluate, and continually update a core set of valid performance measures to be employed consistently across the system for the performance incentive payment component of Michigan's Blueprint. Additional duties of this body are to review recognition criteria for defining and designating Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions, striving for alignment with existing criteria and administrative simplification. These measures will include both health care delivery and population-level performance measures, and will recognize and reward achievements in areas such as

infrastructure development, clinical quality, cost containment, coordination of care, and patient experience of care. The process of developing and updating the measures will be transparent, which will generate confidence among providers who are accountable to the measures.

J3. Implementing the Service Delivery and Payment Model

Early in the year 2014, initial criteria will be established for Level I and Level II Accountable Systems of Care, as well as for Community Health Innovation Regions. The Policy and Planning Office will choose regions in which to test the Innovation Model, as well as comparable regions that will serve as comparison sites. Subsequently, criteria for Accountable System of Care and Community Health Innovation Region participation will be finalized and reflect the required functions described in chapter E. Model refinement will be conducted with input from the steering committee, participating payers, and participating Accountable Systems of Care.

Accountable Systems of Care

Michigan believes that Medicaid Health Plans are critical partners that can actively collaborate with Accountable Systems of Care; or, if they meet the criteria, they can function as Accountable Systems of Care.

Defining the role of health plans within Accountable Systems of Care will be undertaken by the test participants. Services to be included in partial capitation arrangements, such as models of behavioral health and social service linkages, will be selected during the planning phase, as will conditions, such as at-risk pregnancy and high-utilizer populations to be included in global capitation arrangements (as described in chapter E).

Early in the testing phase, Accountable Systems of Care will begin providing care under the new model and will include high-volume Medicaid primary care practices. Initially, it might be the case that not all primary care practices are Patient Centered Medical Homes. It is the role of the Accountable System of Care to assist such practices to add that capacity. Interprofessional teams that include care managers and community health workers, among others, will be in place to support Patient Centered Medical Home and Accountable System of Care activities. During this phase, the Accountable Systems of Care will enhance access to care and establish models for behavioral health integration. They will leverage the work of Michigan Health Information Network Shared Services in consent management for data sharing. Also, the Accountable Systems of Care will establish links between public health and community services. Accountable Systems of Care are expected to add capacity over time: for example, it is anticipated that one or more Level I Accountable System of Care will achieve Level II status by the end of the testing phase and move from shared savings to a capitation payment model.

Accountable Systems of Care are built upon a foundation of Patient Centered Medical Homes and the substantial infrastructure developed by the provider organizations that participated in the Michigan Primary Care Transformation demonstration project, as well as Federally Qualified Health Centers supported by the Michigan Quality Improvement Network. In 2015, the results of the Michigan Primary Care Transformation demonstration project will be available. Progress to date suggests there is a case for continuing the program and scaling it up across Michigan. If warranted, Michigan will request continued multi-payer participation in the Michigan Primary Care Transformation program, based on the model developed during the demonstration.

In the Michigan Primary Care Transformation demonstration project, Medicaid directly pays the eligible primary care providers and physician organizations for the assigned Medicaid managed care enrollees. As part of the roadmap to move progressively to the new service delivery and payment model, Medicaid will seek approval from the Centers for Medicare and Medicaid Services to integrate the Patient Centered Medical Home and care coordination payments into the capitation rates paid to the contracted Medicaid Health Plans.

Community Health Innovation Regions

During the testing phase, all design and payment test sites will have a Community Health Innovation Region, a consortium that includes community members and facilitates collaboration among a wide variety of community stakeholders. Initial milestones for Community Health Innovation Regions include the demonstrated completion of a community health needs assessment, and development of strategic priorities. Based on the needs assessment and strategic priorities, the Community Health Innovation Regions will implement multi-sector, evidence-based strategic interventions. As the testing phase comes to an end, Community Health Innovation Regions will have demonstrated the use of effective strategies to improve health and well-being, reduce community health risk, and create greater integration across the system. Community Health Innovation Regions will be provided with technical assistance to help them identify creative funding mechanisms, such as partnering with non-profit hospitals' community benefit efforts and/or by engaging community development stakeholders and philanthropic organizations within the framework of the Community Reinvestment Act. Finally, policies will be considered that encourage broad-based, sustainable financing streams such as community benefit dollars, social investments bonds, and community trust funding as described in chapter E. Taken together, these efforts will enable

Community Health Innovation Regions to secure sustainable funding for ongoing investments in population-level strategies to improve health outcomes.

Data Systems and Health Information Technology

Milestones for data systems and health information technology are based on the needs of the State Innovation Model elements, as well as on the vision for how health information technology and exchange will evolve in the learning health system.

The Blueprint’s approach to data exchange will leverage federal initiatives to advance the adoption and meaningful use of health information technology, as well as investments already made in health information exchange. Chapter F describes the health information technology needs of each model element and how the Blueprint addresses those needs. The rapid-cycle improvement feedback loops pictured in appendix 4.1 show how emerging technologies and emerging needs can co-evolve, allowing the ongoing implementation of the Blueprint the flexibility to make targeted investments and test the results before scaling up.

Learning Systems

At the outset of the planning phase, a self-evaluation plan will be developed to monitor progress of Michigan’s Blueprint. The evaluation plan will include questions to be tested, initial performance metrics, and a method for provider and patient feedback using both qualitative and quantitative data collection. The project management team will work with the Steering Committee to establish quality improvement feedback loops between all parts of the system including Accountable Systems of Care, Community Health Innovation Regions, and the Michigan Department of Community Health. Design and payment test sites will receive training in the science of improvement methodology and will use rapid-cycle improvement processes to make improvements at every level of the system: Patient Centered Medical Homes, Accountable Systems of Care, Community Health Innovation Regions, and State governance bodies.

Technical assistance resources will be identified and made available to the design and payment test sites to ensure that they have the assistance they need to succeed in the transformation process. The extent of need and topic areas for technical assistance will be assessed in collaboration with participating Accountable Systems of Care and Community Health Innovation Regions – as these entities may have existing transformation resources. The Policy and Planning Office and Accountable Systems of Care may draw on existing resources (listed in table J.1) that have been developed collaboratively using government and private funding.

Ongoing rapid-cycle improvement processes will be embedded throughout the testing and dissemination phases to assure that stakeholders who are implementing the Health Innovation Plan continually improve the delivery and payment models. The plan for collecting data was described in chapter I and will leverage existing data collection processes. Systematic processes will be put

Table J.1 Example Technical Assistance Resources and Tools

Education 2 Practice
Michigan Care Management Resource Center
Michigan Center for Effective IT Adoption (Regional Extension Center)
Michigan Peer Review Organization
Many businesses, universities, and non-profit organizations

in place to capture and share lessons learned from rapid-cycle improvement processes at all levels of the system. These processes are depicted in appendix 4.1. Dashboards will be created and continually updated throughout the transformation process. The model will be continually updated in response to these self-evaluation results.

Stakeholder Engagement

Early in the planning phase, a plan for broad stakeholder engagement will be completed, including government departments and agencies, business, payers, community members, providers, philanthropy, and all other relevant stakeholders from Accountable Systems of Care and Community Health Innovation Regions. Required representation of patients/consumers and providers in the governance of Accountable Systems of Care and Community Health Innovation Regions will ensure these critical partners are engaged. Communication and feedback loops will be created to ensure ongoing engagement of stakeholders. In addition, it is within the Community Health Innovation Region that entities such as local service organizations, government agencies, businesses, schools, and city/township entities will be engaged in efforts to align resources and collaborate to improve health outcomes. Non-profit hospitals will be engaged around their Community Benefit requirement.

Policy Considerations

In order to successfully implement Michigan's Blueprint, the Policy and Planning Office will need to monitor state and federal policy developments that impact the Blueprint, as well as propose regulations to facilitate transformation. During the planning phase, the Office will conduct an environmental scan of the regulatory landscape. The Policy and Planning Office will work with the Office of Legal Affairs to ensure that Michigan's Blueprint complies with applicable state and federal laws, Medicaid policy, and state regulations. In addition, the Office will coordinate with the Department of Insurance and Financial Services and the Department of Licensing and Regulatory Affairs regarding policy matters, to ensure a broad approach to health care policy and enhanced collaboration between departments. The Policy and Planning Office will also seek the opinion of the Attorney General when needed. Early in the planning phase, the Policy and Planning Office will work with the Medicaid Agency to develop any Medicaid waivers necessary for the testing phase. Waivers currently under consideration for the implementation of the Healthy Michigan Plan for Medicaid expansion (see below) will be instrumental in positioning Medicaid and the Children's Health Insurance Plan to participate in health system transformation.

One of the major concerns for the development and implementation of the Accountable Systems of Care model is safeguarding providers and payers from legal risks of participation in the test. During the planning phase, structuring agreements and relationships will be critical to circumvent issues with both state and federal laws regarding physician self-referral laws (Stark laws), anti-kickback laws and, most importantly, antitrust laws (found in the Sherman Act, the Clayton Act and the Federal Trade Commission Act) that are intended to prevent unfair collusion and monopolistic behavior. Michigan's Blueprint will be developed to proactively assess the Model for antitrust implications and will structure the Model to avoid antitrust concerns.

The Policy and Planning Office, in conjunction with the Office of Legal Affairs will explore whether a regulatory approach that would preempt federal antitrust laws could be put into place. Antitrust issues will be addressed upfront to balance the need to create competitive health care markets, while lifting

unnecessary burdens on innovative delivery and payment models that integrate and coordinate care. Accountable Systems of Care encourage competition in the health system market, but provider agreements that could affect market allocation among competitors require continuous attention to antitrust considerations throughout the planning, testing, and dissemination phases of the Michigan Blueprint for Health Innovation. The State will work with the Office of Legal Affairs, housed within the Michigan Department of Community Health, and the Michigan Attorney General to ensure that the Michigan State Innovation Model has successfully mitigated these legal risks.

Early in the dissemination phase, the State will obtain the necessary authority to expand payment models for Accountable Systems of Care statewide. The Michigan Department of Community Health sees innovative delivery and payment as a priority for Medicaid/Children's Health Insurance Program and the contracted Medicaid Health Plans, and intends to place greater emphasis on these innovations through its development of future incentive and procurement efforts. The Policy and Planning Office will also coordinate agreement on common definitions and payment mechanisms for Patient Centered Medical Homes and Accountable Systems of Care.

The privacy of personal health information, particularly behavioral health information, and the security of health information exchange is a vital area to address. Many laws exist to protect this information. Education about the laws and consistent enforcement needs to be a top priority of the State to ensure the success of the Blueprint. Michigan's approach to health information exchange has privacy and security at the core. Michigan Health Information Network Shared Services convened a stakeholder work group to address both the technical and policy issues associated with the electronic exchange of behavioral health information. Reports on cyber-security and patient consent have already been delivered to the Health Information Technology Commission. Currently, Michigan Health Information Network Shared Services has convened numerous stakeholders in a work group to develop a behavioral health consent form in conjunction with Governor Snyder's Mental Health Diversion Council, in order to accelerate the ability of health care providers to electronically exchange behavioral health information exchange, while meeting all state and federal regulations and laws. Recommendations will be reported to the Health Information Technology Commission at the March 2014 meeting.

The Policy and Planning Office will work with the Office of Policy and Legislative Affairs within the Department of Licensing and Regulatory Affairs to determine how to define and manage responsibilities of community health workers. As discussed in chapter G, the Michigan Community Health Worker Alliance is taking the lead in convening community stakeholders to determine the best approach to regulation, licensure, and certification. The Policy and Planning Office will seek their input to inform policy about the regulation of community health workers.

Healthy Michigan Plan

Public Act 107, The Healthy Michigan Plan for Medicaid expansion was signed into law on September 17, 2013. It contains key policy levers that advance the Blueprint and that will help Medicaid and the Children's Health Insurance Program leverage the State Innovation Model and Blueprint testing. Collaborations required to implement Michigan's Blueprint (such as the Performance Measurement and Recognition Committee) include the same stakeholders as those required to work together by the legislation. In addition, the Healthy Michigan Plan directs the Department of Community Health and the

Department of Insurance and Financial Services to work together on medical cost containment, and gives them statutory authority to study health care system performance and make recommendations.

Per the legislation, the Department of Community Health recently convened a symposium to examine the issues of emergency department overutilization and improper usage. By December 31, 2014, the Department of Community Health must submit a report on the causes, best practice recommendations for reducing inappropriate utilization, and how those best practices are being implemented related to the medical program, enrollee behavior, and health plan access issues.

A “Michigan Health Care Cost and Quality Advisory Committee” will be convened with representation from the Department of Community Health, the Department of Insurance and Financial Services, and both houses of the State legislature. The Committee is charged with submitting a report by December 31, 2014 with recommendations on the creation of a database on health care cost and quality in the state.

The Healthy Michigan Plan describes benefit design changes that promote value-based purchasing and healthy behaviors. By September 30, 2016, the pharmaceutical benefit will be designed that utilizes co-pays at levels that encourage the use of high-value, low-cost prescriptions (such as generics and 90-day supplies). Cost sharing is implemented as a tool to drive value-based purchasing and to promote healthy behaviors. Required cost sharing can be reduced by the contracted health plan if healthy behaviors are being addressed as attested to by the contracted health plan, based on uniform standards developed by the Department of Community Health in consultation with the contracted health plans. The uniform standards shall include healthy behaviors that must include, but are not limited to completing a Department of Community Health-approved annual health risk assessment to identify unhealthy characteristics. Cost sharing reductions are limited based on such things as enrollees’ inappropriate usage of emergency departments.

The Department of Community Health is directed to collaborate with contracted health plans and providers to create financial incentives for: plans that meet specified population improvement goals; for providers who meet specified quality, cost and utilization targets; and for enrollees who demonstrate improved health outcomes or maintain health behaviors.

The Healthy Michigan Plan directs the Department of Community Health to pursue a range of innovations and initiatives to improve the effectiveness of the medical assistance program and to lower overall health care costs, and to report on efforts by September 30, 2015. It also allows for the use of telemedicine, which will facilitate the testing of some innovative care approaches in Michigan’s Blueprint.

Additional Policy Efforts

Several other efforts are underway that will support the implementation of the Michigan State Innovation Model.

- The Michigan Department of Community Health Strategic Priorities serve as a foundation for the Department, and provide clear priorities that support the State Innovation Model, including the following:
 - Implementing the Michigan Health and Wellness 4 x 4 Plan

- Ensuring access to high quality behavioral health and developmental disabilities services
 - Promoting the continued adoption of electronic health records
 - Integrating comprehensive and coordinated person-centered health care
- The Governor’s Health and Wellness 4x4 Plan embraces four healthy behaviors: healthy diet, regular exercise, annual physical exam, and avoidance of all tobacco use. Four health metrics are monitored: body mass index, blood pressure, cholesterol level, and blood sugar/glucose level. The 4 x 4 Plan envisions a broad, collaborative, multi-sectoral approach that includes state and local government, schools, businesses, and community organizations- to fundamentally overhaul the health of Michiganders by creating healthy communities and empowering and educating individuals through a variety of innovative interventions.

The 4x4 Plan incorporates a health-in-all-policies approach as the following Departments are partners along with the Michigan Department of Community Health: Agriculture and Rural Development, Transportation, Human Services, Natural Resources, Michigan Economic Development Corporation, and Office of the State Employer.

- The Public Health Accreditation Board has set a series of common objectives to assure that health departments meet a common set of standards and measures to ensure continuous improvement, which aligns with Michigan’s Blueprint. This accreditation builds on the ideas of better communication, collaboration, and quality improvement.
- Non-profit hospitals are required by the Patient Protection and Affordable Care Act to demonstrate that they meet the Community Benefit requirement by filing a written report describing how the hospital serves the community. This policy will provide an additional incentive for non-profit hospitals to participate in the Michigan State Innovation Model.

Summary

Michigan’s Blueprint is designed to move the State away from fee-for-service payment models, which are responsible for much of the episodic and fragmented care that drives high costs. The Blueprint supports improvements in the delivery of care through better integration and coordination across systems. Success requires co-evolution of delivery and multi-payer payment models that are supported by health information technology infrastructure, continuous learning processes, and effective governance systems. This roadmap lays out a plan to successfully develop and implement innovative delivery and payment models that will break down silos and bring together the people and resources to improve health, health care and control costs. Testing the model elements in multiple geographies will provide the opportunity to refine the model before it is expanded to additional payers and regions in years four and five.

Table J.2 Timeline of Milestones

2013-2014	2015	2016	2017	2018-2019
Governance				
<ul style="list-style-type: none"> - Design and payment model test finalized -Grant received from Center for Medicare and Medicaid Innovation -Policy and Planning Office within the Michigan Department of Community Health tasked with responsibility for State Innovation Model governance and health system innovation - Steering Committee established -Performance measurement and recognition committee established -Project management support staff/subcontractors in place -Regions to serve as test sites selected along with matched comparison regions -Model test application submitted to Center for Medicare and Medicaid Innovation 	<ul style="list-style-type: none"> -Business associate agreements, data use, and data sharing agreements negotiated -Multiple payers agree to use common core metrics -Dashboard developed and in place with transparent performance measures -Plan developed and executed to align payment models across payers, standardize performance measures, and simplify administrative policies -Benefit design recommendations made by Steering Committee -Rapid-cycle improvement process employed -Model refined and updated in response to self-evaluation results 	<ul style="list-style-type: none"> -Performance recognition plan implemented -Performance measurement and recognition committee achieves consensus on additional areas for administrative simplification -Health benefits designed that encourage patients to seek care from Patient Centered Medical Homes and Accountable Systems of Care, to engage them in informed decision-making and to use health care services wisely -Rapid-cycle improvement process employed -Model refined and updated in response to self-evaluation results 	<ul style="list-style-type: none"> -Key characteristics of successful model design and payment incorporated into Patient Centered Medical Home, Accountable System of Care, and Community Health Innovation Region criteria -Policy and Planning Office scale up successful elements of the model from design and payment test sites to other areas of the state and populations -Rapid-cycle improvement process employed -Model refined and updated in response to self-evaluation results 	<ul style="list-style-type: none"> -Continued need for Steering Committee assessed -Performance measurement and recognition committee made permanent -Rapid-cycle improvement process employed -Model refined and updated in response to self-evaluation results

Table J.2 Timeline of Milestones				
2013-2014	2015	2016	2017	2018-2019
Accountable Systems of Care and Patient Centered Medical Homes				
<p>-Level I and Level II Accountable System of Care criteria established</p> <p>-Readiness and capacity of potential Accountable Systems of Care assessed</p> <p>-Accountable Systems of Care to participate in the test identified</p> <p>-Accountable Systems of Care formal governance/legal structure established</p> <p>-Partial capitation model finalized: covered services and payment defined</p> <p>-Global capitation model finalized: specific conditions to be covered, and payment rates set</p> <p>-Respective roles of Medicaid Health Plans and Accountable Systems of Care with respect to data sharing and case management negotiated</p> <p>- Consensus among an initial set of payers obtained to implement the model</p> <p>-Contracts with Medicaid Health Plans and Accountable Systems of Care are signed</p>	<p>-Patient Centered Medical Home program updated in response to evaluation results of the Michigan Primary Care Transformation demonstration project</p> <p>-All Patient Centered Medical Homes in test regions eligible to participate in Michigan Primary Care Transformation</p> <p>-Accountable Systems of Care begin providing care under the new model</p> <ul style="list-style-type: none"> • Interprofessional teams in place to support Patient Centered Medical Home and Accountable System of Care activities • High-volume Medicaid primary care providers participating • Access enhanced • Models for behavioral health integration implemented • Models of coordinated care implemented • Community linkages in place • Role and engagement in Community Health Innovation Region established 	<p>-Patient Centered Medical Home and Accountable System of Care model and criteria refined with input of the Steering Committee, participating payers, and participating Accountable Systems of Care</p> <p>-Michigan Primary Care Transformation program expanded to cover additional designated practices statewide</p> <p>-Accountable Systems of Care demonstrate achievement of quality standards</p> <p>-Successful model elements of the Accountable Systems of Care are incorporated into model design and payment</p> <p>-Additional payers make decision to adopt new payment systems</p> <p>-Level I Accountable System of Care demonstrate capacity enhancements to achieve Level II and move from shared savings to a capitation payment model</p> <p>-Global capitation available for additional condition(s)</p>	<p>- Criteria for Accountable System of Care and Community Health Innovation Region participation finalized</p> <p>-Accountable Systems of Care demonstrate achievement of quality standards and cost containment</p> <p>-Preponderance of test geography population enrolled in a non-fee-for-service payment model</p> <p>-Statewide opportunity for Accountable System of Care designation and payment available</p>	<p>-Successful pilot components scaled up to other geographies, populations and systems</p> <p>-Preponderance of population statewide has a relationship to a Patient Centered Medical Home</p> <p>-Preponderance of state population enrolled in a non-fee-for-service payment model</p> <p>-Additional (commercial) payers make policy decision to adopt new payment systems</p>

Table J.2 Timeline of Milestones				
2013-2014	2015	2016	2017	2018-2019
Community Health Innovation Regions				
<ul style="list-style-type: none"> -Initial Community Health Innovation Region criteria established -Readiness and capacity of potential Community Health Innovation Regions assessed -Community Health Innovation Region Boards established, by-laws adopted, and backbone infrastructure in place -Broad cross-sector representation in Community Health Innovation Regions achieved including community engagement -Community Health Innovation Regions to participate in the model test are identified -Role and engagement with local public health and Accountable Systems of Care established 	<ul style="list-style-type: none"> -Community Health Innovation Regions implemented according to the new model: <ul style="list-style-type: none"> • Community Health Innovation Regions have completed community health needs assessment and set strategic priorities with the community • Multi-sector, evidence-based strategic interventions are implemented • System in place for assuring links between the delivery system and social care services for comprehensive non-duplicative care -Technical assistance is provided to identify sustainable funding mechanisms 	<ul style="list-style-type: none"> -Successful model elements of the Community Health Innovation Regions are incorporated into updated criteria 	<ul style="list-style-type: none"> -Community Health Innovation Regions demonstrate added value -Community Health Innovation Region functional elements updated in response to self-evaluation results -Sustainable funding is secured for the Community Health Innovation Region (e.g., Community Benefit funding, community trust fund, etc.) -Statewide opportunity is offered for Community Health Innovation Regions (in communities with Accountable Systems of Care) 	<ul style="list-style-type: none"> -Successful Community Health Innovation Region pilot components scaled up to other geographies, populations, and systems -Preponderance of state population has a Community Health Innovation Region
Data Systems and Health Information Technology				
<ul style="list-style-type: none"> -Agreement to obtain Medicare data and other participating payer data in place -User requirements documented for provider directory that tracks provider affiliations and patient participation in Accountable Systems of Care -Funding secured for necessary 	<ul style="list-style-type: none"> -Accountable Systems of Care, payers, and the Office of Policy and Planning have data systems in place to track participation and performance -Accountable Systems of Care have health information exchange capability in place -Community Health Innovation Regions have developed internal process for identifying 	<ul style="list-style-type: none"> - Admit/discharge/transfer messages available across networks with all hospitals and Accountable Systems of Care in test regions -Multi-payer cost and quality data aggregation system created -Meaningful Use Clinical Quality Measures database populated -System design reviewed 	<ul style="list-style-type: none"> -Meaningful Use Clinical Quality Measures database expanded to more providers -System design reviewed and updated based on agile development process 	<ul style="list-style-type: none"> -System design reviewed and updated based on agile development process

Table J.2 Timeline of Milestones				
2013-2014	2015	2016	2017	2018-2019
<p>investments in model testing infrastructure</p> <ul style="list-style-type: none"> -Technical assistance is plan in place to help entities enhance technical capacity -Cost/quality database for model test tracking -Project administration database(s) created -Project database to track capability of Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions in place -Structured process for shared continuous quality improvement and agile development in place 	<p>and investing in supporting technology for: community health needs assessments, community resource database</p> <ul style="list-style-type: none"> -Plan for standardized data analytics and reporting in place -Plan developed for statewide multi-payer cost and quality data aggregation based on results of feasibility study and recommendations of Cost and Quality Committee -Medicaid Enterprise interfaces with other Department of Community Health and State of Michigan systems -Medicaid Clinical Quality Measurement Recovery and Repository Service in place -System design reviewed and updated based on agile development process -Technical assistance is plan in place to help entities enhance technical capacity 	<p>and updated based on agile development process</p> <ul style="list-style-type: none"> -Technical assistance plan is in place to help entities enhance technical capacity 		
Learning Systems				
<ul style="list-style-type: none"> -Self-monitoring plan finalized • Stakeholder consensus on questions to be tested • Initial performance metrics finalized • Determine method for provider & patient feedback (mix between qualitative and 	<ul style="list-style-type: none"> -Structured process for sharing lessons learned are in place -Systems are in place that provide actionable data at levels of Accountable System of Care and Project Governance • Accountable System of Care and practice level dashboards refined • Community dashboards in place 	<ul style="list-style-type: none"> -Structured process for sharing lessons learned in place -Annual survey conducted (patient/provider) and focus groups for self-evaluation -Characteristics of top performing Accountable Systems of Care, Community Health Innovation Regions, and primary care practices identified 	<ul style="list-style-type: none"> -Annual survey conducted (patient/provider) and focus groups for self-evaluation -Characteristics of top performing Accountable Systems of Care, Community Health Innovation Regions, and primary care 	<ul style="list-style-type: none"> -Final impact evaluation results of State Innovation Model test available

Table J.2 Timeline of Milestones

2013-2014	2015	2016	2017	2018-2019
<p>quantitative methods)</p> <ul style="list-style-type: none"> • Rapid-cycle improvement process developed <p>-Feedback loops between Accountable Systems of Care, Community Innovation Regions and Michigan Department of Community Health are established to provide policy input from local and state levels</p> <p>-Technical assistance resources developed and made available</p>	<p>and refined</p> <p>-Accountable Systems of Care and Community Health Innovation Regions implement Rapid-cycle improvement processes</p> <ul style="list-style-type: none"> - Baseline surveys conducted for self-evaluation - Baseline data for self-evaluation collected and analyzed 		<p>practices identified</p> <p>-Impact evaluation conducted</p>	
Stakeholder Engagement				
<p>-Patient/person engagement plan created that includes broad stakeholder representation including individuals from vulnerable populations</p> <p>-Accountable Systems of Care and Community Health Innovation Regions have structure in place to engage stakeholders in quality improvement of the delivery system</p> <p>-Communication and feedback loops created to ensure ongoing engagement of stakeholders in place</p> <p>-Patient/person</p>	<p>-Patient/person engagement tools and mechanisms including person-centered care planning are widely adopted in Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions</p> <p>-Stakeholders are engaged in quality improvement at all levels collaboratively</p> <p>-Model is updated in response to stakeholder feedback</p>	<p>-Stakeholders are engaged in quality improvement at all levels</p> <p>-Stakeholders are engaged in cross-sector collective impact activities in the community to improve health and health care outcomes</p> <p>-Model is updated in response to stakeholder feedback</p>	<p>-Model is updated in response to stakeholder feedback</p>	<p>-Model is updated in response to stakeholder feedback</p>

Table J.2 Timeline of Milestones

Table J.2 Timeline of Milestones				
2013-2014	2015	2016	2017	2018-2019
engagement tools and mechanisms identified				
Population Covered				
	-Test regions, members of: <ul style="list-style-type: none"> • Medicaid/Children’s Health Insurance Program • Medicare • State employees -Statewide <ul style="list-style-type: none"> • Michigan Primary Care Transformation program Patient Centered Medical Home population 	-Test regions, members of: <ul style="list-style-type: none"> • Medicaid/ Children’s Health Insurance Program • Medicare • State employees • Additional commercial payer -Statewide <ul style="list-style-type: none"> • Michigan Primary Care Transformation program Patient Centered Medical Home population 	-Test regions, members of: <ul style="list-style-type: none"> • Medicaid/ Children’s Health Insurance Program • Medicare • State employees • Additional commercial payer -Statewide <ul style="list-style-type: none"> • Michigan Primary Care Transformation program Patient Centered Medical Home population 	-Statewide <ul style="list-style-type: none"> • Medicaid/ Children’s Health Insurance Program • Medicare • State employees • Commercial payers covering >70% of population
Policy Considerations				
-Medicaid and Medicare agreement on Accountable Systems of Care elements: <ul style="list-style-type: none"> • Patient enrollment • Partial capitation services covered and rates • Global capitation conditions covered and rates • Risk adjustment • Continuity of care adjustment -Medicaid Waivers	-Medicare and Medicaid agreement to extend and expand Michigan Primary Care Transformation in place <ul style="list-style-type: none"> -Patient Centered Medical Home payments integrated into Medicaid Health Plan capitation rates -Data sharing agreements and policies reviewed/ revised as needed -Privacy and security policies in place to protect patients/consumers -Consent form to exchange behavioral health information 	-Legislation, if needed for multi-payer data aggregation <ul style="list-style-type: none"> -Data sharing agreements and policies reviewed/ revised as needed -Anti-trust, anti-kickback and Stark law protections in place -Agreement, if needed on data standardization in place -Department of Insurance and Financial Services in conjunction with the Michigan Department of Community Health begins to regulate and/or incentivize participation 	-State obtains necessary authorities to expand payment models for Accountable Systems of Care statewide <ul style="list-style-type: none"> -Medicaid State Plan updated to reflect Patient Centered Medical Home and Accountable System of Care delivery models -Data sharing agreements and policies reviewed/ revised as needed 	-Department of Insurance and Financial Services regulations strengthened as needed to support addition of commercial payers <ul style="list-style-type: none"> -Consumer privacy policies reviewed and updated as needed -Community trust and/or other sustainable funding mechanisms established to

Table J.2 Timeline of Milestones				
2013-2014	2015	2016	2017	2018-2019
<p>in place</p> <p>-Survey conducted on relevant state and federal law for the plan</p> <p>-Initial model test data sharing and informed consent policies addressed</p> <p>-Michigan Health Information Network Shared Services develops the trust framework and process for securing health information exchange</p> <p>-Scope of practice approach updated</p> <p>-Anti-trust, anti-kickback, and Stark laws being addressed</p> <ul style="list-style-type: none"> • Review applicability of legislation/State Action Doctrine • Consult Attorney General <p>-Graduate Medical Education funding policies updated to promote primary care and interprofessional team education</p>	<p>electronically adopted</p> <p>-Patient education and outreach developed in regards to consent and privacy</p> <p>-Legislation to preempt federal anti-trust laws enacted</p> <p>-Legislation in place to support regulation of community health workers</p>	<p>of Michigan health insurance providers in the State Innovation Model</p>	<p>-Consumer privacy policies reviewed and updated</p> <p>-Anti-trust, anti-kickback and Stark law protections in place</p> <p>-Existing data standards are reviewed and refined</p>	<p>support Community Health Innovation Regions</p> <p>-Anti-trust, anti-kickback and Stark law protections in place</p>

¹ Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

² Best, A., Greenhalgh, T., Lewis, L., Saul, J., Carroll, S. and Bitzi, J. Large-System Transformation in Health Care: A Realist Review. *The Milbank Quarterly*. Vol. 90, No. 3, 2012 (pp. 421–456).

