State Innovation Model Operational Plan Award Year 3 Update

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State of Michigan
Department of Health and Human Services

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A. PROJECT SUMMARY

A.1 SUMMARY OF MODEL TEST

Reinventing Michigan's health care system is one of the state's top priorities. This ambitious objective 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.

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

At the core of the governor's vision is an efficient, effective, and accountable government that collaborates on a large scale to provide quality service to Michiganders. The vision, which had been developed through a year-long process that included input from stakeholders and subject matter experts, has five key elements. Three of these—Patient-Centered Medical Homes (PCMHs), Accountable Systems of Care, and Community Health Innovation Regions (CHIRs)—would support person- and community-centered care and drive improvements in population health. The other two—health information and process improvement infrastructure and a value-based payment model—would provide the structure and incentives needed to deliver efficient, effective, high-value care. Each of these components, comprising the Michigan State Innovation Model, would contribute to improving outcomes for three SIM priority populations: individuals at risk of high emergency department utilization, pregnant women and babies, and individuals with multiple chronic conditions.

Since funding for the model test began in 2015, activities and circumstances at the state and federal level, along with an assessment of the multi-payer landscape in Michigan, have influenced the pace and scale of implementation. Additional time was required for MDHHS to establish SIM goals, governance, and department-wide alignment. A notable evolution was the decision to move away from the Accountable Systems of Care model as a key component of Michigan's model test. This shift began with Michigan's Year 2 Operational Plan.

As the state moved from planning in Award Year 1 to implementation and operationalization in Award Year 2, the Michigan SIM team learned from its challenges and made accomplishments across a wide scope of component initiatives. Award Year 3 continues down the path of reinvention by evaluating, refining, modifying, and optimizing SIM initiative business

requirements to ensure further success, while at the same time developing long-term strategies and sustainability models.

Michigan's Year 3 Operational Plan describes how the state, through the Michigan Department of Health and Human Services (MDHHS), plans to utilize State Innovation Model (SIM) Cooperative Agreement funds to continue its vision of empowerment: a person-centered health system that coordinates care across medical settings and with community organizations to address social determinants of health, improve health outcomes, and pursue community-centered solutions to upstream factors related to poor health outcomes. MDHHS continues to organize the implementation of the SIM program under three main components: Population Health, Care Delivery, and Technology.

POPULATION HEALTH

The Population Health component centers on Community Health Innovation Regions, or CHIRs (pronounced "shires"), which are intended to build community capacity to drive improvements in population health. The goal of the CHIR is to grow and strengthen broad community partnerships and build a shared value of health through local governance bodies.

Community Health Innovation Regions

Community Health Innovation Regions form the foundation of the Population Health component of the SIM Program. A CHIR is a broad partnership of community organizations, local government agencies, business entities, health care providers, payers, and community members that comes together to identify and implement strategies that address population-level health, upstream conditions that affect health equity, and which work towards health system transformation. These partnerships work under a collective impact model for a more coordinated investment into the upstream factors that influence the social, economic, and environmental determinants of health. Collective impact involves a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants. In addition, each CHIR is identifying and addressing issues impacting health equity. The state has selected five regions of the state in which to test the CHIR model. Each of the five SIM CHIRs is supported by a backbone organization that serves as, or contracts with, a fiduciary and acts as a neutral convener for the CHIR's governing body.

Table A.1-1 CHIRs and Backbone Organizations

CHIR	Backbone Organization	Fiduciary
Genesee Region	Greater Flint Health Coalition	Greater Flint Health Coalition
Jackson Region	Henry Ford Allegiance Prevention and Community Health	Henry Ford Allegiance Prevention and Community Health
Muskegon Region	Muskegon Community Health Project	Muskegon Community Health Project
Northern Michigan Region[1]	Northern Michigan Public Health Alliance	Northern Health Plan
Livingston/Washtenaw Region	Center for Healthcare Research and Transformation	Center for Healthcare Research and Transformation

The overarching mission of the CHIR regions is to align priorities across health and community organizations and support the broad membership of the CHIR in developing and implementing health system change strategies. Specifically, CHIRs will assess community needs, define regional health priorities, support regional planning, increase awareness of community-based services that address social determinants of health, and increase Clinical-Community Linkages. All CHIRs are required to focus initially on reducing emergency department utilization, which is a statewide priority, while also assessing community needs and identifying region-specific health improvement goals.

The backbone organization has the responsibility to ensure that the broad-based coalition is convened and facilitated, and that other coalitions and community groups are appropriately integrated into the system and programmatic work of the CHIR. The backbone organization itself does not have authority beyond other governing body members, except for the responsibility to ensure that the CHIR is convened and ensure governance structure is established. Decisions about spending are made collectively by the CHIR governing body, of which the backbone organization is a member. The backbone organization itself does not have disbursement authority for CHIR funding, except for the yearly administrative funding allocated to it to carry out administrative responsibilities (e.g. convening and facilitating the membership and governing body), and providing program management for the operations of the CHIR governing body. The disbursement authority for general CHIR funds from the SIM rests with the CHIR governing body. The backbone organization has no special authority within the governance structure of the CHIR governing body, and is solely charged with supporting its

[1] The Northern Michigan region is defined as the following 10 counties: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, and Wexford.

membership in the decision-making and implementation of consensus activities. The backbone organization is intended to be a neutral convener that facilitates cross-sector, systems-change efforts, as determined by the CHIR membership. The CHIR backbone organization serves administrative and fiduciary functions and is the broader collective's liaison to the state. Key fiduciary functions include scope negotiations, contract execution, completing CMS unrestriction requests, and submitting budgets and financial reporting.

Each CHIR backbone organization receives a fixed amount of SIM funding to support administrative functions and transformational funding that varies based on the number of Medicaid beneficiaries in the region. Transformational funding is to be used to support actions and interventions proposed by CHIRs, such as designing and implementing Clinical-Community Linkage activities, local hublets, or other programs, policies, and environmental strategies for population health improvement of the SIM target populations. Each CHIR has submitted a comprehensive plan to fulfill the CHIR requirements. After an initial planning and implementation period, all CHIRs are expected to be fully operational in early 2018.

The primary goal for Award Year 3 of the CHIR component is the full operationalization of the five test regions, culminating in the creation of a Michigan CHIR Pilot Manual. The manual will be created by the State of Michigan in collaboration with the CHIRs and other stakeholders. The consolidated manual will be used by the state and the CHIRs to further define and, where appropriate, standardize the model in an effort to engage additional partners in support of an extended pilot. The manual will include such items as the backbone organization's role, the infrastructure for Clinical-Community Linkages, hubs, referral networks, and the financial model to be used to support the infrastructure. In Year 3, the CHIR regions will establish evaluation parameters, including measures and analysis, to better determine progress towards CHIR goals and objectives. This evaluation will provide significant input to the development of the final CHIR Pilot Manual.

CARE DELIVERY

The Care Delivery component encompasses a Patient-Centered Medical Home (PCMH) initiative and the promotion of alternative payment models.

Patient-Centered Medical Homes

With the state's focus on person- and family-centered care and strong evidence that the PCMH model delivers better outcomes than traditional primary care, the Patient-Centered Medical Home has been viewed, from the outset, as the foundation for a transformed health system in Michigan. The SIM PCMH Initiative is built upon the principles of a Patient-Centered Medical Home, and these principles define the model at a general level regardless of the designating organization. Particular value is placed on core functions of a medical home, such as enhanced

access, whole person care, and expanded care teams that focus on comprehensive coordinated care and population management.

Following the release of an Intent to Participate process in fall 2016 to PCMH-accredited organizations within the five SIM CHIR regions and to current Michigan Primary Care Transformation (MiPCT) project participants[2] across the state, the state identified approximately 350 practices interested in and eligible for participation in the PCMH Initiative. These practices represent over 2,000 primary care providers and collectively serve all of the Medicaid beneficiaries affiliated with these practices and providers. Approximately 50 percent of the practices are in a SIM CHIR region. Approximately 15 percent of the total Medicaid beneficiary population in the state is eligible for participation in the SIM PCMH Initiative.

As a condition of participation in the initiative, PCMHs are required to work toward two practice transformation objectives. All participating PCMHs are required to work toward the practice transformation objective of developing Clinical-Community Linkages. This requirement can be satisfied by the development of partnerships between the primary care practices and the community-based organizations that provide services and resources to address significant socioeconomic needs of the practice's patient population. Practices based within a SIM CHIR region are encouraged to work in close collaboration with CHIR partners to develop Clinical-Community Linkage processes and support the alignment of interests and goals among health care and community-based organizations. In addition, practices must select a secondary practice transformation objective from a list of 11 approved activities identified in the 2017 SIM PCMH Initiative Participation Agreement and Participant Guide, including telehealth adoption, medication management, group visit implementation, and integrated clinical decision making.[3] The 2018 PCMH Initiative Participation Agreement provides guidance to practices both within a CHIR and those located outside of CHIRs on the development and implementation of their Clinical-Community Linkages. In addition, the PCMH Initiative has a collaborative learning network called the Practice Transformation Collaborative that is focused on supporting participants in the development and sustainable implementation of their Clinical-Community Linkages.

The state has established a payment model specific to the SIM PCMH Initiative to support practice transformation and care coordination. Each practice participating in the PCMH Initiative will receive payments for its attributed Medicaid beneficiaries. Practices will receive $1.25 per member per month (PMPM) to support practice transformation (i.e., investment in

[2] A description of and more information about the Michigan Primary Care Transformation project can be found at https://mipct.org/.

[3] Up to date information on the PCMH Initiative can be found at http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76092_77452---,00.html.

practice infrastructure and capabilities) and a PMPM care management and coordination payment that varies by type of Medicaid beneficiary from $2.75 to $7.00. The participating payers are 11 Michigan Medicaid Health Plans. This payment model has been specifically designed to support alignment across various programs that providers may be actively involved in, such as the national Comprehensive Primary Care Plus (CPC+) program and the Blue Cross Blue Shield of Michigan Physician Group Incentive Program.

The Michigan SIM PCMH Initiative has set the following high-level goals for the coming award year:

- Champion models of care that engage patients using comprehensive, whole person oriented, coordinated, accessible, and high-quality services centered on an individual's health and social well-being.
- Support and create clear accountability for quantifiable improvements in the process and quality of care, and in health outcome performance measures.
- Create opportunities for Michigan primary care providers to participate in increasingly advanced Alternative Payment Models, thereby increasing the likelihood of success in All-Payer Combination Alternative Payment Model efforts.

Alternative Payment Models

In developing its model for health system transformation, the state understood the importance of providing incentives for delivering care based on value rather than on the number of services delivered. Alternative Payment Models (APMs) provide incentive payments to health care practices for providing high-quality and cost-efficient care. The state is working to promote the use of APMs through two primary strategies: (1) setting goals for the use of APMs, starting with payers in the Michigan Medicaid program, and (2) creating a multi-payer payment and service delivery model, including a potential partnership with CMS for Medicare alignment. The overarching goal is to promote service delivery innovation and maximize the opportunities for providers to receive enhanced reimbursement for improving patient health.

In support of the first strategy, the state collected comprehensive baseline information on Medicaid Health Plan participation in APMs, and is convening an APM workgroup to engage health plans and other relevant internal stakeholders in developing appropriate goals for the percentage of payments that Medicaid Health Plans are making using APMs. MDHHS is in the process of approving Medicaid Health Plan APM strategic plans, which includes establishing these goals and overall APM strategy within each Medicaid Health Plan. These APM strategic plans and the goals they contain will be finalized by the end of calendar year 2017 and will be reviewed annually. Medicaid Health Plans will move into more detailed implementation

planning in the beginning of 2018. MDHHS looks forward to sharing more information about the Medicaid Health Plan APM strategy as these plans are finalized.

The second strategy will involve working with CMS to explore multi-payer demonstration or waiver approaches, including the potential for a custom Medicare participation option in Michigan. MDHHS is considering the multi-payer options available within the context of state and federal landscapes to determine the appropriate path forward.

TECHNOLOGY

The SIM Technology component is where the state is leveraging its new and existing statewide infrastructure and related health information exchange (HIE) initiatives to enable and support advances in population health, payment strategies, and care delivery strategies.

Michigan has established the Relationship and Attribution Management Platform (RAMP) to ensure a foundation for supporting care coordination and identifying relationships between patients and providers. RAMP is designed to support several critical aspects of care management and coordination, including a health provider directory, a system for tracking active care relationships between patients and health care providers, the exchange of quality-related data and performance results, and the transmission of admission, discharge, and transfer (ADT) notifications. Leveraging the statewide health information exchange infrastructure in the development of RAMP allows the state to take advantage of a widespread network of networks to increase interoperability and support the goals of the initiative.

High-level technology goals for the coming year include the following:

- Transition RAMP components to be used in support of broader statewide and multi-payer initiatives that align with the state's Advanced Planning Documents.
- Transition current data flow to one that supports leveraging the statewide health information network and the core use cases such as the Active Care Relationship Services (ACRS) and Health Provider Directory.
- Ensure continued alignment of the ADT use case with Medicaid Health Plan contractual requirements.
- Continue the use case onboarding by the state-designated HIE, collection of data through the statewide health information network, and define how this data is to be used within the state.
- Establish a roadmap for increasing the quality and detail of patient-level attribution data within the Medicaid Health Plan ACRS file.
- Develop a use case for the collection and reporting of social determinants of health data.

- Define the data-sharing needs and requirements of CHIRs and other community-based organizations.
- Establish standards for the technology platform and data requirements of Clinical-Community Linkages.

A.2 END STATE VISION

Michigan has a developed an ambitious plan to improve the health of all Michiganders by addressing social determinants of health in primary care by effectively linking to community systems and innovative HIE/HIT solutions. Michigan looks to improve population health, the quality of health care, and reduce health care costs while developing sustainability models for each major SIM component.

The SIM Program will support this vision by:

- Developing and executing a broad stakeholder engagement plan to facilitate collaborative discussions on the current focus of SIM, future direction for the remainder of SIM, and sustainability strategies. In addition, the state will explore potential models for ongoing stakeholder engagement strategies, which may include establishment of external advisory groups.
- Exploring the feasibility of focused CHIR pilot program pending the results of the proof of concept.
- The state will work collaboratively with health plans, health care systems, providers and other stakeholders to develop a consistent and sustainable model for Clinical-Community Linkages.
- The state and Medicaid Health Plans will work collaboratively to develop a model for sustainable funding of PCMH Care Managers and Care Coordinators.
- Assessing the intersection of housing and the impact on cost associated with health care and other related costs.
- Developing a housing program across all CHIRs to sustain housing coordination and support functions.
- Further integrating housing programs into the CHIR model.
- Aligning the health care and population health goals of the state with an updated State of Michigan Plan for Improving Population Health.

The state will explore convening key stakeholders and external advisory groups charged with continuing the work that SIM has started. They will provide guidance for the evolution of the CHIR Initiative, multi-payer alignment strategies, payment models, quality metrics, and incentive programs. The finalized stakeholder engagement plan will challenge participants to

work collaboratively to develop program sustainability using community benefit dollars, shared savings models, advanced payment strategies, grants, and the development of additional funding options.

Michigan has put an emphasis on targeting upstream social determinants of health by coordinating efforts between PCMHs and community organizations. This will be achieved by providing community organizations and coalitions with governance best practices, requirements for implementing Clinical-Community Linkages, and training assistance on creating change at the system level.

The Plan for Improving Population Health will align department initiatives and interagency efforts to improve the health of all Michigan residents. Policies and business requirements developed in support of PCMHs, APMs, and CHIRs will align with the Population Health Improvement Plan.

The State of Michigan has also leveraged and continues to leverage existing infrastructure that has been funded through federal, state, and public sources. The HIE/HIT initiatives aim to improve and propagate key statewide use cases, continue to move providers away from claims-based decision-making, and promote the use of EHRs and clinical data for measurement, care management, and population management.

A.3 Updated Driver Diagram

A thorough review of the driver diagram's primary and secondary drivers indicated that all drivers save one were still feasible and accurate to the aims of the project. The secondary driver for Population Health pertaining to Accountable Systems of Care was changed to reflect the program's emphasis on Clinical-Community Linkages. The only other changes made to the diagram were minor grammatical changes for clarity and brevity. The updated Driver Diagram is included in Appendix 1.

A.4 Updated Master Timeline

Table A.4-1 Michigan SIM Master Timeline Year 3

Michigan SIM Master Timeline Year 3	
Task Name	**Quarter**
Population Health Initiative	
Development of Individual Local Operational Plans (LOPs)	
Develop SIM Year 3 Participation Guide	Q1 2018
Update CHIR Individual Local Operational Plans (5 Regions)	Q2 2018

Michigan SIM Master Timeline Year 3	
Task Name	**Quarter**
CHIR Implementation	
Operationalize Clinical-Community Linkages	Q1 2018
Operationalize Additional Interventions Specific to Each CHIR	Q1-Q4 2018
Project Monitoring and Improvement	Q1-Q4 2018
Collaborative Learning	
CHIR Coaching and Technical Assistance	Q2-Q4 2018
Collaborative Platform Website	Q1 2018
ABLe Change Training	Q1-Q4 2018
Annual CHIR Summit	Q4 2018
Housing Initiative	
High Level Design - Housing Initiative	Q1 2018
CHIR Sustainability	
Develop CHIR Sustainability Plan	Q2-Q3 2018
Plan for Improving Population Health	
Develop Plan for Improving Population Health	Q1-Q4 2018
Patient-Centered Medical Home Initiative	
Performance Monitoring and Compliance	
Care Management/Care Coordination	Q1-Q4 2018
Compliance Monitoring and Reporting	Q1-Q4 2018
Participant Support and Learning Activities	
Virtual Meetings with SIM PCMH Participants; Annual Kick-Off, Quarterly Update	Q1 2018
Practice Transformation Collaborative Learning	Q1-Q4 2018
Care Coordination Collaborative	Q1-Q4 2018
Annual Summits	Q2, Q3 2018
Care Manager and Coordinator Trainings and Skill Development	Q1-Q4 2018
Participant Payment and Model Execution	
Payment Disbursement	Q1-Q4 2018
SIM PCMH Initiative Onboarding	
Initiative Requirements Definition/Adjustments	Q3 2018
Participant Onboarding	Q3-Q4 2018
Participant Information Maintenance Process	Q1-Q4 2018
Alternative Payment Models (APMs)	
APM Work Groups	
Maintain Internal APM Coordination, Status Monitoring and Governance Processes	Q1-Q4 2018
Maintain External Medicaid Health Plan (MHP) APM Workgroup Collaboration	Q1-Q4 2018

Michigan SIM Master Timeline Year 3	
Task Name	**Quarter**
APM Stakeholder Engagement	
Conduct Provider APM Request For Information Data Collection	Q1 2018
Conduct Provider and Provider Association Engagement on APMs and Performance Measurement	Q2 2018
Medicaid Health Plan (MHP) APM Strategic Planning	
Enhance/Improve the MHP APM Strategic Plan Template	Q3-Q4 2018
Review and Approve Initial MHP APM Strategic Plans	Q1 2018
Provide an Annual Process MHP APM Strategic Plan Updates and Approvals	Q2-Q4 2018
State-Preferred APM Models	
Further Define and Support MHP Implementation of State-Preferred APM Models	Q2-Q3 2018
Review Effectiveness of the MHP Extra Credit Approach for State-Preferred APMs and Consider Other Motivating Strategies	Q1-Q4 2018
MHP APM Performance and Incentive Structure	
Conduct MHP Contract Compliance Activities Related to MHP APM Goals	Q1-Q4 2018
Mature APM-Focused Elements of the MHP Performance Bonus	Q2-Q3 2018
APM Model Reporting Process	
Conduct APM Reporting Process to Monitor MHP APM goals	Q1-Q4 2018
Develop MHP APM Annual Narrative Progress Report	Q2 2018
Add APM Component of MHP Annual Focus Study	Q4 2018
APM Quality and Outcome Measures	
Review Effectiveness of Initial Quality Measure Approach for APMs	Q1-Q4 2018
Develop Plan to Enhance APM Performance Measure Consistency Over Time	Q2 2018
Multi-Payer Alignment	
HIE Use Case Implementation Alignment	
Collaboration with Commercial Payers on HIE Use Case Alignment	Q1 2018
Comprehensive Primary Care Plus (CPC+) Program Coordination	
PCMH Participation Requirements Alignment	Q3 2018
PCMH and CPC+ Coordination	Q1-Q4 2018
Care Management and Care Coordination Coding Alignment	
Align CM/CC Coding Sets Across Payers/Programs	Q1 2018
Align CM/CC Claims Billing, and Monitoring Across Payers/Programs	Q1 2018
Shared Provider Data Portal	
Shared Data Infrastructure Usage	Q2-Q4 2018
APM Commitment	
Development of APM Goals for Medicaid and Other Michigan Commercial Payers	Q2-Q4 2018
Technology Initiative	
Quality Measures and Reporting	
Monthly Ongoing Reporting (Patient Lists, Care Management Reports, Quarterly Progress Reports)	Q1-Q4 2018

Michigan SIM Master Timeline Year 3	
Task Name	**Quarter**
Relationship & Attribution Management Platform (RAMP)	
Long Term Optimized Attribution Design	Q1 2018
Long Term Attribution Optimization Technical Implementation	Q3 2018
Health Directory Optimization	Q4 2018
Monthly Ongoing Attribution Calculations	Ongoing
Use Case Onboarding	
Quality Measurement Information	Q2 2018
Admission, Discharge, and Transfer Notices (ADT)	Q3 2018
CHIR Technology	
Clinical-Community Linkages	Q4 2018
Program/Project Management	
Year 4 Planning	Q3 2018
Status Reporting	Ongoing
Sandbox	
PCMH Participation Data	Q4 2018
Data Quality	Q2 2018
Housing Data	Q1-Q3 2018
Other	
CareConnect 360 Feasibility Study	Q2 2018

Table A.4-2 Michigan SIM Preliminary Milestone Timeline Year 4

Michigan SIM Preliminary Milestone Timeline Year 4	
Task Name	**Quarter**
Population Health Initiative	
CHIR Implementation	
Maintain and Optimize Clinical Community Linkages	Q1-Q4 2019
Operationalize Interventions Specific to Each CHIR	Ongoing
Project Monitoring and Improvement	Q1-Q4 2019
Collaborative Learning	
Develop Coaching and Technical Assistance Transition Plan	Q1 2019
Transition CHIR Coaching and Technical Assistance	Q2-Q4 2019
Migrate Platform Website	Q1 2019
Annual CHIR Summit	Q3 2019
Housing Initiative	
Implement Housing Initiative	Q1-Q4 2019
CHIR Sustainability	
Finalize CHIR Sustainability Plan	Q2 2019
Update Model Design Based on Evaluation	Q3 2019
Develop Post-SIM Execution Plan	Q4 2019

Michigan SIM Preliminary Milestone Timeline Year 4	
Task Name	**Quarter**
Plan for Improving Population Health	
Roll Out Plan for Improving Population Health	Q1-Q4 2019
Patient Centered Medical Home Initiative	
Performance Monitoring and Compliance	
Care Management/Care Coordination	Q1-Q4 2019
Compliance Monitoring and Reporting	Q1-Q4 2019
Participant Support and Learning Activities	
Virtual Meetings with SIM PCMH Participants; Annual Kick-Off, Quarterly Update	Q1-Q4 2019
Participant Payment and Model Execution	
Payment Disbursement	Q1-Q4 2019
Alternative Payment Models (APMs)	
APM Work Groups	
Maintain Internal APM Coordination, Status Monitoring, and Governance Processes	Q1-Q4 2019
Maintain External MHP APM Workgroup Collaboration	Q1-Q4 2019
APM Stakeholder Engagement	
Continue Provider APM RFI Data Collection	Q1 2019
Continue Provider and Provider Association Engagement on APMs and Performance Measurement	Q2 2019
Medicaid Health Plan (MHP) APM Strategic Planning	
Implement MHP APM Strategic Plan	Q1 2019
Implement Annual MHP APM Strategic Plan Updates and Approvals	Q2 2019
MHP APM Performance and Incentive Structure	
Conduct MHP Contract Compliance Activities Related to MHP APM Goals	Q1-Q4 2019
Mature APM-Focused Elements of the MHP Performance Bonus	Q1-Q4 2019
APM Model Reporting Process	
Conduct APM Reporting Process to Monitor MHP APM goals	Q1-Q4 2019
Develop MHP APM Annual Narrative Progress Report	Q2 2019
APM Quality and Outcome Measures	
Execute Plan to Enhance APM Performance Measure Consistency Over Time	Q1-Q4 2019
Multi-Payer Alignment	
Update Multi-Payer Alignment Strategy	Q1 2019
Technology Initiative	
Quality Measures and Reporting	
Monthly Ongoing Reporting (Patient Lists, Care Management Reports, Quarterly Progress Reports)	Q1-Q4 2019

Michigan SIM Preliminary Milestone Timeline Year 4	
Task Name	**Quarter**
Relationship & Attribution Management Platform (R.A.M.P.)	
Develop Transition Plan for Attribution Mode	Q1 2019
Transition Attribution Technical Solution to Operations	Q3 2019
Use Case Onboarding	
Transition Quality Measurement Information (QMI) to Operations	Q3-Q4 2019
Transition Admission, Discharge & Transfer Notices to Operations	Q1 2019
CHIR Technology	
Document Community Clinical Linkages Technology Guidance/Requirements	Q1-Q2 2019
Program/Project Management	
Year 4 Close Out	Q3-Q4 2019
Status Reporting	Ongoing
Sandbox	
Data Quality	Q1-Q4 2019
Housing Data	Q1-Q4 2019

Table A.4-3 Michigan SIM Year 2 Timeline Milestone Status

Milestone	Complete (Y/N)
Care Delivery	
Attribution Process	Y
Care Coordination	Y
Practice Transformation	Y
PMCH Onboarding	Y
Reporting/Metrics	Y
Provider Enablement	Y
Monitor/Enforcement, Process Improvement	Y
Multi-Payer Alignment	N[4]
Program Management / Governance	
Establish Program Management & Delivery Office	Y
Implement Program Governance	Y
Execute Stakeholder Engagement	Y
Technology	
Care Coordination / Practice Transformation Enablement	Y
Initial Performance Metrics Implementation	Y

[4] Please see Michigan NCE reporting and latest QPR for Year 2 multi-payer status.

Milestone	Complete (Y/N)
Future Performance Metrics Planning	Y
Population Health Support (CHIR, CCL, CLN)	Y
Participation Metrics	Y
Population Health	
Initialize / Monitor CHIR Initiative	Y
Backbone Outreach/Onboarding	Y
CHIR Implementation & Operationalization of Local Plans	Y
Reporting/Metrics	Y
Accountable Systems of Care CHIR Integration	Y
Collaborative Learning	N[5]

B. General SIM Policy and Operational Areas

B.1 SIM Governance

B.1.a Management Structure Update

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

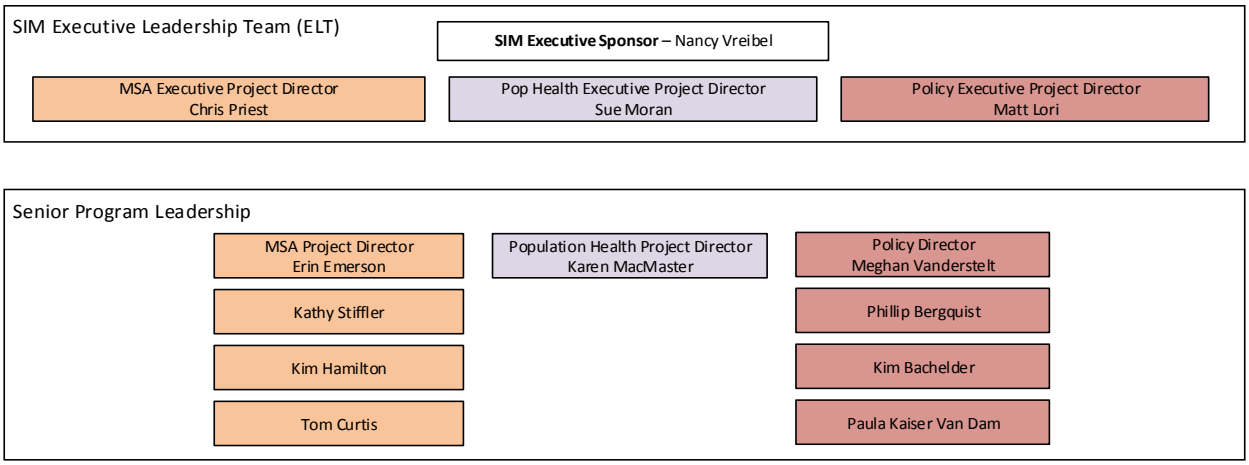
In June of 2017, an updated SIM organization and governance structure was approved and implemented by MDHHS. Specifically, the expansion of leadership and governance includes an Executive Leadership Team consisting of departmental directors from the Medical Services Administration (MSA); Population Health and Community Services Administration; and the Policy, Planning, and Legislative Services Administration. This newly-expanded executive representation and governing body ensures the work initiated by the SIM grant is aligned with broader departmental vision, goals, and related objectives. Regular bi-monthly governance meetings are planned, where status, planning, issues, risks, and other program-related topics are discussed; resolutions and mitigations formulated; and decisions are documented. This

[5] Collaborative Learning, as defined in Y2 Operational Plan, has shifted to the PCMH Initiative

input and guidance is essential in the oversight and success of ongoing operations and SIM planning cycles.

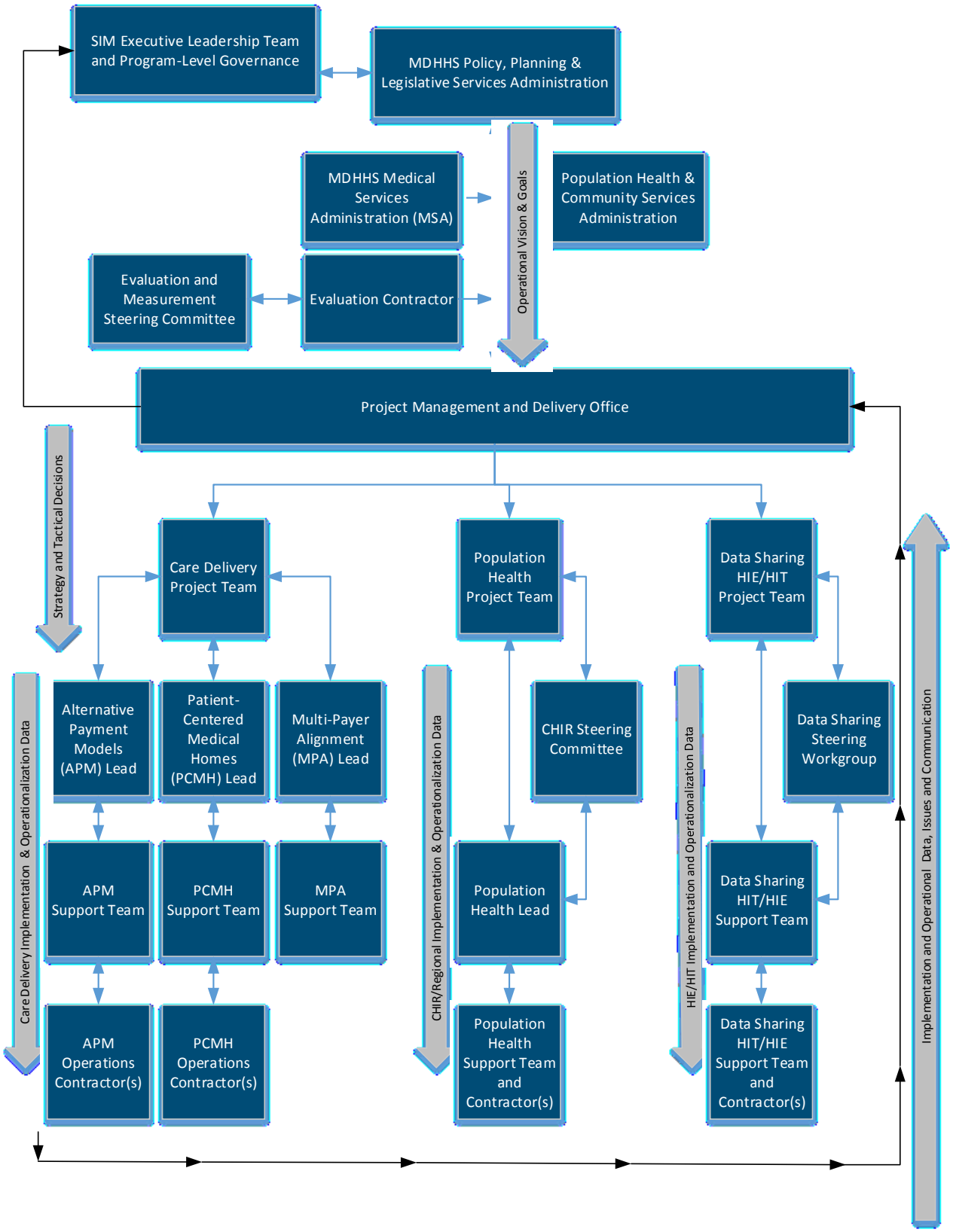
The Michigan SIM team's Year 2 plan outlined a comprehensive public/private commission and component committee structure. Ongoing evaluation of that approach has resulted in a change of strategy. The new focus is on developing and finalizing a broad stakeholder engagement plan to facilitate collaborative discussions on the current focus of SIM, future direction for the remainder of SIM, and sustainability strategies. In addition, the state will explore potential models for additional ongoing stakeholder engagement strategies, which may include establishment of appropriate external advisory groups.

Figure B.1-1 SIM Executive and Senior Program Leadership



See Appendix 2, SIM Organization Model, for full details.

Figure B.1-2 Michigan SIM Organizational Chart



The SIM team also continues to supplement the formal governance and operational structure with additional ad hoc and regular participant and other stakeholder engagements. These include, but are not limited to, a possible new steering committee with focus on the Community Health Innovation Region (CHIR) Initiative and Evaluation and Measurement. These advisory committees are comprised of subject matter experts from various MDHHS departments and administrations, and other key personnel and Michigan SIM partners. Additional input is also sought and gathered via participant workshops, learning sessions, and other component- and program-wide activities. See Section B.1.d (Stakeholder Engagement) for detailed information regarding these bodies and their role in the management, governance, and oversight of the SIM program in Michigan.

Program teams, constituent roles, and contractors supporting the program remain fairly consistent with the Year 2 plan, with the following exceptions: Segal and Company will no longer be supporting the Care Delivery component, and Michigan State University's engagement has been expanded beyond the BRFFS survey and data analysis to include CHIR Initiative evaluation services and a systems change initiative (ABLe Change Framework). The CHIR evaluation is being led by Pennie Foster-Fishman, Ph.D., MSU Department of Psychology. The ABLe Change engagement is facilitated through the Michigan State University Department of Psychology's System exChange office. Additional information about both initiatives can be found in the Population Health CHIR Initiative component detail section, Section C.4, of this plan, the State-Led Evaluation section, Section D.1, and in the SIM budget narrative that accompanies this Operational Plan Update in the Year 3 Non-Competing Continuation submission.

The SIM Year 2 Operational Plan detailed a staffing plan including roles and responsibilities, professional development, and other parameters that remain fully intact. The program management roles, subject matter experts, and other supporting positions continue to operate as designed and include additions of more, but similar, roles to those outlined in that plan. The program management office organization referred to as the Program Management and Delivery Office (PMDO) continues to coordinate and support all personnel and teams to ensure the successful implementation of ongoing operations of component initiatives and other non-component tasks. The PMDO framework coordinates, supports, tracks, and reports on the portfolio of component projects, activities, and other engagements required to meet the near- and long-term program goals. The base processes and structure incorporates the capabilities and expectations of state and CMS stakeholders, and overall SIM requirements. The PMDO provides standards and applies best practices solutions across program and project structure, governance, management, measurement, communication, risk management, change control, and other critical processes required to effectively and efficiently meet SIM goals. Additional

focus has been, and will continue to be, on the end state vision, strategy, and sustainability of the SIM components beyond the SIM Test period.

B.1.b DECISION-MAKING AUTHORITY

The updated executive leadership team and existing management structure continues to support the flow of planning, implementation, and operational data required to drive informed decision-making across all levels of SIM program governance. The addition of the Executive Leadership Team (ELT) has provided further accountability and added a final escalation path for program issues, risks, and other required direction. The executive layer of governance, with direct ties to department- and state-level leadership and strategists, improves decision-making authority and better supports the alignment of SIM planning and implementation with the vision and improvement goals MDHHS has for the health care continuum in Michigan.

The expanded SIM governance, coupled with the existing program and component management structure, provides additional leadership from MDHHS executives, increases bandwidth of state subject matter experts, facilitates dissemination of decisions and direction, and empowers component teams to escalate issues and risks while streamlining the resolution and mitigation processes. The inclusion of, and input from, these individuals is imperative for the final planning, implementation, and operationalization of the SIM components in the remaining years of the project period. It further ensures the work aligns with and supports the broader vision and goals of the State of Michigan. The individuals, titles, contact information, and specific SIM roles are in included in the table below.

Table B.1-1 SIM Component/Project Area Key Staff Directory

SIM Component / Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
Executive Leadership	SIM Executive Sponsor	Nancy	Vreibel	517-373-3626	VreibelN@michigan.gov
Executive Leadership	SIM MSA Executive Leadership	Kathy	Stiffler	517-241-9944	StifflerK@michigan.gov[6]
Executive Leadership	SIM Population Health, State Evaluation, and CHIR Executive Leadership	Sue	Moran	517-284-4730	MoranS@michigan.gov

[6] Chris Priest, originally identified as the MSA representative for SIM, has left MDHHS.

SIM Component / Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
Executive Leadership	SIM Policy, Planning & Legislative Services Executive Leadership	Matt	Lori	517-284-4040	LoriM@michigan.gov
Governor's Office Representative	Sr. Policy Advisor, Office of the Governor	Elizabeth	Gorz	N/A	Gorze@michigan.gov
Sr. Program Leadership	Policy Director	Meghan	Vanderstelt	517-284-4758	VandersteltM@michigan.gov
Sr. Program Leadership	MSA Project Director	Erin	Emerson	517-284-1132	EmersonE@michigan.gov
Sr. Program Leadership	Care Delivery Business Owner	Kathy	Stiffler	517-241-9944	StifflerK@michigan.gov
Sr. Program Leadership	Population Health Business Owner	Karen	MacMaster	517-284-4022	MacMasterK@michigan.gov
Sr. Program Leadership	Medicaid Operations Business Owner	Brian	Keisling	517-284-1183	KeislingB@michigan.gov
Sr. Program Leadership	Actuarial Business Owner	Penny	Rutledge	517-284-1191	RutledgeP1@michigan.gov
Sr. Program Leadership	Alternative Payment Model Business Owner	Phillip	Bergquist	517-284-4046	BergquistP@michigan.gov
Sr. Program Leadership	Medicaid Quality Lead	Tom	Curtis	517-284-1152	CurtisT2@michigan.gov
Sr. Program Leadership	Multi-Payer Alignment Business Owner	Kim	Hamilton	517-284-1147	HamiltonK@michigan.gov
Sr. Program Leadership	HIE/HIT Data Sharing Business Owner[7]	Erin	Mobley	517-284-4043	MobleyE2@michigan.gov
Sr. Program Leadership	CHIR Business Owner	Paula	Kaiser-VanDam	517-241-0638	KaiserP@michigan.gov
Sr. Program Leadership	SIM Communication Liaison	Brad	Barron	517-284-4048	BarronB@michigan.gov
Sr. Program Leadership	Integration Lead	Mark	Cascarelli	734-277-7684	CascarelliM@michigan.gov

[7] Kim Bachelder, the current SIM HIE/HIT business owner, will depart the Michigan SIM Program prior to Year 3 start.

SIM Component / Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
Sr. Program Leadership	Administrative Program Manager	Andy	Spencer	248-559-7910	SpencerA6@michigan.gov
Evaluation	State Evaluation Lead	Clare	Tanner	517-324-7381	CTanner@mphi.org

B.1.c REGULATORY AUTHORITY

The state has leveraged several policy opportunities to support the implementation of care delivery through Patient-Centered Medical Homes, CHIRs, and Alternative Payment Models (APMs). Michigan has been successful in using its regulatory oversight to align health insurers to initiate transformation of the delivery of health services. The following areas have provided further support of SIM initiatives.

Medicaid Contract Revisions

Michigan's Medicaid contract has aligned Medicaid Health Plans (managed care organizations) across ten regions in the state. This contract has recently been revised to support SIM in the following areas.

Value-Based Payment Models

Consistent with MDHHS' vision and strategy to move reimbursement from fee-for-service to value-based payment models, the department's primary focus is on improving quality and efficacy of care while reducing avoidable costs. MDHHS' contract with the Medicaid Health Plans increases the total percentage of health care services reimbursed under value-based contracts. Value-based payment models are those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries.

Value-based payment models may include:

- Total capitation models
- Limited capitation models
- Bundled payments
- Supplemental payments to support practice-based infrastructure and team-based care delivery models
- Payment for new services that promote more coordinated and appropriate care, such as care management and community health worker services, which are traditionally not reimbursable

To provide visibility and progress transparency, each health plan will report at least semi-annually on the percentage reimbursed under value-based payments, which must comply with payment reform goals. These reports will also contain other metrics related to health care services that comply with payment reform goals. MDHHS utilizes the Healthcare Payment Learning and Action Network Advanced APM framework to define payment methodologies for reporting, goal setting, and monitoring purposes. As Medicaid Health Plan APMs progress, MDHHS intends to consider the CMS Quality Payment Program advanced APM definition and criteria as well.

Michigan's APM Initiative is a portion of the department's strategy to move along both state and federal roadmaps for more value-based and other advanced alternative payment models. According to CMS, alternative payment models are a "payment approach that gives added incentive payments to provide high-quality and cost-efficient care," which "can apply to a specific clinical condition, a care episode, or a population." [8]

Alternative Payment Models

As the state continues its focus on payment transformation activities in alignment with the Health Care Payment Learning and Action Network (LAN) framework, Medicaid Health Plans must describe their timeline and action plan to meet contractually established payment reform threshold requirements for FY 18 that include the use of APMs. Health plans must describe how their approaches and initiatives are designed to align with APMs in use by Medicaid or SIM.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has allowed practices to use multi-payer APM options. Practices can combine participation to be considered as participating in multiple APMs. The strategy is to operationalize value-based payment under the Medicaid contract. To build consistency, the contract also aligns definitions on those who are considered PCMHs across SIM and the health plans.

See Section C.2, Alternative Payment Models, for a complete SIM APM Strategy for Michigan.

Patient-Centered Medical Homes

Michigan's contract recognizes the need to support a Patient-Centered Medical Home (PCMH) model, both to ensure patient care is managed across a continuum of care, and to access specialty services as appropriate. Health plans agree to support and promote PCMH adoption among Michigan primary care practices, including, but not limited to, coordinating care for enrollees served by a practice in the network that is:

- a PCMH in a SIM region.

[8] https://qpp.cms.gov/apms/overview

- a previous Michigan Primary Care Transformation (MiPCT) practice.
- a practice participating in Michigan's PCMH Initiative.

All health plans must comply with MDHHS guidance related to the SIM PCMH Initiative, including, but not limited to:

- Sharing data and exchanging health information.
- Coordinating health plan care management activities and care managers with care management and coordination activities and staff embedded in participating practices.
- Making payments according to the Initiative payment model to participating practices or physician organizations for beneficiaries determined eligible by MDHHS.

Accreditation and Certification

Health plans are required to contract with primary care practices that are recognized as Patient-Centered Medical Homes by any of the following organizations:

- The National Committee for Quality Assurance (NCQA)
- Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP)
- Utilization Review Accreditation Commission (URAC)
- Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home
- The Joint Commission (TJC) Primary Care Medical Home
- Commission on Accreditation of Rehabilitation Facilities-Health Home (CARF)
- Other PCMH standards approved by MDHHS

Care Management

Health plans must report the percentage of primary care practices with embedded or shared care managers. In addition, standardized work processes are required between health plan care management staff and the embedded and shared care managers at practices. This promotes coordination and avoids duplication of services. Such work processes must include establishing a single point of contact between the health plan and an embedded care manager.

CHIR Support

As community-based initiatives funded by SIM develop in a health plan's service area, plans are required to participate in the CHIRs and related initiatives. See Section C.4 for complete CHIR Initiative detail.

Medicaid Health Plans and Managed Care Contract

Medicaid Health Plans (MHPs) are required to support the SIM initiatives through their contract with the Medical Services Administration in the Michigan Department of Health and Human

Services. That contract states that “as community-based initiatives funded by SIM develop in [the] Contractor’s service area, including Community Health Innovation Regions (CHIRs), Contractor must participate in these initiatives.” Many of the other requirements in the MHP contract also will contribute to MHP support of SIM, such as the support of Patient-Centered Medical Home expansion and coordination with accountable systems of care. This requires MHPs to contract with primary care practices that are recognized as Patient-Centered Medical Homes by any PCMH standards approved by MDHHS and to support care managers in a way that promotes coordination and avoids duplication of services.

The MHP contract also requires several activities pertaining to data aggregation, analysis, and dissemination to support population health management. This includes utilizing data to “address health disparities, improve community collaboration, and enhance care coordination, care management, targeted interventions, and complex care management for [several] targeted populations.” They are also required to “participate in initiatives to develop […] reports for primary care practices that will support practice activities to improve population health management, including, but not limited to, an actionable list of Enrollees for primary care practices that identify the targeted populations.” These are just a few examples of the ways in which MHPs are required through their state contract to engage in activities that will support the overarching vision and mission of the Michigan SIM.

The primary care practices that participate in the SIM PCMH Initiative have each signed a memorandum of understanding signifying their agreement to carry out the activities required for participation, including collecting and reporting data needed to support program management and evaluation of the initiative.

Health Equity

Health plans must participate in the Medicaid Health Equity Project and report all required information to MDHHS. An annual report is submitted to MDHHS on the effectiveness of its evidence-based interventions to reduce health disparities, and includes such considerations as:

- Number of participants experiencing a disparate level of social needs, such as transportation, housing, food access, unemployment, or education level
- Number participating in additional in-person support services such as Community Health Worker, patient navigator, or health promotion and prevention programs delivered by a community-based organization

Health Information

Two recent changes in state requirements affect the sharing of behavioral health information. The first change is the passage of Public Act 559 of 2016, which amends the Michigan Mental Health Code to allow for the sharing of mental health records for the purpose of treatment,

care coordination, and payment. As a result, health care providers and health plans no longer need written consent to share mental health records for these purposes. The second change is the promulgation of the revised 42 CFR Part 2 rule (Confidentiality of Substance Use Disorder Patient Records), which governs the sharing of substance use disorder information. The two aforementioned regulatory changes will have a significant impact on the sharing of behavioral health information within the Michigan health care system.

In addition, the PCMH participation guide issued this year introduces the Relationship and Attribution Management Platform (RAMP). The RAMP has been created to support:

- The identification and capture of relationships between patients/consumers and their health care delivery team members.
- The facilitation of active exchange of necessary information between these identified individuals and organizations.
- The provision of infrastructure necessary for the PCMH Initiative and the Comprehensive Primary Care Plus (CPC+) program to be effective.

The state-designated entity for health information exchange in Michigan, Michigan Health Information Network Shared Services (MiHIN), is engaged in the RAMP project to leverage the widespread interoperability network MiHIN has established in the State of Michigan, along with multiple tools and services to support the goals of this large undertaking. A number of use cases have been created by MiHIN to facilitate statewide exchange of health information.

As a result of RAMP, the Active Care Relationship Service tracks patient-provider attributions by identifying which health care providers have active care relationships with patients or consumers. This service acts as the basis of the RAMP process by allowing RAMP to match patients or consumers with their attributed care team members. This mechanism supports exchange of information between members of the extended health care delivery team, including the patient. The MiHIN Health Provider Directory includes the electronic service information required to know how and where health relationship and payment information is to be delivered electronically for each health care provider.

Certificate of Need

An independent 11-member commission oversees the certificate of need program to address anti-competitive concerns and to evaluate any significant market changes. Reviews are conducted by the evaluation section of MDHHS. The program balances cost, quality, and access issues, without political influence.

Community Health Innovation Regions (CHIRs)

CHIRs are a critical element of the Population Health component of the SIM Program. CHIRs are charged with assessing community needs, defining regional health priorities, supporting regional planning, increasing awareness of community-based services, and increasing linkages between health and social services. CHIRs are focused both on reducing emergency department use and on region-specific population health goals.

Each CHIR submitted a comprehensive operational plan to meet participation requirements. Operational plans submitted to and approved by MDHHS in June of 2017 included a 12 month budget and activity timeline. These plans will be updated annually. Initial plans are focused on developing and implementing strategies for identifying people who make frequent visits to the emergency department and using a screening tool to assess their needs related to social determinants of health, such as housing, financial assistance, food access, and employment. CHIRs will also work to develop Clinical-Community Linkages among Patient-Centered Medical Homes, emergency departments, and community-based organizations in their regions to establish a referral and care management process to meet the needs identified through the screening process.

B.1.d STAKEHOLDER ENGAGEMENT

Engagement of key internal and external stakeholders, thought leaders, and participants has been a priority in the implementation of the State of Michigan's SIM Test. The overarching strategy for engaging stakeholders is twofold: core participant engagement, and the engagement of external stakeholders who can support implementation of SIM during the model test and help sustain the program after the test has been completed. This section provides an overview of the ways in which stakeholders are being engaged in the SIM PCMH Initiative, the CHIRs, and the SIM Program overall. It also lays out plans for future engagement of stakeholders in the overall governance of the initiative.

Patient-Centered Medical Home Initiative

Several stakeholder groups are engaged in the implementation of the Michigan SIM Patient-Centered Medical Home (PCMH) Initiative.

Table B.1-2 PCMH Stakeholder Engagement Methods

Stakeholder	Method	Purpose
Primary care practices/providers	• Annual summits • Office hours	To build capacity to support the model that has been

Stakeholder	Method	Purpose
Physician organizations	• Annual summits • Quarterly meetings • BCBSM Physician Group Incentive Program meetings • Office hours	designed for the PCMH Initiative, create standardization across key stakeholders, support team-based care and transitions.
Care managers/ coordinators	• Annual summits • Office hours • Virtual learning opportunities • Required training	
Medicaid Health Plans	• Care Coordination Collaboratives • Monthly meetings with MHPs • Participate in MHP care manager and quality director calls • Participate in bi-monthly meetings with MHP contract managers	To support MHPs in realizing the value of the SIM PCMH Initiative and work with MHPs to carry out a blended funding model using both MSA and MHP dollars to support the PCMHs.
BCBSM and Priority Health	• Work with University of Michigan operations partners on care management/coordination payment models and coordinate across training standards	To promote alignment between MHP and commercial payment strategies.
CHIR backbone organizations	• Virtual and face-to-face trainings are open to them • Invited to annual PCMH summit • Statewide CHIR Summit	To support shared alignment, reduce duplication, establish Clinical-Community Linkages, and develop shared guidance and requirements.
Health care trade associations	• Ad-hoc meetings with multiple association representatives • Participation in individual association meetings	To share information with a wider audience of interested stakeholders and provide a way for the associations to support their members who participate in the model test.

Stakeholder	Method	Purpose
Patients/beneficiaries/ consumers	• Non-SIM PCMH Initiative patient family advisory councils • Future: patient experience surveys	To ensure patients and families have a voice in the design of initiatives that affect their health.

Community Health Innovation Regions

Several stakeholder groups are engaged in the implementation of the Michigan SIM Community Health Innovation Regions.

Table B.1-3 CHIR Stakeholder Engagement Methods

Stakeholder	Method	Purpose
CHIR backbone organizations	• One-on-one calls (1/month) • Cohort calls (2/month) • Summits • Monthly newsletter • ABLe trainings (three 2-day sessions) • Coaching calls • Technical assistance calls	Develop specific strategies for each region to improve the health of the community, and support cross-region collaboration and learning.
PCMH Initiative Practices	• Monthly CHIR governance meetings include representation from locally participating PCMHs practices and provider organizations • Invited to participate in CHIR summits	To develop alignment and collaboration to improve Clinical-Community Linkages within each region.

Stakeholder	Method	Purpose
Patients/beneficiaries	• CHIR governance bodies must have 51 percent community representation (vs. clinical) and must include a community member to represent patients • Most regions have plans to engage beneficiaries directly to help them understand CHIRs • A patient satisfaction survey is under development	To engage patients and beneficiaries in identifying strategies for improving the health of the community as well as to increase their understanding of the connections between community and clinical health models.
MDHHS	• Monthly CHIR steering committee meetings with representatives from several agencies within MDHHS	To engage MDHHS leadership in setting the vision and direction for the SIM model test and to identify ways to leverage existing initiatives.
Local and Public Health Departments	• Electronic and other communication channels • Participation in backbone organization and governance/advisory bodies	Ensure local efforts are coordinated and bolster integration of services and response to community needs.

General Stakeholder Engagement

In early 2017, the SIM team conducted a survey of the approximately 1,500 stakeholders who have signed up for the SIM listserv. Since the Michigan SIM Program began, the listserv has been used to share updates on the project milestones and invite people to participate in and learn more about the model components. Approximately 200 stakeholders replied to the survey, which was designed to find out what types of information stakeholders want from the SIM team, and whether they are closely involved with the initiative, are trying to find out how they might become more involved, or are simply trying to follow SIM's progress.

The information that SIM stakeholders need varies, but falls into a few main categories:

- General project status updates
- Updates on major changes or project benchmarks
- Policy or regulation changes or implications
- Role-specific information (e.g., for PCMHs or CHIRs)

Several specific vehicles have been identified for delivering the information to stakeholders and for soliciting stakeholder input. The following are vehicles that are or will be developed and disseminated on a routine basis:

- Annual SIM summary
- Care Delivery newsletter
- CHIR newsletter
- General SIM newsletter
- Quarterly executive leadership updates
- Semi-annual legislative budget update
- Annual stakeholder survey (to support development of the operational plan and evaluate SIM communications)

A summary of the status of the Michigan SIM Test was developed and disseminated in spring 2017, and two editions of the general Michigan SIM newsletter have been disseminated through the SIM listserv to date. The summary offered a review of the overarching vision and mission of the Michigan SIM project, along with a status report on the program's core components. The newsletter has been used to share more timely updates and information about how progress toward SIM's goals and objectives will be assessed. These documents have been well-received, and the current plan is to update the SIM summary on an annual basis and disseminate the general SIM newsletter on a quarterly basis.

The SIM website will also get an overhaul in the coming award year. The program's stakeholder engagement consultant has conducted an analysis of the current website and offered recommendations for improving the look, flow, and content of the site. The goal is to make the website a resource that anyone interested in the Michigan SIM project can use to learn about the background and current status.

As the program continues to work to integrate the SIM model into the everyday function of the health care system in Michigan, the state will explore models for ongoing stakeholder engagement, including the possible establishment of external advisory groups. Whether through such groups or other avenues, the state will engage stakeholders in ongoing collaborative discussion on the current focus of SIM, direction for the remainder of the model test, and sustainability strategies.

The strategy outlined in this section of the Operational Plan Update is encompassed in the SIM Communication Implementation Plan, which is included in Appendix 5.

B.2 HEALTH CARE DELIVERY SYSTEM TRANSFORMATION PLAN

B.2.a SERVICE DELIVERY MODELS AND PAYMENT MODELS

Michigan's health system transformation strategies are centered on expanding focus beyond traditional clinical care and systematically supporting whole person centered care. These strategies are being realized by building on the foundation of previous programs with both proven and promising practices.

The Patient-Centered Medical Home (PCMH) Initiative leverages the core tenants of PCMH designation to build on a foundation of provider-delivered care management to support whole person oriented care. Additionally, PCMH Initiative participants are engaged in the development and implementation of Clinical-Community Linkages, an effort to identify and address social determinants of health. Approximately half of the PCMH Initiative participants are located within one of the Michigan SIM Test Regions, and are partnering directly with their CHIR backbone organization (as other community partners) to support the development or strengthening of a community network of service providers. Through these partnerships, SIM participants (CHIRs and PCMHs) are creating a community-developed solution to address both clinical and non-clinical determinants of health. While each clinical setting or community may be developing a unique model to serve their population, at the core of their model development is the systemization of a process to support screening for social need across clinical and non-clinical settings, a defined process for linking patients to the resources they need, and continuous improvement of these processes.

While grant and community funds have been used to support the infrastructure development needed to implement these linkages, the provision of care coordination is often only reimbursable in a clinical setting. Participants in the PCMH Initiative receive a Health Care Payment Learning and Action Network Category 2A payment to support infrastructure transformation costs, and the provision of Care Management and Coordination Services. A braided model of funding (utilizing both SIM grant funds and Medicaid funds) has made this approach possible by leveraging grant funds to support practice transformation and clinical practice improvement activities, and Medicaid funds to support the provision of services. While many of the care management and coordination staff from PCMH Initiative participating practices support the CHIR Clinical-Community Linkage models, in most cases there are additional care coordination staff employed by non-clinical entities. CHIRs are working with payers locally to support a sustainable funding model for this arrangement.

The Michigan Department of Health and Human Services' drive to support the transformation of the care delivery system is also being supported through Michigan's Managed Care Organizations. In partnership with the Medicaid Health Plans, MDHHS is working to increase the

opportunities for providers to engage in APMs. Efforts have been made to identify priority service delivery models to focus on through these APMs; included in these priorities are primary care capitation, a provider-delivered care management/PCMH model, and physical and behavioral health integration.

All of these efforts combined are being supported to drive actionable change and allow large-scale transformation. Leveraging the landscape created prior to SIM and the lessons learned during Year 2, SIM Year 3 plans to continue to bolster strategies to create a sustainable future for the delivery and payment model and the practices and providers participating in it.

Patient-Centered Medical Homes

The Patient-Centered Medical Homes Initiative is a statewide effort that continues to be a core tenant of the State Innovation Model Test. The efforts of the initiative will build upon the accomplishments created during CY 2017 activities. The core PCMH requirements for CY 2018 will remain very similar to those outlined during CY 2017, with the majority of changes focusing on closer alignment with requirements used in the Comprehensive Primary Care Plus (CPC+) program to ensure greater consistency for providers participating in both state and federal initiatives. With participating providers subject to Medicare Access and CHIP Reauthorization Act (MACRA) through either the Merit-based Incentive Program System (MIPS) or an alternative payment model such as CPC+, MDHHS has carefully aligned care delivery and practice transformation requirements with nationally recognized clinical practice improvement activities. For 2018, this alignment includes adopting numerous CPC+ practice care delivery requirements as defined by CMS in areas where the SIM PCMH Initiative has similar aims to improve provider understanding of transformative expectations. Additional alignment has been forged with commercial payers in the state, focused on shared learning requirements and service providers for care managers, and on support for health information exchange participation.

Primary Care practices and providers participating in the PCMH Initiative will continue to be required to maintain compliance with requirements that include a set of core primary care or PCMH capabilities, provision of care management and coordination services, use of health information technology and exchange, demonstrated performance on specific quality and utilization measures, and execution of clinical practice improvement activities focused on Clinical-Community Linkages and population health management.

Community Health Innovation Region Integration

During the 2017 calendar year, the Community Health Innovation Regions have each completed detailed CHIR Operational Plans describing their 12-month budget and activity timeline. These plans describe their clinical linkages approach, specifically focusing on the identification of

individuals who make frequent visits to the emergency department and the use of a screening tool to assess their needs as related to the social determinants of health. Moving forward, the focus will be on the implementation of screening tools and a referral system to ensure local beneficiaries are directed to the appropriate resources to meet their needs. These efforts are being coordinated through a single backbone organization, and include both community based partners and clinical partners, many of which are also participants in the PCMH Initiative.

In support of these goals, efforts have been focused on the development and strengthening on the Clinical-Community Linkage models of care. Communities focus at a local level on the best mechanisms to financially support sustainable service coordination in a non-clinical setting. While the APM strategies MDHHS is pursuing are not focused on community-level intervention, these mechanisms could ultimately have an impact on the clinical providers participating within the CHIR by offering opportunities to engage in payment mechanisms that support better service integration and coordination. See Section C.4 for further details on the CHIR Initiative.

Alternative Payment Models

The past year of SIM was a critical time in determining the most effective methods to increase the use of Alternative Payment Models within the State of Michigan. Both the state and federal health care landscapes continued to evolve, which prompted MDHHS to consider and subsequently develop a broader APM strategy than was originally envisioned as part of SIM.

After multiple interactions, it was determined that the best way to achieve buy-in and to increase the use of APMs in the state was to work in partnership with the state's Medicaid Health Plans to increase the spread of APMs to a larger number of providers and make a wider variety of APMs available to support innovative care delivery efforts. The program moved forward with this concept, and recently requested that each MHP contracted with the State of Michigan submit a draft APM strategy for review. An early review of each MHP's draft APM strategy has provided great insight into the impact, concerns, and direction these MHPs foresee with increasing the use of APMs over the next 12-18 months. MDHHS looks forward to sharing more information about MHP APM strategies as they are finalized.

As the state continues to review each of the draft APM strategies submitted, regular bidirectional communication will take place to continue making progress in implementing critical aspects of the APM strategy including APM data collection and monitoring, state-preferred APM models, a more consistent alignment of quality and outcome measures, APM related performance bonus data, and more.

The state-preferred APM models are an area of significant APM effort, representing payment approaches which support MDHHS' goals and correspond with areas of provider interest. MDHHS understands its unique leadership position in helping to promote such models in

Michigan, but also appreciates the importance of allowing flexibility in provider-plan payment arrangements. To this end, the state-preferred APM models offer an opportunity for MDHHS to influence APM approaches and support MHPs in adopting certain APM with their provider networks without MDHHS operating the APMs itself. MDHHS and the MHPs are together beginning a process to ascertain the number of provider organizations within the state interested in participating in the PCMH state-preferred APM model, the first model to be implemented through this approach. This information is being used to gain a more accurate understanding of the provider interest landscape, and for the MHPs to gain a better understanding of the impact of adopting one or more of the preferred models before MHPs pursue provider APM contracts. See Section C.2 for more details on Alternative Payment Models.

B.2.b QUALITY MEASURE ALIGNMENT

The landscape in Michigan has allowed the State Innovation Model team to leverage existing efforts to support quality measure alignment within the Care Delivery and Payment Reform strategies. Prior to the implementation of SIM in Michigan, a multi-stakeholder initiative, the Physician-Payer Quality Collaborative (PPQC), had begun work to align and streamline clinical quality measure processes across payer partners and providers statewide. To this end, the Michigan SIM team initially set out to align with the progress of the PPQC.

Background and History of the PPQC

The Physician-Payer Quality Collaborative is led by the Michigan State Medical Society with support from MiHIN. The PPQC's measure alignment work was motivated by the Michigan State Medical Society Executive Council of Physician Organizations identifying quality measure alignment as their top priority for 2015 and beyond in a member survey. During the regular quarterly Payer Qualified Organization Day held by MiHIN, it was identified that commercial and state payers also recognized quality measure processes as a significant pain point needing improvement.

The Michigan State Medical Society and MiHIN then partnered to form the Physician-Payer Quality Collaborative to bring all groups to the table to find solutions. The PPQC worked to identify a set of quality metrics which demonstrate participating payers' commitment to reducing the administrative and reporting burden to providers in the state. When these efforts originally began, representation was primarily that of commercial payer partners and larger physician organizations.

Over the course of Michigan's Year 1 implementation and operationalization of the PCMH Initiative, and through the development of the State Innovation Model, Michigan Medicaid and its managed care organizations became involved in the process, bringing individual Medicaid

Health Plans to the table as well. At this point, multiple commercial and public payers in the state have contributed to the effort, including Medicaid, Blue Cross Blue Shield of Michigan, Meridian, Molina, Priority, and United Healthcare. In addition, providers across the state have been represented by physician organizations and other health systems partners, making this a true collaborative effort to identify a superset of quality metrics. The PPQC has identified a set of 27 quality measures that had overlap between national and local quality reporting programs.

In Year 2, the State Innovation Model team began efforts to leverage the PPQC measure set to support one of the main pillars of the Care Delivery strategy, the Patient-Centered Medical Home Initiative. In order to support participant monitoring and participants' internal quality efforts, a subset of the PPQC measures were selected for use within quality reporting though virtual dashboards. These metrics were selected based on multiple considerations, including:

- The population being served within the PCMH Initiative.
- Whether a particular metric is a Center for Medicare & Medicaid Innovation (CMMI) priority metric for SIM.
- The ease with which a data aggregator could collect, store, and disseminate the data.

As the PCMH Initiative was operationalized in CY 2017, the measure set identified in late CY 2016 to support the initiative was introduced using a blend of 2015 Healthcare Effectiveness Data and Information Set (HEDIS) and custom measure specifications. However, it became clear that alignment on quality measure titles and descriptions was not nearly as important as alignment in the technical specifications of these measures. Therefore, additional efforts though Year 2 were focused on the review of measure specifications, and further alignment with other statewide initiatives and priorities, including the development of the Michigan Medicaid Comprehensive Quality Strategy. Through this process, the SIM team refined the monitoring and evaluation measure set (see Table B.2-1 below) to be used for the PCMH Initiative, which includes a set of utilization measures.

Table B.2-1 PCMH Initiative Monitoring and Evaluation Measures

Quality	Utilization
1. Adolescent Well Care Visits 2. Adult BMI Assessment 3. Appropriate Testing for Pharyngitis 4. Appropriate Treatment for URI 5. Breast Cancer Screening 6. CDC: Blood Pressure Control 7. CDC: Eye Exam Performed 8. CDC: Hemoglobin A1c Poor Control 9. CDC: Hemoglobin A1c Testing 10. CDC: Medical Attention for Nephropathy 11. Cervical Cancer Screening 12. Childhood Immunization Status 13. Chlamydia Screening 14. Controlling High Blood Pressure 15. Immunizations for Adolescents 16. Lead Screening 17. Screening for Depression and Follow-Up 18. Tobacco Use Screening and Cessation 19. Weight Assessment and Counseling 20. Well Child Visits 15 month 21. Well Child Visits 3-6 years	1. 30-Day Readmission Rate 2. All Cause Acute Inpatient Hospitalization Rate 3. Ambulatory Care Sensitive Hospitalizations 4. Emergency Room Visit Rate 5. Percent of Attributed Patients Receiving Care Management/Care Coordination Services 6. Preventable Emergency Room Visits 7. Timely Follow-Up with a Primary Care Physician After Inpatient Discharge 8. Total PMPM Cost

Next Steps

During 2018, the SIM team will continue efforts to ensure measure alignment across the Care Delivery and Payment Reform strategies. Supporting common measure specifications, the PCMH Initiative will focus on migrating the identified measures above from HEDIS 2015 specifications to HEDIS 2018 measure specifications for all appropriate measures. For measures that do not rely on HEDIS specifications, efforts will be made to utilize other nationally-recognized methodologies and ensure alignment with the Michigan Medicaid Comprehensive Quality Strategy.

As the Alternative Payment Model strategy is implemented in Year 3, additional efforts to continue quality measure alignment will be pursued, utilizing the Michigan Medicaid Comprehensive Quality Strategy as a foundation to support the alignment of Medicaid Health

Plan and therefore provider quality reporting. Strategies will be deployed to support an aligned core group of measures across the state, and supplemental measures to allow for regional variation, all keeping in mind the purpose to reduce burden among payers and providers.

Following a year of design and infrastructure development, Community Health Innovation Regions will begin piloting their care delivery systems to support Clinical-Community Linkages. As these efforts begin, the SIM team, in conjunction with the CHIRs, will begin to identify effective ways to measure clinical quality improvement within their communities. All efforts will be focused on ensuring that measures are aligned with federal, state, and local initiatives, including SIM PCMH, the Michigan Medicaid Comprehensive Quality Strategy, Michigan State Medical Society's PPQC, CPC+, and other appropriate metrics and measure initiatives.

B.2.c PLAN FOR IMPROVING POPULATION HEALTH

Operational plans for Test Years 1 and 2 included a focus on aligning the Plan for Improving Population Health (PIPH) with the revised State Health Improvement Plan and State Health Needs Assessment, necessary components of the Public Health Accreditation Board accreditation process. MDHHS experienced unforeseen circumstances across an array of issue areas including a departmental merger and a public health crisis. This delayed the pursuit of Public Health Accreditation Board accreditation and the accompanying State Health Needs Assessment and State Health Improvement Plan. While alignment between those efforts will continue to be a priority, the PIPH will build from the existing State Health Needs Assessment and State Health Improvement Plan for Michigan. As the Public Health Accreditation Board accreditation process is revisited, revising those documents will be done in collaboration with the PIPH. A timeline of activities follows.

Table B.2-2 Plan for Improving Population Health Timeline

	2017												2018												2019												2020
		SIM Year 2											SIM Year 3												SIM Year 4												
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
Plan for Improving Population Health (PIPH) Timeline																																					
Develop Strategies and interventions for inclusion in PIPH Schematic	X	X	X	X	X	X	X	X	X	X	X	X																									
Establish workgroups to establish drivers for strategies and interventions			X	X	X	X	X	X	X	X	X	X	X	X																							
Establish Stakeholder engagement Framework									X	X	X	X	X																								
Develop PIPH Schematic										X	X	X																									
Collect supporting documentation/data to include in PIPH												X	X	X																							
Complete Draft 1 of PIPH															X	X	X	X																			
Facilitated Review of Draft 1 (Internal Review 2-day session)																						X															
Incorporate Feedback / Create Draft 2 of PIPH																				X	X	X	X	X	X	X	X	X	X	X	X	X					
Review Draft 2 PIPH																																X	X	X			
Deliver Draft 2 to CMS																																X	X				
Internal Review (1 day session)																																X					
External Review/Public Comment																																	X	X			
Finalize/Approve PIPH																																		X	X		
Final Submission to CMS																																					X

Alignment Across State Priorities

The SIM Plan for Improving Population Health will align with existing population health improvement strategies in Michigan, including the current State Health Improvement Plan, the MDHHS Winnable Battles, and the Michigan Health and Wellness 4x4 Plan. The Michigan SIM priority populations and metrics noted in the Operational Plan align with the CMMI conditions to improve the health of the entire state population, improve the quality of health care across the state, and to reduce health care costs. The Michigan SIM goals, strategies, and metrics outlined in this Operational Plan align with the population health metrics developed by the CMMI/ Centers for Disease Control and Prevention (CDC) team.

Alignment is a key strategy to reduce duplicative efforts and build from existing strengths and assets. Planning for the PIPH will include thoughtful consideration on how much can realistically be achieved in both the short and long terms, given the capacity of communities. PIPH development efforts will include CHIRs at every level. Their knowledge of community needs and assets and their connections with partners will be the infrastructure on which population health improvement efforts are built and progress is made. Their guidance will inform the direction of the PIPH and set the tone for achieving goals that are region/population-specific, measurable with state and local data, achievable, results-focused, and time-bound.

The CHIRs, as regional tests of change, will adapt interventions specific to their own needs, strengths, and partners. Each of the SIM regions will conduct their own population health needs assessment, or use existing regional assessments. The local approach to assessing community need will coordinate with existing sources of assessment data including hospital Community Health Needs Assessments, Community Mental Health agencies' needs assessments, local public health departments' required epidemiology reports, etc. The SIM PIPH will benefit from CHIR knowledge about community assets and resources.

Plan for Improving Population Health Framework

Success in improving the health of Michigan's population will require thoughtfully designing and implementing interventions over the course of the test period, while developing capacity that will remain viable once the demonstration is done. Michigan's approach to improving population health encompasses those difficult tasks; creating and testing models of change in the short term, while facilitating long-term change in how the health care system in Michigan serves those in need. Michigan's model centers on the Clinical-Community Linkage as the intervention that brings the resources to the people who need them. In Michigan SIM, the Clinical-Community Linkage lives in two distinct but equally important spaces; the community (through the CHIR Initiative) and the provider office (through the PCMH Initiative). The collection, capture, transmission, and reporting of information between partners will not only

assist in the effective intervention on an individual basis, but will help Michigan SIM and MDHHS learn key lessons and make meaningful modifications to the model. These four pillars—the Clinical-Community Linkage, CHIR, PCMH, and data—make up the framework of Michigan's Plan for Improving Population Health.

Ongoing Population Health Initiatives

The state will continue to identify ongoing population health initiatives, both SIM-related and not, complimentary to the vision for at-risk populations and the state's five winnable battles[9]. Sustainability of SIM initiatives will be a major consideration and focus of analysis as the plan is fully developed. The non-SIM initiatives include, but are not limited to, the following programs.

Nutrition, Physical Activity, and Obesity Program

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

Healthy Weight Partnership

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

Prevent Block Grant: Getting to the Heart of the Matter in Michigan

This initiative involves implementation of evidenced-based population strategies aimed to have collective impact on increasing healthy lifestyles by decreasing tobacco use and obesity (through increased physical activity and healthy eating) among high risk, vulnerable populations. The strategies will be implemented in two SIM CHIRs, one urban and one rural. Strategies of "Getting to the Heart of the Matter in Michigan" include: implementation of

[9] https://c.ymcdn.com/sites/www.mpca.net/resource/resmgr/Clinical_Conference_2015_/2015_Clincal_Conference_MDHH.pdf

tobacco cessation interventions into routine clinical care; increasing access to healthy foods and places for physical activity; and conducting a media campaign to increase participation in "Getting to the Heart of the Matter in Michigan" activities.

Diabetes Self-Management Education Certification Program

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

Michigan's Diabetes Prevention Program

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

Michigan Partners on the PATH

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

The Michigan Department of Health and Human Services Tobacco Section

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

- Providing help and support for smokers who want to quit. Multiple resources are available, including the Michigan Tobacco Quitline, which offers free provider referrals, free counseling, and free nicotine replacement therapy to those who qualify.
- Promoting smoke-free air spaces, both indoors and out of doors. Michigan has statewide smoke-free air laws that protect residents and visitors from exposure to secondhand tobacco smoke in public places. The most comprehensive one is Public Act 188 of 2009, Michigan's Smoke-Free Air Law, which protects residents and visitors in all the state's restaurants, bars, and businesses, including hotels and motels. Many landlords and rental housing management companies have adopted smoke-free policies for their residents. In fact, Michigan now leads the nation in the number of public housing commissions that have adopted smoke-free policies.
- Protecting youth from exposure to secondhand smoke. There are a number of activities across the state of Michigan related to this endeavor, including Michigan State Board of

Education policies on 24/7 Tobacco-Free Schools and a toolkit from the Board of Education for 24/7 Tobacco-Free Schools.

- Continuing to raise awareness about other tobacco products, both the old (such as spit tobacco) and the new, emerging products.
- Educating and empowering population groups that bear a higher-than-average burden from tobacco use and secondhand smoke exposure. The Michigan Department of Health and Human Services Tobacco Program provides funding for the Michigan Multicultural Network, which works to promote awareness about the risks of tobacco use and its impact on the communities most disparately affected by tobacco use. The agencies that comprise the Network serve African Americans; American Indians; Arab Americans; Asian Americans; Chaldean Americans; Hispanics/Latinos; people who are lesbian, gay, bisexual, or transgender; and veterans.

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

Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have a well-developed understanding of the communities they serve. They link health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs build individual and community capacity by increasing knowledge and self-sufficiency through outreach, community education, informal counseling, social support and advocacy.[10] As a population health improvement strategy, there is overwhelming evidence that the CHW model is effective in increasing access to health care services, improving outcomes, and lowering costs.[11] [12] [13] Various programs in MDHHS utilize community health workers, including Medicaid.

Starting in 2015, MHPs have been required to make CHW services available to their members on a limited basis, either through direct employment or contracting with community-based

[10] APHA Policy Brief #20091, November 2009

[11] James W. Krieger, Tim K. Takaro, Lin Song, Marcia Weaver, "The Seattle-King County Healthy Homes Project: A Randomized, Controlled Trial of a Community Health Worker Intervention to Decrease Exposure to Indoor Asthma Triggers", American Journal of Public Health 95, no. 4 (April 1, 2005): pp. 652-659.

[12] O'Brien, M.J., Halbert, C.H., Bixby, R. et al. J GEN INTERN MED (2010) 25: 1186. https://doi.org/10.1007/s11606-010-1434-6

[13] http://www.michwa.org/wp-content/uploads/MiCHWA_CHW-ROI.pdf

organizations. CHWs may fulfill the role of Care Coordinator in Michigan's SIM PCMH model. CHIRs report that CHWs play a key role in assessing and addressing social determinants of health for community members, but payment models for CHWs continue to be a source of concern and discussion. As capacity increases in CHIRs and their partnerships with health care providers, payers, systems, and policy makers strengthens, their advocacy efforts may play a role in developing sustainable payment strategies for CHWs and the important work they do to improve the health of populations.

Reducing Health Disparities, Ensuring Health Equity

Without improvements in health equity, efforts to improve quality are incomplete. To this end, the Michigan SIM project is attending to the root causes of health inequalities and health disparities by addressing social determinants of health. Social determinants of health screening will take place in all five CHIRs and all active SIM PCMHs in the state of Michigan. The CHIRs and PCMHs will distribute resources or link clients to resources according to their socioeconomic needs in an effort to increase health equity. Michigan is also addressing the needs of those who use the emergency department the most in the state, in an effort to reduce the health disparities seen in this vulnerable, high-needs population.

Health equity and health disparities reduction are key components of other MDHHS program areas, including Medicaid, chronic disease programs, and Health Disparities Reduction and Minority Health Section programming. Michigan SIM will continue to support the goals of these programs at the community level through addressing social determinants of health in the CHIR and PMCH initiatives.

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

Stakeholder Engagement Framework

Creating the PIPH will require partners from different sectors to collaborate on developing shared priorities, interventions, and strategies to address need at the community level. The CHIR model necessitates regional variation in priority issues, strategies, and interventions. The stakeholder engagement framework will facilitate cooperative identification of data needs and health issues, as well as existing assets and resources at the community and state level.

An internal MDHHS workgroup has begun meeting to lay out the process for engaging stakeholders in developing the Plan for Improving Population Health. Stakeholder input will be essential at every stage in the process, from developing guiding principles to drafting final

language. Right-fitting stakeholders to key steps in the process will be necessary to sustain a manageable group size, yet maintain momentum and enthusiasm for the duration of the development process.

At this time, the state envisions a multi-level stakeholder engagement framework that includes a small population health steering committee, larger multi-disciplinary workgroup of 15-18 (including CHIRs), several component- and initiative-based work groups, as well as a series of broader outreach sessions around the state to present and receive feedback on the outputs of the workgroups. Meeting cadence and schedules are forthcoming, and will be developed to give participants as many opportunities as possible to contribute to the group dynamic and plan development.

Multi-sector participation in the PIPH development will give equal voice to social services; health care service providers, systems, and payers; local government; and other expected partners including, but not limited to, those listed below.

- State health officials
- Health care institutions such as hospitals
- Health care providers
- Community-based organizations
- Legislators, local elected officials
- Local boards of health
- Departments of Transportation/Insurance/Parks, Agriculture, Energy, Education, etc.
- Payers
- Purchasers
- Economic development/planning authorities

CHIR participation will be critical to determine where state population health priorities align with local priorities, and how MDHHS resources can be leveraged to support them. Existing CHIR workgroups may be included in issue-based work groups, as many CHIRs have established working groups already.

Clinical-Community Linkages

Improving the health of populations requires addressing non-health related issues that impact an individual's ability to achieve optimal health. Addressing these social determinants of health to support access to services and improve health outcomes is an evidence-based population health improvement strategy, and a key component of the Michigan SIM. The PIPH will include strategies and lessons learned from the SIM efforts in this area.

The Clinical-Community Linkage model is a bidirectional referral protocol or workflow between SIM PCMH practices, other clinical practices, community health workers/care managers, and community services. The Clinical-Community Linkage workflow is supported by people, processes, and tools in order to connect individuals to the clinical and community resources that will best meet their unique needs. While the concepts and steps of the workflow may be similar, the details will vary by community, and for this reason the people, processes, and technology required by each community will also have variation.

In the Michigan SIM, the Clinical-Community Linkage is supported by both the PCMH Initiative and the CHIR Initiative. These efforts are collaborative and mutually reinforcing. Approximately half of SIM PCMH Initiative participants are located in CHIRs, and CHIR governance includes clinicians, health systems, and health care payers. Each effort supports and builds upon the successes of the other, strengthening the capacity at both the provider and community level to address population health issues through assessment of individual need and connection to necessary services. Both PCMHs and CHIRs are required to assess for social needs, make referrals, and ensure that follow up occurs. Individuals are supported in their efforts to improve their health whether they are in the community or at their providers' office. Michigan SIM provides training and support for both PCMHs and CHIRs to build this work into their organizations so that even beyond the test period, these best practices will remain available to community members.

Many PCMHs have already begun talking to their patients about the social determinants of health. They use a social determinants of health screening tool to ask questions about access to food, housing, and other non-clinical elements of health. These can be difficult conversations and staff must be equipped to handle the responses they receive. The PCMH Initiative has made training that includes responsibly engaging in conversations about social determinants of health and documenting needs that arise available for providers and care managers. Staff in provider offices make referrals to social/community services to address needs identified by patients. Beginning in November 2017, all SIM PCMH providers will be required to administer the social determinants of health assessment. Participants in the SIM PCMH Initiative are required to use a tool that addresses specified social needs domains. While the MDHHS SIM team has developed a template social determinants of health screening tool, participants are not required to use the state's template. They must, however, maintain the essence of the tool, which contains the specific domains required by all participants to assess.

CHIRs leverage the capacity of the community to identify and address health and social needs that lead to better outcomes. CHIR Governance includes payers, health systems, clinicians, and social services agencies. Like PCMHs, CHIRs are tasked with developing the capacity to address social determinants of health as drivers of health outcomes. CHIRs have developed their own process to administer social determinants of health assessments across the region, and

mechanisms to share the results of those assessments with partners. They have developed region-specific referral networks and follow up mechanisms that build on their existing resources and partnerships with local health systems and hospitals.

For example, the Livingston-Washtenaw CHIR is using a hublet model to address social determinants of health across their two-county region. Twelve health and social service agencies, with the support from the backbone organization, came together in a unified effort to cooperatively establish consent and referral processes, with support from a jointly chosen uniform data-sharing platform. Deliberate relationship-building exercises were built into partner engagement to facilitate an effective group dynamic that supports ownership of roles and responsibilities. Legal agreements for the data-sharing platform are currently being reviewed. Once implemented, all hublets will be connected and able to share care management notes, care plans, and assessment results to better coordinate services and support improving health. Many CHIRs have also developed shared measurement systems and definitions of success among partners.

The data from the social determinants of health screenings across these initiatives will be used to evaluate the level of need in various populations, as well as the adequacy of resources in the community. Lessons learned from the CHIR and PCMH initiatives will be harnessed to guide efforts in the PIPH. Building the capacity of communities to understand state policy and payment levers and use their existing resources to make recommendations to the state is key to sustainability for CHIRs. Those learnings will be essential in developing long-term population health improvement strategies that will be included in the PIPH.

State Innovation Model Award Year 3

Year 3 will see marked progress toward the development of the PIPH and population health improvement strategies like the Clinical-Community Linkage. All PCMH providers will begin consistently screening for social determinants of health and making referrals to community-based organizations. CHIRs will continue to screen for social determinants of health, and engage a wide range of partners to build capacity for long-term, sustainable change. Stakeholders will begin meeting to determine the process for gathering information to inform the PIPH.

Over the next year, Michigan SIM will:

- Create a detailed timeline for PIPH development that will include a public comment period, draft, and final submission dates to CMMI.
- Establish PIPH guiding principles and a model for improving population health.

- Assess data needs and establish a mechanism to get necessary data to issue-based workgroups so they can establish priority issues and populations. Data sources include Behavioral Risk Factor Surveillance System results, Medicaid claims/encounter data, local public health epidemiology data, among others.

B.2.d HEALTH INFORMATION TECHNOLOGY

Rationale

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

As Year 2 of Michigan's SIM Test comes to an end, Michigan has made significant progress in realizing this vision. The Relationship and Attribution Management Platform (RAMP) launched in early 2017. This model attributes patients to a provider and enables payment to the providers belonging to those provider organizations participating in the PCMH Initiative. These same PCMH providers are also exchanging a variety of message types through Michigan's statewide data sharing infrastructure. PCMH participants are actively participating in the Active Care Relationship Service (ACRS); Admission, Discharge and Transfer messages (ADT); and Health Directory use cases.

Years 3, 4, and Beyond the SIM Award Period

Michigan is well positioned to utilize numerous MDHHS policy initiatives to influence the PCMH providers in the post-SIM world.

- The State of Michigan is developing a comprehensive data sharing strategy throughout MDHHS.
- Medicare Access and CHIP Reauthorization Act (MACRA) implementation began on January 1, 2017. Many of the participating provider organizations and physicians in Michigan's SIM Model test also will be subject to MACRA policies. MACRA supports value-based purchasing through either Alternative Payment Models or the Merit-Based Incentive Payment System. These models incorporate numerous overlapping quality measures. The State of Michigan seeks to leverage the overlap to increase efficiencies in the PCMH provider community between the SIM reporting requirements and the MACRA reporting requirements.

- MSA is developing a Comprehensive Quality Strategy that applies across all Medicaid programs to remain in compliance with managed care regulations. A supporting data sharing and technology plan will be developed to ensure ongoing alignment with State of Michigan needs and PCMH providers' existing reporting requirements.
- Michigan is assessing the feasibility of incorporating PCMH support into the Medicaid Health Plan contracts.
- Michigan will continue to monitor other state and federal policy initiatives for opportunities to leverage SIM work in these areas.

Governance

Health Information Technology (HIT) will be governed by a subset of the overall SIM governance structure, as outlined in Section B.1, SIM Governance. The SIM technology team manages the data sharing requirements, implementations, integrations, and other SIM-dependent technology and interfaces. The technology team's primary goal is to support the Care Delivery and Population Health components while maintaining alignment and compliance to state and federal standards and related initiatives. Figure B.2-1 (Technology Component Governance) depicts the high-level technology team and its overall composition and linkages to the SIM Governance Structure.

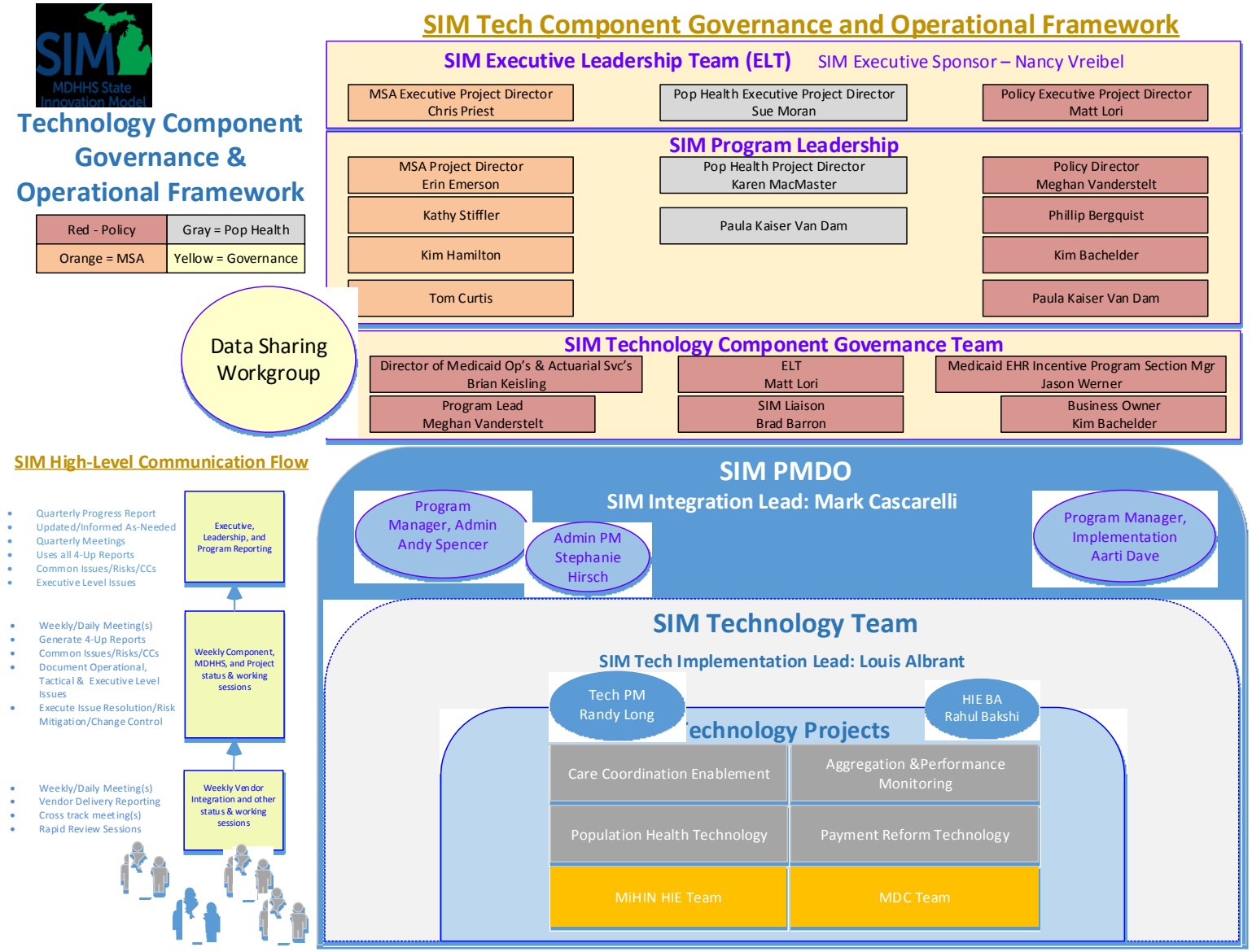
Progress to Date

The governance process has effectively managed the technical development needed to launch the RAMP. Supporting this effort has required strong coordination between numerous partners in the State of Michigan IT infrastructure. The governance process has been supported by SIM Program Management and Delivery Office resources and has leveraged standard System Development Life Cycle technical development practices.

Future

Michigan is in the process of establishing a MDHHS Data Sharing Workgroup. Additional alignment, communication, and idea flow with participants and internal stakeholders will be facilitated via this workgroup, which is part of the overarching SIM Governance. The lessons learned from the SIM project will be critical to identifying statewide technology trends and informing potential efficiencies to be gained in the existing state IT infrastructure. Equally, for the remaining two years of the SIM program, MDHHS Data Sharing Workgroup can inform the SIM Test of potential efficiencies to be gained in any of the technology pillars.

Figure B.2-1 Technology Component Governance



Policy

The State of Michigan will leverage current regulatory levers already in place to accelerate participant adoption of existing state infrastructure and new models. The state will leverage policy and existing and new contracts to accelerate data sharing adoption.

Progress to Date

SIM has gained alignment with the Medicaid Health Plan contract by requiring submission of an ACRS file. This change went into effect on October 1, 2016. Currently, all eleven Medicaid Health Plans have joined MiHIN as qualified organizations and are submitting ACRS files. Eight of the eleven Medicaid Health Plans are receiving ADT messages.

The Michigan Mental Health Code was updated to remove some data sharing restrictions on Behavioral Health data, effective in April 2017.

41 of 43 registered provider organizations are submitting ACRS files and are onboarded into MiHIN's Health Directory tool. 33 of 43 registered provider organizations are receiving ADT messages.

Future

MDHHS is researching a process to further enable the sharing of data currently covered by 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records). As part of that effort, MDHHS is also working to establish a standardized consent process for sharing 42 CFR Part 2 data. New regulations to support HIT/HIE adoption in the state will be continuously monitored during the final two years of the SIM Test and incorporated as feasibility allows.

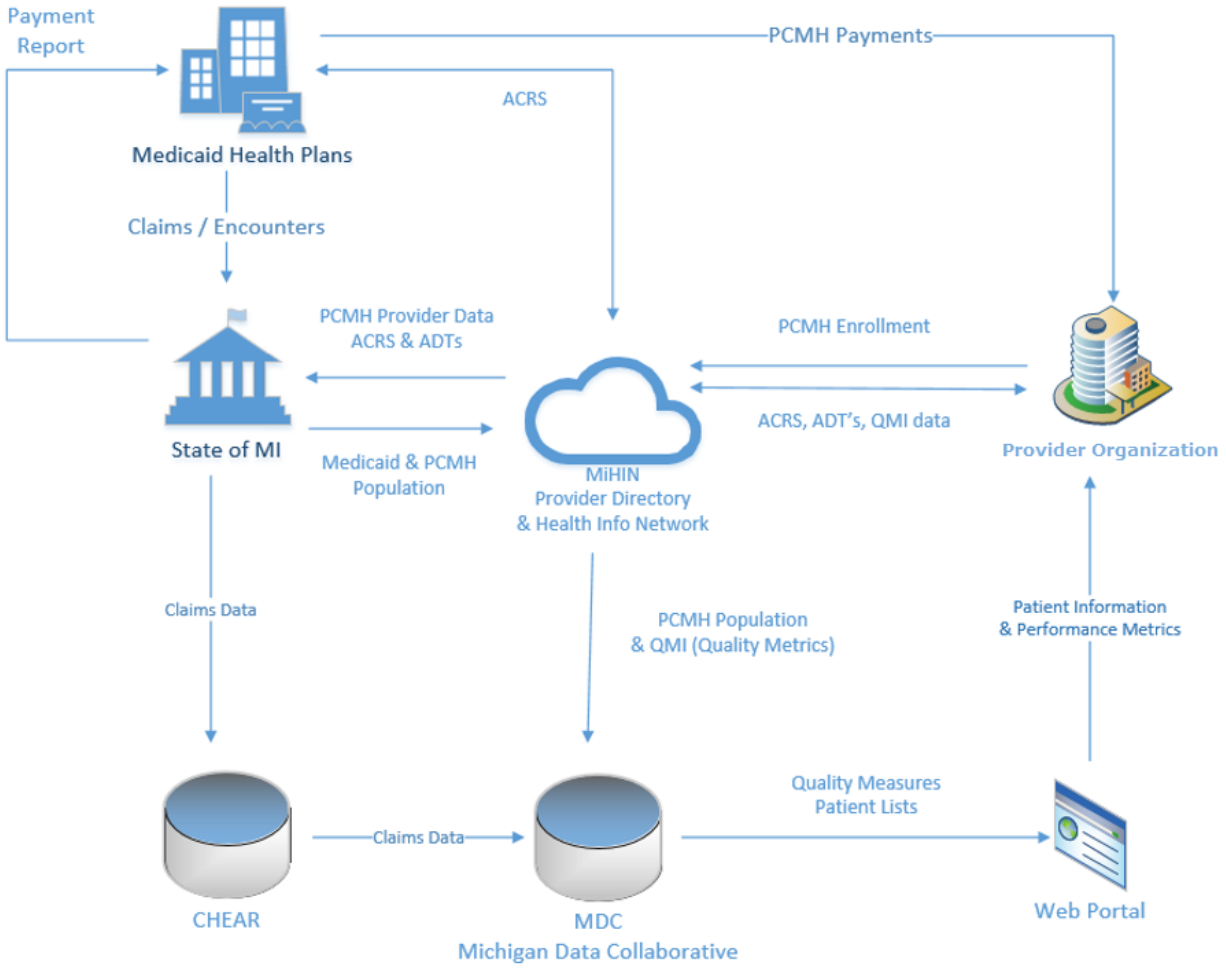
Infrastructure

The technological and architectural strategy, outlined in Figure B.2-2 SIM Technology Overview, to support the SIM vision for health system transformation provides a baseline of data interoperability needed to successfully support the three core objectives:

1. Enabling SIM program performance, comprehensive evaluation, and reporting.
2. Supporting care coordination.
3. Providing a population health monitoring toolset to support greater interoperability between health care and community entities.

Detailed information about the technology contained in the SIM overall technology vision is described later in this section.

Figure B.2-2 SIM Technology Overview



SIM Relationship and Attribution Management Platform

Launched in early 2017, the RAMP model attributes patients to a provider and enables payment to the providers belonging to participating PCMH provider organizations.

Accomplishments

The RAMP model is one of the most valuable successes of the SIM project. The attribution model included as part of the RAMP model allows HIE messages to flow for patients and be delivered to the provider, physician organization, or health plan level. This flexible RAMP model allows many different types of HIE messages to move from the point of care to the members of a patient's care team.

Figure B.2-3 RAMP Diagram

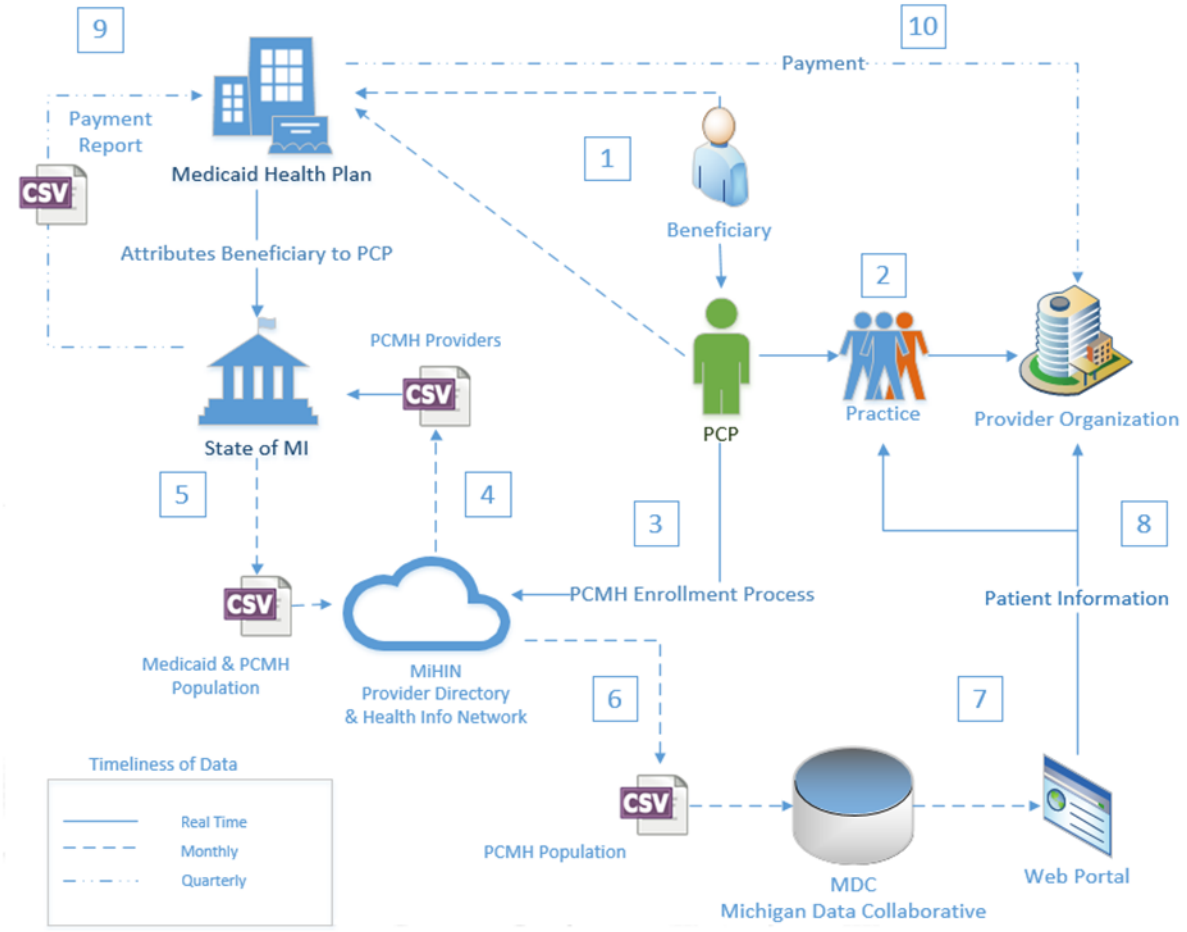


Table B.2-3 Steps in the RAMP Diagram

Step	Description
1	The beneficiary is enrolled in a Medicaid Health Plan, and the beneficiary chooses a Primary Care Physician (PCP) or is attributed to one.
2	The PCP works at a practice, and the practice belongs to a provider organization.[14]
3	Health care PCMH Organization(s) including the PCP join the PCMH Initiative, and it is recorded in the MiHIN Health Directory application.
4	Monthly PCMH provider participation information is transmitted to the State of Michigan.

[14] Some practices are considered independent and do not belong to a Provider Organization.

Step	Description
5	Medicaid beneficiary information and attribution information are transmitted to MiHIN in the form of an ACRS file.
6	PCMH participation (provider and beneficiary) information is transmitted to the Michigan Data Collaborative (MDC).
7	The MDC publishes the information in a web portal in the form of dashboards and reports.
8	Provider organizations log into the web portal to view and download their information.
9	On a quarterly basis, the State of Michigan Actuarial creates quarterly attribution reports and forwards them to each of the Medicaid Health Plans.
10	Medicaid Health Plans create and forward provider specific information to their respective health care provider organizations

The RAMP has supported the timely delivery of payments, which has been critical to allowing providers to improve care delivery in their practice. The payments have allowed practices to invest in new technology or hire care coordinators for patients that require complex case management.

Another success story of the RAMP is that it required many of MDHHS' technical partners to coordinate development efforts and work together to achieve a single IT vision for a statewide initiative. The evolving blueprint can be utilized to support value-based purchasing initiatives in the future.

Finally, the RAMP model required an onboarding of approximately 2,100 providers and physician organizations in the PCMH initiative, across multiple health plans, into Michigan's HIE. This number represents approximately 7.5% of Michigan's registered Medicaid providers when Physician Assistants and Nurse Practitioners are included in the total, and 11.5% of all other registered Medicaid providers. The onboarding has allowed organizations to begin developing processes to receive information on their patients and develop a strategy to utilize this information to improve care management. Much like the SIM program is a test model, these organizations can utilize this information on their SIM patients to then craft a strategy for the rest of their patient population.

Challenges/Lessons Learned

The RAMP process successfully leveraged the statewide multi-payer data sharing infrastructure for the enrollment and tracking of PCMH participants. This information was successfully incorporated into the member-to-provider attribution process. However, additional modification and updates were needed post-launch to achieve performance improvements and

increase attribution match rate accuracy. Michigan has leveraged this learning opportunity to mature configuration management processes, refine the development of test cases, and increase clarity requirements documentation. The fine-tuning work has consumed a significant amount of technology resources in Year 2 and has slowed the development of other use cases.

Technical onboarding of the providers and physician organizations was more challenging than expected. There was a more diverse maturity of the infrastructure amongst the providers and their organizations than was expected.

Going Forward

As the SIM project pushes through Years 3 and 4, the State of Michigan will continue optimization of the RAMP process. These optimizations will be informed by changes made to quality reporting and patient attribution models identified by MACRA. Enhancements to the RAMP process will be prioritized for opportunities which will serve transformation in the post-SIM world.

Additional details on use cases that support RAMP can be found below.

Statewide Active Care Relationship Service Use Case

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

Progress to Date

The vision of this use case has been realized in the first two years of the Michigan SIM Test. Physicians and provider organizations are submitting ACRS files regularly. The submission of timely ACRS files has been a significant component in the launch and fine-tuning of the RAMP strategy. Physicians and provider organizations who submit ACRS files receive a wealth of information from MiHIN. See Michigan's latest QPR for PCMH participation numbers.

Future

The state is examining the possibility of making modifications to the ACRS file format to support enhanced patient-to-practice attribution.

Health Directory Service Use Case

The Health Directory service use case is a statewide directory of health care providers that collects demographic, contact, and electronic service information. Authorized health care organizations and health professionals can use the Health Directory to submit, update, and look

up electronic addresses and electronic service information to facilitate secure exchange of health information.

Progress to Date

The submission of ACRS files has assisted MiHIN in strengthening their Health Directory data in statewide SIM regions. A web portal exists for affiliated providers to view and modify their own information or the information of providers in their organization. For example, a provider organization can modify information for one of their participating providers.

Future

In the final two years of SIM, the SIM team is working to:

- Establish mature configuration management and version control for the health directory.
- Establish data governance for the health directory.
- Implement data quality assurance best practices in support of the health directory.
- Ingrain best practices into data and governance roles and responsibilities.

Common Key Service Use Case

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

Progress to Date

MiHIN is continuing their efforts to develop the Common Key Service independently of the SIM project. Currently, SIM is not utilizing the Common Key Service to perform identification, matching or tracking against the SIM patient population.

Future

The utilization of Common Key Service by the SIM program is on hold while MiHIN continues to enhance this use case. The SIM project will routinely check in with MiHIN on use case development for opportunities to leverage this service.

Performance Metrics and Reporting

The state has sought to develop, design, and implement quality and utilization measures for Care Delivery performance to gather important data and metrics on the performance of provider organizations and initiatives.

Accomplishments

There are multiple success stories for Performance Metrics and Reporting in SIM as Year 2 is closed out. Building on the implementation of RAMP, the State of Michigan was able to design, develop, and implement a set of quality and utilization measures for Care Delivery performance. A provider portal was built to display the quality and utilization information so providers, provider organizations, and the state can monitor their performance against these measures.

Challenges/Lessons Learned

Changes to data collection processes at the providers, provider organizations, and Medicaid Health Plans can reduce the efficiency of data-gathering; to reduce these changes, SIM could work in conjunction with the statewide quality strategy. If multiple initiatives are telling these organizations to pull data in different ways, MDHHS will be encouraged to reconcile wherever possible to align the received data more accurately. Similarly, if data is not available, that information can be coordinated with the department so other state initiatives are aware of that for the future.

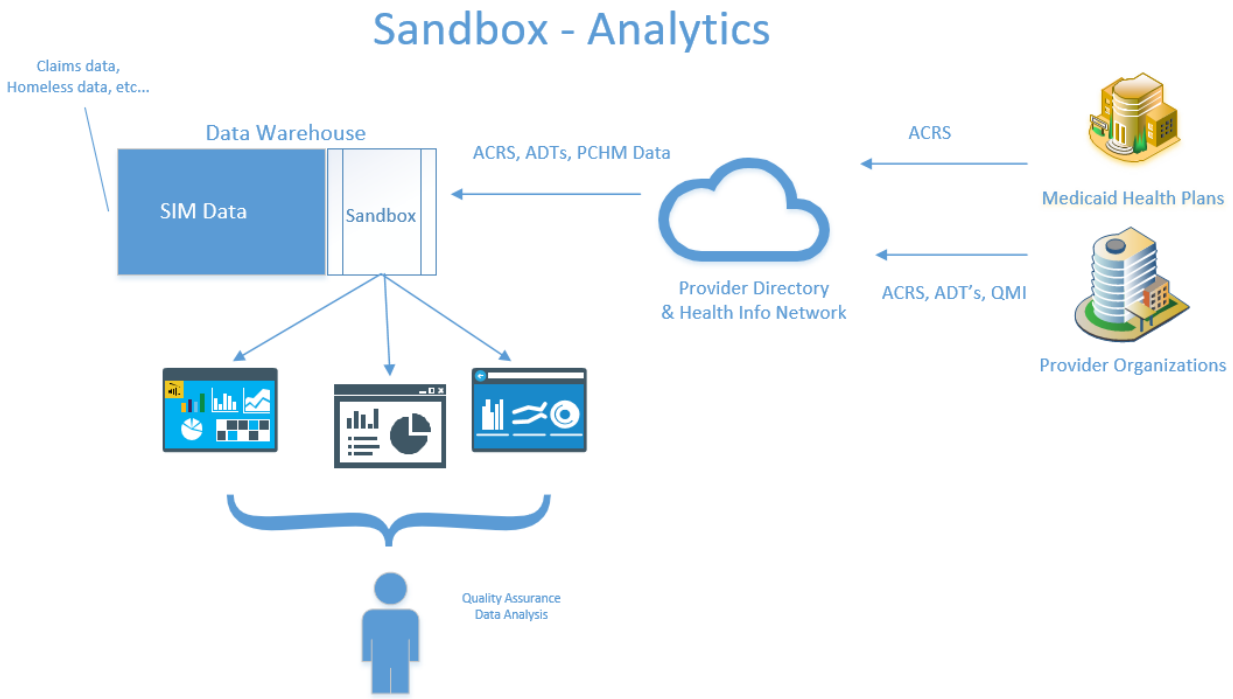
Going Forward

Moving into Years 3 and 4 of the SIM model test, SIM continues to work towards developing expanded quality and utilization measures. Additionally, some changes will be needed to bring collection practices into alignment with the HEDIS 2018 specifications.

The State of Michigan is expecting to complete their Comprehensive Quality Strategy sometime in late 2018. When the results of this strategy are made public, it is expected that some changes will be needed to the Performance Metrics and Reporting pillar to support the updated strategy and ensure common data collection practices across state initiatives.

Sandbox Use Case

Figure B.2-4 Sandbox Use Case Analytics



The SIM sandbox and advanced analytics enables analysts, researchers, and evaluators to conduct quality assurance activities, data discovery, and situational analytics. Many of these analytic users have been building their own ad-hoc reporting systems. The intent of the SIM analytical sandbox is to provide the dedicated storage, processing resources, and support analytic tools to eliminate the need for these ad-hoc reporting systems. The key components of the SIM analytical sandbox are:

- Business Analytics –Supports the self-service Business Intelligence tools used for discovery and situational analysis.
- Analytical Sandbox Platform – Provides the processing, storage, and networking capabilities.
- Data Access and Delivery – Enables the gathering and integration of data from a variety of data sources and data types.
- Data Sources – Sourced from inside and outside the enterprise, it can be big data (unstructured) and transactional data (structured). For example, extracts, feeds, messages, spreadsheets, and documents.

The establishment and rollout of the SIM sandbox and advanced analytics started in the first quarter of SIM Year 2. The need for a secure and controlled area for data quality analysis and advanced modeling was accelerated from the original plan for implementation.

Progress to Date

The SIM technology team worked with the components' business owners and state contractors to model and deploy the sandbox strategy and data storage requirements. The sandbox played an integral role in the quality assurance and data analysis of the RAMP implementation. SIM resources analyzed provider files, ACRS messages, and other data sources to mature the attribution logic. The sandbox was also leveraged in the development of ad hoc analytics regarding PCMH participation metrics and member demographics.

Data from the sandbox was made available to other SIM technical partners in support of advanced dashboard and ad hoc utilization and quality metric reporting.

Future

The sandbox and analytic tools will be leveraged to accelerate the ability to produce population health and other non-claims based measures. As the measures are developed and progress through the quality review and data governance cycles they may be integrated into standard data models for ongoing reporting.

One significant area of focus for the sandbox in Year 3 is in support of the CHIR housing initiative. A second area of focus is the ongoing data quality analysis of the RAMP and data exchange use cases such as ADT and ACRS.

Housing Data

The Housing Analytics Sandbox project has been requested by the SIM CHIR team to support the Population Health housing initiative as defined in the SIM Year 3 Operational Plan. As part of the housing initiative, the SIM technology team is piloting an analytics database, or Sandbox, that will be used to develop a model across all CHIRs to provide data in support of housing coordination and support functions.

Future

The Sandbox will be utilized to integrate information from the Michigan Statewide Homeless Management Information System into the MDHHS Medicaid Data Warehouse. The resulting data will provide a mechanism to assess the intersection of housing and the impact on cost associated with health care and other related items.

Collection of Social Determinants of Health

Social determinants of health have become recognized as a significant contributor to overall health of individuals and communities. The State of Michigan is interested in collecting social determinants of health data in the sandbox for data quality review and data modeling in support of the CHIR housing initiative.

Future

The state has many initiatives in motion to collect social determinants of health data. SIM will continue to monitor the development of these social determinants of health data collection methods. SIM will also continue to refine requirements of what social determinants of health data would be supportive of CHIR needs and leverage work being done within the state to support the CHIRs.

Care Coordination Enablement

The high visibility of patient movement within the health care ecosystem and of provider performance is crucial to the overall SIM vision. So too is facilitating the receipt of patient information and notifications by the provider attribution care team. This information allows the team to coordinate to provide safe, effective and high-quality care.

Advanced use cases identified to support this vision include:

- Coordinating the Care Coordinators
- Statewide Admission, Discharge, and Transfer Notification Service
- Care Summary
- SIM Quality Measures

The implementation of these use cases will leverage the RAMP in future SIM years.

Accomplishments

The first two years of SIM have yielded two principal accomplishments in the Care Coordination Enablement pillar. First, HIE has onboarded Clinical Quality Measures data from a significant number of PCMH providers and participants. Second, ADT messages are flowing to approximately 75 percent of all PCMH participants.

Onboarding this clinical quality data has served as an important demonstration of how clinical quality data can be utilized and attributed at the physician, physician organization, or health plan level. The capability to compile this information did not previously exist within the State of Michigan IT infrastructure, and it will be a necessary component as value-based purchasing becomes an increasingly important part of funding health care.

Having ADT messages flow to providers and physician organizations is a huge success of the SIM Program to date. It gives primary care providers timely insight into hospital admissions and discharges, which gives physicians another avenue to control hospital readmission and improve on other quality measures, such as following up with the primary care provider within 14 days after hospitalization.

Challenges/Lessons Learned

The data quality of the quality measurement information previously received was lacking. Consequently, the state is working to improve clarity on data submissions best practices.

Going Forward

Going forward, the State of Michigan will work to onboard providers who are not currently transmitting clinical quality information. Further, the state will coordinate with MiHIN to develop a Quality Measurement Information data submission best practices document.

As ADT messages flow into the state, the state will continue to examine how the messages can be best utilized within the state itself. ADT messages are being utilized by State of Michigan systems to notify foster care workers when children on their caseloads turn up in the hospital. The state will continue trying to leverage this information to take immediate action when it is to the benefit of the patient.

Additional detail on use cases that support Care Coordination Enablement can be found below.

Coordinating the Care Coordinators Use Case

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

Progress to Date

A workshop and conference call series titled “Coordinating the Care Coordinators” convened a broad community of multi-stakeholder constituents to frame a statewide approach to making care coordination more transparent. The aim of the workshop series was to find opportunities to make care coordination more transparent and easier to manage in Michigan, with an emphasis on infrastructure. Infrastructure includes aspects of the delivery model, reimbursement, regulations, technology, and workflow related to care coordination.

Future

The State of Michigan will continue to monitor opportunities to improve care coordination in Michigan. As this PCMH-sponsored workshop series continues, the Michigan SIM Program will continue to be involved in this process and will evaluate further collaborations in the future.

Statewide Admission, Discharge, and Transfer Notification Service Use Case

The Statewide Admission, Discharge, and Transfer (ADT) Notification Service use case is a statewide service that enables the communication of alerts regarding patients’ care transitions to every care team member attributed to that patient, thus improving post-discharge

transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions. It also allows providers to steer these patients toward clinical and non-clinical interventions that may reduce unnecessary overutilization by preventing avoidable emergency department visits and hospital readmissions.

Progress to Date

The statewide ADT use case has been implemented. Any physician or provider organization submitting ACRS files can receive ADT messages for their attributed patient population. ADT messages transmitted by a hospital move from the hospital to the receiving provider within 15 seconds. This functionality is being leveraged throughout the State of Michigan and the SIM Program to improve follow-up care after hospitalization.

Future

Currently, no further enhancements to the ADT use case are planned. However, significant opportunity exists to leverage this information throughout the State of Michigan.

SIM Quality Measures Use Case

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

Progress to Date

MiHIN is accepting Quality Measure Information from physicians and provider organizations. Quality measures are moving from MiHIN to the state's vendor and are being rolled up into quality dashboards.

Future

During Year 3, MiHIN is expected to make Quality Measurement Information data available to physicians and provider organizations.

Population Health Technology

The Community Health Innovation Regions are responsible for serving their communities as backbone organizations to identify and address factors that impact social determinants of health, such as housing stability. Throughout the first two years of this process, this has taken the shape of the CHIRs developing strategies to address things which may be interpreted as an impediment to health outcomes: for example, homelessness.

Accomplishments

The primary accomplishment for the technology component related to the CHIRs was a review of the CHIR Operations plan. This review has created a foundation for gap analysis of the operation plan versus SIM requirements for capturing or sharing data between the State of Michigan and the CHIRs. Further, it informs potential improvements in Population Health Technology which can be replicated between CHIRs.

Challenges/Lessons Learned

Different communities have different needs. In one community, homelessness might be a central community issue. In another, opioid abuse may be the primary focus. Thus, CHIRs have flexibility to define the plan that will best suit their community and build their program to suit that plan. Correspondingly, the five CHIRs are supporting their communities with different operational plans, different software packages, and different data collection requirements.

Going Forward

One of the critical challenges of the final two years is to establish practices to move data between the state and the CHIRs. This bidirectional data flow is critical for informing data-driven decisions at the both the State of Michigan level and the CHIR level. The requirements for data sharing between the CHIRs and the state will help determine the level of standardization that can be implemented. Once requirements are gathered and the solution defined, the technical capability to move information back and forth between them will be implemented for items that fit within the technology budget. This data will inform Clinical-Community Linkage strategies between providers, community organizations, and the CHIRs.

Technical Assistance

Progress to Date

Patient-Centered Medical Homes have received practice transformation payments to support necessary technology and use case investments in practices. These payments are made at the practice level for the first 24 months of practice participation, and these payments will be made up front to enable early investments into transformation that will positively affect patient outcomes and satisfaction.

Along with the practice transformation payments, practices have received support from partners, Managed Care Organizations, and others in deciding how to invest practice transformation payments to make best use of the funds. Possible investment areas included HIE/HIT systems, workflow management systems, training, and hiring new support staff.

PCMHs received practice transformation rewards and care management support payments through participation in the Michigan Primary Care Transformation demonstration (MiPCT),

until the end of the project in December 2016. In 2017, the State of Michigan has disbursed payments for the first two quarters to practices participating in the PCMH Initiative under SIM.

Future

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

Furthermore, the State of Michigan also plans to provide technical assistance to the CHIRs. The focus of the technical assistance will be clarified through ongoing needs assessment and performance data analysis early in Year 3 of operations. Technical assistance is expected to be finalized, designed, and instantiated before the completion of Year 3.

Summary

Michigan has achieved successes in using the RAMP to support Care Coordination Enablement and Performance Metrics and Reporting. The onboarding of nearly all SIM participating physicians into ACRS and the Health Directory has allowed the RAMP to function as the backbone of the Care Coordination Enablement and Performance Metrics and Reporting initiatives. This backbone allows accurate and timely measurement of physician participation, member attribution, and quality reporting. It has been built to move information such as ADTs quickly from the point of care to the coordinating case manager or physician. Further, the backbone has been built flexibly enough to allow new types of HIE messages to be transmitted to participating physicians, provider organizations, or health plans with minimal changes to the ACRS file.

Michigan continues to support the Population Health Technology initiative by coordinating with CHIRs to collect information about social determinants of health and assess each individual CHIR's technical needs. Michigan will continue to develop this technological pillar throughout years 3 and 4 as it looks to make the CHIR organizations sustainable beyond the SIM period.

B.2.e WORKFORCE CAPACITY

The SIM team monitors workforce capacity in Michigan to ensure opportunities to build and enhance skills across the workforce. A number of steps have been taken to encourage collaborative learning, technical assistance, and peer to peer learning. The following activities have increased training capacity with key partners as the SIM team continues to enhance the workforce.

Workforce Collaboration with Universities

Michigan has a long tradition of collaborating with universities, and the SIM Program will continue to evaluate opportunities for such alignment in Year 3. Potential collaboration could include continued partnership with the Michigan Area Health Education Center (MI-AHEC) whose primary purpose is to help address the workforce shortage of health care professionals in Michigan. As part of a national network of Area Health Education Centers, MI-AHEC was established in 2010 by Wayne State University and supports five regional centers throughout the state in collaboration with other medical/health professional schools. The regional centers help ensure a well-trained health professional workforce and improved access to high quality primary care for all residents, including vulnerable populations.

The Midwest Interprofessional Practice, Education and Research Center (MIPERC) at Grand Valley State University develops collaborative and interprofessional initiatives across disciplines, college and university learning institutions, and health care systems. In conjunction with Grand Valley State University, Michigan State University College of Human Medicine, and Ferris State University College of Pharmacy and Optometry, MIPERC offers an interprofessional educational certificate available online to students from health related disciplines to promote better care while decreasing costs through interprofessional team collaboration.

Michigan State University houses the Michigan Center for Rural Health (MCRH), which plays a key role in assisting in the creation and implementation of partnerships among organizations, health departments, hospitals, government and academia. These local collaborations create opportunities in the areas of network development, quality of care, continuing education, and recruitment and retention of rural health care providers. MCRH offers continuing education programs to rural Michigan using live video programming.

Michigan's SIM program has engaged and funded both ABLe System Change and a formal CHIR evaluation through Michigan State University. See Section C.4 (CHIR Detail) and Section D (Program Evaluation and Monitoring) for more information about these programs.

Learning Capacity

As practices continue to build upon their current PCMH capabilities, SIM-funded training for PCMH Initiative participant care managers and coordinators is available via the Michigan Care Management Resource Center (MiCMRC). The key areas of focus include care management, self-management support, care coordination, and linkages to the community. The MiCMRC provides a mechanism to integrate the collective experiences from around the state.

Statewide, MiCMRC provides evidence-based, standardized, in-person complex care management courses; hosts virtual education/webinars; and offers a library of recorded

webinars, resources, and tools for care managers, physician organizations, physician hospital organizations, and physician practices.

Initial Training Requirements

MiCMRC has worked to standardize a base set of knowledge and develop requirements around care coordination and training for anyone within PCMHs. Both care coordinators and care managers are required to complete a MiCMRC approved self-management training course within the first six months of hire. The MiCMRC has identified a number of approved self-management training programs; however, if this course is completed through the approved vendor, the Michigan Center for Clinical Systems Improvement, the PCMH Initiative will cover the cost of the course, given the critical nature of self-management support to the success of care management and coordination within a PCMH. Care managers are further required to complete the MiCMRC led complex care management training course within the first six months of hire. The cost of this course for new or yet-to-be-trained care managers will continue to be covered by the PCMH Initiative, utilizing a mix of both SIM and Medicaid funds.

The SIM team has expanded the availability of care coordinators to drive the team management approach towards inclusion of certified medical assistants and certified community health workers. Practices can have both certified medical assistants and certified community health workers as members of their team, and these workers are included in the work the practices do under SIM. The inclusion of these team members allows for more flexibility within teams. To assist in expanding workforce capacity, per member per month amounts in the PCMH Initiative payment model both help to pay the salaries of care coordinators and support the infrastructure and practice transformation needed for the services provided by these team members to demonstrate successful outcomes. By offering expanded opportunities for technical assistance and training, the SIM team is better preparing Michigan's workforce to address social determinants of health by increasing assessments and giving referrals. The sustainability of this specific strategy is dependent on the adoption of similar models by payers beyond the SIM funding period.

Longitudinal Learning Activity Requirements

The PCMH Initiative maintains the expectation that all care managers and coordinators will maintain their current licensure or certification, including the requirements to seek continuing education approved by the appropriate professional organization or association. To support this expectation, the initiative requires each care manager and care coordinator to complete a total of 12 education hours per year. The requirement of training throughout the year is termed "longitudinal learning activity." This can be satisfied by either: twelve hours of PCMH Initiative-led care manager and care coordinator webinars/sessions on relevant topics; or six hours of

PCMH Initiative-led care manager and care coordinator webinars/sessions plus six hours of physician-organization-led, or other related learning activity events.

The MiCMRC hosts live, topic-based webinars and trainings throughout the year, many of which provide continuing education credits. In addition, the MiCMRC maintains a library of recorded trainings (many offering continuing education credits) and various resources ranging from sample tools and articles to resources that can be accessed on demand.

Quarterly PCMH Update Meetings

The required quarterly update meetings provide participants with important initiative updates and resources for successful participation. Participation in these virtual meetings is required by all participating practices, physician organizations, and associated staff. There is an event evaluation following every virtual and in-person event that the PCMH Initiative hosts. These evaluations support both the state evaluation and continuous program planning.

Practice Transformation Collaborative

The Practice Transformation Collaborative will provide participants with an opportunity to engage in learning activities that support transformation related to Clinical-Community Linkages and the practice transformation objective that the participant chose during the application. The Practice Transformation Collaborative will provide a series of opportunities for engagement, including two-day face-to-face learning sessions, bi-monthly peer coaching webinars, and monthly action period teaching webinars.

Billing and Coding Collaborative

The Billing and Coding Collaborative was developed to provide support to financial, billing and coding, and care team staff. The Billing and Coding Collaborative will provide a series of web-based learning opportunities to support participants and provide guidance on billing payers to capture appropriate revenue. There is additional potential for in-person learning activities as needs are further identified.

Annual Summits

The PCMH Initiative will support regional annual summits to accommodate participants across the state of Michigan. The annual summit will be geared towards engaging in networking and towards opportunities to build on the foundation of regular learning opportunities. These regional summits will be open to participant staff, including, but not limited to, administrative staff, care managers and coordinators, quality improvement staff, and other leaders within participating organizations.

Affinity Groups

Optional affinity groups have been established to facilitate learning across participants. Below is a list of the affinity groups convened in 2017. Additional affinity groups will be added as needed.

- Care managers and coordinators: The care manager and coordinator affinity group will facilitate networking and promising practice sharing across the state.
- Pediatric care managers and coordinators: The pediatric care management affinity group will facilitate identification of curriculum needs for the pediatric care manager and care coordinators.
- Clinical champions: The clinical champion affinity group will provide peer support and guidance to clinical champions across the PCMH Initiative. This group will be led by a physician champion at the program level or a physician experienced in practice transformation and care manager/coordinator integration.
- Participant leaders: This group will provide feedback on strategy and program operations. In addition, this group will provide a forum to discuss concerns and issues identified by providers, identify best practices in implementation, and develop a collegial network of participant leadership across the PCMH Initiative to support the ongoing transformation process.
- Finance/billing and coding support: The finance/billing and coding support affinity group will serve as a forum for participant staff that serve in the capacity to provide billing and coding services.
- Technology leaders: The technology leader affinity group will focus on the health information technology requirements, including the MiHIN use cases for the initiative.
- Quality improvement leaders: The quality improvement leader affinity group will serve as a forum for participants to explore performance across initiative requirements and metrics, and to share promising practices in leading and addressing change within the context of the Initiative.

Community Health Worker Requirements

The Michigan Community Health Workers Alliance (MiCHWA) is identified as an integral source for Community Health Worker (CHW) information. Initially founded as a small stakeholder coalition, interest in MiCHWA's activities from outside organizations has resulted in an increase in demands for CHW information, presentations on CHW effectiveness, and support for CHW activities. Outside agencies are coming to MiCHWA for information about the CHW role, resources to support CHW employment, and research to make the case for why CHWs are essential health care team members. MiCHWA continues to find new ways to engage CHWs and

stakeholders in these discussions across the state. MiCHWA has aligned trainings with the expectations commercial payers had, thus building consistent capacity across networks.

The MiCHWA Community Health Worker certification curriculum launched in 2015. The curriculum was developed in coordination with employers after the review of a standard curriculum taught in Minnesota. Four classes were completed in 2015. In Michigan, a Community Health Worker certificate is earned upon successful completion of MiCHWA's Community Health Worker curriculum. Currently, certificates of completion are issued by community colleges in partnership with the local agencies delivering the training. MiCHWA keeps a record of all individuals who successfully complete the CHW curriculum.

School Loan Repayment

Michigan maintains the Michigan State Loan Repayment Program (MSLRP) to assists employers in the recruitment and retention of medical, dental, and mental health care providers by providing loan repayment to those who enter into MSLRP service obligations. These service obligations require participants to provide full-time, primary health care services at an eligible nonprofit practice site located in a Health Professional Shortage Area for two years. MSLRP loan repayment agreements are funded by a federal/state/local partnership. Federal funds are awarded by the National Health Service Corps of the Health Resources and Services Administration. State funds are appropriated by the Michigan Legislature, and local funds come from employer contributions toward their employees' loan repayment agreements.

B.3 SIM ALIGNMENT WITH STATE AND FEDERAL INITIATIVES

Michigan continues to find innovative ways to align the work of SIM with both state and federal initiatives to transform the delivery of the state's health care system. As SIM has transitioned from the design phase to implementation, it has become necessary to expand the leadership team to reflect the broad scope of the initiative. To assist in alignment efforts, the executive sponsor of SIM has been elevated to the MDHHS Chief Deputy Director and the executive governance team is rounded out by senior deputy directors in three MDHHS administrations: Medical Services Administration, Population Health Administration, and Policy, Planning, and Legislative Services Administration. This shift will expand opportunities to integrate SIM across these key areas of MDHHS and expand aspects of the initiative.

The following are examples of programs where Michigan has been able to align SIM and department efforts and reduce potential duplication.

MEDICAID INNOVATION ACCELERATOR PROGRAM

As a Medicaid Innovation Accelerator Program (IAP) housing initiative participant, the state is also exploring alignment opportunities with IAP. The SIM Population Health team will leverage the IAP-based training and technical assistance to support the CHIR housing initiative. The IAP program is a collaborative between the Center for Medicaid and CHIP Services and CMMI. The goal of IAP is to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms. Medicaid IAP supports state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities.

The IAP program selected, in consultation with states and stakeholders, four program areas in which to offer technical support: reducing substance use disorders; improving care for Medicaid beneficiaries with complex care needs and high costs; promoting community integration through long-term services and supports; and supporting physical and mental health integration.

In addition, IAP also works with states through its functional areas, or levers, for Medicaid delivery system reform: data analytics, performance improvement, quality measurement, and value-based payment and financial simulations.

HEALTH HOMES

In accordance with Section 2703 (Health Homes) of the Patient Protection and Affordable Care Act of 2010, MDHHS, through the Medical Services Administration, launched the MI Care Team health homes program on July 1, 2016. The MI Care Team health home model is meant to address the complex needs of Medicaid and Healthy Michigan Plan beneficiaries that have chronic physical and behavioral health conditions. MI Care Team is centered in whole-person, team-based care and utilizes an interdisciplinary team of providers who operate in a highly behavioral health integrated primary care setting. To achieve this, the team includes the presence of a nurse care manager and community health worker. The care team will help ensure seamless transitions of care and help connect the beneficiary with needed clinical and social services. With the beneficiary's consent, health information technology (including CareConnect 360) will be used to support care management and coordination through data collection and information sharing. Together, the model will address all facets of a beneficiary's health status, including clinical needs and the social determinants of health.

Currently, 10 Federally Qualified Health Center organizations have been recognized as MI Care Team organizations by the department. These 10 organizations operate integrated care teams at 45 sites in 21 counties of the state. Only one of the 21 MI Care Team-eligible counties, Genesee, is located within a SIM region. The health center organization selected to provide

health home services in Genesee County can utilize their CHIR for connection to community partners and may also serve as a service provider referral resource. The MI Care Team program has close to 4,000 beneficiaries enrolled in the program, as of November 2017.

TECHNOLOGY INTEGRATION

The PCMH Initiative will build upon and continue work with the Michigan Data Collaborative (MDC), a non-profit data collection, enrichment, and provisioning organization established at the University of Michigan, to support the participants by providing reports and a dashboard for the measures described above. Dashboard releases will include interactive functionality that is enhanced over time. The Dashboard will include both visualizations and charts. The PCMH Initiative will utilize aggregated data from the participating payers across medical claims, pharmacy claims and eligibility files to monitor participant performance and compliance.

To further support participants, the MDC will also distribute a PCMH Patient List and aggregate patient count reports, which will be accessed via the secure portal. The MDC will maintain access control for participants wishing to view reports and dashboard displays of the PCMH measures, or to download appropriate lists for their physician organization or practice. The MDC Portal User Acknowledger (responsible contact for a participating organization) will affirm who should have access to the MDC portal from their participating physician organization or practice. Those affirmed will be provided access as an MDC Portal User to download patient lists and other reports and view the measures Dashboard (when available).

Admission, Discharge, and Transfer notifications are widely regarded as a keystone to improve patient care coordination through exchange of health information. By leveraging the SIM technology, ADT messages are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. These alerts are sent to update physicians, care management teams, and payers on a patient's status; to improve post-discharge transitions; to prompt follow-up; to improve communication among providers; and to support patients with multiple or chronic conditions. Michigan has leveraged and enhanced these technology developments through Medicaid, without duplication under SIM, by providing technical assistance and training in support of existing infrastructure.

DUALS INTEGRATION

In an effort to promote non-duplication, MI Health Link has been established as new health care option for Michigan adults ages 21 or over who are enrolled in both Medicare and Medicaid and live in the 23 pilot counties across the state. MI Health Link offers a broad range of medical and behavioral health services, pharmacy, home and community-based services, and nursing home care, all in a single program designed to meet individual needs.

ALTERNATIVE PAYMENT MODEL INTEGRATION

The Medicaid APM strategy utilizes the Healthcare Payment Learning and Action Network (LAN) APM Framework as the basis for both goal creation and measuring progress. The LAN APM framework was first published in January 2016 and modified in 2017 to reflect developments in the APM landscape. The framework establishes a common nomenclature for defining, implementing, and sharing successful payment models and has been widely adopted. Michigan's approach is consistent with the way the U.S. Department of Health and Human Services established nationwide goals for value-based payments and APMs in Medicare. The approach is also supportive of providers pursuing the All-Payer APM Combination Option under MACRA's Quality Payment Program.

HEALTH EQUITY

Michigan has developed the Medicaid Health Equity Project to address racial and ethnic health disparities. Both CHIRs and PCMHs will be helpful in addressing ethnic health disparity rules by focusing attention on social determinants of health and assisting the state in meeting federal regulations.

INTEGRATED SERVICE DELIVERY

As a byproduct of legislation that merged the previous Michigan departments of community health and human services, MDHHS is working to improve the overall customer experience with the state agency. Integrated Service Delivery is a multi-year initiative envisioned to make it easier for Michigan citizens to search for and access benefits and resources that will ultimately lead to better health and self-sufficiency outcomes. Not only is the department improving how public benefits and services are delivered to residents, but it is also focusing on collaborating more closely with community partners to achieve shared goals. As such, the MI Bridges self-service portal, where residents apply for and manage their benefits, is being redesigned and will interface with Michigan 2-1-1 to allow residents to search for local resources and connect with trained community partners.

MI Bridges will facilitate the referral and track whether the organization was able to meet the individual's needs. Moreover, a customer will be able to complete a needs survey to find state programs or local resources that may be helpful, and refer themselves to a community agency through MI Bridges. MI Bridges will also receive a new user-friendly look and be mobile friendly, allowing customers to more easily use MI Bridges from their smartphone or tablet. The new MI Bridges website is currently being piloted in Muskegon County and is expected to become available statewide in January 2018. SIM anticipates that community partners within Community Health Innovation Regions will register in MI Bridges as a local assistance agency.

Additionally, the Integrated Service Delivery initiative anticipates launching the Universal Caseload system as a pilot in January 2018. Universal Caseload will provide the ability to distribute casework among offices and business service delivery areas using a task-based case management processes. With this system, specialists will no longer "own" cases, but instead focus on working on a specific part of the case, sharing with team members the tasks involved in a case. Universal Caseload will be implemented at the same time as new call center technology. This technology provides one phone number for clients to call. The phone number includes an Interactive Voice Response, which can provide case/benefit information and route the caller to the most appropriate local team to answer their question.

OTHER CMMI EFFORTS

Michigan has begun an initiative to improve quality through its practice transformation network. In collaboration with the Altarum Institute, the Great Lakes Practice Transformation Network (GLPTN), a Transforming Clinical Practice Initiative awardee, is supporting organizations through patient-centric practice transformation. It provides direct technical assistance on quality reporting, for example, the Physician Quality Reporting System, and supports local quality improvement efforts to help prepare clinicians for participation in value-based payment systems. This technical assistance program provides assistance at no cost to both primary care and specialty medical providers and their office staff. All the CHIRs are working with local collaborative care networks in support of this endeavor.

COMPREHENSIVE PRIMARY CARE PLUS ALIGNMENT

Michigan is in discussion with a CMMI vendor, TMF Health Quality Institute, to build out a plan for those providers that are in both Comprehensive Primary Care Plus (CPC+) and PCMH to align and share resources and goals in transformative projects. Michigan has recently aligned practice participation to mirror CMS language for participation. One example where Michigan has aligned the programs between PCMHs and CPC+ are social needs screenings. PCMH staff continue to provide presentations at CPC+ trainings to further align the various federal programs.

The SIM team is also working with Blue Cross Blue Shield of Michigan and Priority Health to finalize multi-payer data sharing in addition to shared care delivery models and HIT/HIE priorities. Additional payers may also be added over time.

C. COMPONENT SECTION

C.1 PATIENT-CENTERED MEDICAL HOMES

C.1.a END STATE VISION NARRATIVE

The Medical Services Administration (MSA) and Medicaid Health Plans (MHPs) will jointly develop baseline requirements, standards, and policy for the expansion of a model that supports Michigan primary care providers serving in a Patient-Centered Medical Home (PCMH) setting, and the delivery of care management and coordination services. To this end, the state and MHPs will work collaboratively to develop a mechanism to sustain the model of care and Alternative Payment Models (APMs) supported within the SIM Care Delivery component, PCMH, and other related initiatives. This includes continued support for the inclusion of non-licensed professionals in the delivery of care coordination services while the operations of this model initiative are transferred to the Medicaid Health Plans.

C.1.b STRATEGY NARRATIVE

Building upon Michigan's Multi-Payer Advanced Primary Care demonstration (also known as the Michigan Primary Care Transformation Project or MiPCT), the SIM PCMH Initiative seeks to advance primary care capabilities and infrastructure across Michigan to realize improvements in quality of care and health outcomes and increase participation in alternative payment models. The Initiative launched during SIM Year 2 and engaged approximately 346 primary care practices, which include over 2,100 individual primary care providers serving over 350,000 Medicaid beneficiaries.

At the start of the SIM PCMH Initiative, several key changes were made to the programmatic structure originally used during MiPCT. These changes were made to support further primary care advancement across the state. As a core tenant of the PCMH Initiative, all practices were required to have been designated as a Patient-Centered Medical Home. However, transitioning from MiPCT to the SIM PCMH Initiative allowed for a more inclusive approach to designation, expanding from accepting two designations to five designations. Additional change was explored through the broadening of the care team and including a new care coordinator role as essential to supporting the provision of care management and coordination services as a comprehensive team. This additional team member was also seen as supporting further goals to transform clinical care through the design and implementation of Clinical-Community Linkages. From MiPCT and SIM, the care management and coordination payment approach was restructured to include an element of participant accountability and a risk stratification proxy for acuity/complexity. Building upon Michigan's Health Information Exchange (HIE)

infrastructure, participants were also required to engage in the use of specific HIE use cases (detailed in Section B.2.d).

The core intent of the PCMH Initiative focuses on the model of care transformation and process/quality of care excellence as reflected in the following strategic goals:

1. Champion models of care that engage patients using comprehensive, whole person-oriented, coordinated, accessible and high-quality services centered on an individual's health and social well-being.
2. Support and create clear accountability for quantifiable improvements in the process and quality of care, as well as in health outcome performance measures.
3. Create opportunities for Michigan primary care providers to participate in increasingly higher level Alternative Payment Models.

In continued support of these strategic goals, the PCMH Initiative has planned adaptations to program operations in the coming calendar year. Many of the adaptations to program operations have been executed to produce more tangible alignment between the initiative and other state and national initiatives, with particular emphasis on Comprehensive Primary Care Plus (CPC+). Additional efforts to support advancement within this initiative are focused around adaptations related to care management and coordination and clinical practice improvement activities. In 2018, participants will continue to be supported in the implementation of these requirements through a blended payment model and initiative-led support and learning activities.

The provision of care management and coordination (CMCC) services within a primary care Patient-Centered Medical Home setting remains an important aspect of the PCMH Initiative care delivery model. These efforts will be sustained in the second year of operations (CY 2018). During the first year of operations, participants were required to maintain a specified number of care management and coordination staff members, supporting a ratio of two CMCC staff per 5,000 attributed beneficiaries. Additional requirements detailed that one CMCC staff member must be a licensed professional, a care manager as defined by the initiative, and all subsequent CMCC staff could be either licensed care managers, or non-licensed care coordinators.

In PCMH Calendar Year 2 operations, the initiative is moving away from this defined staffing model to support innovative care models within participating organizations. Participants will still be required to have embedded CMCC staff to support the provision of CMCC services, but instead of the defined staffing ratio, an element of accountability has been introduced. Participants will be measured on the percent of attributed beneficiaries that are receiving CMCC services. The measurement of CMCC services began in 2017 with a set of procedure codes specified by the initiative. This effort will continue with the addition of four more CMCC services that can be submitted as claims to the eleven participating Medicaid Health Plans.

The set of procedure codes that will be accepted in 2018 are outlined below, with the new codes denoted.

- Comprehensive Assessment (G9001)
- In-Person CM/CC Encounter(s) (G9002)
- Telephone CM/CC Services (98966-98968)
- Education/Training for Patient Self-Management (98961, 98962)- NEW
- Care Transitions (99495,99496)
- Care Team Conferences (G9007)
- Provider Oversight (G9008)- NEW
- End of Life Counseling (S0257)- NEW

Provider-delivered care management and coordination services provide a foundation for the clinical practice improvement activities or practice transformation being sought within the SIM PCMH Initiative. Throughout 2017 participation, practices and physician organizations designed plans and processes to support the development or expansion of Clinical-Community Linkages within the primary care practice environment. These efforts included developing or adopting a brief screening tool to assess social needs, developing a screening plan to reach all patients within the practice, linking patients to appropriate community-based resources, and developing a plan to execute quality improvement activities to inform future refinement of Clinical-Community Linkages.

In 2018, the Michigan Department of Health and Human Services (MDHHS) will continue to support participants in the execution and refinement of their Clinical-Community Linkage design. Additional practice transformation efforts within the CY 2018 PCMH Initiative will be focused on population health management. All participants will be required to empanel at least 95% of their patient population, utilize quality and utilization data reports from the Initiative, other payer partners, or internal systems (see Section C.5 for more information on PCMH data sharing) to support quality improvement activities. Defining both practice transformation activities is a new approach in 2018; while Clinical-Community Linkages were required in 2017, participants had an additional choice to select an activity from a menu of practice transformation objectives. A majority of participants selected population health management as their elected objective in 2017, and so to further streamline efforts and provide opportunities for participants to learn and grow from one another, this will be a required objective in 2018.

To continue building on the foundation of care management and coordination and practice transformation within participating locations, MDHHS will invest in capacity building through partnerships with vendors statewide to provide a series of trainings for care managers and care

coordinators (see Section B.2.e, Workforce Capacity). Initiative-led participant support and learning activities will be further refined to ensure support for further building necessary capabilities and functions of participants. Additional efforts will be made to coordinate and collaborate with other national and statewide programs, such as CPC+ and the Transforming Clinical Practice Initiative, to avoid duplication of efforts and reduce provider burden related to technical assistance event attendance.

The Initiative will require attendance at a few key events throughout the year, but most learning activities will be optional to participants. All participating practices will be required to attend the annual initiative launch webinar held early in the calendar year with the goal of aligning participant expectations for the year ahead. All participating physician organizations will be required to attend quarterly virtual update meetings in which programmatic and administrative updates are shared. As mentioned above, there are training opportunities specifically available to care managers and coordinators, with two required courses (upon hire), and a requirement to attend 12 hours of additional learning activities annually. All other learning activities described below will be provided as optional participant support opportunities, meaning there will be no required amount of participation associated with the activities.

Practice Transformation Collaborative

During CY 2017, the Practice Transformation Collaborative was an open, collaborative learning network designed with two in-person learning sessions, monthly action period calls, and bi-monthly peer coaching calls. While participants were encouraged to join as a care team (i.e. have more than one individual participate) and to maintain consistent participation in events, in reality there was fluctuation in participation in the various events, with the exception of a few participants.

In CY 2018, the scope of the Practice Transformation Collaborative will be adjusted, while maintaining the consistent theme of Clinical-Community Linkages and population health management. General support will be provided virtually to all initiative participants on a practice level and at a level consistent with the roles/responsibilities of physician organization/practice leaders. This general support will be designed to allow participants to attend the sessions that are most appropriate to them, and will not require consistent participation. Parallel to the general virtual support, a core group of participant teams will elect to participate in a more focused collaborative learning network, requiring a commitment to consistently participate and share elements of change. This core group will mimic the original design of the collaborative, but will be executed on a smaller scale. The participants in this core group of early adopters will become initiative change agents, serving as models or mentors to other initiative participants in the efforts to strengthen Clinical-Community Linkages.

Topic Focused Sessions (Office Hours)

This virtual convening series is designed to respond to frequently asked questions and specific topics related to participation requirements. It will remain largely unchanged in CY 2018. The topic of focus and the scheduled date/time for each month will be predetermined and published several months in advance.

Potential topics for these events include:

- Initiative care management and coordination tracking codes
- Initiative payment model
- Maximizing billing for services related to Clinical-Community Linkages
- Effective use of initiative measures and dashboards to support quality improvement activities
- Operating efficiently as a multidisciplinary team and maximizing the efforts of all team members, licensed or otherwise

Care Coordination Collaborative

This series of events will serve as an opportunity to gather participating payers and care management, care coordination, and/or community health worker staff members in participating practices or physician organizations, as well as appropriate administrative support staff in these practices or organizations. These events will serve as opportunities to support networking and facilitate exercises to align efforts, reduce potential duplication of services, and identify methods of collaboration for shared beneficiaries.

Annual Summit

Over the history of the MiPCT demonstration there were various forms of an annual summit; the most recent years supported a series of regionalized events. In the first year of the PCMH Initiative, the same format was executed in relation to annual summits hosted in multiple regions throughout the state. In PCMH Calendar Year 1 (SIM Year 2), efforts were taken to update the focus of the event, with a shared agenda strongly supportive of skill-building and knowledge enhancement for all care team members. In PCMH Calendar Year 2, the focus to support all care team members will remain, and the initiative will work with participants to identify potential areas for learning and the development of a robust event agenda.

Technical Assistance

The method for providing targeted technical assistance in PCMH Calendar Year 2 will remain unchanged. Participants will have the ability to submit questions or requests for information to the established listserv and appropriate staff members and access resources on the designated webpage. Initiative staff will also deliver on-site technical assistance as appropriate.

Payment Model

Leveraging a braided funding model, the PCMH Initiative utilizes both Medicaid funding and SIM grant funds to support the model of care, continued participant infrastructure development, and practice capacity building. Medicaid funds are used exclusively in a payment directed to support the development of a robust care management and coordination workforce and service delivery. The care management and coordination per member per month (PMPM) payments are stratified, using beneficiary age and benefit plan type as a proxy for acuity, thus resulting in four distinct rates.

In addition to the Care Management and Coordination payment, the PCMH Initiative utilizes Medicaid funds to support infrastructure development related to practice transformation, designed as a flat per member per month payment based on monthly attribution. The payment model has been structured as a PMPM to align with the methodology used in other programs Michigan providers are accustomed to, such as the Multi-Payer Advanced Primary Care Practice demonstration and the current CPC+ Care Management Fee and Performance Based Incentive Payments payment model. Both of the current PCMH Initiative payments are designed as Healthcare Payment Learning and Action Network (LAN) Framework Category 2A payments, offered in the format of a PMPM payment based on monthly initiative attribution. Participants receive quarterly payments prospectively to ensure their commitment up front, and are required to meet specified performance benchmarks and progress toward clinical practice improvement/practice transformation to avoid payment sanctions or recoupment.

While Medicaid funds are leveraged through the PMPM payments to support the model of care and continued participant infrastructure development, SIM grant funds are planned for capacity building, to further developments from the 2017 PCMH Initiative, and to support practice transformation sustainability. Through the 2017 PCMH Initiative, participants placed a great deal of effort into the design and development of efforts to achieve specified practice transformation. In particular, participants were required actively pursue Clinical Community Linkages to test tools to screen for social need, develop screening plans and methodologies, identify and build relationships with community based partners, and design quality improvement activities to support continued enhancements of the efforts. In addition to the required Clinical Community Linkage, participants further transformed their practices by pursuing one of eleven elective practice transformation objectives (defined based on MACRA Clinical Practice Improvement Activities), and further building Health Information Technology capacity through participation in specified Health Information Exchange Use Cases.

Continuing the efforts from the first year of the Initiative requires continued investment at each practice to implement in a way aimed at supporting sustainable integration of the practice transformation efforts to date. To accomplish this, the PCMH Initiative plans to utilize SIM grant

funds to deliver a one-time capacity-building payment. This payment will be focused on continued efforts to integrate practice transformation efforts such as Clinical Community Linkage design into current workflows. This includes building social needs screening tools into electronic health records, and report design and development for continued quality improvement with Clinical Community Linkages and for active Health Information Exchange participation. This one-time payment, different from the Medicaid funded PMPM payments, will be structured as a single per participant payment based on number of participating practices. There will be five tiers or payment levels as described below:

Table C.1-1 Five Payment Tiers

Tier	Number of Practices	Payment Amount
Tier 1	1 – 2 practices	$10,000
Tier 2	3 – 4 practices	$15,000
Tier 3	5 – 10 practices	$20, 000
Tier 4	11 – 19 practices	$25,000
Tier 5	20 practices or more	$35,000

The proposed capacity-building payment has been suggested as a tiered model, based on the number of practices within a participating organization. The number of practices directly relates to efforts required to ensure effective systems integration and implementation in a sustainable manner, including the number of teams that must be trained on any system adjustments to support these transformative efforts, various system report development, and information transmission. In many cases, organizations participating in the PCMH Initiative that support many practices are working across various health information technology platforms, adding to the complexity of implementing sustainable system wide solutions to support this valuable work. In order to execute this one-time capacity building payment, the PCMH Initiative would require participating organizations to complete an application detailing how funds would be utilized to impact or offset costs related to implementing plans for transformation sustainability.

Performance Monitoring and Initiative-Provided Feedback

Throughout initiative operations, there are several mechanisms deployed to monitor participant performance and aid in providing feedback and information for participants to utilize in internal performance improvement activities. Maintenance of basic participation requirements such as core primary care capabilities are assessed during a quarterly progress report process and through random site audits. Detailed information of clinical practice improvement activities, Clinical-Community Linkages and population health management are gathered during semi-annual practice transformation reporting, and is bolstered by efforts

within the Practice Transformation Collaborative. These reports serve as an opportunity for MDHHS to monitor the progress of participants within the initiative. However, there are additional opportunities for MDHHS to monitor overall initiative progress and provide information to participants to support their own efforts in progressing through the initiative. The items described below outline the various feedback mechanisms the initiative develops for participants:

PCMH Patient Lists

The initiative provides a monthly downloadable patient list to initiative participants containing the attributed population of participating providers.

Care Management and Coordination Tracking Reports

The initiative provides both a monthly report and quarterly downloadable reports to participants. These reports contain CMCC tracking information for a three-month period and are provided approximately 30 days after the end of the subsequent quarter to allow for claims lag and run-off (e.g. a report delivered in late July would contain tracking for January, February and March). This report will include the number of patients that received a care management and coordination service (represented through claims billed to participating payers which contain the initiative's tracking codes), the total attributed population, and a calculated percentage of patients receiving CMCC services.

The initiative also provides both a monthly report and quarterly downloadable reports to participants. These reports contain performance information related to the metric that measures the number of patients that received a follow-up visit with the primary care physician within 14 days of an inpatient discharge. The quarterly report for this measure follows the cadence of the CMCC tracking report, including information for a three-month period and arriving approximately 30 days after the end of the subsequent quarter to allow for claims lag and run-off.

In addition to providing these reports to participants, the initiative will review reports on a quarterly basis to ensure participants are meeting initiative-defined performance benchmarks. The first time a practice falls bellows the identified benchmark, a warning will be provided and a performance improvement plan instituted. If the practice falls below the identified benchmark in the next available report, care management and coordination payments will be suspended until the practice meets or exceeds the benchmark on a tracking report.

Interactive Performance Dashboard

The initiative will continue to release an interactive, online performance dashboard to initiative participants. This dashboard contains performance feedback accessible at multiple levels of detail on quality and utilization measures used by the initiative. Dashboards are released

quarterly, and efforts are being made to transition the measures from HEDIS 2015 to HEDIS 2018 specifications (see Section B.2.b, Quality Measure Alignment).

Performance Monitoring Beyond SIM

Ongoing strategy discussion and direction will continue in SIM Year 3 regarding the ongoing calculation of measures, development of dashboards, and publication of results.

C.1.c SUSTAINABILITY NARRATIVE

The SIM PCMH Initiative was designed to be three years in length (calendar years 2017, 2018 and 2019), building upon Michigan's participation in the Multi-Payer Advanced Primary Care Practice demonstration, which ended in December 2016. That three-year program design expanded MDHHS' leadership and operational role, but has also provided an opportunity for MDHHS to re-structure important aspects of the way the Department has supported advancing primary care in the past to be better positioned for future work and long term sustainability. One critical aspect of that restructuring was engaging the state's MHPs as partners in the effort. This includes MHPs taking responsibility for making payments to participating providers (using MDHHS' defined payment model for the initiative) and adjudicating new types of claims for care management and coordination services rendered by participating providers that had not previously been billed to Michigan's MHPs.

That MHP engagement has set the stage for the PCMH Initiative to evolve in the future, including some near-term growth through the definition of a state-preferred alternative payment model (part of the SIM APM strategy) which substantively corresponds with the design of the PCMH Initiative. In calendar years 2018 and 2019, the care delivery model associated with the initiative and the state-preferred PCMH APM will continue to progress in tandem, furthering health system transformation goals and serving as an important bridge between what has historically been a MDHHS-led primary care transformation approach to one which is a collaboration between MDHHS, MHPs, and providers.

During the 2019 participation year, Michigan intends to leverage experience gained through the SIM Program and MHP APM implementations to collaboratively develop an evolved state-preferred advanced primary care APM model which MHPs can operationalize with providers beginning in 2020. The state-preferred model will serve as a vehicle for providers participating in the current PCMH Initiative to continue their SIM efforts in partnership with MHPs. It may also offer the opportunity for providers not currently participating in SIM PCMH to engage. MDHHS will play a leadership role in co-designing the requirements and components of the state-preferred model (in keeping with MDHHS' goal to encourage APM consistency) as well as providing some financial support to MHPs/providers by incorporating funding used to support the current initiative's payment model within the state's MHP capitation rates.

This approach, while structurally different than the current SIM PCMH Initiative, is the most sustainable trajectory to continue supporting advanced primary care in Michigan that MDHHS has identified to date. MDHHS will continue to consider and analyze other opportunities that offer sustainability and growth potential for SIM's care delivery and payment reform transformation as they become available.

C.1.d WORK PLAN BY DRIVER TABLE

Table C.1-2 PCMH Work Plan by Driver

Goal/Driver 1: Patient-Centered Medical Homes					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Performance and Compliance Monitoring	Care Management / Care Coordination	Define CM/CC Performance Measures	Q1 2018	MDHHS, SIM PMDO	MDC and Technology resources are reflected in the Technology Work Plan by Driver.
		Baseline CM/CC Performance	Q1 2018	MDHHS, SIM PMDO	
		Establish targets	Q1 2018	MDHHS, SIM PMDO	
		Produce PCMH specific measures relative to targets	Q1 - Q4 2018	MDC	
		Produce PCMH monthly, quarterly CM/CC reports	Q1 - Q4 2018	MDC	
	Compliance Monitoring and Reporting	Monitor Care Manager and Care Coordinator requirements	Q1 - Q4 2018	MDHHS, CVI, SIM PMDO	$70,000
		Monitor Care Manager and Care Coordinator performance metrics	Q1 - Q4 2018	MDHHS, MDC, SIM PMDO, CVI, Care Delivery Governance	$70,000
		Monitor PCMH core capability requirements	Q1 - Q4 2018	MDHHS, CVI, SIM PMDO	$70,000
		Monitor HIT/HIE requirements	Q1 - Q4 2018	MDHHS, CVI, SIM PMDO	$70,000
		Monitor Practice Transformation progress reporting requirements	Q1 - Q4 2018	MDHHS, CVI, SIM PMDO	$70,000
		Monitor Corrective Action Plan (CAP) and performance improvement process	Q1 - Q4 2018	MDHHS, CVI, SIM PMDO	$70,000

Goal/Driver 1: Patient-Centered Medical Homes					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Participant Support & Learning Activities	Virtual Meetings with SIM PCMH Participants: Annual kick-off, Quarterly update, monthly office hours	Design and planning	Q1 2018	MDHHS, CVI, CMRC, MDC, MiHIN and other vendors	$70,000
		Implementation	Q1 2018		
	Practice Transformation	Design and planning	Q1 2018	MDHHS, IHI	$300,000
		Implementation	Q1 - Q4 2018		
	Care Coordination Collaborative	Survey target audience	Q1 - Q4 2018	MDHHS, CVI, CMRC, MDC, MiHIN and other vendors	$389,000
		Design and planning	Q1 2018		
		Implementation of live and virtual events	Q2 2018		
	Annual Summits	Design and planning, set up overall theme, strategy	Q2 2018	MDHHS, CVI, CMRC, MDC, MiHIN and other vendors	$389,000
		Ongoing monitoring of project milestones, resolve issues, risks	Q2, Q3 2018		
		Execution of live summits including coordination, facilitation	Q2, Q3 2018		
	Care Manager and Coordinator Trainings and Skills-Building	Maintain ongoing Self-Management curriculum and trainings	Q1-Q4 2018	MDHHS, CVI, CMRC	$70,000
		Maintain ongoing Longitudinal learning virtual curriculum and trainings	Q1-Q4 2018		
		Maintain ongoing Care Coordination Management curriculum and trainings	Q1-Q4 2018		

Goal/Driver 1: Patient-Centered Medical Homes					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Participant Payment Model Exclusion	Payment Disbursement	Review/approve participant payments based on beneficiary and provider attribution counts	Q1-Q4 2018	MDHHS, State Actuary, MSA, SIM Governance	$31,700
		Adjust payment per participant performance (as needed)	Q1-Q4 2019		$31,700
		Submit payment detail for gross adjustment to participating payers	Q1-Q4 2018		$31,700
		Monitor participating payer disbursement of funds to participating providers	Q1-Q4 2018		$31,700
SIM PCMH Initiative Onboarding	Initiative Requirements Definition/Adjustment	Define/Adjust PCMH participation requirements (if needed)	Q3 2018	MDHHS, Care Delivery Governance	N/A
		Define/Adjust PCMH application process (if needed)	Q3 2018		N/A
	Participants Onboarding	PCMH application process setup and approved	Q3 2018	MDHHS, CVI, SIM PMDO, Care Delivery Governance	$70,000
		Communication initiated	Q3 2018	MDHHS, SIM PMDO, CVI	$70,000
		Receive applications; vetted against eligibility criteria	Q4 2018	MDHHS, SIM PMDO, CVI	$70,000
		Final list approved by Governance	Q4 2018	Care Delivery Governance	N/A
		Onboarding initiated by Bureau of Purchasing	Q4 2018	BOP, MDHHS	N/A

Goal/Driver 1: Patient-Centered Medical Homes					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
	Participant Information Maintenance Process	Receive participant information change request	Q1-Q4 2018	CVI	$50,500
		Process change request	Q1-Q4 2018	CVI	
		Verify changes in Health Directory	Q1-Q4 2018	MDHHS	$20,000
		Audit	Q1-Q4 2018	MDHHS, Evaluation	

C.2 ALTERNATIVE PAYMENT MODELS (APM)

The Blueprint for Health Innovation, which formed the basis for Michigan's State Innovation Model, envisioned a future in which value-based payment (that is, financially rewarding or penalizing health care providers based on achievement of target performance levels instead of number of services provided) became a dominant form of health care services reimbursement throughout Michigan. This vision was also strongly represented as part of the Request for Proposal process for the Comprehensive Health Plan Contract in 2015 (i.e. Michigan's Medicaid Health Plan re-bid).

The new Comprehensive Health Plan Contract contained a clear commitment to "increase the total percentage of health care services reimbursed under value-based contracts over the term of the agreement," and also laid a foundation for value-based payment with a focus on rewarding "providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries."

Originally, the focus of this value-based payment effort in SIM was centered on Patient-Centered Medical Homes and a newly developed model called an Accountable System of Care. However, as both the state and federal health care landscapes continued to evolve during early SIM planning and implementation efforts, it became clear that one aspect of SIM's original value-based payment approach, Accountable Systems of Care, was both too narrowly focused to achieve broad alternative payment model adoption and not fully consistent with the needs of Michigan's payers and providers. As a result, while maintaining focus on the same long-term goal, MDHHS has altered course to develop a broader Alternative Payment Model strategy in partnership with the state's Medicaid Health Plans to increase the spread of APMs to a larger number of providers and make a wider variety of APMs available to support innovative care delivery efforts.

During FY 17, MDHHS issued a request for information to providers, hospitals, and physician organizations to help inform the creation of an initial APM strategy. This feedback helped to define the department's direction on preferred APMs. Also in FY 17, MDHHS designed preliminary processes for collecting information from MHPs regarding their adoption of APMs in their provider networks. Data collection tools were developed, discussed, and modified collaboratively with MHPs in an attempt to ensure valid and reliable measurement across all MHPs with respect to their percentage of medical expenditures that fell within certain categories of APM. After multiple rounds of data collection and validation, there still remains room for improvement in order to speak with certainty that measurement across MHPs is

uniformly defined and collected in accordance with understood and mutually-agreed-upon specifications. MDHHS also designed preliminary state-preferred APM concepts through discussions and meetings with MHPs over a period of several months.

C.2.a END STATE VISION NARRATIVE

MDHHS' goal for the Alternative Payment Model strategy during the SIM period is to support each Medicaid Health Plan in establishing an APM strategic plan, which includes specific goals to increase the amount of Medicaid spending in APM framework payment categories 2C through 4 over the course of the next three years (FY 18, FY 19, and FY 20). The LAN APM Framework establishes a common nomenclature for defining, implementing, and sharing successful payment models and has been widely adopted across the country, including as the methodology for establishing and monitoring APM goals in Michigan's APM strategy. MDHHS will monitor each MHP's progress in reaching their APM goals by ensuring a consistent APM measurement protocol in collaboration with the state's MHPs, and utilize multiple levers such as contract compliance, implementation assistance and performance incentives to ensure successful implementation of APMs throughout the Medicaid provider network by Michigan's MHPs. The multi-payer aspect of the state's APM strategy is still under development and will be the focus of further analysis and planning in Year 3.

Long-Term Strategic Objectives/Goals

(All long-term APM strategy objectives represent multi-year goals which will continue beyond the SIM period. Substantial progress, but not necessarily completion, is anticipated by the end of FY 20.)

1. **Increase the overall proportion of Medicaid payment made to providers through a contract which includes one or more APMs.**
    - This objective measures total payments made to a provider through a contract which includes an APM component. For example, if a provider's contract with a MHP includes both fee-for-service (FFS) payment for services and a shared savings payment, this objective measures both the FFS and shared savings amounts because they represent the total amount of payment made through a contract which includes an APM (the shared savings payment). The objective will allow Michigan to quantify overall APM adoption, consistent with a measurement framework used by numerous other states and the United States Department of Health and Human Services nationally.
2. **Increase the amount of Medicaid spending made directly through an APM.**
    - This objective measures dollars paid to providers directly through an APM. Using the example above, this objective would only measure the shared savings

payment itself. The objective allows Michigan to better understand the extent to which APM implementations have the ability to influence provider behavior (through proportional comparison to total payment). Also, the objective allows Michigan to understand opportunities for performance improvement in cases where contracts include APM components but direct APM spending remains low, a potential signal of weak performance.

3. **Work with MHPs to substantially increase payment methodologies with a clear link to quality/outcomes and (to the greatest extent feasible) discontinue utilizing payment methodologies which are wholly volume-based.**
    - This objective reflects the Department's commitment to working with MHPs over the course of the remaining SIM funding period to increase provider payment methodologies that include levels of performance measurement and reward consistent with MDHHS' vision for value-based payment.
4. **Propel greater consistency in the measures used by MHPs to evaluate quality of care and member outcomes in APM contracts.**
    - This objective reflects the Department's commitment to working with MHPs and providers to define a predictable, consistent universe of quality and outcome measures across the entire Medicaid program (all MHPs). Measures used in evaluating and rewarding performance under an APM will be incentivized to come from this defined universe. Eventually, some measures will be incentivized for all APMs, and MHPs will retain flexibility to select other measures contained in the defined universe to reflect regional and MHP-specific performance variation.
5. **Encourage greater consistency across MHPs in the type of APMs available to Medicaid providers in order to strongly encourage payment approaches which coherently support model of care improvement.**
    - This objective reflects the Department's commitment to working with MHPs and providers to define a small number of APMs that will be made available to providers by nearly all MHPs and implemented in a relatively consistent manner across MHPs. This small, consistent set of APMs will allow providers whose patient panels are comprised of members from numerous MHPs to experience a more stable payment framework across Medicaid payers, which is required for practice transformation and innovative care delivery to be attainable both financially and operationally. MHPs will retain flexibility to develop and implement APMs beyond this small consistent set, as well as a moderate level of operational flexibility in implementing the consistent APM set.

6. **Advance the implementation of innovative APMs in Michigan which employ evidence-based and/or promising approaches in encouraging cost-effectiveness and quality performance, and which address social determinants of health.**
    - This objective reflects the Department's commitment to engage in a consistent dialogue with MHPs and providers to bring forward and share APM implementation accomplishments for multi-stakeholder learning and to identify opportunities for collaboration on infrastructure, support, and policy-making that can support successful APM implementations in Michigan.

C.2.b STRATEGY NARRATIVE

During FY 17, MDHHS conducted a significant amount of planning and development work to support the APM strategy, including establishing the MHP APM workgroup, collecting baseline APM reporting from all MHPs, defining the Department's high-level APM strategy, establishing the first APM strategic plan format, defining state-preferred APM models and/or concepts, and receiving the first draft of each MHP's APM strategic plan. These steps form the basis for the Department's first year of APM implementation (FY 18) and provide a platform to build upon in achieving the Department's APM strategic objectives over the course of the next three Medicaid Health Plan contract years. Plans will be ready for implementation in Q1 or Q2 2018, however, it is important to recognize that some elements of the three-year plan will be staggered over the length of the plan. MHPs will have the ability to update their plans annually. It is also valuable to recognize that plans have the ability to implement APMs at any time.

While it is difficult to define all of the work ahead, some near term aspects of the strategy are clear, including several which lead the APM strategy toward achieving MDHHS' long-term APM strategy objectives.

- Establish and maintain an internal Medicaid APM working group to coordinate and implement the APM strategy, including ensuring staffing and contractor resources are retained, status monitoring and reporting processes are completed, and work moves forward to meet objectives.
- Utilize a MHP APM workgroup to collaborate with MHPs in the strategy design for leadership approval, ongoing programmatic reference, and monitor implementation of the Medicaid APM strategy.
    - The APM workgroup was formed and utilized in the creation of MDHHS' initial APM strategy. This workgroup will likely need to be re-convened as implementation gets underway to continue to advance the strategy collaboratively with MHPs.

- Establish regular opportunities to engage providers and other stakeholders in the design and implementation of Medicaid APMs.
    - MDHHS conducted a Provider Request for Information (RFI) during FY 17 to inform the creation of initial APM strategy. MDHHS will need to pursue similar approaches in the future and expand provider engagement opportunities to inform APM implementation, particularly MDHHS' definition of preferred APMs.
- Optimize the format to receive, review, provide feedback, and approve an alternative payment model strategic plan for each MHP.
    - A strategic plan template was created during FY 17 and used for the first draft submission by all MHPs. This template will undergo further improvements (for example, more precise collection of MHP APM goals/targets and more detailed guidance on content) to ensure MDHHS collects information comprehensively from MHPs to approve sound APM strategies. In the future, MDHHS also intends to explore how MHP APMs can or do correspond with CMS Quality Payment Program Advanced APM criteria to support providers pursuing All-Payer APM participation.
- Define a process for MHPs to make updates and/or additions to their APM strategic plan and review/approve as applicable.
- Define and detail a group of state-preferred APM models wherein if an MHP adopts a preferred APM, the MHP is able to receive a form of enhanced/extra "credit" toward meeting their APM goals. Support implementation of these models as needed.
    - MDHHS defined the first group of state-preferred APMs during FY 17 and a preliminary methodology for rewarding additional credit to MHPs when they adopt these preferred APMs. Each dollar of spending made through contracts that align with the preferred APMs will be counted as $2 during MHP APM reporting. This will help MHPs reach their APM goals and encourage greater APM consistency across MHPs.
    - While the state-preferred APMs are fully optional today, over time the Department intends to work with MHPs to implement some MDHHS-defined APMs across MHPs more reliably. The current approach provides an opportunity to take a first step, gain experience, and cultivate familiarity with the concepts before the Department begins to use firmer requirements that can be objectively reviewed for rewarding participation in certain APMs in the future.

- Develop a measurement, monitoring, and incentive structure and processes for rewarding MHP performance relative to MDHHS quality and cost targets, including a meaningful way to motivate adoption of state-preferred APM concepts.
    - Currently, many MHPs have expressed interest in utilizing the state-preferred models as an option in their strategic plans, but most have not fully committed yet. The MHPs are uncertain and/or require additional information about the state-preferred APMs.
    - While the process for development and discussion has been piloted, further effort is needed to define implementation of state-preferred APM concepts relative to contractual or incentivized criteria that can be objectively evaluated and scored across all MHPs. The preliminary extra credit mechanism described above has not been evaluated for inclusion in the current managed care incentive structure.
    - Once these criteria are developed and agreed upon, MDHHS can then more appropriately incentivize or require adoption of state-preferred APMs.
- Refine, implement, receive, and analyze an alternative payment model reporting process to monitor MHP APM goals (i.e. specific numerical goals based on LAN categories).
    - MDHHS conducted two rounds of APM data collection with all MHPs during FY 17 and now has a process to refine moving forward in monitoring APM progress. MDHHS is utilizing the Healthcare Payment Learning and Action Network APM Framework to define payment methodologies for reporting and goal setting/monitoring purposes. Further efforts are needed to concretely define measurement, ensure uniform adoption of measure definitions, and educate MHPs on using the data collection tool in a standardized way. Until this is achieved, the APM baseline will continue to be revisited and data collected should be carefully analyzed and qualified. As MHP APMs progress, MDHHS intends to also consider the CMS Quality Payment Program Advanced APM definition and criteria as part of ongoing reporting.
- Define, implement, receive, and review on an annual basis an APM narrative progress report including opportunities for MHPs to discuss APM progress beyond their numeric goals.
    - MDHHS will need to develop a narrative-based approach to capture APM progress, successes, and challenges that cannot be conveyed through the numerical APM goal reporting. This narrative will need to be received and reviewed at least annually going forward into implementation.

- Define, implement, and conduct an APM component of the annual focus study/on-site review for each MHP to discuss APM progress and provide support as needed.
- Define, implement, and monitor usage of a consistent universe of quality and outcome measures that further the overall Medicaid quality strategy.
    - In the near term, MDHHS will be providing an incentive (extra bonus point) for MHPs to utilize quality and regional disparity measures currently contained in the MHP performance bonus, as well as one or more Prevention Quality Indicators, as part of their APM implementation. MHPs will also have the opportunity to bring forward one measure of focus for their organization that is not currently included in MDHHS' structure for incentive consideration. While MHPs will not be fully required to use this measurement universe in the near term, MDHHS believes the incentive will be a strong motivator for greater consistency and a good starting point to evolve to a fully consistent measurement universe.
- Define and implement APM-focused elements of the MHP performance bonus to further encourage APM goal achievement.
- Monitor evolution and advancements in APM strategy happening across the country, including the work of the Health Care Payment Learning and Action Network to garner promising practices and lessons learned for use in Michigan's APM efforts.

State and Federal Alignment

The Medicaid APM strategy utilizes the LAN APM framework as the basis for both goal creation and measuring progress. The LAN APM framework was first published in January 2016 and modified in May 2017 to reflect developments in the APM landscape. The framework establishes a common nomenclature for defining, implementing, and sharing successful payment models and has been widely adopted. Michigan's approach is consistent with the way the U.S. Department of Health and Human Services established nationwide goals for value-based payments and APMs in Medicare. In addition, the approach is supportive of providers pursuing the All-Payer APM Combination Option under the Medicare Access and CHIP Reauthorization Act's (MACRA) Quality Payment Program.

HIE Dependencies

Certain APMs proposed or implemented by MHPs will benefit significantly from existing infrastructure related to participating providers' use of Health Information Exchange technology, in particular the Statewide Admission, Discharge, and Transfer (ADT) Notification Service use case, the Active Care Relationship Service use case, and the Quality Measure Information use case currently being utilized as part of SIM care delivery efforts. The ADT Notification Service use case is important for providers participating in APMs with utilization

reduction and/or cost savings components such as shared savings payments. ADT notifications are needed to initiate critical interventions like structured transitions in care to prevent re-admissions and future inappropriate use of the emergency department. The Quality Measure Information use case is key in presenting a more comprehensive picture of quality of care, because it can enhance quality data available to a MHP for use in evaluating the success of APM implementations, which are all linked to quality. In the future, the Quality Measure Information use case may also be important to MHPs in structuring provider incentives for quality outcomes that cannot be fully captured using claims-based measures alone. This infrastructure and related implementations are heavily based on the Active Care Relationship Service use case.

The use of HIE technology as part of the Medicaid APM strategy is less direct than in efforts like the SIM PCMH Initiative, where MDHHS mandates use case participation and consumes HIE information operationally. MDHHS' HIE interests in relation to the APM strategy are centered on ensuring HIE infrastructure is available to support MHPs and their provider networks in achieving the quality and utilization goals at the center of APM implementation. Without HIE technology, some of the APMs that MHPs and providers will wish to pursue would be quite difficult to demonstrate success in.

C.2.c SUSTAINABILITY NARRATIVE

The Medicaid APM strategy, in an evolving form, will be a lasting element of Michigan's comprehensive contract with MHPs going forward (including any contract option years exercised) and as part of future contract procurement. During the SIM period, MDHHS has applied and will continue to apply additional capacity and consulting resources to the APM strategy effort to support activities ranging from initial and ongoing design to MHP strategy review and ongoing reporting and monitoring processes. Since the current APM strategy is one of the first times MDHHS and MHPs have implemented payment reform on a large and truly statewide scale, these additional resources have been critical to get the Department's efforts off the ground. But as the APM strategy continues to move forward, numerous aspects are being worked into normal operational processes between MDHHS and MHPs so that the strategy is well-positioned to continue after the SIM Program ends.

C.2.d WORK PLAN BY DRIVER TABLE

Table C.2-1 APM Work Plan by Driver

Goal/Driver 1: Alternative Payment Models					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
APM Working Groups	Maintain Internal APM Coordination, Status Monitoring, and Governance Processes	Maintain communication plan detailing mode, frequency and stakeholders involved	Q1-Q4 2018	Bailit, MDHHS, SIM PMDO	$33,000
		Maintain project plan detailing milestone and activities, and maintain status reporting process for weekly and monthly updates	Q1-Q4 2018	Bailit, MSA, MDHHS, SIM PMDO	
		Maintain governance meetings for ongoing risk, issue resolution, and monitoring project progress	Q1-Q4 2018	Bailit, MDHHS, SIM PMDO	
	Maintain External MHP APM Workgroup Collaboration	Maintain ongoing MHP APM workgroup collaboration into 2018 to monitor strategy implementation	Q1-Q4 2018	Bailit, MDHHS, MHPs, SIM PMDO	
APM Stakeholder Engagement	Conduct Provider APM RFI Data Collection	Establish data collection parameters, criteria, and process	Q1 2018	MHPs	$33,000
		Issue communication to providers, and provider associations	Q1 2018	MHPs	
		Implement process and collect required data	Q1 2018	MHPs	
	Conduct Provider and Provider Association Engagement on APMs and Performance Measurement	Draft engagement plan, timeline and performance measurement criteria based on RFI data	Q4 2018	MHPs	
		Review/approve changes; establish consensus and formalize process for ongoing engagement	Q4 2018	MHPs	
		Set up and launch provider engagement sessions (virtual/live)	Q2 2018	MHPs	
		Provide guidance	Q1-Q4 2018	Bailit, MDHHS	

Goal/Driver 1: Alternative Payment Models					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
MHP APM Strategic Plans	Enhance/Improve the MHP APM strategic plan template	Review the current template specific to language and process pertaining to goals/targets, guidance	Q3 2018	Bailit, MDHHS	$16,600
		Identify gaps, improvements to current state	Q3 2018	Bailit, MDHHS	
		Build desired future state iteratively	Q4 2018	Bailit, MDHHS, MHPs	
	Review/Approve initial MHP APM strategic plans	Receive MHP APM strategic plan submissions	Q1 2018	Bailit, MDHHS, MHPs	$16,600
		Review compatibility with established criteria with the APM workgroup	Q1 2018	Bailit, MDHHS, MHPs	
		MDHHS (MSA) approves the APM strategic plans	Q1 2018	Bailit, MDHHS, MHPs	
	Provide an annual process for MHP APM strategic plan updates and approval	Establish process for annual review of MHP APM strategic plan	Q2 2018	Bailit, MDHHS, MHPs	$16,600
		Review the current MHP APM strategic plan specific to goals/targets, process	Q3 2018	Bailit, MDHHS, MHPs	
		Document updates and ensure incorporation in strategic plans for ongoing implementation	Q4 2018	Bailit, MDHHS, MHPs	
State-Preferred APM Models	Further define and support MHP implementation of state-preferred APM models	Develop quality strategy	Q3 2018	Bailit, MDHHS, MHPs	$16,600
		Provide templates for implementation, monitoring, measurement	Q3 2018	Bailit, MDHHS, MHPs	
	Review effectiveness of the MHP extra credit approach for state-preferred APMs and consider other motivating strategies	Receive Semi-Annual and Annual reports	Q4 2018	Bailit, MDHHS, MHPs	
		Manage execution	Q1-Q4 2018	Bailit, MDHHS, MHPs, SIM PMDO	

Goal/Driver 1: Alternative Payment Models					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
MHP APM Performance and Incentive Structure	Conduct MHP contract compliance activities related to MHP APM goals	Define MHP contract compliance activities, timeline	Q1 2018	Bailit, MDHHS, MHPs, SIM PMDO	$16,600
		Define MHP contract performance monitoring criteria	Q1 2018	Bailit, MDHHS, MHPs, SIM PMDO	
		Ongoing monitoring and performance reports as measured against pre-defined targets/goals	Q1-Q4 2018	Bailit, MDHHS, MHPs, SIM PMDO	
MHP APM Performance and Incentive Structure	Mature APM-focused elements of the MHP performance bonus	Set out benchmarks, timeline	Q2 2018	Bailit, MDHHS, MHPs, SIM PMDO	$8,300
		Develop APM performance bonus model	Q3 2018	Bailit, MDHHS, MHPs	
APM Model Reporting Process	Conduct APM reporting process to monitor MHP APM goals	Define and document monitoring and reporting process	Q1 2018	Bailit, MDHHS, MHPs	$33,000
		Define and establish roles, responsibilities to implement reporting process	Q1 2018	Bailit, MDHHS, MHPs	
		Implement process as defined and documented	Q1-Q4 2018	Bailit, MDHHS, MHPs	
	Develop MHP APM annual narrative progress report	Define and document process to capture narratives	Q2 2018	Bailit, MDHHS, MHPs	
		Define and establish roles, responsibilities to implement narrative progress reporting process	Q2 2018	Bailit, MDHHS, MHPs	
		Develop progress report as documented	Q4 2018	Bailit, MDHHS, MHPs	

Goal/Driver 1: Alternative Payment Models					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
	Add APM component of MHP annual focus study	Define APM component of the annual focus study for each MHP to discuss APM progress	Q4 2018	Bailit, MDHHS, MHPs	
		Implement on-site review and provide support as needed	Q4 2018	Bailit, MDHHS, MHPs	
APM Quality and Outcome Measures	Review effectiveness of initial quality measure approach for APMs	Define and document initial quality measure set against benchmarks, indicators	Q1 2018	Bailit, MDHHS, MHPs, SIM PMDO	$33,000
		Measure and collect data and feedback on quality measures	Q3 2018	Bailit, MDHHS, MHPs, SIM PMDO	
		Review effectiveness and implement next steps	Q4 2018	Bailit, MDHHS, MHPs, SIM PMDO	
	Develop plan to enhance APM performance measure consistency over time	Set up timeline, plan for measure review	Q2 2018	Bailit, MDHHS, MHPs, SIM PMDO	

C.3 MULTI-PAYER ALIGNMENT (MPA)

The Blueprint for Health Innovation, which formed the basis for Michigan's State Innovation Model (SIM), originally promoted multi-payer alignment in testing innovative approaches to paying for value through multiple mechanisms. These mechanisms included multi-payer steering and recognition committees, access to multi-payer data, shared metrics and multi-payer performance reporting, continued multi-payer participation in the Patient-Centered Medical Home component of SIM (based on the Multi-payer Advanced Primary Care Practice Demonstration), and the development of sustainable multi-payer payment methodologies.

With this direction in mind, MDHHS engaged a large multi-payer and multi-stakeholder group of collaborators in 2016 to design a delivery system and payment reform approach which included Medicare, Medicaid, and commercial payer participation in a phased five-year effort to continue care delivery transformation and advance APM implementation in Michigan statewide. These efforts culminated in a detailed concept paper which served as a starting point for discussions with the Centers for Medicare and Medicaid Services (CMS) to pursue Medicare alignment in Michigan's multi-payer model under SIM. However, shortly after those conversations between MDHHS and CMS began, Michigan's selection as a Comprehensive Primary Care Plus (CPC+) region, the federal administration transition, and federal health care reform efforts brought new uncertainties to the health care landscape, which resulted in a sensible pause on Michigan's multi-payer alignment efforts.

After pausing multi-payer efforts for several months in the beginning of 2017, MDHHS reassessed the feasibility of proceeding with the delivery system and payment reform approach developed in 2016. Given the continued uncertainty related to federal health care reform and the implications for Michigan's ability to commit to a large multi-payer initiative, MDHHS has elected to pursue several non-payment facets of multi-payer alignment which contribute to closer payer collaboration. These facets offer a near term alternative to continue Michigan's multi-payer alignment activities outside of a multi-payer payment reform approach. MDHHS continues to monitor the health care landscape and remains open to re-engaging in payment focused multi-payer efforts with CMS and other payers in Michigan in the future.

C.3.a END STATE VISION NARRATIVE

MDHHS' goal for current multi-payer efforts is to create and engage in opportunities that demonstrate an aligned focus and shared priorities with multiple payer partners, particularly those opportunities which support consistency in model of care and broader community involvement in health services delivery.

Objectives

MDHHS has analyzed numerous opportunities to support multi-payer alignment and collaboration to determine a grouping of efforts which promote payer cooperation (and a greater sense of multi-payer alignment for SIM participants) within the scope of current SIM components. For MHPs, several aspects of the SIM multi-payer alignment strategy are reinforced via contractual expectations. With other payers, MDHHS works to pursue opportunities that represent shared goals in order to foster alignment. These opportunities include:

- Health Information Exchange (HIE) Use Case Implementation Alignment: Pursuing HIE technology is a priority for numerous payers in Michigan, in particular commercial partners and Medicaid.
- PCMH Participation Requirement Alignment: Ensuring greater consistency in provider requirements across the SIM PCMH Initiative and CPC+ program where possible.
- CPC+ Program Coordination: Engaging in ongoing collaboration with the CPC+ program to identify opportunities for care model components to meet the requirements of both the SIM PCMH and CPC+ programs, and to align emphasis/messaging with provider participants.
- Care Management and Coordination Coding Alignment: Leveraging similar care management and coordination coding conventions across the SIM PCMH Initiative and commercial partners.
- Care Management and Coordination Collaborative: Supporting greater alignment of assets and better use of care management and coordination capacity across provider and payer resources, in particular across Michigan's MHPs.
- Participation in Community Health Innovation Region (CHIR) Governance: Encouraging payer participation in CHIR governance at the local/regional level in addition to the state's Medicaid Health Plans, in particular with commercial partners.
- Shared Provider Data Portal: Leveraging the same virtual portal for providers to access performance and attribution related information across the SIM PCMH and CPC+ programs.
- APM Leadership: Promoting payer commitment to APM implementation and spread across Michigan by publicly committing to Medicaid APM goals and exercising leadership in asking other payers to make similar pledges.

C.3.b STRATEGY NARRATIVE

- Health Information Exchange Use Case Implementation Alignment
    - MDHHS will continue to collaborate with other payers, particularly Michigan's commercial payers, in the evolution of HIE technology. This collaboration will include shared participation and leadership in the creation and refinement of HIE use cases, as well as substantial alignment on the HIE use cases which are selected as required components for participating providers.
- PCMH Participation Requirement Alignment
    - MDHHS has analyzed the CPC+ Practice Care Delivery Requirements and, for the SIM PCMH Initiative participation year beginning January 1, 2018, altered PCMH Initiative participation requirements to match CPC+ requirements where the requirements had a shared purpose. This process will continue in the future, at least annually, as requirements for both programs continue to evolve.
- CPC+ Program Coordination
    - MDHHS and CPC+ program partners have initiated a series of standing collaborative meetings to assist coordination across the two programs, ranging in purpose from comparing implementation details to ensure coherent obligations for participating providers to avoiding large scheduling conflicts for participant events. This series will continue on a quarterly basis for the foreseeable future and more frequent communication outside of the formal meetings will be pursued as needed.
- Care Management and Coordination Coding Alignment
    - In 2017, MDHHS began using a set of care management and coordination service tracking codes which in large part matched those used by Michigan's large commercial payers. For the SIM PCMH Initiative participation year beginning January 1, 2018, MDHHS will be working to further align these coding sets (both in terms of the codes used and the definitions/billing requirements) to streamline the coding, billing and monitoring aspects of care management and coordination services across payers/programs.
- Care Management and Coordination Collaborative
    - During 2018, MDHHS will sponsor a care management and coordination service collaborative for current SIM participants and payers to collaborate in determining methods to most effectively use care management and coordination resources and create greater consistency in processes across payers. This work will initially focus on multiple Medicaid payers (Michigan's 11 MHPs), but will likely have applicability to a broader payer group in the future.

- Participation in Community Health Innovation Region Governance
    - MDHHS will continue to support MHP engagement in CHIR governance, but also work with local CHIR leaders to invite and encourage payers outside of Medicaid to participate as key stakeholders in the governance of SIM CHIRs.
- Shared Provider Data Portal
    - MDHHS will continue to engage commercial payers and Medicaid Health Plans in forums such as the Health Information Technology (HIT) commission meetings. As MDHHS continues to refine their existing value-based payment models or add new value-based payment models or APM, MDHHS will work with commercial payers and Medicaid Health Plans on shared quality metrics and data exchange use cases. As part of these efforts, MDHH will look to leverage multi-payer technology and infrastructure, which may include statewide data exchange, a shared provider data portal, and other possible solutions to further the multi-payer activities.
- APM Leadership
    - Following additional APM data collection as part of the SIM APM strategy in 2018, MDHHS will publish/share an aggregate APM goal for the Medicaid program as a whole and ask other Michigan payers to make a similar public commitment, as well as participate in an annual update on the state of APMs in Michigan.

C.3.c SUSTAINABILITY NARRATIVE

The sustainability of MDHHS' multi-payer efforts will be impacted significantly by whether or not the opportunity to re-engage in payment focused multi-payer efforts with CMS and other payers in Michigan is feasible during the current SIM period. Multi-payer activities currently being pursued either have a natural end point that corresponds with the end of Michigan's SIM period, or they can be housed within MDHHS using sustainable staff capacity beyond SIM. However, if payment focused multi-payer efforts are re-ignited, the sustainability of those efforts beyond SIM will require further consideration and planning. The APM and multi-payer alignment work in Year 3 will result in a final direction for multi-payer payment alignment, if any, beyond the activities outlined for Year 3.

C.3.d WORK PLAN BY DRIVER TABLE

Table C.3-1 Multi-Payer Alignment Work Plan by Driver

Goal/Driver 1: Multi-Payer Alignment					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
HIE Use Case Implementation Alignment	Collaboration with Commercial Payers on HIE Use Case Alignment	Establish collaboration opportunities with commercial payers	Q1 2018	MDHHS	Multi-payer alignment expenditures are included in the other component Work Plans by Driver.
		Creation and refinement of HIE use cases and ensure alignment across payers	Q2 2018	MDHHS, SIM PMDO	
		Ensure alignment with participating providers	Q2-Q4 2018	MDHHS	
CPC+ Program Coordination	PCMH Participation Requirement Alignment	Alter PCMH participation requirements to align with CPC+ requirements	Q1 2018	MDHHS	
		Ongoing review process to ensure alignment with changes in CPC+ requirements (at least annually)	Q1-Q4 2018	MDHHS	
	PCMH and CPC+ Coordination	Set up quarterly standing collaborative meetings to facilitate coordination	Q4 2018	MDHHS, SIM PMDO	
		Ongoing review of implementation details	Q1-Q4 2018	MDHHS, SIM PMDO	
Care Management and Coordination Coding (CM/CC) Alignment	Align CM/CC Coding Sets Across Payers/Programs	Review usage of CM/CC tracking codes and reimbursement of claims data across various payers/programs	Q2 2018	MDHHS, SIM PMDO	
		Involve various stakeholders in defining and developing common set of codes consistent across various payers/programs	Q3 2018	MDHHS	
	Align CM/CC Claims Billing and Monitoring Across Payers/Programs	Involve various stakeholders in defining and developing common billing, and monitoring standards consistent across various payers/programs	Q3 2018	MDHHS, SIM PMDO	

Goal/Driver 1: Multi-Payer Alignment					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Shared Provider Data Portal	Shared Data Infrastructure Usage	Convene appropriate stakeholders for SIM data infrastructure review	Q2 2018	MDHHS, SIM PMDO	
		Gather commercial payers interests for shared data infrastructure usage in the future	Q2 2018	MDHHS, SIM PMDO	
		Capture business requirements and perform impact analysis related to shared data infrastructure	Q4 2018	MDHHS, SIM PMDO	
		Implementation	2019	MDHHS, SIM PMDO	
APM Commitment	APM Goals for Medicaid and Other Michigan Commercial Payers	Convene Michigan payers for APM goal alignment	Q2-Q3 2018	MDHHS, SIM PMDO	
		Facilitate review and feedback with other Michigan payers	Q2-Q3 2018	MDHHS, SIM PMDO	
		Publish APM goal partnership opportunities for other Michigan payers	Q4 2018	MDHHS, SIM PMDO	

C.4 COMMUNITY HEALTH INNOVATION REGION (CHIR)

Community Health Innovation Regions (CHIRs) are the primary population health component of Michigan's State Innovation Model (SIM) Test program. The CHIRs establish, grow, and strengthen broad community partnerships through local governance bodies and backbone organizations, which act as neutral conveners. The CHIR is regionally focused, providing interventions to address social and economic determinants of health and health disparities and inequities. These interventions are designed to be effective, scalable health system transformation solutions.

The Michigan SIM CHIR Team worked diligently over the last year, producing a number of key deliverables and completing a majority of the planning, design, and implementation milestones. Some of the many successes include:

- Selected 5 regions to participate in the CHIR Initiative.
- Appointed 5 community organization/coalitions to function as backbone organizations.
- Developed a CHIR Participation Guide and financial management manual.
- Established a communication cadence with each CHIR:
    - Monthly individual calls
    - Twice a month cohort calls
    - Monthly technical assistance calls
    - Monthly CHIR Newsletter
    - Onsite visits
    - In-person meetings
- Established funding mechanisms and provided funds to each region for backbone administration and local operational plan development.
- Held onsite working meetings with each region to review and provide feedback on draft local operational plans.
- Regions successfully submitted final local operational plans on schedule.
- All 5 local operational plans and budgets were approved by MDHHS.
- Developed a SharePoint site for backbone organizations to access information and submit project documentation.
- Set up a listserv to share information with backbone organizations and other CHIR participant organizations.
- Began submitting quarterly CHIR participation metrics to CMS.

- Engaged Michigan State University (MSU) for ABLe Framework and Systems Change training.
- The state hosted multiple summits:
    - SIM Summit – This meeting served as a gathering of the SIM program team, MDHHS team members, executive leadership, SIM Participants, and other key stakeholders to officially kickoff implementation activities for the SIM Program.
    - PCMH Summits (annual) – Each interactive regional summit facilitated collaboration and shared learning focusing on efficient team-based care in the primary care setting. Together, participating physicians, practice team members, physician organization leaders and partners addressed clinical and office operations aimed at meeting the diverse needs of the Michigan patient population.
    - CHIR Summit (annual) – Annual gathering of MDHHS, CHIRs, executive leadership, and other key stakeholders to share SIM and MDHHS updates, regional implementation/operational activities, and upcoming programmatic details.

C.4.a END STATE VISION NARRATIVE

The health of Michigan is greatly influenced by social, economic, and environmental factors, such as having quality access to healthy food and safe places to exercise and play. Michigan is targeting upstream social and economic determinants of health by coordinating efforts between PMCHs and organizations in the community that help to remove real barriers and make it easier for people to achieve optimal health. This will be achieved by providing community organizations and coalitions with governance best practices, requirements for implementing Clinical-Community Linkages, and training assistance on creating change at the system level.

The SIM Community Health Innovation Regions are a progression in the development of the state's vision regarding linkages between health care and community. The state supports the collective impact approach to create lasting solutions to social problems on a large-scale within organizations. Organizations need to coordinate their efforts and work together around a clearly defined set of community visions and goals. The CHIR model incorporates the key concepts of focused collective goals, strategic partnerships, shared accountability, and cross-sector strategies for meaningful and sustainable progress on social issues.

Pending the results of the CHIR Initiative proof of concept, the state is developing a plan for a broader pilot to validate and more formally document the impact of the CHIR concept. All health system transformation activities proposed during the CHIR Initiative will align with the

state's Plan for Improving Population Health (Section B.2.c). The state's goal is to develop a comprehensive document that new regions can use to implement and operationalize a successful CHIR. This CHIR Pilot Manual will contain best practices and lessons learned, along with Clinical-Community Linkages standards, financial tools, and additional resources. It will provide guidance for a standardized and repeatable prototypical model for CHIR beyond the SIM Test award period.

Linkages will also be strengthened through the ongoing roles of the Medicaid Health Plans (MHPs), providers, and increasing the roles of Community Mental Health agencies and Substance Use Disorder Treatment providers. The state is committed to working collaboratively with health plans, health care systems, providers and other key stakeholders to develop a consistent and sustainable model for Clinical-Community Linkages. Coordination will continue between PCMHs and community-based organizations, including those with community health workers (CHWs). To sustain the CHIR Initiative and CHWs beyond federal SIM funding, the SIM team, in collaboration with the MSA, will explore integrating additional CHIR and CHW requirements into the MHP contract requirements of 2020.

Housing issues and homelessness were identified across all 5 regions as having a strong correlation with high emergency department utilization, poor health, and impacts other social and economic determinants. As such, it is an aspiration of MDHHS to develop a housing program across all CHIRs to help communities identify individuals in need of housing assistance, develop a sustained model for housing coordination funding, and plans for addressing shortages in housing capacity.

Core CHIR model components will be further developed and detailed during Year 3 and funding sources will be identified during Year 4.

C.4.b STRATEGY NARRATIVE

Community Health Innovation Regions Early Wins

During the past year, each CHIR worked collaboratively with clinical and community entities within their region to finalize an operational plan aimed to improve the health of the community. The local operational plan aligns with the objectives of the SIM program and CHIR Initiative and feeds into the State of Michigan Operational Plan. This methodology supports a bottom-up, top-enabled approach that is central to the State of Michigan approach to SIM.

All five regions received approval letters from MDHHS for the execution of the submitted plans.

While each region developed unique strategies and interventions, there were key accomplishments that were common to all regions:

- Every region has an established governance model that meets or exceeds Michigan SIM requirements regarding community engagement.
- Regions developed strategies and workflows to support Clinical-Community Linkages specific to their communities' needs and characteristics.
- Data sharing approaches and technology solutions were designed to support the community's Clinical-Community Linkage models. These solutions include the development of a social determinants of health screening tool, a referral process to community services agencies, and the tracking of open and closed referrals.
- All regions are prepared to start screening and referring individuals November 1, 2017, and will have completed piloting Clinical-Community Linkages workflows and technology on or before January 1, 2018.

The major activities/milestones for each region are highlighted below:

<u>Genesee Region</u>

- Engaging Stakeholders
    - Partnering with 61 local organizations and engaging diverse community members.
    - Cultivating new and enhanced partnerships to focus on upstream issues.
    - Building the capacity of existing public health committees and task forces.
- Establishing Clinical-Community Linkages
    - Building on the existing Children's Healthcare Access Program to establish a behavioral health specialty hub to provide social determinant of health resources for individuals with lifestyle or behavior needs.
    - Creating a robust community referral network to address health-related social and resource needs.
- Building Data Sharing Capacity
    - Implementing a standardized measure of social determinants of health to be used by the CHIR partners.
    - Developing shared definitions and protocols across six health plans.
    - Developing real-time High Emergency Department Utilization Reports using admissions, discharge, and transfer feeds across three hospitals.

<u>Jackson Region</u>

- Engaging Stakeholders
    - Engaging more than 400 individuals from across 250 agencies in CHIR activities, including workgroups and action teams.

    - Cultivating new and enhanced partnerships across primary care physicians and mental health providers.
    - Developing a community consultant model to engage the broader population.
    - Establishing a firm foundation for the development of an integrated system of care across health and social service providers.
- Building Data Sharing Capacity
    - Developing a virtual community IT Hub that will connect and exchange information within the community.
    - Prioritized the development of a cross-sector shared measurement system to support efforts to collect, analyze, and report data in new ways to help understand community conditions.
    - Developing shared tools, processes, and measurement systems to consistently assess how community needs are being met.
- Addressing Social Determinants of Health
    - Improving access to care with home visits, onsite group visits within affordable housing facilities, and 24/7 triage services.
    - Planning the development of a Community Living Room, a space designed to:
        - Provide resource navigation by CHWs; screenings by paramedics or care managers; and supportive housing services and transportation assistance.
        - Encourage social interaction with peers and CHWs.

<u>Livingston/Washtenaw Region</u>

- Engaging Stakeholders
    - Developing new and enhanced partnerships across Livingston and Washtenaw Counties to support 12 hublets that address social determinants of health.
        - Hublets coordinate services delivered to residents and communicate with providers who are active in the resident's care.
    - Bringing together new geographic partners to serve on the CHIR governing body, work groups, and hublet organizations.
    - Developing ideas to achieve long-term sustainability, including outreach to funders.
- Establishing Clinical-Community Linkages
    - Establishing 12 hublets at medical or social service providers.
        - Full-time CHWs (housed at one hublet) will work across organizations and conduct home visits and provide individual supports to residents.

- Developing Data-Sharing Capacity
    - Developing Hub middleware technology to support care coordination, joint care planning, and data sharing.
    - Creating a community services database, which includes social service organizations and the services they provide.
- Developing Interventions
    - Enhancing care coordination through predictive modeling.
        - Identify residents (at risk of high emergency department use, but not currently high emergency department utilizers) with complex needs who would benefit from enhanced care coordination; refer to hublets for assessment and care coordination.

<u>Muskegon Region</u>

- Engaging Stakeholders
    - Cultivating new and enhanced cross-sector partnerships to focus on upstream issues.
    - Leveraging existing community resources with the Community Coordinating Council serving as an advisory panel.
- Establishing Clinical-Community Linkages
    - Enhancing Clinical-Community Linkages by utilizing a brief screening tool, utilizing improved complex care nursing, and providing CHW and health coach services.
    - Developing Clinical-Community Linkages with data sharing across hospitals, behavioral health, and social service providers.
- Building Data Sharing Capacity
    - Developing new tools, including a common screening tool, evaluation metrics, and a community dashboard.
    - Leveraging an existing system, WellCentive, reconfigured to connect SIM Stakeholders.
- Addressing Social Determinants of Health
    - Addressing housing stabilization by building Housing Assessment and Resource Agency capacity and implementing ICD-10 coding for homelessness.
- Developing Interventions
    - Integrating coaching to support changes in client's health behaviors.

Northern Michigan Region

- Engaging Stakeholders
    - Developing new and enhanced partnerships that connect traditional medical care with community care.
    - Collaborating with non-traditional partners such as local business owners and engaging Medicaid beneficiaries in setting community priorities.
- Establishing Clinical-Community Linkages
    - Developing three Hubs across the ten-county region:
        - Northwest Hub, managed by Health Department of Northwest Michigan in Antrim, Charlevoix, and Emmet counties.
        - Grand Traverse Region Hub, operated by Benzie Leelanau District Health Department in Benzie, Grand Traverse, and Leelanau counties.
        - District 10 Hub, operated by District Health Department #10, in Kalkaska, Manistee, Missaukee, and Wexford counties.
    - Providing Clinical-Community Linkages by assessing social determinants and providing connections to appropriate local resources.
    - Developing a robust web-based resource directory to assist in identifying local service providers.
- Building Data Sharing Capacity
    - Utilizing an electronic screening tool in PCMH settings and leveraging the existing Pathways Hub model and technology.
    - Developing an electronic screening and referral tool distributed across providers and community organizations.
- Developing Interventions
    - Developing and implementing a multi-component educational campaign.
        - The process will assess stakeholder educational efforts currently provided in the region, assess evidence-based campaigns targeting rural communities, and develop a local effort with input and testing from the target population.
        - Public education efforts will be aimed at appropriate use of emergency departments, urgent care, and primary care providers.

For regional CHIR-specific Clinical-Community Linkage and detailed model information, please see Appendix 7, CHIR Case Studies, and Appendix 8, CHIR Clinical-Community Linkage Maps.

CHIR Support and Technical Assistance

MDHHS will continue to provide individual and cross-CHIR support to ensure CHIR strategy/goals align with MDHHS strategy/goals and to successfully complete the implementation of the regional local operational plans. MDHHS is developing an overarching training and technical assistance plan to support the CHIR backbone organization staff and local governing bodies.

Individual supports and technical assistance will be provided by MDHHS in the following capacities:

- MDHHS has assigned regional managers to the CHIRs, who will work closely with the backbone organization on all aspects of the initiative and attend regional governance and membership meetings.
    - The regional manager serves as a single point of contact and will gain insight into governance operations and health system transformational strategies.
- MSU will continue to support CHIRs participating in the ABLe Change framework/community systems training with individualized training designed to accommodate local needs. More information on the ABLe Change framework can be found in Appendix 9.
    - Training sessions consist of three two-day modules, and are spaced approximately three to four months apart to allow participants to apply tools and practices.
    - Participants will understand processes for building a more responsive system, including: engaging diverse stakeholders in all aspects of their initiatives; redesigning and developing systems programs, operations and policies to facilitate desired change; creating adaptive learning processes in response to real-time feedback; and embedding an equity focus.
- The Michigan Public Health Institute (MPHI) will continue to offer support and coaching in multiple ways, including:
    - Providing supplemental coaching focused on clarifying regional goals, exploring issues and identifying potential solutions, making a plan, taking action, and reflecting on what was learned.
    - Identifying needs for capacity-building assistance that fall outside of the expertise of the coaching team and linking CHIRs with resources to meet those needs.
    - Supporting MDHHS in achieving their learning goals in preparation for post-SIM transformation of the business model of health care.

- Providing supplemental coaching on multi-agency/community improvement strategies, including identifying and using data for continuous improvement.

Cross-region supports and technical assistance will be provided by MDHHS in the following capacities:

- Policy
  - MDHHS will develop a policy and feedback loop designed to provide state leaders and policy makers with information from regional stakeholders about implementation barriers and successes so that proper policy levers can be established.
- Technical Assistances Platform
  - CHIR Website - A web-based platform is under development that will allow for CHIRs to interact and share resources. The site will be open to backbone organization staff and CHIR partners determined by each CHIR. MDHHS will also post resources for all CHIRs to access, including technical assistance webinars developed by the state SIM team and others.
- Monitoring
  - MDHHS will continue to offer financial management and contract guidance to the regions. To address one of the biggest challenges faced in the previous year, MDHHS is working diligently and collaboratively with backbone organizations to improve the efficiency and effectiveness of the unrestriction process.

CHIR Evaluation

MDHHS engaged MSU to develop a regional approach that supports the state-level evaluation. The CHIR evaluation is theoretically-driven and strongly participatory in nature. MSU is leveraging its academic resources to develop an empirically-grounded theory of change that drives the selection of evaluation methods, metrics, analyses, and the dissemination of findings. To support its participatory approach to the CHIR evaluation, MSU has convened a CHIR Evaluation Advisory Committee, consisting of two to three members from each CHIR, along with representatives from MPHI and MDHHS. MSU is also meeting with each CHIR's steering committee and relevant workgroups as it develops components of its evaluation plan.

The CHIR evaluation is designed to test the emerging theory of change, identify CHIR successes and understand the processes and contextual conditions that influence CHIR effectiveness. This includes assessing the process and outcomes of the collective impact approach/structure adopted by each CHIR as it supports alignment and sustainability in cross-sector operations. It also includes an examination of the innovations and processes each CHIR develops to support Clinical-Community Linkages and the patient-level outcomes associated with these linkages.

The evaluation will also track shifts in the policy, environment, and systems conditions as they relate to the CHIRs' efforts to target the social determinants of health.

In addition to partnership-building activities, MSU will:

- Provide resources, analyses, and documentation for CHIRs to conduct facilitated self-assessments to understand its collective impact, Clinical-Community Linkage design and process, and shifts in policies, systems, and environmental factors that address the social determinants of health.
- Design and conduct a broad CHIR partners survey that will have horizontal breadth of partners that vary across sectors and services, as well as vertical depth by being administered to staff at all levels of the partner organizations to assess the diffusion of innovation and alignment of policies and practices.
- Conduct observations of governance and workgroup meetings and linkages processes and interviews with key stakeholders, including leadership, front-line staff, and beneficiaries of CHIR efforts.
- Conduct policy and system scans in the form of document review and interviews to assess the impact of CHIR efforts on local organizations, policy makers, and funding/payer agencies.
- Identify and document emerging "bright spot innovations."
- Support CHIR continuous improvement efforts by providing rapid data analysis and feedback and using geographic information systems to support implementation monitoring and social determinants of health needs identification, with the support of MPHI.

Given the overlapping inputs on individual-level outcomes by the overall SIM Program, MSU is working closely with each CHIR and the statewide evaluation to develop a patient/client survey to assess CHIR impacts without duplicating efforts or contributing to survey fatigue (see Section D.1, State Led Evaluation, for additional details).

CHIR Pilot Program

During Year 3, the state aspires to work collaboratively with CHIR participants, stakeholders, and potential funding partners to develop a comprehensive document available to the broader public as a reference to implement and operationalize a successful CHIR. The document will contain best practices and lessons learned, Clinical-Community Linkages standards, financial tools, and other resources providing guidance for a standardized and repeatable prototypical model for CHIRs. MDHHS will leverage existing documentation, such as approved local operational plans, State Of Michigan Operational Plans, and the CHIR Participation Guides, to build out the CHIR Pilot Manual. The purpose of the manual is to incorporate information from

the CHIR activities and similar state and federal initiatives to more clearly articulate a community collaboration and improvement model for the State of Michigan. This will then serve as the basis for gaining support from additional stakeholders for an extended pilot.

This manual will minimally include:

- Role of CHIR in the advancement of person and community based health improvement
- Role of backbone organization, parameters for selection and base funding requirements
- CHIR Governance best practices and lessons learned on national initiatives and SIM regional experience
- Clinical-Community Linkage infrastructure, including technology standards, model scalability, and funding requirements
- Data sharing requirements between state and CHIRs and the compliance implication
- Financial model and appropriate funding levels required to enable transformation during the pilot period
- Approach for broadening CHIR funding sources for a pilot and ongoing sustainability
- State of Michigan organizational requirements to support a CHIR pilot and ongoing sustainability

Housing Program

It has become increasingly clear that stable housing is fundamental to both maintain good health and minimizing the costs of unnecessary emergency room utilization and hospital admissions. Homelessness or unstable housing is a significant social determinant of health and is prevalent in all five CHIRs. Individuals who are homeless may be predisposed to poor health outcomes resulting from poor living conditions, trauma, and food insecurity. These individuals also tend to have limited resources for self-care. For example, a person with diabetes who is experiencing unstable housing may have difficulty managing their condition without an appropriate place to store insulin and access to nutritious food.

Individuals who are homeless may also reside in hard-to-reach places (e.g., heavily wooded areas) or be very transient and with little or no transportation. These access issues create challenges in reaching them and establishing the patient-provider relationships necessary for effective treatment.

Given the importance of housing and Michigan's participation in a Medicaid Innovation Accelerator Program housing initiative, MDHHS will develop and implement a new SIM initiative within the CHIR framework to integrate and coordinate housing and health care that fosters housing stability and efficient, effective use of health care and housing resources.

This program will be implemented in the CHIRs to focus on identifying and prioritizing high-need, high-cost patients who are homeless and connecting them to housing solutions. The program will focus on increasing capacity, coordination, and support functions and connecting the beneficiary to proper housing resources rather than financing the housing.

In alignment with SIM goals, MDHHS will also engage the Michigan State Housing Development Authority for additional housing vouchers for high emergency department utilization resources. Data analytics will be piloted to assess the intersection of housing and the impact on cost associated with health care and other related costs. These analytics will support the model, return on investment, and improved housing prioritization methodology. MDHHS will also evaluate current policies for opportunities to support tenancy support services and housing coordination.

MDHHS will appoint a housing lead to direct design and planning activities and leverage SIM resources to support development and strengthen efforts for CHIR-related activities. The program will start in the five SIM regions, and pending the results of financial feasibility studies, the program may then develop a plan to scale statewide.

Data Sharing

Changes in the health care landscape—including value-based reimbursement, increased health system and provider accountability, and an increase in the number of people with health insurance—have created incentives and demand for addressing social determinants of health by connecting people to the services they need. Michigan SIM requires PCMH participants and CHIRs to begin social determinants of health screens on November 1, 2017. Appropriate data sharing agreements and supporting technology is necessary to meet this requirement and support linking individual needs with community services. Michigan has provided guidance to SIM participants but has allowed latitude on specifics of data sharing and technology approaches. This approach allows participants to explore innovative solutions to meet their unique goals and community influences.

The SIM team will facilitate individual and collaborative discussions to document data sharing needs and strategies to best meet these needs in a responsible and sustainable manner. Additionally, the SIM team will work with the regions to document their individual Clinical-Community Linkage work flows and technical solutions. The information gathered will be used for cross regions collaborative discussions, developing best practices, and informing the state's long-term data sharing strategy.

Finally, the collection of social determinants of health screening data is being defined in collaboration with the SIM regions and PCMH participants. The state will continue to work towards a comprehensive multi-payer strategy for the screening and collection of social determinants of health data.

Clinical-Community Linkages Platform

In Year 2, regional technology efforts focused on the planning, design, and implementation of a Clinical-Community Linkage platform supporting a community Hub model that connects health care payers and providers with their community organizations. This year, each region will focus efforts on fully operationalizing the platform, executing quality improvement strategies, and reporting. For more information regarding CHIR technology guidance see Appendix 10, the CHIR Technology Requirements Participation Guide.

C.4.c SUSTAINABILITY NARRATIVE

Program sustainability has traditionally been viewed narrowly as the act of decreasing dependence on one source of funding and shifting financial support for program implementation to a new funding stream. In reality, program and organizational sustainability is a much more complex and dynamic process. Sustainability will be supported by data that demonstrates program efficiencies and effectiveness; community advocacy; funding diversification; collaborative partnerships that can maximize resources; the capture of generated savings; and the attraction of new investments. Policy-level change will be key to institutionalizing the CHIR model for long-term sustainability. Sustaining the CHIR model beyond the SIM Test period will require strategizing and planning on multiple organizational levels.

At the state level, MDHHS leadership will determine the best department to house the program and to document the resource requirements, financial feasibility, funding options, program impact, workforce capacity, and a number of additional programmatic factors required to pilot the CHIR model in the existing five regions and scale to additional regions. To promote CHIR sustainability, the state is exploring additional grant opportunities and currently funding initiatives, and will look to accelerate the use of community benefit dollars by redirecting the funds toward CHIR activities. In parallel, MDHHS will identify potential funding partners, additional funding sources, and develop additional sustainability strategies.

Community Health Workers are frontline public health workers, serving as liaisons between health/social services and the community to facilitate access to services. Each CHIR has invested substantial resources into hiring additional CHWs. As such, it is a priority for the state to work collaboratively with community-based organizations, health plans, health care systems, providers, and other stakeholders by developing a consistent and sustainable model for CHWs.

Regionally, each CHIR will finalize a robust sustainability plan that identifies additional strategy and funding options specific to the local landscape. The goal is to document how the CHIR will operate post-SIM funding using additional in kind contributions and other potential funding sources (i.e. commercial payers, employers, etc.). The CHIR Participation Guide will contain updated guidance and additional requirements for how each CHIR will develop an MDHHS-approved regional sustainability plan.

C.4.d WORK PLAN BY DRIVER TABLE

Table C.4-1 Population Health Work Plan by Driver Goal 1

Goal/Driver 1: Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions.					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Development of Individual Local Operational Plans (LOPs)	Develop SIM Year 3 Participation Guide	Draft update to participation guide	Q1 2018	SIM PMDO	$112,400
		Facilitate review sessions			
		Incorporate feedback and finalize participation guide			
	Update CHIR Individual LOPs (5 Regions)	Draft 5 individual updates to LOPs	Q2 2018	CHIRs	$840,000
		Facilitate review sessions	Q2 2018	SIM PMDO, CHIRs	
		Incorporate feedback and finalize LOPs for each region	Q2 2018	SIM PMDO, CHIRs	
CHIR Implementation	**Region Implementation** • Genesee • Livingston/Washtenaw • Jackson • Northern Michigan • Muskegon	Operationalize Clinical-Community Linkages	Q1 2018	CHIRs	$5,750,000
		Operationalize additional interventions specific to each CHIR	Q1-Q4 2018	CHIRs	
		Collect and analyze participation metrics	Q1-Q4 2018	CHIRs, SIM PMDO	
	Project Monitoring and Improvement	Document CHIR activities via status reports, conference calls, and on-site visits	Q1- Q4 2018	CHIRs, SIM PMDO	$112,400
		Document lessons learned	Q1-Q4 2018	CHIRs, SIM PMDO	
		Ongoing programmatic monitoring	Q1-Q4 2018	SIM PMDO	

Goal/Driver 1: Improve population health and regional coordination between community and health care entities through Community Health Innovation Regions.					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Housing Initiative	Design Housing Initiative	Conduct collaborative work sessions with subject matter experts and stakeholders	Q1 2018	SIM PMDO	$253,600
		Define housing initiative requirements	Q1 2018	SIM PMDO	
Collaborative Learning	CHIR Coaching and Technical Assistance	Develop coaching plan for each region	Q1 2018	MPHI	$230,000
		Execute coaching plans	Q2-Q4 2018	MPHI	
		Develop CHIR-wide technical assistance schedule and programming	Q1 2018	SIM PMDO	
		Operationalize technical assistance	Q2-Q4 2018	SIM PMDO	
	Collaborative Platform Website	Complete online collaborative platform website planning	Q1 2018	MSU	$1,044,000
		Develop collaborative platform website	Q1 2018	MSU	
		Implement use of collaborative platform website	Q1 2018	MSU	
	ABLe Change Training	Conduct ABLe change training	Q1-Q4 2018	MSU, CHIRs	
	Annual CHIR Summit	Facilitate annual CHIR summit	Q4 2018	SIM PMDO	N/A
CHIR Sustainability	Develop CHIR Sustainability Plan	Document CHIR model components	Q1 2018	SIM PMDO	$262,000
		Define funding requirements	Q2 2018	SIM PMDO	
		Develop pilot program	Q2 2018	SIM PMDO	
		Facilitate stakeholder engagement	Q3 2018	SIM PMDO	
		Finalize pilot funding requirements and stakeholder support	Q4 2018	SIM PMDO	

Table C.4-2 Population Health Work Plan by Driver Goal 2

Goal/Driver 2: Align state health priorities by developing a statewide Plan for Improving Population Health (PIPH).					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Plan for Improving Population Health (PIPH)	Develop Plan for Improving Population Health	Convene PIPH Workgroup	Q3 2018	SIM PMDO, Health Management Associates	$152,775
		Document Plan for Improving Population Health	Q4 2018	Health Management Associates	$152,775

C.5 TECHNOLOGY

C.5.a END STATE VISION NARRATIVE

SIM leveraged existing federal- and state-funded initiatives to define, implement and test a multi-payer statewide data sharing infrastructure and Relationship Attribution Management Platform (RAMP). The state will continue to be engaged in the multi-payer Health Directory Data Governance and maintain the established configuration management, requirements definition, and data quality best practices established under SIM.

The MDHHS Data Sharing Workgroup established under SIM will continue to pursue ongoing alignment of state initiatives. It will continue to focus on standard data formats, efficient data flow, timely use of data and transitioning claims-based metrics to quality data. Also, increased efforts will be focused on the effective use of data rather than data transfer. SIM Technology work will continue through the MDHHS Data Sharing Workgroup to continue the advancement and appropriate use of health care data exchange use cases including, but not limited to, Admission, Discharge, and Transfer (ADT) and Quality Metrics.

C.5.b STRATEGY NARRATIVE

Michigan has achieved great successes in using the RAMP to support Care Coordination Enablement and Performance Metrics and Reporting. The onboarding of nearly all SIM participating physicians into the Active Care Relationship Service (ACRS) and the Health Directory has allowed the RAMP to function as the enabler of the Care Coordination Enablement and Performance Metrics and Reporting initiatives. The RAMP Infrastructure allows accurate and timely measurement of physician participation, member attribution, and quality reporting. It has been built to move information such as ADTs quickly from the point of care to the coordinating case manager or physician. Further, the backbone has been built flexibly enough to allow new types of HIE messages to be transmitted to participating physicians, provider organizations, or health plans with minimal changes to the ACRS file.

Michigan continues to support population health goals by coordinating with CHIRs to collect information about social determinants of health and to assess each individual CHIR's technical needs. The SIM technology team will coordinate meetings with CHIR participants to understand each region's innovative data sharing solutions. The state will then partner with the CHIRs to create a Statewide Technology Roadmap that meets the requirements of the participants and aligns with the state's vision.

C.5.c SUSTAINABILITY NARRATIVE

Michigan SIM leveraged and extended existing state and federal infrastructure investments to meet the data sharing and technology needs of the initiative. Under the SIM program Michigan and the SIM partners and participants explored alternative uses of the infrastructure, tested platforms to support Clinical-Community Linkages, and developed data sharing strategies to support the SIM goals. The lessons learned from the SIM Technology Initiative and data sharing efforts will be integrated into the department's broader multi-year strategic plan and funding models. The state will continue to move forward with the enablement of a statewide multi-payer data sharing infrastructure.

C.5.d WORK PLAN BY DRIVER TABLE

Table C.5-1 Technology Work Plan by Driver

Goal/Driver 1: SIM Technology supports the goals and drivers for the SIM Model initiatives.					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Quality Measures & Reporting	HEDIS 2018 Conversion & Implementation	Run data comparisons between HEDIS 2015 and 2018	Q1 2018	Michigan Data Collaborative (MDC)	$420,000
		Test and approve measure results	Q1 2018		
		Publish results	Q1 2018		
	Monthly Ongoing Reporting (Patient Lists, Care Management Reports)	Q1 data analysis and reports	Q1 2018	MDC	$420,000
		Q2 data analysis and reports	Q2 2018		
		Q3 data analysis and reports	Q3 2018		
		Q4 data analysis and reports	Q4 2018		
	Quarterly Quality & Evaluation Measures Reporting	Q1 data analysis, measure approvals, and report production.	Q1 2018	MDC	$420,000
		Q2 data analysis, measure approvals, and report production.	Q2 2018		
		Q3 data analysis, measure approvals, and report production.	Q3 2018		
		Q4 data analysis, measure approvals, and report production.	Q4 2018		
Relationship & Attribution Management Platform (RAMP)	Long Term Optimized Attribution Design	Complete design and receive approval from stakeholders on an optimized attribution solution to support year 3 SIM initiatives	Q1 2018	SIM Technical Team, Optum	$125,000
		Implement optimized attribution solution	Q3 2018		

Goal/Driver 1: SIM Technology supports the goals and drivers for the SIM Model initiatives.					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
	Health Directory Optimization	Complete design and receive approval from stakeholders on an optimized health directory to support SIM Year 3 initiatives	Q1 2018	SIM Technical Team, MDHHS, MiHIN	$275,000
		Implement optimized health directory solution	Q3 2018		
		Monthly on-going maintenance	Q3-Q4 2018		
Data Sharing Use Cases	Onboarding	Quality Measurement Information (QMI)	Q2 2018	MiHIN	$275,000
		Admission, Discharge, and Transfer (ADT)	Q2 2018		
		Active Care Relationship Service (ACRS)	Q2 2018		
	Production	Quality Measurement Information	Q3 2018		
		Admission, Discharge, and Transfer (ADT)	Q3 2018		
		Active Care Relationship Service (ACRS)	Q3 2018		
	Use Case Development	Complete business requirements	Q1 2018	SIM Technical Team	$38,000
		Develop draft use cases	Q3 2018		
		Complete use case approval process	Q4 2018		
CHIR Technology	Clinical-Community Linkages	Support CHIR technology solutions to support Clinical-Community Linkages	Q4 2018	SIM Technical Team MDC	$38,000
Program/Project Management	Year 4 Planning	Detailed project planning for year 4 of SIM	Q3 2018	SIM Technical Team MDC	$38,000
	Status Reporting	Continued weekly and monthly status reporting	Q4 2018		

Goal/Driver 1: SIM Technology supports the goals and drivers for the SIM Model initiatives.					
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**	**Expenditures**
Sandbox and Analytics	Housing Data	Identify data sources and business needs	Q1 2018	SIM Technical Team Optum MDHHS	$88,400
		Perform data quality profiling	Q2 2018		
		Capture business requirements	Q3 2018		
		Complete development of analytics	Q4 2018		
	Data Quality	Capture PCMH participation data and perform analytics	Q2 2018	SIM Technical Team MDHHS SIM CHIR Team	$88,400
		Complete use case data reviews	Q4 2018		
		Capture and analyze CHIR social determinants of health data	Q4 2018		
	Ad-Hoc Analytics	Gather business needs and produce analytics	Q4 2018	SIM Technical Team	$88,400

D. PROGRAM EVALUATION AND MONITORING

D.1 STATE LED EVALUATION

The state-evaluation will be led by the Michigan Public Health Institute (MPHI) in collaboration with the Michigan Department of Health and Human Services (MDHHS), the System exChange team at Michigan State University, University of Michigan Child Health Evaluation and Research Center, and Michigan Data Collaborative.

The impact evaluation component aims to collect and analyze information on emerging outcomes that will justify continued investment in the model by key stakeholders after the State Innovation Model (SIM) program concludes.

The formative evaluation component aims to surface lessons learned along the way that provide real-time information to SIM stakeholders to aid in implementation, and will inform how the state and other stakeholders should modify, scale, and spread the models during and/or post-SIM.

EVALUATION FOCUS

The evaluation will focus on three interrelated areas that cross both the Patient-Centered Medical Home (PCMH) and Community Health Innovation Region (CHIR) tracks:

1. Care management and coordination
2. Clinical-Community Linkages
3. Community change

The evaluation will look at the process and the outcomes of primary care embedded care management and care coordination, as well as coordinated care across clinical and community settings.

In terms of the Clinical-Community Linkages, the evaluation will focus specifically on the process and outcomes related to the screening for social determinants of health, referral for identified social needs, and follow-up activities.

In the area of community change, the evaluation will focus on the CHIR structure and leadership for collective impact; on community alignment, including the participation of PCMH, provider organizations, and health systems; and on sustainability and policy changes that are created as a result of these efforts.

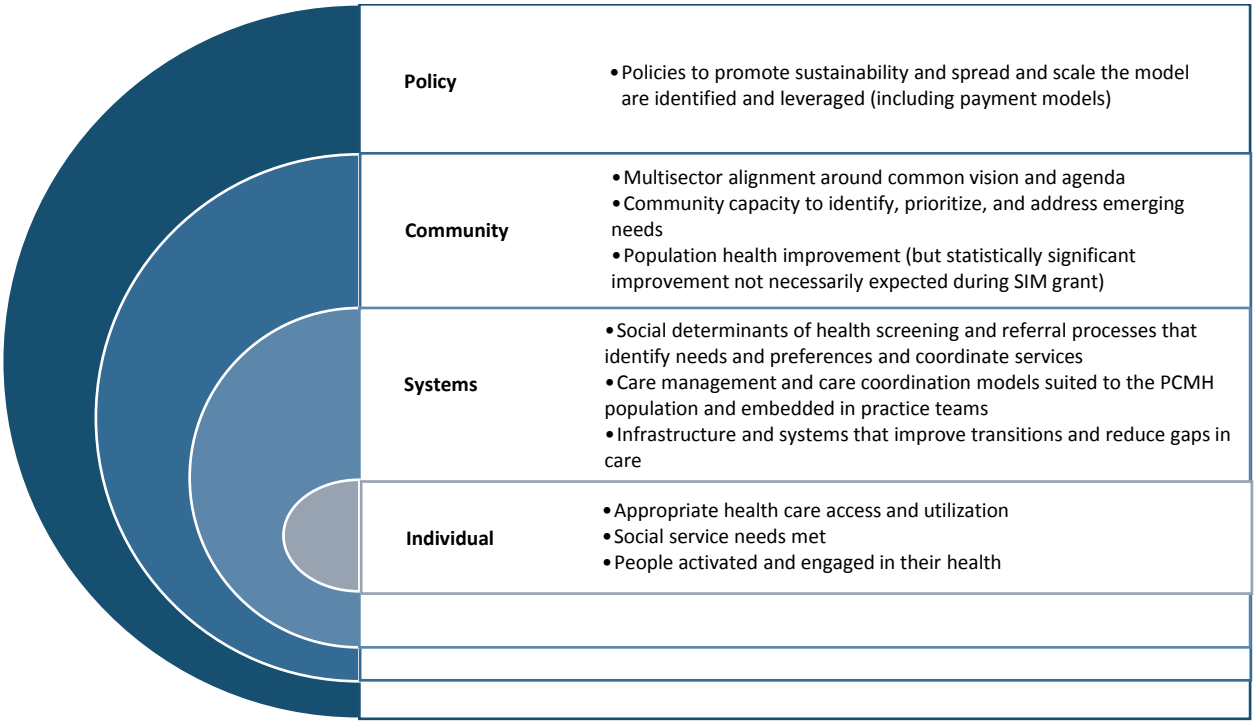
EVALUATION DESIGN

The state-led evaluation will:

- Focus measurement and analysis on the targets to which change is expected to occur.
- Test assumptions about what would have happened without SIM through the use of comparison groups.
- Plan longitudinal analyses and comparison to test theories of differential outcomes.
- Incorporate multiple data sources, including metrics based on claims data and/or clinical data, surveys, administrative data, document reviews, and qualitative feedback such as interviews or focus groups.
- Engage stakeholders as partners in order to get reliable information and data submission.

The evaluation approach assumes that the impact of the implementation of SIM initiatives can and should be happening at multiple levels along the social-ecological model. However, because a 2-3 year demonstration is short, it is particularly important to design the evaluation to enable the capture of promising results – those that predict future success among sentinel populations (those likely to be first impacted). The figure below illustrates some potential outcomes that should be achievable within the SIM timeframe, at each level of the social-ecological model.

Figure D.1-1 Achievable Outcomes by Level



The evaluation should also be designed to capture outcomes that are specifically relevant to the program, among the populations that are expected to be most affected, and in collaboration with key stakeholders who will be impacted by evaluation results. The tables below list additional details for each level on the domains, who or what is impacted, and data that will be collected. For example, this data could be claims data, qualitative data from surveys and focus groups, project monitoring data, etc.

Table D.1-1 Individual Impact

Outcome domain	Who/what impacted?	Data
Individual Impact		
Emergency department and hospital utilization	• Hub clients • PCMH patients receiving Care Management/Care Coordination (CM/CC)	• Longitudinal claims data with comparison group
Improved chronic disease management	• Hub clients • PCMH patients receiving CM/CC	• Pre/post quality metrics with comparison group
Preventive services	• PCMH patients	• Longitudinal quality metrics
Health and well-being	• Hub clients • Patients screened and referred for social determinants of health • CHIR secondary population	• Patient/client survey
Patient activation (engagement in own health)	• Hub clients • (Potential) subsample of PCMH patients receiving CM/CC	• Pre/post patient activation measure survey (with willing CHIRs)
Patient experience	• Hub clients • PCMH patients receiving CM/CC Hub clients	• Patient/client survey
Receipt of needed social services to address social determinants of health	• Hub clients • PCMH patients screened positive & referred	• Patient/client survey • Hub Clinical-Community Linkage tracking system

Table D.1-2 System Impact

Outcome domain	Who/what impacted?	Data
System Impact		
Administrative simplification related to quality measurement	• SIM PCMH practices and physician organizations	The SIM project will propose a data collection plan to address these items, which could include: • Project monitoring data • Participant surveys, focus groups and/or key informant interviews
Care Managers/Care Coordinators and CHWs are embedded in effective care teams	• SIM PCMH practices • CHIR Hubs and care coordination entities	
Social determinants of health screening, referrals, and follow-up are incorporated into normal workflows	• SIM PCMH practices • Hub partners	
Systems for Clinical-Community Linkages: • Target patients most in need • Create and maintain trusted relationships • Are accountable for outcomes	• Hubs • Care coordinators • Referring agencies • Service providers	
Health care, behavioral health, and social services are coordinated and not duplicated	• PCMH practices • Behavioral health providers • Social service providers	

Table D.1-3 Community Impact

Outcome domain	Who/what impacted?	Data
Community Impact		
Effective CHIR structure and leadership requires: • Neutral trusted convener • Diverse membership • Distributed leadership • Ready and able partners	• CHIR backbone • CHIR partners • Community members	A data collection plan to address these items will include: • Project monitoring data

Outcome domain	Who/what impacted?	Data
Community Impact		
Aligned operations consist of: • Shared vision and agenda • Engaged partners • Aligned actions • Data-driven learning and quality improvement	• CHIR backbone • CHIR partners • Community members • MDHHS	• Participant surveys, focus groups and/or key informant interviews • Community-based participatory methods • Observation
Sustaining mechanisms such as: • Public will • Sustainable financing and resource contributions	• CHIR backbone • CHIR partners • Community members • MDHHS	
Health equity approach to population health improvement	• CHIR backbone • CHIR partners • Community members • MDHHS	

The formative evaluation has two interrelated goals: to collect and synthesize information that informs SIM PCMH and CHIR implementation as it is occurring, and to document what it takes to successfully implement SIM PCMH and CHIR so that it can be improved and spread after the SIM Program concludes. The formative evaluation will provide process information around the adoption, implementation, and maintenance of programmatic activities including lessons learned, such as the identification of bright spots and innovation: what was tried and didn't work? What barriers were encountered and how were they overcome?

EVALUATION QUESTIONS

Specific questions to be answered by the state led evaluation are currently being vetted with project stakeholders and are expected to undergo additional refinement.

In terms of PCMH, evaluations have been conducted of earlier multi-payer demonstrations and single payer demonstrations. Evaluation questions posed here focus on new aspects of the SIM model, rather than PCMH per se.

These questions include the following:

- Did the patient populations of participating providers experience differences and/or improvements in quality of care and utilization when compared to similar providers or

populations? Did the differences/improvements and trend comparison to similar providers/populations change over the course of the initiative?

- Did participating provider-delivered care management and coordination services impact quality of care and utilization? Did the duration and/or intensity of these services influence impact?
- How did the initiative's payment model components impact participating provider service delivery and team composition?
- How did participation in the initiative impact practices' primary care capabilities and clinical practice improvement (transformation) over time?
- To what extent did participating provider care teams demonstrate cohesiveness, collaboration, and strong communication? Were higher levels of cohesiveness, etc. associated with better patient quality of care and utilization outcomes?
- How did the initiative's Health Information Exchange use case implementation impact providers' administrative obligations (ACRS, Quality Measurement Information) and the process and quality of patient care?
- Were participating providers successful in implementing the three components of a Clinical-Community Linkage required by the initiative? What impact did the implementation of Clinical-Community Linkages have on members of the care team and the day-to-day process of care carried out by team members with patients? What barriers were experienced in implementation, and what lessons can be learned from the implementation experience of participants? How are participating providers thinking about sustaining Clinical-Community Linkage implementation?
- To what extent did participating providers' relationships and engagement with CHIRs impact their ability to implement Clinical-Community Linkages and successfully link patients to needed supports?

For the CHIR evaluation, the questions can be grouped under these four buckets:

1. Impact
    a. Overall, what makes CHIRs successful?
    b. To what extent did the CHIRs build their capacity to address the social determinants of health at the individual, institutional, and community level?
    c. To what extent did CHIRs promote clinical/ community linkages?
    d. Were the CHIRs successful at linking patients to needed resources/supports?
    e. Which groups benefited from the linkages?
    f. Which ones did not?
    g. Why this differential impact?

h. Overall, were patients' needs met?
i. What changes in the social determinants of health did CHIRs create?

2. Implementation
    a. What strategies and approaches did the CHIRs use that helped them make progress towards their aims?
    b. What does an effective CHIR look like?
    c. How did the CHIRs build their capacity to address the social determinants of health?
    d. How did the CHIR shift the social determinants of health at the individual, institutional, and community levels?
3. Insights
    a. What lessons can the state learn from the CHIRs' efforts?
    b. What lessons can the state learn from the CHIRs' collective impact efforts?
    c. What capacities (knowledge, skills, relationships, roles, policies, procedures, linkages, and infrastructure elements) are needed to address social determinants?
4. Innovation
    a. What are some promising practices in the CHIRs that other areas in the state might want to replicate?
    b. What are some promising practices the CHIRs used in their collective impact efforts?
    c. What are some of the promising practices the CHIRs used to address social determinants?

NEXT STEPS

In the coming months, a formal evaluation plan will detail out evaluation metrics (a subset of project metrics), data collection sources, comparison group design, and a timeline for all coordinated activities across each component and the federal evaluation. This plan will receive input from the CHIR and PCMH stakeholders, implementation contractors, Centers for Medicare and Medicaid Services (CMS)/RTI, and MDHHS leadership.

D.2 FEDERAL EVALUATION, DATA COLLECTION, AND SHARING

Michigan SIM will cooperate with the Centers for Medicare & Medicaid Services to provide requested data and facilitate any needed efforts at the state level to conduct the federal evaluation, as it has to date. The State of Michigan will also use its resources to participate in primary data collection efforts by RTI, which may include surveys, focus groups, and key

informant interviews. The state evaluation team will have the ability to assist in the identification of key participants for these qualitative data collection efforts when needed.

Efforts have been made to continue monthly calls with the federal evaluator on targeted topics within the SIM program. The appropriate content experts from each program component, as well as stakeholders from other divisions within MDHHS, are identified for participation depending on the focus of the call to ensure that a robust recount of activities and upcoming plans can be shared. Planning has begun around scheduling an RTI site visit for 2018, and the state evaluation team will work with the federal evaluator to ensure coordination among the CHIRs and PCMH partners across the program for this event.

The SIM program will also continue to work with CMS and RTI on supplying the quarterly progress reports that provide participation, payer, and performance data from Michigan's target populations and participants. The SIM evaluation team has identified a consolidated list of performance metrics that will be used for the duration of the initiative, which reflect alignment with the PCMH Initiative and state Medicaid goals. See Table B.2-1 (PCMH Initiative Monitoring and Evaluation Measures) in Section B.2.b. As the CHIR Initiative enters into its implementation phase, a set of evaluation metrics for this component will be developed in collaboration with the CHIR evaluation contractor and the communities themselves. These metrics will be added to the quarterly progress report in subsequent quarters.

D.3 Program Monitoring and Reporting

Michigan's approach to program monitoring continues to support the program in achieving better health, better care, and lower cost by facilitating timely and actionable identification of opportunities for improvement and course correction within the program, and providing regular performance feedback to participants.

As outlined in our Year 2 Operational Plan, monitoring activities are focused on three domains: monitoring for outcomes, monitoring for participation and processes, and monitoring for formative feedback and learning.

Monitoring for Quality, Cost, and Health Outcomes

To accomplish outcomes monitoring, the SIM Program will leverage the Model Performance metrics in Appendix 3. The final measure set may further be refined in collaboration with CMS and SIM participant stakeholders over the course of the remaining SIM Test period.

Health Care

Claims and encounter data, supplemented by clinical data and survey measurement for patient experience, will be the key sources for monitoring and reporting on performance on clinical quality, health care costs and utilization, patient experience, and use of care management processes.

Performance metrics are being provided to PCMHs and their physician organizations (where applicable) on dashboards maintained by the Michigan Data Collaborative and accessible by appropriate practice/physician organization representatives and SIM project staff and contractors. The dashboards are designed to support ongoing performance monitoring and continuous improvement within these organizations. Internal and required Center for Medicare and Medicaid Innovation reports will be prepared on a quarterly basis to provide updates to SIM leadership on progress in achieving desired outcomes.

Population Health

Michigan's set of common proposed population health metrics as detailed in Michigan's Year 2 Operational Plan have been modified to better support model performance tracking. Many of these metrics will be collected through the Behavioral Risk Factor Surveillance System (BRFSS). It is intended that individual CHIRs will also select appropriate participation metrics in additional population health-related outcomes and processes of particular local interest, and monitor and report on these measures on a quarterly basis.

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

Relevant Populations

Program monitoring requires understanding outcomes at several levels. Michigan will seek to expand the number of individuals included in the denominators to the greatest extent possible over the course of the SIM Program. The state anticipates reporting, where possible, the population health measures outlined in the Quarterly Progress Report Model Performance and Participation Metrics, using the statewide population as the denominator. However, because over the short term Michigan is more likely to impact populations that are directly touched by programming, monitoring data are also available at the levels of CHIR, practice, and physician organization. The evaluation (described above, and subject to tracking capacity of participating

entities) will drill down even further in an attempt to evaluate outcomes for individuals who received care management or Hub services.

Table D.3-1 Michigan Metric Crosswalk

CMS Recommended Measure	Proposed Core Set Metrics
A. Hospital Readmission Rates	All-cause 30-day readmissions
B. Emergency Department Visits	Emergency department visit rate
C. Patient Experience	Planned survey of a sample of PCMH patients and Hub clients
D. Diabetes Care	Comprehensive diabetes care composite[15]
E. Tobacco Use	Screening and cessation intervention
F. Obesity	Adult BMI assessment; Weight assessment and counseling
G. Total Cost of Care PMPM	Standardized (Medicaid fee schedule) PMPM costs
H. Behavioral Health	Screening for clinical depression and follow-up; BRFSS number of mentally unhealthy days in last 30; Rates of excessive alcohol consumption for adults

PARTICIPATION MONITORING

In addition to monitoring outcomes, Michigan monitors program implementation. Participation monitoring will include certain items specific to PCMHs and CHIRs:

Patient-Centered Medical Homes

Michigan continues to track the number of providers and provider organizations participating, including compliance with SIM-developed expectations. Information compiled by operations personnel (for participation counts, progress in achieving transformation objectives, and alignment with terms of participation) and encounter data compiled by the data aggregator (to track care management activity) is used to develop reports.

CHIR activities

Michigan will track the engagement of key organizations – as well as individuals with lived experience – participating in CHIR governance and operations. Section B.1.d, Stakeholder Engagement, lists some of the organizational types whose participation is to be tracked.

[15] HbA1C Poor Control rates may not be included initially depending on availability of clinical information.

Michigan will also track CHIR reporting on the common measurement platform, through which CHIRs will report on their local region-specific measures. In addition, Michigan will monitor the activities of CHIRs through written progress reports to be submitted quarterly by CHIRs, as well as bimonthly check-in calls with CHIR staff. These monitoring activities will include the development and execution of CHIR-developed operational plans. Lastly, Michigan will require CHIR organizations receiving grant support from Michigan SIM to regularly report on the expenditures of any funds. All of this information will be summarized by CHIR and program monitoring staff for purposes of program monitoring.

MONITORING FOR FORMATIVE FEEDBACK AND LEARNING

Michigan will use readiness assessments, reports from improvement coaches, data gathering by the CHIR evaluation contractor, and feedback from stakeholder committees (see Section B.1.d, Stakeholder Engagement) to monitor the experience of participation (for example, the perceived level of burden; opportunities for improving model design; utility of SIM-provided supports, including HIT/HIE and Collaborative Learning Network; etc.) and the development of skills and expertise for continuous improvement among SIM Program organizations.

Table D.3-2 Population Health and CHIR Feedback

Domain	Primary Audiences	Key Resources	Frequency
Population Health and CHIR			
Population Health Outcomes • BRFSS • CHIR-reported	• SIM leadership • CHIRs	• BRFSS • Online tracking platform(s) • Data aggregator	• CHIR-reported: Quarterly • Others: Annual
Navigation/Clinical-Community Linkages Services	• SIM leadership • CHIRs • Payers	• Tracking platform(s)	Quarterly
CHIR Capacity • Readiness assessment • Updates from coaches • Evaluation data	• SIM leadership • CHIRs	• Coaching and evaluation subcontractors, collaboration site	Ongoing

Domain	Primary Audiences	Key Resources	Frequency
Population Health and CHIR			
Other CHIR Activity & Participation • Counts/tracking of CHIR participants • Development and execution of CHIR operational plans • Completion of Community Health Needs Assessment • Fidelity to participation expectations • Feedback from participants • Lessons learned	• SIM leadership	• Stakeholder committees • CLN • Formative evaluation contractor • Online tracking platform(s)	Quarterly

Table D.3-3 Health Care Delivery and PCMH Feedback

Domain	Primary Audiences	Key Resources	Frequency
Health Care Delivery and PCMH			
Health Care Processes and Outcomes • Clinical quality • Care Management services • Utilization (including Emergency Department utilization analysis and population segmentation) • Disparities	• SIM leadership • Payers • Practices	• Data aggregator • MiHIN	Bimonthly
Health Care Costs	• SIM leadership • Practices	• Actuarial services • Data aggregator	TBD

Domain	Primary Audiences	Key Resources	Frequency
Health Care Delivery and PCMH			
Patient Experience	• SIM leadership • Payers • Practices	• CAHPS survey vendor(s)	TBD
Participation Counts • Providers • Practices • Patients • Payers, including use of Alterative Payment Models (APMs) by Learning and Action Network typology	• SIM leadership	• PCMH operations contractor • Data aggregator • MiHIN • Medical Services Administration	Quarterly (APM use may be measured less frequently in accordance with contract monitoring work of the Medical Services Administration)
Other Participation Monitoring • Regular monitoring to ensure participation compliance • Progress in pursuing PCMH transformation objectives • Feedback from participants • Lessons learned	• SIM leadership	• PCMH operations contractor • Stakeholder committees • Collaborative learning network • Formative evaluation contractor	Quarterly or Semi-annually

D.4 Fraud and Abuse Prevention, Detection, and Correction

While positive, change does produce some element of risk. New exposures may result from payment reform and funding methods under the State Innovation Model (SIM) test. Similarly, existing fraud and abuse measures may be impacted by health system transformation and SIM components. Michigan has a number of tools, processes and control measures in place to deter fraud and abuse in Medicaid and other areas serviced by MDHHS. These measures and SIM-specific impacts are outlined below.

SIM EXPOSURES TO FRAUD & ABUSE

To date, the Department has identified three potential new exposures to fraud and abuse as a result of the SIM program. First, health care costs could potentially be compromised if providers take unjustified action to bill services under claims codes not included in the PCMH participation agreement payment definitions. Additionally, providers could inaccurately increase the severity of a patient's condition in order to obtain more reimbursements from the state. Lastly, providers could potentially withhold clinically necessary and appropriate care to patients within their panel in light of total cost of care accountability. The state is continually assessing vulnerabilities and will continue to identify other fraud and abuse exposures under SIM.

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

Barriers to Implementing SIM with Existing Fraud and Abuse Measures

Michigan is committed to the successful implementation of the SIM Test components and will identify and seek to immediately resolve any policies that would inhibit the current implementation and operational plan or allow abuses or other inappropriate applications of the SIM payment program.

MICHIGAN'S INITIATIVES TO MITIGATE FRAUD AND ABUSE

Michigan will bring several initiatives to mitigate fraud and abuse to bear on the SIM Test, including its managed care contract, a data sharing agreement, the employee code of conduct, and the Office of the Inspector General. The state is deeply invested in ensuring the integrity of the SIM Test and the care provided to Michigan beneficiaries.

Michigan Managed Care Contract

The Michigan Comprehensive Health Care Program for Medicaid beneficiaries mandates a number of measures for Medicaid Health Plans to implement for fraud and abuse in their service areas within the State of Michigan. The Michigan Comprehensive Health Care Program includes policies and procedures for fraud, waste, abuse, and reporting noncompliance.

Contractors are also subject to compliance and reviewing procedures. MDHHS can utilize a number of remedies and sanctions to deal with noncompliance.

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

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

The content of the compliance report provides the state with a comprehensive picture of how the health plans are curtailing fraud, waste, and abuse. Health plans are required to describe their data mining and algorithms efforts or program integrity ideas that are applied to claims data to help in fraud, waste, and abuse identification. Plans also provide a complete list of tips and grievances: complaints or referrals relating to program integrity received by the plans that require some sort of investigation. Health plan audits of their providers are performed on a scheduled or ad hoc basis. Lastly, plans submit their list of provider disenrollment, whether those providers were separated for cause or on a voluntary basis.

Data Sharing Agreement

MDHHS uses standard and specialized data sharing agreements. These agreements outline the method for sharing data, the process for sharing data, the entities that are allowed to use the data and how, and procedures in the case of a security breach. The data sharing agreements help to protect against fraud and abuse in regards to personal health information and other sensitive data.

State Employee Code of Conduct

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

Office of the Inspector General

In addition to the above, the state OIG will work with the state's Medicaid Managed Care division to review SIM requirements and model payment methods to identify potential gaps in fraud and abuse polices. The OIG will work to develop, if necessary, modifications and additions to existing policies and procedures associated with SIM-related Medicaid and Population Health-related component and fiduciary integrity. The OIG will also play a role in the evaluation of CHIR-based programs where fraud and abuse potential may exist.

E. LIST OF APPENDICES

The following appendices have been submitted as separate files.

1. Updated Driver Diagram
2. SIM Organizational Model
3. SIM Participation and Model Performance Metric List
4. Risk Assessment and Mitigation Strategies
5. Communication Implementation Plan
6. ~~PCMH Participation Agreement~~
7. CHIR Case Studies
8. CHIR Clinical-Community Linkage Maps
9. ABLe Change Framework
10. CHIR Technology Requirements Participation Guide