Submission Date: December 1, 2018

Grant Number: 1G1CMS331407

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 work of operationalizing this vision is organized under three main umbrellas: Population Health, Care Delivery, and Technology. Within each of these areas, the Michigan Department of Health and Human Services (MDHHS) has built on the state's existing infrastructure to embed transformative models for delivering and financing health care that will be sustained long after federal State Innovation Model (SIM) funding is gone. The state has marshaled financial and human resources to improve outcomes for three SIM priority populations: individuals at risk of high emergency department utilization, pregnant women and babies, and individuals with multiple chronic conditions.

Over the course of Award Years 1 through 3, the Michigan SIM team learned from its challenges and made accomplishments across a wide scope of component initiatives. Award Year 4 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 4 Operational Plan describes how the state, through MDHHS, plans to utilize 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. To achieve the vision, MDHHS continues to leverage state employee-led contractor teams. This approach is necessary due to resource constraints and competing statewide health priorities.

POPULATION HEALTH

Community Health Innovation Regions

A Community Health Innovation Region (CHIR) is a unique model for improving the wellbeing of a region and reducing unnecessary medical costs through collaboration and systems change. CHIRs engage a broad group of stakeholders to identify and address factors that affect residents' health, such as housing, transportation, food insecurity, and access to high-quality medical care. The CHIR model creates a neutral space for partners to unite around a common vision, aligning their objectives and services to meet the needs of the community. The result is a community that is purposeful in its response to residents' needs, creating conditions that meaningfully support an individual's ability to have a higher, more productive quality of life.

The state selected five regions in which to test the CHIR model. CHIR partners are organized by a neutral backbone organization that facilitates the development and implementation of key strategies, creating the necessary capacity to sustain progress on stated objectives. CHIR steering committees provide a clear leadership structure and promote shared accountability among partners for aligning their resources to address priority community health needs. It takes a comprehensive group of committed organizations to meet the needs of a community. No one entity can do this alone.

Table A.1-1 CHIRs and Backbone Organizations

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

All five CHIRs became fully operational in Award Year 3 and spent the year carrying out their local operating plans, with a focus on increasing Clinical-Community Linkages. To support Clinical-Community Linkages, each CHIR established a "hub" to serve people identified as

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

needing assistance with social determinants of health. Referrals come into the hub from community-based organizations and primary care providers participating in the SIM Patient-Centered Medical Home Initiative. These community-based organizations and primary care practices screen patients using a common assessment tool that identifies needs related to social determinants of health. The CHIRs are working on developing a data sharing system to electronically track referrals and use of services.

There are no plans at this time to expand the CHIR initiative beyond the five current regions. The state has, however, developed guidelines, policies, and other foundational materials as part of the pilot. These materials could be used in the event the decision to expand is made and funding is made available.

The primary goal for Award Year 4 of the CHIR component is developing a solid sustainability plan and finalizing a Michigan CHIR Pilot Manual. The manual will be a comprehensive document that new regions can use to implement and operationalize a successful CHIR, providing guidance for a standardized and repeatable model for CHIRs beyond the SIM Test award period.

Health Through Housing

All CHIRs were initially required to focus on the statewide priority of reducing emergency department utilization while also assessing community needs and identifying region-specific health improvement goals. In Award Year 3, each CHIR identified lack of housing supports as a problem in their region. Given the importance of housing and Michigan's participation in a Medicaid Innovation Accelerator Program housing initiative, MDHHS has developed and will implement a new SIM initiative within the CHIR framework to integrate and coordinate housing and health care. The goal of this integration is to foster housing stability and efficient, effective use of health care and housing resources.

MDHHS launched a housing package for CHIR communities called the Health Through Housing Initiative. The initiative includes capacity building among permanent supportive housing providers, strategies to improve the homeless response system in CHIRs, and a pilot project for serving people who are both homeless and frequent users of health care services. The 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.

Plan for Improving Population Health

Michigan's Plan for Improving Population Health (PIPH) will include an assessment of the overall health of the state as well as measurable goals, objectives, and interventions to improve the health of the entire state population; improve the quality of health care across the state; and reduce health care costs.

Improving population health requires addressing non-health related issues that affect a person's ability to achieve optimal health. Addressing social determinants of health by supporting access to community-based services is an evidence-based population health improvement strategy. Michigan's plan will center on the development of Clinical-Community Linkages to connect people with the resources they need to be healthy.

CARE DELIVERY

Patient-Centered Medical Homes

With the state's focus on person- and family-centered care and strong evidence that this model delivers better outcomes than traditional primary care, the Patient-Centered Medical Home (PCMH) 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.

As of October 2018, approximately 340 practices representing 2,100 primary care providers are participating in the Michigan SIM PCMH Initiative, serving over 365,000 Medicaid beneficiaries. Approximately fifty percent of the practices are in a SIM CHIR region. Approximately seventy-six percent of the total Medicaid beneficiary population in the state is eligible for participation in the SIM PCMH Initiative.

In Award Year 3, participating PCMHs have been heavily focused on improvements to care delivery, including establishing new Clinical-Community Linkages or strengthening existing relationships. 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, MDHHS began collaborating with Medicaid Health Plans (MHPs) to establish a state-preferred PCMH model designed to sustain advanced primary care capabilities such as care management and coordination, health information technology, and enhanced access. The model is designed to encourage continued transformation through Alternative Payment Models.

In 2019, MDHHS will continue to support SIM PCMH participants in the execution and refinement of Clinical-Community Linkages, while spurring additional practice transformation efforts focused on population health management. The PCMH Initiative will also add a quality

performance incentive payment, known as the Performance Incentive Program, which is based on a combination of quality and utilization measures.

The Michigan SIM PCMH Initiative intends to continue its focus on 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 that are 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.

Alternative Payment Models and Multi-Payer Alignment

In developing its model for health system transformation, the state recognizes 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) pursuing non-payment facets of multi-payer alignment, such as health technology and quality measures, to facilitate broader payer collaboration and reduce provider burden. 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, MDHHS is collaborating with MHPs to increase adoption of APMs. The state collected comprehensive baseline information on MHP participation in APMs and asked MHPs to submit strategic plans for increasing APM-based payments. MDHHS also recommended a set of quality metrics for MHPs to use as a basis for APMs. In the coming award year, MDHHS intends to support MHPs in establishing APM strategic plans that include specific goals to increase the amount of Medicaid spending in the LAN APM framework categories of 2C through 4.

Throughout the SIM award, MDHHS has analyzed numerous opportunities to support multi-payer alignment and collaboration. While alignment among MHPs is reinforced by contractual obligations, MDHHS will pursue opportunities to foster alignment with other payers through shared goals. Among these opportunities are alignment of quality metric incentives, health information exchange use case implementation, continued collaboration with federally-led

medical home initiatives, and encouraging payer participation in CHIR governance at the local and regional levels.

High-Level Care Delivery Milestones

Table A.1-2 High-Level Care Delivery Milestones

Reference ID	Program Area	Milestones	AY4 Quarter
1	Care Delivery/PCMH	Analyze PCMH Initiative participant performance on defined Care Management and Coordination benchmarks to establish status in relation to the performance-based funding model.	Q1 & Q4
2	Care Delivery/PCMH	Produce PCMH Initiative participant-facing Care Management and Coordination performance reports to support active engagement and quality improvement activities within participation practices.	Q1 - Q4
3	Care Delivery/PCMH	Monitor PCMH Initiative participants across program participation requirements to ensure model fidelity and in support of valid program evaluation.	Q1 - Q4
4	Care Delivery/PCMH	Ensure program fidelity through enforcing PCMH Initiative program requirements by issuing corrective action plans, adjusting payment, or terminating participation as applicable.	Q1 - Q4
5	Care Delivery/PCMH	Establish PCMH Initiative participant technical assistance strategy and plan to ensure provider growth and continued health systems transformation.	Q1 & Q2
6	Care Delivery/PCMH	Invite stakeholder feedback through facilitation of technical assistance planning committees to ensure stakeholder needs are being met.	Q1 - Q3
7	Care Delivery/PCMH	Execute technical assistance strategy.	Q1 - Q4
8	Care Delivery/PCMH	Continue investment into Care Management and Coordination workforce development through a core competencies training program and targeted learning opportunities.	Q1 - Q4

Reference ID	Program Area	Milestones	AY4 Quarter
9	Care Delivery/PCMH	Ensure continued SIM PCMH Initiative program operations through maintenance of participant demographic information and payment coordination.	Q1 - Q4
10	Care Delivery/PCMH	To the extent necessary, explore the possibility of managing a coordinated provider eligibility process for MHP-led APMs such as the State-Preferred PCMH Model.	Q2
11	Care Delivery/APM	Ensure ongoing provider community and MHP engagement in sustaining PCMH and Care Management and Coordination activities through the development and execution of a coordinated and transparent communications plan.	Q1 - Q4
12	Care Delivery/APM	Increase the overall proportion of payments made to providers by MHPs that include one or more APMs.	Q1 - Q4
13	Care Delivery/APM	Work with MHPs to substantially increase payment methodologies with a clear link to quality/outcomes.	Q1 - Q4
14	Care Delivery/APM	Ensure greater consistency in the measures used by MHPs to reward improvements in quality of care in APM contracts.	Q1 - Q4
15	Care Delivery/MPA	Engage other payer partners (commercial, CMS/Medicare, employers) in a collaborative effort to align provider incentive programs around shared quality and utilization goals.	Q2
16	Care Delivery/MPA	Engage other payer partners (commercial, CMS/Medicare, employers) in a collaborative effort to align information sharing and data exchange programs to support care coordination and reduced provider burden.	Q1

Reference ID	Program Area	Milestones	AY4 Quarter
17	Care Delivery/MPA	Generate a standardized mechanism for tracking provider-delivered care management services to ensure a lens of equity and quality improvement can be applied to continued access to these services.	Q3

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 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 Medicaid Health Plans, commercial payers, and their providers to take advantage of a widespread network of networks to increase interoperability and support the goals of the initiative.

In Award Year 3, the SIM technology team worked with the Michigan Health Information Network (MiHIN) to implement the Clinical Quality Measure Reporting and Repository (CQMRR) use case. The CQMRR use case enables health care providers to transmit clinical quality measures to payers electronically.

The SIM technology team also partnered with the state's Homeless Management Information System and Medicaid administration to identify health care utilization patterns and costs for homeless individuals with chronic disabilities and how those change when they become enrolled in permanent supportive housing. This partnership and the data it renders will be critically important to the CHIR-based Health Through Housing initiative.

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

- Continue the use case onboarding by the state-designated HIE and the collection of data through the statewide health information network. Define how this data is to be used, and who will be accountable for action.

- Develop care management strategies relative to the ADT use case.
- Establish a roadmap for increasing the quality and detail of patient-level attribution data within the Medicaid Health Plan Active Care Relationship Services (ACRS) file.
- Validate the accuracy of ACRS, ADT, and other use cases to establish the integrity of HIE as a care management support system.
- 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 ACRS and Health Provider Directory.
- Ensure continued alignment of the ADT use case with Medicaid Health Plan contractual requirements.
- Explore the development of a use case for the collection and reporting of social determinants of health data in partnership with Medicaid Health Plans and other programs/administrations within MDHHS.
- 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 developed and continues to refine an ambitious plan to improve the health of all Michiganders by addressing social determinants of health in primary care through effectively linking to community systems and innovative HIE/HIT solutions. Michigan looks to improve population health and the quality of health care, and to reduce health care costs while developing sustainability models for each major SIM component.

The SIM Program will support this vision by:

- The state will continue to work collaboratively with Medicaid Health Plans and providers to ensure effective payment mechanism(s) for continued support of provider-delivered care management and coordination services.
- The state will continue to develop the working partnership with Medicaid Health Plans to increase the use and progression of alternative payment methodologies with a clear link to quality and outcomes.
- The state will work collaboratively with health plans, health care systems, providers, Community Health Innovation Regions (CHIRs), and other stakeholders to ensure a

sustainable model for Clinical-Community Linkages. This will include the identification of best practices in social need data collection, use, and sharing.

- Pursuing state general funds for the continuation of a CHIR pilot program and provider-delivered care management and coordination services.
- Developing a comprehensive resource document that new regions can use to plan and implement a successful CHIR.
- Continued development of a housing program across all CHIRs to connect homeless high-cost frequent utilizers of emergency services with permanent housing resources and short-term supportive services funding to stabilize and improve their health.
- Aligning the health care and population health goals of the state with an updated State of Michigan Plan for Improving Population Health while exploring the feasibility of the CHIR model as a foundational element of the Plan.
- The state will continue to analyze the Statewide Active Care Relationship Service and Statewide Admit, Discharge, and Transfer Service for broader engagement and utilization within state programs and business practices.
- Leading a broad stakeholder engagement plan to facilitate collaborative discussions on the ongoing activities for the remainder of SIM and post-SIM sustainability strategies. In addition, the state will continue to explore potential models for ongoing stakeholder engagement strategies, which may include establishment of external advisory groups.

As demonstrated by the key points above, Michigan has put an emphasis on health system transformation by targeting upstream social determinants of health and 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 state believes that working beyond clinical walls is fundamental to improving outcomes, lowering total costs of care, and empowering residents to improve their overall health and wellbeing.

These post-SIM goals were developed through a coordinated effort and align with the direction of key administrations within the Michigan Department of Health and Human Services. We believe this end state to be achievable and critical to the future health of our state.

A.3 UPDATED DRIVER DIAGRAM

A thorough review of the driver diagram's primary and secondary drivers indicated that all primary drivers were still feasible and accurate to the aims of the project. However, some changes did need to be made to the secondary drivers. The secondary drivers pertaining to the integration of CHIRs and PCMH practices via clinical-community linkages and the utilization of a

knowledge management platform to share best practices needed to be deemphasized in favor of adding an additional pair of drivers under the Improve Population Health aim to reflect the program's increased emphasis on Housing. The updated Driver Diagram is included in Appendix 1.

A.4 UPDATED MASTER TIMELINE

Table A.4-1 Michigan SIM Preliminary Milestone Timeline Year 4

Michigan SIM Preliminary Milestone Timeline Year 4	
Task Name	**Quarter**
Population Health Initiative	
CHIR Implementation Project Monitoring and Improvement	
Regional Implementation	Q1-Q4
Project Monitoring	Q1-Q4
Implementation Support	Q1-Q4
Collaborative Learning	
Coaching and Technical Assistance	Q1-Q4
Transition CHIR Coaching and Technical Assistance	Q2-Q4
Migrate Platform Website	Q1
Annual CHIR Summit	Q3
Housing Initiative	
Implement and Operate Housing Initiative	Q1-Q4
CHIR Sustainability	
Finalize CHIR Sustainability Plan	Q2
Update Model Design Based on Evaluation	Q3
Develop Post-SIM Execution Plan	Q4
Plan for Improving Population Health	
Roll Out Plan for Improving Population Health	Q1-Q4
Care Delivery Initiative	
Performance Monitoring and Compliance	
Care Management/Care Coordination	Q1-Q4
Compliance Monitoring and Reporting	Q1-Q4
Participant Support and Learning Activities	
Virtual Meetings with SIM PCMH Participants; Annual Kick-Off, Quarterly Update	Q1-Q4
Participant Payment and Model Execution	
Payment Disbursement	Q1-Q4
SIM PCMH Initiative Transition to MHP	
Participant Communications	Q1-Q4
Alternative Payment Models (APMs)	
Communication and Coordination	
Maintain Internal APM Coordination, Status Monitoring, and Governance Processes	Q1-Q4
Maintain External MHP APM Workgroup Collaboration	Q1-Q4
MHP APM Strategic Plans	
Collect, validate, analyze and report narrative and quantitative data	Q2-Q4

Michigan SIM Preliminary Milestone Timeline Year 4	
Task Name	**Quarter**
APM Quality Strategy	
Review and enhance quality approach to APMs	Q3-Q4
Implement Annual MHP APM Strategic Plan Updates and Approvals	Q2
APM Bonus Program	
Leverage the MHP Capitation Withhold to Sustain PCMH in MHPs	Q1-Q2
Multi-Payer Alignment	
Regional Measure Incentive Alignment	
Regional Measure Incentive Alignment	Q2-Q4
HIE Use Case Implementation Alignment	
Collaboration with Commercial Payers on HIE Use Case Alignment	Q1-Q4
CPC+ Program Coordination	
PCMH Participation Requirement Alignment	Q1-Q4
PCMH and CPC+ Coordination	Q1-Q4
Care Management and Coordination Coding (CM/CC) Alignment	
Maintain alignment of CM/CC Coding Sets Across Payers/Programs	Q1-Q4
Technology Initiative	
Quality Measures and Reporting	
Monthly Ongoing Reporting (Patient Lists, Care Management Reports, Quarterly Progress Reports)	Q1-Q4
Relationship & Attribution Management Platform (RAMP)	
Develop Transition Plan for Attribution Mode	Q1
Transition Attribution Technical Solution to Operations	Q3
Use Case Onboarding	
Transition Quality Measurement Information (QMI) to Operations	Q3-Q4
Transition Admission, Discharge & Transfer Notices to Operations	Q1
CHIR Technology	
Document Community Clinical Linkages Technology Guidance/Requirements	Q1-Q2
Program/Project Management	
Year 4 Close Out	Q3-Q4
Status Reporting	Q1-Q4
Sandbox	
Data Quality	Q1-Q4
Housing Data	Q1-Q4

Please see component-level work plan by drivers for detailed tasks associated with the noted program milestones.

B. General SIM Policy and Operational Areas

B.1 SIM Governance

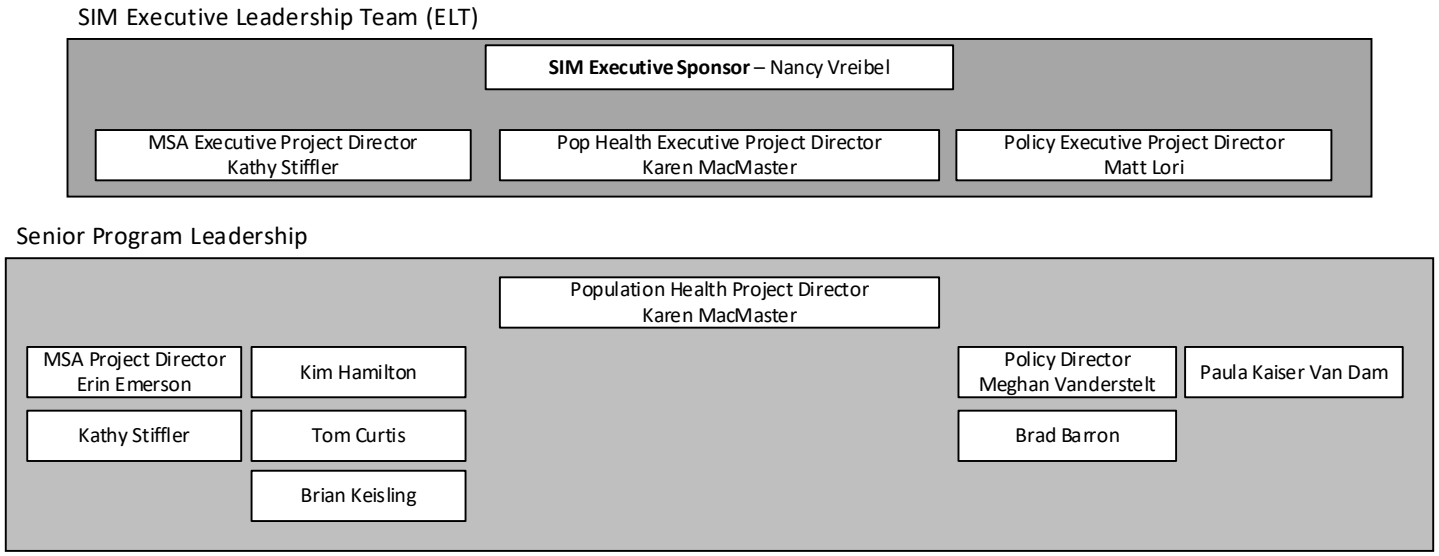
B.1.a Management Structure Update

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.

During Award Year 2, 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. Similarly, during Award Year 3, additional representation was added from the MDHHS Bureau of Community Services to reflect the added focus on housing within the Community Health Innovation Region (CHIR) initiative. 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 are formulated; and decisions are documented. This 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 is continuing to explore potential models for additional ongoing stakeholder engagement strategies, which may include establishment of appropriate external advisory groups and internal sustainability and transitional elements.

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



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

B.1.b DECISION-MAKING AUTHORITY

The updated executive leadership team and existing management structure continues to support the monitoring and 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 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		Time Allocation	
	Position/Title	First Name	Last Name	Phone Number	Email Address	SIM Funded %	State In-Kind Contribution %
Executive Leadership	SIM MSA Executive Leadership	Kathy	Stiffler	517-241-9944	StifflerK@michigan.gov	0%	10%
Executive Leadership	SIM Population Health Executive Leadership, and Plan for Improving Population Health Business Owner	Karen	MacMaster	517-284-4730	MacMasterK@michigan.gov	0%	10%
Executive Leadership	SIM Policy, Planning, and Legislative Services; CHIR Executive Leadership	Matt	Lori	517-284-4040	LoriM@michigan.gov	0%	10%
Governor's Office Representative	Sr. Policy Advisor, Office of the Governor	Elizabeth	Gorz	N/A	GorzE@michigan.gov	0%	5%
Sr. Program Leadership	Policy Director and Evaluation Business Owner	Meghan	Vanderstelt	517-284-4758	VandersteltM@michigan.gov	25%	10%
Sr. Program Leadership	MSA Project Director	Erin	Emerson	517-284-1132	EmersonE@michigan.gov	0%	15%
Sr. Program Leadership	Medicaid Operations Business Owner	Brian	Keisling	517-284-1183	KeislingB@michigan.gov	0%	10%
Sr. Program Leadership	Actuarial Business Owner	Penny	Rutledge	517-284-1191	RutledgeP1@michigan.gov	0%	5%
Care Delivery	Actuarial Lead	Glenda	England	517-284-1142	EnglandG@michigan.gov	0%	10%

SIM Component / Project Area	Component/Project Lead			Contact Information		Time Allocation	
	Position/Title	First Name	Last Name	Phone Number	Email Address	SIM Funded %	State In-Kind Contribution %
Care Delivery	Actuarial Coordinator	Robert	Young	517-284-1139	YoungR10@michigan.gov	0%	10%
Sr. Program Leadership	Medicaid Quality Business Owner	Tom	Curtis	517-284-1152	CurtisT2@michigan.gov	0%	25%
Sr. Program Leadership	Alternative Payment Model Business Owner	Kim	Hamilton	517-284-1147	HamiltonK@michigan.gov	0%	10%
Sr. Program Leadership	Data Sharing Business Owner	Erin	Mobley	517-284-4043	MobleyE2@michigan.gov	25%	10%
Sr. Program Leadership	Technology Business Owner	Kim	Bachelder	517-284-4046	BachelderK@michigan.gov	25%	15%
Sr. Program Leadership	CHIR and Housing Initiative Business Owner	Paula	Kaiser Van Dam	517-241-0638	KaiserP@michigan.gov	0%	25%
Sr. Program Leadership	SIM Program Coordinator, Communication Liaison, and Multi-Payer Alignment Business Owner	Brad	Barron	517-284-4048	BarronB@michigan.gov	50%	40%
Sr. Program Leadership	Housing Initiative Lead	Lynn	Hendges	517-284-8018	Hendgesl2@michigan.gov	0%	25%
Sr. Program Leadership	Integration Lead	Mark	Cascarelli	734-277-7684	CascarelliM@michigan.gov	100%	0%
Sr. Program Leadership	Administrative Program Manager	Andy	Spencer	248-559-7910	SpencerA6@michigan.gov	100%	0%
Evaluation	State Evaluation Lead	Clare	Tanner	517-324-7381	CTanner@mphi.org	100%	0%

B.1.c REGULATORY AUTHORITY

The state has utilized several policies to support the implementation of care delivery through Patient-Centered Medical Homes (PCMHs), 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 advanced support of SIM initiatives.

Medicaid Contract Revisions

Michigan's Medicaid contract is reviewed on an annual basis and continues to align Medicaid Health Plans across ten regions in the state. This contract supports SIM in the following areas.

Value-Based Payment Models

MDHHS' contract 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 annually on the percentage reimbursed under value-based payments, which must comply with payment reform goals. 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.

Alternative Payment Models

Medicaid Health Plans must describe their timeline and action plan to meet payment reform threshold requirements established within the contract. This includes 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.

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

State Preferred Model

The State-Preferred PCMH Model is the goal for 2020. It has been designed to encourage sustained primary care capacity, such as care management, enhanced access, and continued transformation through alternative payment models (APMs).

MDHHS recognizes the development and implementation of the State-Preferred APMs as a collaborative process between the Medicaid agency and Medicaid Health Plans (MHP). MDHHS has also solicited feedback from the provider community regarding the implementation of various payment models.

As part of this process, MDHHS has prioritized Minimum Provider Requirements that comprise the foundational primary care capabilities for participation in the State-Preferred PCMH Model with any MHP.

MDHHS conducted a provider application process to address the priority areas and will provide a list of eligible providers to support the MHPs in the implementation of the State-Preferred PCMH Model in Fiscal Year 2020. This year's application process engaged 216 providers.

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. The Managed Care Division is working with all 11 MHPs to achieve these objectives. As a result, numerous aspects have been inserted into normal operational processes between MDHHS and MHPs. Because of this, the strategy is well-positioned to continue after the SIM Program ends.

Patient-Centered Medical Homes

Michigan's contract recognizes the need to support a Patient-Centered Medical Home 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.
- a previous Michigan Primary Care Transformation 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

The 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." See Section C.4 for complete CHIR Initiative detail.

Community Health Workers

Support of community-based population health initiatives is a component of the Population Health Requirements in the MHP contract, allowing plans to contract with community-based organizations to deliver services that address socioeconomic, environmental, and policy domains. Additionally, this supports contracts with community-based organizations that provide services such as care coordination, and community health worker-delivered interventions.

Data Integration

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."

The primary care practices that participate in the SIM PCMH Initiative each sign 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. Each health plan submits an annual report to MDHHS on the effectiveness of its evidence-based interventions to reduce health disparities. The report includes such considerations as:

- The number of participants experiencing a disparate level of social needs, such as transportation, housing, food access, unemployment, or education level.
- The 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.

Certificate of Need

An independent 11-member commission remains in place to oversee 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 continues to operationalize the plan it submitted the previous year to meet participation requirements. Plans focus on developing and implementing strategies to identify people who make frequent visits to the emergency department, and then using a screening tool to assess their needs related to social determinants of health, such as housing, financial assistance, food access, and employment. See Section C.4 for complete CHIR details.

PCMH Participation Guide

To assist practices in advancing SIM, a PCMH Participation Guide was released last year that continues to be regularly updated. This model guide presents the basic services to be provided.

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 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 designed for the PCMH Initiative, create standardization across key stakeholders, and to support team-based care and transitions.
Physician organizations	• Annual summits • Quarterly meetings • Office hours	
Care managers/ coordinators	• Annual summits • Office hours • Virtual learning opportunities • Care Coordination Collaboratives	

Stakeholder	Method	Purpose
Medicaid Health Plans	• APM Workgroup • Care Coordination Collaboratives • Bi-monthly Plan Meetings • Bi-monthly Enrollment Workgroup • Bi-weekly Operations Workgroup Meeting • Participate in MHP care management director and quality director calls	To support MHPs in realizing the value of the care delivery model supported within the SIM PCMH Initiative, work with MHPs to execute directed payments for the PCMH Initiative, and engage in designing the future of supporting a team-based care delivery model within the PCMH setting.
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.
Patients/beneficiaries/ consumers	• Non-SIM PCMH Initiative patient family advisory councils • 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) • CHIR summits • Monthly newsletter • ABLe trainings (three 2-day sessions) • Coaching calls • Technical assistance calls	To develop specific strategies for each region to improve the health of the community, and support cross-region collaboration and learning.

Stakeholder	Method	Purpose
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.
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	To engage patients and beneficiaries in identifying strategies for improving the health of the community and 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	To 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 being disseminated on a routine basis:

- Annual SIM summary
- SIM PCMH Initiative 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)

An updated summary of the Michigan SIM Test was developed and disseminated in spring 2018, and numerous 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.

In addition, the Michigan SIM team has developed a video to educate stakeholders on the CHIR model, Clinical-Community Linkages, and social determinants of health, and is developing a brochure to describe the CHIR model. The SIM website also received an overhaul after the program's stakeholder engagement consultant conducted an analysis of the current website and offered recommendations for improving the look, flow, and content of the site. The site now serves as a resource for anyone interested in the Michigan SIM Test to learn about the background and current status.

The Michigan SIM team released an updated survey through the listserv to find out whether these communication methods have been useful and to identify any additional strategies the

team should be using to connect with stakeholders. This information will be used to develop an updated communications plan that will provide a foundation for stakeholder engagement in Award Year 4.

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.

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 systematically supporting whole person-centered care. To that end, the State Innovation Model programs have emphasized the importance of leveraging experience from previous programs, and allowing for innovation through the exploration of promising practices.

Michigan's SIM Care Delivery Programs and Population Health Programs

The Patient-Centered Medical Home Initiative leverages the core tenants of PCMH designation to build on a foundation of provider-delivered care management supporting 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 both within and outside Michigan SIM test regions. Approximately half of the PCMH Initiative participants are located within one of the Michigan SIM Test Regions. These participants are partnering directly with their CHIR backbone organization as governing body representatives, social need screening and referral partners, and as a resource to support the development or strengthening of a community network of service providers. This may be accomplished through collaborating on strategy development, participating in systems change efforts, increasing community representation on governance and other works groups, or other means.

Through these partnerships, SIM participants 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 the 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 have received 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. 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, and in some regions have been able to successfully leverage partnerships with Medicaid Health Plans to financially support navigation and coordination services delivered by a community health worker.

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.

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 the first three years, SIM Year 4 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 the first two operational years of the Initiative. While the core participation requirements of the PCMH Initiative requirements for Calendar Year 2019 will remain very similar to those of Calendar Year 2017 and Calendar Year 2018, there will be adaptations in the Initiative's payment model to drive an increased focus on quality. At the core of the Initiative is the care delivery model focused on whole-person and family centered care. Beyond PCMH designation, all participants must adhere to the requirements that are outlined in the following categories: Operations, Core Primary Care (PCMH), Clinical Practice Improvement Activities (Practice Transformation), Care Management and Coordination, Health Information Technology, and Practice Support and Learning Activities. MDHHS has historically and will continue to ensure alignment between the PCMH Initiative program and

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 through either the Merit-based Incentive Program System 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.

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, the provision of care management and coordination services, the use of health information technology and exchange, demonstrated performance on specific quality and utilization measures, and the execution of clinical practice improvement activities focused on Clinical-Community Linkages and population health management. Both the provision of care management and coordination services, and performance on specific quality and utilization measures will have an impact on participant payments in the final year of the PCMH Initiative. This comes from the introduction of the Care Management Improvement Reserve and the Performance Incentive Program. The Performance Incentive Program is described later in Section C.1.b.

Community Health Innovation Region Integration

During the 2018 calendar year, the Community Health Innovation Regions have each completed detailed CHIR Operational Plans describing their 12-month budget and activity timeline. These plans focused on the implementation of the social determinants of health screening tool and a clinical-community linkages 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 of 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 for 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, it will engage in regular bidirectional communication with the MHPs to further progress in implementing critical aspects of the APM strategy. Critical aspects include 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 that 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. MDHHS is using this information to gain a more accurate understanding of the provider interest landscape, and MHPs are using this information to gain a better understanding of the impact of adopting one or more of the preferred models, before the 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 Michigan Health Information Network (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, MiHIN 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) 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 Per Member Per Month Cost

During 2018, the SIM team continued efforts to ensure measure alignment between the Care Delivery and Payment Reform strategies. Supporting common measure specifications, the PCMH Initiative focused 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, MDHHS employed other nationally-recognized methodologies, such as the Agency for Healthcare Research and Quality, to ensure alignment with the Medicaid Managed Care Plan Division.

Based on the current Medicaid contract, MDHHS has placed an emphasis on population health to improve the quality of health care for Michigan Medicaid beneficiaries. To support this effort, MDHHS selected the APM work to serve as a vehicle to reduce regional disparities.

MDHHS has utilized its data warehouse to pull several CY16 HEDIS measure rates by Medicaid Health Plan Prosperity Region. To identify low performing regions, logistic regressions were run for each measure. The analysis focused on comparing Region 10 rates to all other regions. MDHHS focused on Region 10 because it is the most populated region where performance tends to be lower. Low performing regions were characterized as those regions with statistically significant lower rates than Region 10.

As the Alternative Payment Model strategy was built out in Year 3, additional efforts were made to align quality measure incentives with quality improvement needs as a foundation to support the alignment of Medicaid Health Plans and therefore provider quality reporting. With a focus of supporting alignment and continuity among payers and providers, efforts focused on developing a quality program that aligned on a core group of measures across the state, and supplemental measures to allow for regional variation. The table below illustrates the regional measure sets.

Table B.2-2 Regional Quality Measures

Region	**Regional Measure**
Region 1	Appropriate Testing for Children with Pharyngitis
Region 2	Chlamydia Screening in Women – Total
Region 3	Chlamydia Screening in Women – Total
Region 4	Diabetes Eye Exam
Region 5	Chlamydia Screening in Women – Total
Region 6	Appropriate Testing for Children with Pharyngitis
Region 7	Chlamydia Screening in Women – Total
Region 8	Chlamydia Screening in Women – Total
Region 9	Diabetes A1C Screening

Region	Regional Measure
Region 10	Diabetes A1C Screening Timely Prenatal Care Chlamydia Screening in Women – Total

Next Steps

Within the final operational year, the SIM team will continue to focus on alignment across SIM programs and state programs. In 2019, the PCMH Initiative will introduce the Performance Incentive Program, which will assess participant performance on the key quality and utilization measures from Table B.2-1 PCMH Initiative Monitoring and Evaluation Measures.

B.2.c PLAN FOR IMPROVING POPULATION HEALTH

Progress Update

MDHHS made steady progress toward developing Michigan's Plan for Improving Population Health (PIPH) in SIM Year 3. MDHHS selected the Deputy Director of the Population Health Administration as the business owner responsible for leading the Plan's development to ensure alignment with future, broader public health assessment and planning activities. MDHHS also formed an internal workgroup, which includes partners from mental health and Medicaid, to guide the development of the PIPH and to support alignment across department administrations. In SIM Year 3, the workgroup began meeting monthly and accomplished several milestones with facilitation support from the Michigan Public Health Institute (MPHI). Milestones include reaching consensus on the vision and purpose of the PIPH, developing a broad outline and guiding principles, creating a strategy for stakeholder engagement, and forming subcommittees to inform components of the PIPH.

The purpose of Michigan's PIPH is to: "Describe how Michigan is creating health, equity, and wellbeing through clinical and community based prevention strategies that address the social determinants of health." Michigan's PIPH is grounded in the idea that population health will improve if Michigan works across sectors to leverage its resources to address the root causes of health inequity and improve access to the conditions that promote health. One key aspect of Michigan's PIPH is that, rather than focusing on a specific health outcome, the PIPH will be directed at addressing the social determinants that underlie disparities in multiple health outcomes. Following robust discussions on the current state of health in Michigan and the ideal future state, the current vision statement for the PIPH is: "Creating the conditions for optimal health for all people in Michigan." The PIPH mission statement is: "To build partnerships with the whole community that share accountability for creating conditions that foster health,

equity, and well-being for all." These statements may be modified through the process of gathering stakeholder feedback.

Michigan's PIPH will focus on three main components: care delivery, Clinical-Community Linkages, and community conditions. The Plan will target social determinants of health at each of these layers, focusing on strategies to change systems and pursue equity. The Plan will build on Michigan's SIM design by identifying opportunities to:

1. Shift practices within the care delivery system toward a focus on identifying needs and linking patients with community services.
2. Create stronger linkages between clinical and community services and settings.
3. Shift community conditions so that the environments in which people live promote health, including the physical, service, social, and economic environment.

Through SIM, Michigan focused on coordinating efforts between the care delivery system and organizations in the community. However, Michigan recognizes that the deep health inequities across the state cannot be addressed without changing the conditions in which people live. The PIPH will build on capacity built through SIM and across the state to address social determinants of health through strategies that connect people with services and through strategies that change conditions.

Health Status & Public Health Capacity Committees

Two PIPH committees meet on a monthly basis to inform the development of various sections of the PIPH; the Health Status Committee and the Public Health Capacity Committee. Guiding principles were created to direct the work of each committee, and each operates under a committee charter. MDHHS staff with special knowledge and expertise in each area comprise the committees. Each committee has an appointed committee chair, responsible for providing direction to the work, with facilitation support from MPHI. The Health Status Committee is charged with identifying indicators that articulate the health status of Michiganders, with intentional emphasis on the social determinants of health. The Public Health Capacity Committee is charged with identifying the available public health capacity in Michigan across programs and initiatives focused on social determinants, and identifying the needs and gaps in capacity impacting population health.

Stakeholder Engagement

The Workgroup has developed a broad stakeholder engagement plan to use to gather input at various levels. At this stage of the process, specific activities and strategies to involve stakeholders have been identified, and will set the stage for activities in SIM Year 4. Some examples of upcoming stakeholder engagement strategies include:

- A technical assistance call attended by the CHIRs to provide an update on PIPH progress and solicit feedback on direction and priorities.
- A convening of Michigan local health department health officers to solicit feedback on specific areas of focus for population health.
- Attending existing and newly established meetings with Michigan Health Plans, Physician Organizations, and Hospitals to gather feedback on the plan and discuss future implications with implementation.
- Involve representatives from Medicaid to identify areas of potential collaboration with Michigan Medicaid Health Plan Incentive Programs.

Plans for SIM Year 4

Michigan's PIPH work will continue into SIM Year 4 and build on progress made in Year 3. The Population Health Administration SIM Workgroup will guide the development of the Plan, forming ad hoc committees as needed to address specific topics or Plan components. In addition, the Population Health Administration SIM Workgroup will identify potential strategies for addressing social determinants of health, identify existing levers that can support moving these strategies into action, and will develop a PIPH implementation plan. Collective learnings from sub-committees will inform the development of the PIPH.

Alongside implementation of the Plan, a key area of focus for Year 4 will be generating robust stakeholder engagement and ownership for the strategies outlined in the Plan. The final draft of the complete PIPH will go to public comment for Michiganders in September 2019. The final deliverable of the PIPH will be submitted to the Centers for Medicare and Medicaid Services (CMS) in January 2020.

Strengths & Barriers

Michigan has a multitude of strengths and assets supporting this work. The workgroup and two sub-committees are comprised of members with a wealth of knowledge and expertise who guide the development of the PIPH. MPHI employs a collaborative and inclusive approach to facilitation, with emphasis on collective decision-making. Finally, clear timelines, expectations, and guidance are provided for all members involved in the PIPH development process.

Existing and future challenges to the completion and implementation of the PIPH are limited yet difficult to project at this time. Some potential barriers include:

- The unpredictability of strategic direction changes with upcoming gubernatorial election in November 2018.
- The time constraints and competing priorities of workgroup and committee members.

- The complexities of creating integrated strategies across administrations with different funding structures.
- Obtaining stakeholder engagement and buy-in at both the local and state level.

B.2.d HEALTH INFORMATION TECHNOLOGY

Rationale

The 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 3 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. Components of the platform continue to function in an integral manner to generating patient lists to participating providers within the SIM PCMH Initiative. For the past year it has provided funding to Medicaid Health Plans for payments to 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); Health Directory; and the Clinical Quality Measure Reporting and Repository (CQMRR) use cases.

Year 4, and Beyond the SIM Award Period

Michigan is well positioned to utilize numerous MDHHS policy initiatives to influence the 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 APMs 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 provider community between the SIM reporting requirements and the MACRA reporting requirements.

- 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 make improvements to the RAMP by ensuring appropriate data sharing requirements are in place, and that the data is provided in a secure manner. The governance process also helped coordinate the review and approvals of the improvements by multiple data owners. Supporting this effort has required coordination between numerous partners in the State of Michigan and SIM components.

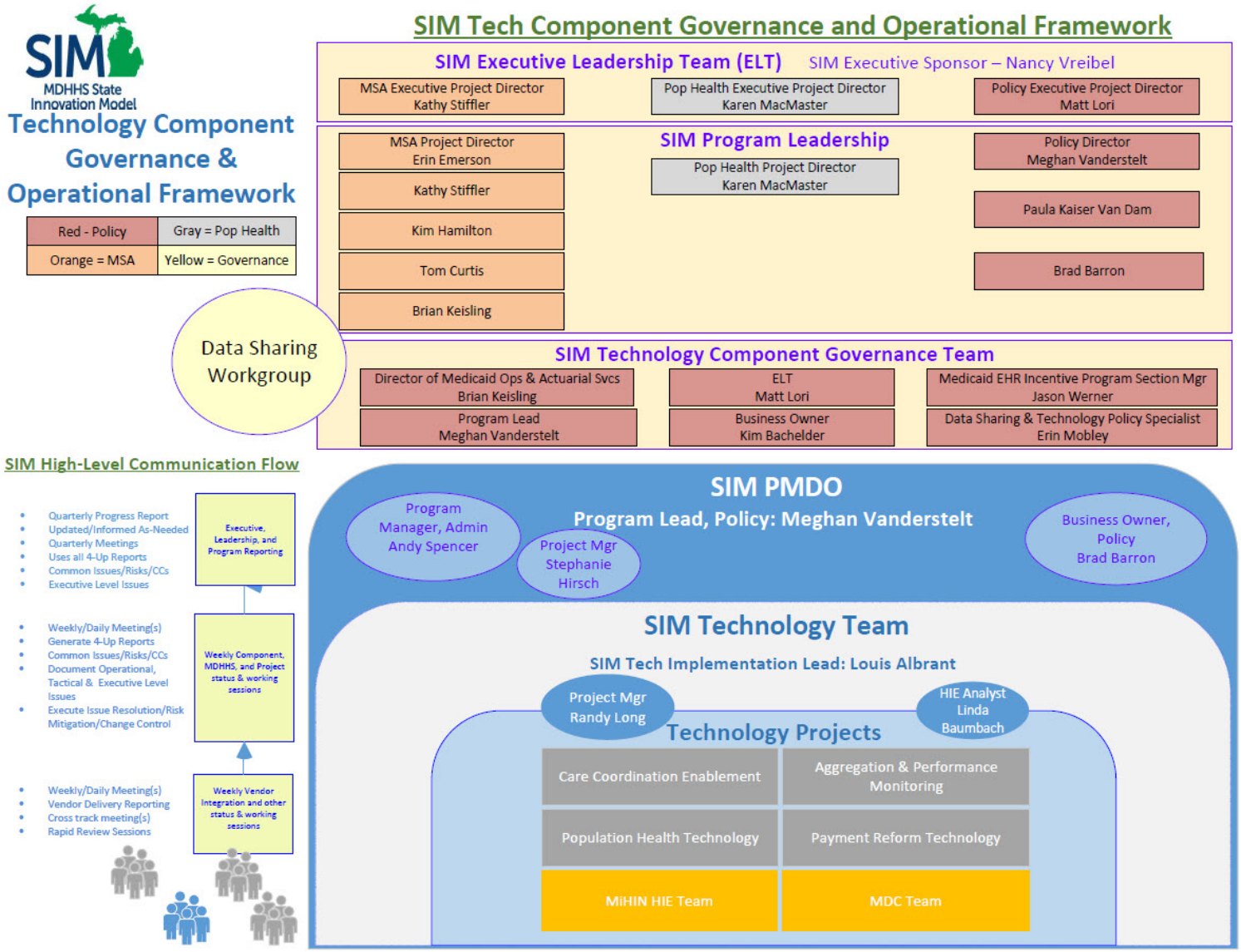
In the area of HIT infrastructure, the governance process has been supported by SIM Program Management and Delivery Office resources and has leveraged standard System Development Life Cycle technical development practices. The successes of the RAMP will be leveraged to explore the transition of RAMP components to the Medicaid Health Plans, which will aid in the sustainability strategy and allow for the continuation of value-added services in the post-SIM environment.

With regards to the Housing Initiative, Michigan successfully leveraged the current SIM technology work to combine Medicaid claims information, homeless and housing data, and ADT messages to show underlying causes of chronic homelessness. This work has allowed Michigan to identify high priority homeless persons eligible for housing vouchers.

Future

As part of the overall SIM Governance, Michigan will continue to evaluate other opportunities to combine homeless data with other data sources in order to further understand the underlying causes of chronic homelessness. 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 HIT infrastructure.

Figure B.2-1 Technology Component Governance



Policy

The State of Michigan will utilize current regulatory levers already in place to accelerate participant adoption of both existing state infrastructure and new models. The state will leverage policy and contracts, both existing and new, 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. Ten of the eleven Medicaid Health Plans are receiving ADT messages.

43 of 43 registered provider organizations are submitting ACRS files and are onboarded into MiHIN's Health Directory tool. 41 of 43 registered provider organizations 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. This change was the impetus which allowed for ADT messages from emergency department visits to be used more readily. In fact, the emergency department visit ADTs have now been added to the care coordination tool CareConnect360, allowing for care coordinators to better understand the patient, the care the patient has received, and to coordinate future care with a more holistic view of the patient.

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 has also worked to establish a standardized consent process for sharing 42 CFR Part 2 data. SIM staff will monitor changes to regulations created at both the state and federal levels, such as the Trusted Exchange Framework and Common Agreement, and will work to integrate these changes into the remainder of the SIM test if they are relevant to Michigan's HIE.

Future

MDHHS has officially published Version 4.0 of the standard consent form as well as the related educational documents. The updated version of the form is compliant with all of the new requirements under the Michigan Mental Health Code and 42 CFR Part 2 final rule. Version 5.0, which is currently under development, has significantly improved the reading level and accessibility for consumers.

Infrastructure

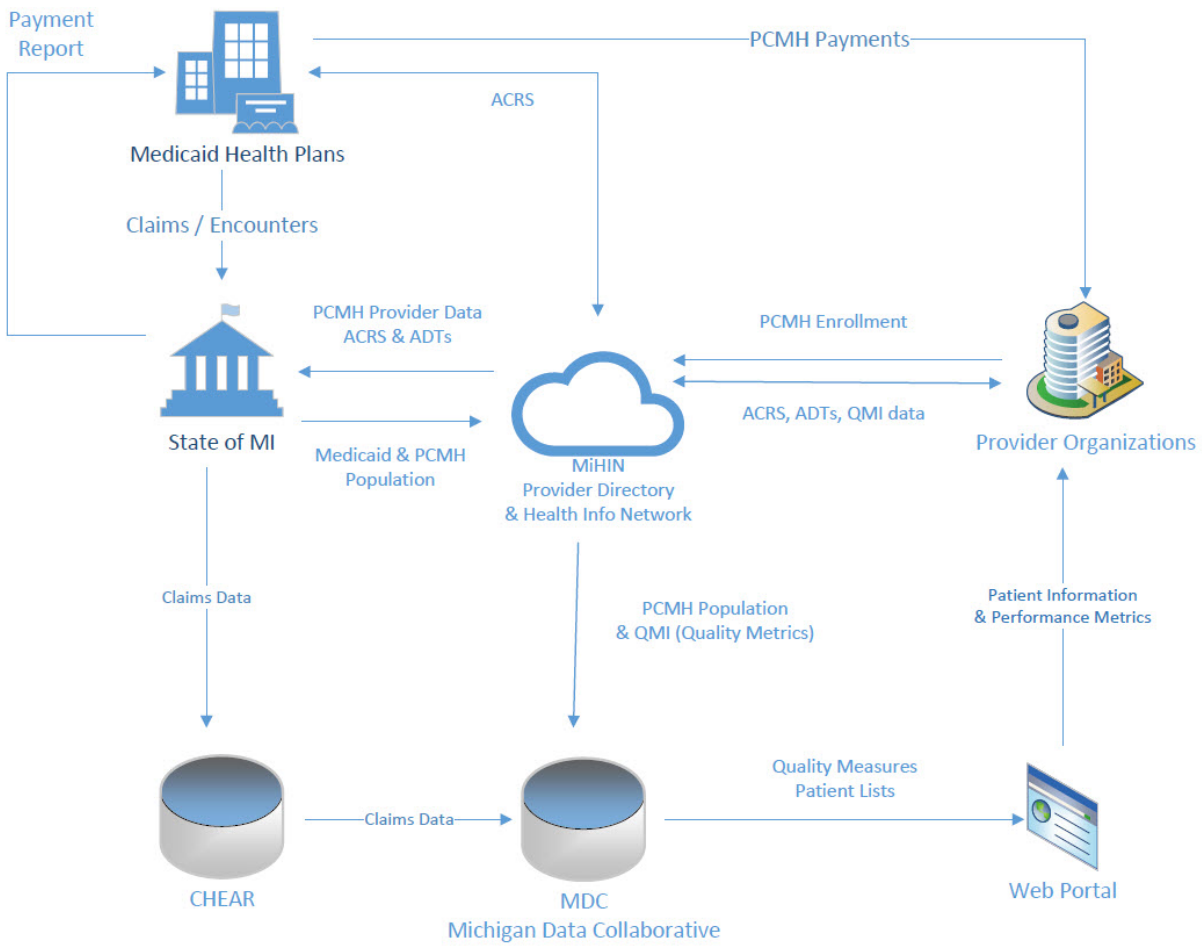
The technological and architectural strategy to support the SIM vision for health system transformation is outlined in Figure B.2-2 SIM Technology Overview. This strategy provides a

baseline of data interoperability implemented by SIM that is 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 to 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. As part of the Year 3 initiative, the technology team focused on optimizing the RAMP to improve matching results and decrease monthly processing time. New processes were introduced that enabled the team to decrease the amount of time it takes to produce the monthly attribution file. The team also brought on an additional data analyst to help analyze the attribution files and associated data. Because of these initiatives, the monthly RAMP processing time and the overall quality of the matching process improved.

Figure B.2-3 RAMP Diagram

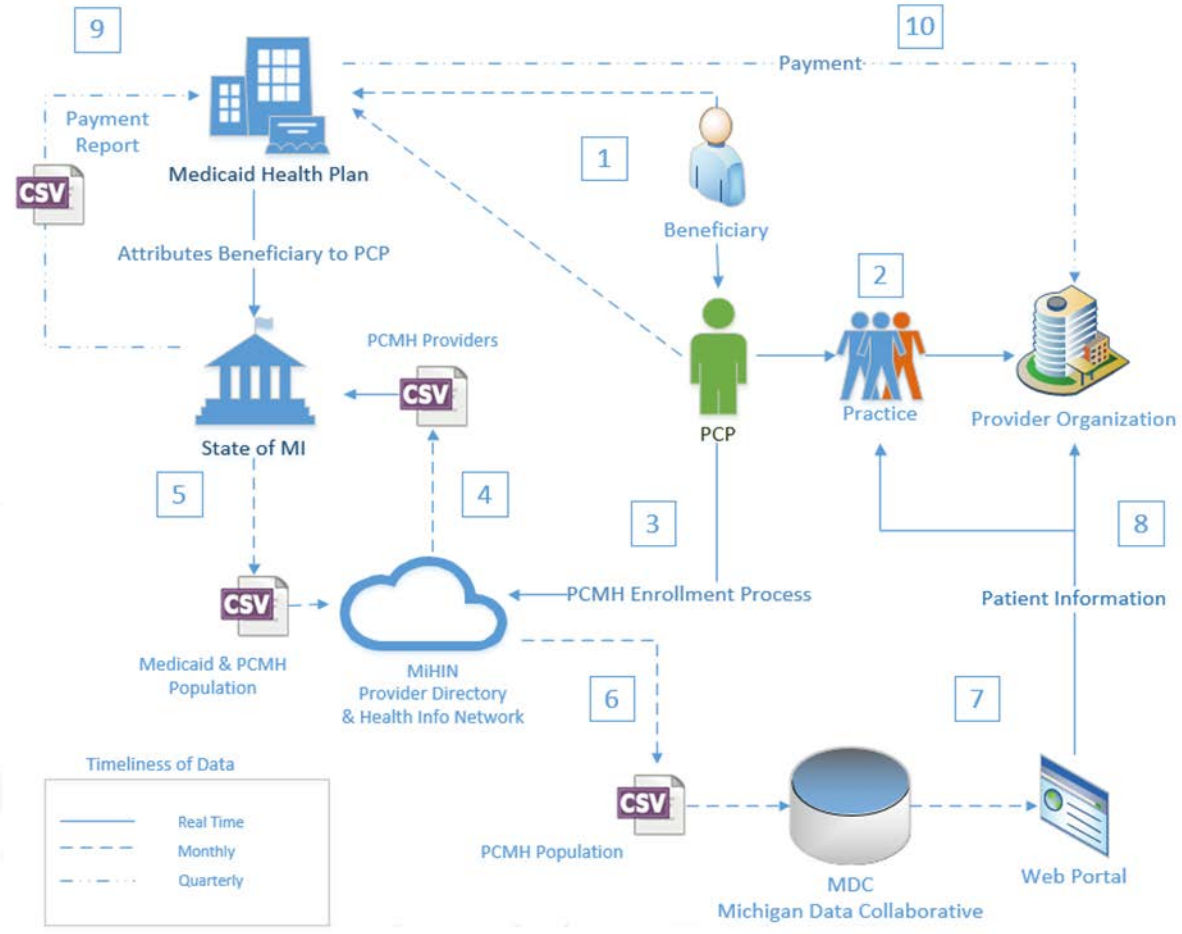


Table B.2-3 Steps in the RAMP Diagram

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.[2]
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.
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.
7	The Michigan Data Collaborative publishes monthly attribution reports and quarterly quality/utilization measure dashboard information on a program-specific web portal.
8	Provider organizations log into the web portal to view and download their information.
9	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 continued to support the timely delivery of payments, which has been critical to allowing providers the ability 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.

Challenges/Lessons Learned

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.

There is still a challenge around the reported attribution of patients to providers stated by providers compared to the reported attribution by Medicaid Health Plans. During Year 3, the

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

SIM technology team incorporated Medicaid Health Plans' stated attribution into the RAMP process. This helped clarify and correct some discrepancies in the attribution process.

Going Forward

As the SIM project completes Year 3 and moves into Year 4, MDHHS, alongside the MHPs, will be developing a model that highlights the core components of the care delivery model used in the Initiative. As part of this transition, some of the technology implemented by SIM will be decommissioned and/or transitioned to other parties, such as the MHPs. At this time, MHPs will not be incentivized to use the HIE use cases included in the RAMP; however, as the validity and reliability of the data improves, the managed care plan division will assess the possibility of adding it to the performance bonus pool incentive criteria. Additional details on use cases that support RAMP can be found below.

In AY4, MDHHS' Medical Services Administration will be analyzing the current RAMP infrastructure and how it has been used within the SIM demonstration to support the SIM PCMH Initiative. This analysis will determine the appropriateness of RAMP use for daily Medical Services Administration and plan operations. At this time, efforts are focused on analyzing specific components of RAMP against currently embedded processes to determine how the use of RAMP components could potentially inform modernizing current operations through HIE.

The SIM demonstration allowed MDHHS the ability to support MHPs in onboarding to certain use cases (Statewide Active Care Relationship Service, Health Directory, and ADT). All eleven Medicaid Health Plans have completed onboarding for those three use cases, except for one plan that has not completed onboarding for the ADT use case. That plan is completing internal analysis for how to receive and utilize information from this use case within their daily operations. In addition, many of the MHPs participate in the state's pilot with the CQMRR (often called Quality Measure Information in SIM) use case. Most of the mature use cases within the state are provider-focused, although they offer many opportunities to the payers as well. Currently, MDHHS requires all MHPs to participate in and to incentivize their provider networks to participate in the statewide HIE. MDHHS does not require participation in specific use cases – that is left up to the discretion of the MHPs. MDHHS will continue to require MHPs to participate in HIE, while allowing flexibility to determine the most appropriate use cases and methods for participation in the near term. MDHHS will continue to explore to what extent plan participation impacts quality of care and beneficiary health outcomes.

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 was realized in the first two years of the Michigan SIM Test. During Year 3 of SIM, the technology team focused on optimizing the attribution process by implementing procedures to compare Active Care Relationship files from PCMHs with the beneficiary information provided by Medicaid Health Plans. Physicians and provider organizations continue to submit ACRS files regularly, which the SIM technology team used as part of the SIM attribution process.

Future

While Physicians and provider organizations may continue to submit ACRS files, they will no longer be required to submit them for SIM. The attribution process will be handled by the Medicaid Health Plans.

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 continued to assist 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

For the final year of SIM the technology team will work with the Medicaid Health Plans and the SIM Care Delivery team to transition the management of SIM PCMHs from the MiHIN Health Directory to the Medicaid Health Plans.

Common Key Service Use Case

It was decided during year 2 that SIM will not be utilizing the service to perform identification, matching, or tracking against the SIM patient population. This is due to ongoing challenges of rolling out a statewide common key service. SIM will continue using its existing matching logic that takes advantage of the national provider Organizational Identification Directory. This process requires manual review of the data on a monthly basis, and it is producing successful results.

Progress to Date

It was decided during Year 2 that SIM will not be utilizing the Common Key Service to perform identification, matching or tracking against the SIM patient population.

Future

The Common Key Service Use Case will not be needed for SIM and the transition of RAMP to the Medicaid Health Plans.

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

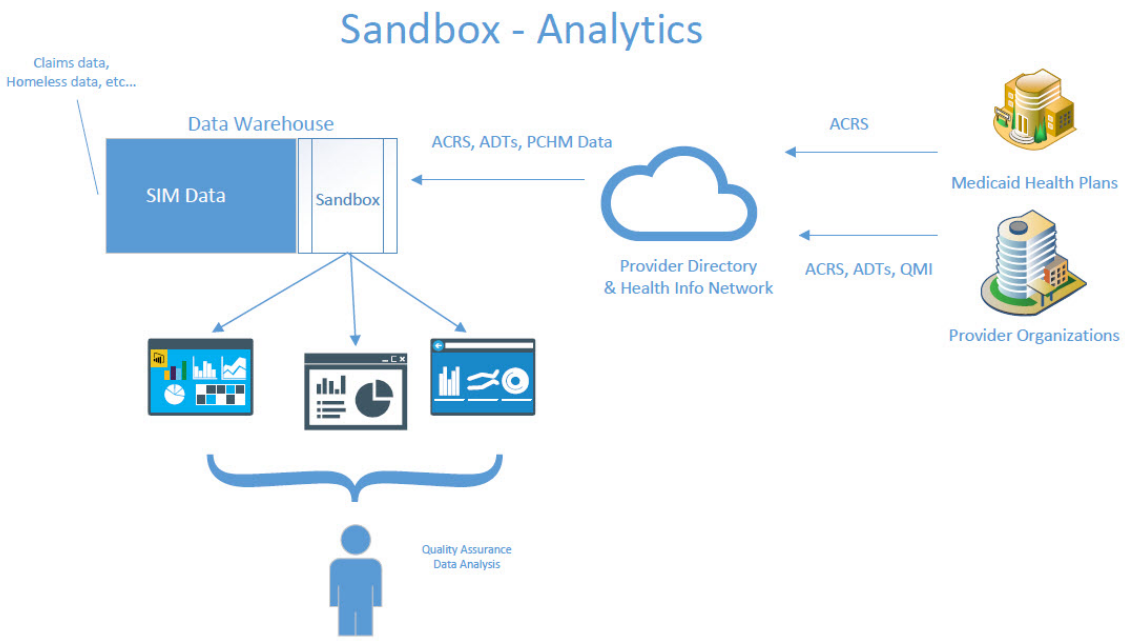
For Year 3 of SIM the technology team, working with the Care Delivery team, focused on expanding the quality and utilization measures. With the continued onboarding of Quality Measure Information (QMI) data from PCMH participants, expanded metrics were rolled out that utilized this data. This allowed the SIM program the ability to monitor the performance of providers and provider organizations on a wider range of measures.

Going Forward

Moving into Year 4 of the SIM model test, SIM will work with the SIM Care Delivery team on the transition of the performance metrics and reporting to the Medicaid Health Plans.

Sandbox Use Case

Figure B.2-5 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

During Year 3 of SIM, the sandbox played an integral role in the quality assurance and data analysis for the optimization of the RAMP. SIM resources analyzed provider files, ACRS messages, and other data sources to mature the attribution logic.

The introduction of housing and homeless data into the Sandbox allowed the SIM Technology team the ability to support the MDHHS and CHIR initiatives to reduce homelessness. Technology infrastructure and processes were implemented to receive Homeless Management Information System (HMIS) and Medicaid data into the Sandbox where extensive data analysis was performed by the technology team. Because of this analysis the SIM technology team was able to provide a prioritized list of homeless individuals with high emergency department utilization that would be eligible for housing vouchers.

Future

The sandbox and analytic tools will continue to be leveraged to accelerate the ability to produce population health and other non-claims based measures. For Year 4 of SIM, the team is working to capture both PCMH and CHIR social determinants of health data. This data is needed by the SIM Evaluation team for evaluation purposes, as required by the program.

A second area of focus is the ongoing data quality analysis of the RAMP and data exchange use cases such as ADT and ACRS.

For Year 4 of SIM, the team is evaluating all initiatives that have been pursued within the sandbox. The team will look to transition those that are sustainable to the state's data warehouse team, who will continue to support approved users.

Housing Data

The Housing Analytics Sandbox project was 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.

Progress to Date

The SIM Technology team, working with the Michigan Coalition Against Homelessness state agency and MDHHS, was able to define data and technical requirements for gathering HMIS data. Once defined, the team implemented technology and processes to pull HMIS and Medicaid data into the SIM Sandbox for analytics purposes. The team was able to perform extensive analytics around this data and provide detailed reports to appropriate stakeholders.

Future

The Sandbox will be used to continue to analyze the HMIS and Medicaid data to meet the CHIRs' housing initiatives. 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 and Care Delivery initiatives.

Progress to Date

The state has many initiatives in motion to collect social determinants of health data. Currently, the SIM technology team is working with the state's network of networks to begin architecting the technology needed to capture PCMH social determinants of health data for evaluation purposes. SIM is also working with the CHIRs on their need to capture social determinants of health data, also for evaluation purposes. Both of these initiatives require the review, and in some cases the creation of, data usage agreements to ensure that any data flowing among interested parties is approved and secure.

Future

For Year 4 of SIM, the technology team will focus on supporting the two initiatives described above: PCMH social determinants of health data capture and CHIR social determinants of health data capture. The team will continue architecting and implementing the solution needed for PCMH social determinants of health data capture and will monitor the CHIR data needs as that initiative evolves.

Care Coordination Enablement

The high visibility of provider performance and patient movement within the health care ecosystem 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:

- 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

Year 3 of SIM yielded two principal accomplishments in the Care Coordination Enablement pillar. First, HIE completed the onboarding of Clinical Quality Measures data from PCMH providers and participants. Second, ADT messages are flowing to all PCMH participants.

Onboarding this clinical quality data has served as an important demonstration of how clinical quality data can be used 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. With the flow of clinical quality measures data, the Care Delivery team was able to provide expanded quality measures to the PCMH providers and participants to help with care coordination.

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

Some of the PCMH providers had challenges providing the necessary data to support the quality measures initiative, either due to technology or staffing resources. The state worked closely with its partner, MiHIN, to help support those who needed more onboarding help.

Going Forward

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.

Statewide Admission, Discharge, and Transfer Notification Service Use Case

The Statewide 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, some of the ADT messages are being reviewed as part of the CHIR Housing initiative to evaluate the feasibility of using the data as part of the formula for understanding high emergency department utilizers.

Clinical Quality Measure Reporting and Repository Use Case

The Clinical Quality Measure Reporting and Repository (CQMRR) 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 is leveraging the growing infrastructure of Quality Metric Reporting to help collect data for the quality component of SIM. Participating physicians and their physician organizations provide necessary data to MiHIN, who then routes this data to entities with permission to utilize this data.

Progress to Date
During Year 3, MiHIN started accepting quality measure information from physicians and provider organizations. Clinical Data is currently moving from MiHIN to the state's vendor and is being rolled up into quarterly quality and utilization dashboards.

The dashboards generated by the Michigan Data Collaborative on behalf of MDHHS are available to Participating providers within the SIM PCMH Initiative. The dashboards contain regular reports, including Patient Lists, delivered on a monthly basis identifying Medicaid beneficiaries that are attributed to the provider and eligible for the Initiative; care management and coordination reports, identifying the services that are being captured through the claims submission process; and quarterly releases, refreshing quality and utilization measure performance. While participating practices vary in their utilization of the dashboard, many use the dashboard in order to:

- Understand the eligible patient population.
- Target individuals for care management and coordination services (based on patient list or quality indicators).
- Track claims submission/adjudication and performance against initiative benchmarks.

- Identify gaps in service. Quality and utilization measures displayed on the dashboard can be “drilled down” to the patient level (depending on user access) to identify missed opportunities.

Future

During Year 4, the SIM Technology team will explore opportunities for MDHHS to maximize the potential of this use case, including but not limited to support for Medicaid Health Plans that choose to participate in the use case. The Medical Services Administration (MSA) will discuss the improvement of clinical quality measure data collection by MHPs, and as is the case in managed care, MHPs will have the flexibility to adopt these new requirements as they see fit. The SIM team suspects that there will be variability in the adoption by MHP, however, this will not be certain until the requirements for a sustained Care Delivery model have been identified as part of post-SIM sustainability planning. The CQMRR use case may be an option for some MHPs to implement this MSA objective if it meets the desirable standards and business needs of an MHP.

Population Health Technology

The Community Health Innovation Region backbone organizations are responsible for serving their communities 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 technology solutions to capture social determinants of health data. This review created a foundation across all CHIRs that offered preparation for SIM to capture the social determinants of health data in Year 4.

Challenges/Lessons Learned

CHIRs were given the flexibility to utilize the best practices and any existing software and infrastructure to implement a data collection solution for SIM. Correspondingly, the five CHIRs are supporting their communities with different software packages and have different data collection requirements.

Going Forward

One of the critical challenges of the final year 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.

One of the technical challenges of collecting social determinants of health data from the CHIRs is the lack of standardization among the individual CHIR surveys. As the SIM technology team moves forward in defining the technical requirements to gather this data, it is considering ways to group survey questions that fall into the same social determinant. This will allow Michigan to collect non-standardized survey questions across multiple CHIRs and perform standardized evaluation and reporting. Despite this challenge, the state is moving with collecting social determinants of health data. The value of moving forward outweighs the challenges.

Technical Assistance

Progress to Date

Patient-Centered Medical Homes received practice transformation payments to support necessary technology and use case investments in practices. These payments were made at the practice level for the first 24 months of practice participation, and these payments were provided to enable early investments into transformation that will positively affect patient outcomes and satisfaction. The end of Calendar Year 2018 marks the transition from supportive infrastructure (practice transformation) payments. From that point on, participating organizations will be responsible for regular maintenance of health information technology and exchange participation.

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

Prior to this, some 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.

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. Ongoing technical assistance is expected to be identified, finalized, designed, and instantiated throughout the final year of the SIM grant.

Summary

Michigan has achieved successes in using the RAMP to support Care Coordination Enablement and Performance Metrics and Reporting. The onboarding of 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 has allowed the team to produce 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 continued to support the Population Health Technology initiative by coordinating with CHIRs as they developed their software to collect information about social determinants of health. Michigan will continue to develop this technological pillar throughout Year 4 as it looks to implement the necessary data usage agreements and infrastructure needed to collect the CHIRs' social determinants of health information and to make the CHIR organizations sustainable beyond the SIM period.

B.2.e WORKFORCE CAPACITY

MDHHS works across a multitude of partners to develop capacity in Michigan to build and enhance skills across the workforce. A number of ongoing activities have developed skills through collaborative learning, technical assistance, and peer to peer learning. The following activities have increased skillsets within Michigan's workforce. The SIM team has leveraged some of these resources throughout the cooperative agreement.

Workforce Collaboration with Universities

The Michigan Area Health Education Center (MI-AHEC) is a collaborative partner 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 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 the 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.

Care Management Workforce Capacity

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 developed a standardized set of requirements for care coordination and training 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 number of trained care coordinators through the 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 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 continues 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.

Annual Summits

The PCMH Initiative will support three 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.

Office Hour Sessions

The PCMH Initiative has streamlined several of its collaborative sessions into monthly office hour sessions to provide operational, technical, topic-based, and current health care policy information in a timely and concise manner. Using a webinar format, participants are able to access sessions that will both inform and allow for peer learning. Topics are determined based on Initiative current happenings, trends throughout the Initiative, and through feedback from PCMH Initiative participants.

As part of this offering, a Pediatric Office Hour Session was added in 2018. The PCMH Initiative offers three Pediatric Office Hour Sessions in 2019. They are one hour in length, and a recording is made available.

Community Health Worker Requirements

The Michigan Community Health Workers Alliance (MiCHWA) is identified as an integral source for community health worker information. Agencies are coming to MiCHWA for information about the community health worker role, resources to support community health worker employment, and research to make the case for why community health workers are essential health care team members. MiCHWA continues to find new ways to engage community health workers 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. 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 community health worker curriculum.

CHIRs have been using SIM resources to train community health workers to increase capacity. The state is drafting a budget request (Proposal for Change) to fund the development and implementation of a community health worker certification process and registry. This is viewed as a crucial next step in pursuing the ability to bill for community health worker work and engaging additional funders such as Medicaid and Commercial Health Plans.

School Loan Repayment

Michigan maintains the Michigan State Loan Repayment Program to assist employers in the recruitment and retention of medical, dental, and mental health care providers by providing loan repayment to those who enter into Michigan State Loan Repayment Program 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. Michigan State Loan Repayment Program 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 align the work of SIM across various state and federal initiatives to improve service delivery of health care. The leadership team continues to align policy efforts through active participation of key leadership at the department, including the MDHHS Chief Deputy Director and an executive governance team comprised of senior deputy directors in three MDHHS administrations: Medical Services Administration, Population Health Administration, and Policy, Planning, and Legislative Services Administration. The following are examples of programs where Michigan has been able to align SIM and department efforts to enhance service delivery and reduce potential duplication.

MEDICAID INNOVATION ACCELERATOR PROGRAM FOR HOUSING

Michigan was selected and has begun implementation of a Medicaid Innovation Accelerator Program targeting housing and health care services for the most vulnerable homeless and high Medicaid utilizers. The SIM Population Health team leveraged the Innovation Accelerator Program-based training and technical assistance to support the CHIR housing initiative.

This innovative program aims to:

- Use integrated data to identify a set of Michigan’s most vulnerable individuals
- Help these residents access crucial services

- Increase the capacity of agencies to bill Medicaid for housing case management services

Using data from HMIS and Medicaid claims, MDHHS will identify a set of individuals within the five CHIRs who are chronically homeless and utilize emergency rooms at high rates. The CHIRs will connect these people with high-quality case management services, with the goal of transitioning them into permanent housing and offering them health services and other services that will decrease emergency visits. At the same time, MDHHS will be supporting CHIRs in making improvements to housing support systems in their communities. MDHHS will also provide support and training for housing service providers. The department will help providers bill Medicaid for housing services and build capacity both in and outside of CHIRs to do so.

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 in 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. This past year, education efforts regarding behavioral health needs have led some practices to certify staff as specialists so they can bill for services.

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 function as a service provider referral resource. The MI Care Team program maintains approximately 4,000 beneficiaries enrolled in the program as of November 2018.

OPIOID HEALTH HOMES

Michigan has launched an opioid health homes model in October of 2018. This is a collaborative model utilizing Section 2703 of the Affordable Care Act, which allows states to design comprehensive care coordination for Medicaid beneficiaries with chronic conditions. In the northern Michigan CHIR area, the Northern Michigan Regional Entity (Region 2 Prepaid Inpatient Health Plan) is partnering with the Michigan Department of Health and Human Services to provide treatment for persons with Opioid Use Disorder in Michigan's Northern Lower Peninsula. The program is aimed at providing cutting edge recovery-oriented services to combat the rise of drug overdose deaths that has more than tripled since 1999. The organizations selected to provide health home services in the Northern Michigan region can utilize their CHIR for connection to community partners and may also serve as a service provider referral resource.

TECHNOLOGY INTEGRATION

The PCMH Initiative will build upon and continue work with the Michigan Data Collaborative, 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. Dashboards now include both claims-based and clinical data-based measures. 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. The data will be collected through existing technology solutions such as MiHIN and the state's data warehouse.

To further support participants, the Michigan Data Collaborative distributes a PCMH Patient List and aggregate patient count reports, which will be accessed via the secure portal. The Michigan Data Collaborative 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 Michigan Data Collaborative Portal User Acknowledger (the responsible contact for a participating organization) will affirm who should have access to the Michigan Data Collaborative portal from their participating physician organization or practice. Those affirmed will be provided access as a Michigan Data Collaborative Portal User to download patient lists and other reports and view the measures Dashboard (when available).

ADT 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.

ALTERNATIVE PAYMENT MODEL INTEGRATION

The Medicaid APM strategy uses 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 developed the Medicaid Health Equity Project in 2010 in partnership with its Medicaid Health Plans to identify racial and ethnic health disparities. Beginning in 2016, Michigan Medicaid managed care provided incentives to its MHPs to reduce racial disparities in key quality measures. Key priorities have included Chlamydia screening, timeliness of prenatal care, and low birth weight rate. While some improvements have been made in reducing the gaps in care experienced by Black Medicaid managed care beneficiaries relative to their White counterparts, statistically significant disparities remain for nearly all 13 HEDIS quality measures being analyzed as part of the Medicaid health equity report. In the future, Michigan will expand the list of HEDIS-specified measures being used to assess for racial and ethnic disparities, extract and calculate these disparities using the Medicaid data warehouse, and leverage these data to develop benchmarks and incentives for reducing disparities across the entire Medicaid managed care program in partnership with its MHPs. These new measures and incentives, some defined regionally, will position both CHIRs and PCMHs as potentially helpful partners in addressing racial and ethnic health disparities. Additionally, contract language and incentives will increasingly focus on social determinants of health, further encouraging MHPs to collaborate with CHIRs and PCMHs and other community coalitions.

INTEGRATED SERVICE DELIVERY

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 has also received a new user-friendly look and is mobile-friendly, allowing customers to more easily use MI Bridges from their smartphone or tablet. Community partners within CHIRs have the ability to register in MI Bridges as a local assistance agency.

Additionally, the Integrated Service Delivery initiative launched the Universal Caseload system. Universal Caseload has provided the ability to distribute casework among offices and business service delivery areas using a task-based case management processes. With this system, specialists 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 was 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 provides case/benefit information and routes the caller to the most appropriate local team to answer their question. SIM is providing information to local PCMHs and CHIRs on how to effectively utilize the portal and will spend time in Year 4 exploring how to connect all information being gathered regarding social needs screenings.

BEHAVIORAL HEALTH INTEGRATION

The Section 298 Initiative is a statewide effort to improve the coordination of physical health services and behavioral health services in Michigan. This initiative is based upon Section 298 in Michigan Public Act 268 of 2016. The Michigan legislature approved a revised version of Section 298 as part of Public Act 208 of 2018.

Under the revised Section 298, the legislature directed the department to develop and implement up to three pilots and one demonstration model to test the integration of physical health and behavioral health services. The Department selected the three pilot sites in March

2018 through a Request for Information process. The pilot sites include: Health West and West Michigan Community Mental Health; Saginaw County Community Mental Health Authority; and Genesee Health System.

The Department is working with the Community Mental Health Service Programs and Medicaid Health Plans in the pilot sites to complete the implementation process. SIM has targeted this initiative for potential collaboration opportunities in Year 4. Once these pilots are fully operational, they have the potential to greatly influence the structure and performance of Michigan's health care system.

ACCOUNTABLE HEALTH COMMUNITY

The work of SIM aligns with the Federal Accountable Health Communities model. The MDHHS CHIR Business Owner has met with leaders from the Health Net of West Michigan. The business owner has invited their participation in convenings with regional CHIR representatives, and will include them in sustainability conversations. Michigan sees overlap and alignment with the Accountable Health Community model, as both models promote clinical-community collaboration in the following areas:

- Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs.
- Referral of community-dwelling beneficiaries to increase awareness of community services.
- Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services.
- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.

OTHER CMMI EFFORTS

Michigan continues to improve quality through its practice transformation network. In collaboration with the Altarum Institute, the Great Lakes Practice Transformation Network (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 continues discussions with a CMMI vendor, TMF Health Quality Institute, to build out a plan for those providers that are in both CPC+ and PCMH to align and share resources and goals in transformative projects. One example where Michigan has aligned the programs between PCMHs and CPC+ is social needs screenings. PCMH staff continue to provide presentations at CPC+ trainings to further align the various federal programs.

The SIM team continues to work 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

Building upon the core model established in Award Year 3, the Medical Services Administration (MSA) and Medicaid Health Plans (MHPs) will jointly develop comprehensive requirements, standards, and policy for sustaining the State-Preferred Patient-Centered Medical Home (PCMH) Model that supports the delivery of care management and coordination services to Medicaid managed care beneficiaries. To this end, MSA and the MHPs will continue to work collaboratively to sustain the model of care and Alternative Payment Models (APMs) supported within the SIM Care Delivery component, PCMH, and other related initiatives.

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.

The provision of care management and coordination (CM/CC) 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 Calendar Year 2019. Additional requirements detailed that one CM/CC staff member must be a licensed professional, a care manager as defined by the initiative, and all subsequent CM/CC staff could be either licensed care managers, or non-licensed care coordinators.

In PCMH Initiative Calendar Year 2019, participants will be required to maintain their embedded CM/CC staff teams to support the provision of CM/CC services. Participants will be measured on the percent of attributed beneficiaries that are receiving CM/CC services. The measurement of CM/CC services began in 2017 with a set of procedure codes specified by the initiative. Starting in CY 2018 the Initiative implemented a quarterly CM/CC benchmark of 2.5%

The Michigan Department of Health and Human Services (MDHHS) utilizes a set of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes to identify CM/CC services for SIM PCMH Initiative eligible populations. MDHHS does not currently utilize a risk stratification process within the demonstration attribution, therefore all

attributed beneficiaries within the Initiative are eligible for CM/CC services. Claims with these service codes are utilized in the calculation of participant performance.

As all but 2 of the 12 codes in use within the SIM PCMH Initiative are new to Michigan Medicaid and are considered tracking-only codes, MDHHS and the SIM PCMH Initiative stakeholders experienced some barriers in the initial roll out of the tracking process. Barriers included PCP limitations in processing/submitting tracking codes as claims to their respective payers (MHPs), Michigan Medicaid Health Plan timely and appropriate adjudication of tracking codes, and MDHHS' ability to appropriately process tracking codes. The introduction of the CM/CC tracking codes occurred in January 2017. The duration of the 2017 calendar year was used to identify and begin to mitigate the barriers encountered with service tracking.

Beginning in 2018, processes were put into place to support the further development of a benchmark using the claims with these tracking codes as a foundational element. Due to the barriers experienced in the introduction and use of the tracking codes, MDHHS utilized both 2017 and participation year as a data gathering period, to draw a baseline performance and develop a benchmark for 2018 service delivery.

The 2.5% benchmark was developed recognizing the barriers providers and MHPs have experienced in this new process. The benchmark will remain at 2.5% in the 2019 participation year. However, as a part of the MDHHS APM Strategy, the State Preferred PCMH Model will require MHPs to utilize the CM/CC tracking code set as a function of data capturing, not only for provider, but for plan performance toward their APM requirements. MDHHS believes this is the precursor towards supporting a transparent mechanism for ensuring beneficiaries receive the needed CM/CC services, and for MDHHS to better identify priority populations for these services.

Beginning in CY 2019, the PCMH Initiative will implement a Care Management Improvement Reserve, where a portion of the per member per month payment will be retained by MDHHS for poor performance on the 2.5% care management benchmark. Participants will have the opportunity to earn the Care Management Improvement Reserve back through satisfactory performance against the CY 2019 performance benchmark (also set at 2.5%).

The set of procedure codes that will be accepted in 2019 are outlined below.

- Comprehensive Assessment (G9001)
- In-Person CM/CC Encounter(s) (G9002)
- Telephone CM/CC Services (98966-98968)
- Education/Training for Patient Self-Management (98961, 98962)
- Care Transitions (99495,99496)

- Care Team Conferences (G9007)
- Provider Oversight (G9008)
- End of Life Counseling (S0257)

Over the first two years of the Initiative, MDHHS has experienced barriers with the implementation of the tracking codes. However, continued focus on this aspect of the Initiative has provided some opportunity to engage all stakeholders to improve appropriate adjudication of these codes to ensure accurate representation of the care management services that are being provided at the participant level. At this point MDHHS has confidence in the process and the mechanisms in place to support participants, Medicaid Health Plans, and internal teams to implement the Care Management Improvement Reserve in the final year of the SIM-funded PCMH Initiative.

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. In November 2017 the Initiative mandated the administration of a screening tool to assess social determinants of health needs that match domains approved by MDHHS. The approved domains include: Health Care; Food; Employment and Income; Housing and Shelter; Utilities; Family Care; Education; Transportation; and Personal and Environmental Safety. The tool also includes the required assessment of urgency of the identified needs. Participants are also required to implement 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 2019, MDHHS will continue to support participants in the execution and refinement of their Clinical-Community Linkages design. Additional practice transformation efforts within the CY 2019 PCMH Initiative will be focused on population health management. All participants will be required to empanel at least 95% of their patient population, and 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. The Initiative plans to continue the requirement of Population Health Management and Clinical-Community Linkages to support practice transformation objectives.

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). In 2018 the Initiative expanded opportunities for participant support and learning activities. Based on positive feedback

received from participants, the Initiative will continue to provide these opportunities to ensure enhanced capabilities and functions of participants.

The Initiative will require attendance at 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 courses required 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.

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 2019. 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
- Effective use of initiative measures and dashboards
- Operating efficiently as a multidisciplinary team and maximizing the efforts of all team members, licensed or otherwise
- Effectively operationalizing Clinical-Community Linkages

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.

In 2018, a planning committee was created and leveraged to help inform Care Coordination Collaborative event planning and ensure activities met the needs of participants at the local level. The membership of the Care Coordination Collaborative Planning Committee was purposefully comprised of representatives from MHPs, Community Health Innovation Regions,

MDHHS staff, and Initiative participants to ensure that stakeholders integral to care coordination were included. Data collected from 2018 events is informing event planning for future events, including at least one in-person event in 2019. Feedback from the Care Coordination Collaborative planning committee resulted in the creation of living resource documents to provide contact information that will foster local care coordination connections and networking between Medicaid Health Plan, Primary Care Provider, and community-based organization care management staff. These resource documents allow coordination across the levels of care within the community. The Care Coordination Collaborative is looking towards the long-term sustainability of the relationships created in 2018, and it will seek to foster them in the events of 2019.

Listening Sessions

New in 2019, the PCMH Initiative will be coordinating live listening sessions for participants. Participants will be able to join the conversation and the development of a comprehensive care delivery system that supports whole-person centered care through care management and coordination to follow the SIM funding period. These sessions will be offered both live and via webinar, and will gather participants across disciplines and geographic areas to identify what they see as the key components of "sustainability." These sessions will also be opportunities for MDHHS to update PCMH Initiative participants on the activities planned, completed, and underway to support their vision of sustainability.

Annual Summit

In the first year of the PCMH Initiative, the Initiative executed a regionalized event approach in the form of annual summits hosted in multiple regions throughout the state. In SIM Year 2, efforts were made 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 2018, the Initiative convened a planning committee to help inform the creation of the annual summit, ensuring the focus would support all care team members. The Summit Planning Committee began meeting in early 2018 and informed all logistical decisions such as venues, format, agenda/break-out session topics, speaker composition, etc.

The 2019 Annual Summit will leverage previous learning successes and feedback to bring a robust leaning opportunity for all attendees in each of three regions. The planning committee members will serve as Summit ambassadors to facilitate a peer-learning environment and encourage ongoing networking and collaboration among Initiative participants.

Technical Assistance

The method for providing targeted technical assistance in SIM Year 4 will remain unchanged. Participants will have the ability to submit questions or requests for information to the established listserv and appropriate staff members and to access resources on the designated

webpage. Initiative staff will also deliver on-site technical assistance as appropriate. Initiative staff are available for focused calls/meetings with participants as requested.

Payment 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. A portion of allocated Medicaid funds are used exclusively in a payment directed to support the development of a robust care management and coordination workforce and service delivery. 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. Beginning in January 2019, the PCMH Initiative will add a quality performance incentive payment based on participant performance. This payment will be a combination of quality and utilization measures and will leverage the current Michigan Data Collaborative dashboard for monitoring and compliance. This payment is known as the Performance Incentive Program.

While the Care Management and Coordination PMPM is designated as Healthcare Payment Learning and Action Network (LAN) Framework Category 2A payments, the Performance Incentive Program that will be introduced in 2019 will move the PCMH Initiative payment model to a LAN Framework 2C payment, incentivizing providers for quality vs. quantity of service. Participants receive retrospective quarterly PMPM payments based on monthly initiative attribution, described in Section B.2.d. Performance Incentive Program participants are additionally required to meet specified performance benchmarks to avoid payment sanctions or recoupment. The Performance Incentive Program payment will be provided retrospectively based on performance. The combination of these two payments will allow for not only consistent staffing and resource allocation, but will also incentivize providers to meet quality goals.

While Medicaid funds are leveraged through the PMPM payments to support the model of care and continued participant infrastructure improvements, SIM grant funds are planned for capacity building, to further developments from the 2018 PCMH Initiative, and to support practice transformation sustainability. Through the 2018 PCMH Initiative, participants placed a great deal of effort into ongoing care delivery improvements to meet performance metrics. In particular, participants were required to report on operationalization and ongoing improvements to Clinical-Community Linkages, testing and improving tools to screen for social need, refining screening plans and methodologies, building relationships with community-based partners, and implementing quality improvement activities to support continued enhancements of the efforts. In addition to the required Clinical-Community Linkages, participants further transformed their practices by pursuing a population health strategy and

building internal capacity to consume and act upon information provided by Health Information Exchange Use Cases.

In 2018, continuing the efforts from previous years and building upon investment at each practice to implement sustained practice transformation efforts, the PCMH Initiative utilized SIM grant funds to deliver a one-time capacity-building payment. This payment was awarded to eligible participants to enable them to continue their efforts to integrate practice transformation efforts such as Clinical-Community Linkage design into current workflows. This included integrating 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 work was done in conjunction with the CHIRs in the five communities participating in SIM.

In Award Year 4 PCMH Initiative participants will be required to report on their use of the One-Time Financial Support for Capacity Building award and how it improved their practice transformation efforts.

Performance Monitoring and Initiative-Provided Feedback

Throughout PCMH 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. The maintenance of basic participation requirements such as core primary care capabilities is assessed during a quarterly progress report process and through random site audits. Detailed information on clinical practice improvement activities, Clinical-Community Linkages, and population health management is gathered during semi-annual practice transformation reporting. 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 PCMH Initiative provides a monthly downloadable patient list to initiative participants. This download contains the attributed population of participating providers. In 2018 these reports were expanded to include specific patient demographic information, payer information, and other pertinent information to support patient outreach and service provision.

Care Management and Coordination Tracking Reports

The Initiative provides both a monthly report and quarterly downloadable reports to participants. The quarterly reports contain CM/CC 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-out (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 CM/CC services.

The initiative also provides both a monthly report and quarterly downloadable reports to participants regarding the CM/CC follow up after inpatient discharge measure. These reports contain 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 CM/CC 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-out.

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. Starting January 2019, the PCMH Initiative will reserve a portion of the PMPM payment based on participant performance in three previous quarters (Q4 2017, Q1 2018, and Q2 2018). Participants will have the opportunity to earn the reserve back if their performance meets Initiatives benchmarks in 2019.

Interactive Performance Dashboard

The Initiative will continue to release an interactive, online performance dashboard to be utilized by 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 the transition from HEDIS 2015 to HEDIS 2018 specifications is complete.

Performance Monitoring Beyond SIM

Ongoing strategy discussion and direction will continue in SIM Year 4 regarding the continued 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 for 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. This includes some near-term growth through the definition of a state-preferred PCMH model, part of the SIM APM strategy, which substantively represents the core elements of the PCMH Initiative.

During the 2018 participation year, Michigan leveraged experience gained through the SIM Program and MHP APM implementations to collaboratively develop a core set of provider requirements for the state-preferred PCMH APM model. MHPs can operationalize these requirements with providers beginning in 2020. Collaboration will continue in the 2019 participation year to further define MHP responsibilities and identify areas to expand the core model to a comprehensive model over time, taking into consideration risk stratification, provider compliance monitoring, and quality improvement. The state-preferred model will serve as a vehicle for providers participating in the current PCMH Initiative to continue their care management and care coordination services for Medicaid managed care beneficiaries in partnership with MHPs. It may also offer the opportunity to engage providers not currently participating in PCMH with MHPs. 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. MDHHS will also explore a sustainable payment strategy to support care management and care coordination services for Medicaid managed care beneficiaries.

This approach, while structurally different than the current SIM PCMH Initiative, is the most sustainable trajectory that MDHHS has identified to date to continue supporting advanced primary care in Michigan. 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.1-1 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**
Performance and Compliance Monitoring	Care Management / Care Coordination (CM/CC)	(Reference ID[RID] 1) Implement 2018 CM/CC performance measures compliance plan	Q1	MDHHS, SIM PMDO
		(RID 1) Implement 2019 CM/CC performance measures compliance plan	Q4	MDHHS, SIM PMDO
		(RID 2) Produce PCMH monthly, and quarterly CM/CC reports	Q1 - Q4	MDC
	Compliance Monitoring and Reporting	(RID 3) Release participant progress report – a mechanism to monitor core program requirements, including: Care Manager and Care Coordinator requirements, PCMH core capability requirements and HIT/HIE requirements	Q1 & Q3	MDHHS, University of Michigan Health System (UMHS), SIM PMDO
		(RID 3) Receive and evaluate participant progress reports	Q2 & Q4	MDHHS, UMHS, SIM PMDO
		(RID 3) Release participant semi-annual practice transformation report as a mechanism to monitor practice transformation progress reporting requirements	Q2 & Q4	MDHHS, UMHS, SIM PMDO
		(RID 3) Receive and evaluate participant semi-annual practice transformation reports	Q3 & Q4	MDHHS, UMHS, SIM PMDO
		(RID 4) Ongoing monitoring of open participant Corrective Action Plans and performance improvement processes	Q1 - Q4	MDHHS, UMHS, SIM PMDO

Goal/Driver 1: Patient-Centered Medical Homes				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
Participant Support & Learning Activities	Virtual Meetings with SIM PCMH Participants: Annual Kick-Off, Quarterly Update, Monthly Office Hours	(RID 5, 6) Design and planning of events	Q1 - Q2	MDHHS, UMHS, CMRC, MDC, MiHIN and other vendors
		(RID 7) Implementation of live and virtual events according to technical assistance plan	Q1 - Q4	
	Annual Summits	(RID 5, 6) Design and planning, set up, overall theme, strategy	Q1 - Q3	MDHHS, UMHS, CMRC, MDC, MiHIN and other vendors
		(RID 7) Execution of live summits including coordination, facilitation	Q4	
	Care Manager and Coordinator Trainings and Skills-Building	(RID 8) Maintain ongoing Longitudinal learning virtual curriculum and trainings	Q1 - Q4	MDHHS, UMHS, CMRC
		(RID 8) Maintain ongoing Complex Care Management curriculum and trainings	Q1 - Q4	
Participant Payment Model Exclusion	Payment Disbursement	(RID 9) Review/approve quarterly participant payments based on monthly beneficiary and provider attribution counts	Q1 - Q4	MDHHS, State Actuary, MSA, SIM Governance
		(RID 9) Adjust quarterly payment per participant performance (as needed)	Q1 - Q4	
		(RID 9) Submit quarterly payment detail for gross adjustment to participating payers	Q1 - Q4	
	Participants Onboarding	(RID 10) State-Preferred PCMH application process setup if needed	Q2	MDHHS, UMHS, SIM PMDO, Care Delivery Governance
		(RID 10) Receive applications; vetted against eligibility criteria	Q4	MDHHS, SIM PMDO, UMHS
	Participant Information Maintenance Process	(RID 9) Process participant information change request as received throughout demonstration period	Q1 - Q4	UMHS
		(RID 9) Verify changes in Health Directory	Q1 - Q4	MDHHS

Goal/Driver 1: Patient-Centered Medical Homes				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
SIM PCMH Initiative Transition to MHP	Participant Communications	(RID 11) Develop formal transition plan in collaboration with APM workgroup through coordinated meetings and information sharing processes	Q1 - Q4	MDHHS
		(RID 11) Communicate transition plan through all appropriate channels as details are available	Q1 - Q4	MDHHS

C.2 ALTERNATIVE PAYMENT MODELS (APMS)

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 two years (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 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 4.

Long-Term Strategic Objectives/Goals

(All long-term APM strategy objectives represent multi-year goals that 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 payments made to providers by Medicaid Health Plans that include one or more APMs.
    - This objective measures total payments made to a provider through an MHP contract that includes an APM component. The objective will allow Michigan's Managed Care Plan Division 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.
    - This objective also measures dollars paid to providers by an MHP directly through an APM. The objective allows Michigan's Managed Care Plan Division to better understand the extent to which APMs have the ability to influence provider behavior, by proportional comparison to total payment.
2. Work with MHPs to substantially increase payment methodologies with a clear link to quality and outcomes.

- This objective reflects the Department's commitment to working with MHPs to increase provider payment methodologies that reward improvement in quality measure performance.

3. Ensure greater consistency in the measures used by MHPs to reward improvements in quality of care in APM contracts.
    - This objective reflects the Department's commitment to working with MHPs to define a set of quality measures. Incentives for these quality measures would be designed across all MHPs based on regional disparities in performance.

C.2.b STRATEGY NARRATIVE

During Fiscal Year 2018, the Department launched the first year of APM implementation and provided a platform to build upon in achieving the Department's APM strategic objectives over the course of the next two MHP contract years. MHPs submitted strategic implementation plans that were approved during FY 18. MHPs described significant use of category 2B payments (pay for reporting), and will be increasing the use of Categories 2A, 3, and 4 over the next three years. Shared savings models seem to be the key area of exploration as a way to add quality improvement incentives to their provider contracts. 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.

Objectives for FY 19:

- Continue to convene the Medicaid APM workgroup to coordinate and implement the APM strategy. This includes ensuring that staffing and contractor resources are retained, that status monitoring and reporting processes are completed, and that work moves forward to meet objectives.
- Utilize an MHP APM workgroup to collaborate with MHPs in the strategy design for leadership approval, to offer ongoing programmatic reference, and to monitor implementation of the Medicaid APM strategy.
- Design the incentive strategy to reward MHPs for contracting with PCMHs using the State-Preferred Model.
- Implement the process defined in FY 18 for MHPs to make updates and/or additions to their APM strategic plan and review/approve as applicable.
- Continue to refine, implement, receive, and analyze an alternative payment model reporting process to monitor MHP APM goals. These are specific numeric goals based on LAN categories.
    - MDHHS ensured that reliable and verifiable data was collected from all MHPs to establish the baseline for FY 16/17. Iterative submissions of data were compared

to previous MHP submissions as well as to other MHP submissions operating in similar regional service areas, overall capitation payments made to MHPs, and their year-over-year strategic targets. Any questions or needs for clarification regarding the data were then addressed through multiple rounds of interviews, modifications, and feedback. The intensive validation process took a year to complete, but was necessary should the Medical Services Administration decide to incentivize advancement of APMs using this metric and data collection process. This baseline informed goal-setting in FY 18 and will continue through FY 20.

    - MDHHS is using the Healthcare Payment Learning and Action Network APM Framework to define payment methodologies for reporting and goal setting/monitoring purposes. As the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program definition and criteria progress, MDHHS will consider the implications to APM strategy.

- 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.
- Define, implement, and conduct an APM component to the annual focus study/on-site review for each MHP to discuss APM progress and provide support as needed.
- Implement and monitor usage of a consistent subset of quality and outcome measures that further the overall Medicaid quality strategy.
- Implement APM-focused elements of the MHP performance bonus to further encourage APM goal achievement.

State and Federal Alignment

The Medicaid APM strategy uses the LAN APM framework as the basis for both goal creation and progress measurement. 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. It has been widely adopted. Michigan's approach is consistent with the way the United States Department of Health and Human Services established nationwide goals for value-based payments and APMs in Medicare. In addition, the approach supports providers pursuing the All-Payer APM Combination Option under the Medicare Access and CHIP Reauthorization Act's (MACRA) Quality Payment Program.

HIE Considerations

Certain APMs proposed or implemented by MHPs may benefit from existing infrastructure related to participating providers' use of Health Information Exchange technology. In particular,

these use cases are the Statewide Admission, Discharge, and Transfer (ADT) Notification Service use case, the Active Care Relationship Service (ACRS) use case, and the Clinical Quality Measure Reporting and Repository (CQMRR) use case currently being used 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 CQMRR use case is key in presenting a more comprehensive picture of quality of care, because it can enhance the quality data available to an MHP for use in evaluating the success of APM implementations, which are all linked to quality.

MDHHS will continue to work with MHPs to assess the validity of HIE attribution; the accurate dissemination of ADT and other use case information; the development of protocols for care management and care coordination associated with accurately attributed information (including accountable parties to action); and to evaluate the value that CQMRR may bring in structuring provider incentives for quality outcomes that cannot be fully captured using claims-based measures alone. This infrastructure and the related implementations are heavily based on validating and improving the accuracy of attribution using 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. Michigan's 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 if the MHPs choose to use the HIE infrastructure for their business needs. Without HIE technology, it would be quite difficult to demonstrate success in some of the APMs that MHPs and providers may wish to pursue, if the MHPs and providers do not already have a technical solution for receiving valid and reliable information from their providers. Medicaid is taking a collaborative, less-prescriptive approach to HIE with their Medicaid Health Plans. Though HIE encouragement will likely remain, the manner in which it is adopted will be more at the authority of the individual health plans, and the purpose will be focused on quality measurement and improvement rather than data sharing infrastructure without connections to monitoring for health outcomes and incentives for improvement.

C.2.c SUSTAINABILITY NARRATIVE

The Medicaid APM strategy will be a lasting element of Michigan's comprehensive contract with MHPs going forward. The objectives of the APM strategy are to improve quality, move away from fee-for-service, and ensure consistency in regionally-defined quality measure

incentives. The Managed Care Division is working with all 11 MHPs to achieve these objectives. As a result, numerous aspects have been inserted into normal operational processes between MDHHS and MHPs. Because of this, 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**
Communication and Coordination	Maintain Internal APM Coordination, Status Monitoring, and Governance Processes	(Reference ID[RID] 11-14) Maintain ongoing internal APM workgroup collaboration into 2019 to continue to develop APM strategies and goals; target quarterly convenings (minimum)	Q1 - Q4	Managed Care Plan Division (MCPD)
	Maintain External MHP APM Workgroup Collaboration	(RID 11-14) Maintain bi-weekly MHP APM workgroup collaboration during operational meetings into 2019 to discuss timelines and deliverables for APMs	Q1 - Q4	MCPD
		(RID 11-14) Maintain weekly planning meeting to draft documents to inform MHPs of APM plans and activities	Q1 - Q4	MCPD
MHP APM Strategic Plans	Implement annual process for MHP strategic plan review and update	(RID 11-14) Collect and review APM Progress Reports – First submission (May), final submission (June)	Q2	MCPD
		(RID 11-14) Conduct site visits to MHPs to monitor and evaluate APM progress and barriers	Q2	MCPD
Data Collection Tool	Update tool	(RID 12) Update template and distribute to MHPs for completion; conduct technical assistance webinar to inform MHPs on proper completion of data collection tool	Q1	MCPD
	Collect, validate, analyze and report narrative quantitative data	(RID 12 & 13) Analyze, report, and share APM data to leadership and partners to evaluate and compare MDHHS to national trends	Q2	MCPD

Goal/Driver 1: Alternative Payment Models				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
APM Quality Strategy	Review and enhance quality approach to APMs	(RID 13 & 14) Pull, clean, and analyze quality metrics to identify performance disparities. Complete analysis of regional measures to evaluate effectiveness of regional measure approach	Q3 - Q4	MCPD
		(RID 13 & 14) Complete additional analysis to identify opportunity to expand measure set to include in APMs	Q3 -Q4	MCPD
		(RID 13 & 14) Pull, clean, and analyze quality metrics for plan-specific measures to identify year to year trends.	Q3 - Q4	MCPD
APM Bonus Program	Leverage the MHP Capitation Withhold to Sustain PCMH in MHPs	(RID 11) Define quantifiable sustainability goals for PCMH sustainability	Q1	MCPD
		(RID 11, 13 & 14) Collaboratively validate sustainability goals and develop measures to pursue sustainability goals with MHPs	Q1 - Q2	MCPD
		(RID 11, 13 & 14) Develop bonus withhold programs to achieve sustainability goals, including alignment with regional measures needing quality improvement	Q1 - Q2	MCPD
		(RID 11, 13 & 14) Implement bonus program for PCMH sustainability with clear deliverables from the MHPs	Q3- Q4	MCPD

C.3 MULTI-PAYER ALIGNMENT (MPA)

Michigan's 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 previous Multi-Payer Advanced Primary Care Practice Demonstration; and the development of sustainable multi-payer payment methodologies.

Previously, MDHHS engaged a large multi-payer and multi-stakeholder group of collaborators to design a delivery system and payment reform approach that 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 in 2016 which served as a starting point for discussions with 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. Subsequently, increased staffing and systems demands placed on the Medical Services Administration during SIM Award Year 3 in preparation for implementation of legislatively enacted Medicaid work requirements have further hindered meaningful progress towards multi-payer alignment.

MDHHS has reassessed the feasibility of proceeding with the delivery system and payment reform approach developed in 2016. Given the continued challenges related to federal health care reform and the impacts on state resources to address major legislative changes, Michigan will not be able to commit to a large multi-payer initiative during SIM Award Year 4. MDHHS has reframed its approach and is focusing on non-payment facets of multi-payer alignment, such as health technology and quality measures, to facilitate broader payer collaboration. These facets offer a near term alternative to continue the conversation with stakeholders around 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 future payment-focused multi-payer efforts with CMS and other payers in Michigan.

C.3.a END STATE VISION NARRATIVE

MDHHS' goal for current multi-payer efforts is to pursue 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 to reduce the potential for provider burden.

Objectives

Throughout the SIM award, 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. 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 the continued pursuit of:

- Regional Measure Incentive Alignment
    - Provider feedback often refers to the challenges and burden of pursuing incentives from multiple providers around multiple (unrelated) measures. MDHHS plans to explore alignment opportunities amongst the Medicaid Health Plans and other payers operating within the same regional area and working to align quality metric incentives. The intent will be to focus on one primarily poorly performing measure across payers within the region.
- 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 between the SIM PCMH Initiative and CPC+ program.
- 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
    - Continue to monitor and maintain alignment of care management and coordination coding conventions implemented across the SIM PCMH Initiative, commercial partners, and nationally as much as possible while identifying the future state of care management and coordination implementation and tracking.
- Care 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.
  - Payer participation varies between the CHIR regions. Currently,
    - Genesee has one MHP participating, plus Blue Cross Blue Shield of Michigan.
    - Muskegon has one MHP participating.
    - Northern Michigan has two MHPs participating.
    - Jackson has two MHPs participating.
    - Livingston/Washtenaw has six MHPs participating.

C.3.b STRATEGY NARRATIVE

- Regional Measure Incentive Alignment
  - MDHHS will work with MHPs and other payers on aligning quality metric incentives on a regional basis and focus on one primarily poorly performing measure across payers within the region. This process would not require changes to existing systems already in place, but it would be instrumental in emphasizing areas where a shared quality improvement is recognizably needed. This will also provide a certain level of consistency to the providers participating in multiple quality improvement programs.
- 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 has altered PCMH Initiative participation requirements to match CPC+ requirements where the requirements had a shared purpose. This process will continue during SIM Award Year 4. Post-SIM, the state will explore contractual guidelines to

ensure MHPs move towards aligning their PCMH requirements as 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. These meetings range in purpose from comparing implementation details to ensure coherent obligations for participating providers, to avoiding large scheduling conflicts for participant events. This collaboration will continue through the end of SIM and more frequent communication outside of the formal meetings will be pursued as needed.
- Care Management and Coordination Coding Alignment
    - MDHHS uses a set of care management and coordination service tracking codes which in large part matched those used by Michigan's large commercial payers. MDHHS has aligned these coding sets both in terms of the codes used and the definitions/billing requirements. This was done in order to streamline the coding, billing, and monitoring aspects of care management and coordination services across payers/programs. MDHHS will continue to monitor and revise coding as the need arises.
- Care Coordination Collaborative
    - MDHHS sponsors a care coordination collaborative for current SIM participants and Medicaid Health Plan payers. These members collaborate in determining methods to most effectively use care management and coordination resources to support networking. They also facilitate exercises to align efforts, reduce potential duplication of services, and identify methods of collaboration for shared beneficiaries. MDHHS anticipates this work will likely have applicability to a broader payer group in the future.
- Participation in CHIR 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.

C.3.c SUSTAINABILITY NARRATIVE

The sustainability of MDHHS' multi-payer efforts as originally presented in previous operational plans was significantly impacted by legislative changes on the federal and state levels of government. Federal changes through the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) made the State's multi-payer model less interesting to Medicare and provided a policy lever to align Medicaid Health Plans

with provider-facing incentives from Medicare. Coupled with this, the increasing demands on employee and systems resources to accommodate state legislative changes has led Michigan to recognize that it will not be able to commit to a large multi-payer initiative during SIM Award Year 4. However, the state has reframed its approach and is focusing on non-payment facets of multi-payer alignment, such as health technology and quality measures, to facilitate broader payer collaboration. The foundation established during SIM's fourth year will set MDHHS up for future multi-payer opportunities. These include:

- Sustaining the PCMH core model of care and primary care transformation through the Medicaid Health Plan contract and the department's APM efforts to encourage expansion.
- Maintaining a level of commonality in requirements across all payers to reduce provider burden and for future transformation opportunities.
- Continued collaboration, participation, and leadership in the creation and refinement of HIE use cases.
- Pursuing a concerted focus on the provider incentives placed on one or more poorly performing quality measures between multiple Medicaid Health Plans and also other payers within a region.

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**
Regional Measure Incentive Alignment	Regional Measure Incentive Alignment – Reference ID(RID) 15	Present the Medicaid regional measure analysis to other payers, including data collection, analysis methodology, and findings by region	Q3	MCPD
		Present the Medicaid managed care incentive programs associated with this regional measure analysis to other payers including program criteria, incentives available to managed care plans, and provider-facing requirements	Q4	MCPD
		Investigate whether other payers can mimic the Medicaid regional measure analytical method	Q4	MPA Team
		Convene other payers and review the outcomes of their regional measure analysis (dependency upon outcome of prior activity)	Q4	MPA Team
		Discuss opportunities for aligning provider-facing incentives and requirements around commonly low-performing measures	Q4	MPA Team
HIE Use Case Implementation Alignment	Collaboration with commercial payers on HIE use case alignment – RID 16	Analyze the validity/reliability of existing use cases (ACRS and ADTs for example)	Q1-Q4	MPA Team, HMA
		Present the validity/reliability to Medicaid Health Plans	Q4	MPA Team, HMA
		Analyze the current incentives available to providers from MHPs related to using Use Cases	Q2-Q3	MPA Team

Goal/Driver 1: Multi-Payer Alignment				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Evaluate quality measure performance relative to the use of Use Cases	Q4	MPA Team, HMA
		Present Medicaid findings of Use Case validity/reliability and provider uptake for managed care beneficiaries to other payers	Q4	MPA Team
		Investigate whether other payers can mimic the Medicaid analytical method	Q4	MPA Team
		Convene other payers and review the outcomes of their Use Case analysis	Q4	MPA Team
		Discuss opportunities for aligning provider use of Use Cases as it relates to improving quality of care	Q4	MPA Team
Care Management and Coordination Coding (CM/CC) Alignment	Maintain alignment of CM/CC Coding Sets Across Payers/Programs	(RID 17) Monitor usage of CM/CC tracking codes and claims data across various payers/programs and by race/ethnicity	Q2-Q4	MDHHS, MPHI, MDC, HMA

C.4 COMMUNITY HEALTH INNOVATION REGION (CHIR)

Community Health Innovation Regions (CHIRs) are the primary population health component of Michigan's 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, designing and implementing interventions to address social and economic determinants of health and health disparities and inequities. These interventions are designed to be effective, scalable community system transformation solutions.

C.4.a END STATE VISION NARRATIVE

The health of Michigan's residents 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 PCMHs 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 actionable change strategies at the community level.

The SIM CHIRs are a progression in the development of the state's vision regarding linkages between health care and community, and the CHIR concept will be a foundational component of the state's Plan for Improving Population Health (Section B.2.c). The state supports the collective impact approach to create lasting solutions to social problems. 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.

The state's goal is to develop a comprehensive document that new regions can use to plan and implement a successful CHIR. This document will outline a standard prototypical model for CHIRs beyond the SIM Test Model period and will include guidance on effective governance and Clinical-Community Linkages standards, summaries of the roles and responsibilities of key CHIR entities and partners at the state and regional levels, financial tools, and other resources.

The development of this document will be a key deliverable in the overall CHIR sustainability plan. During SIM Award Year 4, the team will use the model description to segment the elements and identify suitable funding sources for each element.

C.4.b STRATEGY NARRATIVE

Award Year 3 has been a period of remarkable progress in executing the overall CHIR strategy. All five CHIRs have implemented a screening and referral process for social determinants of health, including technological solutions and associated inter-agency data sharing agreements. Communities have engaged in substantive analysis of community strengths and needs, and they have designed actionable strategies to address upstream factors of systemic issues such as housing, transportation, etc. CHIRs have engaged in collaborative planning efforts around issues of housing and have explored ways in which they can support an improved homeless response system in their communities. They have also participated in cross-regional information sharing and collaborative planning, and they have provided considerable support to the statewide evaluation of the CHIR component. CHIRs are a key element of the state's Plan for Improving Population Health and regional representatives have been instrumental in the development of the vision and direction of the plan.

Major strategies to be pursued during Award Year 4 include the continued development of Clinical-Community Linkages, community systems change work, improving the homelessness response system in CHIR communities, CHIR model refinement and development, codifying the role of community health workers, cross-regional CHIR collaboration, and individual CHIR support and technical assistance. Each of these priority areas is more fully described below.

Clinical-Community Linkages

The state has worked with the CHIRs to provide Clinical-Community Linkage direction and process implementation support to the CHIRs and to advise the state in identifying and amplifying Clinical-Community Linkage best practices. The state has provided onsite technical assistance to regional Clinical-Community Linkage Workgroups and has established a statewide workgroup. This statewide workgroup is designed to identify and troubleshoot common problems across CHIRs and to advise the state on issues around data collection and sharing.

The purpose of the Clinical-Community Linkage is to enhance the ability of community-based organizations and clinical providers to more effectively impact the overall health of all individuals and the community they live in, by collaboratively identifying and addressing social and medical needs. Specifically, the Clinical-Community Linkage function involves screening individuals for social and economic factors that may negatively impact their overall health, linking to appropriate community resources, conducting quality improvement activities to determine the effectiveness of the community resource, and improving coordination of resources and partnership expansion.

Clinical-Community Linkage priorities and strategies for Award Year 4 include: continuing to support implementation and maturity of the CHIRs Clinical-Community Linkage Framework; the

development of a set of statewide shared metrics to measure Clinical-Community Linkages; and working with CHIRs to incorporate the MI Bridges portal, the state's public assistance benefit online system, into existing workflow with a focus on building organizational and community capacity to improve population health.

To support the CHIRs, a statewide Clinical-Community Linkage Workgroup will meet monthly to continue to identify opportunities to improve existing Clinical-Community Linkage processes in FY 2019.

In Award Year 3 each CHIR has worked hard to establish and launch a community-wide Clinical-Community Linkages Framework. This section outlines the initial strengths and opportunities for CHIRs in Michigan. The state will work with each CHIR individually to identify their maturity in the process and determine a plan for improvement. Currently Michigan's CHIRs are in the early stages of implementation and development of their Clinical-Community Linkage Framework.

Table C.4-1 depicts the defined Clinical-Community Linkage Framework model. The four critical levels necessary for Clinical-Community Linkage are listed on the left column. For each level, there are five stages of maturity listed on top from left to right. The state will work with each region to identify where they are at in the maturity model and develop a plan for enhancing and building their Clinical-Community Linkage framework.

Table C.4-1 Defined Clinical-Community Linkage Framework Model

Interconnected Levels	Screening	Reviewing & Engaging	Leveraging & Linking	Adding Value & Closing Loop	Scanning & Improving
Individual / Family	Individuals are engaged and activated through the social needs screening process.	Individuals work with an organization or provider to discuss and prioritize their needs. *Create an MI Bridges account at this step	Individuals are provided resources available within the organization completing the screen, and are also linked to outside organizations based on identified needs. *MI Bridges can be used at this step	Follow-up is completed by the individual and/or organization to ensure completion of the linkages or referral (a closed loop). *A closed loop does not always indicate that a need has been met.	Individuals play a vital role in the improvement process by providing feedback, participating on an advisory group, etc.
Organization / Agency / Provider	Staff outreach to individuals across the population to screen and identify areas of needs.	Staff use motivational interviewing techniques and active listening to further understand needs and to develop a customized action plan in partnership with the individual.	Staff start work with the individual to leverage their own assets to meet their needs and open referrals or links to additional resources where appropriate.	The organizations, agencies, and providers completing the screen work with the individual served to close the loop. *A closed loop does not always indicate that a need has been met.	The organizations, agencies, and providers completing the screen will use the information to identify opportunities to improve the process, both on an individual client level and across the population served.
Community Sector by Social Determinant of Health	Community sectors inform the screening questions and help to identify organizations to screen individuals.	Organizations, agencies, and providers within defined sectors by social determinant of health develop a plan to meet the needs of those they serve and identify gaps in resources.	Organizations, agencies, and providers within defined sectors by social determinant of health coordinate activities to close service gaps in a community. (For example, coordinated entry.)	Organizations, agencies, and providers within defined sectors by social determinant of health adapt and change internal policies and/or procedures to meet the community's needs.	Organizations, agencies, and providers within defined sectors by social determinant of health continue to scan and adapt to the changing needs of the community, including policy change.
Community Collective Action / Integration	Community collective action and policy is used to inform the development and delivery of a shared social need screening tool.	CHIR governing body and/or Clinical-Community Linkage workgroup regularly meets to review shared Clinical-Community Linkage process, data, and experiences. (This is at all individual, organizational, and sector levels.)	CHIR governing body and/or Clinical-Community Linkage workgroup regularly meets to strategize the Clinical-Community Linkages' development and maturity.	CHIR governing body identifies gaps within the community, and the CHIR backbone organization facilitates identifying resources and strategies to address these gaps through advocacy work.	CHIR governing body utilizes feedback from local, regional, and state coalitions; resources; and data to inform collective action.

Individual Level

There is a Clinical-Community Linkages Framework that is coordinated across the community to screen and link individuals and families to organizations regardless of where the screening takes place. At the individual level a social determinants of health screening is administered, ideally by a community health worker. This screening works to identify the individual's needs and provides a tool to lead the discussion on prioritizing linkages. In a mature model, the individual will additionally play an equal role at decision-making bodies to improve the overall response system.

Organization Level

At the organization level, organizations, agencies and providers play a vital role in Clinical-Community Linkages by providing outreach and screening to individuals to identify needs. In a mature model, organizations are effectively screening the holistic needs of all individuals, coordinating connections to community resources and have adopted a continuous improvement work culture to remain flexible to respond individual needs as well as those across populations served. Examples of these organizations include the Local Public Health Department, a Community Action Agency, a Patient Centered Medical Home Practice, and the Local Emergency Food Organization.

Sector Level

At the sector level, sector alignment within a social determinant of health is needed to build the infrastructure to meet the complex needs of individuals and families. Sectors are critical to informing the screening question intents and assisting organizations in developing plans to meet the needs of those they serve. In a mature model, each sector will have coordinated activities to close gaps and provide a coordinated entry to individuals. Each sector will also remain adaptive to community needs and provide content expertise in advising policy changes as needed. Example sectors include the Food Sector, Employment Sector, and Education Sector. A more detailed example would be the Housing Sector's use of Housing Coordinated Entry. This is essentially the lead organization by social determinant of health domain that coordinates the response system and resources for that domain.

Community Level

At the community level, sectors align their response system and intake to meet the collective needs of individuals. In a mature model, there is implementation of a shared social determinants of health screening tool throughout the community along with a designated leadership body that represents each sector equally. This leadership body will continuously work on cross-sector alignment, equity, and community population health strategies. An example of this leadership body would be the Community Health Innovation Region in a given region.

Individual CHIR Support and Technical Assistance

As each CHIR matures in building their Clinical-Community Linkages Framework, the state will work with each CHIR to look for opportunities to enhance each section of the process.

Current State

The CHIRs are in the early stages of the Clinical-Community Linkages maturity model. Working with the CHIRs in Award Year 3, the state has identified a few strengths that have emerged, including:

- Intentionally focusing on prioritizing alignment and Clinical-Community Linkages in one sector (health). It is best practice to work through each sector individually prior to working on cross-sector alignment. Social determinants of health screening has been implemented at the PCMH practices and hubs are receiving referrals by social determinant of health domain.
- A few of the CHIRs have developed a risk stratification process to identify which individuals whose care would be best managed by the PCMH practice, and which ones would be best served by the hub. This is a recommended process for each CHIR to implement.
- A few of the CHIRs have created and use an additional needs assessment. This secondary assessment is completed after referral to a hub (screening done prior to referral). This is used to further clarify the needs of the individual and the referrals or linkages that would be most appropriate.
- Two CHIRs have implemented a client survey early in the Clinical-Community Linkages intervention to be used to inform real time process improvement efforts.
- One CHIR has implemented a Clinical-Community Linkages onboarding and prioritization process of adding new organizations into the Clinical-Community Linkages framework. It is recommended to onboard new organizations who are not only ready to be part of the Clinical-Community Linkages framework, but also those that are receiving the highest number of referrals for services. The state will work with the other CHIRs to replicate this process.
- All of the CHIRs have created a Clinical-Community Linkages or similar workgroup that meets regularly to discuss their framework, process, and data to drive real-time decision making. They have also used their data to inform the recruitment of community organizations who are providing services but are not listed in the MI Bridges or 2-1-1 directories.

Future Opportunities

In Award Year 4, the state will work with the CHIRs to strategize solutions for the following opportunities:

- Make scheduled monthly targeted calls with each CHIR to discuss strengths and opportunities, in addition to the CHIR's participation in the monthly statewide call.

- Work with the CHIRs to have equal representation at their leadership governance and Clinical-Community Linkages workgroup by sector: health, food, education, and employment. Identifying leaders from each sector to be equally represented in leadership/governance is a critical component in creating a community response system. In a mature Clinical-Community Linkages model, sector leads are responsible for developing, implementing, and monitoring cross-sector alignment.
- Identify one or two sectors to develop alignment strategies to address a social determinants of health need. This could be a replication of the process used in the health sector.
- Continue to work with CHIRs on adding additional reporting metrics to capture the Clinical-Community Linkages process in the community. This includes creating a tracking mechanism for linkages initiated and closed using technology. Currently, not all CHIRs have the technology to capture these fields. For example, most CHIRs are currently only able to pull data from their hub based on the initial need the individual was referred for. In a mature Clinical-Community Linkages model, the CHIR will be able to holistically look at what needs were identified at the time of screening and then be able to track the decrease in needs identified as linkages are initiated. These metrics can be used when seeking funding for sustainability.
- Review and create a process for the organization and staff to integrate MI Bridges into workflow and utilize action planning with individuals. This includes recommendations for recruiting community partners to list their information on 2-1-1.
- Expand social determinants of health screening to additional sectors such as community-based organizations. The state will also work with each CHIR to develop a risk stratification process for the referrals from the community-based organization to the hub and/or PCMH.
- Provide and compare 2-1-1 data with CHIR data to better understand how the community response system and Clinical-Community Linkages Framework are being utilized.

Community Health Worker Role

The roles of community health workers are integral to the success of the CHIRs, particularly as they relate to the Clinical-Community Linkages. Community health workers provide screening and referral services in medical practices, community organizations, and in hub settings. Community health workers have also been valuable in conducting home visits to help locate individuals who have been identified as needing services, high emergency room utilizers, or those disconnected from care.

In Award Year 4, the state will work with CHIRs to inform and provide support to community health worker sustainability and certification efforts. Michigan is currently working on a certification process for community health workers to support reimbursement for services.

Currently, most community health worker programs rely on grants and demonstration project funding. Sustainable funding is critical to improving population health in Michigan.

Community Systems Change

All CHIRs are engaged in community systems change efforts. Some of the backbone organizations have been in existence since long before the SIM project began, and they have been analyzing community strengths and challenges and designing community-based solutions for many years. In Award Year 3, the SIM project offered training and ongoing consultation in the ABLe Change community systems change framework (ABLe Change). This approach, developed by Dr. Pennie Foster-Fishman and Dr. Erin Watson from Michigan State University, employs six guiding principles to effect lasting change in community conditions[3]:

- Engage Diverse Perspectives
- Think Systemically
- Incubate Change
- Implement Change Effectively
- Adapt Quickly
- Pursue Social Justice

The ABLe Change process provides a common language and framework for communities to employ as they pursue changes in policies, services, and community conditions that impact population health in their regions. The process encourages communities to examine complex problems through an equity lens and to design concrete and measurable steps toward pursing social justice.

In Award Year 3, over 150 partners from two of the CHIRs (Northern and Jackson) completed three 2-day training sessions with Drs. Foster-Fishman and Watson. Multi-sector teams from both CHIRs worked to define target problems and system boundaries, design powerful change strategies, effectively implement solutions, and develop a learning environment for continuous quality improvement.

Please see Appendix 3 for regional success narratives for each of the five SIM-sponsored Community Health Innovation Regions.

<u>Northern Region</u>

As a result of participation in the ABLe Change training, the Northern Region has established four topic-based action teams to address identified problems: Access to Healthy Food, Active

[3] Foster-Fishman P., and Watson E. *ABLe Change: Simple Rules, Small Wins, Big Changes*, Michigan State University, ablechange.msu.edu/index.php. Accessed 7 Sept. 2018.

Living, Affordable Housing, and Transit. In addition, the Northern Region has launched several additional community-based strategies to improve conditions and to enhance the health and wellbeing of the resident population:

- Region-wide Health in All Policies Initiative
- Three community connections hubs that provide social determinants of health screening and referral services
- Social determinants of health screenings in 32 patient-centered medical homes
- Piloting social determinants of health screenings in emergency department settings
- Community Health Assessment Steering Committee

Jackson Region

The Jackson Region has set up several standing and ad hoc work groups to drive implementation of community-based efforts that resulted from the ABLe Change process and other collaborative initiatives:

- Community Assessment Workgroup
- Ambulatory Care Access – Call Center Redesign
- Ambulatory Care Access – Alternative Visit
- Behavioral Health Crisis Respite
- Community Living Room
- Community Engagement Corps
- Social Service Navigation Platform

The above-mentioned action teams and strategies for the Northern and Jackson Regions will continue to be supported and monitored through SIM in Award Year 4. Technical assistance and continuous quality improvement support will be provided by SIM CHIR staff, by the Michigan Public Health Institute Center for Community Health, and by Drs. Foster-Fishman and Watson.

In Award Year 4, two more CHIRs (Livingston-Washtenaw and Muskegon) will complete the 6-day ABLe Change training series and will develop action teams to implement strategies designed as part of the training.

Housing Program

Housing and homelessness were identified early on by all participating CHIRs as factors that significantly affect population health in Michigan. As stated in the End State Vision for CHIRs in the Award Year 3 Update of Michigan's SIM Operational Plan, the state has aspired to develop a housing program 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.

In 2018, the state was selected to participate in a Medicaid Innovation Acceleration Program around housing and homelessness. CHIR activities for Award Year 4 related to the housing program are more fully described in Section C.5.

CHIR Model Development

As stated in the End State Vision, the state is planning to develop a comprehensive document that new regions can use to plan and implement a successful CHIR. To that end, the SIM CHIR team has been analyzing CHIR best practices throughout the implementation period and has been documenting potential process improvements to inform the development of this document.

In the SIM Model Test period phase of CHIR implementation, regions were allowed a high degree of flexibility in designing and developing their local decision-making processes and their Clinical-Community Linkages model and the technology solutions to support it. This was done to support the emergence of innovative and promising practices that could then be refined and incorporated into the next phase of CHIR implementation.

A new participation guide for existing CHIRs was released in April 2018 to assist them in updating their local operating plans for Award Year 4. The release of this guide presented an opportunity to clarify current expectations and to make process adjustments where it would not be disruptive to do so.

The state recognizes that future CHIR implementation phases will require more standardization of certain elements of the CHIR model. An important step toward standardization is to very clearly describe the essential structures and functions of the CHIR and to adopt consistent language and messages around the current work. Some of this language is currently in the vetting process with the Executive Leadership Team and will be incorporated into a toolkit of communication assets during SIM Award Year 4.

Findings from the collective impact evaluation, the provider and participant surveys, the quantitative data from individual-level interactions, and from Medicaid claims analysis will be used to assess which parts of the model worked well and which parts need to be adapted in future implementation phases. Some of the data from these activities is becoming available now, and additional reports will be reviewed as they are submitted by Michigan's evaluation contractors in 2019. Preliminary evaluation findings have highlighted some elements of Michigan's theoretical framework that are most important to the success of the collective impact effort. Michigan will prioritize specific focus on these elements in the development of the guidance for new CHIRs:

- CHIRs adopting a shared vision
- Members championing CHIR goal
- Generating public will for a focus on social determinants of health
- Aligning systems through community change capacity and leveraging community change
- Creating a learning orientation and using continuous improvement practices
- Prioritizing inequities

The implementation document for the next phase of the CHIRs will provide detailed guidance on the roles and responsibilities of various entities and partners at the regional level. The manual will also describe state-level resources that will support the work (e.g. technological solutions, technical assistance), as well as how the CHIR work aligns with existing state priorities and initiatives.

Proposed roles and responsibilities for key regional entities include:

Regional Collaborative Steering Committee

- Provides regional leadership and oversight for all pilot program activities.
- Engages in community assessment and strategic planning regarding structure and priorities of regional collaborative work.
- Engages potential local funders of program services and creates plans for local sustainability in cooperation with state-level partners.
- Identifies appropriate regional fiduciary and backbone organizations.
- Approves regional operational plans, budgets, contracts, and the staffing of backbone organizations.
- Participates in cross-regional and statewide leadership meetings and conferences as appropriate.

Regional Fiduciary

- Accepts responsibility for ensuring proper oversight, integration, and management of all pilot program activities.
- Receives funds from the statewide fiduciary and administers them at the regional level according to the established vision and priorities.
- Provides financial management and administrative services to support regional activities.
- Enters into contracts with each regional fiduciary for pilot program activities.
- Enters into contracts with statewide providers of project management, training/technical assistance functions, and technological solutions.

- Engages statewide funding collaborative in articulation of program evaluation needs and arranges for evaluation services.

Regional Backbone Organization

- Drives day-to-day implementation of collective action and community change strategies.
- Serves as the ongoing convener of collaborative work groups and strategy implementation teams.
- Maintains focus on external relationship building and community engagement.
- Hosts regional gatherings/trainings and manages implementation of community change activities.
- Provides staff support to the regional collaborative steering committee.
- Interfaces with and maintains communication with all relevant local/regional partner entities.
- Provides program point of contact to statewide structure and maintains active engagement with statewide collaborative activities.

Regional Service Providers

- Respond to requests for proposals for direct program service activities, technological development/support, and other associated activities.
- Receive funding from the regional fiduciary to support approved scope of work.
- Provide periodic reports on deliverables and progress toward objectives.
- Prepare and submit applicable program evaluation data.
- Participate in local and/or statewide gatherings and trainings as appropriate.

State of Michigan

The implementation document will also describe the state's role in overseeing, convening, and evaluating the CHIRs post-SIM. However, at this time the details regarding the state's role are less defined than the regional level roles and responsibilities. These details will become clearer after the state transitions to a new Governor and new MDHHS administration leadership. In the interim, the Cross-Regional CHIR Collaboration activities will continue in SIM Year 4.

Cross-Regional CHIR Collaboration

A defining feature of the SIM CHIR component has been a purposeful and multi-faceted approach to cross-regional information sharing and collaboration. Throughout Award Year 3, the state CHIR team has maintained a cadence of quarterly in-person gatherings, monthly

teleconferences, and written communications to keep CHIR members aware of significant developments in other regions and to share best practices and lessons learned.

Examples of agenda topics from in-person meetings and teleconferences from Award Year 3 include:

- SIM State-level Updates
- Care Delivery Component Update
- Data Sharing, Privacy and Consent
- Engaging Medicaid Health Plans in CHIR Work
- Clinical-Community Linkages CHIR Technology Solutions
- Michigan's Redesign of the MI Bridges Self-Service Portal
- Center for Medicare and Medicaid Innovation Technical Assistance – CHIR Sustainability
- State Minority Health & Equity Resources
- Understanding Hospital Community Benefit Programs
- Michigan's Behavioral Health Standard Consent Form
- Plan for Improving Population Health Vision & Direction
- CHIR Data Collection and Evaluation
- Michigan's Medicaid Innovation Acceleration Program Housing Initiative

In Award Year 4, the SIM CHIR team will continue to offer similar opportunities for cross-regional sharing and training. Relevant topics will be selected in partnership with CHIR backbone organization staff, other state staff, and partners. Sustainability of CHIR efforts after the SIM Test Award period will be of particular interest in the coming year.

Individual CHIR Support and Technical Assistance

In addition to the cross-regional collaboration support described in the previous section, the state will continue to provide ongoing support to CHIRs individually in Award Year 4 through a variety of means.

Regional Managers

The state designates a regional manager to work with each CHIR to serve as a primary point of contact with the state regarding operational issues. When possible, regional managers attend leadership meetings in CHIR communities to ensure alignment between regional activities and state project priorities. Regional managers also assist CHIRs in preparing operational plans, budgets and financial unrestriction requests. CHIRs submit monthly implementation and financial status reports to their regional manager, and these documents are reviewed together during individual CHIR calls to identify and troubleshoot any barriers to meeting project

objectives. Regional managers also document the training and technical assistance needs for their assigned regions and provide or arrange for support as necessary.

Clinical-Community Linkages Support

In addition to the cross-regional support of Clinical-Community Linkages described earlier, the state's CHIR team also provides individual CHIR technical assistance. When possible, team members travel to CHIR communities to attend Clinical-Community Linkage workgroup meetings in person. Team members also provide telephone support to troubleshoot individual issues encountered by the CHIRs related to their Clinical-Community Linkages work.

ABLe Change Coaching

Between each two-day session of ABLe Change training, the state supports individual coaching for the CHIR by a Michigan State University ABLe Change coach. These coaches address specific concerns raised in the training and assist backbone organization staff in addressing issues such as community power dynamics, strategic planning, engaging community residents, and policy change strategies. Coaches remain engaged with the CHIR even after the entire six-day series has been completed. In Award Year 4, ABLe Change coaching will be increasingly focused on sustainability of current change strategies and programmatic interventions.

C.4.c SUSTAINABILITY NARRATIVE

The state is actively developing a sustainability plan for the CHIR component and is well-positioned to meet the deliverables for a detailed plan as outlined in the Operational Plan – Award Year 4 Update Awardee Guidance document. The state proposes to establish a multi-sector funding collaborative, which will be a public-private partnership whose purpose is to finalize the vision for the next phase of CHIR implementation post-SIM, provide oversight of all program activities, and to contribute funding for specific aspects of the work. CHIRs are also actively developing sustainability plans, which are focused on continued funding and institutionalization of the Clinical-Community Linkages functions and the community-level change strategies created through the ABLe Change process.

In August 2018, the SIM Executive Leadership Team reviewed several potential alternatives for CHIR sustainability after the SIM Test Award period. The Executive Leadership Team chose to submit a substantial budget request to support CHIR infrastructure, administration, and technology/data analysis, as well as implementation support, technical assistance, and program evaluation at the state level. A portion of these funds will be designated for the development of a certification process for community health workers, whose role is vital in the Clinical-Community Linkages process. Program oversight and management will be housed, at least temporarily, in the Policy, Planning and Legislative Services Administration within MDHHS.

Assuming that state general funds and other sources of state revenue are designated for CHIR sustainability as requested, the executive leadership will leverage these funds to attract investments by other public and private entities. Exploratory meetings with potential funders have already begun at the state and regional levels. In the first quarter of Award Year 4, the state will continue holding individual meetings with potential funding partners and will explore a larger group convening with interested parties (including newly elected officials and their staff) to provide an overview of the CHIR concept and the work thus far. Revenue contributions from the funding collaborative will be used to support state and local program infrastructure, as well as cross-regional interventions targeting specific health issues that are priority problems for more than one CHIR region. Local CHIR sustainability plans will focus on the maintenance and institutionalization of community-specific interventions developed during the SIM Test period.

By the end of the first quarter of Award Year 4, the state will complete all requirements for the first deliverable of the sustainability plan and will be well on the way toward development of a detailed roadmap for CHIR sustainability.

C.4.d WORK PLAN BY DRIVER TABLE

Table C.4-2 Population Health Work Plan by Driver Goal 1 (Community Health Innovation Regions)

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**	**Frequency**	**Responsible Party**
CHIR Implementation Project Monitoring and Improvement	**Region Implementation** • Genesee • Livingston/Washtenaw • Jackson • Northern Michigan • Muskegon	Continued implementation of Clinical-Community Linkages and Process Improvement, which is outlined within the Clinical-Community Linkages section below.	Q1 - Q4	**CHIR:** Daily regional implementation **PMDO:** Monthly collaborative calls with all regions	CHIRs and SIM PMDO
		Continued implementation of interventions specific to each CHIR: Genesee • Implement New Paths Opioid Overdose recovery program • Administration of social determinants of health screens to substance use patients in the emergency department • Implementation of Adult and Child 6-week health literacy and education programs	Q1- Q4	**CHIR**: Daily planning, implementation and monitoring **PMDO**: One individual call each month and 2 collaborative calls with all regions monthly to facilitate group problem solving	CHIRs and 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**	**Frequency**	**Responsible Party**
		• Community-wide campaign to promote healthy behaviors Jackson • Continued operation of Community Living Room to reduce social isolation and provide guests opportunity to link with necessary supports for basic needs • Crisis R&R Center – staffed with peer support workers and a licensed counselor to give patients an alternative to emergency room visits • Expand telemedicine and alternative visit modalities • Housing Initiative Muskegon • School based trauma informed intervention • Resilience zones • Housing Initiative • Expand food intervention program			

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**	**Frequency**	**Responsible Party**
		Northern • Conduct Thrive North Community Health Assessment • Implement Health in All Policies • Housing Initiative • Provide navigation services • Continued support of strategy teams to address active living, transportation, and healthy eating Livingston / Washtenaw • Design and implementation of strategies to improve wellbeing of residents by addressing basic needs and mental health • Reduce harm from substance use by increasing access to appropriate treatment modalities • Improving integration and coordination of substance use and mental health			

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**	**Frequency**	**Responsible Party**
		services, and affordable housing and transportation • Reducing inequities in service systems and community living conditions			
		Implement new interventions specific to each CHIR	Q1 - Q4	**CHIR:** Daily if within the region's scope **PMDO:** Supports the regions during regularly scheduled collaboration calls three times a month	CHIRs and SIM PMDO
		Collect and analyze participation metrics	Q1 - Q4	**CHIR:** Quarterly submission **PMDO:** Quarterly review, analysis and submission to CMS	CHIRs and SIM PMDO
	Project Monitoring and Improvement	Document CHIR activities via status reports, conference calls, and on-site visits	Q1 - Q4	**CHIR:** Submits status reports monthly **PMDO:** Reviews status reports with regions once a month on individual calls and visits each site at least once a month	CHIRs and SIM PMDO
		Document lessons learned	Q1 - Q4	**PMDO:** Once a month or as they arise via calls, site visits and other means	CHIRs and SIM PMDO
		Ongoing programmatic monitoring	Q1 - Q4	**PMDO:** Daily	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**	**Frequency**	**Responsible Party**
	Implementation Support	Provide input and support to regions in maintaining/meeting MDHHS program requirements	Q1 - Q4	**PMDO:** Monthly site visits, calls & attendance for regionally planned working sessions	SIM PMDO
		Provide guidance and best practice information on implementation of new interventions	Q1 - Q4	**PMDO:** Monthly and ad hoc	SIM PMDO
		Review and approve program applications and quarterly work plan reports in EGrAMS	Q1 - Q4	**PMDO:** As received and in alignment with Budget team's deadlines	SIM PMDO
		Review monthly program status reports to monitor implementation progress and ensure regions are meeting key deliverable and milestones in support of SIM goals and objectives	Q1 - Q4	**PMDO:** Monthly tracking and discussions	SIM PMDO
		Collaboratively develop issue and risk mitigation strategies when needed and escalate as appropriate to state resource team	Q1 - Q4	**PMDO:** Monthly collaborative calls and site visits	SIM PMDO
		Create presentation templates and speaking outlines for backbone organization staff to report on the CHIR work to internal and external audiences	Q1 - Q2	**PMDO:** As needed throughout grant period	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**	**Frequency**	**Responsible Party**
		Collaboratively develop communication strategies and tools to describe CHIR work and accomplishments	Q1 - Q2	**PMDO:** As needed and throughout grant period	SIM PMDO, PSC
		Ongoing programmatic monitoring	Q1 - Q4	**PMDO:** Daily	SIM PMDO
	Financial Oversight & Monitoring	Review, Approve, & Monitor Unrestriction Requests for CHIR backbone organization and contractor funding	Q1 - Q4	**PMDO:** As received and aligned with budget team deadlines	SIM PMDO
		Ensure alignment of scope & deliverables outlined within Unrestriction Requests with SIM goals and objectives		**PMDO:** As received and aligned with budget team deadlines	
		Assist regions with CMS feedback on Unrestriction Requests to resolution		**PMDO:** As received and aligned with budget team deadlines	
		Monitor spending patterns of regions and approve monthly financial reports		**PMDO:** Monthly	
	Integration of Regional Efforts into State Initiatives	Represent CHIRs on state planning work groups (Plan for Improving Population Health) and associated subcommittees	Q1 - Q4	**PMDO:** Monthly participation in PIPH work groups representing CHIRs (PIPH groups meet 3 times a month)	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**	**Frequency**	**Responsible Party**
		Develop content regarding the CHIR work and accomplishments for internal and external presentations	Q1 - Q3	**PMDO:** Ongoing (CHIR Committees have formed and meet once a month but content is being developed weekly)	SIM PMDO
		Identify areas of integration of the CHIR work into existing programs and initiatives at the state	Q1 - Q4	**PMDO:** Ongoing	SIM PMDO
Collaborative Learning	CHIR Coaching and Technical Assistance	Continue implementation of coaching plans for each region	Q1 - Q4	**MSU:** In person meetings once a month and as needed coaching via phone or in person meetings	Michigan State University (MSU)
		Implement CHIR-wide technical assistance schedule	Q1 - Q4	**MSU:** Monthly **PMDO:** Monthly	MSU and SIM PMDO
		Conduct ad hoc calls with regions as necessary to address specific issues, problems, and concerns	Q1 - Q4	**MSU & PMDO:** Monthly	MSU and SIM PMDO
		Document lessons learned	Q1 - Q4	**All:** Ongoing	CHIRs, MSU, SIM PMDO
		Document training and TA needs	Q1 - Q4	**MSU & PMDO:** Ongoing	MSU and SIM PMDO
		Plan and execute additional TA requests/identified needs	Q1 - Q4	**MSU & PMDO:** As needs arise	MSU and SIM PMDO
	Collaborative Platform Website	Orient CHIRs with new collaborative website platform	Q4 AY3-Q1 AY4	**MSU:** One-time introduction and ongoing support	MSU
		Update and maintain website content	Q1 - Q4	**MSU:** Ongoing	MSU

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**	**Frequency**	**Responsible Party**
	ABLe Change Training	Complete ABLe Change Training for remaining regions	Q1 - Q3	**MSU:** Completion of Muskegon and Livingston/Washtenaw ABLe Change Training	MSU
Clinical-Community Linkages	Enhance tri-sector partnerships and build community capacity	Develop strategies to strengthen existing partnerships with nonprofits, employers, and health care systems within each region with further enhancement of Clinical-Community Linkages	Q1 - Q2	**EDL:** Monthly during collaborative calls and individualized monthly meetings with regions	Every Day Life (EDL)
		Develop strategies to create new partnerships with relevant community and health care-based organizations for each region	Q1 - Q2	**EDL:** Monthly during collaborative calls and individualized monthly meetings with regions	EDL
	Incorporate MI Bridges Integrated Service Delivery (ISD) into Regional Workflows	Gap analysis of current regional workflows	Q1	**EDL:** Once with each region	EDL and CHIRs
		Identify areas of integration for MI Bridges application into existing regional workflows	Q1 - Q2	**EDL:** Once with each region	EDL
		Integrate MI Bridges ISD into regional workflows	Q2 - Q3	**EDL:** Once with each region	EDL and CHIRs
		Documentation of analysis, lessons learned and best practices	Q1 - Q4	**EDL:** Ongoing	CHIRs

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**	**Frequency**	**Responsible Party**
		Identify other areas of integration for Homeless Management Information System/hub technologies into regional workflows	Q1 - Q2	**EDL:** Ongoing	EDL
	Enhance participation and use of current Clinical-Community Linkages across sectors	Identify key leaders from local community-based organizations, health system leaders and employers to engage in CHIR/Clinical-Community Linkages model	Q1 - Q2	**EDL:** Once with each region and as needed	EDL
		Develop engagement strategies with each region	Q1 - Q2	**EDL:** During monthly meetings	EDL
		Execute engagement strategies with each region	Q2 - Q4	**EDL:** Ongoing	EDL
	Clinical-Community Linkages Continuous Process Improvement	Identify Clinical-Community Linkages benchmarks across other established state Clinical-Community Linkages models	Q1	**EDL:** Once	EDL
		Develop a strategy to enhance each region's Clinical-Community Linkages processes and infrastructure	Q1 - Q2	**EDL:** Once initially and continuously improve upon identified strategies	EDL
		Execute strategies for Clinical-Community Linkages enhancement	Q2 - Q4	**EDL:** Ongoing	EDL

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**	**Frequency**	**Responsible Party**
		Develop a roadmap of enhancements to the processes and infrastructure of each region's Clinical-Community Linkages solutions (used for CHIR sustainability planning and post-SIM CHIR activities)	Q1	**EDL:** Ongoing during monthly meetings (in person and by telephone/WebEx)	EDL
		Participate regularly in CHIR steering committees and Clinical-Community Linkages work groups to provide insight and guidance	Ongoing	**EDL:** Ongoing monthly collaborative calls facilitated by EDL and participation in Region specific CCL meetings	EDL
		Work with each region to benchmark and self-evaluate their Clinical-Community Linkages process and effectiveness	Q4 AY3 - Q1 AY4	**EDL:** Ongoing during monthly meetings (in person and by telephone/WebEx)	EDL
		Work with CHIRs to develop/update Clinical-Community Linkages components of local operational plans	Q4	**EDL:** Once during Ops Plan submission period	EDL
		Review and make recommendations for approval of CHIR Operational Plans, Work Plans, and Reports	Ongoing	**EDL:** Once during Ops Plan submission period	EDL

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**	**Frequency**	**Responsible Party**
	CHIR Metrics & Measurement	Collect CHIR Summary level Clinical-Community Linkages data monthly	Ongoing	**EDL:** Monthly	EDL
		Analyze each region's Clinical-Community Linkages summary level data and provide comprehensive reports to state leadership and regions to identify areas of strength and areas of opportunity	Ongoing	**EDL:** Monthly	EDL
		Implement and facilitate Clinical-Community Linkages work group to discuss progress of regions collaboratively and provide insight and direction for enhancing the maturity of each Clinical-Community Linkages solution	Ongoing	**EDL:** Monthly	EDL
		Work with MDHHS/MPHI SIM Evaluation team members to assist with evaluation of various components of SIM including Clinical-Community Linkages effectiveness	Ongoing	**EDL:** Ongoing	EDL

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**	**Frequency**	**Responsible Party**
		Develop report inclusive of descriptions of Clinical-Community Linkages, level of integration with MI Bridges ISD, analysis of findings, alignment of findings with state goals, and identify priority areas of improvement	Ongoing	**EDL:** Ongoing	EDL

Table C.4-3 Population Health Work Plan by Driver Goal 2 (CHIR Sustainability)

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
Population Health/SIM CHIR - End State Vision	Sustainability Planning: Analysis involves reviewing evaluation data, surveys, region success stories etc. Documentation brings together the analysis in written and graphical form.	Analysis of progress toward original SIM CHIR goals and objectives **Frequency:** **PMDO:** Ongoing analysis	Q4 AY3 – Q1 AY4	SIM PMDO
		Documenting the findings of the analysis of progress toward original SIM CHIR goals and objectives **Frequency:** **PMDO:** Ongoing documentation	Q1 - Q2	SIM PMDO
		Analysis of new and anticipated levers to target post-SIM (policy, infrastructure etc.) **Frequency:** **PMDO:** Ongoing analysis	Q1 - Q2	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Documenting the findings of the analysis of agreed upon levers post-SIM **Frequency:** **PMDO:** Ongoing – iterative document with state feedback	Q1 - Q2	SIM PMDO
		Development of strategies to meet anticipated levers post-SIM **Frequency:** **PMDO:** Once – document requiring iterative evolution by obtaining state feedback and buy-in	Q1 - Q2	SIM PMDO
	Revised End State Vision	Utilize analysis and additional levers identified to inform a revised End State Vision **Frequency:** **PMDO:** Once	Q1	SIM PMDO
		Definition of post-SIM CHIR model targets, population health goals and or health care spending/savings goals **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q3	SIM PMDO
		Identify existing infrastructure and opportunities to build upon from SIM CHIR work into post-SIM CHIR work **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Documentation of the desired state of CHIR structure and desired outcomes **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q3	SIM PMDO
		Documentation of requirements to meet goals and objectives of post-SIM CHIR model **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Documentation of accomplishments through SIM grant to achieve original SIM End State Vision **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1	SIM PMDO
		Analysis and documentation of changes in State Landscape (political transitions, market changes etc.) **Frequency:** **PMDO:** Document developed iteratively in collaboration with state leadership	Q1 - Q2	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
Roadmap for Sustaining Investments	Sustainability of existing work and infrastructure	Identify areas of existing SIM program elements to sustain post-SIM (inventory of activities/investments) **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Identify strategies for sustaining existing elements **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q3	SIM PMDO
		Identify what components will accelerate health care transformation **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1	SIM PMDO
		Identify areas which cannot/will not be sustained post-SIM award **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q1	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Development of primary and secondary drivers **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Identify resources required to sustain activities/investments post-SIM **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Identify one-time investments via SIM program **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1	SIM PMDO
		Owner identification (What department will maintain the post-SIM work) **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q1	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Identification of non-existent inputs necessary to support the post-SIM model **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Documentation of strengths and weaknesses of current model **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1	SIM PMDO
		Identify strategies for improving upon sustained elements **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Develop scaling strategies and requirements **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1-Q3	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Identification of potential funders **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1-Q2	SIM PMDO
		Development of strategies to engage potential funders **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1-Q2	SIM PMDO
		Development of timelines for engagement of potential funders **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q1-Q2	SIM PMDO
		Development of opportunities for potential funders **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership and identified (interested) potential funders	Q4 AY3 - Q2 AY4	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
Post SIM CHIR Model Refinement and requirements	CHIR Pilot Manual	Integration of existing knowledge of SIM CHIR program into Pilot Manual (best practices, lessons learned, etc.) **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q4	SIM PMDO
		Documentation of strategies to enhance existing structures, processes, and resources for continuation of model post-SIM **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Identification of operational capacity to maintain and implement/scale out of CHIR model post-SIM **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q3	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Development of funder engagement strategies throughout program **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q3	SIM PMDO
		Development of requirements to report to engaged partners **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q2 - Q3	SIM PMDO
		Risk assessment and mitigation strategies **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1 - Q2	SIM PMDO
		Identification of resource requirements **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q2 - Q4	SIM PMDO

Goal/Driver 2: Determine a sustainability plan and proposed model for continuation of CHIR pilot program				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Identification of alignment between current and proposed state initiatives **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q4	SIM PMDO
		Development of strategies to integrate post-SIM CHIR work into other MDHHS areas **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership	Q4 AY3 - Q1 AY4	SIM PMDO
		Evaluation Requirements **Frequency:** **PMDO:** Document developed iteratively in collaboration with CHIRs and state leadership using monthly committee meetings and SharePoint for document sharing and obtaining feedback	Q1	SIM PMDO

Table C.4-4 Population Health Work Plan by Driver Goal 3

Goal/Driver 3: 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**
Plan for Improving Population Health (PIPH)	Develop Plan for Improving Population Health	Convene PIPH Workgroup **Frequency:** **MPHI/PMDO:** This workgroup is convened once a month for 1.5 hours	Q1-Q2	SIM PMDO, MPHI

Goal/Driver 3: 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**
		Finalization of PIPH Priorities **Frequency:** **MPHI/PMDO:** Documented once through an iterative process utilizing subject matter experts from various departments in MDHHS, Medicaid, CHIRs and PCMH participants	Q4 AY3 - Q1 AY4	SIM PMDO, MPHI
		Identify potential stakeholders **Frequency:** **MPHI/PMDO:** Iterative process. The SIM team has identified initial stakeholders and continue to identify more as our process and documentation evolve	Q4 AY3 - Q2 AY4	SIM PMDO, MPHI
		Develop stakeholder engagement strategies and timelines **Frequency:** **MPHI/PMDO:** Iterative process. Timelines are developed and revised as the process continues to mature	Q4 AY3 - Q1 AY4	SIM PMDO, MPHI
		Execute stakeholder engagement strategies (staggered approach) **Frequency:** **MPHI/PMDO:** Iterative process	Ongoing	SIM PMDO, MPHI
		Identify alignment with SIM CHIR program **Frequency:** **MPHI/PMDO:** Iterative process	Ongoing	SIM PMDO, MPHI

Goal/Driver 3: 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**
		Identification of strategies for addressing social determinants of health throughout Michigan **Frequency:** **MPHI/PMDO:** Iterative process. A subcommittee has been formed, it is the PIPH Health Status Committee. This group surveys the state's existing and potential capacity to address social determinants of health. As the group adds new participants, the group learns more.	Q2 AY3 - Q2 AY4	SIM PMDO, MPHI
		Alignment with SIM CHIRs for potential implementation of strategies **Frequency:** **MPHI/PMDO:** Iterative process	Ongoing	SIM PMDO, MPHI
		Continue PIPH Data Committee gatherings **Frequency:** **MPHI/PMDO:** Monthly convenings and regular work assignments	Ongoing	SIM PMDO, MPHI
		Identify existing data within MI used to inform the plan **Frequency:** **MPHI/PMDO:** Iterative process	Q4 AY3 - Q2 AY4	SIM PMDO, MPHI
		Continue PIPH Capacity Committee gatherings **Frequency:** **MPHI/PMDO:** Monthly convenings and regular work assignments	Ongoing	SIM PMDO, MPHI
		Identify existing capacity within Michigan to address social determinants of health **Frequency:** **MPHI/PMDO:** Iterative process	Q4 AY3 - Q2 AY4	SIM PMDO, MPHI

Goal/Driver 3: 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**
		Develop strategies to align with existing capacity efforts and enhance strategies collaboratively **Frequency:** **MPHI/PMDO:** Iterative process	Q1 - Q2	SIM PMDO, MPHI
		Regular check-ins with CDC project officer to maintain alignment with CMS requirements for PIPH **Frequency:** **MPHI/PMDO:** Quarterly	Ongoing	SIM PMDO, MPHI
		Analysis of data provided by PIPH Data Committee **Frequency:** **MPHI/PMDO:** Iterative process	Q1 - Q2	SIM PMDO, MPHI
		Documentation of data findings and strategies for use **Frequency:** **MPHI/PMDO:** Iterative process	Q1 - Q2	SIM PMDO, MPHI
		Documentation of capacity opportunities and strategies for incorporation **Frequency:** **MPHI/PMDO:** Iterative process	Q1 - Q2	SIM PMDO, MPHI
		Draft 1 of PIPH **Frequency:** **MPHI/PMDO:** Iterative process	Q2	SIM PMDO, MPHI
		Draft 2 of PIPH **Frequency:** **MPHI/PMDO:** Iterative process	Q3	SIM PMDO, MPHI
		Finalization of PIPH **Frequency:** **MPHI/PMDO:** Iterative process	Q4	SIM PMDO, MPHI

C.5 HOUSING PROGRAMS

Housing instability and homelessness is a barrier to positive long-term health outcomes. MDHHS will build community capacity across all CHIRs (and eventually statewide) to identify the local frequent emergency department user population in need of housing assistance and develop a sustained model for housing prioritization and service coordination.

This goal will be achieved through three drivers:

1. Improving the Homeless Response System
2. Building Local Capacity
3. Data Integration

C.5.a END STATE VISION NARRATIVE

The health of Michigan's residents is greatly influenced by their access to stable, permanent housing. Michigan is targeting housing as a social determinant of health and working to connect homeless high-cost frequent utilizers of emergency services with permanent housing resources and short-term supportive services funding to stabilize and improve their health.

The SIM CHIRs are a progression in the development of the state's vision regarding linkages between health care and community, including housing. The state supports the collective impact approach to create lasting solutions to social problems.

The work of this project will result in better long-term health and housing outcomes for some of the population's most vulnerable people. It will reflect a reduction or shift of overall Medicaid costs and/or emergency department utilization due to stable housing and supportive services. Finally, it will propose alternative funding options for supportive services providers which allows them to better serve formerly homeless clients in need of intensive case management to maintain their housing stability.

C.5.b STRATEGY NARRATIVE

Award Year 3 has allowed Michigan to build a program that will help communities identify individuals in need of permanent supportive housing assistance, develop a sustained model for housing coordination, and develop plans for addressing needs in housing capacity. Michigan has identified two primary outcomes and activities to help it reach its end state vision.

Outcome 1: Increase the amount and availability of stable housing and supportive housing services for the most vulnerable homeless and high Medicaid utilizers.

- Establish annual statewide permanent supportive housing pipeline production goals.

- Encourage local Public Housing Agencies to mirror the Michigan State Housing Development Authority voucher homeless preference policy.
- Advocate for changes to the Qualified Allocation Plan that will create additional permanent supportive housing units.
- Propose legislative incentives to support development of new and access to existing rental properties. Examples of these incentives include things such as the damage abatement fund or tax credits for renting to the target population.
- Collaborate with the United States Department of Housing and Urban Development to encourage Public Housing Agencies to partner in continuums of care.
- Combine operating subsidies with services funding through a Michigan State Housing Development Authority/MDHHS partnership.
- Explore community health benefit funds from hospitals for outreach, rental assistance, and supportive services funding.
- Explore funding with managed care organizations, structuring per diem Medicaid within or without the existing managed care carve out.
- Continue to advocate for federal supportive services funding with the United States Department of Health and Human Services (including the Substance Abuse and Mental Health Services Administration, the Administration for Children and Families, etc.) and other relevant agencies.
- Examine behavioral health contracts with pre-paid inpatient health plans to determine why tenancy supports currently allowable in state Medicaid plan are not being accessed/billed for at local levels.
- Submit new waiver(s) to CMS to enable more tenancy supports to be included in the state Medicaid plan.

Outcome 2: Improve population prioritization, coordination; test and scale solutions

- Conduct local technical assistance and training on quality supportive housing development and operations.
- Develop a clear definition of exactly which services should be provided in permanent supportive housing for this population.
- Integrate physical and behavioral health resources and services with housing assistance.
- Prioritize permanent supportive housing referrals for target population within local coordinated entry system.
- Train housing agencies on becoming Medicaid billable agencies or facilitate partnerships between housing agencies and Medicaid billable agencies.
- Work with housing agencies currently billing Medicaid to develop guidance for other agencies.

- Establish plan for monthly Homeless Management Information System uploads into the state data warehouse to enable data match and local prioritization.

Data Integration

Michigan has matched its statewide Homeless Management Information System (HMIS) records to its Medicaid Master Person Index to identify overlapping clients. Michigan is in the unique position of being one of the few states to use a single statewide software solution to track its homeless population through HMIS. HMIS has the potential to provide state government and project partners with data elements that can be combined and leveraged with pre-existing data sets to appropriately identify and prioritize highly vulnerable populations.

By matching recent HMIS data with the Medicaid Master Person Index system, MDHHS has been able to identify an initial cohort of individuals who are frequent users of emergency department services and who are homeless.

The long-term goals of this data integration are:

- Identify strengths and weaknesses within the current HMIS system which can be leveraged or improved to increase data quality and match rates with the Medicaid Master Person Index.
- Building cross-sector collaboration that includes both public and private partnerships at the planning, service delivery, and database/outcome measurement levels.
- Adding data sources to develop a more comprehensive vulnerability index to aid in prioritizing housing resources.

C.5.c SUSTAINABILITY NARRATIVE

The state is actively developing a sustainability plan by:

1. Providing capacity building education to permanent supportive housing providers to deliver high quality housing permanent housing and supportive services.
2. Requesting the acceptance of a Medicaid waiver that includes the approval of tenant support services as billable activities.
3. Creating an automated data match process which will routinely identify those individuals experiencing homelessness with high physical and mental health needs so that the most intensive resources can be prioritized to assist this population.

C.5.d WORK PLAN BY DRIVER TABLE

Table C.5-1 Housing Work Plan by Driver

Goal/Driver 1: Implement the Health Through Housing Initiative. The initiative includes the Frequent User Pilot, the systematic collection of data results, training Permanent Supportive Housing agencies to improve quality and qualify for Medicaid billing, and improving the Homeless Response System.				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
Systems Improvement	Technical Assistance and Training	Develop best practice training curriculum for supportive housing agencies selected to participate in the Health Through Housing Pilot	Q1	Corporation for Supportive Housing (CSH)
		Perform best practice training for supportive housing agencies selected to participate in the Health Through Housing Pilot	Q1	CSH
		Offer web-based best practice training for public supportive housing agencies not participating in the Health Through Housing pilot program, up to 100 participants statewide	Q1	CSH
		Technical assistance for public supportive housing agencies, quality review, and quality standards	Q1 - Q3	CSH
		Training on serving individuals with opioid use disorders in supportive housing	Q1 - Q3	CSH
		CHIR web training on cross-system mapping and partnership development	Q1	CSH
	Homeless Response System Improvement Plan	MDHHS plan guidance document	Q1	MDHHS Housing and Homeless Services Section

Goal/Driver 1: Implement the Health Through Housing Initiative. The initiative includes the Frequent User Pilot, the systematic collection of data results, training Permanent Supportive Housing agencies to improve quality and qualify for Medicaid billing, and improving the Homeless Response System.				
Milestone/Measure of Success	**Budget Activity**	**Action Steps Necessary to Complete Activity**	**Timeline**	**Responsible Party**
		Backbone organization development & completion of systems improvement plan	Q1	CHIR
		Backbone organization to initiate execution of systems improvement plan	Q1	CHIR
Health Through Housing Pilot	Data Analysis	Analyze client progress tracking reports produced from pilot public supportive housing agencies	Q1 - Q3	SIM PMDO/ MDHHS Housing and Homeless Services Section
Evaluation	Health Through Housing Program Evaluation	Perform evaluation of Health Through Housing Pilot Program	Q1 - Q4	MPHI
	Evaluation of Systems Improvement to the Homeless Response System	Perform evaluation of the improvements made to the Homeless Response System	Q1 - Q4	MSU
	Evaluation of Homeless Management Information System	Perform evaluation of HMIS data quality, process, and policy	Q1 - Q4	SIM PMDO

C.6 TECHNOLOGY

C.6.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. In addition, 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, ADT and Quality Metrics.

C.6.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 all SIM participating physicians into the 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 has been optimized to further allow 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 and PCMHs to collect information about social determinants of health and to assess each individual CHIR's technical needs. The SIM technology team met with CHIR participants to understand each region's innovative data sharing solutions and to ensure the solutions were able to share social determinants of health data with the state. Michigan will continue to work with each individual CHIR to collect this data and provide evaluation reporting. Throughout AY4, SIM will assess the process of data collection within each CHIR and construct a statewide strategy for social determinants of health collection. The strategy will feed into the sustainability planning process for the SIM Model Test.

As the CHIRs continued to evaluate their communities and areas to focus on to improve population health, all CHIRs identified homelessness as an area of concern. Michigan started collecting the homeless data in Award Year 3 and will continue to support the CHIR's initiatives in this area by performing analytics and providing reporting on high priority homeless persons who may be eligible for homeless vouchers.

With the SIM program coming to an end, Michigan is working to define and implement the initiatives for sustainability for SIM components that have been successful. One of those initiatives is transitioning the RAMP process and payments to providers over to the MHPs where the value has been demonstrated and where the process meets the business needs of the MHPs.

C.6.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.6.d WORK PLAN BY DRIVER TABLE

Table C.6-1 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**
Quality Measures & Reporting	Monthly Ongoing Reporting (Patient Lists, Care Management Reports)	Q1 data analysis and reports	Q1	Michigan Data Collaborative (MDC)
		Q2 data analysis and reports	Q2	
		Q3 data analysis and reports	Q3	
		Q4 data analysis and reports	Q4	
	Quarterly Quality & Evaluation Measures Reporting	Q1 data analysis, measure approvals, and report production	Q1	MDC
		Q2 data analysis, measure approvals, and report production	Q2	
		Q3 data analysis, measure approvals, and report production	Q3	
		Q4 data analysis, measure approvals, and report production	Q4	
RAMP	Monthly ongoing production of the Filtered SIM Participation File (SPF) for attribution	Q1 Filtered SPF Files	Q1	SIM Technology Team, Optum, MDC
		Q2 Filtered SPF Files	Q2	
		Q3 Filtered SPF Files	Q3	
		Q4 Filtered SPF Files	Q4	
	Support of Transitioning RAMP to the Medicaid Health Plans and decommissioning of RAMP	Define technical support needed, create plan for decommissioning and seek stakeholder approvals	Q1	SIM Technology Team, MDHHS, Michigan Health Information Network (MiHIN)
		Implement tasks and processes needed to decommission	Q4	
CHIR Technology	Clinical-Community Linkages	Support CHIR technology solutions to support Clinical-Community Linkages	Q4	SIM Technology Team, MDC

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**
Program/Project Management	Post-SIM Planning	Project deliverables related to closing the project	Q4	SIM Technology Team, MDC
	Status Reporting	Produce weekly and monthly technology status reports for the program and the state.	Q4	
Sandbox and Analytics	Housing Data	Define technical architecture and requirements to an ongoing, monthly data load of housing data	Q1	SIM Technology Team, Optum, MDHHS
		Implement monthly process to load housing data	Q1	
	Data Quality	Capture PCMH social determinants of health data and perform analytics	Q1	SIM Technology Team, MDHHS, SIM CHIR Team
		Capture and analyze CHIR social determinants of health data	Q2	

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 (MSU), the University of Michigan Child Health Evaluation and Research Center, and Michigan Data Collaborative (MDC).

The impact evaluation component aims to collect and analyze information on emerging outcomes that will justify continued investment in the model by key stakeholders after the 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 two interrelated areas that cross both the Patient-Centered Medical Home (PCMH) and Community Health Innovation Region (CHIR) tracks:

1. Clinical-Community Linkages
2. Community change

In addition, 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.

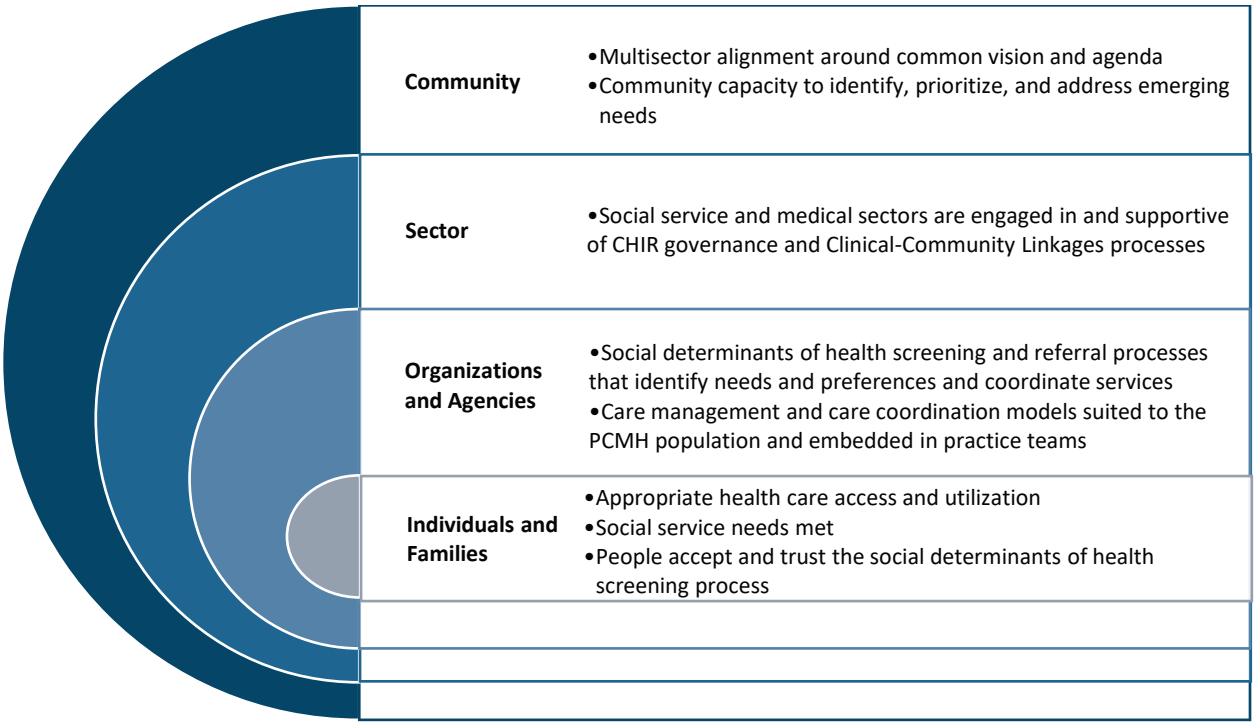
EVALUATION DESIGN

The state-led evaluation will:

- Focus measurement and analysis on the targets to which change is expected to occur.
- Plan longitudinal analyses and comparison to test theories of differential outcomes across groups.
- 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



At the community, sector, and organization/agency levels, the evaluation hypothesizes CHIRs will lead a transformative change process. The evaluation tests a series of hypotheses about this process. This process is hypothesized to begin as CHIR partners come together and organize for action, then began to create action with visible impact on how members and partners behave and coordinate activity. The practices supporting collaboration are subsequently hypothesized to become embedded and ultimately sustained in the communications patterns, shared vision, alignment, continuous improvement, and equity culture.

At the individual level, surveys and claims data are the key data sources. The following HEDIS based metrics will be analyzed: emergency department visits, preventable ED visits, acute hospital admissions, all-cause readmissions, and total per member per month (PMPM) costs.

All data sources with the exception of interviews are used for both PCMH and CHIR analysis. Interviews were used only in the analysis of CHIRs. All data sources are summarized in the following list:

- **Collective Impact Survey:**
    - This is a survey conducted in 2018 and 2019 of CHIR members, partners, and stakeholders. A section of the collective impact survey that measures Clinical-Community Linkages screening and linkage attitudes and activities is also administered to PCMH providers statewide.
- **Patient/Client Experience Survey:**
    - Conducted of a sample of PCMH patients and CHIR/hub clients – specifically focused on acceptance of the Clinical-Community Linkages screening and linkage process.
    - For CHIRs, in 2018 this was a pilot, in 2019 it will be for all CHIRs.
- **Claims data analysis:**
    - Medicaid analysis of utilization and cost metrics focused on PCMH patients and CHIR/hub clients with identified social determinants of health.
- **Process metrics:**
    - Screening and linkage data reported by PCMHs and CHIRs.
    - For PCMHs, this is administrative data. For CHIRs, this is summary data.
- **Individual-level Clinical-Community Linkages data:**
    - Screening and linkage data submitted on an individual basis by all CHIRs and participating PCMHs, linked to Medicaid claims data.
- **Interviews:**
    - These focus on CHIR partners.

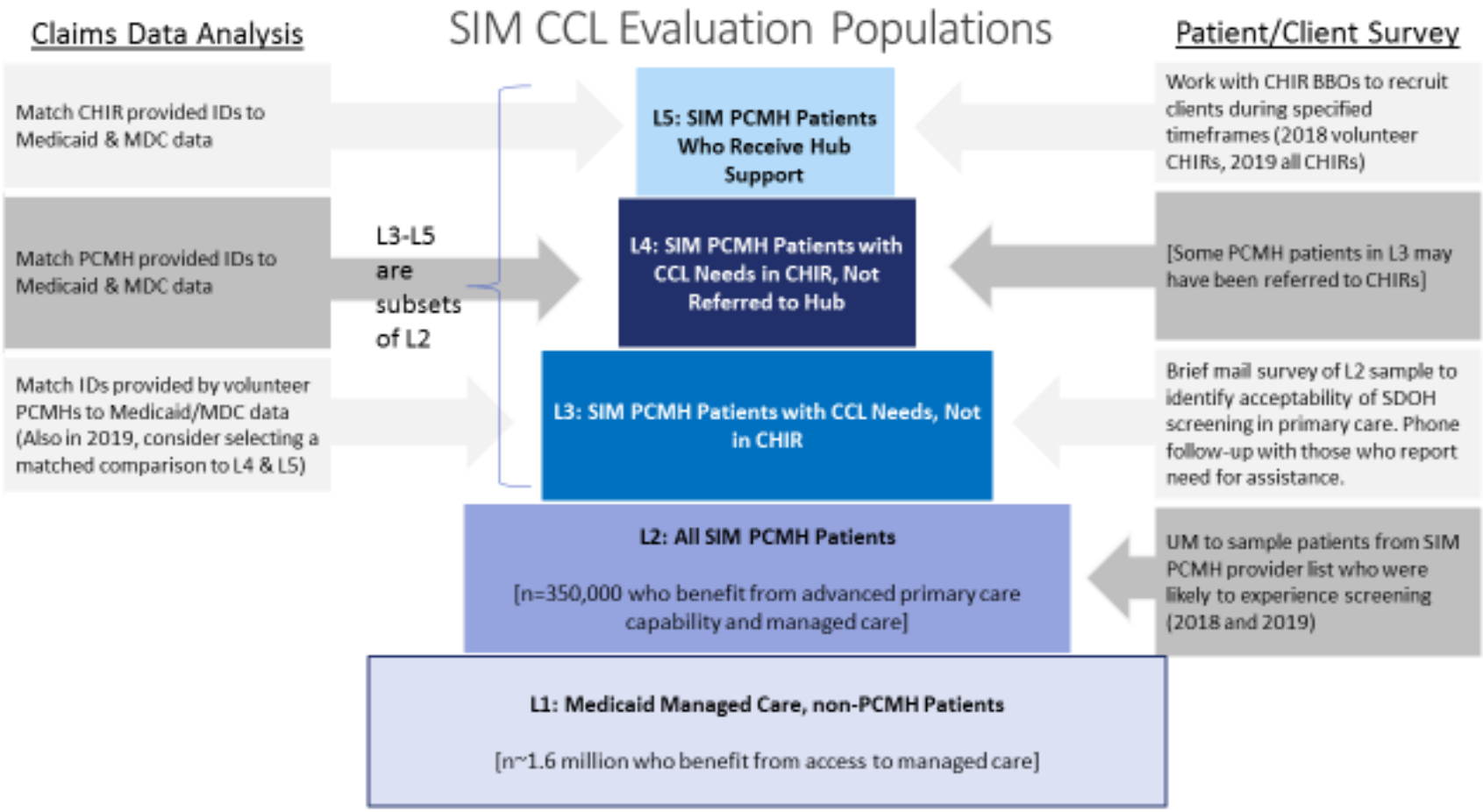
Process metrics for the CHIRs/hubs relate to screening, linkage, and follow up and are summarized in Table D.1-1. A parallel set of metrics is being computed for PCMH practices who are volunteering to provide Clinical-Community Linkages data.

Table D.1-1 Clinical-Community Linkages Process Metrics (CHIR version)

Domain	Metrics
Engaged Partners	• Number of sites screening clients • Number and percent of PCMH practices screening clients
Coordination	• Number of active clients per navigator/Care Coordinator/community health worker
Screening	• Number of screens completed • Number of screens by site • Number of unduplicated Medicaid clients screened
Need Identification	• Number and percent of clients who screened positively for at least one social determinant of health area • Number and percent of clients who screened positively for multiple social determinants of health needs • Number of social determinants of health needs identified per client • Number and percent of clients reporting needs in each social determinant of health domain
Clients Served	• Number of clients served by hub • Percent of hub clients served who had multiple social determinants of health needs
Successful Linkages	• Number and percent of clients linked to needed community services • Number and percent of clients linked to needed community services by social determinants of health area • Number and percent of successfully completed community service linkages • Number and percent of successfully completed community service linkages by social determinants of health area
Unsuccessful Linkages	• Number and percent of clients not linked to needed community services • Number and percent of clients not linked to needed community services by social determinants of health area • Number and percent of clients who do not receive services by social determinants of health area and reason for not receiving (e.g., transportation, time/location, language barriers, waitlist for services, etc.)

Figure D.1-2 below depicts the layers of Medicaid patient population and how they are expected to be affected by SIM Clinical-Community Linkages programming elements. It also identifies which sub-populations will be included in individual level data collection and/or analysis.

Figure D.1-2 SIM Clinical-Community Linkages Evaluation Populations



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:

- Were the 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?
- Did the patient populations touched by SIM interventions of care management or social determinants of health screening and community linkage experience differences and/or improvements in utilization when compared to similar providers or populations? Did the duration and/or intensity of these services influence impact?
- Do patients with social needs feel that the screening and referral process was appropriate?
- 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 clients' 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?

CURRENT STATUS AND NEXT STEPS

MSU has completed round one of the Collective Impact Survey, and is currently cleaning and analyzing the data. MPHI drafted a set of provider questions to be included in the CHIR survey. These questions are currently being fielded statewide among SIM PCMH providers, care

managers, office managers, and Provider Organization practice liaisons. Once the provider survey closes (estimated September 7), MPHI will analyze the provider survey subset of the Collective Impact survey.

University of Michigan has designed a PCMH patient experience survey and presented it to PCMH practices via webinar. University of Michigan, with consultation from MPHI and MDHHS, is creating a sampling plan and preparing to deploy phase I of the Patient survey. University of Michigan is in discussion with two CHIRs who have volunteered to test a process for administering a hub client experience survey in fall 2018.

MPHI is currently analyzing Medicaid paid claims for those patients who have an identified care management billing code. MPHI's next step will be to take a comparison sample of patients and conduct difference in difference analysis. In order to analyze clients served by the hub, MPHI has requested Medicaid ID numbers of individuals served by the hubs. MDHHS is currently negotiating data use agreements with the CHIRs to ensure access to this information by the evaluator.

MSU is preparing to conduct qualitative interviews of key CHIR stakeholders.

D.2 Federal Evaluation, Data Collection, and Sharing

Michigan SIM will cooperate with the Centers for Medicare and 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 the federal evaluators (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 2019. Currently the site visit for 2019 is scheduled for March/April 2019. Site visit activities will include a set of key informant interviews with state staff, CHIR staff, PCMH providers, Medicaid Health Plans, and consumer advocates. The 2019 site visit will also include focus groups with providers and consumers. The evaluation coordinator is working with RTI to be a helpmate with evaluation all activities.

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 SIM Test 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 by providing regular performance feedback to participants.

As outlined in the SIM Award Year 4 Operational Plan Update, 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 as defined in Michigan's quarterly progress report (QPR). 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 and survey data will be the key sources for monitoring and reporting on performance for clinical quality, health care costs and utilization, patient experience, and the use of care management processes.

Performance metrics (for example Breast Cancer Screening) 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 previous Operational Plans) have been modified to better support model performance tracking in Year 3 and improved further for Year 4. The Behavioral Risk Factor Surveillance System (BRFSS) will be used to collect data on these metrics. MDHHS intends 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 to the SIM team 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

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. 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. However, over the short term Michigan is more likely to impact populations that are directly touched by programming/intervention. 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[4]
E. Tobacco Use	Screening and cessation intervention
F. Obesity	Adult BMI assessment; Weight assessment and counseling

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

CMS Recommended Measure	Proposed Core Set Metrics
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 in the SIM project, 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 and 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.

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, which may be, for example, the perceived level of burden; opportunities for improving model design; and utility of SIM-provided supports, including HIT/HIE and Collaborative Learning Network, plus others. It will use these same information sources to monitor 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
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	Quarterly
Patient Experience	• SIM leadership • Payers • Practices	• CAHPS survey vendor(s)	Bi-annually
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 alternative payment model 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 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 SIM 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 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 Office of the Inspector General 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 Agreements

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 Office of the Inspector General 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 Office of the Inspector General 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 Office of the Inspector General 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. CHIR Success Narratives