

i. MODEL TEST PROJECT NARRATIVE

Part 1: Plan for Improving Population Health

Reinventing Michigan's health care system is one of Governor Rick Snyder's top priorities. Stakeholders across the state desire a health system that achieves optimal population health, great experience of care, and lower total costs. To achieve this goal, the Michigan Department of Community Health (the Department) proposes to engage payers, providers, purchasers, and communities to implement Michigan's *Blueprint for Health Innovation*, the product of an intensive stakeholder engagement process supported by a State Innovation Model design grant. The *Blueprint* emphasizes delivery system transformation, payments based on value rather than volume, effective use of policy levers to support change, and investments to improve population health. We propose to test innovative delivery system and payment models in selected regions, and, assuming testing results in optimal outcomes, incorporate lessons learned into statewide rollout, achieving statewide transformation within five years.

The *Blueprint*, along with the *State Health Improvement Plan* (2012) provides a foundation for improving population health. Priorities include addressing significant challenges to the health of both adults and children. In 2012, an estimated 17.8% of Michigan residents were in fair or poor health. Michigan's rate of obesity is the fifth highest in the country and has increased consistently among all age groups. More than two-thirds of adults are overweight, and are at increased risk for heart disease, Type 2 diabetes, and many types of cancer. Obesity disproportionately affects low income and minority groups, and obesity-related chronic diseases are especially prevalent within Michigan's African-American and Hispanic communities. Low income and minority groups also have higher rates of chronic obstructive pulmonary disease, a smoking-related illness that is the third leading cause of death in Michigan. More Michigan

adults smoke compared to adults nationwide (23.3% compared to 19%). Michigan's infant mortality and low birth weight rates are higher than the national average, with significant disparities by race and geography.

Aims. During the model design process, stakeholders committed to the aims of better health, better care, and lower costs, and set targets that are specific, measureable, attainable, realistic, and timely. The population health goals below are consistent with recommended measures, and outcomes will be monitored annually at the state and community levels. These initial goals that we are setting for ourselves through this process reflect the state's determination to tackle the challenges of better health and better care at a lower cost. While the model is being tested and continues to evolve, these goals and metrics will also evolve to better reflect what is occurring on the ground and other external factors.

Blueprint better health goals by 2020 include reduction of infant mortality to 6.5 per 1,000 live births (baseline = 7.4 per 1,000 live births), and teen birth rates by 5% (baseline = 30.1 per 1,000 women ages 15-19); reduction of adult obesity by 5% (baseline = 31.1%) and adolescent obesity by 10% (baseline = 12.1%); an increase in adequate physical activity and consumption of fruits and vegetables by 20% (baseline = 19.7% and 17.8%); reduction of excessive alcohol consumption by 10% (baseline = 6.1%); an increase in childhood immunization status rates by 5% (baseline = 87%); and reduction of proportion of adult cigarette smokers by 10% (baseline = 23.3%). Over the long term, the *Blueprint* will also enable Michigan to reduce overall morbidity towards national benchmarks. Targets include the percentage of adults reporting fair or poor health reduced from 14% to 10%, the average number of physically unhealthy days in last 30 from 3.5 to 2.6, and the average number of mentally unhealthy days from 3.7 to 2.3.

Blueprint better care goals by 2020 focus on goals related to access to primary care, care

coordination, appropriate utilization, achieving clinical quality benchmarks, and patient-reported experience. Increased access to high-quality primary care will be measured by an increase in the number of multi-payer Patient Centered Medical Homes to 1,000 by 2020 and a corresponding increase in patients served. Michigan aims to reduce the number of residents reporting no personal health care provider from 15.8% to near zero. Increasing access to primary care and other health system improvements will reduce all-cause hospital admissions, readmissions within 30 days, ambulatory care-sensitive admissions, admissions to a neonatal intensive care unit, and emergency department visits. Quality outcomes will be measured in the domains of comprehensive diabetes care, controlling high blood pressure, tobacco use and advice to quit, depression screening, childhood immunization rates, and timeliness of prenatal care. Baseline values and targets for these measures are contained in the *Blueprint*. Finally, Michigan providers are increasingly using the Consumer Assessment of Healthcare Providers and Systems Patient Centered Medical Home survey to measure patient experience of care. This survey will be employed during the Model Test. The Performance Measurement and Recognition Committee, created to implement the *Blueprint*, will finalize additional quality metrics based on stakeholder input and guidance from the Centers for Medicare and Medicaid Services.

Blueprint cost goals by 2020: While implementation of the *Blueprint* is intended to achieve better population health and lead to a greater experience of care, this innovation is also intended to lead to a cost avoidance over five years, such that Medicare and Medicaid expenditures are less than what they would otherwise be – without making budget cuts, and while enhancing care and health of individuals. Specific savings targets and rationale is demonstrated in the financial analysis, and is based on reduced inpatient admissions, readmissions, inappropriate emergency department use, better management of chronic disease; improved birth outcomes; more

appropriate utilization of tests and procedures; and decreased administrative complexity.

Strategies. Recognizing that population health is the product of multiple factors, the *Blueprint* requires the concerted effort of many entities at local and state levels. Stakeholder feedback during the model design phase was resounding about the need to build in a sustainable mechanism to promote partnerships between the health care delivery system, public health, and community services. Based on this feedback, the *Blueprint* proposes that Community Health Innovation Regions organize partners based on the collective impact model. They will leverage community benefit and public health accreditation requirements to conduct collaborative community health needs assessments that will identify key health concerns, illuminate root causes of poor health outcomes, and set strategic priorities. As part of the Model Test, these entities will be held accountable to develop and implement action plans to organize and align contributions from all partners, and track and report key health indicators.

Simultaneously, the Department and its contractors and consultants will develop informational materials, and provide technical implementation assistance and best practice guidance, drawing on current programs and resources as well national evidence-based programs. These will be available on a “Health Innovation Website.” Examples of current interventions include the Michigan Health and Wellness Campaign (targeting tobacco use, poor nutrition, lack of physical activity, obesity reduction, age-appropriate screenings, and control of blood pressure, blood sugar, and cholesterol), the Michigan Primary Care Transformation Program, the Healthy Michigan Plan, the Michigan Infant Mortality Reduction Plan, and many local initiatives described in the *Blueprint*. The Department will collaborate actively with the Centers for Disease Control and Prevention in developing this guidance. Model Test participants will be engaged in Collaborative Learning Networks that will share experience across communities and provide

direct input into state programmatic development.

Partners. Governor Rick Snyder has assigned responsibility for the State Innovation Model initiative to the Department, which will partner with consumers and advocacy organizations, professional and organizational associations, large health systems, behavioral health providers, payers, business, Federal and other state government departments, and philanthropy. At a local level, the Department will partner with many entities, including regional health improvement organizations, chartered value exchanges, multi-purpose collaborative bodies, Aligning Forces for Quality regions, and 43 local health departments. A Population Health Advisory Board will be created to formalize this partnership, and provide guidance to the development and implementation of the Population Health Improvement Plan. The Community Health Innovation Regions will bring together additional local partners including providers, health systems, consumers, community services and supports, foundations, faith-based groups, and others.

Summary. To conclude, population health improvement is a key objective of Michigan's Model Test Proposal. Key health targets will be monitored and reported annually on public dashboards. The overarching strategy to address population health is to establish Community Health Innovation Regions, which will be accountable to improve population health Strategies will draw on existing plans, updated based on collaboration with the Centers for Disease Control and Prevention and local experience. The resulting strategies will be included in a Population Health Improvement Plan, and disseminated extensively.

Part 2: Health Care Delivery System Transformation Plan

Michigan's *Blueprint* is founded on the belief that delivery system transformation is needed and achievable using a market-based approach in which families, businesses, and public programs pay for the outcomes we want (better health at lower cost); while physicians, hospitals,

and providers across the spectrum are valued and compensated for the high quality of care they desire to give. The State of Michigan is well positioned to convene stakeholders around a common approach that moves Michigan toward this transformation. Michigan proposes to do this through testing new service delivery models in which care is coordinated across the system and community.

The *Blueprint* describes a foundation of strong primary care, combined with payment models that align incentives toward shared goals, technology to support care processes, the use of best practices from the field of improvement science to engage all stakeholders in the transformation process, enhancements to the health care workforce, and utilizing the skills of multiple professionals in care teams.

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

Accountable Systems of Care are financed by payment models that align incentives across the delivery system towards producing value over service volume. Proposed payment models are

built on evidence that financial accountability, coupled with high quality standards, can eliminate wasteful health care spending through better care delivery, better care coordination, and optimal utilization of services. Moreover, financing mechanisms that pay for value shift the focus of care to primary care, prevention and behavioral health; which in turn requires attention to the patient as a whole person and recognition that multiple factors drive health outcomes and cost. This realization motivates health care providers to collaborate to drive down health risk in the community. The Community Health Innovation Region provides a structure for this collaboration – eliminating silos and promoting efficient use of resources and collaborative problem solving that will attract funding.

Providers must not be exposed to more risk than they have the capacity to manage. Michigan's transformation plan therefore includes a glide path from a low risk, yet still accountable, payment model based on shared savings, to comprehensive payment models that offer more flexibility and more rewards.

In addition to payment reform, transformation may require a range of interventions, including supportive policies and workforce considerations, infrastructure investments, technical assistance, data, and active engagement of stakeholders in a learning health system. Parts 4-8 of this proposal address these topics.

Part 3. Payment and Service Delivery Models

Central to Michigan's *Blueprint* are three innovative service delivery and payment models that will be tested regionally before being rolled out statewide: Patient Centered Medical Homes, Accountable Systems of Care, and Community Health Innovation Regions. Patient Centered Medical Home transformation is well underway in Michigan, providing a foundation for the development of Accountable Systems of Care with clinically integrated networks for coordinated

patient care, and supporting payment models that provide a path towards increased provider responsibility for value over volume.

As described in the *Blueprint*, Michigan has made substantial progress in engaging providers in the process of practice transformation. Patient Centered Medical Homes are statewide with most payers, over 1,500 providers, and Federally Qualified Health Centers serving over a million beneficiaries in medical homes. Since there is a multi-payer demonstration already underway, this will not be a focus of the Model Test.

The Healthy Michigan Plan waiver extends Medicaid eligibility to all Michigan citizens earning below 133% of the Federal poverty level. Medicaid began enrolling the Healthy Michigan population starting April 1, 2014. As of July 10, 2014, approximately 323,000 people have enrolled. Medicaid now covers over 2.17 million people – approximately 19% of the total population. The combined effects of Medicaid eligibility increases and the dramatic transformation efforts of Michigan’s primary care practices (including the safety net) are critical to ensuring that every Michigan resident will be able to access a primary care provider.

Michigan’s Accountable System of Care model builds on the Medicare Accountable Care Organization and other payer accountability models, such as clinically integrated networks and Organized Systems of Care. This model will bring multiple payers into alignment to promote appropriate and coordinated care and administrative simplicity, while holding providers accountable for total cost of care and quality outcomes. Payers participating in the Model Test initially will include Medicaid, Medicare, and commercial insurers. Not all Accountable System of Care participants will have the capacity to bear downside financial risk for performance initially. To account for this, the Model Test requires test pilot participants to commit to a glide path, moving from Level I and Level II payment models with graduated levels of risk and

increasing opportunity to capture rewards from reduced administrative complexity and more efficient care. Level I participants will participate in shared savings with additional per member per month payments based on provider capacity (including care management for moderate and complex patients), and performance incentive payments based on quality metrics. At Level II, the Accountable System of Care will participate in more advanced payment models, including partial capitation and population-specific global capitation. The Model Test proposes an attestation model that defines the population prospectively. The model will have other requirements, such as requiring Medicaid enrollment levels based on the proportion of Medicaid beneficiaries in the surrounding Test community.

The Community Health Innovation Region described in Part 1 is based on a collective impact model. Some communities in Michigan have already developed sustainable funding mechanisms to support the backbone organization for a Community Health Innovation Region, such as support from local business and payers, hospital community benefit funding, public funding, and philanthropy, including the United Way. Better coordination of funding will reduce programmatic fragmentation and promote collaboration at the community level.

Test Population. A Model Test will allow Michigan an opportunity to roll out the *Blueprint* using a phased approach, with a four-year goal of statewide coverage. Service delivery and payment reform will be implemented first in communities with high capacity, while other communities receive implementation assistance and infrastructure investment for planned implementation in the next two years. To better understand both capacity for and interest in participating in the Model Test, the Department conducted a statewide survey of entities who felt they could lead an Accountable System of Care or Community Health Innovation Region. Questions covered topics including capacity for building systems of coordinated care, monitoring

population health and cost outcomes, using data to drive change, addressing population health, and managing financial risk. Questions also covered network adequacy and the extent of planning already undertaken in anticipation of transformation efforts stimulated by the innovation model. Surveys were returned by individuals with decision-making authority.

Taken together, and counting only those entities/networks who self-reported high capacity and interest to move towards risk based payment, respondents reported responsibility for primary care for over half of Michigan’s population, covering 45 counties, 76% of Medicare beneficiaries, 46% of Medicaid enrollees, 45% of hospital beds, and 80% of primary care providers (see Table 1).

Many entities responded with the desire to lead Community Health Innovation Regions, including chartered value exchanges, Aligning Forces for Quality communities, health improvement

| Table 1. Characteristics of Potential Test Regions | |
|---|------------------------------------|
| System Component | Coverage |
| Payers | 3 (Medicaid, Medicare, commercial) |
| Primary Care Providers | 5,330 (80% of MI total) |
| Hospitals | 41 facilities, 13,000 beds (45%) |
| Population | 5,408,393 (54%) in 45 counties |
| Medicare Beneficiaries | 1,305,013 (76% of MI total) |
| Medicaid Beneficiaries | 1,515,622 (46% of MI total) |

organizations, hospital community benefit organizations, coalitions of public health departments, and others. Many of these entities reported that they had begun planning for the Model Test with other entities from across the health care and human services delivery spectrum.

To ensure Model Test success, a formal capacity assessment will be completed in the first year to finalize regions that will be included in the Model Test in Wave I, and those that will take

an additional year of planning and be included in the Model Test in Wave II. Participation milestones in the Operations Plan are based on inclusion of 10 regions in the Model Test.

Medicaid and commercial payers are already committed to new payment models. Medicare participation is essential as well, but can be based on alignment with Accountable Care Organizations or through other means, developed in partnership with Health and Human Services. For a Level II Accountable System of Care, Michigan has proposed developing, over time, global capitation models for three target populations: at-risk pregnancy, super utilizers of emergency departments, and individuals with multiple chronic diseases. These payment models could be tested with all payers and populations, and are further described and quantified in the Financial Analysis.

Accelerating Transformation. Following implementation with initial payers, the Department will begin negotiations with additional payers. The Department has already reached out to self-insured employers, including the State of Michigan. These employers will need time to offer these products to their employees. While not all regions will participate in the Model Test, Michigan has a systematic plan to spread successful elements of the model statewide, and will continue outreach to all regions through multiple channels described in Part 6 below.

Part 4: Leveraging Regulatory Authority

The Michigan Department of Community Health recognizes that aspects of the *Blueprint* may need to be addressed by leveraging state regulatory authority. Therefore, responsibility for the Model Test is placed in the Office of Health Policy and Innovation which also oversees policy functions such as certificate of need evaluation, workforce transformation, Health Information Technology coordination (discussed in Part 5), and liaison to the legislature, Governor's Office, and other departments of the executive branch. At this time, no immediate

regulatory barriers are foreseen.

Certificate of Need. Michigan's approach to its certificate of need program balances cost, quality, and access issues, without undue political influence. An independent 11-member commission develops the review standards, and updates them every 3 years on a rolling basis. Reviews are conducted by the evaluation section of the Department. The evaluation section and the commission are committed to ongoing process improvements designed to enhance the efficacy, efficiency and transparency of the process. Working with innovation model leadership, the certificate of need program can help address anti-competitive concerns by using established health policy considerations in evaluating any significant market changes.

Workforce. As part of Governor Snyder's commitment to reforming the regulatory environment in Michigan, an advisory committee including State innovation leadership assembled in 2013 to conduct a systematic review of Michigan's Public Health Code. A primary objective of updating the Code is to verify that health care professionals practice at the top of their training and licensure, and to review the overall licensing scheme for emerging health professions while being attentive to the goal of avoiding unnecessary regulation. A policy objective of the *Blueprint* is to incorporate non-traditional professions, such as Community Health Workers, into service coordination while also supporting standards for the training and skill sets of these occupational groups so that their outcomes can be measured.

Medicaid Managed Care Contracting. Michigan Medicaid has a mature managed care system, and envisions all eligible enrollees being in a managed care plan by 2015. During the Model Test, the Department will encourage the Medicaid Health Plans to contract with Accountable Systems of Care. In this relationship, Health Plans will be responsible for contracting with Accountable Systems of Care to provide a defined set of services specific to

each payment model. They are also responsible for reconciling shared savings allocations based on a defined methodology, providing member services, and managing beneficiary provider assignments, among other tasks. The health plans will be encouraged to develop collaborative partnerships with the Systems – providing support to Accountable Systems of Care developing beneficiary utilization monitoring and alerts, beneficiary risk assessment, patient engagement services, and feedback reporting. The Health Plans have been successful in providing such services historically, and are positioned to provide guidance and leadership moving forward.

The Healthy Michigan Plan. The Healthy Michigan Plan and approved waiver provides for a number of leverage points to implement the *Blueprint*, just as implementing the *Blueprint* will advance a number of objectives contained in the Healthy Michigan Plan. For instance, the Department will collaborate with contracted health plans and providers to create financial incentives for plans that meet specified population improvement goals; for providers who meet specified quality, cost, and utilization targets; and for enrollees who demonstrate improved health outcomes or maintain healthy behaviors. Value based principles in Healthy Michigan include copayment levels and cost sharing based on choosing low cost/high value services and engaging in healthy behaviors. Per the legislation, Department has convened stakeholders and experts in partnership with the University of Michigan to examine the causes of, and best practice recommendations for reducing, inappropriate utilization of emergency departments. Payment reform that aligns health plans and providers to coordinate care across settings has been a major focus of this discussion and may likely be featured in recommendations to the legislature. Michigan’s proposed service delivery and payment Model Test specifically targets the population of super-utilizers, and the Accountable System of Care model creates the aligned incentives that are critical to addressing this problem across multiple care settings and providers.

Part 5. Health Information Technology

Michigan's Health Information Technology & Exchange Roadmap. The Health Information Technology Coordinator, the executive director of Michigan's state-designated entity for health information exchange (Michigan Health Information Network Shared Services), and the director of Michigan Medicaid's Health Information Technology Office meet regularly to update a state-level conceptual Roadmap coordinating multiple public and private initiatives focusing on the use of health information technology and secure data exchange. Michigan's Roadmap supports the *Blueprint* goals and innovation models, and the Model Test will help advance the development of real-time, standards-based interoperable health information exchange.

Michigan's collaborative approach to data exchange promotes shared public-private state-level services and data infrastructure to support population health, care, and payment, including results delivery, public health reporting, care coordination and patient safety, quality and administrative reporting, and patient engagement. Michigan has worked with federal partners and other states advancing plans for quality data infrastructure that aligns quality reporting among payers and supports real-time quality improvement at the practice level. Several projects with great promise for care coordination across the continuum are on the Roadmap, as well as ongoing privacy and security initiatives. The *Blueprint* details ongoing developments.

Current State. Fifty-three percent of over 23,000 eligible providers have received Medicare or Medicaid Electronic Health Record Incentive Program payments, as well as 90% of all hospitals. Forty-four percent of those in the Medicaid program have received Meaningful Use Stage One payments. Michigan's Regional Extension Center now assists Medicaid specialists as well as primary care providers. A recent technological capacity assessment revealed that all

Community Mental Health entities were using information technology to some extent, with the majority using Certified Electronic Health Record Technology. Michigan is making strides in improving communication between behavioral health and physical health providers using a Medicaid web-based platform (CareConnect360) to provide insight into claims data from multiple programs as well as extracts for population health analytics. The state-designated entity is convening stakeholders to establish vendor-neutral behavioral health exchange based on standardized data and consent agreements. Integrating more payers, the Continuity of Care Document and Admission/Discharge/Transfer data in real-time, and providing more analytic support for forecasting is on the Roadmap.

The state-designated entity is an independent, nonprofit organization acting as the backbone organization creating the necessary cooperative governance agreements and technical infrastructure for health information exchange needs. By setting up shared services, governance and trust agreements, the data exchange community is rapidly expanding beyond regional health information exchange providers to include health systems, vendors, HealtheWay, and commercial payers through “Qualified Organization” agreements specifying the type of data exchange the entity wishes to accomplish. Michigan’s health information exchange dashboard shows to date: nearly 5 million immunization records received from 1,165 sources (and 547 in the queue), 60 labs ready to go into production with public health reportable lab results to state registries, and 54 hospitals sending out over 1 million Admission/Discharge/Transfers messages per week on the all patient-all payer notification service. Work on an electronic Clinical Quality Measure Recovery and Repository with the Medicaid Electronic Health Record Incentive Program holds great promise in furthering the adoption and meaningful use of standards-based technology. The ongoing collaborative/competitive approach supported by Department policy is

the heart of the *Blueprint's* approach to a standards-based, interoperable technological infrastructure. Michigan's award-winning public health-Medicaid collaboration demonstrates the state's commitment to accelerating interoperable technology that improves care coordination and public health.

Even so, stakeholders wish interoperability and communications were more advanced. Providers consistently report challenges in the areas of having multiple systems within a network to integrate; connecting to, and using, data exchange services; receiving and using standard messages; having appropriate documentation templates for complex care management services; and having usable registry and clinical decision support functionality for population health management. The Model Test will address these issues by ensuring that project stakeholders are represented in the health information exchange decision-making, using supporting policy levers to promote information exchange, infrastructure investments, and offering technical assistance for infrastructure capacity development.

Governance. State innovation model governance and health information leadership are well integrated. The Office of Health Policy and Innovation includes the Health Information Technology Coordinator to oversee innovation efforts and statewide health information exchange promotion supporting a comprehensive, interoperating health and human services information systems infrastructure, working closely with other state-level leaders as described above. In addition to Department representation on the state-designated entities' Board of Directors, the Coordinator and Medicaid Health Information Technology Director and their staff participate in work groups and committees to address issue resolution, use case selection, privacy, security, and production and operations. These groups meet regularly to make decisions on issues raised by stakeholders. This approach has already had success in developing consensus-based data

governance agreements. As providers and consumers join the board, this structure will prove even more useful to identifying and resolving issues as they arise.

Policy. Model Test participation requirements and local infrastructure funding will be dependent on alignment with the Roadmap. The state will continue to support the adoption of standards for electronic health records and inter-system data exchange. The Model Test regions will be required to demonstrate widespread electronic health record adoption and inter-system data exchange, and will be required to connect to the statewide network.

Infrastructure. In the pre-implementation year, the Roadmap will develop in concert with the capacity assessments of Model Test participants. It is very likely that health care settings will need to adopt, customize, interface, or change electronic health records and other information systems as the learning health system improves data exchange capacity. As Michigan transitions into new payment models, Accountable Systems of Care will be incentivized to participate in health information exchange, which in turn depends on the information system capacity of their providers. The Department may consider inclusion of such costs in contracts, if the investments are consistent with the Roadmap.

Tracking Model Test performance will necessitate adaptations of existing infrastructure. In the pre-implementation year, project staff will develop detailed requirements in concert with stakeholders, and carefully examine available resources to determine how best to leverage work to date to accomplish performance data aggregation, participation tracking, patient segmentation, and program eligibility identification. The Steering Committee will advise on recommendations for investments in project-specific needs. Solutions that meet project needs will be developed in a manner that conforms to the Seven Conditions and Standards, is responsive to similar initiatives, and is scalable to be a statewide resource.

Technical Assistance: The participant interest survey confirmed the strong need for assistance to realize the promise of the technology and infrastructure already in place. Accordingly, the project will work with Test participants to help them realize the most effective use of the technology resources at their command, and ensure that they have access to secure, effective exchange services. Accountable Systems of Care are expected to have the capacity to assist affiliated practices to optimize technology, including effective workflow redesign. The project will make technical assistance resources (including Michigan's Regional Extension Center partners) available to assist the Accountable Systems of Care in performing this role. The Collaborative Learning Network for Health Information Technology and Exchange will help identify gaps in capacity and share best-practice solutions.

Summary. Michigan's current Roadmap is embedded in the health innovation model. Michigan enthusiastically partners with the Office of the National Coordinator to advance the interoperability and effectiveness of health information technology and exchange. The Model Test will focus on addressing barriers to use of technologies and systems that exist, as well as building out infrastructure to support operations of new payment models and using data to drive change.

Part 6. Stakeholder Engagement

Current Stakeholder Support. Since receiving the model design award, the Michigan Department of Community Health has engaged broad stakeholder groups from across the state. The survey of stakeholders described in Part 3 demonstrates the active interest and planning that is occurring among diverse groups across Michigan. A sample of this support is further demonstrated by the attached letters of support that include commercial insurers, Medicaid Health Plans, statewide professional and organizational associations, health systems, Accountable Care Organizations, consumer-oriented health coalitions, community mental health, and business groups. It should be noted that health systems and providers have specifically committed to moving towards payment models with accountability for total cost of care; and payers have committed to participate in quality measure alignment.

Plan for Maintaining and Increasing Engagement. During the Model Test period, the Department will build on this momentum by employing a strategy to generate longstanding stakeholder commitment to shared goals. This strategy engages Model Test participants in a continuous learning system that uses data and participant feedback to refine the model and embed ongoing quality improvement. Investments in a collaborative infrastructure to engage the health care delivery system and businesses, along with public health, community members, and service providers in community-wide population health planning will increase participation on every level, as will the ongoing recruitment of consumers, payers, employers, and providers to participate in the Test. A statewide communications plan directed at the public will engage stakeholders who can assist in advisory and educational capacities.

Michigan has consulted with national experts in improvement science to develop the stakeholder engagement plan. Evidence suggests that stakeholders remain engaged in working

toward a shared agenda when the process is meaningful and their interests are met. The Model Test will create the following bodies that promote engagement.

The Office of Health Policy and Innovation will coordinate the above activities and bodies, as well as develop and conduct the statewide communications plan. The Director of this Office is Michigan's 'Ambassador' for state innovation model activities, and will meet regularly with interest groups, policy makers, and other state agencies. She and her staff will present at meetings and events across the state. The Office will develop a website with public facing information, as well as a private collaboration site for participants.

The Community Health Innovation Region engages cross-sector partners to improve population health, with effective strategies to include community members. Within the delivery system, personnel from Accountable Systems of Care will be trained in quality improvement techniques. Primary care providers become designated Patient Centered Medical Homes by demonstrating capacity for patient engagement and self-management support.

The Steering Committee will include leaders from participants in the Model Test, along with state planners from the Department, the Governor's Office, and key contractors. This Committee will oversee programmatic decisions that affect Model Test participants.

Collaborative Learning Networks will ensure pilot participants across the state accelerate transformation by sharing best practices. These networks are the lynchpin for transmitting feedback from front line implementers to the Steering Committee and Office of Health Policy and Innovation.

A Population Health Advisory Board will meet semi-annually and include stakeholders who are indirectly involved in the Model Test, who have important guidance to offer, and whose support will be important in scaling up the model. This Board will also provide guidance to the

development of the Population Health Improvement Plan.

The Performance Measurement and Recognition Committee will engage stakeholders in developing and maintaining core performance measures that are acceptable and useful to multiple payers, providers, and consumers.

Other methods to be deployed include engaging subject matter consultants to develop a learning curriculum that will be offered using webinars, and who will be available for follow-up in-person consultation and capacity building. Annual summits will be conducted in collaboration with local Community Health Innovation Regions. Summits will focus on sharing information that will help a broader group of stakeholders learn from the Model Test.

Part 7: Quality Measure Alignment

Throughout the stakeholder engagement process, providers have strongly advocated for alignment of a core set of measures across the health system. Payers in the state are very aware of this issue, and are committed to ameliorating it. The *Blueprint* aims to achieve greater alignment among payers in developing shared metrics and standardized reporting methodologies. Selecting a core set of measures that will drive performance improvement across the health system is critical to assure accountability to outcomes and to provide relevant and usable information for making ongoing improvements at all levels of the health system. Within 12 months, during the pre-implementation phase, Michigan will develop the plan and will select and align quality measures for a transformed health system that achieves the three-part aim.

A multi-stakeholder performance measurement and recognition committee, as described in the *Blueprint*, will meet regularly to review and align indicators currently reported by providers to various groups, to assure that measures are meaningful and that they drive system improvement. This committee will be comprised of relevant stakeholders from private and public sectors, including representatives from Test participants, purchasers, payers, providers, state and local government, and health care consumers. The main charge of this committee will be to develop, implement, evaluate, and update a core set of performance measures for performance tracking tied to payment, and for continuous quality improvement processes. Measures will include both health care delivery and population-level performance measures. They will recognize and reward achievements in areas such as process improvement, clinical quality, cost of care, coordination of care, and patient experience of care. The committee will have a systematic process to research and leverage ongoing efforts in Michigan and nationally to crosswalk and streamline indicators. The validity of these measurements would therefore be

tested in the ongoing evaluation, and the value of the innovation model in improving quality of care and experience of care would be validated. The transparent process of developing and updating the measures that includes providers, plans and consumers will generate broad confidence among stakeholders who are accountable to the measures.

Progress to date: Several initiatives have already united payers in collaborations to evaluate and select quality metrics based on national standards such as the Healthcare Effectiveness Data and Information Set, among others. As part of the Michigan Primary Care Transformation Project, 32 Provider Organizations submit their quality data to the data aggregator, and are interested in having access to comparative data for their own quality improvement processes. The Michigan Quality Improvement Consortium unites payers and providers to benchmark metrics and set improvement targets, with the mission that "... interventions designed and implemented by each plan to improve consistent delivery of services will be at the discretion of individual plans, but guidelines, performance goals, measurement methodology, and performance reporting will be standardized." Michigan's participation in the Health Information Technology Trailblazers Initiative brought together stakeholders to discuss quality measures and a vision for developing statewide automated quality measurement, reporting, and feedback information infrastructure, which helped create linkages between these organizations and others, such as the Michigan Quality Improvement Network that supports quality initiatives and alignment of quality measures for community health centers.

Initiatives to align payers and reduce the burden on providers by standardizing and automating reporting are on the Health Information Technology Roadmap described in part 5 above. Standardized quality measures delivered by electronic health records reduce provider reporting burden and yield faster, more actionable results. Commercial engines are available to

parse quality indicators from encounter data, and are being tested by the Managed Care Plan division of Medicaid as part of a Centers for Medicare and Medicaid Services Adult Medicaid Quality grant. This work in turn supports the development of metrics as required by the Healthy Michigan Plan, and as the efforts evolve and grow it puts statewide alignment well within reach.