BUDGET NARRATIVE

1. SUMMARY

Ohio projects that a total investment of $98.6 million is required to undertake the State Innovation Model (SIM) test over the four-year period 2015-2018. Ohio is seeking $75 million in SIM collaborative agreement funding (Table 1, p2) and will commit $23.6 million in additional resources from state funding and other federal grant opportunities. In addition, in-kind contributions in personnel and fringe benefits costs will comprise an additional $105.5million. The Ohio SIM test is forecasted to return savings of up to $12.6 billion across the system over the period 2015-2020.

The Ohio Department of Medicaid (ODM) considers SIM a top priority that will fundamentally change its focus and activities. ODM therefore expects to operate the new payment models (episodes and PCMH) indefinitely beyond the period of the SIM testing grant. Over time, the operating model is expected to shift, as more of the ODM staff's day-to-day activities incorporate elements of operating episodes and PCMH, replacing some activities occurring today. In addition, with an increasing proportion of the Medicaid population in managed care, the direct role of ODM in operating these models may shift over time.

Since 2012, $11.8 million has been dedicated to support the design, implementation and operation of new payment models in Ohio. $3 million of this was federal funding from the SIM Design grant and $8.8 million was state funding (ODM). In addition, $1.3 million in-kind was received from the state, and $800,000 in-kind was received from health plans.

Table 1. Ohio SIM Model Test budget by year and funding source (in millions)

Object class category	2015	2016	2017	2018	TOTAL for 2015-2018
A. Salaries and Wages (Personnel)	$ 0.112	$ 0.112	$ 0.112	$ 0.112	$ 0.448
B. Fringe benefits	$ 0.044	$ 0.044	$ 0.044	$ 0.044	$ 0.176
C. Travel	$ 0.006	$ 0.006	$ 0.006	$ 0.006	$ 0.024
D. Equipment	$ -	$ -	$ -	$ -	$ -
E. Supplies	$ -	$ -	$ -	$ -	$ -
F. Contractual	$ 19.8	$ 18.8	$ 18.2	$ 17.6	$ 74.4
H. Other	$ -	$ -	$ -	$ -	$ -
Total direct charges	$ 19.9	$ 19.0	$ 18.3	$ 17.8	$ 75.0
J. Indirect charges	$ -	$ -	$ -	$ -	$ -
SIM GRANT TOTAL	**$ 19.9**	**$ 19.0**	**$ 18.3**	**$ 17.8**	**$ 75.0**
In-kind contributions	$ 26.2	$ 26.4	$ 26.7	$ 27.0	$ 106.2
Additional funding	$ 5.0	$ 7.6	$ 6.4	$ 4.6	$ 23.6
TOTAL	**$ 51.1**	**$ 53.0**	**$ 51.4**	**$ 49.4**	**$ 204.8**

2. BUDGET AND EXPENDITURE PLAN DETAIL

A. Salaries and Wages (Personnel) and B. Fringe Benefits ($624,000)

The Ohio SIM test is a strategic priority for ODM, and it is anticipated all Medicaid employees will spend some portion of their time working on it. The associated personnel and fringe benefits costs are categorized as an in-kind contribution from the state. SIM funding will be used to cover the salary of the Project Director in the Ohio Department of Medicaid. The Ohio Department of Health and Office of Health Transformation will provide in-kind support by way of salaries and fringe benefits over the period of the SIM test (Table 3, p12).

C. Travel ($24,000)

SIM funding will cover travel expenses for the Project Director for 4 trips, 2 nights each including airfare, meals, hotel, and other ground travel.

D. Equipment ($0)

Medicaid will not purchase any meaningful amount of equipment for the Ohio SIM Test.

E. Supplies ($0)

SIM funding will not be requested for this component. The cost of supplies and miscellaneous will be covered by vendors as described in the next section (F) below.

F. Consultant, Vendor, and Contract Services ($ 74.4 million)

SIM funding will be used for contract and vendor services. Costs are projected based on experience from a considerable amount of work to date, including design and implementation of six episodes and development of a PCMH charter, analyzing other state SIM applications, and reviewing vendor bids for similar activities with adjustments for differences in Ohio.

Medicaid will work with several contractors to support the Ohio SIM Test over the four year test period. Each will be selected based on their unique capabilities to meet specific Model Test needs and deliverables. Medicaid already has working relationships with the following vendors who are likely to be among those used: Hewlett Packard, Mercer, McKinsey & Company, and the Public Consulting Group. Medicaid will pursue contracts with vendors through a mix of formal RFPs, interagency agreements, use of existing contract vehicles where applicable, and other mechanisms in line with State of Ohio laws and policies.

Costs for contract and vendor services described below can be grouped into categories specific to the episode model, those specific to the PCMH model, and others applicable to both episode and PCMH models. $38.7 million is required for episode-specific activities, including model design/analytics/delivery, reporting and provider engagement. $18.7 million is required

for PCMH-specific activities, including model design/analytics/delivery, reporting, , provider enrollment contracting, and monitoring. $17.0 million is required for other activities that encompass both models, including program management, regulatory filings/activities, MCO contracting, patient engagement, and state program evaluation.

Once contract vendors are selected, Ohio will immediately revise the above cost item information to include the following information specific to each contractor: Name of Contractor, Method of Selection, Period of Performance, Scope of Work, Method of Accountability, and Itemized Budget and Justification. The Itemized Budget and Justification will include contract staff positions dedicated to the SIM program including the annual salary, percentage of time budgeted, total number of months, and any indirect costs. Tasks, deliverables, and the Expected Rate of Compensation will be clearly stated.

Ohio does not propose to charge to the SIM grant any contracts with individual consultants.

Program management ($6.3 million). $6.3 million is required to maintain and refine program governance, conduct overall project management, support CMS/CMMI interactions and requests, consider regulatory changes, support general, payer-centric and employer-centric stakeholder engagement, and help engage with Medicaid MCOs. $1.9 million is anticipated for 2015, $1.8 million for 2016, decreasing to $1.3 million per year for 2017 and 2018. This is expected to be contracted to a consulting firm with experience and expertise in payment innovation, large scale project management, and familiarity with Ohio and its stakeholders.

Episode model design, analytics, delivery ($24.9 million). $11.2 million is required to select episodes, gather clinical input, analyze key choices, define quality metrics, and

summarize key elements in *Detailed Business Requirements* documents that will be used by MCOs to launch episodes in a consistent manner. It is expected that design costs per episode would be $400,000 per episode in 2015 and 2016, decreasing to $190,000 per episode in 2017 and 2018. $5.5 million is required to develop and run the episode analytics engine and algorithms, implementation costs are projected to be $125,000 per episode. $4.6 million is required to collect and integrate claims and non-claims data, run the analytics algorithms every quarter, maintain the model and update billing codes, with operating costs projected to be $20,000 for data collection/integration per quarter and $25,000 per episode per quarter in 2015, $20,000 in 2016, $15,000 in 2017 and $10,000 in 2018. Evaluation and refinement costs are projected to be $600,000 in 2015 and $1 million annually thereafter. This cost category is anticipated to be contracted to healthcare analytics vendor with deep experience in designing episodes in a public multi-stakeholder process. $4.9 million of state funding has already been committed to the design, implementation and reporting of the first six episodes in Ohio.

Episode reporting ($7.4 million). $5.4 million is required to produce quarterly reports for each episode for each accountable provider, with costs expected to be $25,000 per report in 2015, $22,000 in 2016, $19,000 in 2017 and $15,000 in 2018. Report design (refinement) for new episodes, together with program evaluation, are expected to cost $500,000 per year. This cost category is anticipated to be contracted to a healthcare analytics vendor with deep experience in episode reporting.

Episode provider engagement ($6.5 million). $2 million is required to develop the episode provider engagement approach, which will include identifying messages and

communication channels, coordinating with key stakeholders, creating both basic episode educational documents and advanced training materials (i.e., tools on how to interpret reports), and models for targeted, direct provider support. $1 million per year for 2015 and 2016 is required to implement the strategy. $2.5 million is needed to conduct operations, $1 million per year in 2016 and 2017, decreasing to $500,000 in 2018. A number of different types of vendors would be considered for these activities including media/communication firms, consulting firms, IT vendors, provider associations, etc.

PCMH model design, analytics, delivery ($8 million). $4 million is required to lead a collaborative, multi-stakeholder process to detail all aspects of the state's PCMH model including attribution logic, requirements for participation, quality metrics, etc. This will include $3 million in 2015 for overall design and $500,000 each in 2016 and 2017 for refinements during regional rollout. $1 million is needed to create the analytics engine/models including total cost of care algorithms; $500,000 in 2015, decreasing to $250,000 in 2016 and 2017. Operating costs for the PCMH model are anticipated to be $1 million annually from 2016 on, covering data collection and integration, together with regular data refreshes and analytics. This cost category is anticipated to be contracted to a healthcare analytics vendor with deep experience in designing PCMH programs and technical models in a multi-payer environment.

PCMH reporting ($3 million). $1 million is required to design PCMH report templates, $500,000 is needed to implement reporting, and $500,000 annually starting in 2016 for operating reporting (local data collection, portal data incorporation, generation of quarterly

reports). This cost category is anticipated to be contracted to healthcare analytics vendor with deep experience in designing, developing, and producing PCMH reports.

Provider contracting enrollment ($3.3 million). $250,000 is required to implement provider recruitment and re-contracting in relation to PCMH, and $1 million per year thereafter to manage re-contracting. An administrative vendor is anticipated to provide this service.

PCMH provider engagement ($2.7 million). $500,000 is required to design PCMH program educational materials and plan the approach to raise awareness prior to program launch, and $2.2 million is to implement this outreach plan in support of regional enrollment ($1 million in 2015, $400,000 each year for 2016-2018).

PCMH monitoring ($1.8 million). Existing Medicaid staff will design the approach to PCMH monitoring. $250,000 is needed to implement the strategy, including auditing provider compliance with PCMH technical requirements and milestones. $500,000 per year is needed for annual operations, including liaising with providers regarding performance, developing performance improvement strategies/plans and managing re-certification/disenrollment from PCMH program. This cost category is anticipated to be contracted to consulting/evaluation vendors that have experience developing PCMH monitoring approaches for other payers.

Patient engagement ($4 million). $4 million will be used to fund promising innovations in patient engagement, encouraging healthy competition and fostering public/private partnerships. $500,000 will be used to design the approach to select, fund and develop such initiatives, $500,000 to implement and $1 million each year in 2016-2018 to operate them.

State and local entities will submit proposals for innovations they would like to test through an innovation competition, and the state will run a competitive process to select pilots to fund.

MCO/rate-setting ($2.6 million). $1.4 million is required for design costs, covering ad hoc analyses/support (e.g., actuarial support for PCMH shared savings model, requests from the legislature). A further $1.2 million in operating costs is needed for ongoing incremental actuarial support, to incorporate the impact of episodes and PCMH on MCO rate-setting. An actuarial firm will provide these services.

State evaluator cost ($4 million). $4 million of SIM funding will be applied for state-wide program evaluation, $1 million per year for each year during the period 2015-2018. Vendor(s) that lead evaluation will have experience evaluating episode-based payment and PCMH models in large-scale, multi-stakeholder initiatives.

Table 2. Total contract and vendor costs by operating cost category (in millions)

Note changes in categories and totals.

Cost category	2015	2016	2017	2018	Total
Program management	1.9	1.8	1.3	1.3	6.3
Model design, analytics and delivery - episodes	5.0	5.8	7.0	7.2	24.9
Reporting - episodes	1.1	1.6	2.0	2.6	7.4
Episode provider engagement	2.5	2.5	1.0	0.5	6.5
Model design, analytics and delivery - PCMH	3.5	1.8	1.8	1.0	8.0
Reporting - PCMH	1.5	0.5	0.5	0.5	3.0
Provider contracting enrollment	0.3	1.0	1.0	1.0	3.3
PCMH provider engagement	1.5	0.4	0.4	0.4	2.7
PCMH monitoring	0.0	0.8	0.5	0.5	1.8
Patient engagement	1.0	1.0	1.0	1.0	4.0
MCO / rate setting	0.6	0.7	0.8	0.7	2.6
State evaluator	1.0	1.0	1.0	1.0	4.0
Grand Total	**19.8**	**18.8**	**18.2**	**17.6**	**74.4**

H. Other ($0)

There are no other costs included in the Ohio SIM Test budget.

I. Total Direct Cost ($75.0 million)

As described above, the total direct cost of the Ohio SIM test is $75.0 million over the four-year period 2015-2018.

J. Indirect Costs ($0).

SIM funding will not be requested for indirect costs.

3. OTHER

In-kind services and resources ($105.5 million). In-kind support is anticipated from OHT, ODH and ODM by way of personnel and fringe benefits (Table 3, p12). In addition, commercial payers will also have personnel and fringe benefit costs related to the SIM project and are likely to invest in the following cost categories for their covered populations: model design, analytics, and delivery for episodes and PCMH models (implementation and operation), episode reporting (operation), PCMH reporting (implementation and operation), re-contracting (design and implementation) and payment (implementation). Potential additional areas of investment are payer/provider connectivity (design, implementation and operation), and provider enrollment and contracting (implementation and operation).

Other grants or revenues ($ 17.3 million). The state will commit state resources to fund several activities to support SIM operations and infrastructure. These include provider support,

payment, payer/provider connectivity, provider/provider connectivity and system infrastructure, and incremental funding for MCOs/rate setting.

Provider support – inbound ($1 million). $250,000 is required to educate customer support staff on episode and PCMH models and to develop capabilities to manage issue resolution. $250,000 per year is anticipated for fielding inbound provider inquiries and to continue staff training to reflect changes to episodes and PCMH models, reporting and payments. A consulting firm with experience in setting up provider support functions and delivering training to inbound provider support staff is anticipated to provide this service.

Payment ($3.5 million). $500,000 is required in 2016 to deliver provider support payments (e.g., PMPM fees) for PCMH. An additional $1.5 million per year is needed from 2017 to define a consistent payment approach, develop API to payment systems, create system capability to issue bonuses and "withholds", reconcile payments and update the payment system as needed. This is likely to be Medicaid's MMIS vendor, which manages Medicaid's payment infrastructure and administers current payments.

Payer/provider connectivity ($2.5 million). $500,000 is required to design modifications to the existing provider portal functionality (i.e., to add new reports), $500,000 is needed to implement portal updates, $500,000 per year is needed to load new reports on a quarterly basis, distribute reports to providers, capture, store and transmit clinical data to the analytics engine, and to analyze and report on provider utilization. These services are anticipated to be provided by an IT vendor.

Provider/provider connectivity and system infrastructure ($10 million). $2 million will be used in 2015 to finalize the HIT strategy and $2 million to expand the state data gateway to an enterprise service. $4 million is budgeted in 2016 and $2 million in 2017 to finalize the implementation of the HIT plan. This will include detailed design in several critical topics that will be determined during the strategy (e.g., all payers claims database, HIE, integrated reporting), connect public health registries to the enterprise HHS data warehouse, and program management. Consulting/IT vendors are anticipated to work with OHT and the HIT Council to design the strategy and implement the specific initiatives.

MCO/rate-setting ($0.2 million). The state will fund $0.2 million in additional support for actuarial support operating costs, to incorporate the impact of episodes and PCMH on MCO rate-setting. An actuarial firm will provide these services

Expected or needed funding from other federal sources ($6+ million). With the announcement of the Transforming Clinical Practice Initiative, the state anticipates a Practice Transformation Network (PTN) will play a key role in supporting practice transformation and complement Ohio's SIM payment and delivery models. The State of Ohio is working with various stakeholders to request at least $6 million in PTN funding to provide targeted practice transformation technical assistance, for example for practices in underserved communities or where health disparities are significant. (This will further supplement the funds for provider support included in the PCMH payment model that are intended for practice reinvestment.) Depending on the scope of PTN(s) developed in Ohio, this targeted funding for high-needs practices may be part of a larger PTN collaborative agreement. The state will partner with local

and regional organizations with relationships with provider communities and experience designing and implementing PCMH practice transformation strategies to collaborate on a PTN approach that also complements the goals of SIM. In the case of a PTN funding not being awarded in Ohio, practice transformation activities will continue (i.e., with the abovementioned funds for provider support in the PCMH payment model), but the pace of transformation may be slower.

Attestation that Innovation Center funding will not supplant any other funding sources. We attest that Innovation Center funding will not supplant any other funding sources. Please find attached a table of key personnel from the Office of Health Transformation, Ohio Departments of Medicaid and Health with role, salary, and time allocated to the project.

Table 3. In-Kind Contributions (in millions)

Source	Support	Rationale for inclusion as in-kind support
OHT	**$1.7**	• Will support planning, program management and vendor management for operations, to ensure the success of this initiative. • Six FTEs will be working on the initiative for 80% of their time. Salaries and fringe benefits are subject to administrative claiming. • In kind contribution includes salaries, fringe benefits and travel to/from meetings for the duration of the grant period.
ODH	**$35.3**	• Will contribute program/policy leadership, project management, subject-matter expertise, analytics expertise, working with vendors to support the design, implementation and operation of the multi-payer PCMH and episodes models, including engaging stakeholders to obtain buy-in throughout the duration of the project. • ~294 FTEs will be working on this initiative for 30% of their time. • In kind contribution includes salaries, fringe benefits and travel to/from meetings for the duration of the grant period.
ODM	**$68.5**	• Will contribute program/policy leadership, project management, subject-matter expertise, analytics expertise, working with vendors to support the design, implementation and operation of the multi-payer PCMH and episodes models, including engaging stakeholders to obtain buy-in throughout the duration of the project. • ~550 FTEs will be working on this initiative for 30% of their time. Salaries and fringe benefits are subject to administrative claiming. • In kind contribution includes salaries, fringe benefits and travel to/from meetings for the duration of the grant period.
TOTAL	**$105.5**	

Ohio SIM Key Peronnel						
Division	**Name**	**Title**	**Salaries**	**Allocation (Low)**	**Allocation (High)**	**Responsibilities**
OHT	Greg Moody	Director	120,016	20%	80%	Overall convener on behalf of Governor, leadership of all SIM efforts and multi-stakeholder strategy leadership
OHT	Aaron Crooks	Director of Government Affairs	115,003	10%	40%	Responsible for all legislative activities to further SIM efforts
OHT	Monica Juenger	Director of Stakeholder Relations	85,009	80%	100%	Responsible for all stakeholder management and communication, including federal government interface, provider group, payer group, patient advocate, and other stakeholder convening and outreach
OHT	Rick Tully	Policy Manager	75,358	50%	100%	Responsible for all SIM contracts and vendor management, and key advisor and convener on all SIM behavioral health related activity
OHT	Theresa Hatton	Office Manager	69,722	50%	100%	Responsible for management of all front office functions for SIM, including scheduling meetings, managing calendars, coordinating convening space and technology
ODM	John McCarthy	Director	128,003	20%	80%	Cabinet level implementation leader of overall SIM effort
ODM	Mary Applegate	Medical Director (On Loan to Health)	235,934	20%	80%	Responible for all clinical input, final decision making, and all convening of clinical advisors for overall effort, including overall leadership of all health quality initiatives under SIM
ODM	Vacant	Deputy Director, Chief of Policy	TBD	20%	80%	Responsible to ensure seamless integration of SIM into larger Medicaid environment and architecture
ODM	Jennifer Demory	Chief of Staff	93, 205	10%	40%	Responsible for SIM related hiring, management of human relations to support SIM execution
ODM	Roger Fouts	Chief Operating Officer	111,592	20%	80%	Responsible for oversight of all provider relations (call center, ombudsman office)
ODM	Michelle Horn	Chief Financial Officer	105,498	10%	40%	Responsible for all SIM implications of overall medicaid budget and tracking of flows of funds
ODM	James Tassie	Chief Legal Officer / General Counsel	104,166	10%	30%	Responsible for all legal, statutory, and regulatory implication of SIM
ODM	Heather Sullivan	Sr. Legal Counsel	83,783	10%	30%	Responsible for all data use agreements
ODM	Mel Borkan	Chief Strategy Officer	102,814	20%	40%	Responsible for overall allocation of project management resources
ODM	Eric Skorma	Chief Information Officer	108,160	10%	30%	Responsible for oversight of all Medicaid data infrastructure and resources to support SIM payment strategies
ODM	Sam Rossi	Communications Director	75,379	20%	75%	Responsible for all communications strategy, outreach strategy, website strategy, press relations
ODM	Dale Lehmann	Chief, Managed Care Contract Administration	98,030	20%	50%	Responsible for all MCP contract implications of SIM, and coordination with MCPS for successful implementation
ODM	Jim Downie	Chief, Federal and State Compliance	90,979	75%	100%	Day to day deputy project manager for all SIM activities, including data anlysis and quality and operational strategy.
ODM	Kimberly Movshin	Financial Project Manager	87,194	75%	100%	Day to day deputy project manager for all SIM activities, including data anlysis and quality and operatoinal strategy.
ODM	Meagan Groves	Section Chief, External Business Relations	85,592	20%	40%	Responsible for all first line responses to and routing of provider inquiries, as well as provider training
ODM	Ogbe Aideyman	Chief, Bureau of Health Plan Policy	99,341	10%	50%	Responsible for integration of SIM into all hospital payment strategies
ODM	Mitali Ghatak	Director, Financial Management, Planning and Ra	102,815	10%	50%	Responsible for all SIM ramifications of actuarial and rate setting activities
ODM	Kendallyn Markman	Section Chief, Data Analytics	87,880	20%	50%	Responsible for all MCP related data quality hygeine and issue resolution
ODH	Richard Hodges	Director	130,499.20	20%	50%	Cabinet level implementation leader of overall SIM effort
ODH	Mary Applegate, MD	Chief Medical Officer (interim)	184,995.20	10%	50%	Responible for all clinical input, final decision making, and all convening of clinical advisors for overall effort, including overall leadership of all health quality initiatives under SIM
ODH	Heather Reed	Bureau Chief, Community Health Services and Pa	99,340.80	60%	100%	Responsible for activities related to primary care workforce development
ODH	Amy Bashforth	PCMH Administrator	89,398.40	60%	100%	Responsible for monitoring and information sharing of PCMH activities
ODH	Melissa Bacon	Chief Policy Advisor	110,260.80	10%	40%	Responsible for policy oversight and integration

** Allocations meant to reflect percent of time spent on SIM responsibilities in any given week -- low column represents a low allocation week and high column represents a high allocation week*