JOHN R. KASICH
GOVERNOR
STATE OF OHIO

September 20, 2012

Michelle Feagins, Grants Management Officer
Office of Acquisition and Grants Management
Centers of Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 733 H-02
Washington, DC 20201

Intent to apply for a State Innovation Model Design Grant

Dear Ms. Feagins,

I am pleased to notify you that the State of Ohio is applying for a State Innovation Model (SIM) Design Grant. Ohio is seeking the Design Grant to refine our existing State Health Innovation Plan and to scale up two specific healthcare payment and service delivery innovation models: (a) patient-centered medical homes (PCMH) and (b) episode-based payment.

In January 2011, I created the Governor's Office of Health Transformation (OHT) to reform Ohio's health care payment and delivery systems. OHT focused first on getting our own system in order by modernizing Medicaid and streamlining health and human services infrastructure then worked with other state agencies to build strong partnerships between providers, insurers, academic institutions, consumers, and employers. As a result, Ohio has several health care reform initiatives already underway, including a multi-payer integrated care delivery system for Medicare-Medicaid enrollees, health homes for Ohioans with severe mental illness, a 10-percent set aside within the Ohio Medicaid nursing home per diem that links payment to person-centered outcomes, and the PCMH Education Pilot Project—a learning collaborative of 50 primary care teaching practices engaged in practice transformation and involving both medical and nursing training and education in advanced primary care.

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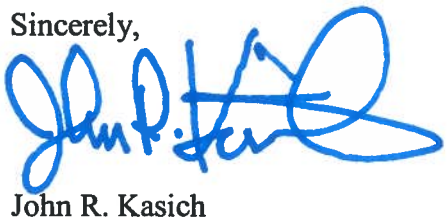
The SIM Model Design Grant is well-timed for Ohio to build on its success and engage other public and private sector partners to design and implement new payment and delivery systems that signal powerful expectations for better care. OHT, headed by Greg Moody, will lead this effort for the State. We will rely on an already-established Governor's Advisory Council on Payment Innovation to provide input from prominent Ohio employers, health plans, health systems, and consumer advocates. And we will keep in place a multi-payer State Innovation Model "Core Team" that helped us prepare Ohio's Design Grant application, including Aetna, Anthem, CareSource, Medical Mutual, UnitedHealthcare, and Ohio Medicaid (we look forward to Medicare joining this Core Team).

We are excited that the CMS Innovation Center continues to encourage states to provide leadership in payment innovation and service delivery model implementation. We look forward to meeting that challenge in Ohio and working with the CMS Innovation Center, Medicare, and others to improve the way we deliver and pay for care. Please let me know if there is anything more I can do to support your favorable consideration of Ohio's State Innovation Model Design Grant application.

Sincerely,



John R. Kasich

Governor

Ohio | Governor's Office of Health Transformation

STATE INNOVATION MODEL

DESIGN GRANT APPLICATION

State of Ohio

9/21/2012

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Project Abstract

Ohio is applying for the State Innovation Model (SIM) design grant to improve overall health system performance by engaging public and private payers in statewide implementation of Patient Centered Medical homes (PCMH) and Episode Based Payment models.

Goals: Ohio Governor John Kasich created an Office of Health Transformation in January 2011 to develop a healthcare system that is more effective and efficient, promotes evidence-based patient-centered care for all Ohioans, and focuses on prevention and maintaining and restoring health rather than simply treating disease. Ohio's current approach embraces the goals of the Center for Medicare and Medicaid (CMMI) State Innovation Plan. The design grant will accelerate Ohio's capability to:

- Expand the capacity and availability of qualified medical homes to most Ohioans across Medicaid/CHIP, Medicare, and commercially insured patients in a 3-5 year timeframe; and
- Define and administer episode based payments for acute medical events across Medicaid/CHIP, Medicare, and commercially insured patients in a 3-5 year timeframe.

Budget and Use of Funds: Ohio proposes a comprehensive nine-month project, starting October 2012, that engages public and private sector stakeholders to:

- Formalize a comprehensive State Innovation Plan that builds on ongoing transformation activities, with potential refinements based on learning to date and stakeholder feedback;
- Finalize the design of PCMH and episode based payment models and plan implementation at scale across Ohio; and
- Complete the SIM testing grant application.

Ohio's SIM initiative will require sophisticated project management and facilitation, rigorous research and analysis, and extensive stakeholder engagement. The state's initial estimates suggest this effort will cost the state and its partners about $7.1 million to support subject matter expertise, human capital, and infrastructure. The state proposes to fund its SIM initiative through a combination of $4.1 million support from the state and private payers and $3 million in requested design grant funds from CMMI.

Projected Impact: Ohio's SIM initiative will encompass the majority of Ohioans across the full range of health services, from preventive to post-acute. The program is potentially applicable to:

- 11 million Ohioans, including 1.6 million Medicaid beneficiaries;
- $82 billion in statewide health expenditures, including $15 billion on Medicaid; and
- 80 percent of total health care spending is addressable through PCMH and 50-70 percent is addressable through episode based payments.

Project Narrative

A. STATE HEALTH CARE INNOVATION PLAN DESIGN STRATEGY

VISION AND CONTEXT

Governor John Kasich in his first week in office created a new Office of Health Transformation to engage private sector partners to improve Ohio's overall health system performance. Rather than letting our current health care payment systems continue to drain the value out of the care we buy, the Governor's plan for Ohio is to design and implement systems of payment that signal powerful expectations for better care. Ohio's focus is on wellness and prevention, and promoting effective, patient-centered, timely, safe, efficient and equitable care for everyone.

Ohio plays a significant role in the national healthcare landscape. As the 7th largest state in the country, its policies have broad and considerable impact. Health policies affect 11 million Ohioans, across Medicare (1.6 million), Medicaid (1.6 million), commercial (6.5 million) and uninsured populations (1.6 million)[1]. Financial implications are weighty, with $82 billion in annual health expenditures across Medicare ($19 billion)[2], Medicaid ($15billion)[3], and the private sector ($49 billion)[4]. And Ohio has proved a successful testing ground for innovations, making nation-leading strides in comprehensive primary care, integrated care for the dual-eligible population, PCMH medical curricula, and maternal and prenatal care.

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[1] Kaiser State Health Facts, 2010
[2] CMSNHEA, 2009
[3] Kaiser State Health Facts, 2010; $11 billion federal funds; $4 billion state funds
[4] CMSNHEA, 2009. Estimated as total health care spend less Medicare and Medicaid spend

Ohio has a clear vision for health transformation that relies on forward-thinking, solutions-oriented strategies to bring health system performance in line with these heartland values:

- **Market based**: Reset the basic rules of health care competition so the incentive is to keep people as healthy as possible.
- **Personal responsibility**: Reward Ohioans who take responsibility to stay healthy – and expect people who make unhealthy choices to be responsible for the cost of their decisions.
- **Evidence based**: Rely on evidence and data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost.
- **Transparent**: Make information about price and quality transparent, and get the right information at the right place at the right time to improve care and cut costs.
- **Value**: Pay only for what works to improve and maintain health – and stop paying for what doesn't work, including medical errors.
- **Primary care**: Transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible.
- **Chronic disease**: Prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs.
- **Long-term care**: Enable seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.
- **Innovation**: Innovate constantly to improve health and economic vitality – and demonstrate to the nation why Ohio is a great place to live and work.

Ohio must overcome challenges to achieve its vision – the same challenges that every health care payer confronts in an expensive and fragmented system that struggles to demonstrate value:

- **Fragmented system with sub-optimal purchasing:** Health plans pursuing disparate payment and delivery systems create mixed incentives for providers. Patients often face a disjointed provider system, with inadequate coordination and accountability. Similarly, Ohio health and human services policy, spending and administration are split across multiple state and local government jurisdictions, impeding innovation and lacking accountability.
- **Growth in healthcare spending:** The fragmented system increases healthcare spending, which is growing at an unsustainable rate. When Governor Kasich took office in 2011, Medicaid spending was growing four times faster than the Ohio economy and now consumes 30 percent of total state spending and 3.6 percent of the Ohio economy (2011). Similarly, Ohio's commercial healthcare premiums (PMPM) have grown 8.6 percent per year over the past three years.
- **Spending not correlated with better outcomes:** Higher spending in Ohio does not correlate to better value. Ohioans spend more per person on health care than residents in all but 17 states, yet higher spending has not resulted in better outcomes; The Commonwealth Fund's 2011 State Scorecard on Health System Performance ranked Ohio #37 in health outcomes.

OHIO HEALTH CARE INNOVATION PLAN

Ohio has created a comprehensive innovation plan to address these challenges. Governor Kasich created the Governor's Office of Health Transformation (OHT) in January 2011 to address Medicaid spending issues, plan for the long-term efficient administration of the Ohio Medicaid program, and engage private sector partners to improve overall health system

performance in Ohio. OHT has significant authority to coordinate strategic planning and budgeting across multiple state agencies, including the Office of Budget and Management, Bureau of Worker's Compensation and Ohio Departments of Administrative Services, Aging, Alcohol and Drug Addiction Services, Developmental Disabilities, Health, Insurance, Job and Family Services, Mental Health, Rehabilitation and Corrections and Youth Services. Working together, and with input from the private-sector, these agencies developed a comprehensive three-phase innovation strategy to improve overall health system performance in Ohio.

Phase 1: Modernize Medicaid. ***Key priority initiated in 2011.***

Governor Kasich's Jobs Budget (HB 153 enacted June 2011) included comprehensive Medicaid reforms to improve the quality of health care for 2.2 million Ohioans served by Medicaid. These reforms include a multi-payer integrated care delivery system for Medicare-Medicaid enrollees, health homes for Ohioans with severe mental illness, and a ten-percent set aside within the Ohio Medicaid nursing home per diem that links payment to person-centered outcomes. These initiatives are designed to prevent illness and avoid costly emergency room visits, integrate physical and behavioral health care benefits, and allow more seniors and people with disabilities to live at home instead of in nursing homes. By resetting Medicaid payment rules to reward value instead of volume, the Jobs Budget also stabilized Medicaid program spending. Medicaid cost savings played a key role in closing an unprecedented budget gap of $8 billion in 2011.

Phase 2: Streamline Health and Human Services. ***Key priority initiated in 2012.***

Ohio health and human services (HHS) policy, spending, and administration are split across multiple state and local government jurisdictions. The complexity and fragmented nature of this structure is inefficient and consistently produces programs that function isolated within one

system rather than working across systems to coordinate all of the services a person might need.OHT is focused on restructuring and consolidating HHS operations and right-sizing state and local service capacity to be more efficient. Current priorities include integrated claims payment and eligibility systems. The ultimate goal is to share services in a way that improves customer service, increases program efficiencies, and reduces costs for Ohio's taxpayers.

Phase 3: Engage private sector partners in payment reform. ***Key priority for 2013.***

Thirty-six states are ahead of Ohio when it comes to offering employers a healthy workforce. This is unacceptable to Governor Kasich. Rather than letting current health care payment systems continue to drain the value out of the care we buy, Governor Kasich directed OHT to convene and engage public and private sector partners to design and implement systems of payment that signal powerful expectations for better care. For the State of Ohio, this effort includes all of the agencies with a role in health care regulation (e.g., Insurance, Health, Tax), health care purchasing (e.g., Administrative Services for state employees, public employment retirement systems, Medicaid, Workers' Compensation), and economic development (e.g., Jobs Ohio, Development Services). The ultimate goal is to align public and private health care purchasing power to standardize and publicly report performance measures, and reform the health care delivery payment system to reward the value of services, not volume.

ROLE OF THE STATE INNOVATION MODEL IN OHIO

The SIM design grant is well-timed to assist Ohio in accelerating the third phase of its Health Innovation Plan and taking promising health care payment innovation models to scale. Ohio

already is a testing ground for payment innovation (see the examples in Exhibit 1 below).

Exhibit 1: Examples of public and private sector led care delivery system and payment reform initiatives

	Payment type		
	FFS, P4P	Episode based	Population based
State of Ohio-led	▪ Home Choice ▪ Nursing facility incentive framework ▪ Managed Care performance framework	▪ HHS Strong Start Ohio	▪ SPMI – health homes for severe and persistent mental illness ▪ PCMH Education Pilot Program
Medicare-led	▪ Nursing Facility Preventable Hospitalizations	▪ Community Care Transition Programs (Medicare and Medicaid)	▪ Medicare shared savings ACO's at UH, Summa, Mercy ▪ Pioneer pediatric ACO at Rainbow babies
Private health plan-led	▪ Shared savings with LTC pharmacies (United) ▪ Hospital performance incentive program (Aetna) ▪ Shared savings with Ohio Health (Medical Mutual)	▪ Bundled payment tests, e.g. transplants, hip replacements, frequent ED users (United, Aetna, Medical Mutual) ▪ Cleveland Clinic bundled payment contracts with employers	▪ Hybrid PCMH program with quality bonuses rolling out 2013 (Anthem) ▪ Statewide PCMH Recognition Program (Aetna) ▪ Network building project with PCMH focus (Medical Mutual)
Multi-payer			▪ PCMH in three largest MSAs including CPCi in Cincinnati ▪ Partner for Kids Expansion ▪ Community Oncology Medical Homes

The SIM design grant will enable Ohio to take payment innovation to the next level of effectiveness. It will provide the resources necessary to coordinate current initiatives, learn from them, and design new programs to scale. The SIM design grant will enable Ohio to:

- **Be bold and galvanize stakeholders** to roll out a statewide payment reform program that includes all regions, providers and populations;
- **Support local innovation** by providing the resources to connect to community initiatives, assessing performance, and scaling up initiatives that work;

- **Advance multi-payer** leadership to create consistent incentives and standardized reporting rules, enable change in practice patterns, generate the necessary scale to justify investments in new infrastructure, and motivate patients to play a larger role in their health; and
- **Control cost growth** while improving quality, care outcomes, access to care, and Ohioans experience with the health care system.

PROPOSED PAYMENT AND SERVICE DELIVERY MODELS

While Ohio's public and private payers will continue to pursue various payment models, Ohio's State Innovation Plan will focus on advancing two scalable, high impact models: patient-centered medical homes and episode-based payment.

Model #1: Patient-Centered Medical Homes (PCMH)

Ohio's first goal is to expand the capacity and availability of qualified medical homes to most Ohioans across Medicaid/CHIP, Medicare, and commercially insured patients in a 3-5 year timeframe. This objective is based on strong evidence that PCMH improves health outcomes and patient satisfaction, and lowers costs.

Benefits of PCMH

PCMHs address the known gaps in the existing health care delivery system by aligning with several core principles: patient-centered and whole-person oriented, team-based approach, care coordination and integration, quality and safety, and enhanced access. Empirical evidence underscores the cost and quality benefit of a well-designed and executed PCMH:

- Community Care of North Carolina's care coordination for Medicaid/CHIP enrollees across both large and small physician practices resulted in an annual savings of $400 million for the aged, blind and disabled population, with improved quality and outcomes;
- Nurse care coordinators for Medicare patients with high acute utilization at Massachusetts General Hospital resulted in an annual net savings of 7 percent; and
- Group Health PCMH pilot for a 9,200 patient practice in Washington State resulted in $10 per member per month savings with a 30 percent drop in emergency department visits and a 6 percent drop in in-patient admissions.

Foundation for success

The state has made significant progress toward transforming its healthcare system away from a high-cost, fragmented and disconnected system to a coordinated, value-driven system based in part on the PCMH model of care. Existing PCMH activity in Ohio includes:

- **Multi-payer PCMH pilots** in three major cities that include FQHCs, private clinician's offices, and hospital-based practices. The Columbus, Cleveland and Cincinnati areas, through Access HealthColumbus, Better Health Greater Cleveland, and the Health Collaborative of Cincinnati have established PCMHs that can serve as models for the SIM design. Additionally, the Cincinnati/Dayton area has been selected as one of seven regions nationally to participate in the CMMI Comprehensive Primary Care initiative (CPCi). Currently there are almost 160 provider sites in Ohio that are PCMH-recognized through the National Committee for Quality Assurance (NCQA) or the Accreditation Association for Ambulatory Health Care (AAAHC). Ohio will partner with these organizations throughout the model design period to develop a broader PCMH approach across the state.

- **The Ohio Patient-Centered Primary Care Collaborative (OPCPCC)**, a coalition of 400+ primary care providers, insurers, employers, consumer advocates, government officials and public health professionals working together to coordinate statewide efforts to implement best practices to advance patient-centered primary care. The State of Ohio will rely on OPCPCC throughout the SIM initiative for input into PCMH model design.
- **The PCMH Education Pilot Project**, a State-funded grant program that provides technical assistance to convert 50 primary care practices in underserved areas to PCMH status and use those sites for training in advanced primary care. These 50 sites have already begun their transformation through a contract with TransforMED. A statewide public health and health care collaboration, called the PCMH Education Advisory Group (EAG), comprised of various stakeholders from government agencies, educational, medical, and nursing organizations, provides input and guidance for the implementation of the project. All sites selected in the pilot have an affiliation with a medical or nursing school and will be training medical and nursing students, interns and residents on a patient-centered model of care using a curriculum developed by the EAG.

Challenges to address in the SIM design process

Ohio will need to address many challenges in order to implement PCMH at full scale and ensure desired improvements in performance, including:

- Geographic expansion, including urban and rural geographies in Ohio with a mix of delivery system structures, populations, existing primary care capacity, etc.;
- Patient engagement and support, including linkages to disease self-management programs in the community;

- Incorporation of behavioral/mental health management through public and private sector partnerships;
- An aligned attribution model that accounts for variation across practice patterns;
- Portal and registry development, access expansion via telemedicine and potentially other aspects of Health Information Exchange related to medical homes; and
- Primary care workforce development through curriculum reform, primary care education scholarships and implementation of the Ohio Primary Care Workforce Plan.

Model #2: Episode-based payment

Ohio's second goal is to define and administer episode-based payments for acute medical events across Medicaid/CHIP, Medicare, and commercially insured patients in a 3-5 year timeframe. Episode-based payments represent a significant opportunity, applicable to as much as 70 percent of healthcare spending, including most procedures (e.g., pregnancies, total hip replacement), outpatient care of more acute conditions (e.g., upper respiratory infections, some forms of cancer), and inpatient hospitalizations (e.g., stroke, pneumonia).

Benefits of episode-based payments

Episode-based payments directly reward providers for high-quality, patient-centered, cost-effective care in the right setting. They incent care coordination, evidence based approaches, appropriate settings of care, and value-conscious use of diagnostics. Because episodes are anchored in a specific outcome they enable a "performance dialogue" at a level of specificity that is relevant to decision makers. Episode-based payments also produce long-term pricing signals to encourage medium-to-long term innovation. Episode-based payments empower providers by enabling payers to identify, designate, and reward a Principal Accountable Provider (PAP), who

coordinates the patient's team of providers. PAP designation hinges on a clinician's ability influence performance improvement for patients during an episode of care. In most cases, the best-positioned entity is a physician or hospital but, in some cases, could be a mental health professional or urgent care facility. Several compelling success stories underscore episode-based payments' potential for quality and cost impact:

- Diagnosis-related groups (DRGs), a narrower form of episode-based payment, had a dramatic, favorable impact on length of stay and the cost of hospitalizations after being introduced in the 1980's;
- Geisinger Health System's bundled reimbursement system for Coronary Artery Bypass Graft Surgery (CABG) procedures reduced readmission rates by 44 percent, the number of patients with complications by 21 percent, and average procedure costs by 15 percent;
- A Medicare bundled payments pilot for CABG procedures (1997) reduced costs by an estimated 16 percent, with no adverse impact on quality measures; and
- Current efforts in the State of Arkansas highlight that episode-based payment can be implemented at scale in outpatient and inpatient settings across a wide spectrum of conditions and events, despite a highly fragmented delivery system.

Foundation for success

Ohio's current public and private efforts provide a strong foundation to introduce episode-based payments:

- The CMS-funded Community Care Transition Program (CCTP) has been rolled out in three regions across Ohio (CCTP pays Community-Based Organizations an all-inclusive rate per eligible discharge, once per beneficiary per 180-day period);
- Ohio Medicaid is preparing to rebase the state's DRG system and, for the past 18 months, has been working with an Ohio Hospital Association Payment Group that is providing input on DRG policy and laying the foundation for future episode-based payment reforms; and
- In the private sector UnitedHealthcare has launched a pilot to pay select providers bundled case rates for organ transplants and The Cleveland Clinic has contracted with multiple employers who will pay a bundled fee for high cost procedures (e.g. CABGs).

Challenges to address in the SIM design process

Implementing episode-based payments at scale will require overcoming several challenges that will be explored during the design phase:

- Designing a payment model that will work "at scale" in Ohio (key choices include prospective vs. retrospective administration, absolute vs. relative performance measurement, episode definition and inclusion/exclusion of costs/claims, model for risk and severity adjustment, exclusions, regional adjustment, etc.);
- How key design choices may vary by market, condition, care type, or provider type;
- Approach to scale-up, including episode and/or geographic sequencing;
- Approach to performance measurement and reporting;
- Method for incorporating quality measures to complement cost into performance measurement and method to capture non-claims quality data;

- Degree of gain or risk sharing, regardless of model;
- Criteria and approach to select/designate an accountable provider for each episode;
- Approach to support providers in transitioning to episode-based payment including performance reporting, education, etc.; and
- Scalable operating model including an analytic tool that integrates data sources, informs payment design choices and synthesizes performance reporting measures.

UNIQUE FEATURES OF OHIO'S MODEL

Ohio's payment reform initiative approach is unique in the following important ways:

- **Breadth, scale and diversity:** Ohio's size, along with its plan to transform payment across the majority of its populations and the full range of care delivery, makes this initiative uniquely high impact. The Ohio healthcare landscape encompasses a diversity that represents the nation at large, including a mix of urban and rural communities, patient populations, provider types (e.g. academic medical centers, for-profit and community health systems), and a true multi-payer system that includes many large national, regional and local players. The lessons learned from a statewide solution in Ohio could be applicable across the nation.
- **Impetus for change:** Ohio's high per capita medical costs and poor health outcomes point to a low-value current state that is ripe for change. The state's history of innovation and multi-stakeholder collaboration among consumers, providers and payers will support a successful transformation.

- **Organizational capability to succeed:** The Governor's Office of Health Transformation has been building momentum for 18 months and is ready to facilitate the state's next phase of work related to multi-payer payment innovation. OHT aligns activities across all of the State's regulatory, economic development, and health care purchasing agencies. Together, these agencies represent more than $17 billion in health care purchasing power, concentrated in Medicaid ($14 billion), public employee and state teachers' retirement systems ($1.5 billion), and current state employees ($522 million).[5]
- **Extensive medical training:** One of Ohio's particular advantages in this initiative is the richness of its medical training programs. Ohio has one of the highest per capita rates of medical training and has developed an advanced primary care curriculum for medical and nursing students to be implemented in PCMH practices around the state. This curriculum has been shared with state and national partners to build workforce skills needed to provide quality-driven, team-based, patient-centered care. These efforts will help to generate a pipeline of talent to fill workforce needs in a broad based PCMH rollout. These efforts will advance PCMH efforts nationally as well, as Ohio-trained healthcare providers seek out similar innovative, advanced primary care models across the country.

COORDINATING WITH OTHER PROGRAMS AND POLICIES

Ohio's payment reform initiative intentionally aligns with a number of federal programs. Better coordination will benefit these initiatives by sharing knowledge, avoiding duplication, and communicating a clear scope to external stakeholders. OHT will coordinate these efforts:

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[5] State of Ohio Health Care Purchasing Power in 2011, Office of Health Transformation survey (October 2011).

- **National Quality Strategy and Healthy People 2020**: In 2011, Ohio Medicaid developed a data-driven state quality strategy anchored in the National Quality Strategy's six strategy priorities. Ohio developed performance measures with incentives for managed care organizations (MCOs)in conjunction with public and private, state and regional quality improvement efforts, many of which were in response to CMMI opportunities. These quality strategies and improvement efforts are advancing Healthy People 2020's goals. For example, Ohio's Perinatal Quality Collaborative (OPQC), with the help of a Medicaid CMS Transformation Grant, developed the original research and quality improvement toolkits to diffuse the evidence-based practice of not inducing a delivery without medical indication until after 39 weeks of gestation. This current grant effort layers payment reform into the Ohio quality strategy, providing long-term sustainability. It also refines current quality measurement and methodology.
- **Home and Community Based Services (HCBS) Waivers:** Ohio currently participates in HCBS waiver programs, all of which promote community based care. Specific waivers focus on the aged, individuals with disabilities, and those with developmental disabilities. These segments are among the most in need of specialized care coordination. Ohio will tailor PCMH and episode-based payments design to transform care for these populations, coordinating model design with existing programs where appropriate.
- **Affordable Care Act (ACA) Delivery System Changes**: Ohio is working with CMS to implement an Integrated Care Delivery System (ICDS) program to improve care and cost coordination for Medicare-Medicaid enrollees. Ohio has selected private health plans to manage ICDS populations based on the plans' proposed service delivery and payment

innovation initiatives. Ohio will continue to encourage these private payers to pursue their own innovations, while also facilitating adoption of its PCMH and episode-based payments designs. Also, in October 2012, Ohio will implement an enhanced PCMH program to coordinate behavioral and physical health care services through Medicaid Health Homes for people with serious mental illness. During the SIM design phase, Ohio will determine its strategy for coordination with existing PCMH programs.

- **CMMI Comprehensive Primary Care initiative (CPCi)**: As a participant in CPCi, Ohio payers in the Cincinnati region have met regularly to launch a comprehensive multi payer medical home effort across 75 practices. Ohio will determine its relationship with CPCi during the SIM design phase. For example, Ohio will explore the possibility of expanding CPCi into other parts of the state, and will consider selectively adopting elements of CPCi's design.

USE OF STATE POLICY LEVERS

The Governor's office embraces transformational healthcare change and will actively explore state policy levers that support payment reform. Over the past 18 months, Ohio has made more health care code changes than in the previous 15 years. Going forward, policy levers include:

- **State regulation and laws**: The state's upcoming budget process coincides with the SIM design phase, which enables close alignment of payment reform and other state policies;
- **Medicaid and other insurance contracts**: The State's contract renewal and amendment processes present opportunities to proactively advance proposed changes from the design phase (currently $7.2 billion of the State's $17 billion in total health care purchasing power is purchased through private insurance contracts);

- **Existing federal Medicaid waivers** or new waiver requests; and
- **Economic development**: Ohio is well-organized through its Jobs Ohio initiative and Department of Development Services to engage and build employer support to signal powerful expectations for better care.

OHIO'S PROPOSED PAYMENT INNOVATION DESIGN PHASE

Over the next nine months, defined by CMMI as the "design phase", Ohio will refine its State Innovation Plan, define a strategy to implement PCMH and episode-based payments at scale, and complete the SIM testing grant application. Ohio's approach to the design phase includes:

- **Fact-based decision making** based on significant data gathering and rigorous clinical and technical analysis. These analyses include mapping the patient journey and care pathway for a condition, evaluating cost and frequency of components of care, evaluating cost and quality by provider type and service location, estimating savings opportunities by intervention, and measuring performance with statistical validity.
- **Existing experience and expertise** from initiatives in the public and private sectors in Ohio, in other states, and at federal level. Ohio will directly engage leaders of these initiatives and seek guidance from external experts, academics, and other public leaders with experience related to payment reform.
- **Multi-payer collaboration** that brings together agencies within the state of Ohio, a coalition of leading private health plans, and leading self-insured employers.
- **Meaningful stakeholder engagement** that builds on existing relationships among state officials and leading payers, employers, consumers and providers.

- **Emphasis on progress over perfection** to achieve quick and continuous learning rather than waiting for the perfect solution.

B. STAKEHOLDERS

Over the past 18 months, OHT has achieved a high level of stakeholder participation in health transformation. More than 3,500 Ohioans have signed up to follow OHT activities through regular email updates. Stakeholder input significantly influenced the final design of the state's ICDS program for Medicare-Medicaid enrollees, Medicaid health homes for people with serious mental illness, and the ongoing effort to build PCMH capacity. And stakeholder support was critical to OHT's success working with the Ohio General Assembly to enact Ohio's most aggressive health care reform package in decades. OHT will build on these already-strong relationships to engage the following stakeholders throughout the SIM design process.

- **Employers**: OHT will gather input and feedback from a mix of employers and groups that represent their interests. A group of high-profile Ohio headquartered employers already serve as part of the Governor's Advisory Council on Payment Innovation. The State also plans to engage business organizations such as the Ohio Business Roundtable and the Ohio Chamber of Commerce in health care payment innovation.
- **Consumers**: Ohio will engage both individual patients and advocacy groups (e.g., Legal Aid Society, Universal Health Care Action Network). Input from consumers will shed light on the shortcomings in today's payment and delivery systems and collect input on potential design choices. They will also serve as communication channels to update consumers on any changes to their care delivery.

- **Health plans**: Ohio has already established a core working group of leaders from major health plans (described in more detail below). This group will align design choices in the SIM process wherever coordination is beneficial. Each member will participate in regular working sessions and commit the internal resources necessary to complete the SIM design phase and ultimately test new payment models.
- **Providers**: Ohio has multiple existing communications channels already established with hospitals and clinicians that offer input on the largest opportunities to transform care and delivery models to improve value (e.g., patient experience, quality of care, total cost). The goal of working with providers in the SIM process is to identify payment reforms that will be embraced by providers as a path toward improving overall health system performance.

C. PUBLIC AND PRIVATE PAYER PARTICIPATION

OHT convened a core team of public and private payers to help design and implement Ohio's payment innovation models, and to assist in the preparation of this grant application. The core team includes the Ohio Medicaid program and the state's five largest private health plans: Aetna, UnitedHealthcare, CareSource/Humana, Anthem BCBS, and Medical Mutual.[6](Given CMS' substantial expertise and the 14 percent of Ohioans covered by Medicare, Ohio is seeking CMS' participation on this core team as well.) At the first meeting of the core team on September5, 2012,the plans' regional CEOs and medical and network management experts agreed to:

- Provide input on the overall architecture and vision for Ohio payment innovation;

[6] Largest plans by number of covered lives in Ohio, across Medicare, Medicaid and commercial.

- Assist to define and implement a specific strategy to scale PCMH and episode-based payments across Ohio's public and private sectors;
- Participate in all SIM core team design sessions and bring appropriate subject matter experts (e.g., networking experts, medical management);
- Send senior executives with decision making authority and/or the ability to influence corporate vision to key meetings;
- Share information without divulging confidential information as necessary for program design (e.g., claims data, membership information); and
- Conduct analytics that inform design choices across payers.

Letters of support from the core team participants are attached in Section VII. Ohio will also actively update and solicit feedback from private payers that are not represented in the core team.

D. PROJECT ORGANIZATION

The Governor's Office of Health Transformation (OHT), headed by Director Greg Moody, will provide executive leadership for Ohio's SIM initiative. In August 2011, OHT established a formal governance structure to coordinate Ohio's payment innovation activities. This governance structure, summarized in Exhibit 2 below, consists of the following six entities:

1. **OHT Project Management Team**: This existing team includes Executive Director Greg Moody, Communications and Government Affairs Director Eric Poklar, Stakeholder Outreach Director Monica Juenger, Legislative Liaison Angela Weaver, Fiscal Project

Manager Rick Tully, and Information Technology Project Manager Rex Plouck. Over the next year, the OHT team will commit 50 percent of its resources to payment innovation.

2. **State of Ohio Payment Innovation Task Force**: This existing group will set the state's payment reform mission and policy goals and provide governance for all state sponsored programs. It includes all of the State agencies with responsibility for health care regulation, health care purchasing, and economic development, and will convene periodically to support the SIM design process.

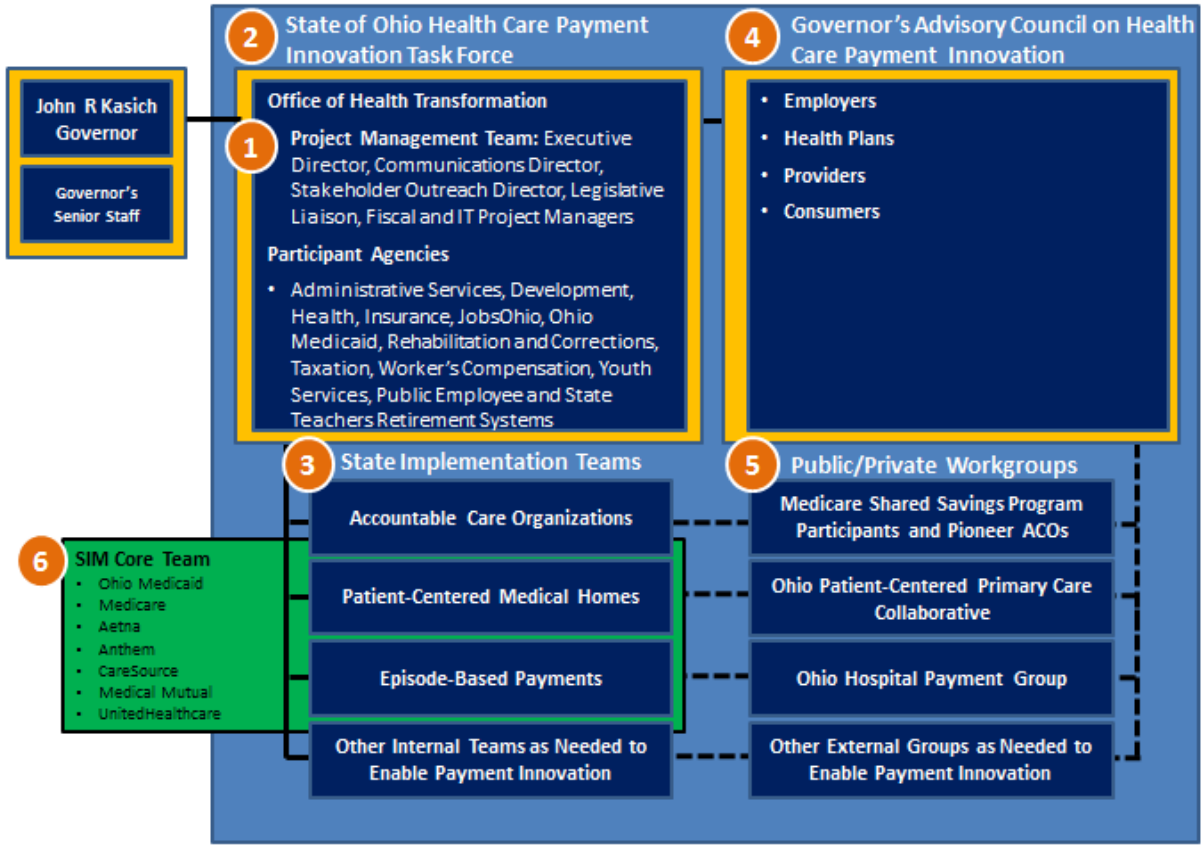
3. **State Implementation Teams**: OHT will establish program specific work teams as needed, including dedicated teams for PCMH and episode-based payments. OHT will provide day-to-day project management and leadership to all of the state implementation teams. Ohio Department of Health Director Ted Wymyslo, MD, will lead the PCMH team and Ohio Medicaid Director John McCarthy will lead the episode-based payments team.

4. **Governor's Advisory Council on Payment Innovation**: This existing external stakeholder advisory group will align public and private payment reform objectives and recommend subject matter experts for participation in Advisory Workgroups (#5). The Advisory Council will have direct access to the Governor's office but no formal decision rights.

5. **Public/Private Advisory Workgroups**: OHT will identify existing workgroups or convene new teams as needed to help design and implement public/private payment innovation programs. The Advisory Workgroups will augment State Implementation Teams with additional subject matter expertise in PCMH and episode-based payment solutions. The existing Ohio Patient-Centered Primary Care Collaborative (OPCPCC) and Ohio Hospital Payment Group will serve as the initial Advisory Workgroups for SIM activities.

6. **SIM Core Team**: OHT created a core team of public and private payers to help design and implement Ohio's payment innovation models (described earlier in Section C). The core team is committed to the SIM design process and taking new payment models to scale.

Exhibit 2: Ohio Health Care Payment Innovation Governance



E. PROVIDER ENGAGEMENT

OHT has been active in engaging providers to improve overall health system performance, particularly regarding PCMH. The Ohio Patient-Centered Primary Care Collaborative now has over 400 members, many of whom are health care providers, and the 160 PCMH providers recognized through NCQA and AAAHC demonstrate a high level of interest and engagement.

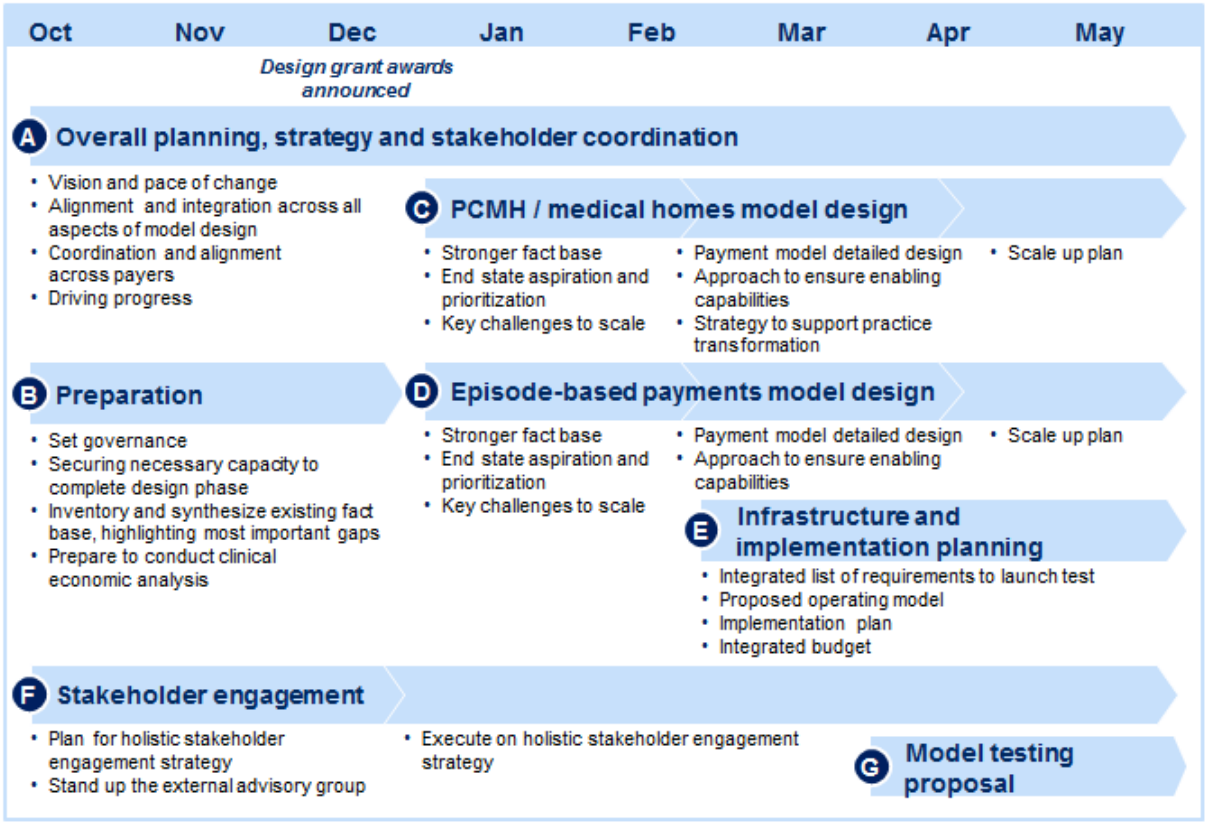
These ranks continue to grow, along with the number of providers expressing interest in learning more. Ohio's goal is to co-design new payment models in close collaboration with providers and their representative associations, many of which are now actively advocating reimbursement for outcomes and quality of care rather than volume. This collaboration will take place through:

- **The Governor's Advisory Council on Payment Innovation**: A select group of Ohio health systems and physicians on the council will provide input on the overall architecture and vision for Ohio payment innovation.
- **Targeted outreach**: Ohio will engage a targeted set of providers (systems, clinicians, and other practitioners) to better understand their current process and workflows, challenges with current payment models, and infrastructure capabilities and gaps. These providers will also advise on key design choices. They will be selected based on the likelihood and degree of impact that the new payment model has on their practices and will be engaged through a mix of approaches, including workshops, one-on-one sessions, webinars, etc.
- **Broader community outreach**: Ohio will also conduct broader community outreach to involve as many Ohio providers as possible, including outreach through the Ohio Academy of Family Physicians, Ohio Chapter of the American Academy of Pediatrics, Ohio Nurses Association, Ohio State Medical Association, Ohio Osteopathic Association, Ohio Hospital Association, and Ohio Association of Community Health Centers.

Project Plan and Timeline

Over the next nine months, Ohio will develop a more robust payment reform strategy and approach to test PCMH and episode-based payments. Elements of this approach follow.

Exhibit 3: Design phase work plan



A. Overall planning, strategy and stakeholder coordination

- Vision and pace of change: Set Design Phase goals and timelines
- Alignment and integration across all aspects of model design: Identify points of intersection between different design elements and ensure communication between streams of work
- Coordination and alignment across payers: Facilitate decision-making and alignment across payers by leading meetings, understanding perspectives and promoting buy-in
- Drive progress: Identify initiatives that are falling behind and help drive additional resources or guidance to areas that need it

B. Preparation for formal "Design phase"

- *Finalize governance*: Finalize governing bodies' membership, organization and decision rights and align with stakeholders
- *Secure necessary capacity to complete design phase*: Refine the understanding of what resources and capacity are needed and fill those needs with in-house or external resources
- *Inventory and synthesize existing fact base, highlighting most important gaps*: Conduct a comprehensive review of existing data sources; aggregate sources and create a plan to obtain data that does not exist
- *Prepare to conduct clinical economic analysis*: Prepare to conduct clinical economic analysis including identifying, structuring, and prioritizing key analyses and assess data availability

C. PCMH/Medical Homes model design

- *Build a stronger fact base*: Fill key gaps identified during Preparation
- *End state aspiration and prioritization*: Define more specific target populations, regions, provider types
- *Key challenges to scale*: Understand and prioritize specific challenges to scaling medical homes such as geographies that lack access, funding capacity, specialized care needs, or how small physician practices can handle infrastructure investments and risk levels
- *Payment model detailed design*: Make fact-based decisions across multi-payer group on structural elements such as qualification/requirements, payment level for care coordination, outcomes-based incentives, and patient attribution algorithm, etc.
- *Approach to ensure enabling capabilities*: Create a detailed plan for providing system infrastructure, care coordination tools, EMR adoption requirements and other capabilities
- *Strategy to support practice transformation*: Create a plan to help providers shift their internal organization to reflect new requirements
- *Scale up plan*: Determine the timing, participants, and criteria for participants' continued involvement

D. Episode-based payments model design

- *Stronger fact base*: Strengthen the fact base and define end state aspiration and prioritization of episode types
- *Key challenges to scale*: Identify specific challenges to episode-based payment such as administrative complexity, risk variation at small scale, lack of widely adopted standards for episode definition, and lack of clinical and financial integration among providers
- Payment model detailed design: Define payment model mechanics, such as prospective vs. retrospective, absolute vs. relative performance measurement, gain/risk share levels, detailed episode definitions (e.g., index claim, exclusions, adjustments) and quality metrics

- Approach to ensure enabling capabilities: Create a detailed plan to attain operational / technical requirements, e.g. analytic engine, provider reports, and customer service
- Scale up plan: Determine the sequencing / phasing of episode roll-out and sequencing of patient / provider participation

E. Infrastructure and implementation planning to support both PCMH and episode-based payments

- Integrated list of requirements to launch test: Achieve an overall understanding of total infrastructure needs for model testing
- Proposed operating model: Create a plan for smooth operations, including patient and provider engagement and support, regulatory and contractual alignment, continuous improvement and program evaluation, etc.
- Implementation plan: Determine the sequencing of roll-out waves, including prioritization of markets, RFP's for vendors, and cross-functional PMO
- Integrated budget: Estimate the ongoing project needs and craft detailed sources and uses of funds

F. Stakeholder engagement

- Stand up the external advisory group: Finalize the governance structure and launch the external advisory group
- Plan for holistic stakeholder engagement strategy: Determine who to engage and create a detailed plan to engage each group
- Execute on a holistic stakeholder engagement strategy, including defining, preparing for, and conducting a wide range of stakeholder interaction

G. Model testing proposal

- Write the grant application, using the output from A-F and filling in gaps as needed to fulfill application requirements

Budget Narrative and Expenditure Plan

BUDGET OVERVIEW

Ohio will use a rigorous, inclusive, fact-based approach to complete the design phase that includes four types of activity: (1) executive leadership, (2) program management, (3) research and analysis, and (4) stakeholder engagement. We estimate a total cost of $7.1 million, $3 million of which we are requesting as a grant under the SIM cooperative agreement. Ohio intends to commit significant resources to lead the effort, including 50 percent of OHT capacity plus substantial time and resources from other health-related departments and the Medicaid program. The state will focus on executive leadership, program management, and some aspects of research and analysis. We also anticipate SIM core team stakeholders contributing meaningful in-kind resources. Given the technical nature of the work, analytic complexity, and our desire to be as fact-based as possible, the state expects to secure substantial third party support from a consultant to provide payment and delivery model expertise, research and analysis capacity, some complementary program management, and stakeholder engagement. We also anticipate working with one or more third party partners to help convene and engage providers.

DESIGN PROCESS REQUIREMENTS

Four types of activity are required to achieve the deliverables outlined in the project plan:

- **Executive leadership** and multi-payer facilitation to drive overall progress, assess choices, make key decisions, address challenges, align participating payers, and build support and alignment from important decision makers;

- **Program management** to gather and synthesize input from stakeholders, sequence key activities, manage performance against deliverables, arrange logistics (e.g. scheduling, document production) and surface and resolve issues;
- **Research and analysis** to (1) understand care patterns and cost structures, (2) identify financial implications and tradeoffs of design choices and implementation approaches, (3) assess current infrastructure and identify gaps and investment/actions to address them, (4) understand patient needs, preferences and clinical and economic profiles, (5) evaluate model design choices based on qualitative and quantitative analysis, and input from experts, payers and leaders of similar efforts, and (6) ensure compliance with all laws and regulations; and
- **Stakeholder engagement** to manage stakeholder interactions and input, develop creative and technically robust supporting materials, secure and administer required infrastructure (e.g. websites, webinars, video conferences) and manage public communication.

DESIGN PROCESS FUNDING

The State of Ohio and SIM core team will contribute significant in-kind resources to fund much of the required executive leadership, program management, research and analysis, and stakeholder engagement. These resources include an estimated $1.3 million commitment from OHT and other state agencies and additional $800,000 from SIM core team health plans (the State is not requiring a formal commitment of resources from SIM team members but acknowledges the significant in-kind contribution associated with participating in core team activities). These resources include human capital, including executive level sponsors, project managers, subject-matter experts, highly skilled analysts, communication experts and creative

resources; expertise in multi-payer payment reform, team leadership, Ohio healthcare landscape, data analytics, and PCMH and episode-based payment; and infrastructure, including tools, systems and other "hard costs" to enable clinical analysis and stakeholder communications. Exhibit 4 below shows the estimated commitment of State and SIM team in-kind resources.

Exhibit 4: Estimated budget overview

	Provider of resources and expertise			
Activity categories	State	Health Plans	Consultant	Total
Executive Leadership	$350,000	$100,000	$250,000	$700,000
Program Leadership	$250,000	$100,000	$750,000	$1,100,000
Research and Analysis	$500,000	$500,000	$3,500,000	$4,500,000
Stakeholder Engagement	$200,000	$100,000	$500,000	$800,000
Total	$1,300,000	$800,000	$5,000,000	$7,100,000
Source of Funding				
In-kind	$1,300,000	$800,000		$2,100,000
State Funds			$2,000,000	$2,000,000
SIM Grant Request			$3,000,000	$3,000,000
Total	$1,300,000	$800,000	$5,000,000	$7,100,000

Ohio is requesting $3 million in SIM design grant funding to provide additional capacity and expertise that will be required to execute its design strategy. Ohio will seek a consulting firm with the required expertise to provide these third party services. Based on past experience, Ohio estimates consulting costs will be approximately $5 million. Ohio requests a $3 million SIM grant towards these costs and will contribute an additional $2 million in state funds. The

requested funds correspond to object class category F ("Contractual") on standard form 424A. Ohio is not requesting SIM grant funds for any of the other object class categories (all project costs associated with personnel, fringe benefits, travel, equipment, supplies, etc. are being provided in-kind by the State and SIM core team participants).

GRANT FUNDED CONTRACTOR REQUIREMENTS

OHT will select a qualified consulting firm or firms through a competitive request for proposals (RFP) process. The period of performance will begin in December 2012 and end June 30, 2013. The State will award the contract to the consultant that demonstrates the greatest experience and capacity to cost effectively provide expert input on episode and PCMH design and multi-payer payment initiatives, complementary program management, significant research and analyses, and targeted support of stakeholder engagement. An itemized budget will be developed through the RFP process and include at least the following services and deliverables:

- Support State team in planning and managing the overall effort;
- Provide expert input on episode and PCMH design, including lessons learned from analogous efforts;
- Provide expert input on leading multi-payer payment initiatives, including lessons learned from analogous efforts;
- Structure approach to conduct system diagnostic, assess model choices, and scale-up;
- Identify most critical required facts, and structure and prioritize key analyses;
- Lead and perform a significant portion of research and analyses that cut across payment models;

- Lead and perform a significant portion of research analyses related to episode-based payment;
- Describe and assess infrastructure and implementation approaches;
- Support development of an ongoing operating model and budget;
- Support development of financial forecast and estimate of model design impact on health spending;
- Support and participate in SIM core team and Governor's Advisory Council meetings;
- Provide input and coaching for other stakeholder interactions; and
- Structure State Innovation Plan.

OHT will work with CMMI and the SIM core team, including Medicare, to finalize the scope of contractor activities.

Financial Analysis

A. Recent health care cost trends in Ohio

Part 1 Table 1: PMPM estimates by payer and category for Ohio beneficiaries

Per capita health care cost and health care cost trend estimates			
		Est. PMPM cost CY2010 $ Dollars	Est. most recent annual trend rate Percent
Medicaid/CHIP	Adult	406.02	4.2
	Child	193.42	-0.5
	Duals (only)	2,118.51	1.1
	Disabled/Elderly (without duals)	1,874.26	3.3
Private/ Other	Individual	389.08	6.9
	Family	1,090.25	7.0
Medicare	Dual Eligible	1,376.80	0.5
	Medicare FFS	809.59	4.1
	Medicare Part D	239.00	1.5
	Medicare Advantage	822.28	2.0

B. Focus areas and categories of services cost and utilization

This will be determined as part of the Design Phase.

C. Major changes in Medicaid/CHIP or private health plans market

Ohio has seen relatively modest growth in per-capita Medicaid spend on Adults and non-dual ABDs from 2008-2010. PMPM growth for duals has been restrained, and child PMPMs have shown marginal contraction. Growth in Medicaid spend was driven primarily by a large expansion in beneficiaries due to the recession (~8% CAGR 2008-10). Enrollment growth has been highest among adults and children – categories most sensitive to economic conditions. Pressure on enrollment growth was expected to decline with an improving economy and declining unemployment. Ohio Medicaid enrollment growth has slowed dramatically in 2011 with 2011 beneficiary-months growing at ~2.5%.

Ohio's performance relative to other states[7] varies considerably by category. Ohio ranks 4th in Child PMPMs, 19th in Adult and 37th for dual eligibles (1st = lowest PMPM). Ohio's high per capita spend on ABD (including duals) is directly reflected in total spend – in 2010, ABD accounted for ~20% of enrollees and ~68% of the total spend.

Ohio continues to embrace managed care and almost all eligible children and parents receive services through an MCO. Ohio ranks 5th in Comprehensive[8] Managed Care Enrollment as a % of Total Medicaid Enrollment.

Growth in individual (6.9% CAGR) and family (7.0% CAGR) premiums for Ohio from 2008-2010 are comparable to those observed nationally (individual – 6.1%, family – 6.2%). The differences in state and national growth rates are not statistically significant[9]. 2011 growth for individual (7.6%) and family (9.5%) premiums in Ohio mirror a nationwide spike in premiums, attributed to ACA changes and expectations of increased utilization driven by economic recovery.

D. Approach to develop detailed financial information and health care cost data

Table 2 A-E: Current and projected per capita cost, utilization and unit cost by payer, category of enrollee and category of service

- Use state decision support system (DSS) to analyze Medicaid data by enrollees and service
- Create projections for each cost element, taking into account national and state trends, existing initiatives and expected policy changes
- Disaggregate each element by utilization and average unit cost by analyzing per-claim data
- Perform similar analyses for Medicare data obtained via collaboration with CMS and ResDAC
- Train and support participating core group payers to conduct analyses using a similar approach internally and to share synthesized results

Table 3 A-E: Current and projected per capita cost, utilization and unit cost by payer, category of enrollee and category of service, with model intervention

- Baseline approach similar to that for Table 2
- Determine populations being addressed, priority segments and rollout sequence. This will inform growth evolution for model projections
  - Analyze spend and clinical data by type, episode, region, payer, condition, patient type, etc.

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[7] FY2009, Kaiser state health facts

[8] Defined in federal regulations as inpatient hospital services and any three of the following services: (1) outpatient hospital; (2) rural health clinic; (3) FQHC; (4) other laboratory and x-ray; (5) nursing

[9] The premiums were estimated based on MEPS survey data

- Estimate impact of model changes on utilization and unit cost for each cost element
  - Assess variations in cost by patient profiles, disease state, common challenges across payer types to understand source of value in a given population
  - Assess variation in cost and quality by provider type or location of service to assess impact of changes in referral patterns or provider performance improvements
  - Assess variation in devices and services used by physicians, to assess the impact of greater adherence to evidence-based care and decreased waste
  - Statistical analysis to establish the influence of demographic and clinical factors on cost of care

Table 4 A-B: Estimated net savings and ROI from model intervention by payer and category of enrollee (3-year)

- Analyze anticipated cost savings by payer type and adjust for interactions with existing initiatives and policy
- Estimate ROI for each cost element by aggregating total federal, state and private investment for the element as well as anticipated savings accruing to all payers

APPENDIX: NOTES ON THE FINANCIAL ANALYSIS

Sources, notes and assumptions for Financial Template Part 1 Table 1 (1/2)

Medicaid / CHIP	
Source	▪ Ohio Medicaid Decision Support System (DSS) ▪ Based on paid claims and beneficiary data
Categories	
Adult	Adults who are not ABD (Aged, Blind, Disabled) and not duals
Child	Children (0-20) who are not ABD and not duals
Duals (only)	All dual eligibles including partial and full eligibles
Disabled/Elderly (w/o duals)	All ABD who are not duals
Footnotes	
1. Includes net FFS payments and capitation expenses	
2. Data computed for calendar year, and includes payments made during the calendar year	
3. PMPM calculation uses actual beneficiary member months	
4. Does not include payments made to disproportionate share hospitals (DSH)	
Private	
Source	▪ AHRQ Medical Expenditure Panel Survey (MEPS) ▪ Survey of employers that collects information on employer-sponsored health insurance ▪ Data collected by the U.S. Census Bureau
Categories	
Individual	All employees with single coverage (~50% of all plans nationwide)
Family	▪ Does not include employee-plus-one coverage ▪ If a family coverage plan offers more than 1 pricing level, information reported is for a family of 4
Footnotes	
1. Estimates of total premium for employer sponsored health insurance are used as a proxy for PMPA cost	
2. ~39k employers across the U.S. surveyed in 2010, with an ~82% response rate; sufficient sample to generate state level estimates	
3. The survey collection year is the current calendar year	
4. Estimate excludes samples where the employer does not provide health insurance	
5. PMPM calculation assumes members are enrolled all 12 months	
Medicare FFS	
Source	▪ Institute of Medicine, Geographic Variation in Medicare Spending and Utilization (GV) database ▪ Data sourced from CMS's Chronic Condition Data Warehouse (CCW)
Footnotes	
1. FFS spending measures were developed based on the amount Medicare pays for services and do not	
2. Estimate includes beneficiaries enrolled in both Part A and Part B, with a year or more of spending data and over the age of 65	
3. Residents assigned to state using their Social Security Administration (SSA) state / county code	
4. PMPM calculation assumes members are enrolled all 12 months	

Sources, notes and assumptions for Financial Template Part 1 Table 1 (2/2)

Medicare Dual Eligible	
Source	▪ ICDS Data Book prepared by Mercer Consulting on behalf of the Ohio Department of Jobs and Family Services ▪ Data sourced from CMS Medicare eligibility and claims for FFS beneficiaries, CY 2009-2010 ▪ Data sourced from ODJFS MMIS eligibility and claims, CY 2009-2010
Footnotes	
1. Growth rate computation uses only 2 years (2009-2010) limited by data availability	
2. Includes beneficiaries 18 or older, with Part A + Part B coverage, eligible for full Medicaid benefits, and not enrolled in managed care	
3. The ICDS Data Book is publicly accessible, and includes only non-identifiable, county level aggregates	
4. PMPM calculation uses actual beneficiary member months	
5. Does not include Part D spend	
Medicare Advantage	
Source	▪ Kaiser Family Foundation and Mathematica Policy Research analysis ▪ Data sourced from CMS Medicare Advantage County Ratebook
Footnotes	
1. Payment rate is weighted by Medicare Advantage enrollees in HMO, local PPO, PFFS, and PSO contracts	
2. Medicare Advantage rates presented reflect base rates for Aged beneficiaries and not actual payments to MA plans, which are adjusted based on enrollee status	
3. Data presented is for 2010 for comparability	
Medicare Part D	
Source	▪ CMS Prescription Drug Coverage Data ▪ Medicare Prescription Drug Event (PDE) data
Footnotes	
1. Includes PDP, MA-PD and Employer Contract data	
2. Drug costs include ingredient cost, pharmacy dispensing fees, other fees (e.g. vaccine administration)	
3. Includes amount paid by the member and all other payers	
4. PMPM calculation uses actual beneficiary member months	
5. Includes drugs covered under Part D prescription drug benefit program only	
6. This data does not represent final Medicare payments, since plan payments are based on prospectively determined PMPM amounts and not PDE	
7. CMS software used to access this data is classified as a BETA test release	