Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2020-21 Budget Cycle

Request Title

R-09 Bundled Payments

Dept. Approval By: _____

OSPB Approval By: _____

____	Supplemental FY 2019-20
____	Budget Amendment FY 2020-21
X	Change Request FY 2020-21

Summary Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$8,041,836,169**	**$0**	**$8,067,168,372**	**$743,065**	**$65,915**
	FTE	500.0	0.0	504.1	1.9	2.0
	GF	$2,319,338,108	$0	$2,329,173,946	$63,224	($35,320)
	CF	$997,104,608	$0	$998,896,068	$68,307	$53,276
	RF	$91,709,248	$0	$91,596,531	$0	$0
	FF	$4,633,684,205	$0	$4,647,501,827	$611,534	$47,959

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
01. Executive Director's Office, (A) General Administration, (1) General Administration - Personal Services	**Total**	**$38,610,714**	**$0**	**$40,590,766**	**$142,306**	**$148,005**
	FTE	500.0	0.0	504.1	1.9	2.0
	GF	$13,478,948	$0	$14,470,561	$46,961	$48,841
	CF	$3,571,232	$0	$3,714,633	$24,192	$25,161
	RF	$2,436,543	$0	$2,305,357	$0	$0
	FF	$19,123,991	$0	$20,100,215	$71,153	$74,003
01. Executive Director's Office, (A) General Administration, (1) General Administration - Health, Life, and Dental	**Total**	**$4,790,328**	**$0**	**$6,054,935**	**$20,084**	**$20,084**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,700,447	$0	$2,211,097	$6,628	$6,628
	CF	$421,237	$0	$525,947	$3,414	$3,414
	RF	$126,088	$0	$138,532	$0	$0
	FF	$2,542,556	$0	$3,179,359	$10,042	$10,042

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$66,598**	**$0**	**$72,132**	**$215**	**$224**
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1) General Administration - Short-term Disability	GF	$24,002	$0	$26,864	$70	$74
	CF	$5,301	$0	$5,495	$37	$38
	RF	$2,206	$0	$1,639	$0	$0
	FF	$35,089	$0	$38,134	$108	$112
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$6,333**	**$6,587**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$2,089	$2,173
	CF	$159,398	$0	$166,329	$1,077	$1,120
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,167	$3,294
	Total	**$1,984,802**	**$0**	**$2,182,512**	**$6,333**	**$6,587**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Supplemental Amortization Equalization Disbursement	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$722,807	$0	$812,689	$2,089	$2,173
	CF	$159,398	$0	$166,329	$1,077	$1,120
	RF	$46,310	$0	$49,606	$0	$0
	FF	$1,056,287	$0	$1,153,888	$3,167	$3,294
	Total	**$2,506,384**	**$0**	**$2,273,794**	**$6,530**	**$1,900**
01. Executive Director's Office, (A) General Administration, (1) General Administration - Operating Expenses	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,014,866	$0	$939,016	$2,155	$627
	CF	$243,961	$0	$197,797	$1,110	$323
	RF	$13,297	$0	$13,297	$0	$0
	FF	$1,234,260	$0	$1,123,684	$3,265	$950
	Total	**$21,581,862**	**$0**	**$17,517,486**	**$100,000**	**$100,000**
01. Executive Director's Office, (A) General Administration, (1) General Administration - General Professional Services and Special Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,015,380	$0	$4,503,802	$33,000	$33,000
	CF	$2,615,231	$0	$2,547,721	$17,000	$17,000
	RF	$150,000	$0	$150,000	$0	$0
	FF	$12,801,251	$0	$10,315,963	$50,000	$50,000

Line Item Information	Fund	FY 2019-20 Initial Appropriation	FY 2019-20 Supplemental Request	FY 2020-21 Base Request	FY 2020-21 Change Request	FY 2021-22 Continuation
	Total	**$74,893,151**	**$0**	**$80,930,645**	**$600,000**	**$60,000**
01. Executive Director's Office, (C) Information Technology Contracts and Projects, (1) Information Technology Contracts and Projects - MMIS Maintenance and Projects	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$9,972,677	$0	$11,030,317	$39,600	$9,900
	CF	$6,385,552	$0	$6,963,036	$20,400	$5,100
	RF	$12,204	$0	$12,204	$0	$0
	FF	$58,522,718	$0	$62,925,088	$540,000	$45,000
	Total	**$7,895,417,528**	**$0**	**$7,915,363,590**	**($138,736)**	**($277,472)**
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,285,686,174	$0	$2,294,366,911	($69,368)	($138,736)
	CF	$983,543,298	$0	$984,608,781	$0	$0
	RF	$88,876,290	$0	$88,876,290	$0	$0
	FF	$4,537,311,766	$0	$4,547,511,608	($69,368)	($138,736)

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Department Priority: R-9
Request Detail: Bundled Payments

Summary of Incremental Funding Change for FY 2020-21			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
Total Funds	**$0**	**$743,065**	**$65,915**
FTE	0.0	1.9	2.0
General Fund	$0	$63,224	($35,320)
Cash Funds	$0	$68,307	$53,276
Reappropriated Funds	$0	$0	$0
Federal Funds	$0	$611,534	$47,959

Summary of Request:

The Department requests an increase of $743,065 total funds, including $63,224 General Fund, $68,307 cash funds, and 1.9 FTE in FY 2020-21 and $65,915 total funds, including a decrease of $35,320 General Fund, an increase of $53,276 cash funds, and 2.0 FTE in FY 2021-22 and ongoing to implement a bundled payment methodology for certain episodes of care. The Department's requested cash fund funding includes the Healthcare Affordability and Sustainability Fee cash fund. This request represents an increase of less than 0.5% from the Department's FY 2019-20 Long Bill total funds appropriation.

Current Program:

Colorado's Medicaid program currently provides health care access to about 1.3 million people with a budget of $10.7 billion. The Department spends the majority of its budget to pay providers who deliver services to Medicaid members. Most providers are paid on a fee-for-service basis, meaning the Department pays for each incurred service based on a set rate.

In recent years, the General Assembly has authorized the Department to establish modern payment methodologies within the Medicaid program and created processes to ensure the adequacy of payment rates. Key examples include HB 12-1281, which created a process for the Department to implement payment reform pilot programs within the Accountable Care Collaborative, SB 15-228, which established the Medicaid Payment Rate Review Advisory Committee, and HB 17-1353 which defined the Accountable Care Collaborative in statute and authorized the Department to implement performance-based payments for Medicaid providers. As a result of these, and other initiatives, the Department has enrolled all members in a regional organization that helps members make sure they get the health care and services they need[1]; established a rate review advisory committee and analysis process to determine where rates are inadequate and are inhibiting access to care[2]; and, is developing new payment methodologies that move away from traditional fee-for-service payments and towards payment structures that provide payments based on the provider's performance.[3]

Further, the Department continues to provide resources to providers to help control costs and identify unnecessary or duplicative care. In SB 18-266, the General Assembly provided the Department resources to, among other things, provide information to providers participating in the Accountable Care Collaborative regarding the cost and quality of medical services provided by hospitals and other Medicaid providers. In FY 2018-19, the Department rolled out a suite of powerful cost and quality assessment capabilities through the PROMETHEUS Analytics tool to the seven Regional Accountable Entities (RAEs) responsible for coordinating care for Medicaid members, hospitals, and primary care providers. The tool identifies costs incurred for potentially avoidable complications (PACs) during episodes of care, which can then be rolled up to identify opportunities at the individual physician, primary care medical home, specialist, and hospital levels. Ultimately, this toolset enables providers to improve their referral patterns towards more cost effective, higher quality physicians and hospitals, enables hospitals to identify and self-correct inefficient, lower quality care delivery, and enables the Department to direct members seeking provider locator services to higher performing providers. PROMETHEUS Analytics explains, "PACs were created to determine the amount of unexplainable variation in total costs of care that could be reasonably attributed to complications under the control of providers and can be used to create incentives for both cost-saving and for quality analysis."[4]

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[1] https://www.healthfirstcolorado.com/health-first-colorado-regional-organizations/

[2] https://www.colorado.gov/pacific/hcpf/medicaid-provider-rate-review-advisory-committee

[3] https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3

[4] http://prometheusanalytics.net/deeper-dive/potentially-avoidable-complications

Problem or Opportunity:

The implementation of complex payment methodologies, such as bundled payments, require additional administrative costs to calculate and administer. Without additional appropriations for staff and support, the Department is unable to alter payment methodologies. Aligning payment with high-value services are critical components in ensuring members have sufficient access to care, that quality outcomes are achieved, and that services provided are cost effective. The Department has an opportunity to address these goals by implementing bundled payment methodologies for certain episodes of care.

Proposed Solution:

The Department requests an increase of $743,065 total funds, including $63,224 General Fund and 1.9 FTE in FY 2020-21 and $65,915 total funds, including a decrease of $35,320 General Fund and 2.0 FTE in FY 2021-22 and ongoing to implement a bundled payment methodology for certain episodes of care. If this request is not funded, the Department would lack the resources necessary to implement bundled payments.

The Department would initially target maternity episodes for the bundled payments. A bundled payment methodology incentivizes providers to serve members in a more cohesive manner through a treatment episode and to reduce expenditure on potentially avoidable complications during that episode. Currently, Medicaid pays providers each time a service is delivered without regard to any other services the member is receiving for his or her condition. If a member is pregnant, for example, Medicaid pays the following providers separately: the obstetrician for prenatal visits, delivering the baby, and post-natal visits; the radiologist for ultrasounds; the laboratory for bloodwork and urine tests; and the hospital for the facility charges during the delivery. If separate physicians serve the member for prenatal visits and the delivery, the Department would pay for those claims separately. This creates silos in the care experience, even though they are all treating the same medical condition.

Under a bundled payment methodology, the Department would set a target budget for the entire maternity episode, including all services related to that condition. The Department would hold the main care provider accountable to that budget – for maternity services, this would likely be a hospital, but for another episode it might be a community mental health center or a physician. The budget would be based on historical average expenditure for the episode, with a targeted reduction to the costs associated with potentially avoidable complications (PACs) for that episode, as calculated by the PROMETHEUS Analytics tool. An example of a PAC for a maternity episode would be post-operative wound infection after a caesarean delivery. The budget set for a participating provider would include some target level of reduction in costs for these types of complications, incentivizing the provider to provide evidence-based treatment and refer members to the highest performing specialty providers in order to reduce expenditure on PACs in that year. This would result in costs avoided for the Department in the short term as providers adapt changes to their treatment plans to achieve the pre-determined budgets for the episodes.

The Department would continue to pay providers based on submitted claims, but after the episode is naturally completed, such as after the postpartum period for maternity, the Department would reconcile actual expenditures for each service to the budget. If expenditures were higher than the budget, the main care

provider would owe the Department all or part of the difference. If expenditures were lower than the budget, the Department would share savings with the main care provider.

The Department plans to implement maternity bundles in FY 2020-21. In FY 2021-22, the Department would reconcile expenditure on actual services incurred during the episode for those providers that participated. In that year, the Department would only include upside risk – i.e., there would be shared savings but no penalty if providers spent over the budget. Over time, the Department would incorporate more downside risk in the bundles. The Department would investigate other episodes to target in future years. The bundled payments would be an option for providers statewide, but would remain a voluntary contract arrangement.

Bundled payments incentivize providers to coordinate care and deliver evidence-based care to members, which fits with the Department's FY 2019-20 Performance Plan Pillar 3 to improve health outcomes for members. This methodology also ensures providers are delivering the right services to people at the right price, which fits with Pillar 2 to control costs in the Medicaid program.

Anticipated Outcomes:

The Department anticipates that implementing bundled payments for episodes of care would result in cost savings as participating providers coordinate care for their patients with other key providers to reduce expenditure on potentially avoidable complications from the episode. These savings would be realized in the short term as providers work to lower overall costs on services related to the episodes. This would also result in better health outcomes for members, as it shifts providers towards a more cohesive approach to treating the episode.

There is evidence that an episode-based payment system has been effective for maternity episodes. Harvard School of Medicine[5] conducted a difference-in-differences analysis of perinatal spending within large commercial insurance providers in Arkansas and neighboring control states before and after the Arkansas insurance providers implemented an episode-based payment model for perinatal services. The report concluded that after the model's implementation, intrapartum facility spending decreased by 6.6% and postpartum spending decreased by 15.9%, while all other changes to maternity spending were statistically insignificant. Since intrapartum facility spending accounted for half of spending and postpartum spending accounted for only small portion of spending before implementation, most of the savings resulted from changes to intrapartum facility spending.

The report further concluded that the decrease in intrapartum facility spending did not result from fewer services being provided but rather from the price of the services dropping due to primary providers referring members to lower priced secondary facilities. From previous studies that have found little correlation between

[5] (Harvard School of Medicine, 2018) Effects of Episode-Based Payment on Health Care Spending and Utilization: Evidence from Perinatal Care in Arkansas, https://scholar.harvard.edu/files/ccarroll/files/carroll_etal_ebp_2018.pdf

facility prices and health outcomes,[6] the report concludes that this change in referral patterns was unlikely to have affected health outcomes.

Among Medicaid programs that have an active or developing episode-based payment system, including Arkansas, Connecticut, Ohio, Oklahoma, New York, and Tennessee, all them offer or require the methodology to be used for maternity services. Data is available for Arkansas and Tennessee's programs. Based on preliminary data, Arkansas has seen a 3.8% drop in perinatal episode expenditure and Tennessee has seen a 7.7% drop.[7]

Assumptions and Calculations:

Please see Appendix A for detailed calculations on all components.

The Department is using existing funds in FY 2019-20 to begin working on implementing bundled payments for maternity services. The Department assumes that over the course of FY 2019-20, it would gain approval from the Centers for Medicare and Medicaid Services (CMS) for the methodology change, execute contracts with participating providers, set budgets for each provider, and be ready to implement the initiative on July 1, 2020. In FY 2021-22, the Department would reconcile expenditure for participating providers to the budgets. The Department assumes that in the first few years of implementation, only three large providers would participate. These providers would have the most potential for shared savings by participating. The Department would work on the planning and development for the next episode of care in FY 2020-21.

Administrative Resources

To implement bundled payments, the Department would need administrative resources to design the bundles, clear the methodology with CMS, contract with providers that want to participate, push relevant claims data to participating providers, and reconcile the payments retroactively. The Department would need two FTE to maintain the bundled payment methodology. The Department would also need funding to create a data interface between the reporting layer of the claims system and the participating providers, as well as contractor funding for an actuary to assist the Department with calculating the budgets for the bundles.

One FTE would be a rate/financial analyst. This position would set the budgets for the episodes, which requires in depth analysis of claims data of current payments for services related to an episode, separated by typical costs for the episode and expenditure on PACs. The position would work with the actuary to ensure the budget is reasonable and with affected providers to reach agreement on the budget. The position would

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[6] 1. Cooper, Z., Craig, S., Gaynor, M., and Van Reenan, J. (2015). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. NBER Working Paper, 21815.

2. Ho, K. and Pakes, A. (2014a). Hospital Choices, Hospital Prices, and Financial Incentives to Physicians. American Economic Review, 104(12):3841–3884.

3. Ho, K. and Pakes, A. (2014b). Physician Payment Reform and Hospital Referrals. American Economic Review: Papers and Proceedings, 104(5):200–205.

[7] http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf

also be responsible for reconciling payments with providers based on the set budget to actual performance and either making payments with shared savings or recouping money from the provider.

The second FTE would be a contract manager responsible for setting up contracts with the participating providers and monitoring performance of the providers to ensure appropriate access to care is maintained. This position would submit the State Plan Amendment (SPA) necessary to implement the payment methodology to CMS for each episode of care. In addition, the position would investigate other potential episodes that would benefit from a bundled payment methodology through research of Medicare and other states, as well as through stakeholder meetings with Medicaid provider groups.

For participating providers to be successful at ensuring costs remain within the set budget, they would need claims data for their members on all the claims related to their episode. The Department estimates that it would need $600,000 in FY 2020-21 to implement enhanced dynamic reporting in the claims system that can be restricted to the Medicaid members attributed to that provider. This would be based on the provider's authorization via multi-factor authentication. The Department would need to provision all participating providers with access to the reporting tool. The Department estimates that it would be able to receive a 90% enhanced federal match through an Advanced Planning Document (APD) for the build out phase of the project. In FY 2021-22 and ongoing, the Department estimates that it would need $60,000 per year to maintain the tool and configure it for any new episodes of care.

The Department estimates that it would need $100,000 each year in contractor funding for its actuary. This is based on an average rate of $200 per hour for an estimated 500 hours each year. The actuary would provide support with the model development to calculate the bundles for the episodes. This is based on the scope of work for the actuary to calculate per-member per-month rates as requested in FY 2018-19 R-7, "Primary Care Alternative Payment Models," which included 875 hours of work per year. Bundled payments would be less complicated as they rely heavily on the existing PROMETHEUS Analytics tool, and the Department adjusted its estimate downward accordingly.

Savings to Episodes of Care Payments

The Department assumes that it would spend less on episodes of care through a bundled payment methodology, because the budgets for the episodes would be set with a targeted reduction to expenditure on potentially avoidable complications (PACs) and the providers would be incentivized to reduce costs incurred by members on PACs during the episode, in the short term. For maternity episodes, for example, the hospitals may decide to check in regularly with the member during the postpartum period, with the goal of preventing the member from incurring complications that lead to hospital visits and other unnecessary treatments. In the first year of implementation for each episode, the Department would target a relatively low percentage reduction of PACs. The Department estimates that the budgets would include a 10% reduction to PACs in the first year, and that participating providers would target care to achieve the reduction. The Department estimates that the budgets would include larger reductions of 15% to PACs in the second year and 20% in the third year of implementation as providers develop more effective ways to reduce expenditure on unnecessary complications. The Department estimated savings for participating providers based on the total

expenditure spent on PACs for those practices, as calculated by the PROMETHEUS Analytics tool, and the target reduction to PAC expenditure each year.

The Department would reconcile expenditure after the conclusion of the first year. The Department would share savings with participating providers, meaning that if the provider successfully reduced costs on PACs by 10% the Department would pay some share of that to the provider. The Department assumes it would share 50% of savings in this manner through the reconciliation process. In future years, the Department would incorporate downside risk for the provider. That would mean that if the provider did not reduce costs on PACs to the budgeted amount, the provider would owe the Department a share of the expenditure. This would guarantee savings to the Department in future years, even if some providers do not successfully reduce costs.

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

Table 1.1: FY 2020-21 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$142,306	1.9	$46,961	$24,192	$0	$71,153	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$20,084	0.0	$6,628	$3,414	$0	$10,042	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$215	0.0	$70	$37	$0	$108	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$6,333	0.0	$2,089	$1,077	$0	$3,167	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$6,333	0.0	$2,089	$1,077	$0	$3,167	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$6,530	0.0	$2,155	$1,110	$0	$3,265	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$100,000	0.0	$33,000	$17,000	$0	$50,000	Table 2.1 Row C
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$600,000	0.0	$39,600	$20,400	$0	$540,000	Table 2.1 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($138,736)	0.0	($69,368)	$0	$0	($69,368)	Table 2.1 Row D
J	**Total Request**	**$743,065**	**1.9**	**$63,224**	**$68,307**	**$0**	**$611,534**	**Sum Rows A through I**

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

Table 1.2: FY 2021-22 Summary by Line Item								
Row	**Line Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Notes/Calculations**
A	(1) Executive Director's Office; (A) General Administration; Personal Services	$148,005	2.0	$48,841	$25,161	$0	$74,003	FTE Calculations
B	(1) Executive Director's Office, (A) General Administration, Health, Life and Dental	$20,084	0.0	$6,628	$3,414	$0	$10,042	FTE Calculations
C	(1) Executive Director's Office, (A) General Administration, Short-term Disability	$224	0.0	$74	$38	$0	$112	FTE Calculations
D	(1) Executive Director's Office, (A) General Administration, SB 04-257 Amortization Equalization Disbursement	$6,587	0.0	$2,173	$1,120	$0	$3,294	FTE Calculations
E	(1) Executive Director's Office, (A) General Administration, SB 06-235 Supplemental Amortization Equalization Disbursement	$6,587	0.0	$2,173	$1,120	$0	$3,294	FTE Calculations
F	(1) Executive Director's Office, (A) General Administration, Operating Expenses	$1,900	0.0	$627	$323	$0	$950	FTE Calculations
G	(1) Executive Director's Office, (A) General Administration, General Professional Services and Special Projects	$100,000	0.0	$33,000	$17,000	$0	$50,000	Table 2.2 Row C
H	(1) Executive Director's Office, (C) IT Contracts and Projects, MMIS Maintenance and Projects	$60,000	0.0	$9,900	$5,100	$0	$45,000	Table 2.2 Row B
I	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals	($277,472)	0.0	($138,736)	$0	$0	($138,736)	Table 2.2 Row D
J	**Total Request**	**$65,915**	**2.0**	**($35,320)**	**$53,276**	**$0**	**$47,959**	**Sum Rows A through I**

Table 2.1: FY 2020-21 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Bundled Payments for Maternity Care									
A	Department Staff	$181,801	1.9	$59,992	$30,907	$0	$90,902	50.00%	FTE Calculations
B	Data Exchange	$600,000	0.0	$39,600	$20,400	$0	$540,000	90.00%	BIDM design and development costs
C	Contractor Funding	$100,000	0.0	$33,000	$17,000	$0	$50,000	50.00%	Actuary costs
D	Savings on Episodes of Care	($138,736)	0.0	($69,368)	$0	$0	($69,368)	50.00%	Table 3, Row J
E	**Total for Bundled Payments**	**$743,065**	**1.9**	**$63,224**	**$68,307**	**$0**	**$611,534**		**Row A + Row B + Row C + Row D**

Table 2.2: FY 2021-22 Summary by Initiative									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP**	**Notes/Calculations**
Bundled Payments for Maternity Care									
A	Department Staff	$183,387	2.0	$60,516	$31,176	$0	$91,695	50.00%	FTE Calculations
B	Data Exchange	$60,000	0.0	$9,900	$5,100	$0	$45,000	75.00%	Ongoing data exchange costs
C	Contractor Funding	$100,000	0.0	$33,000	$17,000	$0	$50,000	50.00%	Actuary costs
D	Savings on Episodes of Care	($277,472)	0.0	($138,736)	$0	$0	($138,736)	50.00%	Table 3, Row J
E	**Total for Bundled Payments**	**$65,915**	**2.0**	**($35,320)**	**$53,276**	**$0**	**$47,959**		**Row A + Row B + Row C + Row D**

Table 3
Estimated Savings from Bundled Payment Methodology for Maternity Episodes

Row	Item	FY 2020-21	FY 2021-22	FY 2022-23	Source/Comment
A	FY 2017-18 Amount Spent on Maternity Episodes	$31,300,360	$31,300,360	$31,300,360	Prometheus tool; includes three target providers
B	Projected Caseload Trend for Pregnant Adults	26.64%	26.64%	26.64%	February 15, 2019 Forecast
C	Total Projected Amount Spent on Maternity Episodes	$39,638,776	$39,638,776	$39,638,776	Row A * (1 + Row B)
D	Average Rate of Potentially Avoidable Costs	3.50%	3.50%	3.50%	Prometheus tool
E	Amount Spent on Potentially Avoidable Costs	$1,387,357	$1,387,357	$1,387,357	Row C * Row D
F	Target Reduction in Potentially Avoidable Costs	10.00%	15.00%	20.00%	Assumed, see narrative
G	Estimated Savings from Bundle	($138,736)	($208,104)	($277,471)	Row E * Row F * -1
H	Percentage of Savings Shared with Provider	50.00%	50.00%	50.00%	Assumed, see narrative
I	Estimated Payments from Shared Savings	$0	$69,368	$104,052	Prior year's row G * Row H * -1
J	**Total Net Savings from Maternity Episodes**	**($138,736)**	**($277,472)**	**($381,523)**	**Row G - Row H**

R-9 Bundled Payments
Appendix A: Calculations and Assumptions

FTE Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- Beginning July 1, 2019, new employees will be paid on a bi-weekly pay schedule; therefore **new full-time General Fund positions are reflected in Year 1 as 0.9615 FTE** to account for the pay-date shift (25/26 weeks of pay). **This applies to personal services costs only; operating costs are not subject to the pay-date shift.**

Expenditure Detail		FY 2020-21		FY 2021-22	
Personal Services:					
Classification Title	Biweekly Salary	FTE		FTE	
RATE/FINANCIAL ANLYST III	$2,610	1.0	$65,259	1.0	$67,872
PERA			$7,113		$7,398
AED			$3,263		$3,394
SAED			$3,263		$3,394
Medicare			$946		$984
STD			$111		$115
Health-Life-Dental			$10,042		$10,042
Subtotal Position 1, #.# FTE		**1.0**	**$89,997**	**1.0**	**$93,199**
Classification Title	Biweekly Salary	FTE		FTE	
ADMINISTRATOR IV	$2,456	1.0	$61,405	1.0	$63,864
PERA			$6,693		$6,961
AED			$3,070		$3,193
SAED			$3,070		$3,193
Medicare			$890		$926
STD			$104		$109
Health-Life-Dental			$10,042		$10,042
Subtotal Position 2, #.# FTE		**1.0**	**$85,274**	**1.0**	**$88,288**
Subtotal Personal Services		1.9	**$175,271**	2.0	**$181,487**
Operating Expenses:					
		FTE		FTE	
Regular FTE Operating	$500	1.9	$962	2.0	$1,000
Telephone Expenses	$450	1.9	$865	2.0	$900
PC, One-Time	$1,230	1.0	$1,230	-	
Office Furniture, One-Time	$3,473	1.0	$3,473	-	
Other					
Other					
Other					
Other					
Subtotal Operating Expenses			**$6,530**		**$1,900**
TOTAL REQUEST		1.9	**$181,801**	2.0	**$183,387**