

Report to the
California Center for Rural Policy
Humboldt State University

**Care Delivery and
Payment Reform Strategies
to Advance Health Care Value
in Humboldt County**

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The California Center for Rural Policy and Humboldt IPA has convened a health system and provider leadership group to collaboratively identify payment and care reform models to accelerate large scale transformation in health and health care delivery in Humboldt County. This report highlights several options for staged payment reform models that may be tested on a pilot basis, and subsequently scaled as the supporting payment and shared risk infrastructure activity is further developed. The consideration and implementation of these models will occur under the auspices of a CEO Roundtable and Community Advisory Committee. The long-term goal is to advance the Triple Aim of better care, better health and affordability, and to establish an accountable care community for health.¹

Background

Humboldt County has been the home of a number of initiatives to improve health care quality and value. Humboldt was one of 17 Robert Wood Johnson Foundation (RWJF) Aligning Forces for Quality sites, an eight year initiative to improve quality and reduce cost. In an effort to sustain delivery system reforms and advance value-based alternative payment models, the California Center for Rural Policy (CCRP) and Humboldt IPA (HIPA) convened a policy leadership group of key constituents, including representatives from St. Joseph Health System, Mad River, Open Door Community Health Centers, Humboldt Medical Specialists (HMS) Hospice, Humboldt County Health and Human Services, and United Indian Health Services.

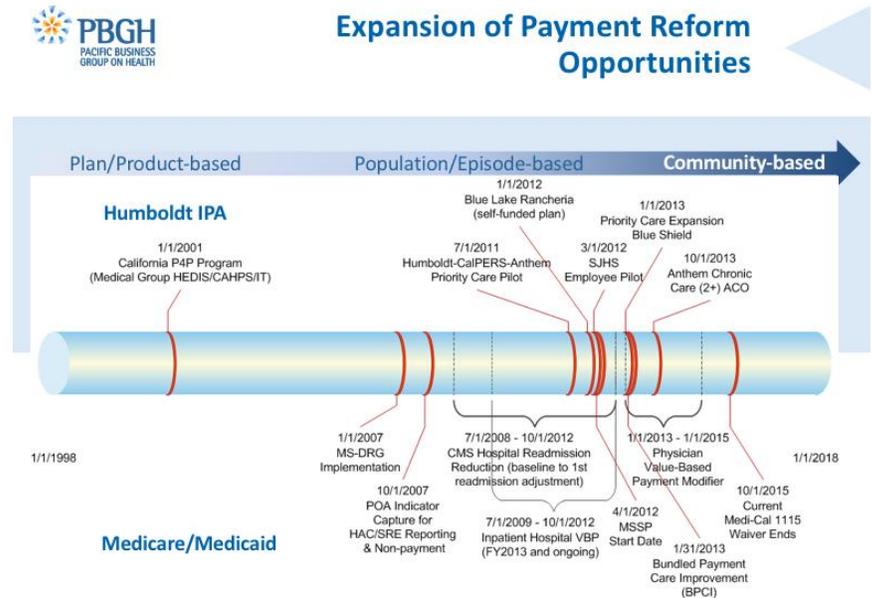
Together, these organizations have initiated an effort to advance a county-wide strategy that promotes health and health care integration. Through cooperation and rationalizing the impact of payment and design changes, the parties seek to pursue the Triple Aim and build an accountable care community for health. The accountable care community model recognizes the social determinants of health, which contribute to both the challenges and solutions for Humboldt County. CCRP engaged the Pacific Business Group on Health and Jay Want, MD, with support from the Robert Wood Johnson Foundation (RWJF) to provide Technical Assistance in developing the initial stages of this effort.

The first activity of this collaboration was a site visit to Grand Junction, CO, a rural community with similar demographic and marketplace features to Humboldt. Participants learned about key success factors and considerations in designing an accountable care community for health. An initial follow-up discussion reinforced an interest in joint efforts to identify early wins, cooperate around services, investment in workforce development and infrastructure such as a family practice residency. At the same time, an advisory community committee consisting of non-health care residents was recommended and initially convened in late January. In March 2015, a follow-up meeting was held and the CEO leadership affirmed the value of cooperation (participants listed in Appendix 1). The group identified coordination on a multi-site rural internship program with UC Davis' clinical rotations as a near-term opportunity for

¹ Nothing in this report should be construed as an intent to limit competition or otherwise create antitrust issues.

collaboration and obtain input in formulating a roadmap for payment reforms to support quality improvement, access and value. A discussion on avenues towards payment redesign emphasized the need to tailor solutions for a rural community. Supplemental information for this report was also gathered through key informant interviews conducted individually with some of the leadership group.

Humboldt IPA has been an incubator for a number of care redesign and payment reform initiatives, ranging from participation in the HMO-based California Pay-for-Performance program to contracting with Anthem Blue Cross under its Enhanced Primary Health Care accountable care model that offers gainsharing based on achieving a set of quality and utilization goals. HIPA also collaborated with large public and private purchasers to support improved care coordination for high risk members with medically complex needs.



The impetus for payment reform that better aligns incentives across all payers is a recognition of the following issues:

- The current cost structure is not sustainable;
- The county’s workforce challenges require a cooperative effort to address; and
- Broad collaboration is required to address the underlying socioeconomic and demographic drivers of health.

The Affordable Care Act has contributed to coverage expansion through Medi-Cal and Covered California. The market is also changing as a result of the growing portion of payments linked to performance through the Medicare Value-Based Purchasing programs for physicians and hospitals. Roughly 30% of Medicare payments will be tied to quality or value through alternative payment models by the end of 2015, with 50% targeted by the end of 2018. Similarly, the structure of commercial health plan contracts with providers is evolving to include more risk-based reimbursement. Finally, Medi-Cal has been advancing a health home model for primary care delivery with managed care being introduced in Humboldt in 2014, and California’s federal Section 1115 waiver application articulates a set of care and payment redesign principles, including “whole-person health care.”

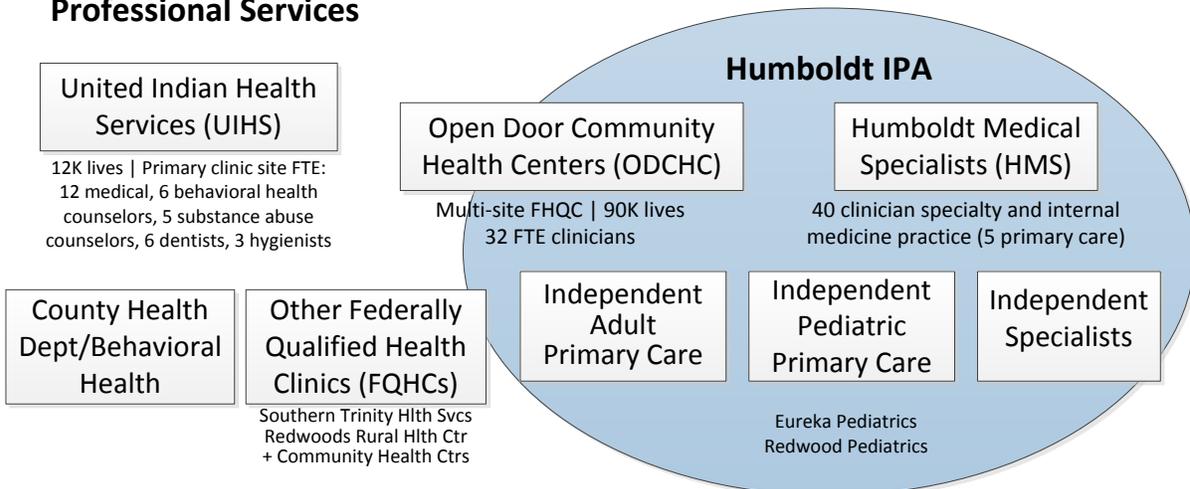
Humboldt Health Care Market

The following are key organizations and attributes of the marketplace:

- Two hospital “systems”: St. Joseph Health and Redwood Memorial (collectively SJHS) about 140 beds combined with 80% market share and part of the Sisters of Orange system. Mad River Community Hospital has 50 beds and 20% market share.
- Humboldt Medical Specialists (HMS) is a 40 clinician specialty practice that recently began recruiting internists. It is an extension of Heritage Group in Orange and owned by SJHS. There are few specialists outside of this group. The general surgery practice remains independent.
- More than half of the primary care is delivered by a multisite FQHC, Open Door Community Health Centers. They report that approximately 50% of their patients are commercial and that they have 90,000 unduplicated patients in their EHR. The largest independent adult PCP practice has seven clinicians. The next largest has four. About one PCP practice a year merges with the FQHC and there are approximately 12 left, mostly solo practitioners. There are two independent pediatric practices.
- The United Indian Health Services (UIHS) provides medical, behavioral health, dental and social services for nine tribes in Humboldt County and the surrounding communities. Its primary clinic site includes 12 medical providers (full time equivalents that are half physicians and mid-level providers), six FTE behavioral health counselors, five FTE substance abuse counselors, serving over 12,000 patients. Additionally, UIHS has six FTE dentists and three hygienists.



Professional Services



- Four payers represent more than 95% of the market: Anthem has approximately 50,000 lives primarily in PPO products, including approximately 3,500 through California Public Employees' Retirement System (CalPERS). Blue Shield has about 12,000, (6,000 through CalPERS HMO and about 6,000 PPO that includes the area school districts). Medi-Cal has recently introduced managed care in Humboldt, which is administered through Partnership Health Plan, with approximately 32,000 members. There are 18,000 Medicare beneficiaries under traditional fee-for-service; Medicare Advantage is not available in Humboldt.
- Among the largest employers in Humboldt are CalPERS, St. Joseph Health, Humboldt Unified School District, Eureka City Schools and Pacific Gas and Electric Company.
- Approximately 6,700 are uninsured as a result of Medicaid expansion and the enrollment of 5,680 members in the state health insurance marketplace, Covered California.
- Humboldt has an Health Information Exchange (HIE)/Quality Improvement organization which has been in place for a number of years and provide population health data, report disparities and gaps in care and measure the impact of quality improvement efforts. The North Coast Health Information Network (NCHIN) expanded its operations in conjunction with the federal Health Information Technology for Economic and Clinical Health (HITECH) incentives that supported data exchange infrastructure investments.

Workforce Issues and Key Challenges

In both the leadership meeting and in individual interviews, participants asserted that workforce issues underlie many of the health care delivery system challenges in Humboldt. Retention of key provider specialties in the community, particularly primary care and behavioral health, has been difficult.

- Over the last 10 years, the net number of physicians has declined by more than 30. It has been difficult to attract and retain new physicians to replace those who are retiring or near retirement; of the 87 providers who left, 44 did so after being in Humboldt for 3.1 years or less. Fifty-three providers are new to the area in the last 10 years and still actively practicing.
- Primary care physician access is a growing problem.
- Outpatient appointments for specialty care routinely take two or more months.
- Behavioral health providers, particularly psychiatrists are insufficient to support community needs, and this is even more severely felt in the county health system where several psychiatrists recently resigned their positions.
- Almost all OB/GYN services are provided by four physicians and two are in their seventies.
- Orthopedic call is available two-thirds of the time, and general surgery is beginning to face coverage issues as well.
- There is a heavy reliance on locum tenens for hospital-based providers.
- There are insufficient ancillary professionals such as laboratory technicians.

Furthermore, gaps in provider coverage in select surgical specialties results in cases being transferred to the San Francisco Bay Area and occasionally Redding, placing greater financial stress on hospitals when such services might contribute favorably to margins.

Principles, Objectives and Goals

The ultimate goal of this effort is to advance towards an accountable care community for health that transforms health and health care delivery while reducing the total cost of care. Health care transformation should reflect the following principles:

- Promote a high performance system in Humboldt where all providers are accountable for their quality, utilization and efficiency.
- Improve the health of the population by supporting prevention, improving care transitions and engaging individuals in self-care for chronic conditions.
- Support workforce development and retention through effective reimbursement models that promote access, particularly for primary care and behavioral health, and maintain competition in the marketplace, while keeping health care dollars in the community.
- Support patient-centered measurement with common metrics that are outcomes-oriented and meaningful to consumers for treatment and provider choice, and to providers for continuous quality improvement.
- Be transparent on cost and quality information and shared savings.
- Align payment incentives with public and private payer incentives to promote value-based benefit designs and with consumer incentives to make informed treatment choices.
- Reduce disparities in health status and health care by integrating with social, economic and environmental determinants of health such as affordable housing and healthy food choices.
- Leverage existing collaborative care models, infrastructure and administrative capabilities among established provider organizations.
- Create efficiency and reduce duplication of services through effective use of health information technology and health information exchange.
- Be tailored to address rural market features and requirements such as geographic access.

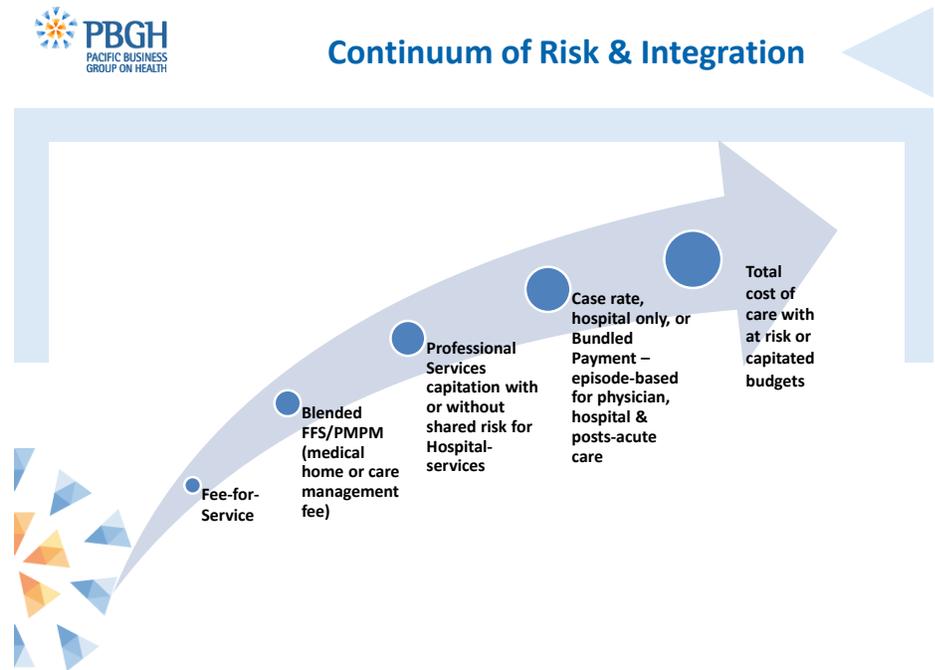
Payment Design Approaches

What follows is a discussion of three illustrative approaches to payment and care redesign:

- 1) Primary care medical home and neighborhood.
- 2) Accountable care with total cost of care target.
- 3) Episode-based payments and bundled payment.

These models are not intended to be mutually exclusive and can work in tandem with each other. Furthermore, there is no single methodology that defines each approach. These models also provide an opportunity to align commercial plan efforts with public payers – both Medicare and Medi-Cal. In the sections below, experience in other states, including pilots in rural communities, are cited as illustrations of working models in care redesign and payment reform. Early efforts to integrate community health strategies are also noted. Each section concludes with a discussion of potential near-term approaches and implementation issues for Humboldt.

There is a continuum of risk and integration across the spectrum of payments. A range of reimbursement structures is already in place, but varies by commercial, Medicare and Medi-Cal. And while there may be de facto cost shift across payers, there is no model that integrates these dollars across private and public purchasers. To support an accountable community for health, cost savings that may be derived from any of these models needs to be reinvested to support critical areas such as primary care and behavioral health, and in economic development and housing that affects the social determinants of health, rather than traditional bricks and mortar-based service expansion.



Primary Care Medical Home and Neighborhood

Humboldt Experience to Date. The Humboldt IPA has had early experience with a primary care-focused initiative, Priority Care, which provided nurse, behavioral health and social worker support to primary care physicians. Priority Care was designed to improve care coordination and case management for a high-risk commercial population with multiple chronic conditions as well as poorly managed acute conditions. Home visits were also provided if the need arose. In a two-year pilot with two large self-funded employers, HIPA received a per member per month (PMPM) case management fee and was eligible for potential gainsharing based on claims cost savings relative to a prior year baseline.

A limited number of primary care physicians are organized in a large group practice that could support such an infrastructure, and that most are solo practitioners or work with one other

partner. Therefore, the most effective use of resources was to host this team at the IPA. A comprehensive face-to-face intake visit with a nurse was crucial for patient engagement in self-care and managing to a set of mutually agreed upon goals that were cogent for the patient. Primary care physicians participated in patient outreach to enlist their patients' engagement with a nurse, resulting in a much higher enrollment rate than traditional health-plan based disease management programs. The IPA team facilitated appointment access and appropriate handoffs, and provided follow-up care upon an inpatient discharge to reduce the likelihood of complications. These capabilities along with parallel patient support systems offered through the Open Door and other federally qualified health clinic sites could be leveraged for the health home requirements of Medi-Cal managed care. Because of the patient volume requirements required to operate at scale, it is infeasible to operate these multi-disciplinary teams at solo and dual physician office sites. It should be noted that Open Door serves both Medi-Cal beneficiaries and commercially insured members, as well as the uninsured.

Medicare and Medicaid. Humboldt County's efforts to move toward more coordinated, value-based payment arrangements across multiple payers can also be informed by the early payment reform experience of participants in the Centers for Medicare and Medicaid Services (CMS) State Innovations Model (SIM) program and implementation of primary care medical home pilots. The SIM program is an initiative of the CMS Innovation Center that helps states to develop and test models for multi-payer payment and health care delivery system transformation over a three- to four-year period. California has received several SIM design grants to support its planning efforts.² Medi-Cal also has expanded its managed care model statewide and awarded administration of the model in Humboldt County to Partnership Health Plan. As Medi-Cal seeks to provide every beneficiary with a health home, this will further expand this patient-centered strategy.

Other States. Arkansas and Colorado are at the forefront of state efforts to coordinate value-based payment approaches across multiple public and private payers. Minnesota and Oregon also promote patient-centered medical homes that are offered under accountable care organizations (discussed further below in the Accountable Care section).³ Michigan provides an additional example where a health plan with a predominant market share has implemented a widespread primary medical home model. Each is deploying some combination of payment and delivery system redesign that centers on a primary-care medical home (PCMH) model, and to varying degrees, also integrates a total cost of care model among its Medicaid and commercially insured populations.

² California State Health Care Innovation Plan, March 31, 2014 California Health & Human Services Agency. http://www.chhs.ca.gov/PRI/CalSIM%20State%20Health%20Care%20Innovation%20Plan_Final.pdf.

³ Kristof Stremikis. Adapted from "All Aboard: Engaging Self-Insured Employers in Multi-Payer Reform, Milbank Memorial Fund & Pacific Business Group on Health, February 2015.

STRATEGIES TO ADVANCE HEALTH CARE VALUE

Component	Summary	Payment Model	Populations Served	Payers Participating	Employers Participating
Arkansas PCMH and Health Homes	<p>Team of health care providers takes responsibility for overall health of patients. Designated primary care doctor coordinates care across clinical settings.</p> <p>Health homes focus on complex, chronically ill patients, supporting behavioral health and long-term needs</p>	<p>Primary care practices receive PMPM payments and shared savings (min. 5,000 patients).</p> <p>Health homes receive a risk-adjusted PMPM fee assessed every 2 years. Upside only with quality requirements.</p>	<p>79% of eligible Medicaid beneficiaries (289K lives) with 600 Medicaid-accepting providers as of Q4 2014. 2016 target is 80% of Medicaid population.</p> <p>Health homes initially targeting adults with developmental disabilities, individuals requiring long term services and support and serious mental illness.</p>	<p>Medicare (CPC only), Medicaid, Arkansas Blue Cross and Blue Shield, QualChoice, Humana</p>	<p>State employees, public school employees, Walmart</p>
Colorado Patient-Centered Medical Homes (PCMH)	<p>Patient-centered medical homes embedded in Regional Care Collaborative Organizations (RCCO) that provide care coordination</p>	<p>Per member per month fee and an additional \$1 PMPM based on performance. Financial risk variable by group</p>	<p>Medicaid Medicare FFS</p>	<p>Medicaid Medicare (Comprehensive Primary Care Initiative-CPCI) 8 commercial payers</p>	<p>Various populations through commercial payers</p>
Blue Cross Blue Shield of Michigan's Value Partnership Program	<p>Value-based primary care (enhanced PCMH beyond NCQA accreditation), specialist, and hospital programs designed to transition the health care system from a fee-for-service model to "fee-for-value."</p>	<p>\$100 M annual physician reward pool with \$40 M uplifts for specialty care Hospital Rewards up to 5% based on efficiency, population performance, readmissions, daily census reporting and participation in selected CQIs</p>	<p>BCBS MI members</p>	<p>Blue Cross Blue Shield Michigan</p>	

Following the successful and widespread deployment of episode and medical-home based payment initiatives over the past several years, state officials in Arkansas have continued the move toward more capitated payment methods through a new "health home" program for patients with complex or special needs. Practices designated as health homes receive a risk-adjusted per member per month fee to work with a patient's medical homes to coordinate medical, community, and social support services. Health home practice teams take responsibility for the overall health of complex, chronically ill patients and have the opportunity to share in upside savings provided certain quality requirements are met.

In Colorado, efforts to introduce payment redesign and create PCMHs under Medicaid have been longstanding.⁴ More recently, Colorado was designated as one of six pilot states for the Centers for Medicare and Medicaid Innovation Comprehensive Primary Care Initiative that is designed to be a multipayer collaborative. Through PMPM fees from Medicare and Medicaid,

⁴ Framework for Transforming the Health Care Payment System in Colorado, Denver, CO: Center for Improving Value in Health Care, 2011. http://www.civhc.org/getmedia/4cc644ea-fcb7-43b8-90fc-aea1ee940cb8/Framework-for-Transforming-the-Health-Care-Payment-System_5.12.pdf.aspx/

as well as commercial plans for participating populations, PCMHs work with Regional Care Coordination Organizations to integrate medical, behavioral health and social services.

Blue Cross and Blue Shield of Michigan (BCBSM) has implemented an enhanced primary care medical home model that includes additional measures beyond what is required under the NCQA recognition program. Launched in 2009, an initial analysis reported savings of \$155 million in its first three years, due to avoided emergency room visits and hospital stays. The plan estimated an additional \$100 million savings in year four. With over 4,000 physicians in more than 1,400 practices statewide designated as PCMHs, patients have expanded access to primary care (24-hour access to a clinical decision-maker) and physicians report improved care outcomes and expanded use of electronic patient registries and performance reporting tools. With BCBSM-designated PCMH practices in 78 of Michigan's 83 counties, patients are getting better care coordination, from follow-up on test results to specialty referral care. Participation in the incentive program was associated with approximately 1.1% lower total spending for adults and 5.1% lower spending for children, with the same or improved performance on 11 of 14 quality measures over time.⁵

Early Accountable Communities for Health Efforts. Several of the PCMH models have expanded their reach through larger accountable care organizations to address disparities in care and more broadly, some of the social determinants of health. For example, through seven community-level Regional Care Collaborative Organizations, Colorado is helping build the capacity of PCMHs to become hubs of a community's network of health care, behavioral and social supports. Pilot efforts are underway to integrate health and social services for special populations, include a child and youth system that encompasses primary care, mental health, child welfare, child care and schools, as well as an integrated delivery model for homeless adults and children that includes physical care, behavioral health and housing.

Blue Cross Blue Shield Michigan members using PCMH providers are also getting better connected to community services and agencies. With many physicians also participating in one of 39 Organized Systems of Care that offer infrastructure and integrated care processes like accountable care organizations, a combined patient registry helps providers address disparities in care. The design of the program also uses a multilingual approach and promotes active communication and coordination with family and caregivers as well.

Humboldt Near-Term Opportunities. The medical home model has much to recommend, but may be difficult to scale in a rural community. As noted above, beyond two primary care group practices, most of the remaining primary care practices are solo practitioners, which makes it challenging to implement medical homes on a large scale basis. Additionally, many of these practices are geographically isolated, operating as small rural health clinics. A recent survey of Rural Health Clinics (RHCs) on their ability to meet National Committee for Quality Assurance (NCQA) PCMH recognition standards suggested that RHCs could benefit from targeted technical

⁵ Lemak CH, Nahra TA Cohen GR et al. Michigan's Fee-For-Value Physician Incentive Program Reduces Spending and Improves Quality in Primary Care, Health Affairs 34, No. 4 (2015), 645-652.

assistance on elements related to improving access to care; ensuring continuity of services from the patient's identified provider; supporting patient self-management skills; developing the practice team; tracking and monitoring referrals; exchanging clinical information; measuring performance; and implementing continuous quality improvement systems and documenting results.⁶

Because Humboldt's primary care practices serve both commercial and Medi-Cal patients, they experience varying administrative requirements, but do not have the volume to achieve economies of scale. Adaptive approaches may be required to provide "medical home-like" services in the smaller practices. As the North Coast Health Information Network is well established, a starting point might be optimizing clinical information exchange, such as medication ordering and tracking laboratory tests.

HIPA's infrastructure provides medical home support and care coordination for HMO and PPO members using its primary care physicians. By building on and expanding the resources already committed, HIPA can help expand medical home capacity in the region. Furthermore, the Open Door clinics are already functioning as medical homes for its patients. At the Open Door federally qualified health centers (FHQC), patients are treated within organized pods that include behavioral health support, social services and specialty referral management. Telemedicine services may also be provided to facilitate specialty consultations, as well as to facilitate access.

Common measures are in use by HIPA for HMO quality reporting through the Integrated Healthcare Association Pay-for-Performance program. Many of these measures are part of the HEDIS reporting requirements for Medi-Cal managed care, but additional efforts can be undertaken to align the measure sets and segment analysis by payer type and socioeconomic data to support interventions to reduce disparities in care. Provider feedback and support for collaborative learning networks can be concentrated through HIPA to reduce primary care administrative burden.

Accountable Care with Total Cost of Care Target

Humboldt Experience to Date. Following HIPA's Priority Care pilot which provided multidisciplinary care support for high-risk members, HIPA worked with Anthem Blue Cross to transition these members into their Enhanced Personal Health Care, or accountable care model. Under this program, HIPA receives a PMPM case management fee for identified high-risk members (added to the Administrative Services Only fees paid by large self-funded employers) and has the ability to earn additional monies based on quality and utilization

⁶ Gale JA, Croll Z and Hartley D. Rural Health Clinic Readiness for Patient-Centered Medical Home Recognition: Preparing for the Evolving Healthcare Marketplace, Maine Rural Health Research Center Working Paper #57, January 2015. <https://muskie.usm.maine.edu/Publications/rural/RHC-Readiness-for-PCMH-Recognition-Working-Paper.pdf>

performance, subject to meeting a quality threshold based on 29 HEDIS and clinical measures, along with three hospital and prescription drug utilization measures. This program is in its initial year so results have not yet been reported.

Medicare and Medicaid. While a number of California provider organizations have applied for the Medicare Shared Savings Program (MSSP), including the Pioneer and Accelerated Payment models, there has not been a strong business case in Humboldt County to assume financial risk for the Medicare fee-for-service population. The relative PMPM spend for the Medicare Service Area (MSA) is not an outlier, such that the savings opportunity from an at-risk arrangement is uncertain. The recently established case management procedure code for post discharge care coordination⁷ will support accountable care absent risk arrangements under MSSP or Medicare Advantage, which is not offered in Humboldt County. The feasibility of the new CMS Next Generation ACO Model has not been assessed.

The Medicare value-purchasing program incentives for reducing readmissions and other hospital quality measures have begun to be implemented; any impact on the Humboldt County hospitals were not part of the publicly reported CMS data set.

The Physician Quality Reporting System and HITECH incentives have had a smaller impact, as the HIE efforts were well underway prior to the implementation of health information technology incentives. The longer term impact of Medi-Cal managed care remains to be seen insofar as the degree of delegated medical management and other operational activities may grow over time. Beyond supporting individual health homes at the practice level, there is an opportunity to align measures and foster accountable care models at an organizational level

Other States. Maine, Minnesota and Oregon are among the states that have been at the forefront of implementing accountable care models, integrating primary care medical home models and other care redesign and payment reform initiatives.^{8 9}

Component	Summary	Payment Model	Populations Served	Payers Participating	Employers Participating
Maine Health Management Coalition	3 Payment and delivery reform models: PCMH, Episode-based payments, ACOs	Variable models State Innovation Model funds also support quality improvement (including Behavioral Health Homes Learning Collaborative) and public reporting.	Medicare Medicaid Commercially insured	Aetna, Cigna, Anthem Blue Cross Blue Shield, State Employees	

⁷ Frequently Asked Questions: Transitional Care Management. American Association of Family Practice. February 2013. Accessed at: http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCMFAQ.pdf

⁸ Stremikis, op. cit.

⁹ Corrigan JM and Fisher ES. Accountable Health Communities: Insights from State Health Reform Initiatives, The Dartmouth Institute for Health Policy & Clinical Practice, November 2014.

STRATEGIES TO ADVANCE HEALTH CARE VALUE

Component	Summary	Payment Model	Populations Served	Payers Participating	Employers Participating
Minnesota ACO / Total Cost of Care Arrangements	Provider organizations accountable for the total care of patients, including population health outcomes, patient care experiences, and the cost per person. Advanced primary care practices work with multi-disciplinary community health teams to coordinate care for patients.	Shared savings to sub-capitation arrangements with both upside and downside risk. Quality requirements. Under a Health Care Homes/MAPCP demonstration, primary care practices receive fee-for-services (FFS) payments plus PMPM fees tied to state certification standards and expectations	2016 goal incorporates the majority of the state’s publicly and privately insured population, current ACO providers, and Hennepin Health	Medicaid, Medicare (Pioneer and Shared Savings Programs), Blue Cross and Blue Shield of Minnesota, Medica	State employees
Oregon Coordinated Care Organizations & PCMH	16 regional entities coordinate physical, mental, behavioral and dental services for Medicaid. Advanced primary care practices work with multidisciplinary community health teams to coordinate care for patients, embedded in Coordinated Care Organizations (CCO)	Global budget tied to a sustainable rate of growth. Primary care practices receive FFS payments plus PMPM fees. Under the Patient-Centered Primary Care Homes (PCPCH) program, primary care practices receive FFS payments plus PMPM fees	Medicaid initially. Commercial expansion in progress	PCMH-Medicare, CareOregon, Oregon Health Authority, Providence Health Plan, Regence BCBS, Tuahly Health Alliance	SIM initiative aims to spread model to other commercial and public payers. State employees (PEBB), OEGB

Several provider organizations in Maine were early adopters of the CMS ACO programs. Building on a strong primary care medical home design, these ACOs seek to improve care coordination by enhancing health information exchange and electronic medical record adoption. Learning collaboratives fostered spread of early lessons on high risk member identification, patient engagement and shared decision-making. The model expanded quickly among private payers for the commercially insured and state employees.

Minnesota’s multi-payer payment and delivery system reform strategy seeks to spread an “Accountable Health Model” framework across Medicare, Medicaid, commercial payers, and self-funded populations in the state. Elements include the development of common measurement tools across payers, improved clinical data exchange at the provider level, and alignment payment and risk-adjustment methods for complex populations. Medicaid providers enter into accountable care arrangements that include sharing both upside and downside risk for costs and meeting quality targets for a defined population of patients. The long-term plan is for ACOs to partner with community organizations and become accountable for the total cost of health for a defined population and/or community.

Oregon’s Coordinated Care Organization (CCO) model was introduced into the state Medicaid program in 2012. CCOs are risk-bearing, community-based entities governed by a partnership among providers of care, community members, and others taking financial risk for the cost of physical, behavioral, and oral health care of a defined population. CCOs are accountable for the health and care of the population they serve and are rewarded for improving both quality of care and health care value. Several are transitioning from fully capitated model to payment based on health care outcomes. Alternative payment methodologies such as pay-for-

performance incentives, shared savings payments, episode-based payments, and enhanced primary care fees are now being adopted by other payers.

Early Accountable Communities for Health Efforts. In Maine, multi-disciplinary Community Care Teams (CCTs) are a key element in PCMH efforts to improve care and reduce avoidable costs for people with complex or chronic conditions. They have embraced elements of the Camden Coalition’s approach to supporting “super-utilizers,” working to identify important psychosocial drivers of well-being, including a sense of belonging, a sense of security and a sense of importance. CCTs work to connect individuals with community resources and peer groups as needed.

Minnesota is in the initial stages of supporting community organizations called “Accountable Communities for Health” that integrate medical care with behavioral health services, public health care, long-term care, social services, and other forms of care. SIM resources are also being used to enhance the workforce capacity needed for team-based, coordinated care, with support to primary care physicians who wish to transform their practices into patient-centered medical homes. ACOs also have discretion to invest resources to address housing and food support in low-income populations where these factors may have an adverse impact on health.

The Oregon CCOs partner with local public health agencies and hospitals to conduct a community health needs assessment (the Affordable Care Act enhanced reporting requirements for how non-profit hospitals allocate their community benefit dollars). Based on their findings, CCOs have discretion in allocating resources to address social and economic drivers of health, including education.

Humboldt Near-Term Opportunities. HIPA has held at-risk contracts and manages capitation for professional services under existing HMO products. While Medicaid managed care implementation is relatively recent, experience will grow with respect to managing capitation on a broader scale. Flexibility in structuring the primary care per member per month allocation could for example, support allocation of expanded behavioral health resources within primary care delivery. Such a model is already in use by Open Door.

The Anthem Blue Cross ACO contract structure includes gainsharing opportunities based on achieving quality thresholds and reducing avoidable inpatient admissions and emergency department use. An evolution of that model could contemplate gainsharing provisions for participating hospitals; possibly using a global budget model initially to establish baseline experience and mutually agreed upon trend targets. The majority of private payer ACO contracts have downside risk.¹⁰

¹⁰ Lewis VA, Colla CH, Schpero WL et al. Am J Manag Care. 2014;20(12):1008-1014. Accessed at: <http://www.ajmc.com/journals/issue/2014/2014-vol20-n12/ACO-Contracting-With-Private-and-Public-Payers-A-Baseline-Comparative-Analysis>

Measuring the total cost of care may be an important starting point in assessing where risk-based contracting or gainsharing arrangements may make the most sense. The Integrated Healthcare Association is integrating an efficiency measure into its P4P program and it may be beneficial to use a common methodology across each payer segment. This approach may be helpful in understanding historical distribution of costs and payment across service lines and areas where public-private cost shift has occurred and the extent to which coverage expansion impacts these trends.

The development of a regional health plan by leveraging the administrative infrastructure of HIPA has been discussed in the past as a means of capturing the total cost of care locally, including the administrative margin and profits of commercial carriers. However, the cost of developing and maintaining an infrastructure for sales and general administrative expense, especially with the complexity of Affordable Care Act reporting and upcoming ICD-10 system conversion requirements, should not be underestimated. Furthermore, meeting state regulatory and industry accreditation requirements is a significant hurdle. Using an accountable care approach or episode-based bundled payment model (see next section) for capturing the total cost of care may be a more effective way to align incentives and collaboratively explore potential administrative cost savings. Expanding HIPA's role in PPO contracting may also serve this objective.

With respect to community health strategies, both Open Door and UIHS manage community gardens that are geared to promoting healthier diets and active lifestyles. Additional efforts may be in place to collaborate with local schools to support education about healthy foods. St. Joseph's Health Foundation is well established and funds a variety of community-based organizations. Additionally, hospital resources help connect low income individuals with food and other subsidy programs. Healthy Kids Humboldt is focused on coverage and access for the community's youth. A local collaboration with public agencies to produce a region-specific community risk assessment and evaluation of the current allocation of community benefit dollars may be helpful to set common goals and avoid potential duplication of effort. There may be opportunities to increase the success of existing programs through alignment of the goals for an accountable community for health.

Episode-based Payments and Bundled Payment

Humboldt Experience to Date. There have been no bundled payment initiatives to date in Humboldt. Neither St. Joseph's Health nor Mad River participate in the CMMI Bundled Payments for Care Improvement (BPCI) program. While there may be individual case rates established in hospital contracts with commercial health plan, such as for obstetrical care and delivery, these do not integrate professional and facility services. Commercial hospital services are generally administered through per diem arrangements.

Medicare and Medicaid. The Medicare Bundled Payments for Care Improvement program has garnered significant attention nationally and statewide. Over 500 hospitals and provider

organizations in California participate in BPCI, with the vast majority engaged in Model 3 (retrospective bundled payment for post-acute care) and secondarily, Model 2 (retrospective bundled payments for acute care hospital stay and post-acute care). The majority of physician organizations opt in for all 48 episodes of care, but hospitals have been more selective, often choosing the orthopedic episode only or orthopedic and cardiac. There are also service volume considerations in assessing the business case for participation, and this is likely an important limiting factor for any of the Humboldt-based facilities. A number of organizations have filed for Model 2 for all episodes as a vehicle to access data and further refine an approach

As part of the California State Innovation Model proposal, bundled payment for maternity care may be considered. While reimbursement for professional fees for obstetrical care often blend rates for C-section or normal delivery, facility payments typically are separate. Given the significant increase in C-section rates statewide, there is consideration of creating a blended rate for Medicaid deliveries. The design would adjust reimbursement based on total spend, with the intent of creating an incentive to reduce avoidable C-sections, while maintaining hospital revenue levels.

Other States. Arkansas and Vermont have been at the forefront of implementing episode-based payment models, in addition to PCMH and other care redesign and payment reform initiatives.^{11,12} The number of state-based programs has also been proliferating through the CMMI State Innovation Model (SIM) program and the Medicare BPCI effort.¹³

Component	Summary	Payment Model	Populations Served	Payers Participating	Employers Participating
Arkansas Episode-Based Payments	Health care providers accountable for the cost and quality of services for a particular diagnosis (e.g., hip/knee replacement) over a defined period (30 days prior to and 90 days after).	Retrospective, episode-based payment for outpatient services. Upside and downside risk. Quality requirements.	Patients receiving care for 15 conditions as of Q4 2014. Episodes rolled out based on clinical condition rather than patient population. 2016 target is 40–50 conditions.	Medicaid, Arkansas Blue Cross and Blue Shield, QualChoice	State employees, public school employees, Walmart
Vermont Bundled Payments & Pay for Performance	Volume-based incentives are replaced with episode-based payments, which encourage collaboration and efficiency across providers and systems. Additionally, P4P incentives are designed to improve quality and efficiency of care.	Retrospective, episode-based payment for acute and post-acute care. Upside and downside risk. Quality requirements.	Approximately 300 oncology patients in a defined area receiving primary, specialty, and hospital care; approx. 100 patients receiving detox and additional inpatient treatment. Medicare will use P4P programs for all providers; P4P expansion to Medicaid and private payers underway.	Medicare, Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA	State employees

¹¹ Stremikis, op. cit.

¹² Health Care Payment Improvement Initiative: Building a Healthier Future for all Arkansans. <http://www.paymentinitiative.org/Pages/default.aspx>

¹³ Painter MW, Burns ME and Bailit MH. Bundled Payments Across the U.S. Today: Status of Implementations and Operational Findings. Newtown, Conn.: Health Care Incentives Improvement Institute, 2012 & 2014 update.

STRATEGIES TO ADVANCE HEALTH CARE VALUE

Component	Summary	Payment Model	Populations Served	Payers Participating	Employers Participating
Wisconsin Partnership for Healthcare Payment Reform	Voluntary stakeholder collaborative testing payment reform models. Acute Care Workgroup selected total knee replacement; Chronic Care Workgroup selected diabetes care. Analytic support through state multipayer claims database.	Payment based on index procedure with post-surgical warranty period of 90 days; rehabilitation included, with outcomes measurement and shared savings.	Pilot with commercial Individual organizations also leveraging experience to undertake Medicare BPCI	Commercial payers Anthem BCBS WI, Physicians Plus, Marshfield Clinic, Unity	Multiple

Initially, Arkansas Medicaid and the private insurers introduced five episodes of care: upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD), and perinatal. The number has since been expanded to a total of 12 episodes of care. Each payer identifies the Principal Accountable Provider for each episode through claims data, which is retrospectively analyzed to compare the actual cost of services compared to expected benchmarks. Participating providers receive quarterly reports on quality and cost metrics so they can track performance against agreed upon benchmarks. Providers share in the savings or excess costs of an episode depending on their performance for each episode. Stakeholders collaborated to define the episodes, including trigger events, duration, services included, as well as minimum case volume requirements and exclusions. Each episode has a defined set of quality measures that providers are required to meet, as well as quality measures for monitoring. Acceptable and commendable thresholds are set for incentive payments, along with a gainsharing limit, gainsharing percentage and risksharing percentage.¹⁴

It should be noted also that Arkansas has been implementing capitated payments as part of their medical-home initiatives for individuals with complex or special needs. Practices designated as health homes receive a risk-adjusted per member per month (PMPM) fee to work with patients' medical homes to coordinate medical, community, and social support services. Health home practice teams take responsibility for the overall health of complex, chronically ill patients and have the opportunity to share in upside savings provided certain quality requirements are met.

Vermont has also recently begun testing reimbursement approaches under a SIM grant, including a shared savings ACO model that involves integration of payment and services across an entire delivery system, a bundled payment model that involves integration of payment and services across multiple independent providers, and a pay-for-performance (P4P) model aimed at improving the quality, performance, and efficiency of individual providers. Vermont's multi-payer efforts originated in 2006 as the Blueprint for Health, a care coordination initiative for the chronically ill that has since evolved into a PCMH and comprehensive community health undertaking. The state passed further reform legislation in 2011 that called for pilots of new

¹⁴ Episodes of Care, Section II, <http://www.paymentinitiative.org/referenceMaterials/Documents/EPISODE%20PROPOSED%20RULES.pdf>

payment models. Vermont is one of eight participants in the CMMI Multi-payer Advanced Primary Care Practice (MAPCP) demonstration.¹⁵

The Wisconsin Partnership for Healthcare Payment Reform began as a voluntary stakeholder collaborative that recognized the status quo was not sustainable. They sought to proactively test payment reform model that would improve quality and reduce costs, while also providing experience in anticipation of Medicare bundled payment program. Key success factors among pilot participants included leadership commitment, organizational culture and engagement of physician champions, along with infrastructure support for data analytics and capture of patient-reported outcomes. Pragmatism was also a key factor insofar as participants recognized their organizations were already accepting and managing risk to varying degrees. Proof of a return on investment was not guaranteed, but participants understood the value of addressing cost drivers collectively, and managed part of that risk by starting with small projects and scaling up. Initial savings reported ranged from flat cost growth to 20 percent reductions from pre-bundle experience. Three hospitals and one additional payer joined in 2014-15.¹⁶

Early Accountable Communities for Health Efforts. Efforts are underway in Arkansas to develop a Behavioral Health Home (BHH) care management model. The intent is to use a “whole-person” approach and address a broad range of issues including access to care; accountability and active participation among providers, patients and caregivers; continuity of care across all medical, behavioral and social supports, and comprehensive coordination/integration of all needed services. Advanced primary care practice programs have also presented opportunities to better integrate behavioral health and social services into primary care. Episode-based approaches may allow more flexibility in allocating payment to these value-added services.

Humboldt Near-Term Opportunities. By setting a combined payment for a team of providers and establishing quality standards, the goal is for providers to have greater accountability for the total cost of care and stronger incentives for care coordination. While this mechanism has been used for patient steerage to high-performing providers in some markets, there is no near-term intent to promote service consolidation in Humboldt. “Bundling” payment sets a fixed price for a set of services over a given time period, but this can be accomplished through a budgeting approach such as Arkansas implemented. This approach allows for a retrospective analysis of services without requiring recontracting among payers and providers. The parties would agree to structural elements as an initial step and analytic approaches to discern potential savings opportunities such as from service duplication or non-adherence to care guidelines. The bundled payment allocation could be for a condition (e.g., diabetes), event (e.g., heart attack) or medical procedure (hip replacement). There are a number of episode definitions that have been defined by Medicare for the BPCI program or other publicly sourced data that could be leveraged.

¹⁵ Bailit M. The Current Vermont Health Insurance Market. Montpelier: State of Vermont, 2011.

¹⁶ Timberlake K. Lessons Learned from Wisconsin’s Partnership for Healthcare Payment Reform, NRHI Webinar, December 10, 2014. Accessed at: <http://www.nrhi.org/uploads/karen-timberlake.pdf>

Bundled payment is associated with reductions in length of stay and utilization of specific services¹⁷. However, given the challenges in addressing volume requirements and case identification in implementing bundled payment, a budget-based approach may be a more feasible first step. Working under a fixed budget target with gainsharing opportunity, the goal is that providers will coordinate with one another to provide the set of services as efficiently as possible, e.g., eliminating unnecessary care, selecting lower-cost drugs, and negotiating lower rates for supplies. Furthermore, this would avoid a number of complexities such as potential antitrust issues that may arise with a recontracting effort around any one specific bundle, though there are documented pathways to address these concerns.¹⁸

Next Steps

The CEO Leadership group will continue to meet to set near-term priorities and goals. Consideration of near-term approaches should take into account alignment with Medicare and Medicaid initiatives, leverage existing resources and state experience, as well as scalability in a rural setting. Humboldt has had unique success in advancing a quality improvement and care redesign agenda through the RWJF Aligning Forces for Quality initiative. While there is no central authority, the CEO Leadership group can help set an agenda for meaningful payment and care delivery redesign that expands access and supports community workforce needs. There is a common interest in reducing the cost of health care and capturing those savings to reinvest in the community and to support a larger prevention and risk reduction strategy.

The table in Appendix 2 summarizes the applicability of the models described in this paper for the Humboldt community:

- Payment/Care Design Approach – Classification into one of the 3 primary design approaches
- Models/Examples – Summary of the model type
- Mechanism/Aim – Approach to changing payment and creating market impact
- Potential Payers – Public or private purchaser which could implement model
- Providers – Providers who are impacted by the model
- Source of Shared Savings – Many of the savings derive from the likelihood of improved care coordination and quality reducing avoidable complications. It should be noted that this does not consist purely of reduced revenues to any one party, but could derive from reduced cost of uncompensated care (e.g., under a fixed DRG payment or reducing potential downstream Medicare readmissions penalties)
- Comments – Specific considerations for Humboldt.

¹⁷ Hussey PS, Mulcahy AW, Schnyer C et al. Bundled Payment: Effects on Health Care Spending and Quality. Closing the Quality Gap: Revisiting the State of the Science. RAND Evidence-based Practice Center, prepared for Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

¹⁸ Gordon J, Martland D, Chenok K et al. Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context, Nixon Peabody and Robert Wood Johnson Foundation

For any of the items, there may be common initial steps to assess: 1) the availability data and information sources, 2) identification of additional physician leadership as champions, and 3) funding sources to support planning and feasibility assessment.

An articulation of the business case for each affected party is important for the feasibility assessment. In some cases, there may not be a clear initial return on investment. As with the Wisconsin-based efforts to test bundled payment, starting small allowed for testing in small pilot situations and scaling up after value was demonstrated (a bundled payment illustration is included as Appendix 3). Beyond considering how the payment redesign would impact incentives and care delivery, stakeholders should assess whether there are longer term impacts on the underlying cost of services provided, focusing on the drivers of cost variability and reducing outliers. While there may be a near-term impact on overall revenue, there may be an improvement on operating margin.

Additional success factors include:

- Adoption of supportive quality measures
- Mechanisms to address unintended consequences
- Alignment of payment incentives with care redesign goals and broader reform initiatives
- Transparency in decision-making processes.

Appendix 1

March 2015 CEO Leadership Group Meeting Participants

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Appendix 2

Summary of Payment and Care Design Approaches

Approach	Models/ Examples	Mechanism/Aim	Potential Payers	Providers	Source of Shared Savings	Comments
Primary Care Medical Home (PCMH)	Humboldt County: Priority Care	Improved care coordination and case management by adding nurse, behavioral health and social worker support to primary care physicians	Self-funded employer Commercial carrier (Anthem/Blue Shield) Medi-Cal managed care (Partnership HP)	Primary Care & FQHCs	Avoidable ED visits and hospitalization Referral to specialists	Collaborate with Partnership Health Plan to expand model to support Medi-Cal health homes initiative
	Humboldt County: Medical Home expansion	Support smaller primary care practices and FQHCs in improving infrastructure to adopt sustainable model.	Self-funded employer Commercial carrier (Anthem/Blue Shield) Medi-Cal managed care (Partnership HP)	Primary Care & FQHCs	Avoidable ED visits and hospitalization Referral to specialists	Adaptive approaches to provide “medical home-like” services in the smaller practices such as optimizing clinical information exchange, such as medication ordering and tracking laboratory tests. Open Door clinics function as medical homes and patients are treated within organized pods that include behavioral health support, social services, and specialty referral management. HIPA or Open Door can provide technical assistance to expand medical home capacity in the region. Consider implementation of key elements of NCQA certification for PCMH designation that would improve care coordination and access
	Advanced Primary Care Models: Behavioral Health Integration	Improve access to behavioral health services with improved member engagement and care coordination.	Self-funded employer Commercial carrier (Anthem/Blue Shield) Medi-Cal managed care (Partnership HP)	Primary Care & FQHCs Behavioral Health	Avoidable ED visits and hospitalization	PMPM allocation to support inclusion of behavioral health services in select primary care practices.
	Integrated Healthcare Association Pay-for-Performance program	Align quality measures between commercial plans and Medi-Cal to reduce administrative burden.	Commercial HMO Commercial PPO (under development)	Primary Care	Health plan allocation for performance payments Reduced provider administrative burden	Current measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS) reporting requirements for Medi-Cal managed care. Leverage existing data from quality reporting to identify interventions to reduce disparities in care and quality improvement opportunities.
	State models: AK, CO, MI	Increase proliferation of and expand services offered by PCMHs through CMS and/or commercial insurer partnerships	Self-funded employer Commercial carrier (Anthem/Blue Shield) Medi-Cal (Partnership HP) Medicare	Primary Care & FQHCs Specialist (Primary care medical neighborhood)	Avoidable ED visits and hospitalization Reduced duplication of services Allocation of savings below budgeted trend targets Health plan P4P	Explore Regional Care Collaborative Organizations, build pilots to test HIPA PCMH integration with other community services

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Approach	Models/ Examples	Mechanism/Aim	Potential Payers	Providers	Source of Shared Savings	Comments
Accountable Care	HIPA and Anthem Blue Cross Enhanced Personal Health Care	Promote care coordination and patient-centered strategies with alignment of provider incentives	Anthem Blue Cross (insured PPO)Self-funded employer	Humboldt IPA and contracted providers	Avoidable ED visits and hospitalization Reduced duplication of services Improved generic Rx utilization	Pilot gainsharing provisions for participating hospitals and/or possibly using a global budget model initially to establish baseline experience and mutually agreed upon quality and trend targets
	Blue Shield commercial ACO model	Promote care coordination and patient-centered strategies with alignment of provider incentives	Blue Shield (insured HMO) Self-funded employer	Humboldt IPA and contracted providers Hospitals	Avoidable ED visits and hospitalization Reduced duplication of services	Review services delegated to HIPA and opportunity/requirements for ACO-structured contract with Blue Shield.
	Next Generation ACO Model	Revised design for the Medicare Shared Savings Program to apply lessons from early adopters and reduce barriers to entry	Medicare	Humboldt IPA and contracted providers	Avoidable ED visits and hospitalization Reduced duplication of services	Assess feasibility
	State Models: ME, MN, OR, VT	Behavioral Health Homes Learning Collaborative, public reporting, Total Cost of Care Arrangements and Accountable Communities for Health, Coordinated Care Organization and multidisciplinary Community Care Teams, Integrated Health Services model	Commercial carrier Medicare Medicaid	Primary care Specialists Hospitals	Avoidable ED visits and hospitalization through care transition mgmt and care coordination Expanded use of physician extenders Reduced duplication of services	Produce a region-specific community risk assessment and evaluation of the current allocation of community benefit dollars in conjunction with public agencies. There may be opportunities to increase alignment across agencies to support the accountable community for health goals

STRATEGIES TO ADVANCE HEALTH CARE VALUE

Approach	Models/ Examples	Mechanism/Aim	Potential Payers	Providers	Source of Shared Savings	Comments
Episode and Bundled Payments	Medicare Bundled Payments for Care Improvement (BPCI) program	Health care providers accountable for the cost and quality of services for a particular diagnosis (e.g., hip/knee replacement) over a defined period (30 days prior to and up to 90 days after - post period of 30, 60, 90 determined by hospital).	Medicare	St. Joseph's Health Mad River Community Hospital Primary care & specialty physicians	Avoidable readmissions Supply chain management (e.g., prosthetic devices) Reduced duplication of services	Analyze volume of cases based on Medicare-defined episodes (a number of hospitals are doing orthopedic only, or secondarily, adding cardiac).
	State models: AK, VT	Vermont Bundled Payments & Arkansas Pay for Performance	Commercial carrier Medi-Cal (Partnership HP)	Humboldt IPA, FQHCs and contracted providers	Avoidable readmissions Supply chain management (e.g., prosthetic devices) Reduced duplication of services	Implement capitated payments as part of medical-home initiatives for individuals with complex or special needs
	State models: AK, TN	Multipayer episode-based budgeting models introduced in Arkansas and Tennessee to address total cost of care for select conditions and services	Commercial carrier Medi-Cal (Partnership HP)	Humboldt IPA, FQHCs and contracted providers	Avoidable readmissions Supply chain management (e.g., prosthetic devices) Reduced duplication of services	Assess feasibility for select services with commercial payers and alignment with Medicare (e.g., BPCI) and Medi-Cal initiatives (e.g., maternity).
	Providence Health & Services (MT)	Bundled payment design developed to align provider incentives and manage overall costs for select orthopedic procedures	Commercial carrier	St. Joseph's Health Mad River Community Hospital	Avoidable readmissions Supply chain management (e.g., prosthetic devices) Reduced duplication of services	Explore revenue neutral contracting model using a bundled payment with commercial payers, with a structured gainsharing for savings and/or trend reduction

Appendix 3

Sample Bundled Payment Approach

An iterative process may address different components of the payment reform areas above. They are not intended to be mutually exclusive. For example, the table below depicts some partial approaches towards an episode-based approach.

	Primary Care Fee-for-Service (FFS) with Care Management Payment	Partial Bundle: Acute e.g. Hip Replacement	Partial Bundle: Chronic e.g. COPD Care	Comprehensive Bundle e.g. Maternity
Primary Care Provider	FFS + Care Management Payment	FFS (no change)	Bundled - <i>Primary care provider</i>	Bundled - <i>OB/Gyn</i>
Specialist	FFS (no change)	Bundled - <i>Orthopedist</i> - <i>Anesthesiologist</i> - <i>Physical therapist</i> - <i>Rehabilitation Facility</i>	- <i>Pulmonologist</i> - <i>Cardiologist</i>	- <i>Anesthesiologist</i> - <i>Well baby, through x weeks</i>
Care Facility	FFS (no change)		FFS (no change)	
Post-Care Facility	FFS (no change)		FFS (no change)	

Source: Center for Improving the Value of Health Care (2011)

Additional resources:

Town R, Gregg W, Moscovice I, et al. Will Bundling Work in Rural America? Analysis of the Feasibility and Consequences of Bundled Payments for Rural Health Providers and Patients. Rural Health research & Policy Centers, September 2011. Accessed at: http://rhrc.umn.edu/wp-content/files_mf/townbundling.pdf