

## Episodic Bundled Payments and Global Payments: Considerations for Health Care for the Homeless Projects

A number of new payment models are being tested or implemented as part of national, state, and local efforts to achieve the “triple aim” which is to improve patient experience, improve health, and reduce costs.<sup>1</sup> Some payment models build upon existing service/visit-based payment mechanisms such as Fee for Service (FFS) and Prospective Payment System (PPS) by offering additional financial incentives, like bonuses, for meeting certain quality and cost metrics. Other models move us further away from these traditional payment mechanisms to a more global approach at financing health care. In these models, providers are offered a fixed rate for a group of services rather than payment for each visit or service delivered; unused dollars are shared among the provider group.

This brief describes two such models—episodic bundled payments and global payments—along with the advantages, drawbacks and issues of both payment models for the HCH community. This brief also outlines strategies for representing your health center in payment reform discussions.

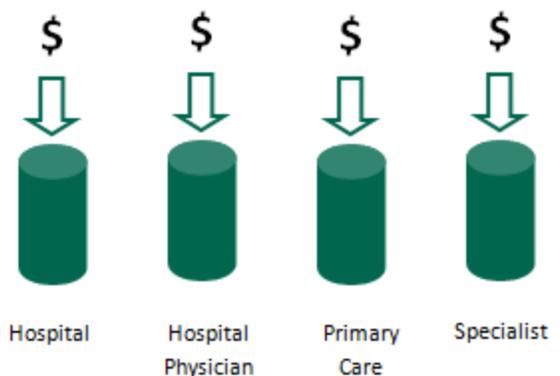
### Overview of Episodic Bundled Payments and Global Payments

The episodic bundled payment (or bundled payment) model provides a fixed rate that is shared among a set of providers who deliver services related to a *specific episode of care* (e.g., diabetes with major complication).<sup>2,3</sup> For example, in a traditional payment model, the hospital, hospital physician, primary care provider, and specialists would each receive a separate payment for disparate services delivered to one patient to treat or manage the diabetic episode (see figure 1). The bundled payment model sets a fixed rate that is shared among all of the service providers (see figure 2).

In a global payment model, providers working together across settings share a fixed rate for *comprehensive care provided over a defined time period* (see figure 2).<sup>4</sup> Unlike the bundled payment model which provides payment for one specific episode, the global payment model supports more integrated interdisciplinary care by addressing the full range of health services for each patient. As such, the global payment model moves farther away from the traditional visit/service-based payment model while the bundled payment model takes a more incremental step.

Figure 1. Traditional Payment System

Each provider is paid for doing work in isolation. The Fee for Service (FFS) approach pays a fee for each service provided. The Prospective Payment System (PPS), used by Medicare (and by Medicaid to pay for services in Health Centers), provides a payment for each visit.

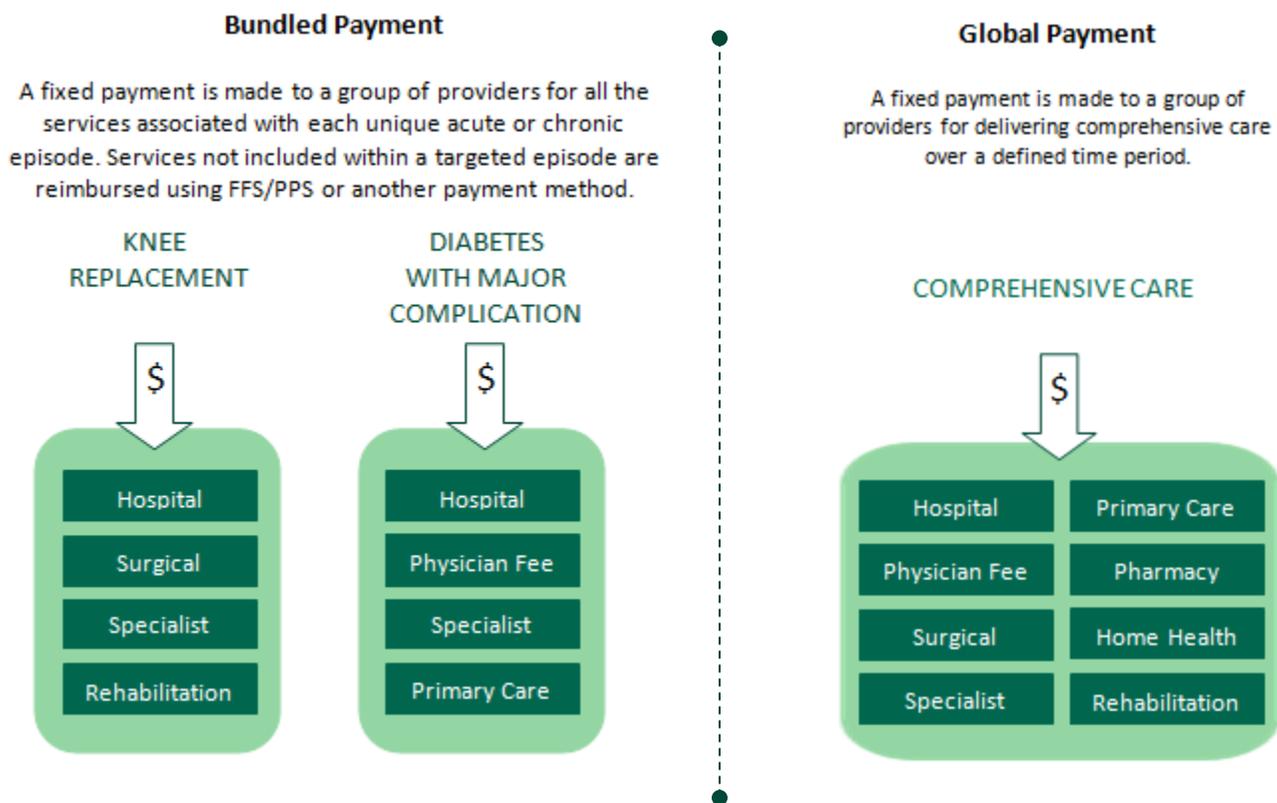


Source: Adapted from Massachusetts Special Commission on the Health Care Payment System, “Recommendations of the Special Commission on the Health Care Payment System,” PowerPoint (Boston: SPHCP, July 16, 2009).

In bundled and global payment models, the payer (i.e., insurer, managed care organization) caps payment rates thus shifting the financial risk to the provider who will assume any costs exceeding the fixed rate; hence, providers attempt to keep costs down through a variety of mechanisms such as improving coordination across settings, reducing unnecessary tests and procedures, and reducing future episodes by engaging patients in prevention and care management activities. As an additional incentive to keep costs down, unused dollars can be shared among the provider group.

Bundled and global payment rates are generally established by local, state, or federal professional groups composed of providers and payers, among others. Payment rates vary across payers and generally take into account historical costs for services delivered by providers, anticipated costs of services associated with established health care standards, and geographic differences. Payment rates are generally set lower than the anticipated cost of care under a service-based model in order to achieve savings and are risk-adjusted (higher payments for patients who have a greater severity of illness) in order to account for the increased resources needed to care for these patients. While some payers may choose to implement a fixed payment model within their own networks, policy makers may initiate payment models regionally or at the state level in order to have a stronger fiscal impact.

Figure 2. Bundled Payment versus Global Payment



Source: Adapted from Massachusetts Special Commission on the Health Care Payment System, “Recommendations of the Special Commission on the Health Care Payment System,” PowerPoint (Boston: SPHCP, July 16, 2009).

Advantages to both models include the opportunity to form more solid relationships with outside providers serving health center patients and the opportunity to increase health center revenue through shared savings. Additional advantages to the global payment model is the potential to get reimbursement for historically unbillable services, like case management, care coordination and medical respite care, needed to meet the holistic needs of vulnerable populations and to support the workforce required to accommodate these needs.

Both models also have drawbacks. One drawback to both payment models is that any costs exceeding the fixed payment rate must be assumed by the provider group. The bundled payment model may have more drawbacks than the global payment model because it is administratively complicated to implement, particularly for patients who would benefit from integrated care to address multiple and complex health conditions. For example, bundled payment models may require practitioners to assign rendered services to a specific episode although several acute or chronic conditions may have contributed to the episode. Table 1 below compares the two payment models including advantages and drawbacks, and highlights those elements of particular interest to homeless health care providers.

Table 1. Comparison of Episodic Bundled Payments and Global Payments		
	Episodic Bundled Payments	Global Payments
<b>Overview</b>	<p>A fixed payment covers all fees associated with an episode of care. An episode of care can be either acute (e.g., knee replacement) or chronic (e.g., diabetes with or without major complication) and can include services such as hospital admission, ambulatory care, primary care, pharmacy, and clinical and professional services provided during a defined window of time.<sup>5</sup></p> <p>For acute conditions, the window of time can begin as far back as 30 days prior to the diagnosis and end up to 180 days following a procedure. For chronic conditions, payments can cover related services provided over the course of a year. Exact time frames depend on the payer.<sup>6</sup></p> <p>In determining which episodes to bundle, decision makers (e.g., insurers, managed care organizations, states) consider the cost of care for the acute or chronic condition, potential for cost savings, and ease of implementation. Services included within the bundle are often based on evidence-based clinical care guidelines and regional or statewide trends related to service use. Because of the complexity of developing bundles, it is common for health systems to only have a few acute or chronic conditions that qualify for bundled payment.</p>	<p>A fixed payment rate covers all health care services for a patient delivered by a network of providers over a period of time (often monthly or annually).</p> <p>In most global payment models, beneficiaries are locked into provider groups that participate within a payer network; though some models have tiered payment structures allowing beneficiaries to seek care outside of a network in exchange for higher out of pocket costs.</p>

<p><b>Advantages</b></p>	<p>Both models encourage multiple providers involved in a patient’s care to work more collaboratively to improve quality and avoid unneeded or duplicative spending. Providers may share any unused dollars as an incentive for keeping costs down.</p>	<p>Global payment models offer provider groups more flexibility in providing holistic, integrated care to meet the unique needs of their patient population.</p> <p>Global payments can accommodate a changing workforce where lower-cost non-physician providers are assuming new roles and responsibilities.</p>
<p><b>Drawbacks</b></p>	<p>In both models, providers bear financial risk for any costs exceeding the payment rate.</p> <p>Distinguishing which services belong to which episode can get complicated for people who have multiple and complex health conditions.</p> <p>Compartmentalizing treatments can muddle efforts to deliver integrated care for people with complex co-morbidities.</p> <p>While bundled models improve coordination and efficiency for some acute and chronic conditions, the model still heavily depends on a FFS/PPS system to cover the cost of care for services and conditions that are not included within an episode.</p> <p>This model creates an incentive to generate more episodes of care since providers are paid per episode.<sup>7,8</sup></p>	<p>Providers have incentives to pick healthier patients in order to achieve greater savings or under-treat patients in need of costly services.<sup>9</sup></p> <p>People experiencing homelessness have higher needs that translate into higher costs. Health centers will need to know how to make a strong case for risk-adjusted payments in order to be reimbursed appropriately.</p>

### Issues to consider for the HCH community

- *Patients who experiencing homelessness may be at higher risk of being excluded from bundled payment arrangements.* Some bundled payment initiatives have limited eligibility for individuals who have gaps in coverage or require significant resources to meet their health care needs.<sup>10</sup>
- *Health Centers may have difficulty negotiating bundled payment rates.* Most Health Centers have little experience negotiating payment rates since their PPS rates are set by states (for Medicaid) and by the federal government (for Medicare). Moreover, Health Centers are not involved in

the full spectrum of patient care during an episode. As such, determining alternative payment methodologies in the early design stages of a bundled payment model may prove to be difficult.

- *Providers serving homeless populations may not realize the same savings and bonuses as providers serving less vulnerable populations and may even experience financial losses.* While payments are adjusted for diagnosis and severity of illness, payment systems often do not take into account the cost of addressing social determinants of health when developing risk-adjusted payment rates. As such, services such as street outreach, medical respite care, and supportive housing are not generally included. Additionally, people experiencing homelessness use the hospital more frequently, have longer lengths of stay, and are in poorer health in general—all of which may impact savings and potential bonuses.<sup>11,12</sup>
- *Homeless patients may be tied to an outside provider group.* HCH providers may be ineligible for reimbursement for services provided to patients covered under another provider network. As more opportunities for health care coverage become available, patients have more flexibility in choosing their provider group. Hence, health centers will want to participate in as many provider networks as possible.
- *A consistently engaged patient population is needed to effectively manage care and keep costs down.* Meeting long-term health care goals and reduced spending requires an ongoing patient-provider relationship.<sup>13</sup> Unfortunately, people who are homeless may tend to use health services in a more episodic manner, which makes it harder to achieve quality goals. As such, health centers may be at a disadvantage for performance-based payments, or bonuses, which are sometimes offered by payers for meeting quality metrics.
- *Health centers have flexibility to offer a wider range of patient services.* Because of the flexibility permitted in global payments, health centers may finance services such as medical respite care, care coordination, and self-management goal setting without the need to demonstrate that a traditional, discrete billable service has occurred.

## Strategies for representing your health center in payment reform efforts

- *Make sure you participate in payment reform discussions early in the process.* Because new payment structures can impact health center payment and health care delivery, it's important that your health center is represented at the earliest stages when concept and design are being determined.
- *Work closely with your primary care association (PCA).* Your primary care association is likely engaged in payment reform discussions, but they may not be aware of HCH-specific service use or disease burden. The PCA can identify opportunities to get engaged in conversations or at minimum keep you informed of payment reform efforts and help represent your health center in discussions. Ensure your PCA is aware of the unique characteristics of an HCH patient base by providing them with demographic and service use data.
- *Be informed about payment models.* There is significant variability among payment reform models being considered and implemented, with each model targeting a specific problem. Understanding the goals and mechanisms of the various payment models will enable you to adequately identify how your health center should be involved.

- *Use health center data to inform payment reform discussions.* Data that includes cost, service utilization, and patient demographics can be used to inform payment rates and performance benchmarks appropriate for your patient population. HCH grantees have a patient group that has poorer health, a higher disease burden, and greater costs associated with treatment. Data is critical to identifying reimbursement rates that more accurately reflect actual costs, which may be higher than those needed for a more general population. Without higher rates, health centers are at risk of experiencing financial loss.
- *Understand your legal protections as a health center under Medicaid.* The federal Benefits Improvement Protection Act of 2000 (BIPA) allows State Medicaid programs to pay health centers using an alternative payment methodology (APM) instead of the PPS. However, the statute requires that total payment to the health center under the APM must be at least equal to the amount to which it is entitled under the PPS, and that each individual health center agree to the use of the APM.<sup>14</sup>
- *Consider infrastructure needs.* Your health center may need to develop new workforce and information technology capacity to improve coordination across care settings, code services that historically were not billable, and track new metrics to document performance.
- *Consider best practices for sharing data.* Data sharing across care settings improves care coordination and enhances the meaningful use of data systems. Accessing more comprehensive insurance claims data for a patient population can be used to assess service utilization patterns (at the individual level or for a larger patient group), determine opportunities for improving care, and to identify areas for building community partnerships. Accessing real time data can be used to address more immediate needs of beneficiaries such as the need for medical respite care for patients admitted to the hospital.
- *Engage your full leadership team.* Help ease transitions into new payment structures by keeping administrative and clinical staff informed of promising practices that might be supported under new payment models. Discuss the advantages and drawbacks involved, and identify strategies to maximize the opportunities for providing additional needed services.

## Conclusion

Nearly every state is engaged in payment reform efforts in order to meet the triple aim of improving health, improving health care delivery, and reducing costs. A wide range of payment reform models is being discussed and there are advantages and drawbacks to each approach, especially for the HCH community. As such, it's important that your health center leadership understands the range of payment methodologies being considered in your area, recognizes the potential risks and rewards associated with each, finds the best approach that meets your patients' needs, and participates in local and state-wide payment reform discussions.

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