

Adopting Multipayer Hospital Global Budgets

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Hospital global budgets are fixed payments made to hospitals for a set of defined services. These payments are determined prospectively, based on historical utilization, and adjusted annually to account for changing demographics, market share, and service mix.

Hospital global budgets address the failure of the market to constrain price and price growth. This type of alternative payment model reduces hospitals' incentive to increase service volume, as hospitals are not paid based on the number of services they deliver. Instead, hospitals are responsible for managing patient service use and operating costs to stay within budget.

Global budgets can also financially benefit hospitals. They provide a steady, predictable revenue source that gives hospitals the flexibility to redeploy resources to other areas, potentially including efforts to improve the health of the communities they serve.

The following steps present a sequence of important decisions for states to work through. The order in which states implement these steps will vary depending on whether the state is leading the design of the hospital global budget model or whether it is using stakeholder feedback to inform model design. States may also choose to phase in certain elements of the hospital global budget model over time.

The steps we have laid out assume that while states are leading the way, they do not yet have statutory authority to implement hospital global budgets or set provider rates. Therefore, states need to secure support and agreement to participate from payers, hospitals, and other stakeholders.

States should be prepared for a process that is both *iterative* and *dynamic*, where questions and strategic

choices may need to be revisited over time. This guide includes examples from four states that have used hospital global budgets: **New York's** Hospital Experimental Payment Program (1980–1987), **Maryland's** All-Payer Model (2014–2018) and Total Cost of Care Model (2018–present), OneCare **Vermont's** model (2017–present), and **Pennsylvania's** Rural Health Model (2019–present).

- Step 1.** Set goals for adopting hospital global budgets and confirm readiness to proceed.
- Step 2.** Determine how to engage stakeholders during the hospital global budget model design process.
- Step 3.** Decide who should convene stakeholders and design the hospital global budget methodology.
- Step 4.** Incorporate the goal of improving overall health care and payment equity into model design, implementation, and evaluation.
- Step 5.** Determine whether to make participation voluntary or mandatory.
- Step 6.** Establish the level of standardization across the hospital global budget model.
- Step 7.** Identify which hospitals and services to include.
- Step 8.** Identify which payers should participate.
- Step 9.** Agree on how to establish and update budgets annually.
- Step 10.** Choose a method for adjusting budgets during the performance year based on hospital utilization.
- Step 11.** Decide how to distribute payments to hospitals.

Step 12. Decide whether the model should include supplemental arrangements that aim to improve affordability, access, quality of care, and population health.

Step 13. Determine who should calculate budgets and manage and oversee the hospital's global budget.

Step 14. Identify opportunities to mitigate hospitals' financial and technical risk.

Step 15. Create a plan for monitoring and reporting on progress.

Step 1. Set goals for adopting hospital global budgets and confirm readiness to proceed.

State goal development. Before engaging stakeholders, the state should consider what its own goals are for the hospital global budget model. A clearly articulated and widely adopted set of goals will provide stakeholders with clarity on what the state aims to achieve and how a hospital global budget model will help it do so. Recognizing that not all stakeholders are likely to support the program, the state needs to build a compelling case for the model by bringing important voices to the table who are willing to commit their time, energy, and political capital.

The goal definition process should involve key state agencies, as collaboration across agencies (and the legislature) will be necessary to succeed. This can be done with all actors assembled together or through a series of individual conversations. States should continuously revisit these goals during the design phase and hold participating entities accountable for meeting these goals.

Goals may include controlling the rate of hospital price growth; reducing potentially avoidable utilization and spending; providing financial stability for hospitals, particularly rural hospitals in financial distress; or improving the health status of the population within each hospital's service area.

Environmental assessment. Each state's environment is unique and will change over time. Before committing to a large-scale payment initiative, the state should consider these questions:

- Is there sufficient state government leadership support within the governor's office and across state agency and legislative leadership?
- Does the state have the support of consumers and consumer advocates, employer purchasers, and other nongovernmental stakeholders?
- Does the state have sufficient resources within or outside the state to provide the necessary staff, policy expertise, operational expertise, and financial support?
- In what ways can hospital global budgets support payers' and providers' key financial and care delivery goals while advancing the broader public interest?
- Which key objections to the proposed model are likely to arise among special interest groups and other stakeholders?

States should conduct an environmental assessment at the outset to understand key stakeholders' perspectives and see where there might be opportunities and barriers. A hospital global budget model significantly changes how hospitals are paid and could garner opposition from insurers and hospitals that are reluctant to change. Therefore, the first thing to do is identify whether there is requisite state leadership to champion a shift toward a hospital global budget model. It is vital that a state has support from agency leaders all the way to the governor's office who will advocate for and support this transformation.

Next, states will need to hold conversations with key stakeholders and other knowledgeable parties who can be valuable in determining the degree of external stakeholder support and readiness. We have listed some viewpoints that state staff should anticipate.

Stakeholder Viewpoints That State Staff Should Anticipate

Stakeholder	Potential opportunities for a hospital global budget model	Potential threats from a hospital global budget model
Consumers and consumer advocates	<ul style="list-style-type: none"> Improved affordability, access, equity, quality of care, and population health 	<ul style="list-style-type: none"> Harmful unintended consequences to affordability, access, equity, quality of care, and population health
Employer purchasers (e.g., businesses, labor organizations)	<ul style="list-style-type: none"> Improved affordability, access, equity, quality of care, and population health 	<ul style="list-style-type: none"> Loss of autonomy to negotiate rates for Employee Retirement Income Security Act (ERISA) plans
Insurers	<ul style="list-style-type: none"> Improved opportunities to align incentives with providers and reduce areas of current conflict 	<ul style="list-style-type: none"> Loss of autonomy to negotiate rates and control other operations under regulated payment model Lack of fit with existing payment practices Burden associated with adopting new model
Legislators	<ul style="list-style-type: none"> Improved affordability, access, equity, quality of care, population health, financial stability, and system accountability 	<ul style="list-style-type: none"> Hospital and insurer opposition due to fear of regulation curtailing their financial and strategic interests
Hospitals	<ul style="list-style-type: none"> Agreement on interests with payers, which may reduce conflict and administrative costs Steady, predictable revenue, especially for smaller rural hospitals Ability to finance care for uninsured people and for population health initiatives 	<ul style="list-style-type: none"> Loss of negotiating power for large, market-dominant hospitals Assumption of financial risk for managing costs Burden associated with adopting new model Concern about how budgets will be established Unintended inefficiencies imposed by more extensive regulation
Nonhospital provider organizations	<ul style="list-style-type: none"> Aligned incentives across care settings if model includes professional services or other nonhospital services 	<ul style="list-style-type: none"> Confusion around how model relates to other alternative payment models
State agencies	<ul style="list-style-type: none"> Improved affordability, access, equity, quality of care, population health, financial stability, and system accountability Ability to modify model to respond to delivery system changes 	<ul style="list-style-type: none"> Need for new statute May require additional financial and personnel resources (including contracted personnel) to support work Regulatory failure resulting from challenge of developing and enforcing complex policy Legislator opposition Harmful unintended consequences to access, equity, and quality of care
Centers for Medicare and Medicaid Services (CMS)	<ul style="list-style-type: none"> Improved affordability, access, equity, quality of care, population health, financial stability, and system accountability Amplify impact of Medicare initiatives through alignment with existing Medicare models 	<ul style="list-style-type: none"> Potential for state to promote model features that conflict with CMS program goals Difficulty in understanding and effectively overseeing the state model Potential political pushback from the state's congressional members

Decision on whether to proceed. After working through the preceding activities, states should know whether circumstances are ripe for proceeding with a hospital global budget model. Because of the considerable effort required to succeed, the state should be confident that there is a sufficient window of opportunity to foster success. In some instances, states may need to make multiple attempts to secure the regulatory authority needed. Preliminary steps include setting the stage for the right moment for moving forward, such as establishing a committee to develop recommendations or commissioning a report on key parameters for the state's hospital global budget model.

Step 2. Determine how to engage stakeholders during the hospital global budget model design process.

There are many ways states can engage stakeholders throughout model design, implementation, and evaluation. Two broad approaches are either to design the model and then gather stakeholder input, or to engage stakeholders from the beginning of the model design process.

State-led design process with stakeholder public comment. In this approach, a state would initially design a straw model of the hospital global budget model, or a draft model intended to aid stakeholder discussion of model components, and then make the model available for public comment. This approach would likely involve fewer resources, since the state is not taking the time and effort to reach consensus with stakeholders on each design decision. It would also ensure that the model aligns with the state's goals and priorities, rather than those of powerful stakeholders. However, this approach may not garner strong stakeholder buy-in unless there is significant preexisting support for the model.

Stakeholder-led design process. If the state chooses to engage stakeholders in the model's design from the beginning, it should create a formal process for discussing each design decision with them. This may involve assembling a formal work group with all of the relevant stakeholders, as well as facilitating meetings where the group provides input on key design decisions. This approach may be more likely to secure buy-in from stakeholders, but it is more resource- and time-intensive.

It is best for states to use this approach when there is little or no buy-in. However, that runs the risk of private organizations influencing the stakeholder work group to

support the organizations' special interests, which may not align with the goals of the state and the public. This, in turn, could limit success.

Stakeholders the state should engage. Regardless of when states seek input during the design process, they should engage these stakeholders: leadership from hospitals and other health care organizations; relevant state agencies; private insurers; the Medicaid agency; consumer and patient advocates; CMS and the Center for Medicare and Medicaid Innovation (CMMI); and the business community, including large employers and labor unions. The state should be mindful of equity considerations when designing the process (see **Step 4**).

Step 3. Decide who should convene stakeholders and design the hospital global budget methodology.

Convening and supporting stakeholder advisory bodies. Once the state identifies its goals for adopting hospital global budgets, it should convene (or identify an appropriate entity to convene) stakeholders to assist in the design, implementation, and evaluation of the model. This entity can also work with stakeholders to establish complementary agreements to control costs and improve quality, if necessary. The convener can be a public agency that has existing relationships with stakeholders, or it can be a private, transparent agency with representation from a variety of stakeholders. The convener will need sufficient staffing to prepare for and facilitate stakeholder advisory body meetings and other working groups as needed.

Designing the hospital global budget methodology. One of the fundamental tasks the convening entity will be responsible for is designing the methodology that states will use to establish and regulate hospital global budgets. The convener, in partnership with stakeholders, will need to consider questions ranging from which key parameters of the hospital global budget should be standardized across payers and hospitals (**Step 6**), to which services to include (**Step 7**), to which data and approach states should use to calculate hospital-specific budgets (**Step 9**).

Responsibility for developing all or specific components of the hospital global budgets can also be left up to individual payers and hospitals through their individual contracting processes. If states take this approach, they should ensure that payers and hospitals adhere to any payment model parameters that should be standardized across payers and hospitals, as described in **Step 6**.

The advantage of delegating responsibility to payers and hospitals is that it may increase their willingness to adopt hospital global budgets, as it leaves room for negotiation. It also reduces the administrative burden placed on one agency. The disadvantage of delegating responsibility is that it may result in less alignment across models than if a single entity developed and managed budgets across payers and hospitals. Further, it is less likely to be effective in slowing hospital spending growth, particularly in the commercial market, as payers and hospitals with significant market power can negotiate terms that are more favorable for them and that may not align with the state's goals for the model.

Maryland's Health Services Cost Review Commission

Established in 1971 to regulate hospitals, Maryland's [Health Services Cost Review Commission](#), an independent state agency, began regulating hospital rates for the commercial market in 1974. In 1977, CMS granted Maryland a waiver granting the commission all-payer rate-setting authority over hospitals. This explicit and extensive authority enabled Maryland to implement and enforce a payment model that aligned with the state's goals and priorities. Specifically, the authority allowed the commission to establish hospital-specific and service-specific rates for all inpatient, hospital-based outpatient, and emergency services.

Maryland's ability to set its own Medicare rates was [codified in federal legislation](#) in 1980, a feature that would likely now be impossible for other states to acquire.¹ The commission began to annually calculate, monitor, and enforce hospital global budgets for the state's 46 acute-care hospitals as part of its 2014 Medicare All-Payer Model Agreement with CMS. It maintains these responsibilities as part of the state's 2019 Total Cost of Care Model.

¹ The terms of Maryland's agreement required the state to set similar rates across all payers. It significantly increased Medicaid and Medicare payment rates so that those rates were equal across public and private payers. CMS is highly unlikely to approve a similar change to Medicare payment rates today. However, states can still negotiate waivers that ensure Medicare participation, facilitate Medicaid participation, and give states the ability to control future prices and price growth.

Rochester Area Hospitals' Corporation

A voluntary nonprofit agency that administered the New York Hospital Experimental Payment Program, the Rochester Area Hospitals' Corporation was incorporated in 1978. The corporation consisted of two members from each participating hospital and two members from the University of Rochester.² Over nearly a decade, the corporation developed a methodology for calculating hospital-specific budgets, reviewed hospital data to identify areas for improved quality and efficiency, approved additional costs associated with certificate of need projects, and acted as a forum in which to discuss health care issues broadly.³

Sources: *A Community Hospital Payment Experiment Outperforms National Experience: The Hospital Experimental Payment Program in Rochester, NY*; *Cost-Effective Health Care: The Rochester Experience*; *Hospital Cost Containment in Rochester: From Maxicap to the Hospital Experimental Payments Program*.

² The employer purchaser community, while not directly represented on the Rochester Area Hospitals Corporation, played a notable role in designing and modifying the payment program over time through their seats on hospital boards and the corporation's finance committee.

³ New York's model ended when the state moved to the all-payer diagnosis-related groups (DRG) payment system.

Step 4. Incorporate the goal of improving overall health care and payment equity into model design, implementation, and evaluation.

It is critical that states incorporate the goals of improving health equity in their hospital model design, implementation, and evaluation processes, because hospital global budget models have the potential to perpetuate and worsen health inequities. Specifically, they will likely preserve existing inequities in access to care and utilization because they often begin with historical payment rates. This model also runs the risk of exacerbating inequities by rewarding payers and providers for serving those who benefit from comparative advantage and penalizing those serving individuals who have been disadvantaged by inequities. The state should include strategies for mitigating these impacts in its design and implementation plan. We highlight three such strategies here.

Ensure representation in governing bodies. Communities of color and low-income communities are not always represented in stakeholder groups. States should ensure that diverse stakeholders have positions of influence in the planning, implementation, monitoring, and evaluation processes. For example, states should ensure that the advisory bodies that design and oversee the hospital global budget model are representative of the state's demographics. Creating representative governing and advisory bodies ensures that many perspectives are considered during decision-making and can foster trust and buy-in from the community.

Adjust budgets to account for social risk and correct existing inequities in payments. States should ensure that hospital budgets reflect their patient population's care needs. Hospitals that serve historically marginalized communities (for example, low-income communities, non-English speaking communities, and communities of color) may need additional resources to properly address their patients' needs. A state can achieve this by recognizing that there may be historical patterns of resource underutilization by certain populations, for example. In response, the state can provide additional financial support to hospitals that primarily serve those populations, which allows such hospitals to work to improve access and facilitate more appropriate utilization. This financial support can take the form of an adjustment to ongoing payments or an up-front, one-time payment. These modifications are essentially a type of social risk-adjustment: they modify quality and cost payments based on patients' social risk factors (such as socioeconomic status, race, or ethnicity) so as to ensure that providers are not penalized for serving disadvantaged groups.

Assessing quality and equity improvements. States should assess improvements in quality and equity in addition to evaluating absolute performance against a hospital global budget. For example, states should consider linking payment to disparities-sensitive quality measures and equity measures.

When assessing performance, states should stratify their results using demographic and social risk factor data, to the greatest extent possible. These data can include race, ethnicity, language, disability status, gender identity,

geography (for example, rural vs urban, zip code), income, insurance status, sex, sexual orientation, and other social risk factors. States can use these measurements to reduce inequities in performance and improve performance for subpopulations that experience inequities.

Step 5. Determine whether to make participation voluntary or mandatory.

Each state will need to determine whether alignment with its hospital global budget model will be voluntary (that is, health care organizations may choose to participate in the model and generally have an option to leave the model at any time) or mandatory. Which approach a state selects depends on which tradeoffs it prefers to make.

Voluntary approach. States can ask health care organizations to enter into a compact affirming that they will participate in a hospital global budget model. A compact may contain a set of common principles, model guidelines, and implementation targets that organizations agree to work toward. While not legally binding, a compact demonstrates a commitment to the model guidelines and implementation targets. States should make an effort to garner signatures from all health plans, providers, and relevant government entities.

A voluntary approach is typically easier to establish but can limit the model's success if payers do not agree to participate; if there are financial challenges that cause payers to withdraw (such as the coronavirus pandemic); or if there are competing, geographically proximate hospitals that do not participate and continue to get paid using different mechanisms. Further, the increasing presence of national payers that prefer not to deviate from a national corporate strategy may make it more difficult for states to rely on a voluntary approach. Three of the four hospital global budget models referenced in this guide use or have used a voluntary approach: Pennsylvania, OneCare Vermont, and New York.

Vermont's Voluntary Approach to Hospital Global Budgets

Vermont's All-Payer Accountable Care Organization (ACO) model has been implemented through a single statewide ACO, OneCare Vermont. Unlike other efforts that were led by a state agency, the ACO negotiated with payers separately to establish a voluntary global budget model for its participating hospitals. This voluntary approach gave OneCare an opportunity to implement a hospital global budget model faster than it may have taken to develop a statewide model.

However, commercial payer participation is limited. The result of the limited commercial participation is that, on average, only 14 to 15 percent of a hospital's net patient revenue is estimated to come from global budgets (according to data for 2020–2022). Therefore, under the current approach, hospital global budgets in Vermont may represent too small a fraction of a hospital's revenue to counteract the incentives of a fee-for-service system.

Sources: *Evaluation of the Vermont All-Payer ACO Model: First Evaluation Report; Preliminary Review of FY2022 Hospital Budget Submissions and Public Budget Hearing Exemptions.*

Mandatory approach. States can use their regulatory or statutory authority to mandate use of a hospital global budget, and they can leverage an agency, such as their insurance department, to regulate the commercial fully insured market. States can also use their purchasing authority to compel payers to use hospital global budgets. Specifically, states can use their Medicaid purchasing authority to require use of hospital global budgets through working directly with hospitals or through their Medicaid managed care organization (MCO) contracts. With MCOs, states can adopt a model-oriented approach (requiring all MCOs to pay hospitals using a specified global budget model) or a goal-oriented approach (specifying that a certain proportion of MCO payments to hospitals must be made through global budget arrangements). Finally, states can integrate use of hospital global budgets within the state employee benefit plan by requiring insurers or third-party administrators to use the model.

The advantage of using a mandatory approach is it guarantees hospital and payer participation. By increasing the proportion of hospital payments delivered through a hospital global budget arrangement, there is a higher likelihood of achieving care transformation and cost containment. However, a mandatory approach is only feasible if a state has regulatory or statutory authority, which may be hard to secure.

Maryland's All-Payer, Hospital Rate-Setting Authority

The Maryland Health Services Cost Review Commission's unique all-payer, hospital rate-setting authority allowed it to compel private payers and Medicaid to use hospital global budget arrangements with the state's 46 general acute-care hospitals beginning in 2014. The commission entered into an agreement with CMS that exempted hospitals from Medicare's inpatient and outpatient prospective payment systems and shifted the state's hospital payment structure to an all-payer, annual global budget. These features ensured that global budgets encompassed 95 percent of hospital revenue.

Source: *Evaluation of the Maryland All-Payer Model: Final Report.*

Combined voluntary-mandatory approach. It is important to note that voluntary and mandatory approaches need not be mutually exclusive. States may choose to make some elements of their hospital global budget initiative voluntary and others mandatory. For example, a state may implement a hospital global budget model through Medicaid and require its state employee benefits plans to align with some or all of Medicaid's model design. At the same time, it can encourage but not require all other commercial insurers to align with the model. This approach is viable only if there is sufficient voluntary commercial payer participation to ensure that hospital global budgets represent the majority of hospital payments.

Step 6. Establish the level of standardization across the hospital global budget model.

There are benefits to fully standardizing how hospital global budgets are calculated and implemented across payers and hospitals. It ensures there is consistency across contracts and that payers and hospitals with significant market power cannot negotiate terms more favorable to them that may contradict the state's goals.

Realistically, though, universal adoption of a uniform methodology may not be possible. One reason is that a uniform approach would require significant state agency involvement to calculate and oversee budgets for each payer and provider. Most states, payers, and hospitals do not have the infrastructure in place to administer hospital global budgets. Moreover, CMS does not have a uniform hospital global model that states could default to.

For these reasons, states may opt to allow for some flexibility in how hospital global budgets between individual payers and hospitals are implemented. This may increase payer and hospital willingness to participate in a voluntary arrangement and can provide an opportunity to tailor the model to unique payer and hospital characteristics. This would also devolve some of the responsibility for designing and negotiating specifics of the contract to individual payers and providers.

It is important to note that some significant degree of alignment must be established to avoid the serious shortcomings of nonaligned value-based payment models: confusing or even contradictory economic signals to providers; increased provider administrative costs; and most importantly, diminished likelihood of improving affordability, quality, and equity.

One state strategy for achieving alignment is to create a base hospital global budget design with a set of standard, core model components that are used across all payers and hospitals, alongside additional opportunities for customization. If states have the regulatory authority, they may choose to make any payer or hospital modifications

from the base hospital global budget model subject to state approval. Which features states choose to standardize will depend on each state's unique environment as well as the key model objectives for the state and its stakeholders.

Areas where states should consider seeking alignment include:

- the data and methodology used to calculate and update budgets annually
- the methodology for adjusting budgets during the performance year
- a minimum set of services to be included in the model.

Exact alignment will be much more difficult to achieve in certain areas, such as how payments are distributed to hospitals. General principles or specific payment parameters can minimize the negative impact of nonalignment.

The Federal Community Health Access and Rural Transformation Model

The Center for Medicare and Medicaid Innovation (CMMI) developed a hospital global budget model called the [Community Health Access and Rural Transformation \(CHART\) Model](#) and launched it in fall 2021. From 2023 through 2028, the model intended to provide prospective capitated payments to rural hospitals in Alabama, South Dakota, Texas, and Washington. However, CMMI determined there was insufficient participation from rural hospitals to proceed with model implementation in January 2023.

The model included a specific methodology for Medicare fee-for-service payments. Commercial participation was voluntary and allowed payers to propose modifications to the payment methodology. As of publication, the program had insufficient participation from rural hospitals to proceed with the first implementation year of the model in 2023.

Step 7. Identify which hospitals and services to include.

The more hospitals and services a state includes in a hospital global budget model, the greater the incentives will be for providers and payers to work together across settings to reduce costs. This may yield a larger impact on cost growth. Which hospitals and services the state includes in its model will affect how it designs other model components, such as the data used to calculate budgets and the method for distributing payments to hospitals.

Hospitals. Global budget models can include all hospitals in a state or region of a state, or they can focus exclusively on a subset of hospitals. Implementing global budgets for all hospitals in a state or region is advantageous, as universal participation can yield strong outcomes. Doing so also makes it easier for states to oversee and administer the model effectively.

Current models include acute-care hospitals and exclude specialty care hospitals. If states are considering the inclusion of specialty care hospitals, they should evaluate whether there are special considerations that must be addressed in the model design.

In addition, it may be administratively challenging to implement hospital global budgets in metropolitan areas with overlapping hospital service areas. Especially in areas served by multiple hospitals, states must determine how to identify hospitals' patient populations for budgeting purposes and must monitor and adjust those budgets based on utilization.⁴

Arrangements that are limited to rural hospitals are easier to implement administratively, because rural hospitals tend to be geographically isolated. This makes it straightforward to identify a hospital's associated patient population. Global budget models focused on rural hospitals are also designed to sustain hospitals that provide necessary services in underserved communities, where financial viability is more precarious.

⁴ A flexible global budget arrangement, as described in **Step 10**, reduces the administrative burden associated with adjusting budgets to account for changes in a hospital's patient population. This arrangement automatically accounts for changes in utilization that may be due to movement of patients from one hospital to another in metropolitan areas by adjusting prices up or down to account for variable costs only.

This approach, however, may have limited impact on overall hospital spending and growth. That's because rural hospitals tend to represent a small percentage of a state's hospital spending. Focusing on a subset of hospitals may also lead to gaming the system as a result of differing payment incentives. Specifically, hospitals that are paid under a global budget arrangement may "shed" patients to hospitals that are paid on a fee-for-service basis in an attempt to maximize savings.

Pennsylvania's Rural Health Model

Focused exclusively on hospital global budgets for rural hospitals, Pennsylvania's Rural Health Model's primary goals is to "support care delivery transformation that improves population health outcomes, increases access to high-quality care, and improves the financial viability of rural Pennsylvania acute care hospitals." Commercial insurers have joined the hospital global budget initiative because they want to provide stability for hospitals that serve the needs of their community effectively. As of 2021, of the 67 hospitals in rural Pennsylvania, 18 participated in the model.

Sources: *The Pennsylvania Rural Health Model: First Annual Report* and *The Pennsylvania Rural Health Model: Second Annual Report*.

Services. The scope of services captured in a hospital global budget will vary from state to state.⁵ There are three primary categories of services: hospital-owned facility services, other facility services that may or may not be hospital-owned, and professional services. Hospital global budgets typically include hospital-owned facility services, specifically inpatient and outpatient hospital services. These often include emergency department services, laboratory services, imaging services, and ambulatory

⁵ Hospital global budget arrangements can also include existing non-claims-based payments, such as disproportionate share hospital (DSH) payments. However, some states may choose to make such payments separately to ensure there are no unauthorized discounted payments to hospitals. Ideally, any additional alternative payment models should be integrated into the hospital global budget model to reduce administrative complexity and to ensure that the incentives of both arrangements are aligned.

surgery. Current models exclude other facility services that may or may not be hospital-owned, such as clinic services (like urgent care centers and federally qualified health centers), home health services, skilled nursing facilities, and other specialty facilities, such as dialysis centers. States must also evaluate whether there are any special considerations that must be addressed in the model design if they choose to include hospital-owned facility services.

To contain costs and align payments more effectively, states should strongly consider including hospital-employed professional services in a hospital global budget model. These professionals represent a significant percentage of total professional spending, since most U.S. physicians are employed by hospitals and other corporate entities.⁶ If hospital-employed professionals are still paid on a fee-for-service basis, they will have volume incentives that conflict with the goals of the hospital global budget model.

If hospital-employed professional services are the only type of professional services captured under a hospital global budget model, then hospitals may shift those services to non-hospital-employed professionals in the community to keep their costs low and adhere to their budget. To prevent this kind of shifting, states can adopt complementary payment or quality arrangements that create incentives for non-hospital-employed professionals to have a shared interest in constraining costs. For example, a state could implement a total-cost-of-care model — a payment model that holds a payer or provider accountable for the cost associated with all services provided to a defined population over a specified time. This incentivizes hospital-employed and non-hospital-employed professionals to work together to constrain costs.

⁶ While the percentage of physicians employed by hospitals and other corporate entities varies by region, this trend is steadily increasing in all regions. Source: *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2020*.

Lack of Alignment Between Hospitals and Physicians in Maryland's All-Payer Model

In Maryland's All-Payer Model, Medicare, Medicaid, and commercial payers continued to pay physicians on a fee-for-service basis because the state lacked the legislative authority needed to modify physician payments and make them more consistent with the incentives hospitals faced under their global budget arrangements. In addition to these payments, hospital-owned physician groups retained productivity targets in their contracts with hospitals that incentivized higher volume, whereas the global budget incentivized lower volume.

This lack of alignment between physician compensation and hospital revenue may have limited the impact of Maryland's model. It was one of the motivating factors for the state to create its Care Redesign Program, which sought to align incentives across hospitals, hospital-based providers, and community-based providers. Under this program, participating hospitals would share with participating providers the financial savings from any reductions in potentially avoidable hospital utilization and internal hospital costs.

Source: *Evaluation of the Maryland All-Payer Model: Final Report*.

Step 8. Identify which payers should participate.

Hospital global budget models work best under an all-payer approach, as it ensures that a hospital will receive the majority of its revenue through this arrangement. It also guarantees that all payers are equitably contributing to funding the hospital global budget. Further, the predictable payment allows hospitals to reorient how they deliver care and invest in population health.

All-payer participation is more likely under a mandatory approach. At a minimum, hospital global budget arrangements should include Medicare fee-for-service, Medicaid fee-for-service and managed care, and a state's

largest commercial insurers. States must secure approval from CMS to implement a hospital global budget model that includes Medicare and Medicaid.⁷ Medicare fee-for-service currently participates in three state global budget models through state arrangements with CMMI.

⁷ If hospital global budgets are paid to hospitals through Medicaid managed care organizations, a state must receive CMS approval through a directed payment preprint. If budgets are paid to all hospitals through Medicaid fee-for-service, a state must secure a state plan amendment that identifies the payment methodology. If budgets are paid through Medicaid fee-for-service but are not implemented consistently across all hospitals, a state must secure a Section 1115 waiver from CMS.

Federal and State Examples of Payer Participation by Market

	CMMI Community Health Access and Rural Transformation Model	Maryland All- Payer Model and Total Cost of Care Model	New York Hospital Experimental Payment Program	Pennsylvania Rural Health Model	OneCare Vermont Model
Approach	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary
Medicare fee-for-service included?	Yes	Yes	Yes	Yes	Yes
Medicare managed care included?	Optional	Yes	N/A	Yes; several insurers, not all	No
Medicaid included? (fee-for-service and managed care)	Yes	Yes	Yes	Yes	Yes
Commercial insurers included?	Optional	Yes	Yes; one major insurer	Yes; several insurers, not all	Yes; one major insurer

Sources: CMS CHART Community Transformation Track Notice of Funding Opportunity; Evaluation of the Maryland All-Payer Model: Final Report; Evaluation of the Maryland Total Cost of Care Model: Implementation Report; Cost-Effective Health Care: The Rochester Experience; The Pennsylvania Rural Health Model: Second Annual Report; Toward Hospital Global Budgeting: State Considerations.

Step 9. Agree on how to establish and update budgets annually.

A critical step in designing and implementing hospital global budgets is establishing and updating budgets for each hospital. Each hospital’s budget must be adequate to fund needed care and support other activities that constrain spending growth (for example, care management and population health activities). These budgets, however, must incentivize hospitals to prevent unnecessary and avoidable utilization as well as to pursue efficient operations.

Data used to calculate budgets. The four states that have experience with hospital global budgets used hospitals’ historical utilization and inpatient and outpatient revenue to produce their budgets. States could adjust historical experience when setting prospective budgets to serve state policy interests, such as promoting efficiency, reducing cross-hospital price disparities, and stabilizing Medicaid payment levels. It is possible to begin using historical data and phase in adjustments over time to reach a desired payment level. Historical data can come from one year or an average across multiple years.

There are two payment approaches states can use with historical data:

- Aggregate data across payers to establish one all-payer hospital-specific budget and calculate one rate for services to use across payers. In this approach, states will likely wish to apply discounts for Medicaid and Medicare, as otherwise this approach would yield significant increases in Medicaid and Medicare rates or significant decreases in commercial rates. The approach is likely feasible only if a state has all-payer rate setting authority, like Maryland does.
- Use payer-specific revenue to establish different rates and hospital-specific budgets for each payer. This approach is likely the one that is the most feasible for states today, as it builds upon the current payment structure.

States can use either approach to develop one rate for all inpatient and outpatient services, rates for specific categories of services, or something in between.

State and Federal Examples of Different Revenue Sources for Calculating Base Budgets

	CMMI Community Health Access and Rural Transformation Model	Maryland All-Payer Model and Total Cost of Care Model	Pennsylvania Rural Health Model
Service categories included	Inpatient and outpatient revenue	Inpatient and outpatient revenue	Inpatient and outpatient revenue
Years of data to calculate base budget	Average across two years	Most recent prior year	Average across three years
Level of data and payment approach	Use payer-specific revenue to establish different rates and hospital-specific budgets for each payer	Aggregate data across payers to establish one all-payer budget; state uses data to calculate service-specific rates for use across payers	Use payer-specific revenue to establish different rates and hospital-specific budgets for each payer

Sources: CMS CHART Community Transformation Track Notice of Funding Opportunity; Evaluation of the Maryland All-Payer Model: Final Report; The Pennsylvania Rural Health Model: First Annual Report.

Budgets can be calculated by a third party, such as a state agency, or by the payers themselves, perhaps through negotiation with the hospitals. Having a third party calculate budgets is preferable because it allows for consistency in methodology across payers and hospitals. However, such an approach may not be feasible for all states.

Factors to consider when updating budgets annually. At minimum, base budgets, which use historical data, must be adjusted to account for inflation, changing demographics, and some market share and service line changes. They can also include adjustments for case mix,⁸ service intensity, quality performance, total cost of care, and uncompensated care. States can also restrict the growth rate of hospital global budgets to constrain annual cost growth (see [Limiting the Rate of Growth in Provider Prices](#)). If states pursue this approach, they should align the budget growth rate cap with any cost saving targets that are incorporated into the model or other cost growth initiatives.

Maryland's Adjustments

Under its All-Payer Model, Maryland adjusted hospital budgets to account for inflation, and it approved changes in service volume due to changing demographics and market share, quality measure performance, and uncompensated care. The state also agreed to limit all-payer per capita inpatient and outpatient hospital cost growth to 3.58 percent, which likely informed the rate at which individual hospital budgets could grow annually. Under the Total Cost of Care Model, Maryland also modestly adjusts hospital budgets for total-cost-of-care performance for the Medicare fee-for-service population.

Sources: *Evaluation of the Maryland All-Payer Model: First Annual Report*; *Evaluation of the Maryland All-Payer Model: Final Report*; *Evaluation of the Maryland Total Cost of Care Model: Implementation Report*.

⁸ Case mix may not always accurately reflect changes in the health status of a provider's patient population due to changes in coding practices. These coding changes can result in larger measured increases in a population's risk than can be explained by demographic changes.

Example budget calculation. The following steps outline how a state could calculate hospital-specific global budgets for each payer and each market. This streamlined example assumes that a state would use historical aggregate revenue for one year (that is, net patient revenue) and aggregate volume (case-mix-adjusted discharges) for inpatient discharges to calculate payer- and market-specific budgets for each hospital that are adjusted to account for inflation and demographics.⁹ Refer to the [example Excel spreadsheet](#) that operationalizes the following steps for calculating a hospital's projected global budget by payer and market:

1. Obtain data on historical net patient revenue and inpatient discharges by payer and market.
2. Calculate case-mix-adjusted discharges for each payer and market by multiplying discharges by the hospital's overall case mix index.
3. Project performance year volumes for each payer and market by adjusting the hospital's historical case-mix-adjusted discharges to account for demographic changes.
4. Project performance year prices for each payer and market by adjusting the hospital's net patient revenue per case-mix-adjusted discharge to account for projected inflation (for example, by using [Medicare Market Basket](#) or [Consumer Price Index](#) data).
5. Project a performance year budget for each payer and market by multiplying the projected volume by the projected prices.

Step 10. Choose a method for adjusting budgets during the performance year based on hospital utilization.

States, hospitals, and payers must monitor a hospital's performance throughout the year to ensure it is on track to meet its global budget. There are two primary ways to adjust payments and guarantee that hospitals meet their budget: through price adjustment or through reconciliation.

⁹ States could expand this example to 1) encompass historical gross patient revenues that include outpatient services by calculating an equivalent case-mix-adjusted discharge and 2) to adjust budgets for additional factors.

Adjusting hospital prices. In a retrospective payment model, hospitals charge for services using a price that reflects anticipated or desired utilization for the year. However, actual utilization may vary from the anticipated or desired level. Adjusting prices during the year is one strategy for ensuring that hospitals meet their predetermined global budget. These adjustments are implemented differently depending on whether the state opts for a fixed or a flexible global budget arrangement.

Fixed global budget arrangements. In a fixed global budget arrangement, a hospital does not receive additional revenue for volume growth. Thus, if a hospital experiences a 1 percent increase in volume, it would be required to decrease its prices by 1 percent to meet its fixed budget. Conversely, if a hospital experiences a 1 percent decrease in volume, it would increase its prices by 1 percent to meet its fixed budget.

This arrangement strongly incentivizes hospitals to reduce utilization, because they retain any revenue associated with that service reduction as savings generated from the model. The [incentive to reduce volume](#) under a fixed global budget arrangement may result in decreased access to services. Further, there is little incentive for lower-cost and high-quality hospitals to accept more patients (possibly at the request of payers or ACOs), because they do not receive any additional revenue to cover the costs associated with treating new patients.

States that pursue a fixed global budget arrangement must ensure that each hospital knows which population it is accountable for — its “reference population.” Defining the reference population is relatively easy when hospitals are geographically isolated and have limited overlap in service areas. It is harder, but essential, to define the reference population for hospitals located in more concentrated, urban areas with overlapping service areas. For these areas, states can define initial reference populations using historical utilization and then make annual adjustments to reflect changes in market share. Note that these adjustments can be complex and highly variable because of small sample sizes.

Hospital Price Adjustment and Patient Attribution in Maryland

The Maryland All-Payer Model allowed hospitals to adjust their prices up or down by five percentage points without prior approval from the Health Services Cost Review Commission (or 10 points with approval) on a monthly basis during the year. Hospitals were required to make these adjustments consistently for all services.

The state also developed a methodology for attributing individuals to hospitals in urban areas. It did this by looking at historical utilization to identify the primary zip codes from which a hospital’s volume originated (its primary service area or PSA), as well as the secondary zip codes (its secondary service area or SSA). The commission monitors how much of a hospital’s costs are from the hospital’s PSA and SSA and adjusts the hospital’s budget if there are significant changes in utilization patterns.¹⁰

Sources: *Evaluation of the Maryland All-Payer Model: Final Report*; *Evaluation of the Maryland All-Payer Model: Second Annual Report*.

¹⁰ According to hospital leaders and stakeholders interviewed for the model evaluation reports, this methodology, termed the “market shift adjustment,” was viewed as administratively complex and that it did not account for changes in severity or resource intensity. They recommended a simpler methodology based on changes in volume adjusted to account for potentially avoidable utilization.

Flexible global budget arrangements. In contrast to a fixed global budget arrangement, a flexible global budget arrangement adjusts budgets to account for changes in utilization but reimburses only for the variable cost of discharges that exceed or fall below expected utilization. In this arrangement, a hospital still receives a predictable revenue source to account for its fixed costs (such as building, equipment, administrative overhead, and salaries). However, a flexible budget dampens a hospital’s incentive to reduce utilization, because its prices will flex up and down to cover the variable costs associated with changes in volume.

Let's consider a hospital that has 50 percent fixed costs and 50 percent variable costs. If this hospital experiences a 1 percent increase in volume, it would be required to decrease its prices by half a percent to meet its budget ($1\% \times 50\%$ variable costs = 0.5%). Conversely, if this hospital experiences a 1 percent decrease in volume, it would be required to increase its prices by half a percent to meet its budget. States could use hospital-specific ratios of fixed to variable costs or vary the ratio of fixed to variable costs by categories of hospitals (for example, based on their location or number of beds). This approach **counteracts the incentive to increase volume** under a fee-for-service approach while reducing the incentive to decrease volume associated with global budgets, since the hospital is paid only for changes in its variable costs associated with volume fluctuations. The hospital's fixed costs will continue to be funded if volumes decrease.

The **companion Excel spreadsheet** referenced in **Step 9** allows users to input the percentage of a hospital's costs that represent variable costs and the change in volume and assess the corresponding impact on prices in a fixed versus flexible global budget arrangement.

Because prices flex up and down to account for changes in utilization, states do not need to define a reference population for a flexible global budget arrangement. However, states can update budget projections from year to year to account for long-term changes in utilization (for example, based on referral patterns).

Reconciliation. Payers and hospitals may opt to reconcile payments to a hospital's global budget, rather than adjust prices, to ensure hospitals adhere to their budget for a given performance year.¹¹ Reconciliation happens retrospectively and can occur multiple times throughout the performance year (for example, monthly or quarterly) or annually after the end of the performance year. Payers can use claims that hospitals submit throughout the year to inform reconciliation to the hospital's global budget. If claims are below the projected budget, payers could make additional payments to the hospital. If claims are higher than the projected budget, payers could reduce payments. Under a flexible global budget arrangement, reconciliation would account for changes in a hospital's variable costs only.

¹¹ The term reconciliation is sometimes used to refer to truing-up payments to fee-for-service spending. Here, we use reconciliation to refer to truing-up payments to a hospital global budget.

Step 11. Decide how to distribute payments to hospitals.

Once states establish the defining features of a hospital global budget model, payers and hospitals must decide on a mechanism for distributing payments to hospitals. Payers can use a retrospective payment approach, a prospective payment approach, or a combination of the two.

Retrospective payment approach. In this approach, hospitals submit claims and receive payments on a fee-for-service basis. Each payer and hospital has specific rates that are based on historical utilization, so the rate multiplied by utilization across payers equals the total global budget for a hospital for a given year. As described in **Step 9**, there can be one flat rate for all services or service-specific rates (which can be complicated to calculate and monitor). This approach requires the least amount of change from hospitals' and payers' current claims processing systems.

Maryland's Service-Specific Fee-for-Service Rates

In the Maryland All-Payer Model, the Health Services Cost Review Commission calculated and set service-specific fee-for-service rates for all payers. Hospitals billed payers throughout the year for each service covered under the global budget they delivered using the price set by the commission. The commission operated a fixed global budget arrangement where hospitals were required to vary their prices based on utilization so that total costs equaled the hospital's annual global budget.

Maryland's approach ended up being complex and required significant state resources to operationalize. This was a result of service-specific rates specified in the terms of its agreement with CMS and other calculations, such as a market shift adjustment that was applied to account for utilization changes.

Source: *Evaluation of the Maryland All-Payer Model: Final Report*.

Prospective payment approach. In a prospective approach, hospitals receive fixed payments on a regular schedule (for example, weekly, biweekly, or monthly) that are equal to a portion of their annual global budget. Hospitals still submit claims for services (which are not paid) to inform budget modifications or reconciliations. This approach ensures that hospitals receive steady, predictable revenue throughout the year, despite any changes in utilization related to seasonality and volume shifts. However, it would likely require hospitals and payers to modify their claims processing systems.

Combined retrospective-prospective approach. States could include both retrospective and prospective payment approaches within the same model. This would allow flexibility for payers to choose the payment model that best suits their needs.

Pennsylvania's Approach for Distributing Payments to Hospitals

In Pennsylvania, CMS makes biweekly fixed payments equal to one-twenty-sixth of a hospital's annual budget for Medicare fee-for-service members. CMS uses claims information submitted by hospitals to modify hospital budgets in future years. It reconciles payments to cost-based reimbursement for Critical Access Hospitals for Medicare fee-for-service members.

Commercial payers make one upfront payment equal to one-twelfth of a hospital's annual budget at the beginning of the first global budget year. After that, commercial payers make payments on a fee-for-service basis and reconcile them monthly to ensure that a hospital's total payments equal its annual global budget.

Source: *The Pennsylvania Rural Health Model: First Annual Report.*

Step 12. Decide whether the model should include supplemental arrangements that aim to improve affordability, access, quality of care, and population health.

States can complement their hospital global budget models with supplemental arrangements, initiatives, or analyses to monitor and improve affordability, access, quality of care, and population health. These supplemental model components can be payer-specific or applicable across all payers. For example, states should monitor for shifting of care to nonhospital settings, which may result in double payment for services (where hospitals retain payment for these services in their fixed global budgets, but once the services shift to nonhospital providers, payers must pay for these services again). They should also monitor for reduced access to services. States can also develop pay-for-performance arrangements to ensure that access to and quality of care (including equity) do not decline.

OneCare Vermont's Shared Savings Arrangements for Community-Based Care

OneCare Vermont, the state's ACO, established shared-savings-like arrangements for community-based care that wrapped around its hospital global budget. The ACO monitors non-hospital-employed provider spending and out-of-area spending for each hospital's health service area. If these costs come in under a specific budget, then OneCare shares savings with the hospital. If the costs are above the budget, the hospital must pay back OneCare. These savings and returns are limited by prenegotiated risk corridors.

Of note, non-hospital-employed providers are able to participate in OneCare Vermont's initiative only if the hospital in its health service area opts to participate.

Sources: *Evaluation of the Vermont All-Payer ACO Model: First Evaluation Report; Toward Hospital Global Budgeting: State Considerations.*

In addition, states may choose to provide one-time or ongoing supplemental payments to hospitals for care management, data analytics, health information technology, and other population health investments. Over time, the savings generated from these investments can be reinvested in care management, population health, and addressing social determinants of health, as well as other social supports. The process for monitoring and distributing savings can be complex. States that have specific priorities can require hospitals to submit plans for how they will reinvest savings in one or more of these areas.

Paying for Capital Investments in New York

New York's Hospital Experimental Payment Program had a 2 percent regional contingency fund designed for capital investments approved by the state's certificate of need program. The Rochester Area Hospitals Corporation, which administered the program, also reviewed and approved hospital-specific proposals and subsequently allocated funds to hospitals from the funds.

Sources: *A Community Hospital Payment Experiment Outperforms National Experience: The Hospital Experimental Payment Program in Rochester, NY; Cost-Effective Health Care: The Rochester Experience.*

Finally, CMMI may require states to establish additional performance targets as part of the negotiation process to

secure a waiver to implement a state hospital global budget model that includes Medicare fee-for-service members.

CMMI’s Cost Savings and Quality Improvement Target in Maryland and Pennsylvania

	Maryland’s All-Payer Model	Pennsylvania’s Rural Health Model
Cost	<ul style="list-style-type: none"> • Generate \$330 million in savings for Medicare • Limit annual all-payer per-capita inpatient and outpatient hospital cost growth to 3.58 percent • Limit annual growth in per-capita total cost of care to no greater than one percentage point above the national Medicare average 	<ul style="list-style-type: none"> • Generate \$35 million in cumulative savings • Limit annual all-payer per-capita hospital cost growth to 3.38 percent • Limit annual per-capita rural Medicare total-cost-of-care growth to no greater than the national rural Medicare growth
Quality	<ul style="list-style-type: none"> • Reduce 30-day readmission rates to unadjusted national Medicare average • Reduce rates of potentially preventable complications by 30 percent 	<ul style="list-style-type: none"> • Increase access to primary and specialty care services • Reduce substance use-related deaths and improve access to opioid use disorder treatment • Reduce rural health disparities through improved preventive and chronic care

Sources: *Evaluation of the Maryland All-Payer Model: Final Report*; *The Pennsylvania Rural Health Model: First Annual Report*.

Step 13. Determine who should calculate budgets and manage and oversee the hospital global budget model.

States can delegate the responsibility of calculating budgets and managing and overseeing the hospital global budget model to one entity or establish separate entities for each function.

Calculating individual hospital-specific budgets. The responsibility of calculating individual hospital-specific global budgets can be assigned to a third party and could be the same public or private entity that is tasked with convening stakeholders to design the methodology, as described in **Step 3**. Having one entity (such as Maryland’s Health Services Cost Review Commission) calculate budgets across payers and hospitals ensures that budgets are calculated consistently. States may opt to delegate this responsibility to the individual hospitals and payers. If a state chooses this approach, it should be prepared to provide technical assistance to ensure that budgets are calculated correctly. It should also develop a process to review budgets to confirm they adhere to any payment model parameters that should be standardized across payers and hospitals, as described in **Step 6**.

Managing and overseeing the hospital global budget initiative. The entity responsible for managing and overseeing the initiative can be the same entity that is responsible for convening stakeholders (as described in **Step 3**), the same entity tasked with calculating budgets (as described in the paragraph above), or a new public agency

or private organization. New York, Maryland, OneCare Vermont, and Pennsylvania each had one entity convene stakeholders to design the model and to manage and oversee the initiative. Such an entity must:

- review monthly reporting to ensure that hospitals are on track to meet their budgets
- oversee the distribution and potential reconciliation of payments
- enforce penalties that are built into the model design
- require and review monthly reporting to ensure that hospitals and the state are on track to meet any supplemental cost, access, quality, and population health targets
- support hospitals to address implementation barriers and the financial risk associated with adopting hospital global budgets
- ensure that hospitals and payers meet model requirements
- carry out monitoring activities as described in **Step 15**.

States should also have a plan for how work will be resourced and staffed during the implementation, monitoring, and evaluation phases. If that work involves a formal agreement with CMMI, it will require ongoing reporting and meetings. If the work is governed by any stakeholder bodies, staffing support will be necessary to

prepare for and facilitate advisory meetings. If the work is performed pursuant to legislation, periodic legislative reporting and legislative testimony may be necessary. Resources and staffing should also be appropriately allocated for the planned monitoring and evaluation activities (see **Step 15**).

Step 14. Identify opportunities to mitigate hospitals’ financial and technical risk.

A hospital global budget model involves financial risk for hospitals and additional administrative and reporting responsibilities for hospitals and payers. It is possible to mitigate this financial risk through the global budget’s design. For example, a flexible global budget arrangement can reduce financial risk for hospitals because it ensures hospitals’ fixed costs and variable costs for any new volume are covered. It can also temper some aspects of the payers’ administrative burden by leveraging the existing claims processing systems and perhaps eliminating the need for budget negotiations between payers and providers (if budgets are calculated by a public or private agency rather than payers and hospitals).

States can also reconcile payments made to hospitals for some or all of their populations to the fee-for-service-equivalent spending. For example, payers may choose to reimburse Critical Access Hospitals or rural hospitals if their incurred costs for the year are above their annual global budget. This type of reconciliation is not a true hospital global budget, because it does not hold a hospital accountable for controlling costs to adhere to its budget. However, reconciliation reduces the risk a hospital incurs and may encourage some hospitals to participate in the model.

States could also use reconciliation as a temporary strategy to transition payment to a hospital global arrangement.¹² Payers could work with hospitals to conduct the steps associated with reconciling payments at the end of the first year of model implementation in order to gain experience with the process. Alternatively, payers could perform a partial reconciliation so that hospitals assume some, but not full, risk for their populations for one or more years.

¹² Payers could also establish a hospital global budget but continue to pay on a fee-for-service basis for one year and not actually reconcile payments.

Payment Reconciliation Approaches

	New York Hospital Experimental Payment Program	Pennsylvania Rural Health Model	OneCare Vermont Model
Reconciliation approach	Monthly reconciliation for variable costs only	Annual reconciliation to cost-based reimbursement for critical access hospitals	Annual reconciliation based on fee-for-service-equivalent spending (within a predetermined risk corridor)
Applicable hospitals	All	Only critical access hospitals have reconciliation	All
Applicable lines of business	All	Medicare fee-for-service	Medicare fee-for-service

Sources: Email correspondence with Al Charbonneau; *The Pennsylvania Rural Health Model: First Annual Report*; *Evaluation of the Vermont All-Payer ACO Model: First Evaluation Report*.

One additional approach to mitigating risk centers on limiting the losses a hospital may incur. For example, hospitals and plans can establish stop-loss provisions that set a specific limit after which a hospital is not liable to pay back an insurer. Hospitals could also purchase a reinsurance policy, independently or through a state-supported program, to help pay for losses after a certain limit.

Even with these protections in place, there may be highly unusual circumstances in which a state may need to consider ad hoc financial assistance. States may want to identify up front the parameters that may warrant such assistance.

Finally, states should be prepared to provide technical assistance to hospitals, payers, and other partners, either through state agencies or other partners. This assistance should address a broad range of provider and payer needs, such as financial projections and monitoring, care redesign, and deployment or enhancement of health information technology tools.

Pennsylvania's Rural Health Redesign Office

As the entity responsible for administering the state's hospital global budget model, the Pennsylvania Department of Health created the Rural Health Redesign Office and then the Rural Health Redesign Center Authority, an independent agency, to recruit model participants and provide support to participating hospitals. Hospitals in the first model cohort indicated that they benefitted from receiving technical assistance from the Rural Health Redesign Office, especially because they had limited staff and time to devote to model implementation.

Source: *The Pennsylvania Rural Health Model: First Annual Report*.

Step 15. Create a plan for monitoring and reporting on progress.

States that undertake hospital global budget models should plan how they will track and report on whether the model is achieving its proposed objectives (described in **Step 1**). State approaches to monitoring their hospital global budget models will vary depending on whether participation in and alignment with the model is mandatory or voluntary. Over time, states can use findings from these assessments, as well as feedback from advisory bodies, to inform model modifications.

Oversight of a mandatory hospital global budget model. If participation in the state's model is mandatory, the state will be responsible for overseeing the payment model and stakeholder adherence to the model's parameters. To monitor adherence to the model, the state should seek authority to perform market conduct exams and review contracts to ensure that health plans are appropriately aligning to model specifications. The state should also meet regularly with hospitals to ensure that health plans are abiding by the terms of the statute or regulation. These meetings can also help identify challenges that participants

might be facing. Finally, states should review any monthly reports they receive from hospitals and payers to assess how hospitals are performing relative to their annual budgets and how hospitals and the state are performing on cost, access, quality, and population health targets.

Oversight of a mandatory and voluntary hospital global budget model. Regardless of whether participation in the state's model is mandatory or voluntary, the state should regularly convene stakeholders to discuss progress toward, and challenges with, meeting the hospital global budget model objectives. Participants should report on their progress in meeting the goals laid out in the established compact or statute (as described in **Step 5**), share feedback on model implementation, and discuss needs for model changes or technical support.

Communicating progress toward hospital global budget model goals. The state should create a plan for communicating its progress toward achieving its goals, including annually assessing statewide cost, access, and quality performance. Keeping the hospital global budget model and its metrics visible is important for maintaining commitment and holding stakeholders accountable to meeting the model's goals. A state's communication plan may involve creating a dashboard containing the hospital global budget objectives and metrics, holding public forums, or publishing annual reports. Qualitative approaches, such as case studies or participant stories, should also be part of the communications plan.

Conclusion

The use of hospital global budgets is still rare in the United States. However, interest is increasing as states seek more rational and sustainable models for funding this vitally important but costly sector. A successful hospital global budget requires broad participation from payers and hospitals, a strong agency to oversee implementation and regulate the model on an annual basis, and a transparent, robust methodology to establish and update budgets over time. States will need sufficient resources and expertise to design and implement a hospital global budget model that aligns with the state's goals. To have maximum impact, hospital global budgets must encompass a significant proportion of hospital payments. For states willing to go the distance, the hospital global model holds the promise of a fundamentally transformed approach to care delivery that better supports community health and bends the curve on costs.

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