Global Budgeting for Rural Hospitals Q&A

Critical Access Hospitals. *As compared with rural hospitals participating in global budgeting in Maryland and Pennsylvania, rural hospitals in other states are much smaller and much more remote.*

Question: Is global budgeting a viable approach for critical access hospitals which are located in very rural areas and may have few admissions already?

Answer: Yes. There is one very small hospital, located in Crisfield, Maryland, that receives a global budget. This budget needs to be sufficient for the needs of the hospital. Even in a small hospital setting, there are opportunities for disease prevention. The hospital in Crisfield recently expanded its behavioral health center, for example. A global budgeting system should generally not anticipate significant reductions in inpatient use in such hospitals, since the utilization is so low to begin with. If there are significant variations in costs, states may consider a shared pool to cover the costs of unanticipated utilization across multiple small hospitals.

Managing a global budget system. *There are a number of design and implementation characteristics of global budgeting approaches.*

Question: Who sets global payment amounts paid to hospitals, what criteria are used to raise or lower them, and how are disputes resolved?

Answer: Each global budgeting program needs a trusted manager, which can be a state agency, a public-private partnership, or, in theory, a federal agency. In Pennsylvania, the Model is currently administered by the Department of Health. The Commonwealth is advancing legislation to create a Rural Health Redesign Center that also functions as an independent agency. In Maryland, this agency is the Health Services Cost Review Commission, which has 7 independent members appointed by the Governor and confirmed by the State Senate. These managing agencies set the criteria for raising or lowering budgets over time and also work to resolve disputes.

Question: How do you set a budget and savings targets:

- If hospital is in the “red”
- If hospital is already the most cost-effective provider (or already below national average)
- If hospital has very few admissions now

Answer: If the hospital is now in the red, a global budget will need to be set at a level where it is possible to succeed economically. A quid pro quo for payers to participate may be a transformation plan that preserves key services but also moves resources to emphasize prevention. If a hospital is cost effective or has relatively few admissions now, the budget should be set at close to the current revenue level.

Savings requirements for the system as a whole (as opposed to hospital by hospital) are established in negotiations with the federal government. The legislative requirement for an Innovation Center model requires health improvement at current or lower expenditures in the Medicare program.

Information systems. *Developing and ensuring the success of global budget systems requires an appropriate information technology infrastructure.*

Question: What type of information systems do hospitals and states need to make the transition to global budgets and what support can be provided to rural hospitals?

Answer: An important role for information systems is to provide insight on key trends in health care expenditures, including total cost of care. Such data allows for better understanding of the drivers of spending and the potential advantage of switching to global budgets.

In addition, participating hospitals can benefit from technical assistance on transformation activities, support for a shift to population health management, and health information technology. In Maryland, rural hospitals joined together and hired a local consulting firm to help them review their data and develop shared initiatives on population health.

Maryland also has a robust health information exchange, which can provide regular report to hospitals about admissions and readmissions, as well as alerts to primary care clinicians about patients receiving acute care. Pennsylvania received additional start-up funds from the federal government to establish the Rural Health Redesign Center, including resources to provide technical assistance to hospitals.

Mitigating unintended consequences. *During the transition to global budgeting, there may be concern about reducing or elimination of services or shifting patients to other facilities to meet savings targets.*

Question: How well can global budgeting programs address the risks of unintended consequences, such as elimination of services or closing inpatient units to reduce costs?

Answer: All payment system have a potential for unintended consequences. For global budgeting systems, there is a risk that hospitals will attempt to increase their margins by changing the provision of services in ways that do not benefit patients. Maryland uses several strategies to mitigate this concern. One is to investigate concerns about inappropriate behavior under the global budget, from other hospitals, payers, and the public. A second is to adjust budgets mid-year in response to abrupt and unplanned changes in service provision. A third is to track market share and shift funds over time to hospitals attracting more appropriate market share by virtue of superior service and high quality. It is also possible to embed certain controls in the underlying methodology, such as by requiring and monitoring hospital transformation and outreach plans as a condition of receiving a global budget.

Question: Could global budgeting create disincentives for communities that depend on the positive economic impact of hospitals?

Answer: No. The rash of closures and the precarious finances of many remaining hospitals pose a real economic threat in rural America. Global budgeting is one way to answer this threat, by stabilizing hospital balance sheets and keeping healthcare revenue in the community.

Moreover, a greater alignment of a hospital's financial interests with long-term community health can create incentives for the hospital to invest its own resources in local businesses and enterprises aiming to boost long-term economic vitality (and health) of an area.

Other partners. *Global budgeting is a pathway not only for hospital sustainability, but for health improvement in a community.*

Question: How can other health (eg, FQHCs and primary care doctors) and non-health partners (eg, public health agencies, housing authorities) be engaged in global budgeting to help hospitals succeed?

Answer: Engagement of partners can happen both at the regional or state level and at the hospital level.

At the system level, special incentives and programs can be created to coordinate care or align efforts focused on social determinants of health. For example, Maryland sets aside funding for regional partnerships, which involve multiple hospitals and their collaborators, and which target specific populations or determinants of health.

At the hospital level, global budgets provide an incentive to expand partnerships that have the effect of reducing preventable utilization. For example, in Maryland, hospitals partner with primary care physicians, behavioral health providers, schools, community advocacy organizations, and others around specific initiatives.

Building consensus. *Multi-payer global budget models require bringing payers together at the table.*

Question: How can states make a compelling argument to payers to participate in a global budgeting model, and what level of participation is needed in order for the model to succeed?

Answer: States interested in global budgeting should start with a vision for rural health that includes stable hospitals focused on the health needs of their communities. This vision can bring along those worried about a rural hospital failure, as well as those focused on unmet health needs in rural areas.

Multi-payer participation is critical to the success of a global budgeting model. That's because transformation is most possible with an aligned set of incentives. In general, about 80% of hospital revenue should be included in a global budget model.

CMS perspective on global budgeting. *CMS partners with states to align payment and delivery system reforms across payers, including Medicare.*

Question: What are CMS's expectations for savings from global budgeting? If enough states are interested, might CMS consider developing a "model roadmap" for global budgeting, and can the federal government help in other ways?

Answer: One purpose of the policy academy was for CMS to gauge the interest of states in global budgeting. If enough states are interested, CMS might decide to create a model roadmap to simplify the process of getting to global budgets for rural hospitals. States should direct these questions to CMS.

State Policy Academy on Global Budgeting for Rural Hospitals
Resource List
Last Updated 5.29.18

Introduction to Global Budgeting for Rural Hospitals

1. Murphy KM, Hughes LS, Conway P. A Path to Sustain Rural Hospitals. *JAMA*. 2018;319(12):1193. doi:10.1001/jama.2018.2967
2. Sharfstein JM. Global Budgets for Rural Hospitals. *Milbank Q*. 2016;94(2):255-259. doi:10.1111/1468-0009.12192

Case studies and white papers

3. Murray R. Toward Hospital Global Budgeting: State Considerations. 2018. https://www.shvs.org/resource/toward-hospital-global-budgeting-state-considerations/.
4. Sharfstein J, Gerovich S, Moriarty E, Chin D. An emerging approach to payment reform: All-payer Global Budgets for Large Safety-Net Hospital Systems. Commonwealth Fund. August 2017.
5. Block R. State Models for Health Care Cost Measurement: A Policy and Operational Framework. 2015. https://www.milbank.org/wp-content/uploads/2016/04/Milbank_Report-State_Models_for_Health_Care_Cost-2.pdf. Accessed May 23, 2018.
6. California Health Care Foundation. Is Bigger Better? Exploring the Impact of System Membership on Rural Hospitals. 2018. https://www.chcf.org/wp-content/uploads/2018/05/BiggerBetterSystemImpactRuralHospitals.pdf. Accessed May 29, 2018.

Rural health

7. Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas— United States, 1999–2014. *MMWR Surveill Summ*. 2017;66(1):1-8. doi:10.15585/mmwr.ss6601a1
8. Garcia MC, Faul M, Massetti G, et al. Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States. *MMWR Surveill Summ*. 2017;66(2):1-7. doi:10.15585/mmwr.ss6602a1
9. Croft JB, Wheaton AG, Liu Y, et al. Urban-Rural County and State Differences in Chronic Obstructive Pulmonary Disease — United States, 2015. *MMWR Morb Mortal Wkly Rep*. 2018;67(7):205-211. doi:10.15585/mmwr.mm6707a1
10. Rab L. How a Tiny Kansas Town Rebooted Its Struggling Hospital into a Health Care Jewel. Politico Magazine. https://www.politico.com/magazine/story/2018/05/26/kansas-hospital-rural-healthcare-218407. Published 2018. Accessed May 29, 2018.

Data on Maryland All-Payer Model (Summary)

11. Health Services Cost Review Commission. Maryland's All-Payer Hospital Model Results. Performance Year Three. Calendar Years 2014 through 2016. March 2018.
12. Sharfstein JM, Stuart EA, Antos J. Global Budgets in Maryland. *JAMA*. May 2018. doi:10.1001/jama.2018.5871

Selected Evaluations of Maryland All-Payer Model (Original Research)

Years Covered	Citation
2014-2016	Giuriceo K, Haber S, Beil H, et al. Evaluation of the Maryland All-Payer Model Third Annual Report. 2018. https://downloads.cms.gov/files/cmmi/md-all-payer-thirdannrpt.pdf. Accessed May 22, 2018
2014-2015	Roberts ET, McWilliams JM, Hatfield LA, et al. Changes in Health Care Use Associated With the Introduction of Hospital Global Budgets in Maryland. *JAMA Intern Med*. 2018;178(2):260. doi:10.1001/jamainternmed.2017.7455
2011-2013	Roberts ET, Hatfield LA, McWilliams JM, et al. Changes In Hospital Utilization Three Years Into Maryland's Global Budget Program For Rural Hospitals. *Health Aff*. 2018;37(4):644-653. doi:10.1377/hlthaff.2018.0112