

Considering the AHEAD Model: Lessons from States on Hospital Global Budgets and Investing in Primary Care

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Webinar Logistics

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Webinar Presenters

Opening Remarks

- **Hemi Tewarson**, Executive Director, NASHP

Moderator

- **Maureen Hensley-Quinn**, Senior Director, NASHP

Speakers

- **William Henderson**, Principal Deputy Director of Medical Economics and Analytics, Maryland Health Services Cost Review Commission
- **Pat Jones**, Interim Director of Health Care Reform, Vermont Agency of Human Services
- **Robin Lunge**, Co-chair of the Global Budget Technical Advisory Group, Vermont's Green Mountain Care Board
- **Kate Sapra**, Director, Division of Multi-Payer Models in the State and Population Health Group, Center for Medicare and Medicaid (CMS) Innovation Center



Overview of AHEAD Model from CMS Innovation Center

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

Hospital Global Budgets & PC AHEAD Overview

Center for Medicare and Medicaid Innovation

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

Statewide Accountability Targets

Total Cost of Care Growth (Medicare & All-Payer)
Primary Care Investment (Medicare & All-Payer)
Equity and Population Health Outcomes via State Agreements with CMS

8-9
Performance
Years

Components



Cooperative Agreement
Funding



Hospital Global Budgets
(facility services)



Primary Care AHEAD

Strategies

Equity Integrated
Across Model

Behavioral Health
Integration

All-Payer
Approach

Medicaid
Alignment

Accelerating
Existing State
Innovations

Hospital Global Budget Overview

What is a Hospital Global Budget under AHEAD?

AHEAD HOSPITAL GLOBAL BUDGET



In the AHEAD Model, hospital global budgets are built “bottom up” from past net patient revenue within the facility (inpatient and outpatient), including hospital outpatient departments.

This historic baseline will be fixed for the duration of the model with annual adjustments for inflation, demographic changes, and service line changes for each Performance Year.

The AHEAD Model aims to support hospitals in transforming care delivery and shifting utilization to primary care and community-based settings, where appropriate, through the incentives and flexibilities of hospital global budgets.

Incentives for Hospital Participation



Initial investment to support hospital transformation in early years of the model



Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community



Increased hospital financial stability and predictability when revenue is decoupled from FFS



Potential use of waivers to support care delivery transformation and engage non-hospital providers in transformation

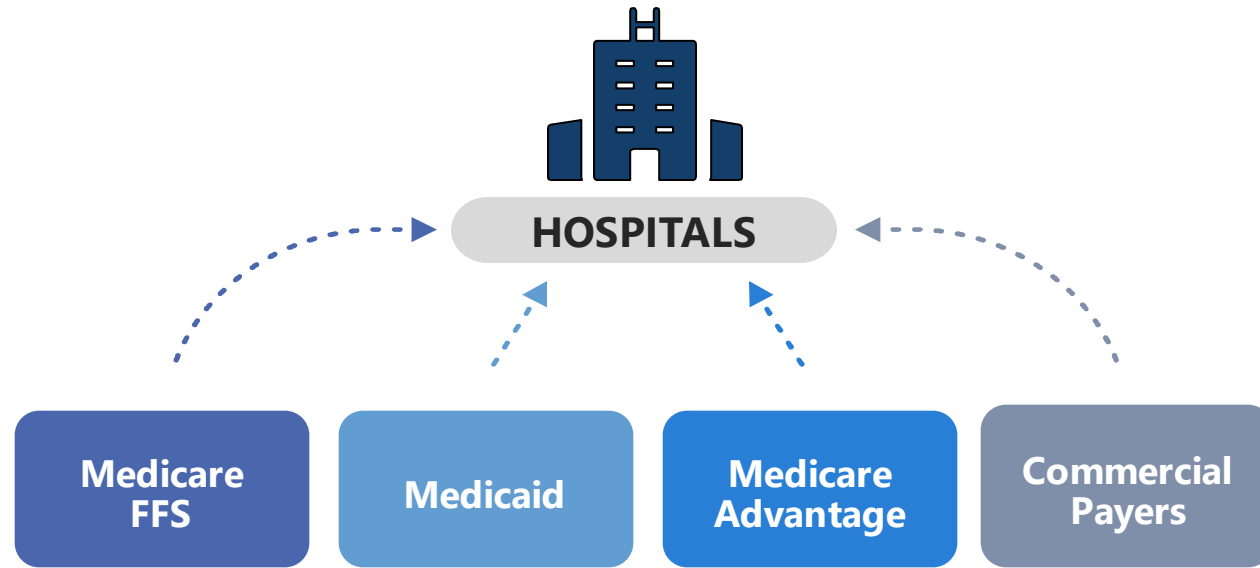


Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery



Opportunity to participate in learning opportunities to facilitate success under global budgets

What are Payer Requirements in the AHEAD Hospital Global Budget?



Medicare FFS

- Participating states with statewide rate setting or hospital budget authority and experience in value-based care may develop their own hospital global budget methodology. CMS will provide alignment expectations for state-designed methodologies in the NOFO and will need to review and approve in advance of a given PY. States are not required to have all-payer rate setting to participate in the AHEAD Model.
- States without these authorities will use a CMS-designed Medicare FFS global budget methodology.
- Medicare FFS global budget will be implemented PY1.

Medicaid

- The state Medicaid agency will be responsible for developing their Medicaid-specific hospital global budget methodology in alignment with principles outlined by CMS (which will be provided in the NOFO).
- CMMI and Center for Medicaid and CHIP Services (CMCS) will review and provide technical assistance on the Medicaid methodology.
- Any Medicaid methodology will need to be approved through normal regulatory processes.
- Medicaid hospital global budget must be implemented during PY1.

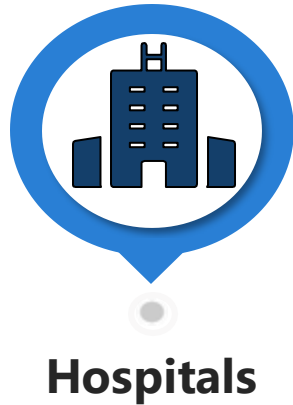
Commercial Payers

Medicare Advantage

- Commercial payer participation can maximize hospital participation by bringing a greater portion of participating hospitals' revenues under a hospital global budget.
- Participating states will develop a methodology with high-level alignment principles outlined by CMS (which will be provided in the NOFO).
- At least one commercial payer must participate in global budgets by PY2.

Eligibility Criteria – Hospitals

Acute care hospitals and critical access hospitals (CAHs) will be eligible to participate in Medicare FFS hospital global budgets under the Model.



Hospitals

- CMS will not require hospital participation.
- Hospital Participants (e.g., acute care hospitals and CAHs) must be a Medicare-enrolled facility in good standing with CMS and located in the participating state or sub-state region.
- In participating states that enact enabling legislation during the performance period, eligible facilities will also include Rural Emergency Hospitals (REH).

State Hospital Recruitment Requirements

At least 10% of Medicare FFS net patient revenue within the state or sub-state region must be under a hospital global budget by the start of the first performance year for the state to remain in the Model. This will increase to 30% by the start of the fourth performance year.

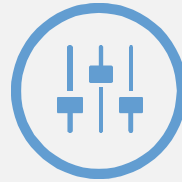
CMS Medicare FFS Hospital Global Budget Methodology

AHEAD Medicare FFS Hospital Global Budget Methodology



Historical Revenue Calculation

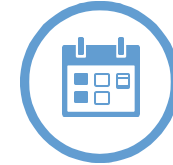
CMS will calculate the hospital's historical revenue for eligible hospital services, combining three years of historical data with percentage weightings more heavily applied to recent years.



Annual Adjustments

CMS will apply adjustments to calculate the current performance year budget and reflect accountability for quality and reducing avoidable utilization:

- Baseline adjustments (e.g., wage index)
- Trend adjustments (e.g., inflation, demographic shifts in age and population size, hospital shifts in services)
- AHEAD-specific adjustments (detailed on next slide)



Global Budget Payments

Each participating hospital will receive a fixed global budget in the form of prospective, bi-weekly payments for Medicare FFS in place of FFS claims for PPS hospitals and cost-based reimbursement for critical access hospitals (CAHs).

The full methodology will be shared with hospitals as part of the recruitment activities, with resources explaining hospital global budgets and sample calculations available for informing participation decisions.

AHEAD Medicare FFS Hospital Global Budget Adjustments



Transformation Incentive Adjustment

Upward adjustment to invest in enhanced care coordination in the first two years of the Model



Clinical and Social Risk Adjustment

Adjustment likely based on Hierarchical Condition Category (HCC) Coding, Area Deprivation Index (state and national), dual eligibility, and Part D LIS status



Health Equity Improvement Bonus

Upward adjustment based on hospital performance on disparities-sensitive measures focused on closing gaps in health care outcomes



Quality Adjustments

Based on performance in CMS programs for PPS hospitals, and an upside option for CAHs under the AHEAD Model



TCOC Performance Adjustment

Upward and downward adjustments based on TCOC of beneficiaries residing in hospital service area, phased in over time



Effectiveness Adjustment

Downward adjustment based on a portion of hospital's calculated avoidable utilization phased-in over time; hospital retains any savings beyond the adjustment

AHEAD Medicare FFS Hospital Global Budget Adjustment Timeline

Adjustment Type	Potential Adjustment	PY1	PY2	PY3	PY4
Transformation Incentive Adjustment	+	✓	✓		
Health Equity Improvement Bonus	+		✓	✓	✓
TCOC Performance Adjustment	+/- <i>Phased-in, delayed downside for safety net and CAHs</i>		✓ <i>(upside only)* (upside only)†</i>	✓ <i>(upside and downside) (upside only)</i>	✓ <i>(upside and downside) (upside and downside)</i>
Effectiveness Adjustment	- <i>Phased-in, delayed start for safety net and CAHs</i>		✓	✓ <i>Begin EA for safety net and CAHs</i>	✓
Quality Adjustments	Based on national hospital quality program performance	✓	✓	✓	✓
CAH Quality Adjustments	<i>Pay-to-Perform would begin in PY5</i>	✓ <i>Pay-to-Report</i>	✓ <i>Pay-to-Report</i>	✓ <i>Pay-to-Report</i>	✓ <i>Pay-to-Report</i>

*Adjustments specific to short-term acute-care hospitals

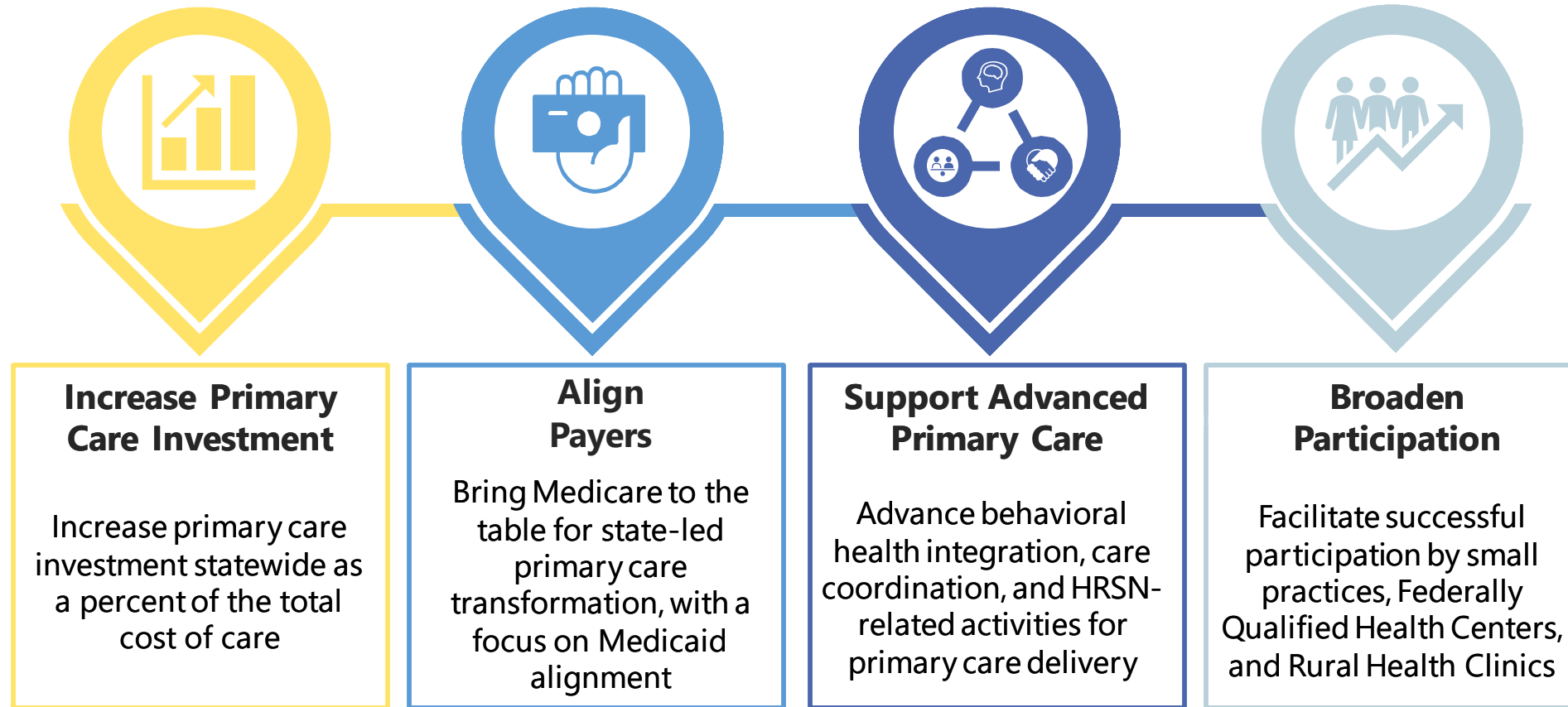
†Adjustments specific to CAH and safety net hospitals

Subsequent PYs will follow same methodology as PY4

Primary Care AHEAD Overview

Primary Care AHEAD Goals

Primary Care AHEAD is flexible to align with each state's Medicaid primary care goals and will bring Medicare to the table for increased investment and care transformation initiatives.



CMMI has committed to introducing primary care tracks with additional risk/capitation in the future. Any future Primary Care AHEAD tracks will align with these program goals.

Eligibility Criteria – Primary Care Practices

Primary care practices may participate voluntarily in the Primary Care AHEAD program to receive a Medicare Enhanced Primary Care Payment and support corresponding care transformation.



**Primary Care
Practices**



Primary Care Practices

- Primary care practices, FQHCs, and RHCs that are located within a participant state or sub-state region and are participating in the state's Medicaid Primary Care Alternative Payment Model (APM).
 - The state's Medicaid Primary Care APM could support a Patient-Centered Medical Home program, health home, or similar care coordination program.
- Hospital-owned practices will only be eligible to participate in Primary Care AHEAD if the affiliated hospital is participating in AHEAD hospital global budgets for that performance year with an exception for FQHCs/RHCs.

Primary Care AHEAD: Enhanced Primary Care Payment

Primary Care AHEAD participants will receive an Enhanced Primary Care Payment (EPCP) to facilitate Medicare FFS investment in advanced primary care and enhanced care management.



Payment

- Participating practices will receive **an average \$17 PBPM* for attributed beneficiaries**, paid quarterly.
- A small portion of this payment (initially 5%, scaled up to 10%) is **at risk for quality performance**.



Requirements

- Participating practices must participate in the state's Medicaid Patient-Centered Medical Homes or other primary care alternative payment model.
- Practices must meet specific Care Transformation Requirements, which will be aligned across Medicaid and Medicare.



Potential Uses

Practices may use the EPCP to invest in infrastructure and staffing to perform advanced primary care (e.g., care coordinators, behavioral health staff, or community health workers).

**A state may earn a higher (max \$21) or lower (floor \$15) PBPM based on hospital recruitment or state TCOC performance.*

Questions



Discussion with Maryland and Vermont



What are your state's overarching health system transformation goals and the primary reasons for pursuing these efforts?



maryland
health services
cost review commission

Maryland's Health Services Cost Review Commission (HSCRC)

William Henderson, Principal Deputy Director,
Medical Economics and Data Analytics

October 26, 2023

Impetus for Maryland to Seek New CMS Waiver



1971: Origins

- Hospital rate regulation was put into Maryland Statute in 1971.
- The State obtained a waiver of federal law that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates in 1977.



2010: Tipping Point and National Health Reform

- Maryland hospitals experienced higher costs and lower payment rates, putting strain on both hospital finances and the State's goal of keeping hospital cost growth at a reasonable level
- National health reform expanded states' abilities to experiment with new ideas to improve the value of health care and constrain cost growth



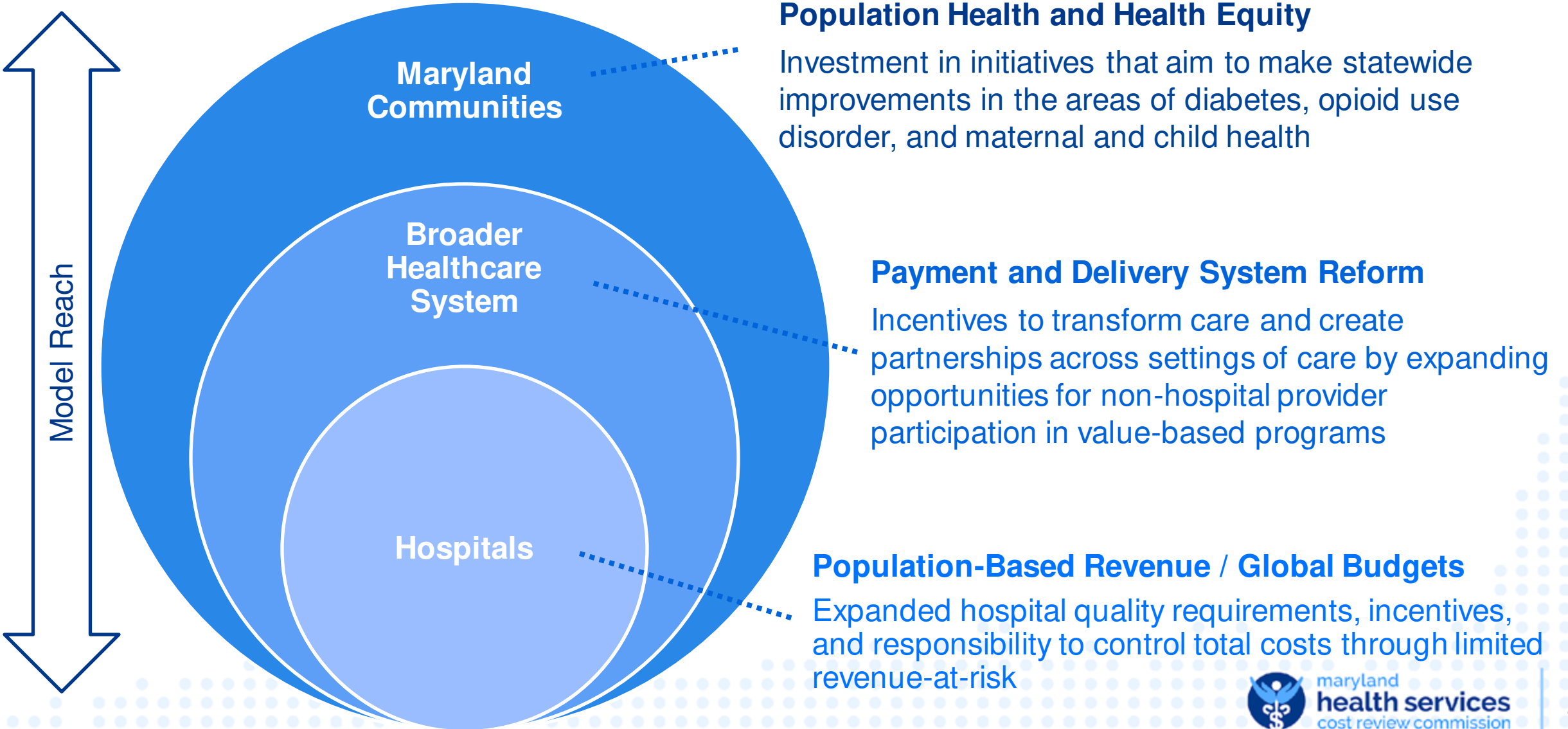
2014: New Waiver

- Maryland obtained an 1115 waiver from CMS to adopt new and innovative policies under the All-Payer Model, and, later, the Total Cost of Care (TCOC) Model

All-Payer Model (2014-2018)

Total Cost of Care Model (2019-2028)

TCOC Model Components



Lessons from States on Hospital Global Budgets and Investing in Primary Care: Vermont's Experience

October 26, 2023

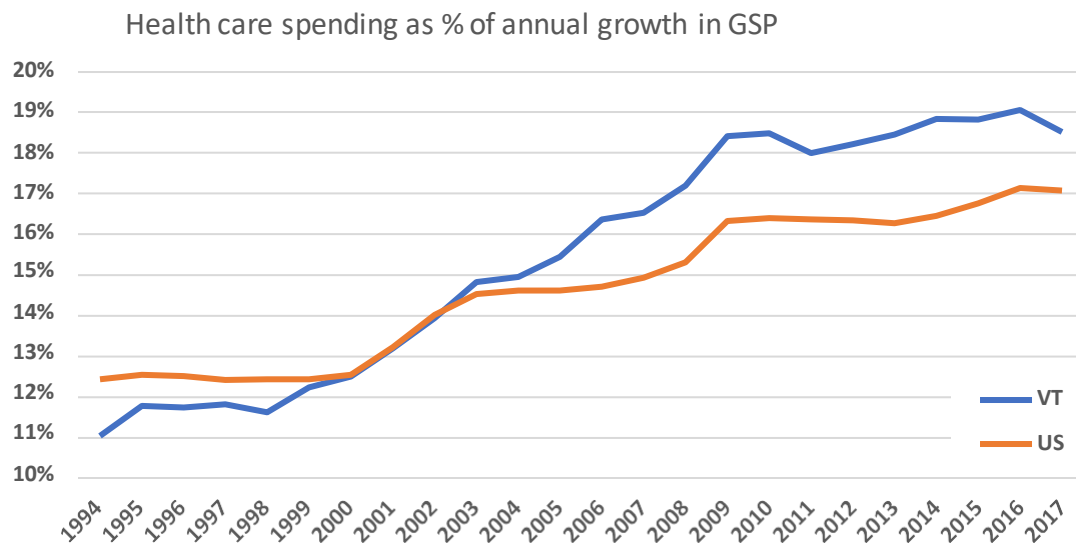
Robin Lunge, Green Mountain Care Board Member

Pat Jones, Director of Health Care Reform, Vermont Agency of Human Services

Problem: Cost Growth Was Unsustainable, and Health Outcomes Needed to Improve

Cost Growth

- In 2017, health care spending in Vermont grew 1.7%.
- Vermont's health care share of state gross product devoted to health care spending was 18.5% in 2017, vs. 11.8% in 1995.



Source: 2017 Vermont Health Care Expenditure Analysis, available at <https://gmcbboard.vermont.gov/data-and-analytics/analytcs-rpts>.

Health Outcomes

- Chronic diseases are the most common cause of death in Vermont. In 2014, **78% of Vermont deaths** were caused by chronic diseases.
- Medical costs related to chronic disease were over **\$2 billion in 2015** and were expected to rise to nearly \$3 billion by 2020.
- Vermont's **death rates from suicide and drug overdose** were higher than the national average.

Overarching Goals –The Triple Aim:

- Improving quality of care
- Improving the health of the population
- Reducing growth in cost of care

Sources: Vermont Dept. of Health, Kaiser Family Foundation

15 Years of Evolving Health Care Reform in Vermont

Vermont has successfully partnered with CMS on a series of payment and delivery system reform initiatives that have led to positive outcomes for CMS, Vermont, and the State's residents.

Vermont is looking to build on strengths in the next iteration.

2014-2016: Commercial & Medicaid ACO

Shared Savings Programs

- Spending growth slowed for ACO-attributed beneficiaries (savings of **\$39.92 PBPM**)
- PBPM expenditures increased less among ACO-attributed beneficiaries with MH/SUD conditions

Source: [SIM Evaluation](#)

2024+: Exploring implementation of pilot **Medicaid** global payments program



Iterative change



Iterative change



Iterative change



Iterative change



2008 - present:

Blueprint for Health

- **\$82M** saved in Medicare (net of \$64M)
- Improved continuity of care, decreased specialist visits, reduced readmissions

Source: [MAPCP Evaluation](#)

2016 - present:

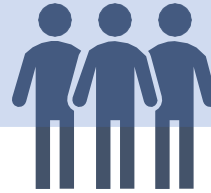
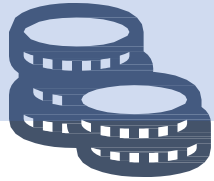
Vermont All-Payer Model

- Over first four PYs, 6.2 percent (**\$686 PBPY**) and 9.9 percent (**\$1177 PBPY**) decreases in cumulative gross spending for Medicare beneficiaries at the ACO and state levels, respectively

Source: [VTAPM Evaluation](#)

2025+: Future model where Vermont aims to shift more dollars into prospective payment while stabilizing its rural health care system.

Vermont All-Payer Model



Test Payment Changes

Population-Based Payments Tied to Quality and Outcomes

Increase Investment in Primary Care and Prevention

Transform Care Delivery

Invest in Care Coordination

Incorporate Social Determinants of Health

Improve Quality

Improve Outcomes

Improve access to primary care

Reduce deaths from suicide and drug overdose

Reduce prevalence and morbidity of chronic disease

Vermont's Current All-Payer Model Agreement

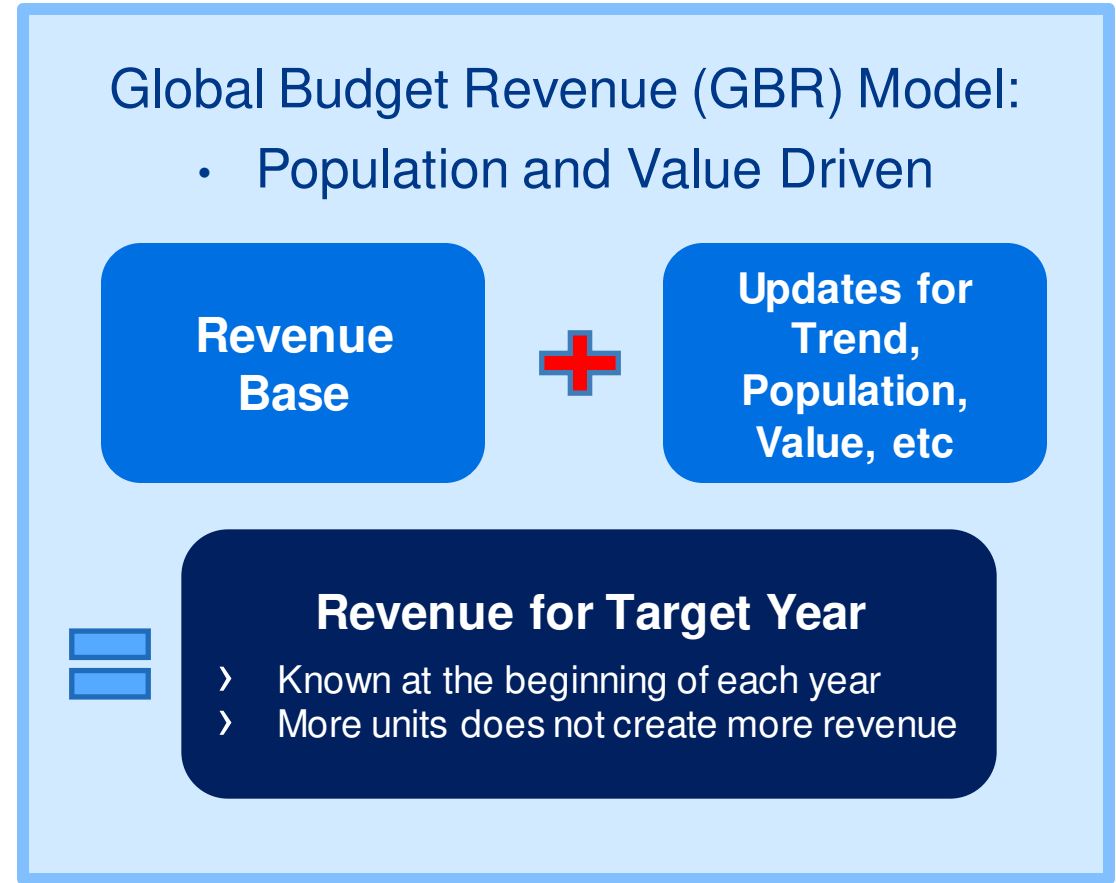
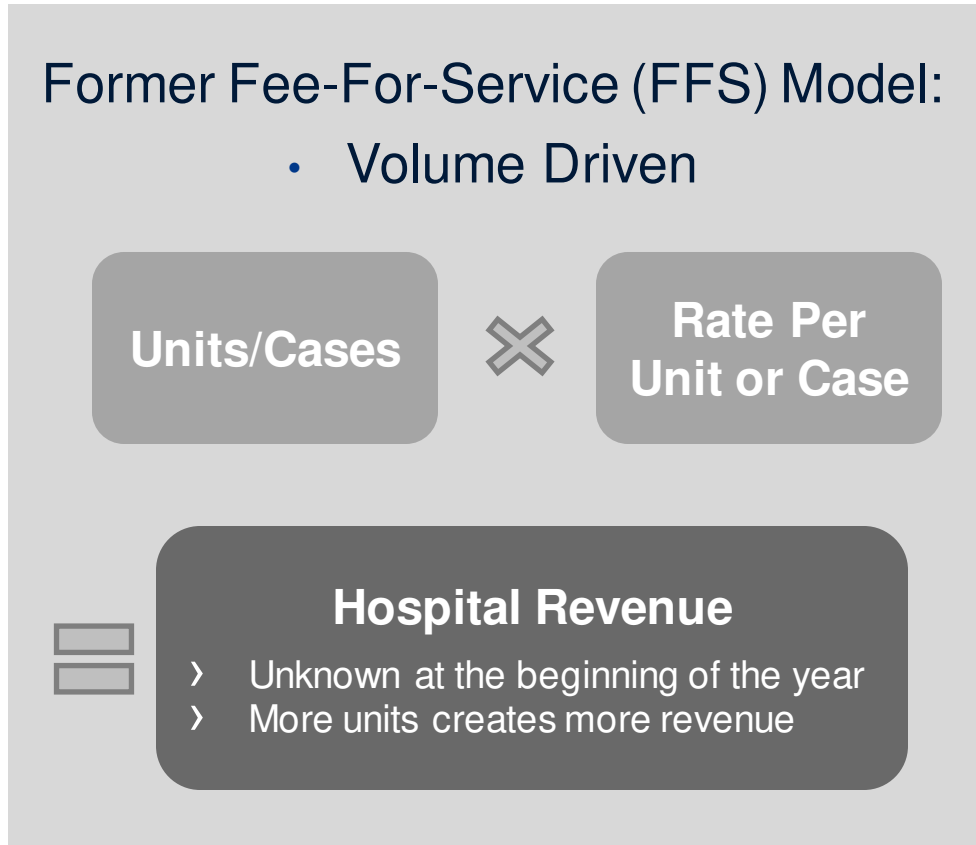
- **2018-2022:** Original performance period, 5 performance years
 - 2023 is first year of a two-year extension period (2023-2024); Vermont and CMMI discussing potential to extend through 2025
- **Key elements:**
 - Federal-state agreement signed by Governor, Secretary of Vermont Agency of Human Services (AHS), Green Mountain Care Board (GMCB) Chair
 - Agreement holds Vermont accountable for performance in three areas:
 - Total Cost of Care
 - Model Scale (e.g., lives attributed to a qualifying ACO program)
 - Population Health Outcomes and Quality of Care Targets – 22 carefully selected measures relating to 3 overarching population health goals:
 - ✓ Improving Access to Primary Care
 - ✓ Reducing Deaths from Suicide and Drug Overdose
 - ✓ Reducing Prevalence and Morbidity from Chronic Illness



Describe your state's approach to the hospital global budget and to investing in primary care

What is a Global Budget?

Rather than let volumes control revenue, HSCRC sets an annual revenue target (GBR) that each hospital must meet.



Key Components of the Global Budget Revenue (GBR)

Common GBR Methodology	
Components of the Update Factor	Fixed revenue base
	Adjustments for Inflation Typically around 3% and includes drug costs changes
	Population and Volume Adjustments Ensures GBRs reflect hospital patient demographics and population growth as well as growth in innovative care
	Adjustments for Quality and PAU Savings Adjusts hospital revenues based on quality outcomes and levels of Potential Avoidable Utilization
	Efficiency, Capital, and Rate Adjustments Measures efficiency of care delivery, provides budgetary advances to cover non-variable expenses and investments, and allows for other adjustments to rates
	Special Funding Programs Provides funding to hospitals to support statewide goals



Other GBR Components

HSCRC assesses hospital GBR to help pay for CRISP, HSCRC (User Fees), Medicaid Deficit Assessment, and other programs (e.g. Nurse Support Program)

Other Impacts on Hospital Revenue

Medicare Performance Adjustment Includes a Traditional MPA program and the MPA Framework
New Model Programs Includes the Care Transformation Initiatives and Care Redesign Programs (includes the Episode Care Improvement and Episode Quality Improvement Programs)

Overview of MDPC Structure

TRACK 1

Standard

Implementation of advanced primary care functions including expanded hours, risk stratification, care management and behavioral health integration

TRACK 2

Advanced

Track 1 requirements + addition of offering of alternative care (e.g., telehealth) social needs screening and linkages, comprehensive medication management, and advance care planning

TRACK 3

Advanced with Upside & Downside Risk

Track 2 requirements + collection of demographics data, prioritizing health related social needs, & expanded alternative care requirements

Payments

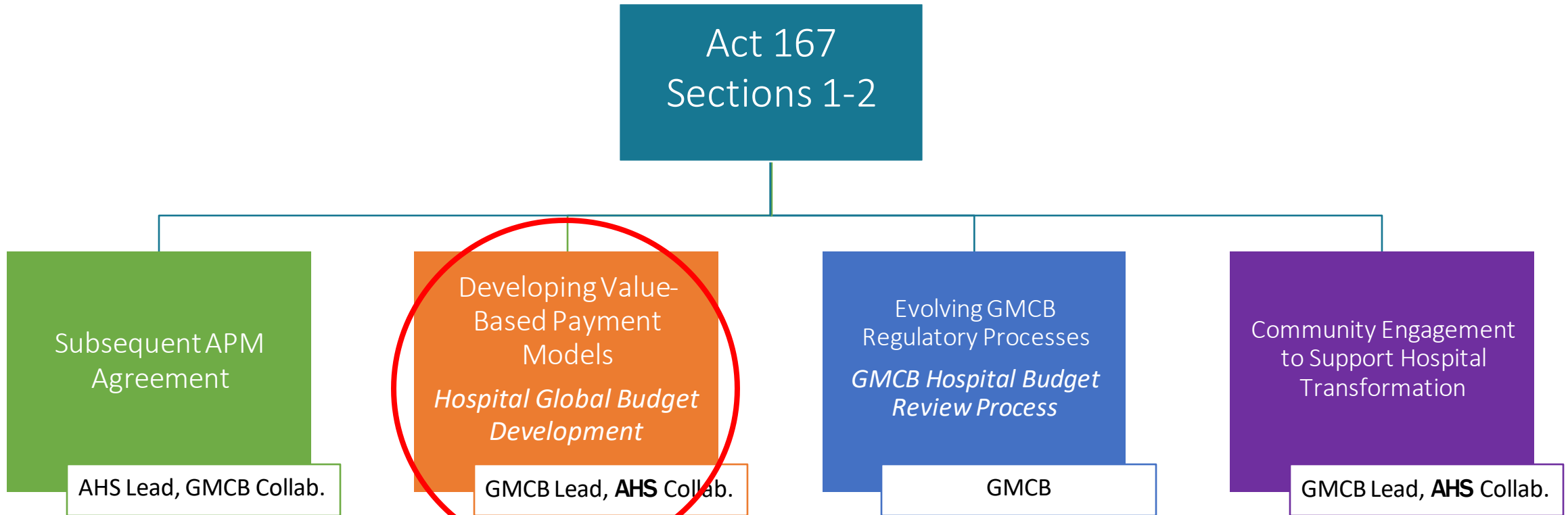
- Care Management Fee (CMF)
 - Performance-Based Incentive Payment (PBIP)
 - Standard FFS billing
 - Health Equity Advancement Resource and Transformation (HEART) (if applicable)
-
- CMF
 - PBIP
 - CPCP + FFS billing
 - HEART (if applicable)
-
- PBP (subject to PBA)
 - Flat visit fee (subject to PBA)
 - Performance-Based Adjustment (PBA)
 - HEART (if applicable)

Vermont Regulatory Context: Hospital Budget Review



- Vermont has regulated hospital budgets since the 1980s
- GMCB establishes a budget for each hospital annually
 - Required regulatory process
 - Comprehensive review of hospital finances:
 - Operating and non-operating revenue and expenses
 - Include professional revenue and expenses, and other facilities owned by the hospital and adjusts for provider transfers
 - Accounts for provider transfers to/from hospital
 - Capital plans
 - Key financial indicators (e.g., operating and total margin, age of plant, etc.)
 - "Efficient and economic operation of the hospital"
- Regulated hospital expenditures account for 50-60% of medical trend in the insured markets

Act 167 Sections 1 and 2



Hospital Global Budgets
Technical Advisory Group
(January 2023-January 2024)

Global Budget TAG: Analysis and Discussion Topics

Scope:

- Defining services included in hospital global budget payments
- Defining populations included in hospital global budget payments
- Commercial payer participation
- Provider participation

Calculating global payments:

- Calculating baseline budget
- Defining potential budget adjustments (annual, periodic, and ad hoc) and adjustment methodologies

Transformation, administration, evaluation:

- Strategies to support care transformation and quality
- Program administration
- Evaluation and monitoring

Members: Representatives of hospitals, payers, unions, advocates; members invited based on technical expertise

Charge: Make recommendations for conceptual and technical specifications for a multi-payer Vermont hospital global budget program

[All materials posted publicly](#)

Vermont's Blueprint for Health Advanced Primary Care Program

Each of Vermont's 13 Health Service Areas (HSAs) receive multi-insurer funding for:

- Primary care practices recognized as Patient-Centered Medical Homes (*>130 practice sites statewide*)
- A multi-disciplinary Community Health Team (CHT) to support people with complex health and social needs

In addition, Medicaid provides additional CHT funding for:

- Hub and Spoke system of Opioid Use Disorder Treatment (*~87 Spoke program sites statewide*)
- Pregnancy Intention Initiative (*~40 practice sites statewide*)
- Blueprint Expansion Pilot supporting universal screening to identify and address mental health and substance use disorders and health related social needs

Foundational statewide infrastructure supporting all HSAs include:

- Funding for Program Managers in each HSA
- Quality Improvement Facilitators
- Population Data and analytics
- Learning Health System opportunities



How does/will your state measure whether these reforms are meeting your identified goals?

Vermont All-Payer Model: Total Cost of Care

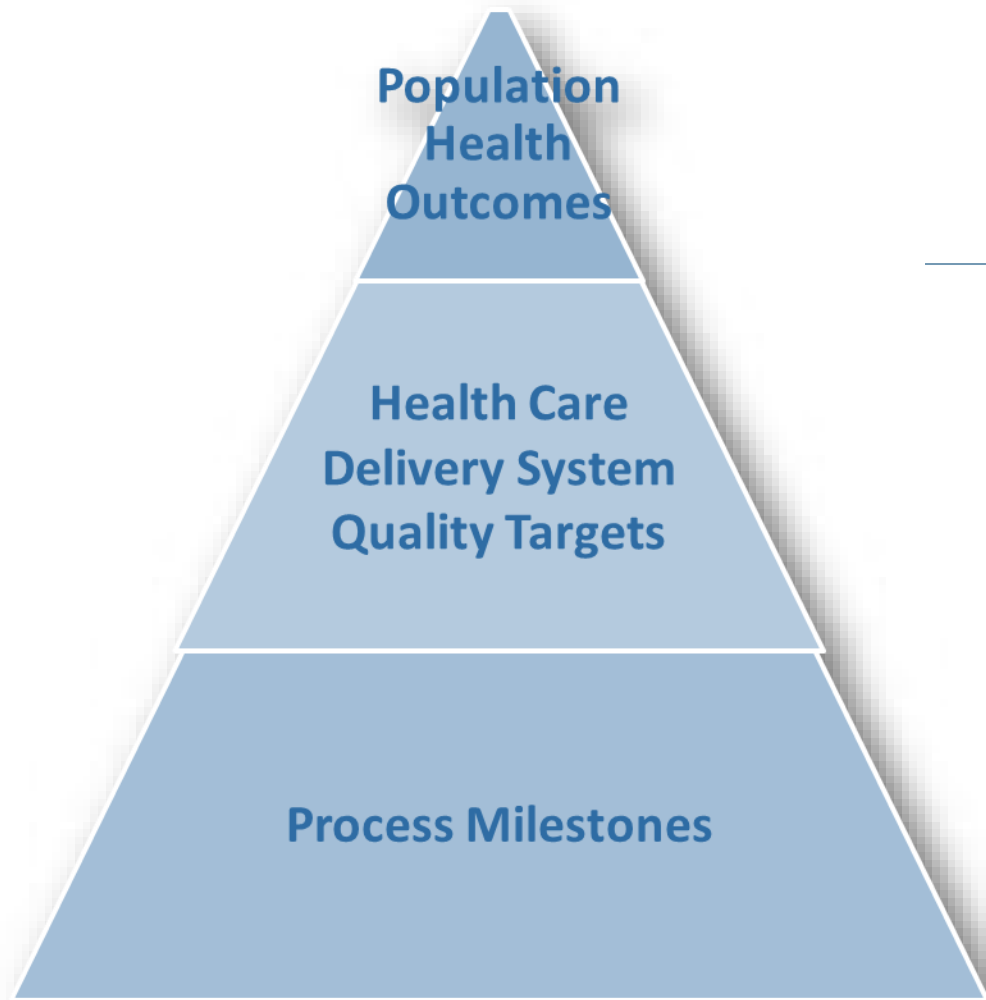
Cost Growth Target: A key objective of Vermont's All-Payer Model is to align the growth in the cost of care to the growth of Vermont's economy over the life of the model.

Health care spending is tracked over the full term of the agreement, with the goal of keeping the average increase in costs to 3.5% – and no more than 4.3% – over that time period.

GMCB **evaluates the state's progress** annually relative to the target, expecting health care utilization and costs to fluctuate year-to-year, especially during uncertain times like the COVID-19 public health emergency.

Growth in health care costs was 4.1% in Year 1 (2018), 4.6% in Year 2 (2019) and 0.4% in Year 3 (2020).

Population Health Goal #1: Improving Access to Primary Care

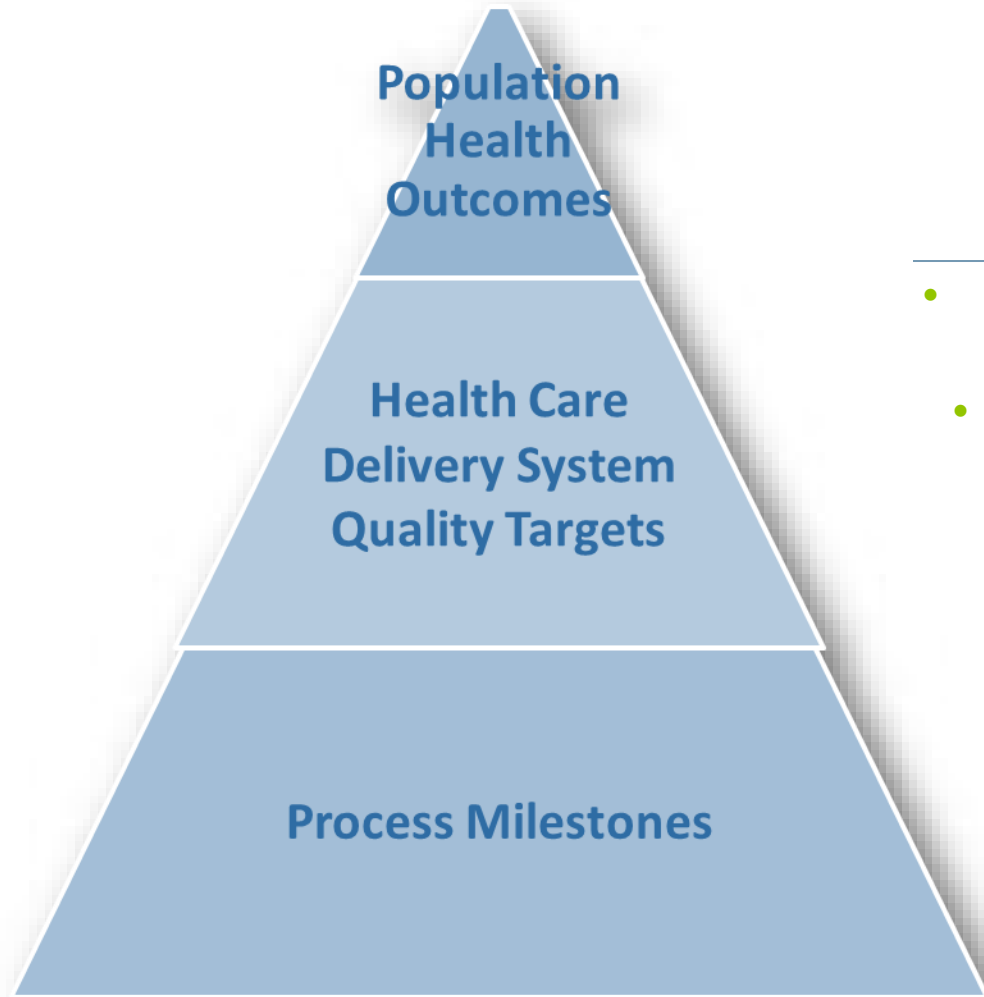


- Increase % of VT Adults Reporting that they have a Personal Doctor or Health Care Provider

- Increase % of VT Medicare Beneficiaries Reporting Getting Timely Care, Appointments and Information

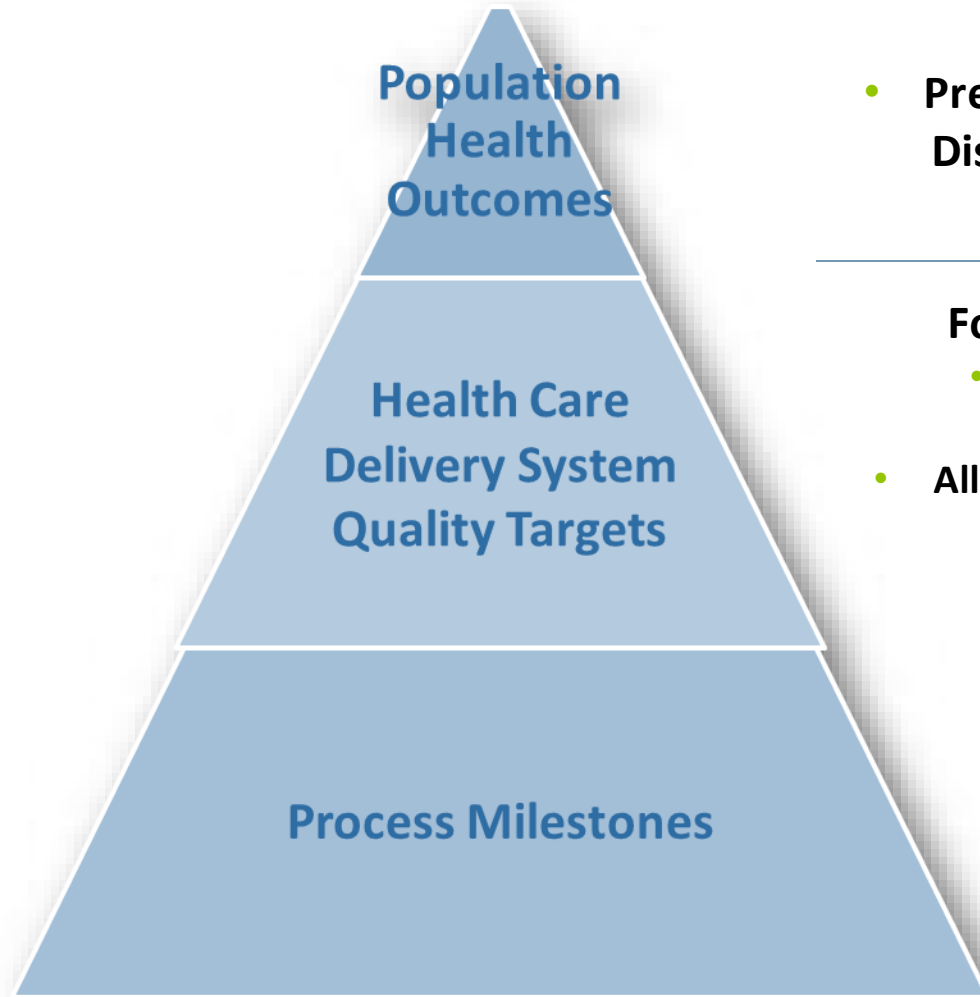
- Increase % of VT Medicaid Children and Adolescents with Well-Care Visits
 - Increase % of VT Medicaid Beneficiaries Aligned with a VT ACO

Population Health Goal #2: Reducing Deaths from Suicide and Drug Overdose



- Reduce Deaths from Drug Overdose
 - Reduce Deaths from Suicide
-
- Increase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 measures)
 - Improve Follow-Up After Discharge from ED for MH and SA Treatment (2 measures)
 - Reduce Rate of Growth of ED Visits for MH/SA Conditions
-
- Decrease # of Morphine Milligram Equivalents Dispensed per 100 VT Residents
 - Increase # of VT Residents Receiving Medication-Assisted Treatment for Opioid Dependence
 - Increase Screening for Clinical Depression and Follow-Up Plan

Population Health Goal #3: Reducing Prevalence and Morbidity of Chronic Disease



- **Prevalence of Chronic Obstructive Pulmonary Disease, Diabetes and Hypertension Will Not Increase by More Than 1% (3 measures)**
-

For VT Medicare Beneficiaries, Improve:

- **Diabetes Hemoglobin A1c Poor Control**
 - **Controlling High Blood Pressure**
 - **All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions**
-

- **Improve Rate of Tobacco Use Assessment and Cessation Intervention**
- **Asthma Medication Ratio of 0.5 or Higher**

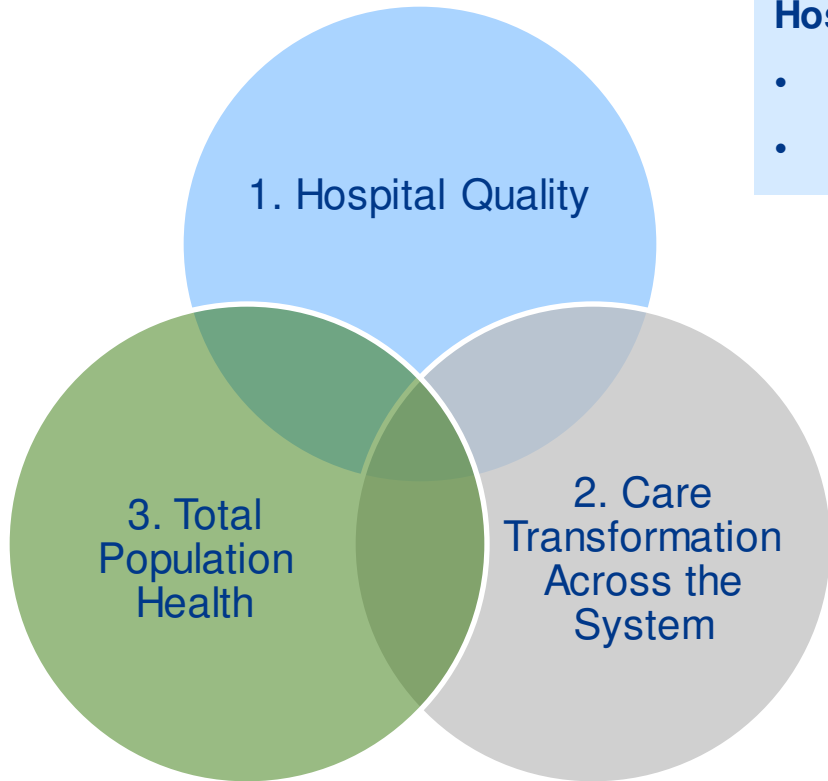
TCOC Model Years 1-4 Performance

Performance Measures	Annual Targets	2019	2020	2021	2022
Annual Medicare TCOC Savings	\$120M (2019), \$156M (2020), \$222M (2021), and \$267M (2022) in annual Maryland Medicare TCOC per Beneficiary of savings for MY4 (2022)	✓	✓	✓	✓
TCOC Guardrail Test	Cannot exceed growth in National Medicare TCOC per beneficiary by more than 1% per year and cannot exceed the National Medicare TCOC per beneficiary by any amount for 2+ consecutive years	✓	✓	✓	*
All-Payer Revenue Limit	All-payer growth ≤ 3.58% per capita	✓	✓	✓	✓
Improvement in All-Payer Potentially Preventable Conditions	Improve upon the CY 2018 PPC rates for 14 Potentially Preventable Conditions (PPCs) that comprise Maryland's Hospital Acquired Condition program (MHAC)	✓	✓	✓	✓
Readmissions Reductions for Medicare	Maryland's aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate at regulated hospitals ≤ the National Readmission Rate for Medicare FFS beneficiaries	✓	✓	**	**
Hospital Population Based Payment	≥ 95% of all Regulated Revenue for Maryland residents paid according to a Population-Based Payment methodology	✓	✓	✓	✓

*0.9 percentage points above the National growth rate in 2022 and 0.6 percentage points above in 2021. CMS did not ask the State to take additional corrective action in part because, in December 2022, HSCRC took steps to reduce 2023 growth (should allow the State to meet their 2023 TCOC Guardrail requirement), and because Maryland's 2022 growth was partly based on CMS OACT estimates of growth that were significantly larger than actual growth.

**HSCRC staff believe the unadjusted readmission rate has increased due to increases in patient acuity in Maryland's hospitals, relative to the nation, an expected effect of GBRs. CMMI has agreed to consider to a risk-adjusted measure but also requested that the State conduct activities related to readmission improvements.

Statewide Integrated Health Improvement Strategy



Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation Goals

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Total Population Health Goals

- Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
- Priority Area 2 (Opioids): Improve overdose mortality
- Priority Area 3 (Maternal and Child Health):
 - Reduce severe maternal morbidity rate
 - Decrease asthma-related emergency department visit rates for ages 2-17

*Value-based models including the Care Redesign Program, Care Transformation Initiatives, and qualifying successor models.



What could your state have done differently and/or what advice would you give other states interested in hospital global budgets or other payment and delivery system reforms?

Lessons Learned

- Despite complexity, need to be able to explain the model to various audiences, including the general public
- Importance of actionable data for transformation and evaluation
- Need for significant and intentional care transformation design and support
- Critical to engage providers from across the care continuum
- Identify and focus on core goals and initiatives
- Must build in sufficient time and resources for implementation and ongoing operations

Lessons for States Considering Global Budgets

- The rate setting system underpins the global budget model because of Maryland's unique history. It is not necessary for states starting from scratch.
 - The basic concept of a global budget is simple and does not require rate setting.
 - Running a global budget model overtop of a rate setting system introduces its own complexities.
- States interested in global budget models should consider long term policy issues at the outset:
 - How should hospital's transform their care delivery model?
 - How should access be protected under a Global Budget Model?
 - How should "retained revenues" be used?
- States interested in global budget models should consider the design of the entire health system and not just hospitals.
 - Hospital payments (IPPS and OPSS) should be aligned with physician payments (PFS).
 - As hospitals transform their care delivery models, services will shift to non-hospital settings.
 - This process should be managed.
- Statewide infrastructure is critical to success.
 - Maryland has a robust all-payer claims database & a statewide health information exchange.
 - Data exchange is hard and its importance to the model success cannot be overstated.

Thank you!

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics
Maryland Health Services Cost Review Commission (HSCRC)

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Thank you!



NATIONAL ACADEMY
FOR STATE HEALTH POLICY

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