



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

# Global Budgets for Hospitals

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

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## Global Budgets for Hospitals

A global budget provides a fixed amount of funding for fixed period of time (typically one year) for a specified population, rather than fixed rates for individual services or cases. The main objective is to constrain the amount a hospital can spend in order to limit the total amount of money spent on health care within the system. This approach contrasts with “line-item budgeting,” which breaks down the amount into specific line items, such as salaries, drugs, equipment, and maintenance. Hospital managers often cannot change line-item allocations without approval from funders (usually a government agency). Essentially, a global budget represents a one-line budget and provides the hospital more management flexibility to allocate resources. Over time, global budgeting has replaced line-item budgeting in developed countries that rely on regulation more than on market forces to control health care spending.

Global budgets for hospitals can be “soft” or “hard.” Under a soft global budget, the purchaser or payer assumes part or all of any overruns. But consensus has emerged that soft budgets are ineffectual. Under a hard global budget, the hospital’s payment is limited to the prospectively set global budget amount, transferring financial risk to the hospital. A core concept is that hospitals would have an

incentive to reduce the unit cost of output, so they are able to increase the volume of services provided through the budget. Conversely, if unit costs rise volume must fall, although the payer can adjust the global budget for reasonable, overall volume growth or declines.

A global hospital budget implies that all payers participate and thus is simpler to operationalize in a single-payer or all-payer environment, such as Maryland. Although a global budget concept may be applied to some but not all payers in a jurisdiction, guaranteeing a budget across all payers, changes in volume for nonparticipating payers would put participating payers at risk. The Maryland all-payer payment reform demonstration, which began in 2014, ties payments for individual services to hospital-specific global budgets. This is intended modify prior incentives in the Maryland all-payer rate-setting program, which limited prices but encouraged increased volume.

A global budget can have many forms, but it must be explicit about the services it funds. The global budget needs a precise method for specifying which patients are included and to which hospital's budget they are to be assigned. Administratively, global budgets sometimes are managed through a contractor positioned between hospitals and purchasers or payers. Spending for items outside the operating budget (e.g., capital, teaching, and research and development) is generally funded outside the global budget. Hospitals may also receive an up-front payment or a temporary addition to their rate base to support infrastructure enhancements for care management and IT capabilities needed to operate under the global budget.

Hospital budgets are generally set through one of three approaches—historical, capitated, and normative—or some combination of the three:

- In the historical approach, which is the most commonly used, the first-year budget becomes the base and subsequent years' budgets are pegged off that experience. The historical cost approach is the easiest operationally and the most common approach.
- Capitation aims to distribute resources based on relative needs of the populations providers serve. However, capitation requires sophisticated data to perform health-status risk adjustment and advanced modeling capabilities and is not widely used for setting global budgets.
- There are many variants of the normative approach to setting budgets. In essence, they use an external rate-setting approach to set a unit price for services, which is then multiplied by the anticipated or desired volume of services. This approach does not necessarily take account of historical levels of activity, access, or provider costs.

Payers can allocate the global budget directly to hospitals, but also can produce cash flow by making unit payments (as in Maryland), per diem payments, or case-based payments. Subsequently, payers would reconcile the resulting payment totals with the agreed-upon budget amount. This payment approach must allow payments for patients who are not part of the hospital's global budget, such as out-of-area individuals seeking urgent care.

In Maryland, once a hospital's global budget is set (based on the hospital's historical revenue), the payers' revenue contributions are apportioned retrospectively based on each payer's proportion of revenue. (Proportion of revenue, in turn, is based on each payer's charges during the year.) The unit prices adjust up or down to all payers based on the aggregate volumes of patients the hospital serves, to assure the hospital complies with the global budget amount.

## Key Objectives

Global budgets give hospitals clear incentives to manage provision of care within a defined budget constraint, emphasizing the policy objective of cost containment. One of the clearest incentives is to reduce the number of admissions that the global budget must cover; the volume of admissions is an important approach to reducing hospitals' variable costs.

## Strengths

- Similar to capitation, global budgeting fundamentally changes the incentives hospitals face, providing a direct incentive to improve operating efficiency and reduce volume of cases, outpatient encounters, and services per patient.
- A hard cap global budget rigorously enforces limits on spending and provides spending predictability for payers and health care policy-makers.
- A global budget, in contrast to a line-item budget, provides hospital management with more autonomy and flexibility to improve efficient production of health services.
- A global budget is relatively straightforward for the hospital to administer, and it is seemingly less susceptible to the fraud associated with false or inflated claims for services. Patient cost-sharing obligations can be included under a hospital global budget if cash flow is based units of service or per diems.

## Weaknesses

- Global budgeting does not apply readily outside of an all-payer or single-payer environment.
- Global budgets do not promote competition among hospitals or reward hospitals for growth in market share, unless they include a mechanism to adjust a hospital's budget for shifts in volume due to desirable changes in referral patterns. (In Maryland, this mechanism is referred to as a market-shift adjustment.)
- Without specific performance incentives and assessments, hospitals under global budgeting can operate within their budgets by limiting spending, even if the spending reduction approach might negatively affect access and quality. In Europe, some hospitals have responded to global budgets by producing queues for elective services.
- The common, historical-basis approach to budget setting reinforces existing resource flows, which may not accurately reflect need or market value.
- Payers may base allowances for annual budget increases on factors unrelated to health, such as the growth in inflation or GDP, or on budgetary constraints outside of the health care sector, thereby eroding the global budget's purchasing power.
- A normative approach presumes the global budget is based on highly granular and accurate data, which may be more aspirational than real in many situations. Too much divergence from historical spending may cause real financial hardship for affected hospitals, which can compromise quality and access to care.

## Design Choices to Mitigate Weaknesses

The global budget's fixed spending limit must contain a framework to ensure that volume levels are achieved or adjusted for, quality standards are met, and changes in service delivery are consistent with payers' wishes. Without such mechanisms, a global budget can become, in effect, a block grant to be spent at the hospital's will, with no guarantee patients will receive needed services. In particular, payers must assess changes in volume of services provided; hospitals operating under fixed or guaranteed budgets may become complacent about competing for patients or providing needed services. This approach to assuring acceptable performance would substitute oversight of hospital activity for costly and cumbersome claims-based oversight. To assure adequacy, budgets can be adjusted fairly easily for

shifts in market share. For example, the Maryland demonstration approach rewards hospitals for increased market share, at a rate meant to approximate each hospital's variable costs. At the same time, the rate is limited by the extent of decrease in admissions in a hospital's area.

Payers may incorporate elements from historical, capitation, and normative approaches to setting global budgets to maximize the advantages of each, although starting with historical budgets will minimize initial disruptions. Mixed approaches can include some element of P4P based on achievement of a few high-level performance targets, such as reductions in average length of stay, readmissions, hospital-acquired conditions, and patient safety measures, to ensure providers do not simply reduce quality and access to adhere to their budgets. Several countries have adopted DRGs not as a payment mechanism, but rather to increase transparency of hospital activity and to permit comparison across hospitals under global budgets.

## Compatibility with Other Payment Methods and Benefit Designs

Global budgets are theoretically compatible with population-based payment approaches, such as shared savings, because they remove hospitals' incentive to increase the volume of services.

Hospitals with global budgets should have cost-sharing approaches compatible with their cash flow approaches. For example, when cash flow is provided through DRGs, first-day deductibles are compatible; however, co-insurance amounts would not be calculable because the average case might be different from an individual patient's experience. In contrast, when cash flow is based on permitted service unit charges or per diems, co-insurance or co-payments for services are possible. Similarly, payers can implement high-deductible plans more readily when cash flow is based on per diems or unit charges than when it is based on DRGs.

Generally, the primary mechanism for cost containment under global budgets is on the provider side, not on consumer demand, with the strong incentive providers have to reduce spending. On the other hand, payers can use patient cost-sharing to split the cost of hospital services with consumers rather than to discipline hospital spending. If anything, absent complementary DRGs and quality measures to monitor and assess hospital activity, under global budgets hospitals already have a strong incentive to admit only patients with real needs for inpatient care. In contrast, other approaches to hospital payment, one way or another, reward hospitals for increasing their volume of cases or services.

Global budgets may be less compatible with certain insurance benefit designs, such as tiered networks. Higher-cost hospitals with static global budgets will realize benefits as patients in tiered network products self-refer to lower-cost hospitals. Given the already strong incentives for cost reduction under global budgets, prior certification and continued stay review would seem to have little role as a benefits management approach.

## The Focus of Performance Measurement

The global budget is oriented toward reducing service volumes and costs, but explicit measures of quality and access to services are needed. Whereas measures for ambulatory care-sensitive conditions, emergency room use, and hospitalization rates may be needed under volume-based payment methods, with global budgets the concern would be overaggressive reductions in rates on these measures to decrease workload. That is, it would be useful but operationally challenging to measure inappropriately denied hospitalizations. But there are measures that could be used to indicate access problems; in Europe, for example, wait times for elective admissions are routinely measured under hospital global budgeting.

## Potential Impact on Provider Prices and Price Increases

As emphasized earlier, a global budget can only work as envisioned in an all-payer context such that the actual payments conform to the budget. In an all-payer system, prices are subject to administrative price setting or limits – ceilings and floors -- on the prices hospitals can charge. The impact of global budgets on commercial insurers' prices will vary based on whether the budget-setting approach is historical, normative, or capitation based. Historically based global budgets incorporate providers' current price structure in the base (absent any dramatic changes in their mix of services). Applying an allowed percentage increase, rather than a fixed dollar amount, for all hospitals in subsequent years, also would incorporate pricing differences already in place.

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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