

PAYMENT MODEL PRIMER

Global Payments

A global payment is a prospectively determined payment made to a group of providers or a health care system that covers most or all of a patient's care during a specified time period.¹ Global payments are typically paid at one pre-designated point, which can either be monthly or after a set of services have been administered.¹ Global payments often encompass physician and hospital services, diagnostic tests, and prescription drugs and can include other services, such as hospice and home health care.¹ Because global payments are designed to take a systems approach, meaning they monitor the performance of a system not limited to a single provider, some states have also explored or implemented global budgets focused on a system of care, such as hospitals.²

HOW IS IT SUPPOSED TO WORK?

Global payments are sometimes thought of as a type of capitated payment focused on managing and improving the health of an overall population or system (see also [Capitation Payment](#) brief). As a result, global payments are also referred to as comprehensive population-based payments. They are usually risk-adjusted to reflect the health status of the group on whose behalf the payments are made.¹ There are some similarities between global and episode-of-care payments, which both cover a set of services, versus paying for them individually.¹ The primary difference is that global payments are made on behalf of a group of patients (e.g., a set of enrollees in a health plan or Medicaid enrollees) and cover care for all

conditions and services specified in the global budget contract between provider and payer organizations.¹

As a result, global payments work best when they set standards and measure outcomes for the full range of services delineated in the contract. Doing so can help identify whether there is cost-shifting or inappropriate service utilization across the continuum of care. Global payments are typically set based on an actuarial analysis and can target patients with different health care conditions or patients with no specific chronic or acute condition.³

WHAT IS THE GOAL?

The goal of global payments is to move away from a fee-for-service (FFS) framework that incentivizes clinicians or medical facilities to bill for as many services as possible to draw down revenue, and instead steer providers and systems toward management of care and health improvement for a population of patients.^{1,4} Policy leaders that launch global payment initiatives seek to incentivize better care coordination across all clinicians and facilities from which a beneficiary receives care, and generally target populations of beneficiaries as a group.^{1,4} These models also seek to ensure high-value care, by incorporating bonuses if certain quality benchmarks are reached, similar to capitated payments.^{1,4}

HOW AND WHERE HAS IT BEEN USED?

Global payments are commonly used by private insurance companies, as well as Medicare Advantage plans and Medicaid managed care plans.⁵ Medicaid programs and other payers use global payments to manage the costs and outcomes of a system of care, such as hospitals. For instance, in 2019 the state of Pennsylvania launched the Pennsylvania Rural Health Model (PARHM).⁶ Under PARHM Medicare, Medicaid, and commercial payers are testing whether the use of global budgets for rural hospitals increases access to care for rural Pennsylvania residents.⁶

Oregon has a unique approach to managed care called Coordinated Care Organizations (CCOs), which differ from traditional Medicaid managed care organizations (MCOs) in other states.⁷ CCOs are locally governed, versus being totally under the purview of the state's Medicaid agency.⁷ Policy and coverage decisions are made through partnerships among health care providers, community members, Medicaid enrollees, and health systems.⁷ CCOs have one integrated global budget for behavioral health, physical health, and oral health services.⁷ They also have flexibility to fund services outside traditional medical services,

to address issues such as social determinates of health (e.g., food insecurity, homelessness), that can drive health outcomes.⁷

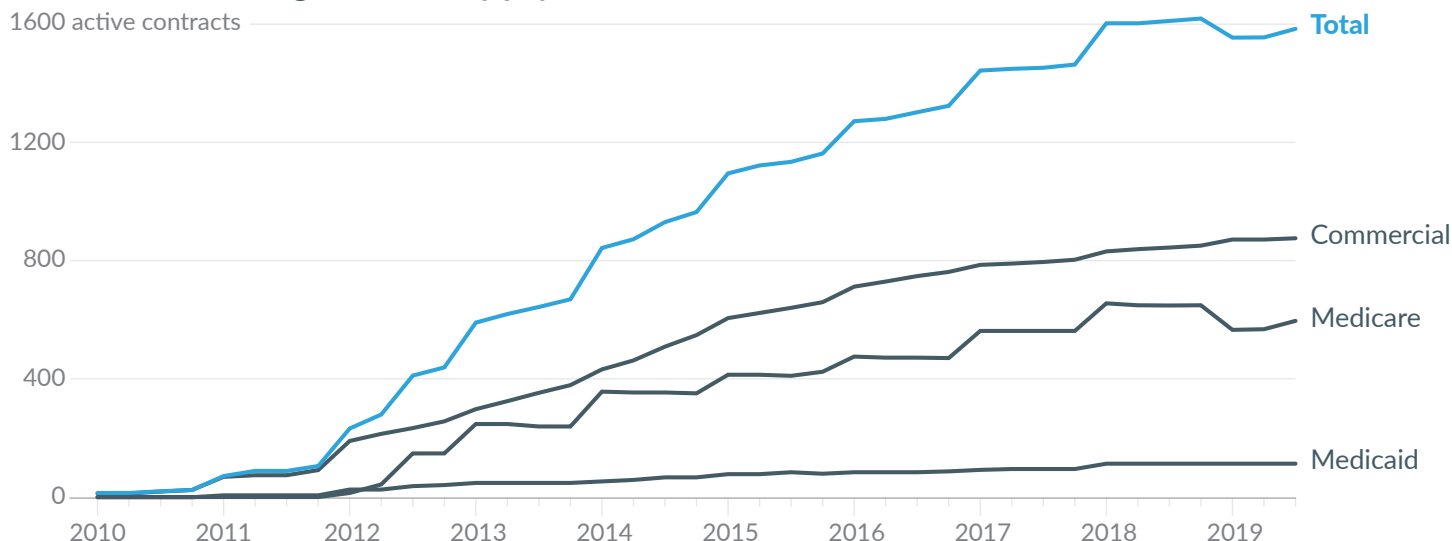
Key components of payment structure

A global payment is designed as a fixed payment to a system or group of providers to cover patient or population costs for a specified time. Payments typically encompass a range of services that otherwise would be billed for individually in a FFS arrangement. Entities that receive global payments can be providers, systems, or intermediary organizations such as accountable care organizations (ACOs) or MCOs.

Clinicians with patients whose care is paid for under a global payment arrangement are incentivized to keep costs low to retain some leftover funds as profit.⁵ To ensure providers do not withhold needed care, globally capitated providers often have to report on quality and utilization measures, which can be linked to performance bonuses or publicly reported.⁵

Global payments are also used by commercial payers, Medicaid, and Medicare to fund health maintenance organizations (HMOs), Medicare Advantage (MA) plans, and MCOs.⁵ Whenever a patient covered by a global capitated plan uses services that are cheaper than the amount paid to the provider organization, the provider organization keeps the remaining funds as profit.⁵ Providers paid under global payments in MCOs, HMOs, or MA plans often have to report on quality and utilization measures, to ensure care is not reduced.⁵

FIGURE 1

Accountable care organizations by payer

Source: Muhlestein, et al. in Health Affairs.⁸

Accountable Care Organizations

Some ACOs use global payment arrangements.^{5,8} Under ACOs, a payer (commercial, Medicare, Medicaid) sets a payment per member over a designated period of time (usually monthly) to a group of clinicians.⁸ These payments can be conditioned on quality metrics, in that providers either receive additional funds, or have some taken away depending on how they perform on specified quality metrics.⁸

In 2018, 33 million people were receiving their care under an ACO.⁸ More than 50% were commercially insured, just over 40% were covered by Medicare and approximately 10% were enrolled in Medicaid.⁸ Figure 1 shows active ACO contracts by type of payer. Not all ACOs utilize a global payments.⁹ Others maintain a FFS payment framework but also incorporate bonus or penalty payments depending on how clinicians perform on preset quality metrics.⁹

Multipayer opportunities or past applications

There are numerous examples of multipayer efforts that use global payment beyond the PARHM model referenced earlier in this brief. All of these

efforts were launched under federal initiatives funded through the Center for Medicare & Medicaid Innovation (the Innovation Center).

- One of the most notable examples of the use of global payment as a multipayer initiative occurred in Maryland.¹⁰ In January 2014, **Maryland Medicaid** implemented an all-payer model for hospitals, which shifted the state's hospital payment structure to an all-payer, annual, global hospital budget that encompassed inpatient and outpatient hospital services. Maryland's all-payer initiative aimed to eliminate differences across payers by establishing uniform payment rates.¹⁰
- The **Community Health Access and Rural Transformation (CHART) Model** is a national model that aims to enable better access to hospital care for individuals in rural areas.¹¹ Under this effort, hospitals receive a prospective payments to cover a set of inpatient and outpatient services.¹¹ The model targets both Medicare and Medicaid enrollees and launched in September 2021.¹¹
- A final example is the **Global and Professional Direct Contracting (GPDC) Model**.¹² Under this initiative, beneficiaries are either auto-as-

signed via claims or voluntarily enroll to be cared for by a provider who has become a direct contracting entity.¹² The premise is similar to ACO models in that clinicians receive a risk adjusted protective payment to cover the costs of patients assigned to them.¹² Clinicians under this model can agree to varying degrees of financial risk, including receiving a single payment that covers the services they provide to a patient, and other medical providers the patient sees as well.¹² This model launched in April 2020, and targets both Medicare and Medicaid patients.¹²

Provider types and provider characteristics

Hospitals

Hospitals often operate under global payment within the Medicare program.¹³ We also found some limited instances of use among private payers and Medicaid programs.¹⁴ For instance, a Blue Cross Blue Shield plan in Massachusetts began a statewide effort to pay hospitals and network physicians using a global payment arrangement in 2009.¹⁵ The Blue Cross Blue Shield of Massachusetts (BCBSMA) developed the Alternative Quality Contract (AQC), under which hospitals received a single global payment that covered all inpatient, outpatient, pharmacy, behavioral health, and other health services BCBSMA patients require.¹⁵ In addition, participating providers were eligible for bonuses depending on their performance on certain quality measures.^{15,16}

Within Medicare, there have been over 30 global payment initiatives targeting cardiac and orthopedic surgical services.¹³ Under the PARHM initiative, 5 acute care hospitals in rural communities participated in the first year.⁶ These facilities included those with a critical access hospital (CAH) designation from CMS.⁶ CAHS are hospitals located more than a 35-mile drive from any other hospital, with no more than 25 inpatient beds, offer 24/7 emergency services, and have an annual average acute care inpatient length of stay of 96 hours or less.⁶ Prospective payment

system (PPS) hospitals also participated.⁶ PPS hospitals are facilities where Medicare payment is made based on a predetermined, fixed amount. In all, participants included 2 independent CAHs, 1 system-owned CAH, 1 independent PPS hospital, and 1 system-owned PPS hospital.⁶

Physician groups

The characteristics of physicians participating in ACOs appear to vary by payer. Among Medicare and commercial providers, physician groups that participated in ACOs tended to be in areas with a higher proportion of well-insured patients.¹⁷ Additionally, they were less likely to include physicians working in areas that are densely populated by patients who are low-income, less educated, and from a racial minority.¹⁸

Practices participating in Medicaid ACOs were more likely to also have both Medicare and commercial ACO contracts.¹⁹ Medicaid ACOs tend to be the most populous, with 43,500 lives on average, compared to Medicare contracts with 17,500 and commercial contracts with 24,300 lives.¹⁹

Medicaid ACO contracts can prove more financially risky for providers compared to commercial or Medicare ACOs.¹⁹ Medicaid beneficiaries are more likely to struggle with social determinants of health (SDOH) issues, such as income, housing, food, and transportation insecurity, and are in need of more behavioral health assistance.¹⁹ Further, Medicaid beneficiaries are more likely to cycle on and off Medicaid than Medicare and commercial enrollees.¹⁹ This churn complicates ACO attribution efforts, putting clinicians at more financial risk, or risk of not receiving incentive payments.¹⁹

WHAT HAVE BEEN THE RESULTS?

Financial

By 2012, approximately 85% of the physicians in the BCBS network in Massachusetts had entered the plans AQC model.¹⁶ Tufts Health Plan, another

insurer in Massachusetts, launched a similar effort, and 72% of its commercial managed care enrollees were under global budgets by 2012.¹⁶ Between 2009 and 2012, costs of services dropped 6.8% compared with costs in a control group.¹⁶ The control group included commercially insured individuals in plans in Connecticut, Maine, New Jersey, New Hampshire, New York, Pennsylvania, Rhode Island, and Vermont.¹⁶ To conduct the analysis claims were reviewed in the encounters database of Truven Health Analytics.¹⁶ By 2016, the average annual medical spending on claims for the enrollees in the AQC initiative was \$461 lower per enrollee than spending in the control states, an 11.7% relative savings on claims.²⁰

The Maryland all-payer model generated \$679 million in Medicare savings from reduced hospital spending between 2014 and 2017.²¹ Commercially insured Maryland patients experienced a 6.1% slower growth in hospital expenditures than a comparison group, however their total spending did not change as a result of higher care utilization.²² Federal auditors found that Medicaid expenditures appeared to decrease slightly from 2011 through 2014, then increased through 2016.²² However, the researchers did not have enough data to quantify the decrease or increase or why expenditures spiked upward in 2016.²²

Under PARHM, Pennsylvania's global budget payments exceeded the Medicare reimbursement amount participants would have been paid under the PPS and cost-based reimbursement methods, in part due to demand in services decreasing during the COVID-19 pandemic.⁶

Low- and high-value services

A 2018 analysis of global payment that appeared in the British Medical Journal found that the payment approach may reduce the overall volume of some services, but may not be precise enough to selectively reduce low-value care.²³

Health outcomes

Maryland's all-payer model reduced inpatient admissions for Medicare beneficiaries, but not expenditures for inpatient facility services.²¹ Inpatient admissions also trended downward for commercial plan members and Medicaid beneficiaries.²¹

Model sustainability

A strength of this model is that the regular payments clinicians and hospitals receive have been relied on as a source of financial security during times of economic downturn.²⁴ For instance, during the COVID-19 pandemic the number of elective procedures being performed dropped, leading to a loss in revenue for both hospitals and physicians.²⁴ Payments received under global payment models helped soften some of these losses according to the Center for Value-Based Insurance Design.²⁴ This was also the case for hospitals participating in the PARHM initiative.⁶

However, PARHM participants did raise concern about long term sustainability of the model.⁶ While the global payments offered under PARHM offered a source of revenue predictability in the short term, the model does not address the trend of decreasing patient volumes being noted at these facilities, as more individuals move away from rural to more populated areas of the state.⁶

Health equity and social determinants of health

In Oregon, since CCO global payments are not tied to specific services, clinicians and hospitals have been able to use funds to address SDOH and equity efforts.²⁵ A similar approach occurs in other states among Medicaid MCOs who use portions of the capitated payments they receive from state Medicaid programs to fund SDOH and equity activities.^{25,26}

What works and what doesn't?

Strengths and impacts

- Global payments can help to ensure adequate payment regardless of severity of illness of patient populations by risk-adjusting payment for services rendered by clinicians or hospitals.²⁷
- Global payments can offer flexibility to make investments in non-visit-based care, social services, system transformation and other efforts that improve health outcomes and reduce costs.²⁷
- Global payments give providers autonomy to target their resources in ways they believe are most effective or beneficial.²⁷
- Global payments can assist in focusing providers on population health rather than volume of services, and encourage clinically appropriate care.

Concerns and downsides

- Clinicians have expressed concern about potential financial risk of global payments if there is not proper stratification for riskier patient populations.^{28,29}
- Low global payments could lead to providers or institutions to “cherry-pick” patients for their panels.
- Some patient advocates have also opposed global payments over concerns that they could result in critically ill patients being denied care, or steered to other facilities far outside of their communities.^{28,29}
- Global payments can make it difficult to identify the frequency of or specific dates of services (e.g., the number of prenatal or postpartum visits).³⁰ As a result models like CHART and GPDC require submission of non-payment claims to allow Medicare to track utilization and measure quality.

WHAT ARE THE OPERATIONAL CONSIDERATIONS?

IT infrastructure and analytics

The use of global payments relies on health information technology to track improvements in quality of care and whether these efforts lead to reduce costs.³ Smaller independent providers, or those who practice in rural areas may lack the resources to purchase or update health information technology systems necessary to track care for patients paid for under a global payment model.³ For a global payment initiative to be successful, participating clinicians must use updated interoperable electronic medical records and will benefit from a connection to their state's health informa-

tion exchange network to access real-time patient information.³

Providers have indicated the need for internal analytics infrastructure to identify care and service delivery improvement opportunities so that they can successfully manage costs within a global budget.³¹ To the extent this infrastructure doesn't exist, states could consider supporting providers with analytics based on reported utilization data, but the utility of these analytics may be somewhat limited due to claims lag.³¹ Examples of analytics that could meet this need for providers include analysis of gaps in care, low-value care, preventive care, or variation in provider performance.³¹

Stakeholder perspective

Clinicians

To take on a global payment, there must be adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors as needed.³² States could consider physician input about the tools and methods used to ensure adequate calculation of the payment.³² Medicaid and other payers should also confirm that clinicians have the HIT infrastructure in place and individuals with the skills to understand and manage risk.³² Global payments can aid in focusing physicians on population health rather than volume of services, and encourage clinically appropriate care but low payments under this model could lead to providers or institutions cherry-picking of patients for their panels.³³ Management of global payment contracts can require physicians and providers to take on increasing amounts of both financial and clinical risk.³³

Large health systems

Integrated health systems like Geisinger Health Plan and the Mayo Clinic may be the most ideal targets for global payment models.³ These systems can more readily align their hospitals, physician practices, and other non-hospital-based providers around a single goal.³ One of the reasons Geisinger noted it had success with its global payment model was that it also operates an insurance plan, so it was able to be operationally aligned across all areas when implementing its maternity billing model.³⁴ Generally, integrated systems may be better equipped to handle the transition to global payments as they have organizational structures already in place that support the processes necessary to manage care within the financial boundaries of a fixed payment.³

Hospitals

The Massachusetts Hospital Association has voiced support for global payments noting they aid in eliminating unnecessary medical procedures.³⁵ Hospital participants in PARHM

expressed disappointment that it did not receive upfront funding to implement the system and protocol changes needed to comply with the model.⁶ However, Pennsylvania Medicaid did provide technical assistance support.⁶ Not getting additional funds presented a challenge for the hospitals that had to find and dedicate funds to implement PARHM-related activities.⁶ These hospitals told federal auditors that additional funds would have allowed them to hire staff to implement programs, including care coordinators for substance use disorder treatment, or to invest in IT infrastructure to expand telehealth services.⁶

Authorities (state and federal)

Global payments have primarily been used within Medicare and with commercial populations.³ As Medicaid programs consider implementing the strategy they will need to take into consideration that the population they serve is more diverse and has higher health needs than the other payers. In addition, some populations such as children within Medicaid have special protections and services under federal law that must be guaranteed under global payment arrangements.³

To ensure adequate access under such models, Medicaid programs will need to conduct an assessment about the ability of providers to accept global payments.³ There is also a greater use within Medicaid of community health centers, which may have more limited access to capital financing to implement the IT and other infrastructure needed to launch global payments.³

In the event Medicaid programs decide to move forward with the use of global payments they could do so in 3 ways: via state plan amendments (SPAs), existing managed care authorities, or a section 1115 waiver:

- Under an SPA, state Medicaid programs must ensure via methodology documentation that global payments are consistent, would ensure quality of care, and be sufficient enough to enlist enough providers. State Medicaid staff will need to outline which claims and pay-

ment data will be used to determine advanced payments, including the source of data, the time period of the data, and how the data will account for population cost variation.³⁶

- Under managed care, state Medicaid programs may develop and implement specific plan procurement or contracting strategies to implement global payments for providers.³⁶
- Should state Medicaid officials decide to pursue such a change via a section 1115 waiver, they would need to outline its payment methodology to CMS officials and how patient attribution, applicable measures, achievement targets, approach to risk-bearing, and incentive payment methodology would be performed or developed.³⁶

Other briefs in this series

- [Bundled Payments](#)
- [Capitated Payments](#)
- [Cost Growth Targets](#)
- [Outcome Incentives and Disincentives](#)

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