

Hospitals Investing in Health: Community Benefit in Massachusetts

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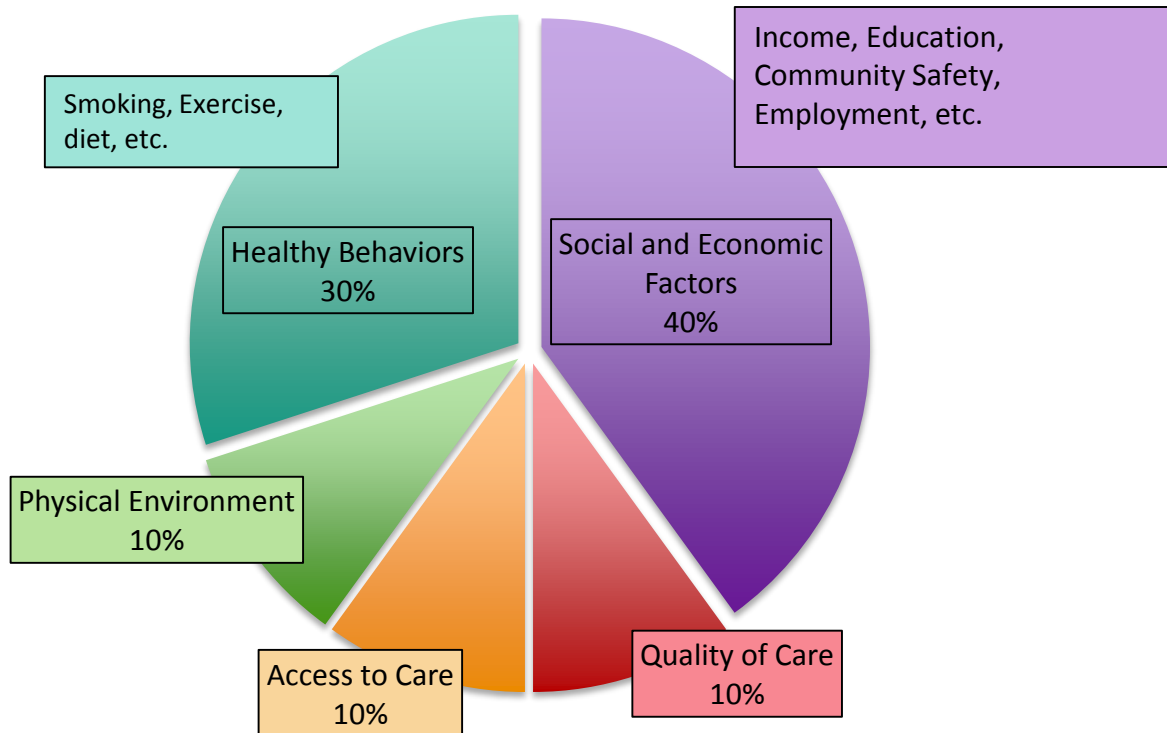
October 26, 2016
Boston

Key highlights of our report

- Movement to address “social determinants” and advance equity is connecting with healthcare providers strategic needs
- Provide a summary overview of MA hospitals’ community benefit resource commitments and programmatic efforts
- Discuss governmental oversight schemes for community benefit guidelines, Determination of Need and PILOT programs
- Share recommendations for policy makers and stakeholders to help catalyze some important conversations

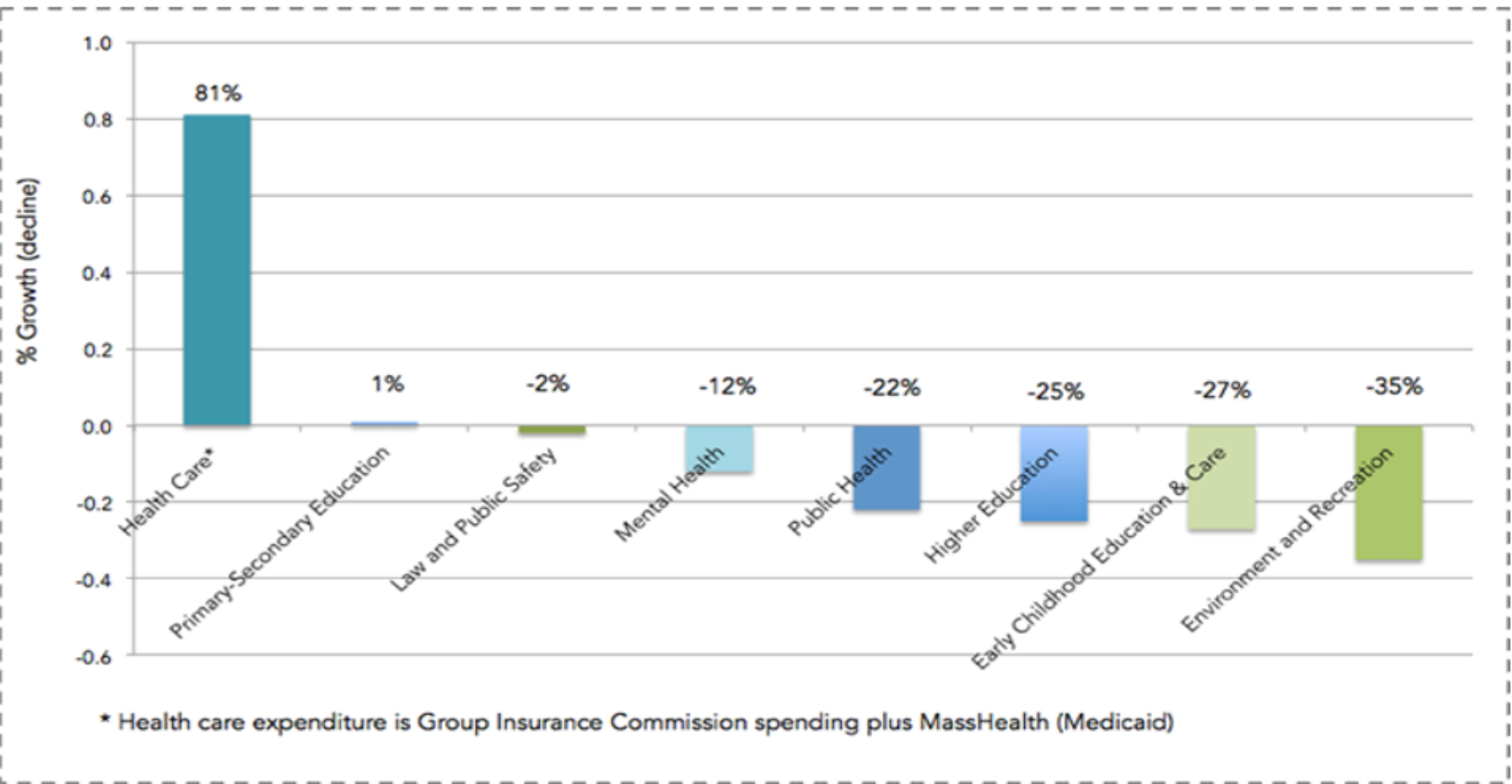
**MOMENT IN TIME:
SOCIAL DETERMINANTS OF
HEALTH AND ADVANCING EQUITY
FOCUS**

Health is primarily defined by social and economic determinants



Data from "County Health Rankings and Roadmaps, University of Wisconsin Population Health Institute

Massachusetts resource commitments disproportionately focused on health care spending 2001-2014



COMMUNITY BENEFIT RESOURCE COMMITMENTS OF MASSACHUSETTS HOSPITALS

Attorney General Annual Community Benefit Report

Expenditures Utilized in the Report

Direct Community Benefit Spending

Determination of Need Expenditures

Total Net Charity Care Spending

Total Community Benefit Spending

Total Patient Expenses

FY 2015 Massachusetts Community Benefit Spending

Massachusetts hospitals

\$564 million in community benefits =

- \$243 m in direct community benefit spending
- \$247 m in charity care spending
- \$74 m in other spending* **

Boston Hospitals

\$297 million in community benefits =

- \$139 m in direct community benefit spending
- \$117 m in charity care spending
- \$41 m in other spending

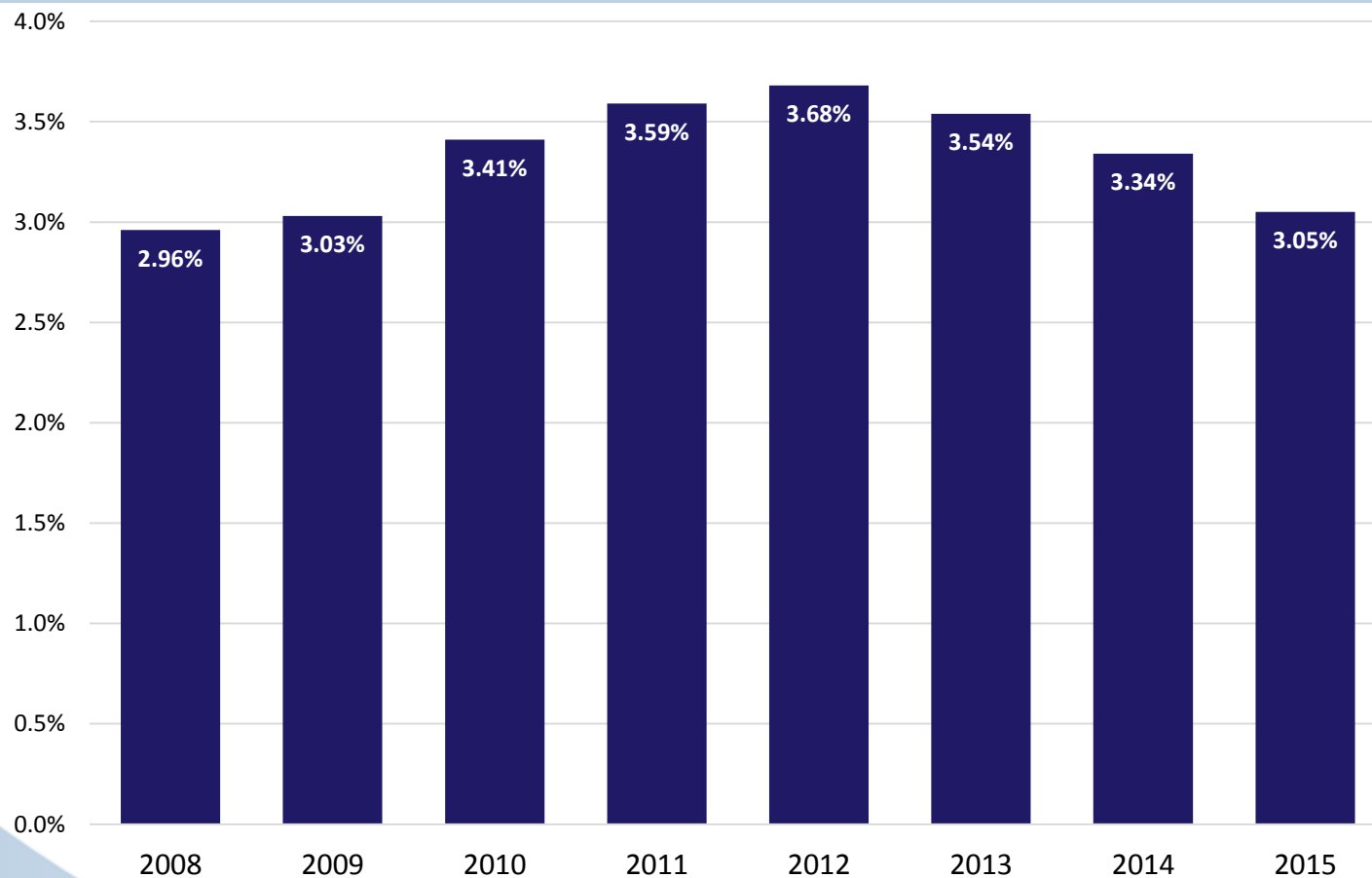
*Data available at

http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

Boston Medical Center and Cambridge Health Alliance did not report during this period

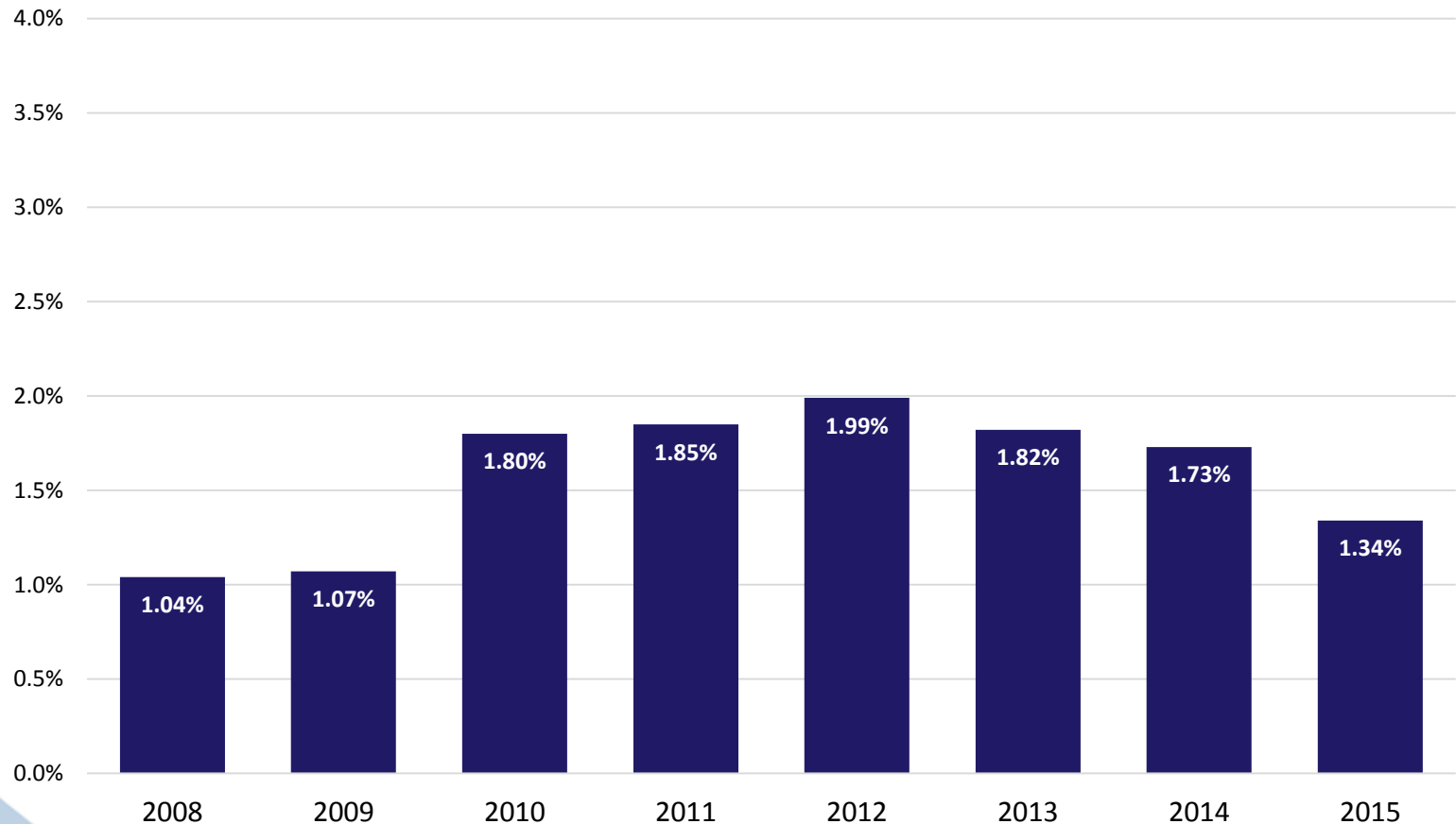
**State wide numbers exclude Metro West and St Vincent's Hospital due to insufficient reporting and Quincy Medical Center which closed during this period.

Total Community Benefit Spending as Percentage of Total Patient Expenses FY 2008 - FY 2015



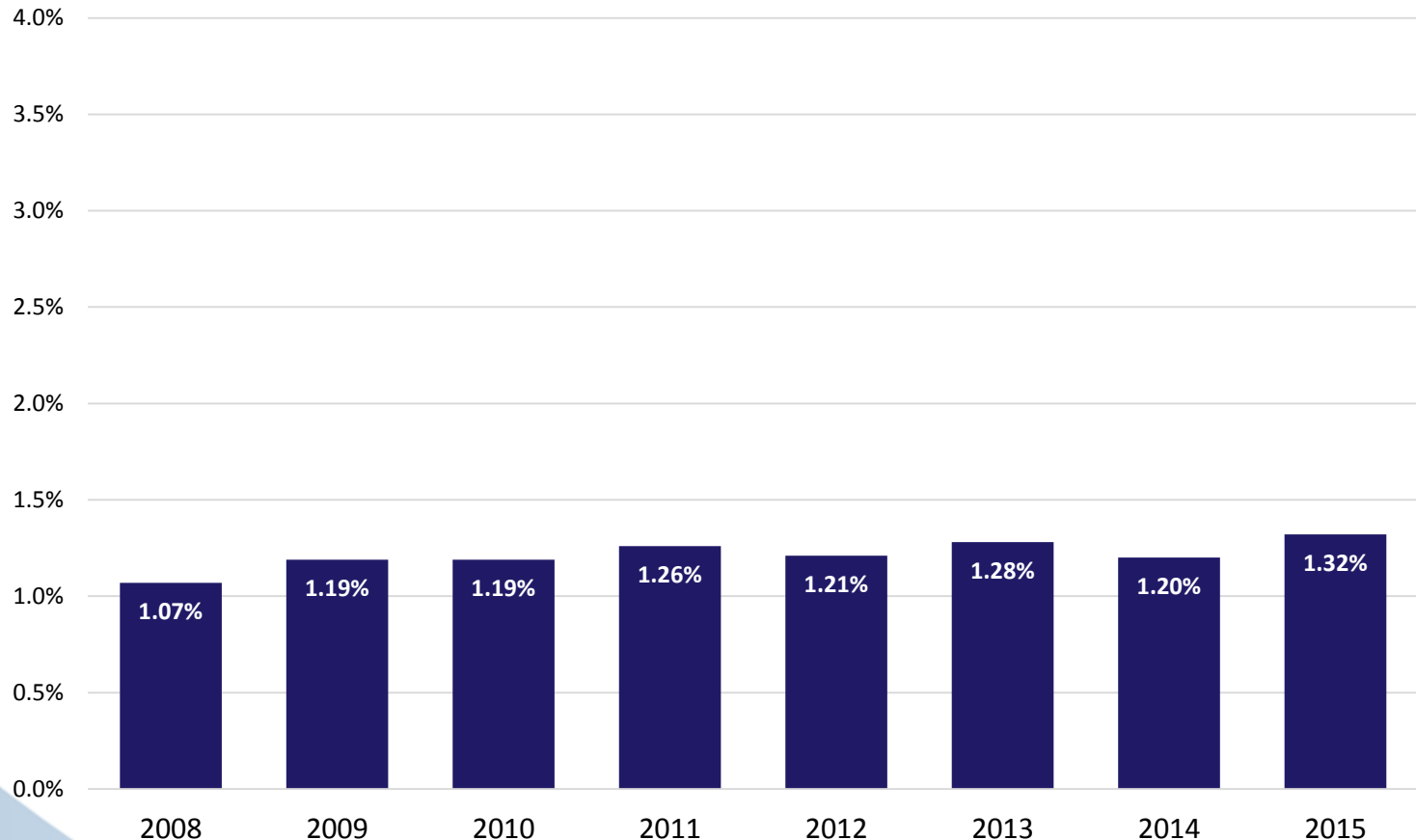
Source: Analysis of data from the Massachusetts attorney general's website:
http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse

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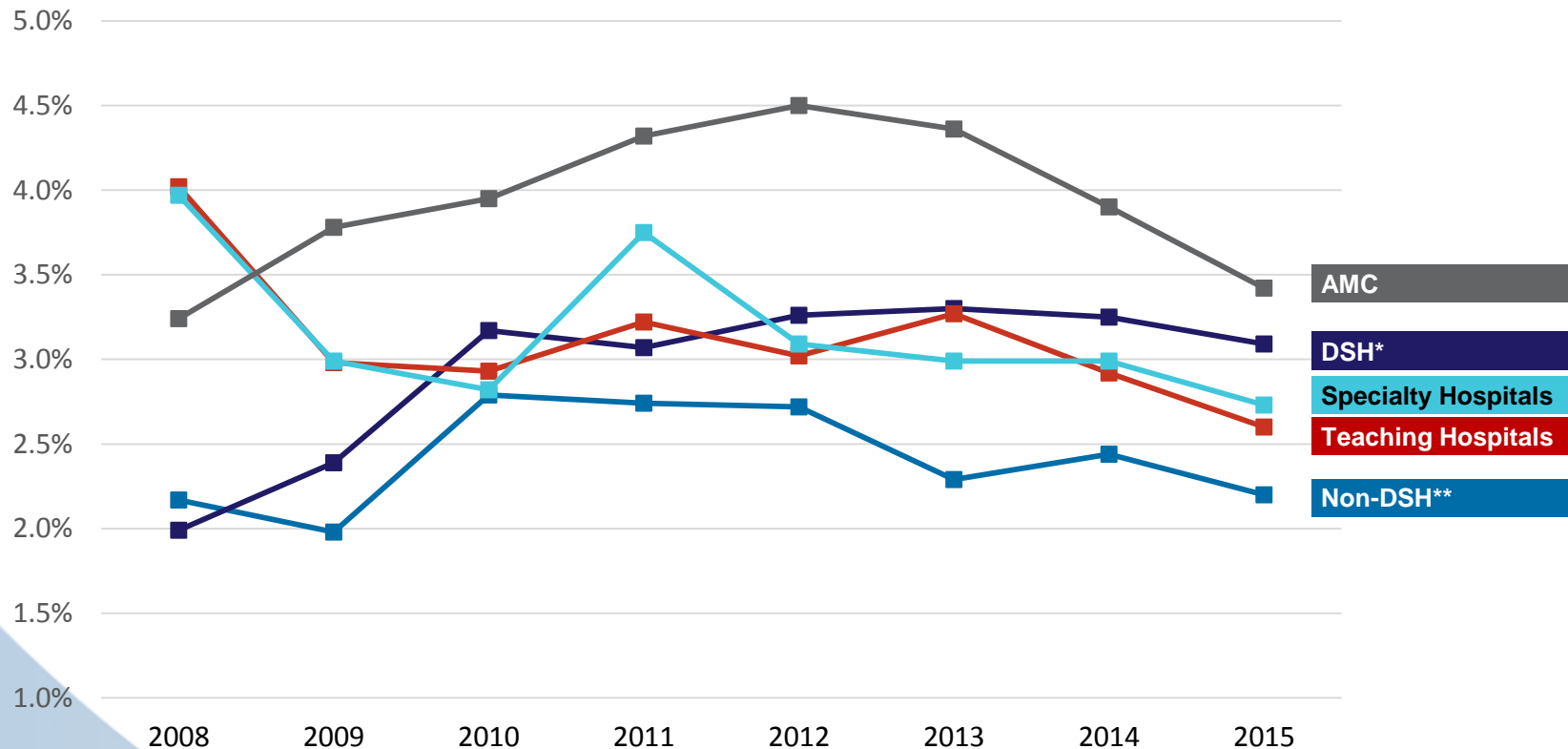
Total Tax Exempt Hospital Spending as Percentage of Total Patient Expenses FY 2015

Hospital Annual Total Patient Expenses (TPE)*	Number of Hospitals Spending <3% TPE For Community Benefits	Number of Hospitals Spending >3% TPE For Community Benefits
Less than \$200 Million	20	4
More than \$200 Million	14	10

About 70% of tax exempt hospitals reported community benefit spending at a level that was less than the 3% suggested “target level” discussed in the Attorney General Community Benefit Guidelines.

*This data excludes MetroWest, St Vincent’s and QMC.

Total Community Benefit Spending by Hospital Cohort as Percentage of Total Patient Expenses FY 2008 - FY 2015



* Community DSH hospitals are those community hospitals that receive at least 63 percent of their gross patient service revenue from government payers.

** Community Non-DSH hospitals are non-specialty acute hospitals that are not AMCs or teaching hospitals, and receive less than 63 percent of their gross patient service revenue from government payers.

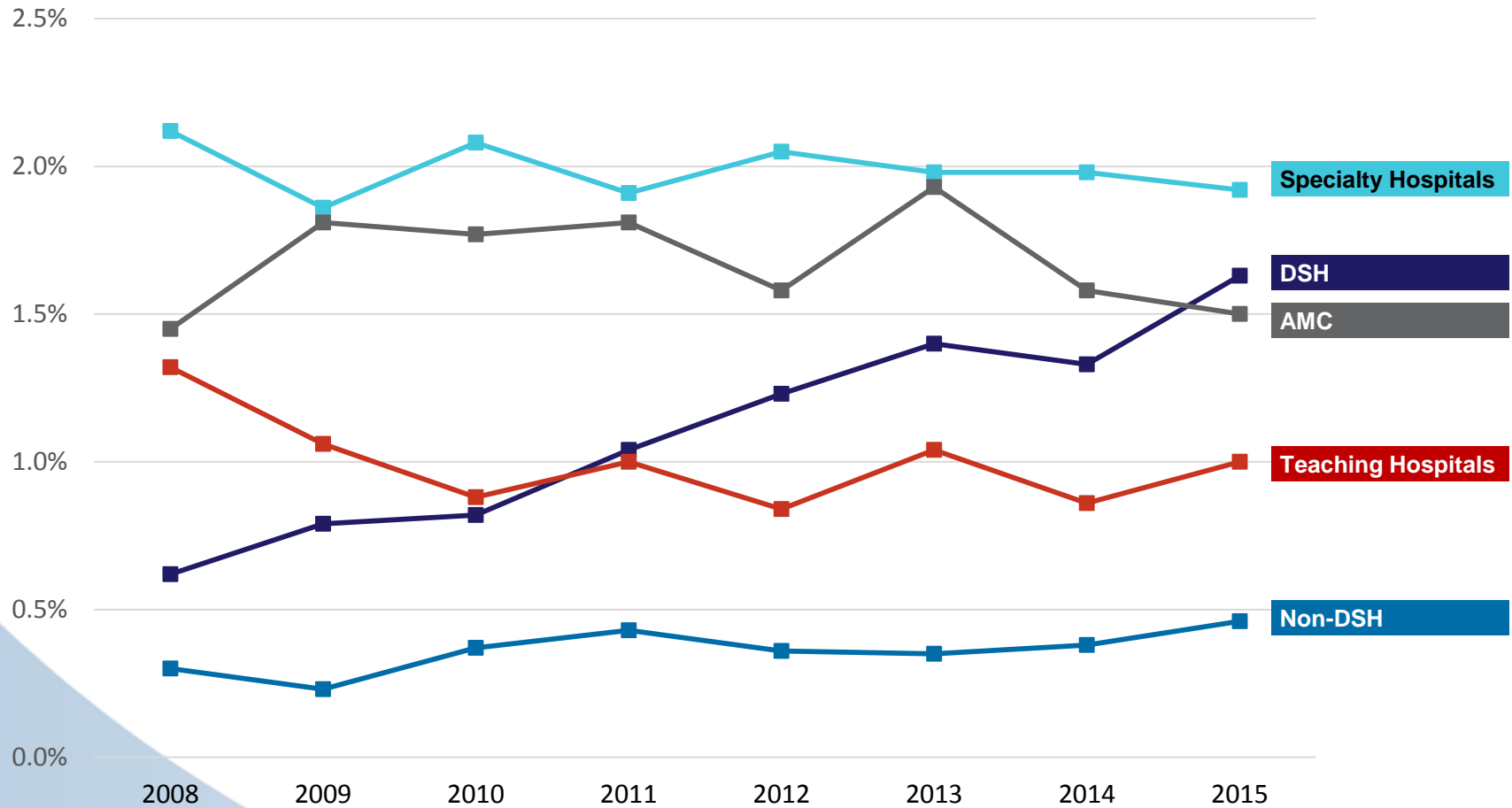
Sources: Hospital designations are from Massachusetts Health Policy Commission Report, Community Hospitals at a Crossroads, January 2016, which utilizes the 2013 cohorts. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>.

Analysis of data from the Massachusetts attorney general's website:

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Sources: Hospital designations are from Massachusetts Health Policy Commission Report, Community Hospitals at a Crossroads, January 2016. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>.
 Analysis of data from the Massachusetts attorney general's website:
http://www.cbsys.ag.state.ma.us/cbpublic/public/hccdownloadreportdatanew.aspx?report_year=2015.

GOVERNMENTAL OVERSIGHT RELATING TO COMMUNITY BENEFIT AND COMMUNITY HEALTH IMPROVEMENT

Multiple agencies with varying oversight leads to fragmentation and lack of strategic investment



Attorney General community benefit program reporting

- Difficult to determine overarching community benefit hospital strategies and priorities
- Lack of uniform coding of community benefit programs
- Reports contain program outcomes but minimal measures tied to population health outcomes, making overall evaluation difficult
- CB investments significantly weighted towards medical care interventions

Fragmentation at provider and oversight level

- Hospitals offer duplicate or competing efforts in some communities for similar health improvement goals
- Lack of strategic approach on community benefit in geographic areas where many providers co-exist
- Some geographic areas receive heightened attention for community benefit efforts and others receive less
- Attorney General oversight accomplished without regard to parallel efforts tied to DoN commitments or PILOT initiatives

Current level of community engagement in community benefit process

- No clear standard of community engagement
- Community partners reported are often organizations consulted only for the assessment process. Few reports of long term, community based partners and their role in setting priorities, financial decisions or implementation of project.
- Burden on community groups to respond after the fact, via web-based commenting process.
- Types of community based organizations engaged not always reflective of the full community or as expansive as the IRS rules allow

COMMUNITY HEALTH EFFORTS AND SPENDING RELATED TO DoN AND PILOT PAYMENTS

Acknowledged areas for improvement in current Determination of Need program

- Over \$64 m in DoN spending reported to the Attorney General since FY 2008
- Funds not documented to ensure spending directly contributes to increased health outcomes and lower costs
- Uncoordinated investments across many issue areas
- Not publicly planned or competitively procured with unclear DPH role

Current level of community engagement does not create sustainable partnerships at the DoN level

- Lack of clear standards in community engagement
- Uneven or limited community engagement in long term planning and implementation of initiatives prevents maximum community health impact
- Need to identify ways to achieve higher value community impact and advance key health priorities through CHI investments

<http://blog.mass.gov/publichealth/wp-content/uploads/sites/11/2016/08/Determination-of-Need.pdf>

PILOT: Payment In Lieu Of Taxes

- Municipalities enact programs to provide funds that offset the loss of property tax for tax exempt properties.
- Institutions with property valued in excess of \$15 m are expected to pay 25% of the potential property tax for city services.
- Hospitals can offset 50% of the PILOT with community benefit programs that meets needs of Boston residents.
- Boston collected \$14.9 m in payments from these hospitals and received \$14.5 m in community benefits.
- Unclear whether PILOT in-kind projects are distinct from or aligned with existing Attorney General community benefit programs. There is no requirement of community engagement.

[Boston PILOT Payments at](https://www.boston.gov/sites/default/files/fy15_pilot_results_for_web.pdf)

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Current assessment is at 2011 levels.

A moment in time



RECOMMENDATIONS

Recommendation 1:

Build on the strong base of current CB guidelines

- **Planning:** Hospitals should include prospective *implementation plans* for the upcoming year and provide an annual evaluation of the prior year's plan
- **Improve Reporting:** More specific detail about spending for specific activities and a clearer coding/classification process for activities
- **Community Engagement:** Encourage all hospitals to hold annual public meetings to discuss implementation plans, review progress to date, and share planned updates. Hospitals should also report on the scope of their community engagement.

Recommendation 2:

Align CB guidelines with existing federal and state rules

- As appropriate, take advantage of IRS encouragement of cooperative community benefits planning and implementation
- Support greater 'social determinant' efforts through use of IRS language describing health needs that may be addressed
- Build on state and federal guidelines to protect low- and moderate-income families from medical debt

Recommendation 3:

Align the DoN process with community benefit planning and oversight

- Create **one** clear standard for community engagement that incorporates key principles for all stages: planning through implementation and evaluation.
- Encourage CHI investments to be aligned with hospital community benefits planning
- Provide greater oversight and evaluation of the CHI process.
- Insure better state geographic equity for resources invested in CHI

Recommendation 4:

Develop a common statewide approach on community benefits and ‘population health’

- Interagency discussions and planning which touch upon these issues should try to develop a common value-added framework
- As the health care delivery and payment systems evolve—take advantage of opportunities to clarify how community health improvement priorities can be supported

Recommendation 5:

Evaluate community benefit practices to meet community health needs

- Convene a technical group to develop evaluation metrics for process and outcome measures for community benefit programs
- Create a 'pilot' evaluation process to test the usefulness of those process and outcome measures relating to population and community health

Thank You

