Hospitals’ Role in Population Health: How Can States Leverage Community Benefits and Health Improvement Activities?

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Introduction: Why we are focusing on the role of hospitals in improving population health

- There is a general expectation hospitals should be involved in population health improvement; today we will discuss factors that contribute to that expectation, and explore whether there is common ground on which to build policy and practice.

- Key questions to be covered:
  - Nonprofit hospitals are required by federal and state policy to demonstrate community benefit and impact on community health. What are they contributing and is it effective?
  - Hospitals are a significant component of health care utilization and cost. How are hospitals participating in accountable care models that include population health goals and metrics?
  - Hospital systems are getting bigger and spreading across state lines. What is the impact of new hospital business models on state regulation and population health activities?
Presentation Overview

- How is Hospital Community Benefit (HCB) measured and reported?
  - Federal policy
  - State policies

- State HCB policy levers
  - Governance
  - Financial incentives
  - Regulatory activities
  - Coordination of planning, measurement activities with hospitals
Federal and State Policies for HCB Reporting
Policy for HCB definitions and reporting starts at the federal level

- The IRS is the regulating agency

- HCB are reported on IRS Form 990 Schedule H

- HCB are broadly defined as *initiatives*, *activities*, and *investments* undertaken by *tax-exempt* hospitals to improve health in the communities they serve
Most HCB reported by hospitals to the IRS are charity care.

“Charity Care and Other Direct Patient Services” consists of:

- Financial assistance for uninsured and underinsured patients
- Shortfall from Medicaid and any other means-tested government programs
“Direct Community Health Improvement” consists of:

- Activities or programs aimed at improving community health
- Community benefit operations
- The need for the activity or program must be clearly documented (i.e., community health needs assessments [CHNAs], request from a local health department)
Caveats and Limitations of Federal HCB Data

- Hospitals have latitude regarding how they define cost
- Self-reported by hospitals
  - Are instructions followed in a consistent manner?
  - Does the IRS audit these data?
- Reported at system level; data for individual hospitals are not broken down
- “Community Building” is reported but does not count in the HCB calculation (e.g., housing, economic development, community support, environmental improvement, coalition building, community health improvement advocacy, work force development)
The Affordable Care Act (2010) set forth new requirements that significantly broaden HCB responsibilities

- In addition to data on HCB expenditures, nonprofit hospitals must:
  - Perform CHNAs at least every 3 years, taking into account input from persons representing community interests
  - Adopt an implementation strategy to meet community health needs
  - Have written financial assistance policies
  - Report on needs being met, why identified needs are not being met, levels of charity care provided, and costs incurred for community benefit activities
The 2014 IRS Final Rule* further clarifies and supports community health improvement activities by hospitals

- Community health needs broadly defined: hospitals must address financial and other barriers to care but also social determinants: prevention, nutrition, other social, behavioral, and environmental factors that influence health in the community.

- CHNA implementation plans must demonstrate an impact that addresses the significant health needs identified in the hospital facility’s prior CHNA(s).

A new website will analyze and display Schedule H data from nonprofit hospitals

Developed and sponsored by:
RTI International
Public Health Institute
The Robert Wood Johnson Foundation

Preview available at
http://www.hospitalcommunitybenefit.org
To monitor HCB, states can start by using IRS reported data

- IRS data has limitations but it is a starting point

- States can make the IRS data more useful by:
  
  - Collecting and analyzing hospital-specific **Schedule H** data in electronic form to facilitate aggregation and trending of financial data for planning, transparency, and compliance
  
  - Collecting and analyzing information from hospital **CHNAs** to align priorities, planning, and performance metrics
States can also require additional HCB reporting as these 31 states have done.

Source: The Hilltop Institute, June 2016
Funded by: The Kresge Foundation
http://www.hilltopinstitute.org/hcbp_cbl.cfm
Examples of additional state reporting requirements

- Voluntary guidelines for community benefit programs
- Specific reporting for charity care expenses, other hospital financial data
- Filing Schedule H with the state
- In-depth reporting in categories beyond Schedule H
- HCB data required for CON
- See Appendix for examples
Other data sources can augment HCB reporting & create a “bigger picture” of needs and resources

- Hospital cost reports
- State Health Improvement Plan (SHIP) metrics
- Medicaid eligibility, claims, and encounter data
- All payer claims databases
- Data submitted for CON applications
- State-administered surveys
- Federal surveys (e.g., Census data, American Community Survey, Behavioral Risk Factor Surveillance System, National Health and Nutrition Examination Survey, National Health and Aging Trends Study)
In Maryland, Hilltop is helping the state build a new reporting tool

- The Maryland Health Services Cost Review Commission has responsibility for HCB reporting and administers the state’s All-Payer Model
  - Population health improvement is a stated goal of the All-Payer Model
- Hilltop is developing a web-based tool for data collection that will facilitate aggregation, analysis, and trending:
  - Community benefit service area (for geo-mapping)
  - Community Health Needs Assessments—partners, identified needs, and priorities
  - Community benefit staff roles/responsibilities
  - External collaborations
  - Community benefit initiatives
111 Maryland zip codes are not part of any hospital’s CBSA

5 Maryland zip codes are covered by 8 or more hospitals
Discussion Questions

- What entities in your state work with hospitals on HCB data collection? (Health Department, AG?)

- What information is available about HCB—either for specific hospitals or aggregate data?

- What are the trends in hospital HCB spending in your state?

- Hilltop’s data about state laws were updated in June 2016. Has there been any legislative or regulatory action in your states that we may have missed?
State Policy Levers to Guide HCB Spending and Activities
The Triple Aim and Population Health Improvement

Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group. ... many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level (Kindig & Stoddart, 2003).
States are increasingly focused on population health improvement to advance the Triple Aim

- SHIPs
- State Innovation Model (SIM) projects
- Medicaid 1115 demonstration waivers
- Health homes
- Public health accreditation
Many other forces are converging as well, prompting hospitals to redefine their role in the community

- Payers – particularly Medicaid – are including population health improvement measures in their contracts

- Hospital business model shifting from volume to value
  - Alternative payment models (e.g., accountable care organizations [ACOs])
  - Global budgets

- Vertical and horizontal integration; hospitals and health systems becoming insurers
Is there a shared vision in your state regarding the role of hospitals in population health improvement?
State policy levers to define and oversee HCB

- Governance
- Financial incentives
- Regulation
- Collaboration
Components of state-level governance

- Who’s in charge of your state’s hospital strategy – in general and specific to HCB? What are their roles and responsibilities?

- Cross-agency collaboration (state and local health departments, attorney general’s office)

- Stakeholder engagement and buy-in
  - Community input
  - Hospital input
Policy levers that create financial incentives to improve population health

- Payment reform
- Value-based purchasing
- State grant programs
Some examples of states using financial incentives

- **Maryland**: Global budgets for hospitals in 2014 as part of its All-Payer Model; transformation implementation grants, care redesign programs, and community health resources.

- **New York**: State health improvement goals embedded in SIM and DSRIP payment reforms.

- **Medicaid ACOs**:
  - **New Jersey**: 2011 law required a 3-year demonstration project launching in 2015; partnership with Nicholson Foundation, which is sponsoring a learning network and infrastructure support to local coalitions.
  - **Vermont**: Medicaid Shared Savings Program launched in 2015; Vermont Next Gen ACO now under development (includes SDH performance measures).
Regulatory policy levers that promote hospital involvement in population health improvement

- Require hospital HCB priorities to align with state priorities
- Require reporting and dissemination of hospital performance metrics
- Establish a threshold for HCB spending by hospitals
Some examples of states using regulatory requirements

- States may specify a minimum level of charity care that a nonprofit hospital must provide:
  - **Illinois** and **Texas** specify the minimum to qualify for state tax exemption.
  - **Pennsylvania’s Institutions of Purely Public Charity Act** permits most nonprofit hospitals to choose from among seven alternative community benefit standards; six of the standards specify a minimum level of community benefits.
  - **Utah** requires, as a condition of property tax exemption, a nonprofit hospital to contribute annual “gifts to the community” in an amount exceeding the value of its annual property tax liability.
Other examples of states using regulatory requirements

- **Maryland, Indiana, and Texas** can impose civil penalties on hospitals for overdue community benefit reports.

- **Indiana** and **Maryland** hospitals must report on the effectiveness of community benefit initiatives.

- **Massachusetts** stresses setting measurable goals for community benefit programs and encourages using existing health status indicators for baseline measures.
Policy levers to promote collaborative planning at the local/state/regional levels

- SHIPs

- Hospital CHNAs required at least every 3 years
  - States have the opportunity to align the timing and focus of these activities
  - Local benefits to collaboration – shared data resources between hospitals and community; focus on common measures for improvement
Some examples of collaborative planning

- **New York:** Department of Health called on hospitals to participate in a collaborative approach to community health assessment and planning; also to identify two New York State Prevention Agenda priorities and at least one health disparity to address with community partners.

- **Utah:** Updated its State Health Assessment to include input from partners beyond the Department of Health and local health departments; actively collaborating with Intermountain Healthcare system—and more recently, the University of Utah—to align and address priorities.
Introducing the next part of discussion

- States differ in their view of hospitals’ role in population health and how best to guide their investments and activities:
  - If you think it should be a smaller role - HCB is required by the federal government, so how can you make the most of it?
  - If you think the hospitals’ role should be more robust – how have/would you augment the federal requirements?
Discussion Questions

- Do you have a strategy about hospitals relating to cost, quality, and delivery system reform?

- Does your strategy include a shared vision regarding the role of hospitals in improving population health?

- Are you using any of these policy levers to encourage hospitals to address population health improvement through HCB activities and initiatives?
  - Financial incentives
  - Regulatory strategies
  - Collaborative planning
Discussion Questions continued

- Are outside stakeholders interested in this work? If so, what is their role?
- What resources are available to help you develop and execute your strategy?
  - Data—hospital reports, state data, federal data
  - Partners—state/local agencies, hospitals, community groups, foundations
- What other resources or tools would be helpful?
- How would you get started?
About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

www.hilltopinstitute.org
Appendix: Examples of state reporting requirements

- California requires nonprofit hospitals to annually submit community benefit plans specifying the economic value of the community benefits to be provided.
- Idaho requires nonprofit hospitals with at least 150 beds to report community benefits.
- Indiana requires nonprofit hospitals to file an annual report of their community benefit plans with the Indiana Department of Health.
Appendix: Examples of state reporting requirements

- New Mexico requires hospitals to report costs associated with charity care.
- Ohio requires hospitals participating in the Hospital Care Assurance Program to collect and report information on the identity and number of people who receive free care to the Department of Medicaid.
- Utah requires community benefit reporting as a condition of property tax exemption.
- Washington requires nonprofit and for-profit hospitals to report charity care provided.
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