How States Can Leverage Hospital Community Benefit Policies to Advance Community Health and Equity

Monday, April 26th, 2021
3-4pm ET
Agenda

- Welcome & logistics
  - Jill Rosenthal, NASHP
- Community benefit overview
  - Allie Atkeson, NASHP
- State presentation: Massachusetts
  - Sandra Wolitzky, Office of Attorney General Maura Healey
  - Noam Yossefy, Office of Attorney General Maura Healey
- State presentation: Oregon
  - Amy Clary, Oregon Health Authority
  - Steven Ranzoni, Oregon Health Authority
- Q & A
Webinar Logistics

- All participants are currently in “listen-only” mode.
- Please share your questions by typing in the Q&A box.
- For tech support, please contact Kelcey Mckinley in the Q&A box.
COVID-19 has highlighted long-standing health inequities across the United States

![Bar chart showing age-adjusted COVID-19 deaths per 100,000 Americans through Aug 18, 2020.]

- **Black**: 118.8
- **Indigenous**: 111.8
- **Pacific Islander**: 105.6
- **Latinx**: 99.2
- **Asian**: 44.8
- **White**: 33.3

Image source: Olivia Foster Rhoades, Harvard University

Investing in social determinants of health can reduce health disparities and advance equity.

- Interventions that address community needs such as housing, income and nutrition support, care coordination, and community outreach can improve health outcomes and reduce health care spending.
- Addressing social needs is also shown to reduce racial disparities.
- Hospitals play an important role in communities as anchor institutions and have an obligation to address these issues.
How do hospitals learn what communities need?

- The Affordable Care Act requires nonprofit hospitals to conduct community health needs assessments (CHNAs) every three years.
- A CHNA’s goal is to identify the most critical health priorities with the help of community members.
- Each hospital must complete a CHNA and develop an implementation strategy to address identified community needs in order to maintain its nonprofit status.
Do hospital community benefit dollars address identified needs?

- A **2017 study** found that in hospital CHNAs:
  - 65% cited health disparities/health equity explicitly;
  - 100% referenced health equity implicitly; and
  - 75% reported external stakeholders identified a need for health equity.
- Yet, only **9% included strategies to address health disparities** in their implementation plans.
Does hospital community benefit spending address social determinants of health?

Charity Care and Certain Other Community Benefits at Cost for Tax Year 2016

- Charity care at cost, 17%
- Unreimbursed Medicaid, 46%
- Unreimbursed costs—other means-tested government programs, 2%
- Unreimbursed costs—other means-tested government programs, 2%
- Community health improvement services and community benefit operations, 3%
- Health professions education, 15%
- Subsidized health services, 9%
- Research, 5%
- Cash and in-kind contributions to community groups, 3%

Current oversight and spending are insufficient for improving community health and advancing equity

- Nonprofit hospitals received over $24 billion in tax exemptions in 2011.
- There is no federal minimum level of community benefit spending required.

- Community health needs assessments identify health equity priorities, but there is no oversight for spending on those needs.

- Spending on community building, those activities that protect or improve a community’s health or safety, accounted for a median of 0.04% of total operating expenses by US hospitals in FY 16.
- A report found that in one state the hospital community benefit program had no impact on community health.
States can lead the way to ensure meaningful community benefit spending

- In exchange for tax exemption, non-profit hospitals must provide community benefit investments
- States can require minimum spending on community benefit

- States can
  - tie hospital community benefit spending to needs identified in the CHNA
  - require community service investments from hospitals
  - require hospitals to link spending to community health improvement activities for maximum impact

- States can evaluate the impact of community benefit programs
- States can use community benefit policy to address the social determinants of health and advance equity
Massachusetts Community Benefits

NASHP Community Benefit Webinar
April 26, 2021

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
Evolution of Community Benefits Reporting in MA

1994 – AGO issues Guidelines for Non-Profit Acute Care Hospitals
1996 – AGO issues Guidelines for HMOs
2002 – AGO revises hospital and HMO Guidelines
2009 – AGO issues further revisions to Guidelines
2009 – IRS introduces Form 990 Schedule H
2010 – Congress enacts ACA § 9007 / IRC § 501(r)
2015 – IRC § 501(r) final regulations in place
2017 – DPH revised Determination of Need standards
2018 – AGO publishes updated Community Benefits Guidelines

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Principles for Updated Guidelines

1. Better Align Reporting Requirements
2. Improve Community Engagement
3. Increase Transparency
4. Facilitate Investment in Common Priorities (e.g., social determinants, statewide public health issues)
5. Encourage Regional Collaboration and Learning
Community Engagement

• Diversity in Decision-Making
• Opportunity for Public Engagement
• Community Representative Feedback Forms
Investment in Common Priorities

**EOHHS Focus Issues**
- Chronic Disease
- Housing Stability & Homelessness
- Mental Illness & Mental Health
- Substance Use Disorders

**DoN Health Priorities**
- Built Environment
- Education
- Employment
- Housing
- Social Environment
- Violence

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Regional Collaboration

Areas for Collaboration

• Joint Community Health Needs Assessment
• Joint Implementation Strategy
• Sharing of Best Practices

Partners in Collaboration

• Hospitals and Other Providers
• Local Public Health Departments
• Community-Based Organizations

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## Program Data

### Populations Served
- Region Served
- Environment Served
- Gender
- Age Group
- Race / Ethnicity
- Languages

### Additional Target Population
- LGBT Status
- Disability Status
- Veteran Status
- Domestic Violence History
- Incarceration History
- Refugee / Immigrant Status
Oregon’s Hospital Community Benefit Program

NASHP Webinar
April 26, 2021

Amy Clary, Research and Data Unit, Office of Health Analytics
Steven Ranzoni, Hospital Reporting Program, Office of Health Analytics
Community Benefit in Oregon

HB 3290 creates Oregon’s cost-based community benefit reporting system

HPA starts new standard annual public reports

HB 3076 institutes spending floor (and more)

“Community benefit’ means a program or activity that provides treatment or promotes health and healing in response to an identified community need.”

“’Community benefit’ means a program or activity that provides treatment or promotes health and healing, addresses health disparities or addresses the social determinants of health in response to an identified community need.”

HEALTH POLICY AND ANALYTICS
Office of Health Analytics
Oregon HB 3076 (2019) …

- Increased hospital financial assistance and addressed medical debt
- Created a new hospital community benefit program and instituted a minimum spending floor
- Eliminated Medicare as a category of unreimbursed cost that counts toward community benefit
Financial Assistance

- Starting in 2020, non-profit hospitals must offer financial assistance to patients based on income relative to the federal poverty level (FPL), with stricter guidelines starting in 2021

<table>
<thead>
<tr>
<th>Income</th>
<th>Financial assistance as of Jan. 1, 2020</th>
<th>Financial assistance as of Jan. 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200% of FPL</td>
<td>Provided at no cost</td>
<td>Provided at no cost</td>
</tr>
<tr>
<td>200% to 300% of FPL</td>
<td>Hospital must adjust on a sliding scale</td>
<td>Reduced by at least 75%</td>
</tr>
<tr>
<td>300% to 350% of FPL</td>
<td></td>
<td>Reduced by at least 50%</td>
</tr>
<tr>
<td>350% to 400% of FPL</td>
<td></td>
<td>Reduced by at least 25%</td>
</tr>
</tbody>
</table>

- Financial assistance policy must be posted in multiple languages
Aligning to address the social determinants of health & health equity

• The legislation explicitly includes as community benefit activities that address health disparities and the social determinants of health

• The program encourages alignment with CCOs, local public health, other programs and partners

“Social determinants of health’ means the social, economic and environmental conditions in which people are born, grow, work, live and age, shaped by the distribution of money, power and resources at local, national and global levels, institutional bias, discrimination, racism and other factors.”
Oregon’s New Community Benefit Minimum Spending Floor

• Only six states have a spending requirement of any kind
• Only Oregon tailors a community benefit spending floor to each hospital or health system
• Program launched January 1, 2021. Two floors posted; more to come soon.
How to Set a Community Benefit Minimum Spending Floor?

HB 3076 required OHA to consider:

1. Historical & current expenditures on community benefits
2. Community needs as identified in the community needs assessments conducted by the hospital and CCOs that serve the same geographic area
3. The overall financial position of the hospital
4. The demographics of the population in the area served
5. The hospital’s need to expand the health care workforce
6. Spending on Social Determinants of Health
7. Taxes paid by the hospital
Statue requires OHA to...

- Develop minimum community benefit spending levels with input from:
  - Representatives of hospitals and hospital-affiliated clinics
  - The general public
  - Individuals with expertise in the economics of health care
- Allow hospitals to choose how OHA applies the spending floor to them (individual hospital and clinics, groups of hospitals and clinics, or entire system)
Spending Floor Approach

- Financial assistance shouldn’t be limited
- Applies to all categories of community benefit
- Prospective
- Uses existing data
- Simple, scalable, flexible
- Does not create negative trends
Spending Floor Methodology
The minimum community benefit level applies for two years

FY22 spending floor = 3-year average of unreimbursed care spending + (Direct Spending Net Patient Revenue Percentage x 3-year average operating margin multiplier)

FY23 spending floor = FY22 spending floor + (FY22 spending floor * 4-year average percent change in net patient revenue, capped at +/- 10%)

Methodology, Explained

Oregon’s formula separates unreimbursed care from investments in community benefit activities and programs, such as spending on social determinants of health or health equity.

*Three-year average of unreimbursed care* is the average of unreimbursed Medicaid, charity care, other public programs, and subsidized health services net costs for FY 2018 - FY 2020.
Methodology, Explained

Oregon’s formula expects more **direct spending** (on community building, social determinants, equity, health professions education) from DRG hospitals than from Type A and Type B hospitals.

*Direct Spending Net Patient Revenue Percentage* is a percentage of net patient revenue for FY 2020. It’s 1.5% for DRG hospitals and 1% for Types A and B.
Methodology, Explained

Oregon’s formula links the minimum spending floor to **operating margin**. Hospitals in robust financial health will have their spending floor adjusted **upward**. Hospitals that are financially struggling will have their spending floor **lowered**.
Transparency

Hospital Reporting Program

Office of Health Analytics
- About Us
- Contact Us

COMMITTEES & GROUPS:
- All Payer All Claims TAG
- APAC Payment Arrangement File Workgroup
- Child and Family Well-Being Measures Workgroup
- Data Review Committee

Community Benefit Minimum Spending Floor

FY22-23 Spending Floor Announcement

Proposed Minimum Spending Floors available for public comment

Legacy Health Minimum Spending Floor (posted 2/1/21)
Legacy Health Minimum Spending Floor Calculation Worksheet (posted 2/3/21)

Legacy Health Includes:
- Legacy Emanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Meridian Park Medical Center
- Legacy Mt Hood Medical Center
- Legacy Silverton Hospital

Legacy Health's Minimum Spending Floor is open for public comment until 3/2/2021

View documents and submit public comments at our website!

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
NEW Community Benefit Dashboard

Oregon hospitals invested $1.6 billion in community benefit statewide in 2019. The unreimbursed cost of care accounts for seventy-five percent of that, while the other twenty-five percent was direct spending in the community.

Unreimbursed cost of care includes the unreimbursed costs associated with providing Medicaid services, subsidized health services, charity care, and any other unreimbursed public program.

Direct community spending includes investments in programs or activities that seek to improve the health of communities and address the social determinants of health and health equity. It also includes investments in research and health professions education, as well as cash and in-kind contributions to groups working in the community.

Dashboard link: https://go.usa.gov/xsbGF

HEALTH POLICY AND ANALYTICS
Office of Health Analytics
NEW Data Reporting

- Hospitals must submit supplemental community benefit narratives beginning FY22
- WHO did they partner with?
- WHAT are the health needs?
- HOW did they address them?
- WHAT investments in SDoH?
Looking Ahead

Challenges

• Impact of COVID-19 on hospital financial trends
• The growth of unreimbursed cost of care

Opportunities

• Public reporting to encourage investments in health equity and upstream factors
• Strong collaboration with CCO community investments
• Emphasis on population health strategies
Community Benefit Resources

https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Hospital-Reporting.aspx
(Or type ‘Oregon Hospital Reporting Program’ in your search bar)

• Community Benefit Tableau Dashboard
• Summary reports
• Raw data
• Spending floor announcements

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Steven Ranzoni: steven.ranzoni@dhsoha.state.or.us
Hospital community benefit spending is an important tool for states in their health and economic recovery from COVID-19.

- NASHP Blogs:
  - Oregon and Connecticut Hold Hospitals Accountable for Meaningful Community Benefit Investment
  - Guest Blog: Massachusetts Attorney General Issues Recommendations to Address Health Inequities
- NASHP Tool: Hospital Community Benefit Spending on Health Equity
- NASHP Chart: How 10 States Connect their Health Improvement Goals to Hospital Community Benefits
- NASHP Community Benefit Resource Center

To learn more or join NASHP’s work on community benefit, contact Elinor Higgins ehiggins@nashp.org