Maryland Community Benefits Overview

January 24, 2020

Agenda

1. Introductions
2. Objectives of the Consumer Standing Advisory Committee
3. Background on the Maryland Total Cost of Care Model
4. Community Health Needs Assessments
5. Hospital Community Benefit Spending
6. Examples of Select Hospital's Community Health Needs and Benefits Spending
7. Aligning Community Benefits with Community Health Needs
8. Discussion and Next Steps

CSAC Objectives

Objectives for the Consumer Standing Advisory Committee

- Ensure the consumer perspective is reflected in, and remains central to, the TCOC Model, including:
  - Promoting a broad understanding of the TCOC Model and its impact on improving population health and health care for consumers/patients; and
  - Gathering input from patients and consumers and representing their voices to ensure that their perspectives are used to inform the design and management of state policies.
- Throughout 2020, the CSAC will narrow their focus to consider the benefit that Maryland hospitals operating under the TCOC Model create within their communities. This will include:
  - The amount of community benefit dollars that hospitals are spending in their communities;
  - Ensuring that a community and consumer health needs perspective is included in hospital community benefit spending decisions to help address identified community health needs and improve population health.

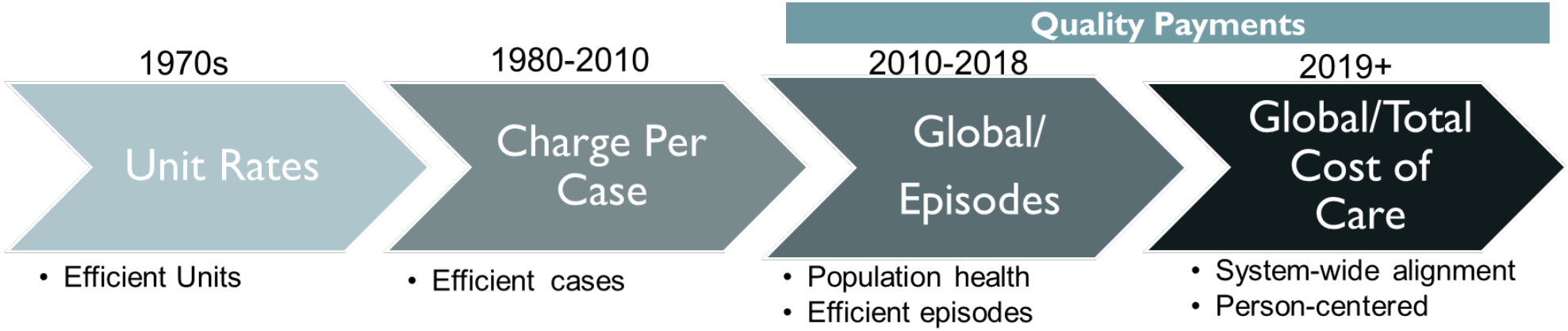
Initial Focus for the CSAC

- Assess the extent that hospital's community health needs assessment reflects local health needs and priorities:
  - Does the hospital's community health needs assessment reflect the needs and views of the community?
  - What are the best practices for hospitals to follow when partnering with the community?
- Assess the extent to which the hospital directs their community benefit spending towards community health needs:
  - Does the hospital's community benefit spending address a genuine community health need?
  - How much of the hospital's community benefit spending is directed towards community health needs?

TCOC Model Background

All-Payer Hospital Rate Setting and Maryland's All-Payer Model

Since 1977, Maryland has operated an all-payer, hospital rate setting system



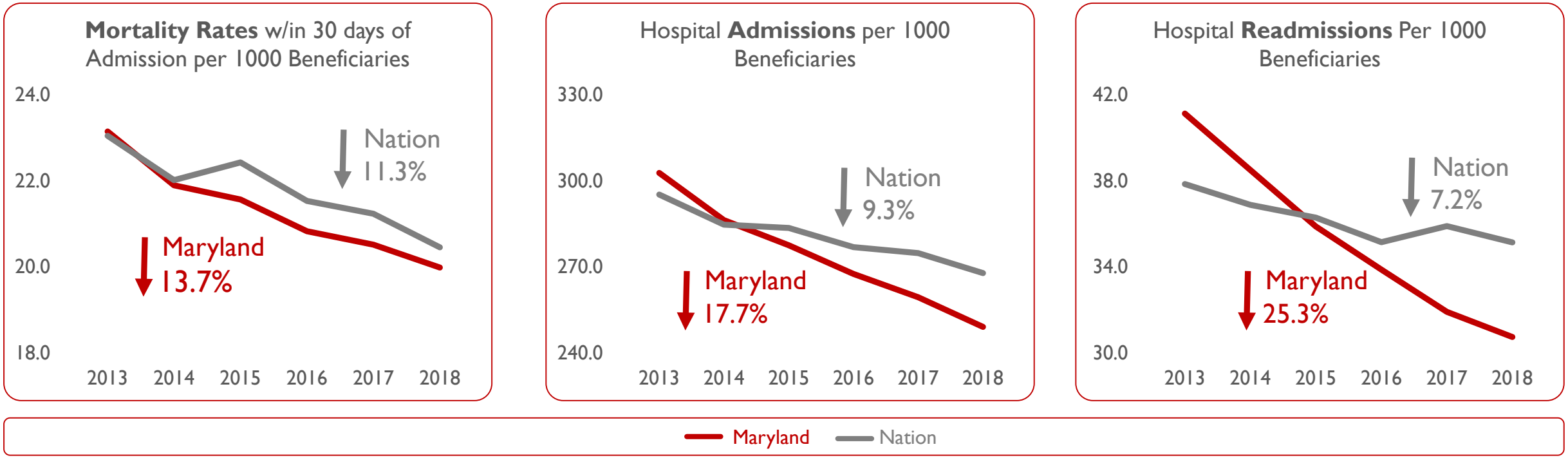
- In 2014, Maryland updated its rate setting approach through the All-Payer Model:
  - Patient-centered approach that focuses on improving care and outcomes
  - Per capita, value-based payment framework for hospitals
  - Stable and predictable revenues for hospitals, especially those providing rural healthcare
  - Provider-led efforts to reduce avoidable use and improve quality and coordination
  - Contractual agreement between Maryland and federal government

All-Payer Model Results, CY 2014-2018

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

*** $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate** (vs. 2013 base)

Progress Under the Maryland Health Model in Medicare FFS

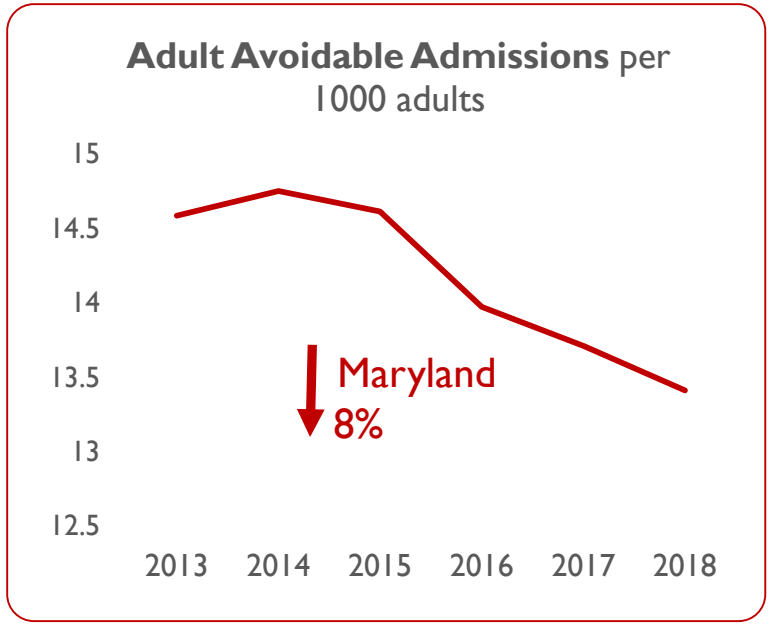


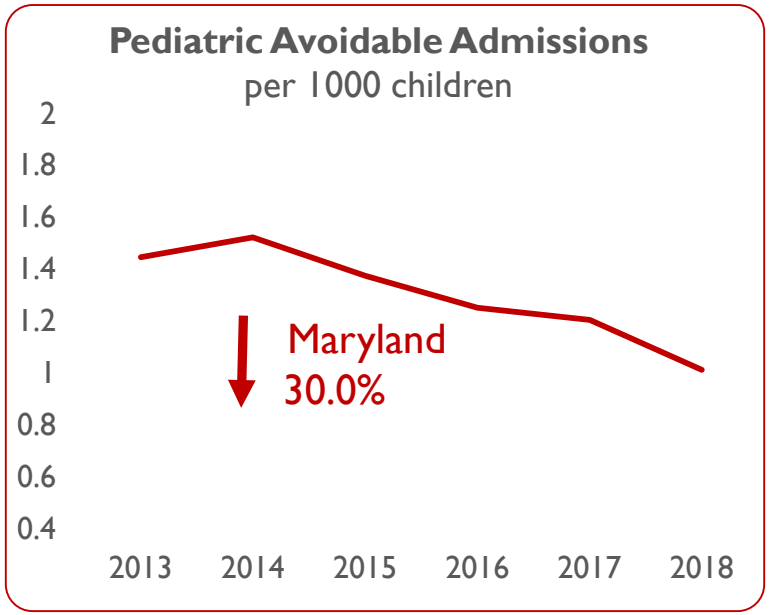
Maryland outperforming the nation on both cost and quality under the Maryland Model:

- Mortality **2.4%** point greater reduction than the nation among Medicare FFS beneficiaries
- Inpatient Admissions **8.4%** point greater reduction than the nation among Medicare FFS beneficiaries
- Inpatient Readmissions **18.1%** point greater reduction than the nation among Medicare FFS beneficiaries

Source: HSCRC analysis of data provided by CMMI, national 5% sample used to derive some national amounts.

Progress Under the Maryland Health Model in All-Payer Avoidable Admissions





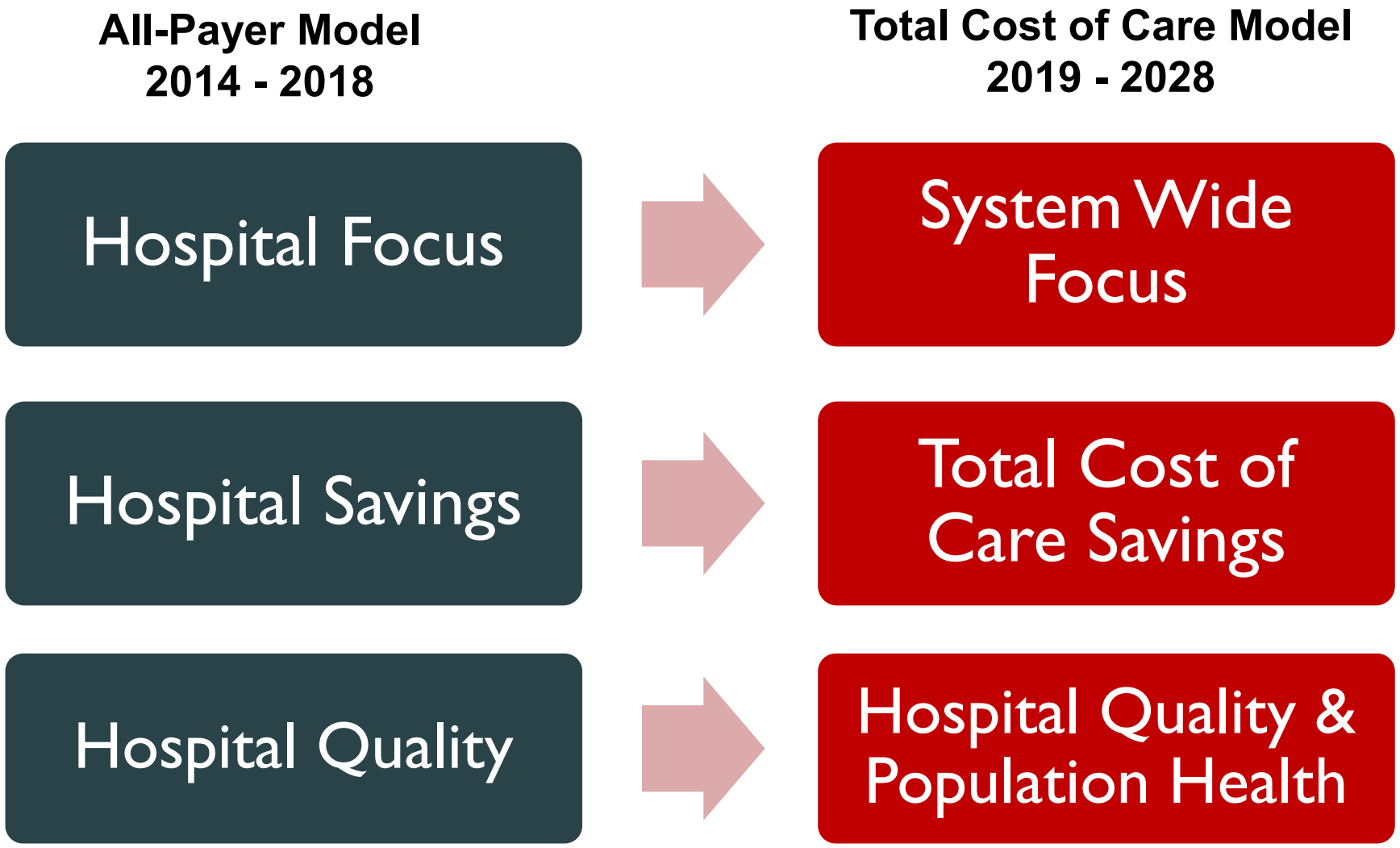
Maryland

Maryland experienced reductions in avoidable admissions under the Maryland Model:

- Adult Avoidable Admissions **8%** point reduction among Maryland adults
- Pediatric Avoidable Admissions **30%** point reduction among Maryland children (age 6-17)

Source: HSCRC analysis of HSCRC case-mix data, national comparison forthcoming

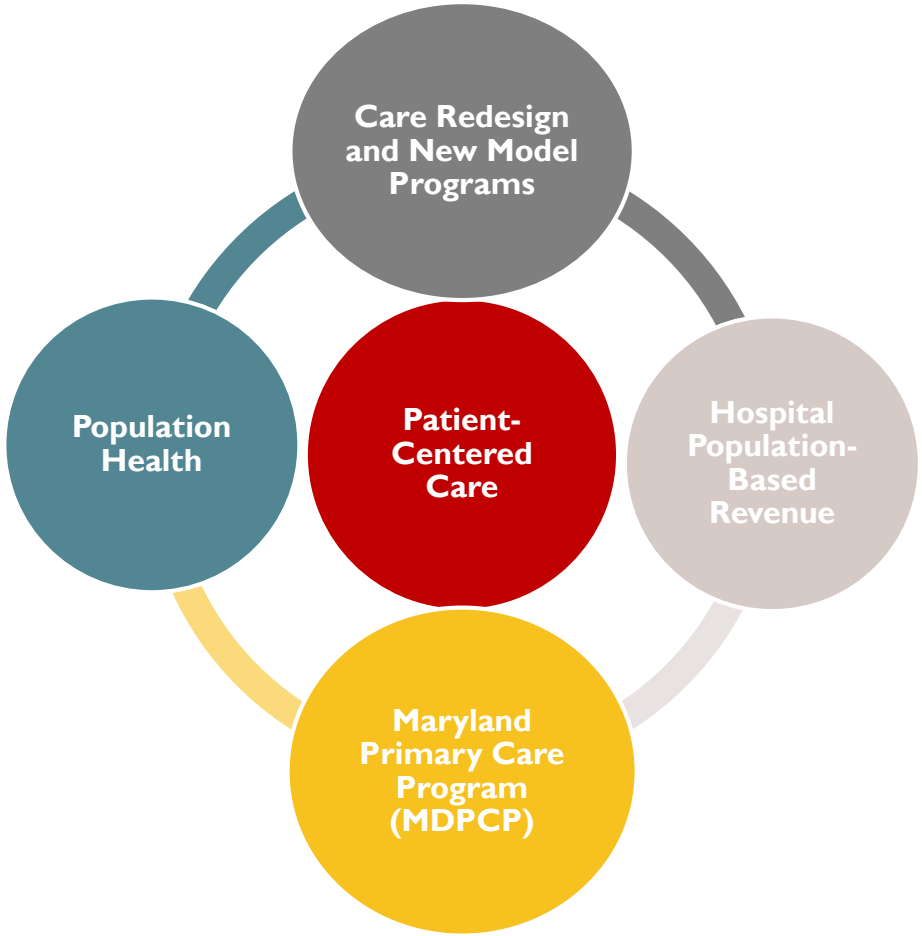
Changes from All-Payer Model to Total Cost of Care Model



Total Cost of Care Targets

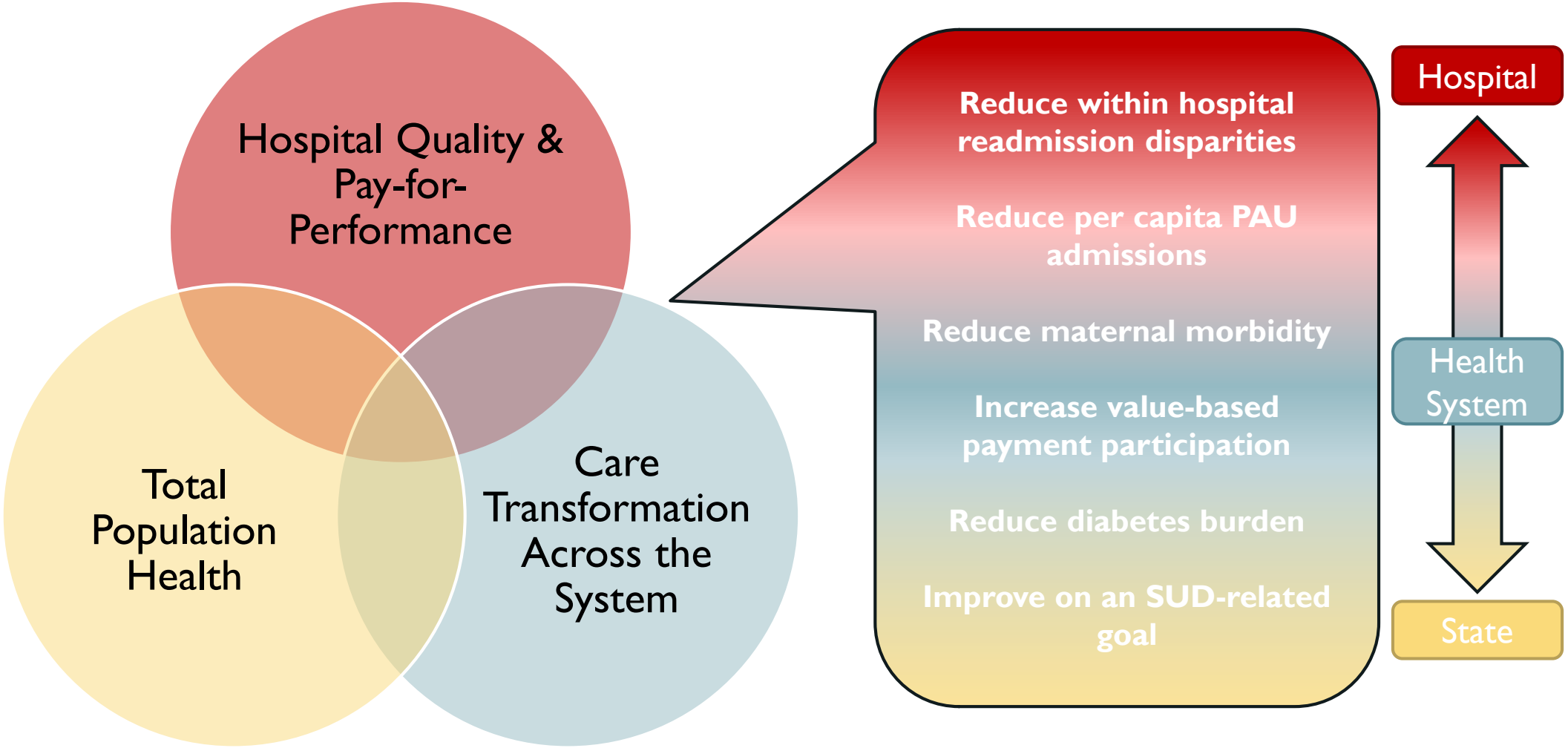
Reduce Medicare Costs	• Achieve $300 million in Medicare savings annually by 2023 (from 2013 base year)
Limit Hospital Revenue	• Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually
Transform Care	• Coordinate care for patients across both hospital and non-hospital settings to reduce disparities, improve health outcomes, and constrain the growth of costs
Improve Population Health	• Address Maryland's highly prevalent chronic conditions

Total Cost of Care Model Components



Component	Purpose
Hospital Population-Based Revenue	Expands hospital incentives and responsibility to control total costs through limited revenue-at-risk Incentivizes improved quality care and reduction of potentially avoidable utilization, reduced readmissions, and avoidable complications
Care Redesign and New Model Programs	Fosters care transformation *across the health system* • Expand incentives for hospitals to work with others • Opportunity for development of "New Model Programs" for non-hospital providers (EQIP) • MACRA eligibility with participation
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees
Population Health	Encourages programs and provides financial credit for improvement in statewide diabetes, opioid addiction, and other priorities

Shared Outcomes and Goals



Maryland's Population Health Priorities

- Diabetes prevention and management
  - Identified as a priority by Maryland State Secretary of Health
  - Initiative being led by the Maryland Department of Health
  - Maryland's statewide ***Diabetes Action Plan*** is now available on MDH website
- Opioid screening, prevention, and treatment
  - Opioid Task Force convened under Lt. Gov. Rutherford in 2015
  - State of Emergency declared by Governor Hogan in 2017
  - State coordinating body, the Opioid Operational Command Center (OOCC), established in 2017

Hospitals Investments in Population Health

- As the Total Cost of Care Model progresses, the State expects to see hospitals investing in population health within the communities they serve.
- We expect that these investments:
  - Address the local community health needs of the hospital's service area;
  - Are impactful and improve the population's health; and
  - Are developed collaboratively with the community and the local public health infrastructure.
- Investments that are made to address a community health need can be integrated into other hospital payment methodologies (ICC, TCOC, etc.).
- Key methodological questions:
  - How does the State help hospitals identify community health needs through a stakeholder process?
  - How does hospital spending tie to community health needs?

Community Health Needs Assessments

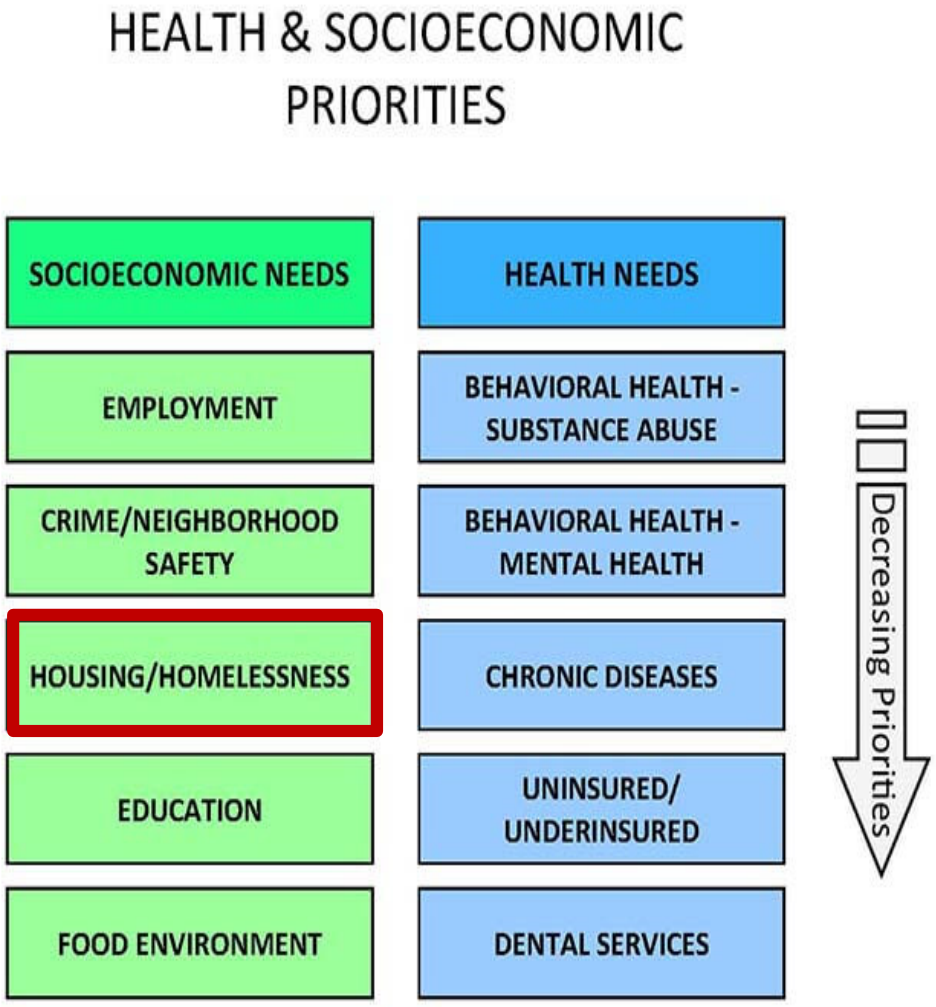
What is a Community Health Needs Assessment?

- The Affordable Care Act requires that hospitals conduct a Community Health Needs Assessment (CHNA) every three years and adopt an implementation strategy to meet the identified needs. To conduct these assessments, a hospital must:
  - Define the community it serves
  - Assess the health needs of that community
  - In assessing the community's health needs, **solicit and take into account input received from persons who represent the broad interests of that community**, including those with special knowledge of or expertise in public health
  - Document the CHNA in a written report and make the report widely available to the public
- A hospital's 501(c)(3) status is contingent on following the guidelines set out by the Internal Revenue Service (IRS) for CHNA development

Community Benefit Regulations under 501(c)(3)

- A Hospital's non-profit status is also dependent on a "Community Benefit Standard" as dictated by Rev. Rule 69-545 and Rev. Rule 56-185
- To demonstrate a community benefit, hospitals must additionally certify that they both provide benefits to a class of persons broad enough to benefit the entire community and operates to serve the public rather than private interest.
- The following factors must be certified to demonstrate community benefit:
  - Operating an emergency room open to all, regardless of ability to pay
  - Maintaining a board of directors drawn from the community
  - Maintaining an open medical staff policy
  - Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare
  - Using surplus funds to improve facilities, equipment, and patient care; and
  - Using surplus funds to advance medical training, education, and research.
- IRS 'Form 990' Schedule H requires hospitals to report their community benefits, community building, and community health improvement.

Example Community Health Needs Assessment



Goal: "Increase access to and healthy housing"

- **Strategy 1:** Expand capacity to identify housing issues among low income, uninsured, and homeless residents including challenges related to asthma triggers and lead among children
  - **Metrics to Evaluate:** Lead poisoning screening rates, Neighborhood Navigator Encounters, Health Leads Connections
    - **Community Partners:** Health Leads, Green & Healthy Homes Initiative, Helping Up Mission, Asthma Program
- **Strategy 2**: Provide social support services to low-income, uninsured and homeless residents including improving homelessness initiatives
  - **Metrics to Evaluate:** Social Determinants Screening rate, Transition housing slots
    - **Community Partners:** Men & Families Center, Helping Up Mission, Center for Urban Families, Southeast Community Development Corp (SECDC), United Way 211, Health Leads, Healthcare for the Homeless, Homeless Connect
- *Housing Initiative Examples:* Helping Up Mission support, Health leads program, Habitat for Humanity, Halfway Housing

Variation in Community Health Needs Process

- Hospitals are required to **solicit and take into account input received from persons who represent the broad interests of that community** but there is a wide variation in how hospitals implement this requirements.
  - Some hospitals partner closely with their local health departments
  - Other hospitals work in a more isolated fashion or within their own system
- HSCRC will explore the hospital's CHNA process and report back to the workgroup with examples of effective processes
  - Staff intend to work with both the hospital and local health departments.
  - Future meetings will discuss best practices for stakeholder and community engagement during the community health needs assessment

Hospital Community Benefits Spending

Hospitals Community Benefit Activities

- Non-profit hospitals 501(c)(3) are exempt from income taxes for organizations that operated exclusively for religious, charitable, scientific, or educational purposes.
  - To qualify for non-profit status, hospitals are required to engage in activities that benefit the communities that they serve.
  - Maryland law exempts state income tax for organizations that are exempt from federal income tax under Internal Revenue Code.
- Maryland Code Health General §19-303 grants the HSCRC responsibility for collecting, analyzing and dictating hospital community benefit reporting annually
- The HSCRC develops a reporting template annually for submission on a fiscal year basis in December
  - The template closely mirrors the IRS 990 Form's Schedule H to reduce reporting burden
  - HSCRC staff review the reports and produce a report to the Commission annually in the spring
  - There is currently no corrective action or auditing process, though State statute does not preclude such actions

What are Community Benefits in Maryland?

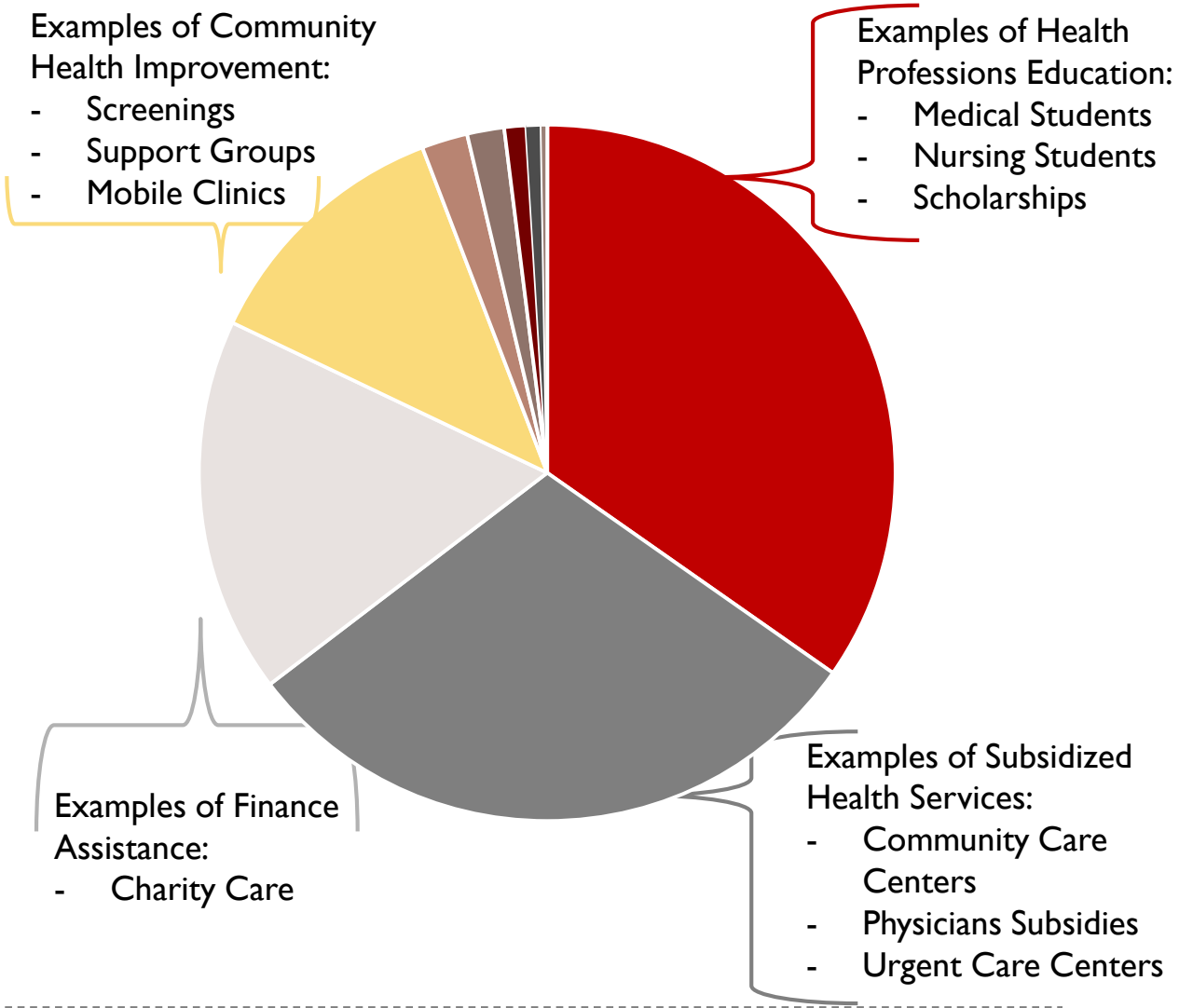
- Per HSCRC guidelines, Community Benefits, "Respond to an **identified community need**, and meet the following criteria:
  - Ultimately improve the **health status and well-being of specific populations** in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;
  - The program is designed to **impact measurable and documented health disparities** and poor health outcomes
  - Generate a **low or negative margin**;
  - Are **not provided for marketing** purposes; and/or
  - The service or programs **would likely be discontinued** if the decision were made on a purely financial basis"
- The HSCRC aligns reporting with the IRS 990 form and spending categories and requires hospitals provide details of their CHNA process and list three programs that address their CHNA findings

Community Benefit Categories in Maryland

- **Medicaid Costs** – Medicaid Deficit Assessment paid by hospitals, net of the payer portion. Non all-payer states report the deficit of direct costs from Medicaid reimbursement as the net community benefit.
- **Community Health Services** – Activities carried out to improve community health, extending beyond patient care activities. These services do not generate inpatient or outpatient bills, although there may be a nominal patient fee and/or sliding scale fee.
- **Health Professions Education** – Net expenses for residencies, continuing education outside of the hospital's expertise, scholarships, health educators and education facilities at the hospital
- **Mission Driven Health Services** – Mission driven health services are services provided to the community that were never expected to result in cash inflows but: 1) which the hospital undertakes as a direct result of its community or mission driven initiatives; or 2) would otherwise not be provided in the community if the hospital did not perform these services.
- **Research** – Clinical and community health research, as well as studies on health care delivery. Counted as the difference between operating costs and external subsidies, such as grants (i.e. only research producing a negative margin).
- **Cash and In-Kind Donations** – Funds and donated work/resources from the hospital. In MD, this is restricted to funds allocated to Community Benefits on the IRS 990 form.
- **Community-Building Activities** – Net expenditures for the development of community health programs and partnerships. These may include housing, economic development, community support, advocacy, coalition building, workforce development and other community activities.
- **Other Items** – Charity Care, Community Benefit Operations and Community Health Needs Assessment Operations

2016 Overview of Maryland Community Benefits Spending

Community Benefit Spending Category	Statewide Total (millions)	Share of Total Community Benefit Spending	Facilities Reporting
Health Professions Education	$484.40	35%	47
Subsidized Health Services	$417.20	30%	40
Finance Assistance at Cost	$243.50	17%	48
Community Health Improvement and Community Benefit Operations	$168.70	12%	48
Medicaid	$29.70	2%	15
Community Building	$24.10	2%	43
Cash and in-kind Contributions to Community Groups	$13.90	1.0%	45
Research	$9.90	0.7%	25
Costs of other Means-Tested Government Programs	$3.70	0.3%	4
Total	$1,395.10	100%	48



Source: HSCRC data and http://www.communitybenefitinsight.org/?page=state_analysis.home

How does Maryland's Community Benefit Spend on Health Needs Compared to the Nation?

	Total CB Spend Per Capita	Community Health Improvement Spend per Capita	Health Improvement as % of CB Spend	Community Building Activities Spend per Capita	Community Building Activities as % of CB Spending
Maryland	$125.96	$24.87	19.7%	$6.85	5.4%
Medicaid Expansion States	$143.01	$10.86	7.8%	$1.62	1.4%
U.S. Average	$129.96	$9.05	6.6%	$1.57	1.1%

- With regards to spending variations across hospital characteristics, regression analysis indicates that whether a teaching hospitals and those located in lower socioeconomic areas have a higher rate of community benefit spending on health improvement community building activities (Singh, 2015)

Sources: Singh, S. R., Bakken, E., Kindig, D. A., & Young, G. J. (2016). Hospital Community Benefit in the Context of the Larger Public Health System: A State-Level Analysis of Hospital and Governmental Public Health Spending Across the United States. *Journal of public health management and practice : JPHMP*, *22*(2), 164–174. doi:10.1097/PHH.0000000000000253 and Singh, S. R., Young, G. J., Daniel Lee, S. Y., Song, P. H., & Alexander, J. A. (2015). Analysis of hospital community benefit expenditures' alignment with community health needs: evidence from a national investigation of tax-exempt hospitals. *American journal of public health*, *105*(5), 914–921. doi:10.2105/AJPH.2014.302436

Examples of Select Hospital's CHNA versus Community Benefit Spending in FY18

Methodology for Assessing Community Benefit Spending

- Hospitals are required to identified their top three community health needs from the community health needs assessment.
  - However, hospitals are not required to identify which community health need their community benefit spending is addresses
  - HSCRC staff made a subjective determination whether the community benefit spending was targeted towards one of the community health needs as identified by the hospital.
- The assessment likely represents and undercount of the spending that is directed towards a community health need. HSCRC's regulations do not allow for a systematic comparison.

Baltimore City Hospital

Community Health Needs Assessment for 2015-2018:

1. Address Mental Health/Substance Abuse (Shared priority with all Baltimore City Hospitals)
2. Reduce Obesity and Impact of Chronic Disease
3. Create Person-Centered Health Neighborhoods to Address Social Determinants of Health

FY18Community Benefit Spending	Hospital's Activities in Community Benefit Category	Part of CHNA?	Share of Community Benefit	Potential CB Spend on CHNA
Health Professions Education	Physicians/Medical Students	NO	15.49%	
Subsidized Health Services	Palliative Care	NO	30.26%	
	Morrell Park	**YES**		**0.04%**
	Community Care Center	**YES**		**3.56%**
	Physician Emergency Department Indigent Care Subsidies	NO		
	Hospital-based Physician Specialty Subsidies	NO		
	House Staff/Coverage Subsidies	NO		
	Primary Care Clinic on campus in West Baltimore	**YES**		**0.60%**
	Health Care Access Maryland Care Management Program	**YES**		**1.71%**
Finance Assistance at Cost	Charity Care	NO	46.30%	
Community Health Improvement and Community Benefit Operations	Support Groups	NO	2.54%	
	Screenings	NO		
	Health Care Support Services	NO		
Medicaid	Medicaid Assessment	NO	2.78%	
Community Building	Physical Improvements and Housing	**YES**	0.77%	**0.77%**
	Community Support	**YES**		
Contributions to Community Groups	Cash Donations	NO	1.05%	
Research	Clinical Research	NO	0.37%	
Costs of Government Programs	Foundation Funded Community Benefit	NO	0.44%	

Total Community Benefit Spent on CHNA Needs: 6.68%

Proportion of Hospital Revenues: 0.8%

Rural Hospital

Community Health Needs Assessment for 2015-2018:

1. Substance Abuse
2. Poverty
3. Heart Disease
4. Access to Care and Health Literacy

FY18Community Benefit Spending	Hospital's Activities in Community Benefit Category	Part of CHNA?	Share of CB	Potential CB Spend on CHNA
Health Professions Education	Physicians/Medical and Nursing Students	NO	2.06%	
Subsidized Health Services	Outpatient and Peritoneal Dialysis	NO	72.49%	
	Cardiology Physicians Practice	NO		
	Primary Care Physicians Practice	NO		
	Obstetric Physician Practice	NO		
	GI Physicians Practice	NO		
	Pulmonary Physician Practice	NO		
	Organizationally Owned Urgent Care	NO		
	Hospitalists	NO		
	Psychiatric Physician Practice	NO		
Finance Assistance at Cost	Charity Care	NO	19.98%	
Community Health Improvement and Community Benefit Operations	Community Health Education	**YES**	1.55%	**0.19%**
	Support Groups	**YES**		**0.01%**
	Self-Help	**YES**		**0.06%**
	Screenings	**YES**		**0.00%**
	Health Care Support Services	**YES**		**1.11%**
	Prescription Medication	**YES**		**0.14%**
Medicaid	Medicaid Assessment	NO	2.04%	
Community Building	Community Support	NO	1.42%	
	Coalition Building	NO		
	Workforce Development	**YES**		**1.32%**
Contributions to Community Groups	Cash and In Kind Donations	NO	0.46%	
Costs of Government Programs	Foundation Funded Community Benefit	NO	0.01%	

Total Community Benefit Spent on CHNA Needs: 2.69%

Proportion of Hospital Revenues: 0.4%

Academic Medical Center

Community Health Needs Assessment for 2015-2018:

1. Improving Socioeconomic Factors
2. Access to Health Services

FY18Community Benefit Spending	Hospital's Activities in Community Benefit Category	Part of CHNA?	Share of CB	Potential CB Spend on CHNA
Health Professions Education	Physicians/Medical and Nursing Students	NO	**68.66%**	
	Other Health Professionals Education	NO		
	Scholarships for Professional Education	NO		
Subsidized Health Services	Teaching Support - Community Education	NO	**7.94%**	
	Broadway Center IOP/OP Grant	**YES**		**0.04%**
	Wilson House	**YES**		**0.05%**
	Social Work Services	**YES**		**0.26%**
	CB Community Service	**YES**		**2.74%**
	Eating Disorders Day Hospital Supportive Housing	**YES**		**0.03%**
	Schizophrenia Day Hospital Housing	**YES**		**0.03%**
	Supportive Housing for Male Substance Abuse Patients	**YES**		**0.29%**
	Pain Treatment Day Hospital Housing	**YES**		**0.00%**
	Mission Driven - Other	**YES**		**3.85%**
Finance Assistance at Cost	Charity Care	NO	**9.70%**	
Community Health Improvement and Community Benefit Operations	Community Health Education	**YES**	**8.12%**	**0.24%**
	Support Groups	**YES**		**0.03%**
	Community-Based Clinical Services	**YES**		**0.14%**
	Screenings	**YES**		**0.00%**
	Free Clinics	**YES**		**0.95%**
	Mobile Units	**YES**		**0.01%**
	Health Care Support Services	**YES**		**4.34%**
	Other Community Health Services	**YES**		**2.12%**
Medicaid	Medicaid Assessment	NO	**2.83%**	
Community Building	Physical Improvements and Housing	**YES**	**1.61%**	**0.07%**
	Economic Development	**YES**		**0.12%**
	Community Support	**YES**		**0.62%**
	Environmental Improvements	**YES**		**0.21%**
	Leadership Development/Training for Community Members	**YES**		**0.00%**
	Coalition Building	**YES**		**0.16%**
	Advocacy for Community Health Improvements	**YES**		**0.25%**
	Workforce Development	**YES**		**0.18%**
Contributions to Community Groups	Cash and In Kind Donations	NO	**0.77%**	
Research	Community Health Research	NO	**0.37%**	
	Cancer Registry	NO		
Costs of Government Programs	Foundation Funded Community Benefit	NO	**0.00%**	

Total Community Benefit Spent on CHNA Needs: **16.74%**

Proportion of Hospital Revenues: **1.88%**

Aligning Community Benefits with Community Health Needs

Community Benefit Spending and Health Reform

- Policy advocacy organizations and experts, like the National Academy for State Health Policy and the Robert Wood Johnson Foundation, have called for enhancing Community Benefit regulation to encourage increased investment in community and population health
  - *"Hospital community benefit expenditures are a critical component of health care reform to strengthen population health improvement efforts at both the federal and state levels. Accountability measures under the ACA in the form of CHNAs provide a framework to ensure that the billions of dollars hospitals receive in tax subsidies are reinvested to meet the significant social and economic needs of communities." (Davis, 2017)*
  - Eleven states (California, Idaho, Illinoi, Indiana, **Maryland**, New Hampshire, New York, Rhode Island, Texas, Vermont and Washington) have tied some form of community needs assessment in their Community Benefit regulations.

Sources: Singh, S. R., Young, G. J., Loomer, L., & Madison, K. (2018). State-Level Community Benefit Regulation and Nonprofit Hospitals' Provision of Community Benefits. *Journal of health politics, policy and law*, *43*(2), 229–269. doi:10.1215/03616878-4303516 and Davis, A. (2017) https://www.acy.org/wp-content/uploads/2017/02/Community-Benefits_1_24_17-for-web-upload.pdf.

Connecting CHNAs and Community Benefits

- Currently, Community Benefit activities are not required to be directed towards community health needs.
  - Hospitals are required to identify the list of community benefit activities they undertook.
  - The hospitals are required to report the unmet community health care needs identified in the most recent "community needs assessment" prepared by the Department or local health department for each county.
  - There is no requirement that the list or sum of community benefit spending aligns with the unmet community health needs.
- Community Benefit spending can be a mechanism for CHNA compliance and reporting of activities taken in response to the community's assessment.

Options for Making the CHNA More Meaningful

- Add Standards and Guidance to Regulations for CHNA development
  - Require a clear process for the community health needs assessment that includes collaboration with local stakeholders, the local health departments, and the Maryland Department of Health.
  - Example: Require MDH or a local health department to approve each hospital's CHNA.
- Require that hospitals report which community benefit spending is addressing a community health need.
  - Require hospitals to identify which community health need the hospital's community benefit project is designed to address.
  - Require that the local health department attest to whether the community benefit spending improves addresses the community health need.
- Other options?

Sources: Workshops from ASTHO/other State available here: http://www.astho.org//uploadedFiles/Programs/Access/Primary_Care/Scan%20of%20Community-Based%20Health%20Needs%20Assessment%20Activities.pdf https://www.hilltopinstitute.org/wp-content/uploads/publications/HospitalCommunityBenefitsAfterTheACA-StateLawLandscapeIssueBrief6-March2013.pdf ASTHO Recommendation #8: https://www.astho.org/Programs/Access/Community-Health-Needs-Assessment/Consensus-Statement/

Next Steps

CSAC Next Steps

- HSCRC will report back to the workgroup on the following:
  - Examples of effective community health needs assessments that involve partnerships of hospitals, local health departments, and community representatives.
  - Options for a methodology to systematically assess the extent to which the hospitals community benefit spending aligns with an identified community health need.
- The next meeting of the Consumer Standing Advisory Committee will be within two months.
  - Date: TBD