

Milbank Memorial Fund

Refining Hospital Community Benefit Programs

Christopher F. Koller

Milbank Memorial Fund

Hilltop Institute, June 15, 2016



Milbank Memorial Fund

111 year old operating foundation

National scope

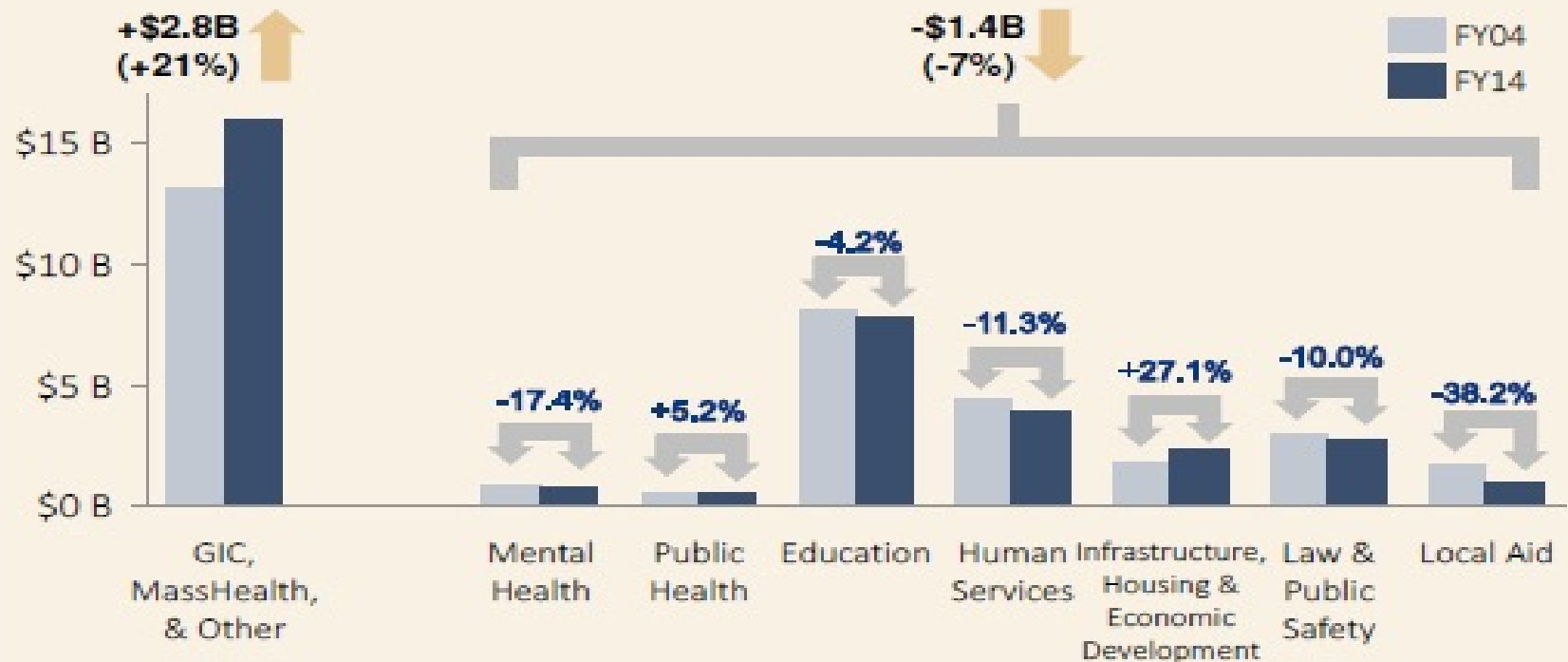
Neutral and bipartisan

“Improving Population Health by connecting leaders and decision makers with the best evidence and experience”



Why States Should be Paying Attention: Health System is “Confiscatory” (D. Berwick)

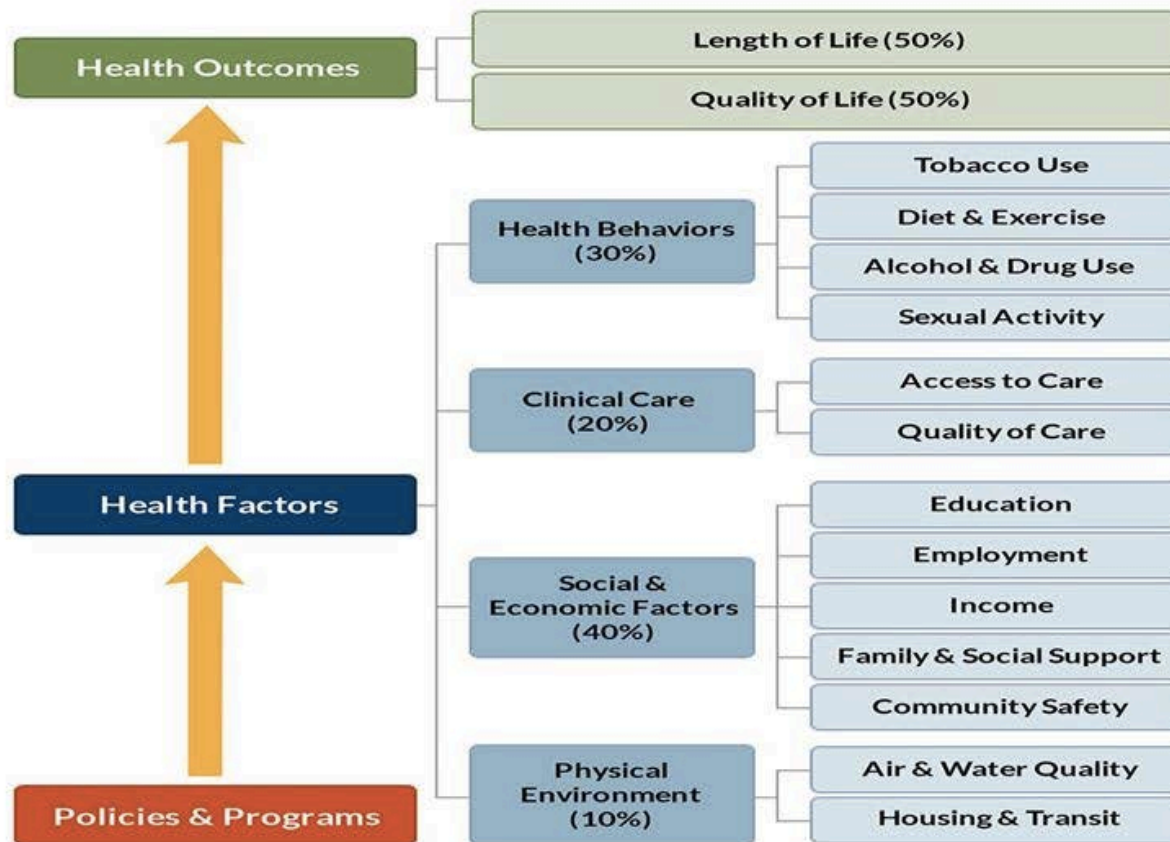
Figure 1.1: State budgets for health care coverage and other priorities, FY2004- FY2014
Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014



NOTE: Figures all adjusted for Gross Domestic Product (GDP) growth; GIC = Group Insurance Commission
SOURCE: Massachusetts Budget and Policy Center

Placing Health System in Perspective

SOCIAL DETERMINANTS OF HEALTH



County Health Rankings model © 2014 UWPHI

al Fund

Recommendations from Rosenbaum

Goal: Broader Investment by Hospitals in Community Health:

1. IRS Clarification on relationship between Community Benefit Spending and CHNA/strategy implementation.
2. Greater transparency on strategy implementation.
3. Eliminate distinction between Community Benefit and Community Building (Part I and Part II. Lessons from Community Reinvestment Act?)

Hilltop Institute Recommendations to States for Community Benefit Policies

1. Build on Federal Rules
 - Community Benefit vs Community Building
 - Electronic Reporting
 - Stakeholder Involvement in CHNA
 - Expand Obligation to Other Providers
2. Promote Regional Collaborations
3. Encourage Multi payer Payment Reforms
4. Monitor Vertical Integration
5. Invest in Metrics

<http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-LeveragingPolicyIssueBrief11-June2015.pdf>



Fund Study: “Moving Upstream”

Why can't policy makers invest in social services?

1. Values conflicts – Population Health not a priority
2. Misaligned economic incentives
 - Payments wrong; Delayed and distributed benefits
3. Differing views on the role of individual responsibility for health.

(Rogan, Bradley; Investing in Social Services for States' Health: Identifying and Overcoming the Barriers. MMF May 2016)



What Can be Done Locally

1. Create local standards for hospitals beyond clinical care, building on federal law
 - Logic: IRS standards may be enough for hospital's non profit tax status but not for license.
 - Charity care decreasing. Medicaid shortfalls and bad debt won't cut it





Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November, 2015

Dear Hospital Chief Executive Officers and Local Health Department Commissioners and Directors:

I am writing to update you on New York State's progress in meeting its *Prevention Agenda* goals, and to transmit guidance for the next cycle of collaborative community health planning.

As of April 2015, the *Prevention Agenda* dashboard showed that 16 of the Agenda's 96 outcome objectives had been met, including the state goal for preventable hospitalizations among adults. In addition to the outcomes that have been met, progress is evident for an additional 22 indicators. There are some areas, such as reducing obesity among adults and reducing pre-term births, where progress is slow.

2. Sara's Second: "Greater transparency on strategy implementation" of responses to CHNA

Hospitals to create up to 375 jobs for disadvantaged city residents



By **Meredith Cohn** · Contact Reporter
The Baltimore Sun

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Hospitals set to create up to 375 new jobs for people in struggling neighborhoods.

DECEMBER 9, 2015, 10:04 PM

Baltimore residents living in struggling neighborhoods hard hit by riots last April will be able to apply for 375 new jobs at area hospitals thanks to an initiative approved by state hospital rate regulators.

After three months of debates and hearings, state regulators reached a last-minute agreement on Wednesday requiring participating hospitals to pay a share of the cost of the program and the rest to come from hospital rate increases. The plan calls for as much as \$10 million in annual rate increases and \$5 million a year from the hospital budgets.

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3. Insist on Provider Payment Reform



4. Support Social Services That Work

Don't Expect Hospitals to Do It All (or Let them)

Figure 2: State Social-to-Health Spending Ratio and Selected Health Outcomes, by Quintile (2009)

a) Percent of adult population that is obese



b) Percent of adults who reported 14 or more days in the last 30 days as mentally unhealthy days



c) Lung cancer mortality rate per 100,000 population



d) Social-to-health spending ratio



Legend (a,b,c): dark gray indicates highest quintile (i.e., poorest health outcomes) and white indicates lowest quintile (i.e., best health outcomes).

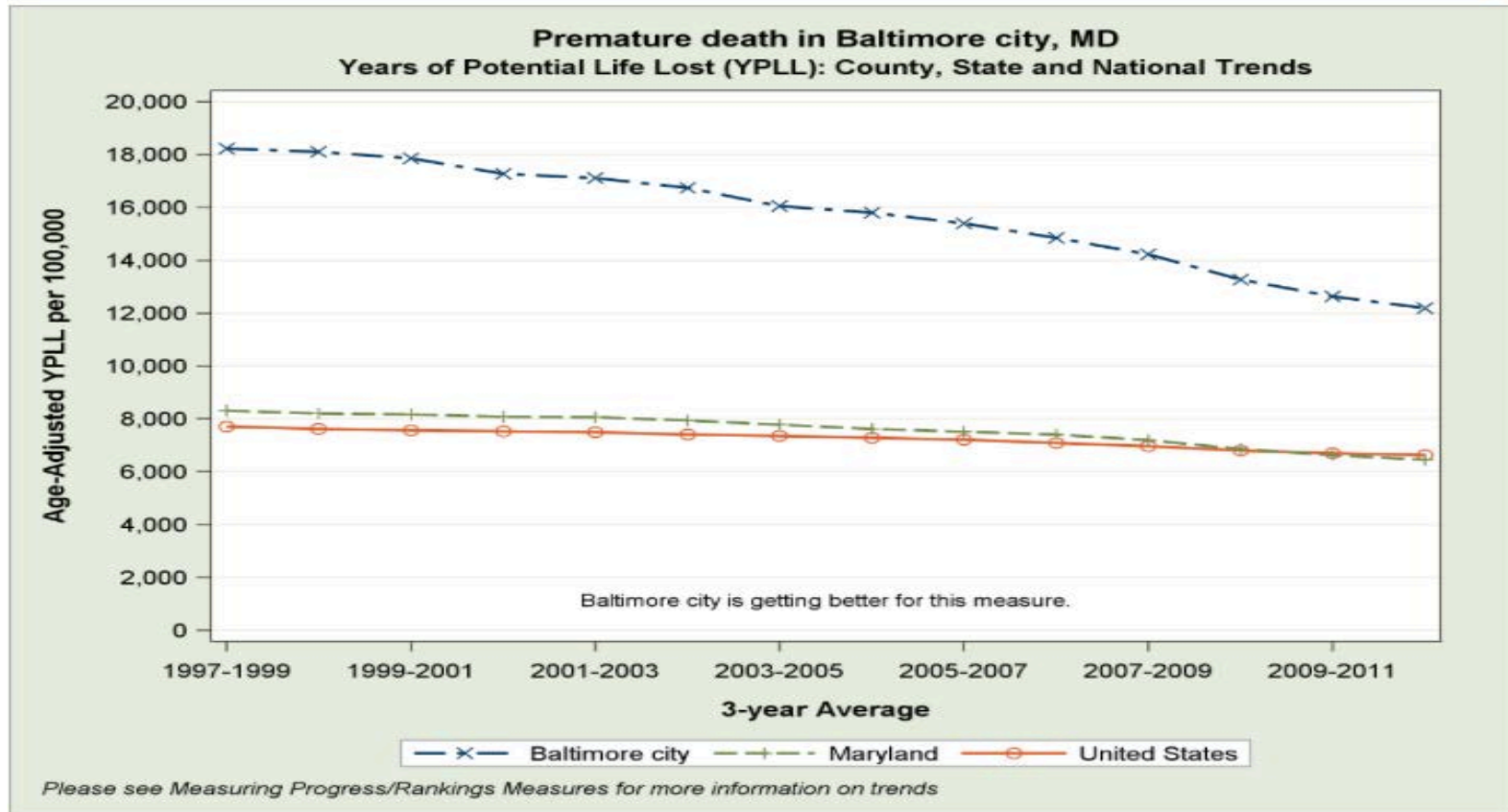
Legend (d): dark gray indicates lowest social-to-health spending ratio; white indicates highest social-to-health ratio.

How do hospitals interact with the social services?

- Connector?
 - Any different from any other provider that treats populations, such as FQHC's?
- Contractor?
 - How does risk bearing change the expectation?
- Developer and Provider?
 - Is this a zero-sum game?



Progress is Possible



Source:

<http://www.countyhealthrankings.org/app/maryland/2015/rankings/baltimore-city/county/outcomes/overall/snapshot>

