AGO Presentation for 2017 Cost Trends Hearing

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Presentation Topics

I. Aligning AGO Community Benefits Guidelines with Broader Population Health Initiatives

II. A Related Question of Proportional Care for Underserved Communities
What Are Community Benefits?

• Hospitals have long been recognized for their charity care and efforts to improve the health of the communities they serve.

• Community Benefits are investments by hospitals and HMOs that further their charitable mission of addressing their communities’ health and social needs.

• Community Benefits reporting programs have developed in many states, as well as federally through reporting to the IRS, as a way of formalizing the provision of these benefits and quantifying their community health impact.
Goals for Updated Community Benefits Guidelines

• Align AGO Guidelines with IRS and DPH standards to decrease administrative burden on participants and harmonize resources for building long-term capacity to improve health outcomes and reduce disparities

• Improve coordination among participants and within regions, and enhance transparency around community engagement throughout the planning and implementation process

• Develop approaches to improving program assessment and transparency (e.g., by enhancing reporting on Community Benefits expenditures)
Breakdown of 2016 Hospital Community Benefits Spending

- Community Benefits Programs: $336,230,105
- Health Safety Net Assessment: $228,582,825
- Health Safety Net Denied Claims: $28,539,269
- Free/Discounted Care: $41,472,032
- Corporate Sponsorships: $9,182,143
Opportunity for Increased Transparency into Substantial Community Health Investments

Community Benefits Programs $336,230,105

E.g., Investment Type

- Community Health Education
- Direct Clinical Services
- Access/Coverage Supports
- Investments in Social Determinants
- Grants/Donations
- Substance Use Disorder
- Housing Stability/Homelless
- Mental Illness / Mental Health
- Chronic Disease
- Other Health Needs Identified by Community

E.g., EOHHS/DPH Focus Issues

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Significant Variation in Payer Populations Served by Providers Is Well Documented by the HPC

Source: Health Policy Commission CMIR (Sept. 7, 2016) at 57; based upon 2015 CHIA hospital discharge data.

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Largest Provider Systems Tend to Have Higher Commercial Mix Than Government Mix

Proportion of Eastern MA GPSR Across Hospital Systems by Payer Type (2015)

- **Commercial**:
  - Largest Two Eastern MA Systems: 50%
  - All Other Eastern MA Hospitals: 50%

- **Medicare**:
  - Largest Two Eastern MA Systems: 47%
  - All Other Eastern MA Hospitals: 53%

- **Medicaid/Subsidized Populations***:
  - Largest Two Eastern MA Systems: 37%
  - All Other Eastern MA Hospitals: 63%

Prior AGO Analysis Showed That Higher Income Communities Are Generally Healthier
Even Among Commercial Discharges, Hospitals Serve Different Proportions of Low-Income Patients

Average Income Quintile of Hospital/System’s Commercial Discharges

1 = lowest income quintile
5 = highest income quintile
Opportunities for Coordinated Oversight of Access Questions

• Department of Public Health – e.g., Determination of Need Regulations
• Health Policy Commission – e.g., CMIRs, Performance Improvement Plans
• Attorney General’s Office – e.g., Health Care Market Oversight, Community Benefits