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Hospital Community Benefits after the ACA: *Building on State Experience*

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Introduction

The Hospital Community Benefit Program, established by The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), is the central resource for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. One of the program's functions is to publish a series of issue briefs on promising practices, new laws and regulations, and study findings on community benefit activities and reporting.

The first issue brief in the series (Folkemer et al., 2011) explored the expanded regulatory framework for hospital community benefits under the Affordable Care Act (ACA),¹ outlining its new community benefit requirements and exploring the challenges and opportunities these present for state policymak-

ers. Examining current state community benefit policies, the brief suggested that state policymakers consider whether existing state policies should be modified to: ensure collaborative, inclusive, and transparent approaches to identifying and prioritizing health needs; encourage nonprofit hospitals' development of community benefit initiatives that are effective and aligned with state public health policy; and develop or enhance existing accountability mechanisms to ensure that nonprofit hospitals' community benefits are responsive to community health needs.

This is the second issue brief in a series, funded by the Robert Wood Johnson Foundation and the Kresge Foundation, to be published over three years. It takes a closer look at three aspects of community benefits af-

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ected by §9007 of the ACA, “Additional Requirements for Nonprofit Hospitals”:

- Community health needs assessment
- Hospital financial assistance and billing and collection policies
- Community benefit reporting and oversight strategies

Community Health Needs Assessment

The Federal Framework. For tax years beginning after March 23, 2012, the ACA requires nonprofit hospitals to conduct community health needs assessments (CHNAs). Any nonprofit hospital that fails to comply with this requirement is subject to a \$50,000 excise tax liability and the potential loss of its federal tax-exempt status (ACA §9007(b), (a)). However, the ACA provides no definition of CHNA and little guidance as to the processes that hospitals should follow, either to conduct these assessments or to address the community health needs they identify. The law specifies only that the nonprofit hospital must:

- Conduct a CHNA within the three-year period that begins on the first day of its first tax year beginning after March 23, 2010, and ending on the last day of its first tax year that begins after March 23, 2012; thereafter, the hospital must conduct a CHNA at least once every three years (ACA §9007(f))
- Incorporate into its CHNA input from “persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health” (ACA §9007(a), I.R.C. §501(r)(3)(B))

This brief considers each of these requirements against a backdrop of federal and state law and practice. This is not a comprehensive account of state experience. Rather, these examples illustrate a range of state policy decisions that can help to inform the interpretation and implementation of §9007 of the ACA.

- Make its CHNA “widely available to the public” (ACA §9007(a), I.R.C. §501(r)(3)(B))

The ACA also requires nonprofit hospitals to develop an implementation strategy to meet the needs identified by the CHNA, describe identified needs not addressed by that strategy, and explain why these needs are not being addressed (ACA §9007(a)-(b)).

A common complaint about the ACA’s CHNA requirement is that it lacks sufficient specificity to serve as an effective guide for compliance. However, the 2010 Schedule H (Form 990) and instructions (both published February 25, 2011) provide some clarification; additional interpretive guidance from the Internal Revenue Service (IRS) is expected.² The ACA’s emphasis on periodic, systematic, inclusive, and transparent assessment and reassessment of community health needs echoes well-established public health practices. Stakeholder and consumer involvement are critical to the overarching purpose of the CHNA, which is to identify the community’s health needs and establish priorities for addressing them. CHNAs inform community benefit planning and foster the nonprofit hospitals’ development of effective programs to improve the health status of the community (NACCHO, 2005; Mani-

toba Health and Healthy Living Accountability Support Branch, 2009).

Defining the Community. Although the ACA does not expressly define the terms “community” or “community health needs assessment,” it does require input from “persons who represent the broad interests of the community served by the hospital facility.” This supports an interpretation that requires a hospital’s CHNA process to target its service area.

The Catholic Health Association (CHA) views a hospital’s geographic service area as a starting point of community definition but recognizes that the scope of a community assessment may need to extend beyond that “in order to include areas of the greatest need, such as where a majority of uninsured persons reside” (2008, p. 67). Examples include areas that are federally designated as “medically underserved” or have a shortage of health professionals; an area the hospital has historically served; or an area that is severely underserved. Moreover, it may be appropriate for a hospital to identify a subpopulation within its defined service area for special focus (e.g., older adults, minorities, pregnant women, children, or those with disabilities) (CHA, 2008).

In a post-ACA discussion draft designed to help nonprofit hospitals assess the needs of their communities and develop responsive community benefit implementation strategies, CHA offers the following factors for a hospital to consider when defining the community it will target for its CHNA: the hospital’s primary and secondary service areas; patient categories (e.g., general patient population, or subsets thereof, such as children or rehabilitation patients); and geographic areas or populations that are “beyond the hospital’s

traditional service boundaries” (e.g., those served by a hospital’s community benefit initiatives, or “opportunity areas” with concentrations of “at risk” populations) (CHA, 2011, pp. 19-20).

State Approaches to Defining the Community of Interest. Several states have implemented their own approaches to identifying a hospital’s CHNA community of interest. In 2003, California’s Office of Statewide Health Planning and Development (OSHPD) initiated a draft community benefit planning guide. The guide recommends that hospitals first define the community, which is conceptualized as a group of people with common features, such as place, identity, or experiences. After a hospital completes its needs assessment and identifies health priorities, OSHPD’s guide directs the institution to develop a more specific definition of the population that it will target for community benefit interventions.

Connecticut recognizes the community benefit responsibilities of both hospitals and managed care organizations (MCOs), whether for-profit or nonprofit. Although the state law requires neither hospitals nor MCOs to develop community benefit programs, it does require a biannual report informing the state whether such a program has been adopted. If a hospital or MCO chooses to develop a community benefit program, it must establish community benefit guidelines that promote preventive care and health improvement for “working families and vulnerable populations” within its service area (Conn. Gen. Stat. §19(a)-127(k)). Program development must be based on an assessment of the needs and resources of targeted populations, “particularly low and middle-income, medically underserved populations and barriers to ac-

cessing health care” (Conn. Gen. Stat. §19(a)-127(k)).

Texas has adopted a similar approach, requiring each nonprofit hospital in the state to develop a community benefit plan that takes into consideration the community’s health needs based on a community-wide assessment. In this context, “community” means “the primary geographic area *and patient categories* for which the hospital provides health care services” (emphasis added), with the “primary geographic area” consisting of at least an entire county (Tex. Health & Safety Code §311.044).

Massachusetts requires nonprofit acute care hospitals to submit community benefit plans as a condition of original licensure (Mass. Gen. Laws ch. 111, §51G(4)); hospitals already licensed may choose to comply with the Attorney General’s voluntary community benefit guidelines. These voluntary guidelines include three approaches that nonprofit acute care hospitals may use to define their communities and develop community benefit plans (Mass. Atty Gen., 2009):

- A *geographic* approach defines the community by political boundaries (e.g., town or city limits) or by the aggregate corporate limits of contiguous municipalities; it is not necessarily limited to a hospital’s direct service area.
- A *demographic* approach focuses on one or more specific demographic groups, such as older adults or uninsured/underinsured populations with low incomes.
- A *health status* approach defines the community in terms of disease prevalence.

It is clear that approaches to defining “community” for health needs assessment

vary substantially from state to state and from hospital to hospital. The absence of any concrete national standard for community definition makes it difficult—in states that have not provided clear legislative guidance—for nonprofit hospitals to confidently focus their CHNA activities (Missouri Foundation for Health, 2009). Moreover, the absence of legislative guidance can frustrate regulators’ ability to hold hospitals accountable for needs assessment and community health improvement.

Promoting Community Involvement in a Collaborative Needs Assessment Process.

The ACA implicitly recognizes that the involvement of consumers, other community stakeholders, and public health experts is essential to hospitals’ meaningful assessments of the health needs and priorities of the communities they serve (ACA §9007(a)).

Both the National Association of County and City Health Officers (NACCHO) and the Association of State and Territorial Health Officers (ASTHO) identify CHNAs as a public health function of state and local health departments (NACCHO, 2008; ASTHO, 2010). As of July 2010, 27 states had participated in the National Public Health Performance Standards Program (NPHPSP), an assessment of state and local public health systems’ capacity and services (ASTHO, 2010). NPHPSP—a collaboration of the Centers for Disease Control and Prevention (CDC), ASTHO, and other national public health organizations—recognizes the assessment of community health status to identify and monitor public health problems, and the assessment of public health capacity and resources, respectively, as essential services of local and state health departments (NPHPSP, 2008a, 2008b).

The Public Health Accreditation Board (PHAB) (supported by the CDC and the Robert Wood Johnson Foundation) will launch a national voluntary accreditation program for state and local health departments in the fall of 2011. Proposed Accreditation Standard 4.1B requires health departments to “engage the public health system and the community in identifying and addressing health problems through an ongoing, collaborative process” (PHAB, 2009).

NACCHO (2010) recommends the following:

IRS reporting requirements should reflect the key characteristics of a high quality process by asking hospitals to document that they are engaged or collaborating in a process that includes the following key phrases:

- Design of a community health needs assessment;
- Identification of relevant assessment indicators and existing data sources;
- Collection of both quantitative and qualitative data, including input from a wide variety of individuals and organizations in the community;
- Identification of community priorities and implementation strategies that are based on assessment data, community input, and the evidence of effectiveness of proposed interventions;
- Implementation of strategies that address community priorities;
- Evaluation of strategy effectiveness
- Demonstration of community health improvement resulting from strategy implementation. (p. 3)

State Approaches to Community Involvement and Collaboration.

State and local health departments use CHNAs to guide public health planning for community health improvement (NACCHO, 2005). This governmental exercise can be adapted to serve as guidance for hospitals performing CHNAs. Hospitals may elect to employ the same health assessment and planning tools used by local health departments in their public CHNA processes. These include, among others, Mobilizing for Action through Planning and Partnerships (MAPP), Planned Approach to Community Health (PATCH), and the Assessment Protocol for Excellence in Public Health (APEXPH) (NACCHO, 2007).

Collaboration among hospitals and public health agencies may serve as a means of fulfilling—at least in part—the ACA requirement that hospital CHNAs take into account input from individuals who represent “the broad interests of the community ... including those with special knowledge of or expertise in public health” (ACA §9007). Moreover, a partnership of health departments, hospitals, and an engaged community can increase the efficiency and effectiveness of hospital community benefit initiatives (Institute of Medicine, 2002).

Several states have recognized the importance of community involvement in hospitals’ needs assessment processes. For example, the Massachusetts Attorney General’s guidelines suggest that hospital community benefit planners seek input from community representatives who reflect the racial, cultural, and ethnic diversity of the populations the hospital serves (Mass. Atty Gen., 2009). Maryland law requires that hospitals *shall* consider state or local health department-developed CHNAs (if available), and that they *may* consult with community leaders,

health care providers, and “any appropriate person that can assist the hospital in identifying community health needs” (Md. Code Ann., Health-Gen. §19–303(b)). Texas requires hospitals to consider the input of local health departments, public-health districts, and other community stakeholders (Tex. Health and Safety Code Ann. §311.044). New Hampshire requires hospital CHNAs to include the reports of public health agencies. Utah mandates annual consultation with county health officials as part of hospitals’ and nursing homes’ CHNA processes (CHA, 2010).

Collaborative approaches to CHNAs, such as those required or encouraged by the laws described above, may not be easy to achieve. Partnerships between hospitals and public health agencies may present challenges in achieving a common focus in the face of differing philosophies and priorities (Israel, Schultz, Parker, & Becker, 1998). On the other hand, hospital/agency partnerships provide an opportunity to leverage scarce public resources available for funding health department-led CHNAs with the private resources that hospitals must devote to CHNAs to achieve ACA compliance.

Hospital Financial Assistance and Billing and Collection Practices

The primary purpose of a CHNA is to identify community health needs for the purpose of developing activities that improve *community* health status. The traditional and still well-accepted understanding of community benefits also includes charity care, financial assistance, and, more recently, protections for patients who find it difficult, if not impossible, to pay their hospital bills. These aspects of community benefits respond to *individual* health needs. This section of the issue brief explores federal and state regulation of hospital financial assistance and billing and collection policies that seek to address financially based disparities in access to hospital services.

The Federal Framework. Section 9007 of the ACA requires tax-exempt hospitals to establish a written financial assistance policy that includes all the following elements (ACA §9007(a)):

- Financial assistance eligibility criteria, and whether free or discounted care is available
- The basis for calculating patient charges

- An explanation of how an individual may apply for financial assistance
- Unless specified in a separate billing and collection policy, the hospital’s potential nonpayment actions, including credit reporting and collection actions
- Measures to widely publicize the hospital’s financial assistance policies in the community

Although the ACA does not mandate that hospitals provide a minimum level of financial assistance, dictate financial assistance eligibility rules, or define a process for determining patient charges, the IRS has released a new Schedule H that requires non-profit hospital organizations to report financial assistance policies and practices in effect during 2010 and subsequent tax years. Hospitals are required to report whether multiple hospital facilities operated by the organization used uniform financial assistance policies, whether the organization used federal poverty guidelines (FPL)³ to determine eligibility for free or discounted care, and what percentages of the FPL or other criteria were

used to determine financial assistance eligibility (IRS, 2011, lines 1-7).

Section 9007 of the ACA requires nonprofit hospitals to adopt, as part of written financial assistance policies, limitations on fees and constraints on billing and collection actions. Although ACA §9007, 2010 Schedule H, and forthcoming IRS guidance will not directly affect state tax policies, they collectively provide a federal framework that policymakers may find useful to reference when re-examining state and local tax policies in a post-ACA environment.

State Approaches to Financial Assistance Policies. Nonprofit hospitals have historically provided a “safety net” for uninsured and underserved patients by offering free or discounted care (Community Catalyst, 2010b). However, after full implementation of the ACA in 2014, there likely will be fewer uninsured individuals seeking hospital care. In that environment, hospital financial assistance policies may need to refocus on *underinsured* patients (i.e., those whose financial resources are inadequate to cover the cost of copayments and deductibles) (Jervis, 2005).

Regulatory approaches to hospital financial assistance and billing practices vary widely among the states. A few require both nonprofit and for-profit hospitals to provide financial assistance. Thirteen states⁴ and the District of Columbia mandate free care for patients unable to pay; eighteen states⁵ and the District of Columbia have uniform standards for free care eligibility; and seven states⁶ require hospital charges for uninsured patients to be based on sliding fee scales that reflect patients’ ability to pay (Community Catalyst, 2010a). Limits on hospital charges for services delivered to uninsured and self-

pay patients are in place in seven states.⁷ Providers in 20 states⁸ and the District of Columbia must notify patients and the public of available financial assistance programs (Community Catalyst, 2010a).

Using the FPL to determine financial assistance eligibility is common among the states (Community Catalyst, 2010a). In Maryland, for example, nonprofit hospitals⁹ must provide free care to patients with family income at or below 200 percent of the FPL, as well as provide reduced-cost care to patients with family income between 200 and 300 percent of the FPL “in accordance with the mission and service area of the hospital,” and to those with family income between 200 and 500 percent of the FPL who have a “financial hardship” (i.e., medical debt incurred over a 12-month period that exceeds 25 percent of family income) (COMAR 10.37.10.26A-2(2)). In addition, a payment plan must be made available to uninsured patients who have family income between 200 and 500 percent of the FPL and request assistance (COMAR 10.37.10.26A-2(3)). New Jersey also requires hospitals to provide free care for patients with family income at or below 200 percent of the FPL (N.J. Admin. Code §10:52-11.8).

Financial assistance requirements may also vary by geographic areas within a state. For instance, Illinois requires rural hospitals to provide discounted care to uninsured patients with family income up to 300 percent of the FPL, whereas urban hospitals must discount charges for services provided to patients with family income up to 600 percent of the FPL when charges exceed \$300 per admission (210 Ill. Comp. Stat. 210 §89/10).

Some states have adopted a slightly different approach. That is, once a patient is determined to be eligible for financial assistance

(generally on the basis of a family income range that references the FPL), the patient's financial responsibility is capped at a specific amount calculated as a percentage of the patient's income. For example, in Illinois, the maximum amount that hospitals may collect from any person who qualifies for discounted care is 25 percent of that person's annual family income (210 Ill. Comp. Stat. 89/10). Similarly, New Jersey caps the payment responsibility of patients who are eligible for reduced-cost care to 30 percent of annual gross income (N.J. Admin. Code, §10:52-11.8); eligibility for discounted care is based on a sliding scale that distinguishes between four income ranges between 200 and 300 percent of the FPL. This means that a patient with a family income equivalent to 230 percent of the FPL is responsible for 40 percent of the charges, whereas a patient with a family income equivalent to 260 percent of the FPL is expected to pay 50 percent of the charges (N.J. Admin. Code §10:52-11.8).

State approaches to billing and collection practices. The ACA prohibits nonprofit hospitals to charge patients eligible for discounted care more than the rate “generally billed” to patients with insurance that covers the service and prohibits the use of gross charges (ACA §9007).

Similarly, some states limit charges to patients who are eligible for discounted care on the basis of rates paid by insurers. California requires hospitals to limit charges to individuals with family income at or below 350 percent of the FPL to the rates paid by Medicare or another government-sponsored health program (Cal. Health & Safety Code §127405(d)). For uninsured Minnesota residents earning less than \$125,000 annually, hospitals have agreed to limit charges to the maximum charged to a third-party payer for

the same service during the previous year (Minn. Hospital Assn and Atty Gen. 2005).

The ACA also bars tax-exempt hospitals from initiating “extraordinary collection actions” before making a reasonable effort to determine whether the patient qualifies for financial assistance (ACA §9007(a)). The IRS 2010 Schedule H requires tax-exempt hospital organizations with tax years beginning after March 23, 2010 to specifically identify the types of collection practices they employed during the tax year (IRS, 2011, lines 15-17).

Fifteen states¹⁰ have adopted billing and debt collection requirements that apply exclusively to medical debt (Community Catalyst, 2010a). Maryland requires written hospital policies that necessitate hospitals’ “active oversight” of third-party debt collection, prohibit selling medical debt, and prohibit interest charges on uninsured patients’ unpaid bills unless a court judgment has been obtained (Md. Code Ann., Health-Gen. §19-214.2). With respect to patients who are eligible for financial assistance, California hospitals may not charge interest on outstanding bills, seek wage garnishment, or seek liens against a patient’s primary residence. Although a third-party collection agency is not subject to the garnishment prohibition that applies to hospitals, a judicial garnishment order may not be granted unless the agency can show that the patient has the ability to pay, taking into consideration the size of the debt and the patient’s current and future financial obligations (Cal. Health & Safety Code §127425).

Like California, New York limits the interest rate that hospitals may charge for medical debt and protects a patient’s primary residence from foreclosure (N.Y. Pub. Health Law §§2807-2809). Pursuant to an agree-

ment between the Minnesota Attorney General and the Minnesota Hospital Association, Minnesota hospitals may not refer a patient's account to a collection agency or file suit against a patient for nonpayment before first confirming that all potentially responsible insurers have been billed and that a payment plan and financial assistance have been offered if the patient is eligible (Minn. Hospital Assn and Atty Gen., 2005, 2007). Similarly, the Massachusetts Attorney General has encouraged hospitals to develop mechanisms for addressing patient complaints about the actions of collection agents and to require third-party collection agents to secure written consent from the hospital before initiating legal action or reporting a patient's medical debt to a credit agency (Mass. Atty Gen., 2009).

State Approaches to Publicizing Financial Assistance Policies. Section 9007 of the ACA requires tax-exempt hospitals to adopt measures that “widely publicize” financial assistance policies in their communities. The 2010 Schedule H (Form 990) requires hospitals to identify methods they have used to publicize financial assistance policies during the 2010 tax year by selecting from options, which include posting the poli-

cy on the hospital's website; attaching it to patient bills; posting it in hospital emergency rooms, waiting rooms, admissions offices, or all of these locations; providing the written policy to patients upon admission; making it available upon request; or “other” methods (IRS, 2011, line 13).

States have adopted a variety of approaches to address this issue. Illinois requires financial assistance policies to be posted on hospital websites and, along with Ohio, requires them to be disseminated in non-English languages commonly spoken in the community (Ill. Pub. Act 094-0885; Ohio Admin. Code 5103:3-2-07.17). Maryland requires hospitals to distribute financial policies to patients at the time of admission, before discharge, with hospital bills, and upon request by patients or their representatives (Md. Code Ann., Health-Gen. §19-214.1). California relies on a similar approach: financial assistance information must be provided in the emergency department, billing office, admissions office, and other various outpatient settings (Cal. Health & Safety Code §127410). The state has also developed a patient-friendly website to help individuals determine whether they are eligible for financial assistance services and to identify potential care providers (OSHPD, 2007).

Community Benefit Reporting and Oversight Strategies

The Federal Framework. From 2007 to 2008, the IRS developed Schedule H (Form 990), the first federal income tax reporting requirements specifically focused on non-profit hospital community benefits. On February 25, 2011, the IRS released the 2010 Schedule H, which includes revised reporting requirements for nonprofit hospitals consistent with those in the ACA.

The ACA's new reporting requirements for federal income tax exemption will permit more effective comparative analyses of community benefits at the national level. With the exception of those relating to CHNAs, the new reporting requirements are effective for federal tax years beginning after March 23, 2010. As described in the next section, some states automatically grant state income tax exemption based on an organiza-

tion's federal tax-exempt status. Other states have their own reporting requirements that may or may not relate to a hospital's qualification for state income tax exemption. In either case, the ACA does not mandate that states alter their own reporting requirements to make state tax exemption standards conform to the ACA requirements embedded in Schedule H. However, state and local policymakers may wish to examine the new federal tax reporting framework to assess its utility for ensuring nonprofit hospital accountability at the state level. States have adopted community benefit reporting requirements to serve different purposes; these purposes may include qualification for state tax exemption or may be designed to serve other state policy objectives.

State Community Benefit Reporting

Requirements. In exchange for the value that nonprofit hospitals and other charitable organizations add to the community, most states exempt them from state tax (Jervis, 2005). At the federal level, hospitals that the IRS determines to be tax-exempt are not required to pay federal corporate income tax. A majority of states determine an organization's nonprofit state tax status in accordance with its federal tax-exempt status (Mancuso, 2002). Of the remaining states, those without a state corporate income tax excuse nonprofits from other forms of state taxation, such as property, franchise, and sales and use tax (CHA, 2010).

Forty-seven states (including the District of Columbia) have a state corporate income tax (Nevada, South Dakota, Washington, and Wyoming have no state corporate income tax). Of these 47 states, 44 use a corporation's federal tax status as the deciding factor in determining its tax status for purposes of state corporate income tax, either automati-

cally¹¹ or through a separate formal application process.¹² Three states¹³ determine a corporation's tax status independently of its federal tax exemption (Mancuso, 2002). The community benefit requirements of one of these three states—California—are discussed in the next section.

States may adopt community benefit reporting requirements as a tool for determining a hospital's qualification for either state nonprofit status or other policy-related purposes. A state may have mandatory,¹⁴ voluntary,¹⁵ or both mandatory and voluntary¹⁶ types of community benefit reporting requirements (CHA, 2010). Seven¹⁷ states have no community benefit reporting requirements. This national variation in state community benefit reporting is a product of each state's unique business, regulatory, and political climate.

States that have mandatory reporting requirements either link them to one or more federal, state, or local tax exemption or require community benefit reporting independent of a hospital's state tax status (CHA, 2010). North Dakota, for example, determines whether a hospital is exempt from state corporate income tax by deferring to its federal tax status, but links mandatory community benefit reporting to state sales and use tax exemption. New Mexico links mandatory reporting to hospital licensure, whereas North Carolina requires mandatory reporting only when nonprofit hospitals apply for tax-free bonds (CHA, 2010). As previously mentioned, Massachusetts has mandatory community benefit reporting for nonprofit acute care hospitals as a condition of original licensure (Mass. Gen Laws ch. 111, §51G(4)); for hospitals already licensed, reporting is voluntary (Mass. Atty Gen., 2009). Of the 14 states with mandatory community

benefit reporting, 7 require nonprofit hospitals to report charity care only (CHA, 2010).

Voluntary reporting requirements can bring about fuller disclosure of hospital community benefit activities and, consequently, greater transparency. The majority of states use this approach to align their community benefit reporting categories with those recommended by the CHA and Schedule H (CHA, 2010).

Other State Approaches to Community Benefit Reporting. Classifying state approaches to reporting is difficult. One approach refers to a “process” and “prescriptive” dichotomy (Goodman, 2009). A *process* approach emphasizes periodic CHNAs and development of community health improvement plans that respond to the community’s needs. States that adopt a process approach typically do not include minimum community benefit thresholds (Goodman, 2009). A *prescriptive* approach requires itemized reporting and may include minimum community benefit thresholds to facilitate accountability.

California’s process-oriented reporting law defines community benefits as “a hospital’s activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status” (Cal. Health & Safety Code §127340(a)). This approach illustrates flexibility in the types of public health-directed initiatives nonprofit hospitals may choose to develop, implement, and report, as long as they fall within state-specified descriptive categories. These categories may include activities such as providing free or reduced-cost care to uninsured or medically indigent patients, medical education, and community health initiatives (Barnett, 2006).

States that take a prescriptive reporting approach (e.g., Texas, Maryland, and Indiana) require more detailed information that can support an appraisal of a hospital’s progress in achieving community health improvement (Batchis, 2005). Texas requires nonprofit hospitals to provide community benefits that must include the provision of charity and government-sponsored indigent health care and may include other components of community benefits, such as medical and community health education (Tex. Health & Safety Code §311.045 and §311.031). Calculated in accordance with one of four alternative measures, a Texas nonprofit hospital must make community benefit expenditures in an amount that meets at least one of these criteria (Tex. Health & Safety Code §311.045; Tex. Tax Code Ann. §11.1801(a)):

- Is reasonable in relation to CHNA-identified community needs, the hospital’s available resources, and benefits that the hospital receives from its tax exemption
- Equals at least 4 percent of the hospital’s net patient revenue
- Equals at least 100 percent of the value of benefits the hospital receives as a result of its state tax exemption
- Equals at least 4 percent of net patient revenue, which, when combined with the value of other charity care and community benefits, equals at least 5 percent of the hospital’s net patient revenue

Standardized community benefit categories and definitions can improve community benefit accountability (Gray & Schlesinger, 2009). Maryland requires hospitals to report community benefit expenditures within specific categories of qualifying activities, including community health services, health professions education, mission-driven health

services, research, financial contributions, community building activities, community benefit operations, charity care, and foundation community benefits (COMAR 10.37.01.03L-3; Maryland Health Services Cost Review Commission (HSCRC), 2010b).

State Accountability Mechanisms.

To ensure compliance with community benefit reporting requirements, some states levy monetary penalties against noncompliant hospitals. For example, Texas and Indiana impose civil penalties of \$1,000 for each day a report is overdue (Hellinger, 2009). Maryland's hospital regulatory agency has the authority to impose on hospitals a civil penalty of \$250 for each day a report is overdue and may refuse to grant a rate increase¹⁸ (COMAR 10.37.01.03N).

California, Indiana, Maryland, Massachusetts, and Rhode Island require nonprofit hospitals to evaluate their community benefit programs (CHA, 2010). Maryland and Indiana hospitals must include a description of their efforts or mechanisms to evaluate the effectiveness of their community benefit initiatives in their annual community benefit reports (Md. Code Ann., Health-Gen. §19-303(c)(2)(v); Indiana Code §§16-21-9-6 and 16-21-9-7).

California similarly requires an evaluative component (Cal. Health & Safety Code

Policy Implications

As state decision makers monitor ACA implementation, they will assess the capacity of the new federal mandates to ensure that hospital community benefit activities actually benefit their communities, are consistent with the intended purposes of tax exemptions, and are aligned with state and local public health priorities. The ACA's approach to communi-

Hospitals provide additional explanation of their community benefit activities in a mandatory narrative section, based on questions developed by reference to pre-ACA federal reporting requirements, as reflected in the 2008 Schedule H (HSCRC, 2009b).

§127355). In 2002, California hospitals' community benefit reports showed common challenges in their efforts to conduct evaluations, including inadequate staffing, problematic availability of relevant data sources, obstacles to coordinating with local public health agencies, competition among community stakeholders, and a lack of internal policies and procedures to encourage accountability (Barnett, 2006). The Massachusetts Attorney General's *Community Benefits Guidelines for Non Profit Hospitals* emphasizes the importance of including an evaluation component as part of the planning, budgeting, and implementation of community benefit initiatives. Finally, a 2009 analysis of community benefit reporting in Texas illustrated the need for standardized definitions of charity care and other community benefits in order to 1) facilitate a fair assessment of community benefit expenditures from hospital to hospital and 2) determine compliance with state community benefit threshold requirements (Texas Legal Services Center, 2009).

ty benefit reporting can help them achieve these objectives. As states evaluate their community benefit policies, they should consider the following key principles and issues:

- The central purpose of a CHNA is to identify community health needs with the goal of improving the health status of a

population. How can states use the ACA's CHNA requirements to improve health within their communities?

- New ACA reporting requirements, together with information provided in Schedule H, will necessitate more standardized reporting of hospital practices related to community benefit expenditures, CHNAs, and financial assistance. How can states use this information to better prioritize and promote the provision of services that are most responsive to community needs?
- States are involved in an array of activities to implement federal health reform mandates. As the ACA's coverage and delivery system changes and quality provisions are implemented, how can states best ensure that hospital community benefit activities are appropriately connected with broader health reform goals?
- Which state accountability approaches can best ensure that nonprofit hospital community benefit activities support and align with state and local public health objectives?

Conclusion

The policy attention given to hospital community benefit provisions in the ACA highlights the important obligation of nonprofit hospitals to address health needs in the communities they serve. To be effective, hospital community benefit activities should be aligned with national, state, and local health goals. State governments have leadership responsibility for meeting the national health improvement goals set forth by the ACA. These include effectively managing chronic conditions, reducing health disparities, assisting those who remain uninsured with access to needed health care services, promoting wellness, and improving community health status. States will need to establish partnerships to effectively address national health priorities and develop collaborations for resolving unique state and local health problems.

The approaches outlined in this issue brief provide an underpinning for successfully connecting hospital community benefits and state health goals. States are paying significant attention to community health needs assessments, financial assistance and collection policies, and reporting requirements. This work can inform the efforts of others to improve hospital accountability. In addition, state and local governments can benefit by accessing information that hospitals submit to federal regulators. In that context, the next issue brief in this series will review what states can learn from the IRS Schedule H and Form 990, and how they can use that information to help them achieve their public health goals.

Endnotes

¹ The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152. The consolidated acts are referred to herein as the Affordable Care Act (ACA).

² By its Notice 2010-39, the IRS requested guidance in advance of rulemaking under ACA §9007. The forthcoming rulemaking is listed in the IRS's 2010-2011 Priority Guidance Plan (www.irs.gov/pub/irs-utl/2010-2011_pgp.pdf).

³ The acronym "FPG" appears in Schedule H (Form 990) and its instructions to signify the "federal poverty guidelines." These are used to determine eligibility for means-tested federal programs (<http://aspe.hhs.gov/poverty/faq.shtml#differences>). The term "federal poverty level" or "FPL" also refers to the guidelines; it is a less formal but equivalent term (<http://www.ocpp.org/cgi-bin/display.cgi?page=poverty>). This issue brief uses FPL because it is more recognizable than the technically accurate FPG.

⁴ CA, FL, IN, IA, ME, MD, NV (limited), NJ, RI, TX, UT, WA, and WV (Community Catalyst, 2010a).

⁵ CA, CO, IN, LA, ME, MA, NV, NH, NJ, NY, OH, OK, RI, SC, SD, TX, VA, and WA (Community Catalyst, 2010a).

⁶ CO, MA, NJ, NY, RI, SC, and WA (Community Catalyst, 2010a).

⁷ CA, IL, MD, MN, NH, NJ, and NY (Community Catalyst, 2010a).

⁸ CA, CT, IL, IN, ME, MD, MA, MN, NH, NJ, NY, OH, PA, RI, SC, TN, TX, UT, WA, and WV (Community Catalyst, 2010a).

⁹ Of Maryland's 47 hospitals, all but one are nonprofit. (Maryland Health Care Commission, 2011; HSCRC, 2010b)

¹⁰ MD, MA, MI, MO, NH, NM, OH, OR, PA, RI, SC, TX, WA, WV, and WI (Community Catalyst, 2010a).

¹¹ The 23 states that grant automatic exemption based on the federal determination are AK, CO, CT, HI, ID, IL, KS, LA, MI, MS, MO, NE, NM, ND, OH, OK, OR, RI, SC, TN, VA, WV, and WI (Mancuso, 2002).

¹² The 21 states (including the District of Columbia) that require a separate application but still base their decisions solely on the federal determination are AL, AZ, AR, DE, DC, FL, GA, IN, IA, KY, ME, MD, MA, MN, NH, NJ, NY, PA, TX, UT, and VT (Mancuso, 2002).

¹³ The three states with a separate determination are CA, MT, and NC (Mancuso, 2002).

¹⁴ The 14 states with mandatory community benefit reporting are AL, CA, IL, MD, MS, ND, NH, NM, NV, PA, RI, TX, UT, and WV (CHA, 2010).

¹⁵ The 20 states that have voluntary community benefit reporting are AK, CO, DE, DC, FL, HI, IA, KS, KY, MA, MI, MO, MT, NE, NJ, OH, OK, SC, TN, and WA (CHA, 2010).

¹⁶ The ten states that have mandatory and voluntary community benefit reporting are CT, GA, IN, ID, MN, NC, NY, OR, VA, and WI (CHA, 2010).

¹⁷ The seven states with no hospital community benefit reporting requirements are AR, AZ, LA, ME, SD, VT, and WY (CHA, 2010).

¹⁸ Under Maryland's unique system of hospital reimbursement (operated under the authority of a Medicare waiver), the HSCRC sets cost-based hospital rates applicable to all payers. Maryland law prohibits hospital charges for services other than at a rate set or approved by the HSCRC (Maryland Code Ann. Health-Gen. §19-219(b)(2)).

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized policy and 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. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

Hilltop's Hospital Community Benefit Program is the central resource created specifically for state and local policymakers who seek to assure that tax-exempt hospital community benefit activities are more responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, and hospitals, as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).



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