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Hospital Community Benefits after the ACA *Leveraging Hospital Community Benefit Policy to Improve Community Health*

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Introduction

More than a decade ago, David Kindig articulated a definition for population health that focuses on health outcomes and the broader social and economic factors that influence health:

Population health refers to the health outcomes of a group of individuals, including the distribution of such outcomes within the group ... many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level. (Kindig & Stoddart, 2003)

Kindig's definition sparked spirited debate among researchers and policymakers and provided a needed framework for public policy. The definition was subsequently reflected in the Triple Aim introduced in 2008 and guided the conceptualization of many of the initiatives in the 2010 Affordable Care Act (ACA). Today, "population health" is sometimes used in a more limited way—e.g., to refer to the "population" of enrollees in a health plan or the "population" of patients in a hospital (Sharfstein, 2014). By referencing Kindig's definition, we are reminded that the concept of population health is much more comprehensive. It encompasses the health outcomes of the broader population, as well as its many sub-groups;

recognizes the importance of the "upstream" determinants of health; and calls for cross-sectoral collaboration to achieve cost-effective resource allocation.

The ACA promotes population health by increasing access to affordable health insurance and authorizing new service delivery and payment models that focus on health outcomes and the quality of care. With more Americans enrolling in public and private health insurance plans, fewer will need to rely on charity care from hospitals. However, hospitals will continue to be an important safety net for uninsured and underinsured populations. To ensure access to and the affordability of hospital care, §9007 of the ACA requires nonprofit hospitals to comply with certain financial assistance policies and billing and collection practices. Further, the ACA encourages hospitals to address population health by requiring nonprofit hospitals to conduct and implement a community health needs assessment at least every three years with participation from public health professionals and community members (Folkemer et al., 2011). The hospital community benefit requirements in the ACA provide unprecedented opportunities to leverage the resources of the health care delivery and public health systems to build a more responsive, integrated system focused on population health.

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The final rules issued by the Internal Revenue Service (IRS) on December 31, 2014, regarding implementation of the ACA's hospital community benefit provisions provide further clarification and support for community health improvement activities by hospitals. The rules state that the "health needs of a community ... include not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or the need to address social, behavioral, and environmental factors that influence health in the community" (IRS, 2014).

Recognition of the importance of population health comes at the same time that a number of forces are

Converging Forces

As discussed below, a number of forces are converging to bring a national focus to population health and the importance of addressing the upstream determinants of health. Hospitals are now actively engaged in the discussion, looking to redefine their role in the community and realign their business models. The Triple Aim's call to improve population health, the hospital community benefit requirements in the ACA, and innovative payment models that reward value instead of volume are bringing about a major transformation in the health care delivery system. State policymakers are advised to monitor these developments and seek new opportunities to further incentivize and support transformative change aimed at improving the health of communities.

The Focus on Population Health is Driving a Realignment of the Traditional Hospital Business Model. In April 2014, the flagship publication of the American Hospital Association reported the following:

The traditional volume-based business model for the general acute care hospital is in its death throes ... The successful business model of the future hinges on which emerging health care payment strategies prevail ... Forward-thinking health care systems are developing strategic plans that redefine the hospital's role in the continuum of health care services. (Butcher, 2014)

converging to bring about a radical transformation in the traditional volume-based business model for acute care hospitals. Payment reform focusing on value and quality is driving change that is redefining the hospital's role in the continuum of care and the health of the broader population. This eleventh issue brief in the series *Hospital Community Benefits after the ACA* discusses these developments and identifies opportunities for state policymakers to encourage the evolution of hospital community benefit policy in ways that complement and support the realignment of the hospital business model, proactively address the social determinants of health, and ultimately improve the health of the entire community.

The article goes on to quote John Bluford, president and CEO of Truman Medical Centers in Kansas City, MO, who said, "The future of the hospital can't be the building on the corner or down the street. It's got to be immersed in the daily culture of the community that it serves" (Butcher, 2014).

Two trends are emerging as hospitals consider strategies for addressing the continuum of care and the health of the broader population. First, new financing and delivery models focusing on value and quality are driving a new wave of vertical integration. Hospitals are purchasing medical practices and acquiring surgery centers, post-acute care facilities, laboratories, imaging centers, ambulatory care centers, and home health agencies. Hospitals are pursuing vertical integration not only through purchases and acquisitions but also through contracting arrangements that involve shared protocols and incentives (e.g., ACOs). Through vertical integration, hospitals can receive more of the premium dollar, offer more expansive managed care products, and have more control over the continuum of care (Summer, 2010; Nichols, Ginzburg, Berenson, Christianson, & Hurley, 2004; Hurley, n.d.; Walston, Kimberly, & Burns, 1996).

Second, hospitals and health systems are also becoming insurers, offering provider-sponsored health insurance plans to local employers and in the state marketplaces. The health insurance exchanges provide a new opportunity for provider-sponsored plans to offer competitive products in the individual and small group insurance markets that have long been

dominated by traditional insurers. Many consumers prefer to enroll in a health plan offered by a local hospital or health system that they know and trust. Consumers will also accept the more limited provider network that these plans offer if the plan is priced competitively. With their own health plans, hospitals and health systems can capture the entire premium dollar and have a greater incentive to coordinate care, lower costs, and keep the populations they serve healthier (Demko, 2014).

The Triple Aim Provides a Framework for Health Reform. The Triple Aim calls for simultaneously improving population health, improving the patient experience of care, and reducing per capita cost. Developed by the Institute for Healthcare Improvement (Berwick, Nolan, & Whittington) and first introduced in 2008, the Triple Aim quickly became the mantra for health reform at the federal level, calling for fundamental change in health care delivery systems to promote the overall health of the population while reducing costs.

The Triple Aim is reflected throughout the ACA. Provisions throughout the legislation promote population health—e.g., increasing access to care by expanding health insurance coverage through the individual mandate, state marketplaces, and Medicaid expansion; accountable care organizations (ACOs) that incentivize providers to take responsibility for population health outcomes; full Medicare coverage for many preventive services so there is no cost to the beneficiary; and requirements for private plans in the individual and small group markets to provide “essential health benefits” that include certain preventive services. The ACA established the National Prevention, Health Promotion, and Public Health Council (§4001), which introduced a National Prevention Strategy in 2011. The National Strategy to Improve Health Care Quality (§3011) resulted in the National Quality Strategy led by the Agency for Healthcare Research and Quality (AHRQ), which uses the Triple Aim as its organizing framework (Stoto, 2013).

ACA Hospital Community Benefit Requirements Promote Community Health. Federal policy dating back to 1969 requires hospitals to provide benefits to the community to maintain tax-exempt status.¹ The value of the nonprofit hospital tax exemption, estimated at \$12.6 billion in 2002, reached \$24.6 billion in 2011 (Rosenbaum, Kindig, Bao, Byrnes, &

O’Laughlin, 2015). Section 9007 of the ACA requires hospitals to conduct a community health needs assessment (CHNA) at least once every three years with input from stakeholders—including stakeholders with a knowledge of public health—and adopt an implementation strategy to meet identified community health needs. The ACA also requires hospitals to comply with provisions related to financial assistance policies, limitations on charges to patients who are eligible for financial assistance, and billing and collection practices.

In addition to federal requirements, 25 states have enacted their own conditional or unconditional requirements regulating provision of charity care and/or community benefits.² As Nelson, Mueller, Wells, Boddie-Willis, and Woodcock (2015) explain, while state laws have focused mostly on reporting requirements and financial assistance policies, a number of forward-thinking states—recognizing that the need for charity care will decline as more people obtain health insurance coverage—are encouraging hospitals to use hospital community benefit dollars to address the social determinants of health and promote community health. With the Medicaid expansion and the availability of subsidized coverage through the state marketplaces, the percentage of U.S. adults without health insurance has dropped 4.2 percent, and hospitals saw a reduction in uncompensated care of \$7.4 billion in 2014 (Gallup, 2015; Kaiser Health News, 2015).

New Payment Models Test the Landscape. Under a fee-for-service system, hospitals and physicians are compensated based on the volume of procedures and tests they order or perform for patients. There is little financial incentive to reduce hospitalizations or the number of procedures; coordinate patient care after discharge; or prevent illness and improve community health. According to Delbanco (2014), value-oriented payment reforms designed to improve quality and reduce waste now account for 40 percent of commercial sector payments to physicians and hospitals. Among these reforms is pay-for-performance, which awards bonuses to providers who meet goals for quality and efficiency. Bundled payments combine reimbursement for multiple providers into one comprehensive payment covering all of the services related to an episode of care (Delbanco, 2014). ACOs are organizations of hospitals, physicians, and other health care providers who are accountable for the

quality, cost, and overall care of a group of patients and share in any savings that are achieved. Patient-centered medical homes (PCMHs) organize primary care with the aim of achieving higher quality and lower costs. Medicaid health homes authorized under §2703 of the ACA target beneficiaries with chronic conditions and aim to provide comprehensive, coordinated services using innovative financing arrangements.

The U.S. Department of Health and Human Services (HHS) continues to encourage expansion of value-oriented payment reforms for Medicare, Medicaid, and commercial payers through these and other models. In February 2015, HHS announced ambitious targets for Medicare value-based payment: 30 percent of Medicare payments should be tied to quality or value through alternative payment models by 2016, and 50 percent by 2018 (Burwell, 2015).

State Innovation Models (SIM) Target Payment Reform and Population Health. The SIM initiative of the Centers for Medicare and Medicaid Services (CMS) is providing support to states to develop and test multi-payer health care payment and service delivery models aimed at improving health system performance, improving quality, and lowering costs for Medicare and Medicaid beneficiaries. In Round One, CMS awarded more than \$300 million to 25 states to design or test new models. In Round Two—currently underway—CMS is providing more than \$660 million to 28 states, three territories, and the District of Columbia for model design and testing (CMS, 2015). Seventeen SIM states are establishing regional collaborative structures, often referred to as accountable health communities (AHCs). CMS is exploring how these models might be expanded, as well as ways to integrate health-related social services into the financing structure (Corrigan, Fisher, & Heiser, 2015).

Global Budgets Address the Triple Aim. Under a global budget, a government agency sets an annual budget for a hospital, a region, or an entire state or nation, and that is the amount of funding available to deliver health care to an entire population. Providers are at risk for excessive spending and are rewarded for achieving performance and quality goals. In Oregon, the state Medicaid agency assigns a global budget to each of the state's coordinated care organi-

zations (CCOs) each year. CCOs consist of partnerships of payers, providers, and community organizations and assume risk for all Medicaid beneficiaries in a designated geographic area. CCOs receive incentive payments for meeting certain performance metrics but stand to lose money if they exceed their global budget (Plaza, Arons, Rosenthal, & Heider, 2014). In Vermont, which already regulates hospital budgets, Rutland Regional Medical Center recently asked to transition to a global budget, and the state is exploring such a system. To move forward, Vermont will first need approval from CMS to include the state's Medicaid program, as well as a federal waiver for Medicare participation (True, 2014). In 2012 in Massachusetts, former Governor Deval Patrick signed legislation establishing an annual global spending target for total health care expenditures with annual growth tied to the growth rate of the state's economy. According to Steinbrook (2012), this legislation built on the reforms enacted in that state in 2006, which became the model for the ACA.

Maryland's new all-payer system is the most far-reaching global budget initiative and aims to transform the state's entire health care delivery system to improve health care, lower costs, and promote population health. The Maryland All-Payer Model Agreement, signed by CMS and the state on February 11, 2014, limits Medicare per capita hospital costs to 0.5 percent less than the actual national growth rate, with the goal of achieving \$330 million in Medicare savings over five years. The agreement also limits annual all-payer per capita total hospital cost growth to 3.58 percent, institutes quality requirements related to readmissions and preventable conditions, and monitors population health outcomes (Maryland All-Payer Model Agreement, 2014; Rajkumar et al., 2014). Global budgets for hospitals are intended to provide a more stable and predictable revenue base as hospitals implement population health approaches to achieve the Triple Aim. An annual budget is set prospectively for each hospital. A Total Patient Revenue (TPR) model was first used by Garrett County Memorial Hospital in Maryland more than 20 years ago; 10 other Maryland hospitals—predominantly in rural areas—subsequently adopted the TPR rate-setting methodology. Presently under the new all-payer system, 90 percent of hospital revenue is under global budgets.

Opportunities for States

Section 9007 of the ACA, together with the IRS final rules, promulgates basic principles and expectations for nonprofit hospitals related to assessing and addressing community health needs, establishing financial assistance policies for individuals and families who are uninsured, and implementing billing and collection practices that protect consumers. State policymakers can build on this framework to shape community benefit policy in a way that emphasizes community health improvement and advances the Triple Aim of better care, better health, and lower costs. Community benefit policy can also be structured to ensure that hospitals—in their role as anchor institutions and key players in local health planning and the delivery of care—partner with state and local agencies in efforts to improve community health (Initiative for a Competitive Inner City [ICIC], 2011). Most importantly, payment reform that rewards value as opposed to the volume of services provided is the key driver forcing the realignment of the hospital business model, and hospitals are coming to understand that improving the health of the broader community will ultimately benefit their bottom line. State policymakers should be cognizant of this and structure policies to complement and support this transformation.

Build on Federal Rules. States have pursued a variety of approaches to augment federal policy to address community benefit goals, including legislation, legally binding agreements, reporting forms, and linking other programs such as the State Health Improvement Plan (SHIP) to the state’s community benefit framework (Nelson et al., 2015). The strategies below can be used to build on federal requirements to more effectively address community health needs.

- *For state reporting, eliminate the distinction between community benefit and community building activities.* This could encourage community building activities aimed at addressing the social and economic determinants of health in states that require hospitals to report community benefit activities and/or expenditures. However, because the IRS still requires separate reporting of these activities on Schedule H, some hospitals may still be deterred from carrying out community build-

ing activities. At the same time, states could work with researchers and federal agencies such as the Centers for Disease Control and Prevention (CDC) to document the outcomes and cost-effectiveness of public health improvements that resulted from community building activities, and this evidence could in turn be used to recommend “safe harbors” for justifying such activities as “community health improvement services” on Schedule H of IRS Form 990 (Rosenbaum, Rieke, & Byrnes, 2014; Corrigan et al., 2015).

- *Require electronic reporting by hospitals.* States could require hospitals to report Schedule H expenditure data electronically to facilitate analysis of expenditures across hospitals. Not all hospitals are currently required to report these data electronically to the IRS. Form 990 filings, while public documents, are available in PDF format only (Noveck & Goroff, 2013). By requiring electronic reporting, states could help address the lack of quantitative data on hospital community benefit expenditures for program monitoring, research, and policy development.
- *Promote greater stakeholder involvement in the CHNA process.* To increase transparency and accountability, states could require hospitals to engage a broader group of public and private stakeholders and report on stakeholder participation throughout all phases of the CHNA process, including assessment, implementation, and evaluation. To foster greater collaboration among hospitals and state and local agencies, states could align the reporting periods for community health assessments performed by state and local health departments with the ACA-required CHNAs that hospitals must conduct every three years. States could also require hospital community benefit expenditures to be tied to initiatives in the community’s CHNA.
- *Expand community benefit obligations to additional health care providers.* New Hampshire extends community benefit requirements to what the state defines as “health care charitable trusts,” which includes nonprofit hospitals, outpatient facilities, nursing homes, medical-surgical facilities, and diagnostic therapeutic facilities.³ Utah,

Pennsylvania, Minnesota, and Texas require nursing homes to satisfy community benefit-like charitable obligations. In addition to increasing resources for community benefit activities, this incentivizes providers along the continuum of care to participate in joint community planning efforts.

Promote Regional Collaboration. The IRS final rules clarify that joint CHNAs involving multi-facility collaborations and collaborations between hospitals and public health agencies is not only permissible but encouraged, as are joint implementation activities (Rosenbaum, 2015). The final rules also clarify that community benefit regulations apply to licensed hospital facilities, meaning that hospital systems composed of multiple hospitals must comply with the facility-specific standard. While some caution that this could impede the collaborative regional planning approach that many hospitals are adopting for their CHNAs, as well as states' SIM initiatives and other regional and statewide delivery system reforms (Corrigan et al., 2015), states could encourage multi-hospital systems to carry out planning at the system or regional level that encompasses planning efforts by local facilities owned by the system.

By encouraging hospitals to participate in regional collaborations involving local health departments, SIM grantees, ACOs, health care providers, and non-health government agencies and community-based organizations, states could better leverage hospital and community resources, minimize duplicative efforts, and align delivery system reforms with efforts to improve community health and address upstream determinants of health (e.g., low income, inadequate housing, limited transportation options, food insecurity, and low educational attainment). For example, the state of New York requires local health departments and hospitals to work with each other and urges collaboration across sectors with other entities as well. Local health departments and hospitals are now collaborating with such entities as regional planning organizations, federally qualified health centers, employers and businesses, community based organizations, rural health networks, other governmental agencies (including those providing mental health and substance abuse services, transportation, housing, etc.), community-based health and human service agencies, local schools and academia, policymakers,

the media, and philanthropic organizations (New York State Department of Health, 2012).

To help finance collaborative efforts, a number of states are establishing Prevention and Wellness Funds⁴ to pool resources “as part of a health improvement and cost-containment strategy to finance community prevention interventions” (Prevention Institute, 2015). Hospital contributions to these trusts qualify as community benefit expenditures, and disbursements from the funds are distributed as grants to community organizations. One example is the Massachusetts Prevention and Wellness Trust Fund, which is financed by a small fee charged to health insurers and acute care hospitals and is presently funded at \$60 million (Prevention Institute, 2015; McGill, 2013).

States should consider involving health legacy foundations in regional collaborations. Niggel and Brandon (2014) report that, in 2010, there were more than 300 of these foundations in 43 states, with assets totaling \$26.2 billion. Health legacy foundations—previously referred to as conversion foundations—were created to receive the proceeds from the sale or conversion of nonprofit hospitals, health care systems, health plans, and specialty care facilities to for-profit entities. The mission of many of these foundations includes prevention and community health improvement, so these could be an important source of supplemental funding for collaborative initiatives. Many of these foundations are recognized for the important role they play in convening community stakeholders.

Encourage Multi-Payer Payment Reform that Rewards Value and Promotes Population Health.

Payment systems that not only require hospitals to assume risk for more efficiently managing patients across settings of care but also hold hospitals accountable for health outcomes for the entire population in their service area are likely to be the most effective mechanism for incentivizing hospital realignment and driving improvements in population health. State policymakers should ensure a supportive environment for delivery system reforms, such as multi-payer ACOs, AHCs, global budgets, and statewide initiatives like the Maryland all-payer system. The federal SIM initiative is supporting many states in these efforts, providing funding and technical assistance for model design and testing.

Monitor Vertical Integration across the Continuum of Care. As discussed above, a new wave of vertical integration is occurring in the hospital sector driven by payment models that reward value and quality. The challenge for state policymakers is how to support strategic vertical integration across the continuum of care while, at the same time, monitoring the outcomes of hospital acquisitions and alliances to ensure a functional, competitive marketplace that deters marketplace domination by one or two large hospital systems and promotes cost containment and the delivery of quality care. Policymakers should exercise caution, as there is no systematic research on the extent to which vertical integration in the health care market promotes economies of scale, greater efficiency, improved care coordination, or better quality (Walston et al., 1996; Nichols et al., 2004). Some anecdotal evidence suggests that vertical integration can even raise prices in more concentrated markets (Summer, 2010). Anti-trust enforcement may have limited applicability here as it is generally more appropriate for blocking mergers of large organizations; other strategies are needed to monitor small or serial acquisitions by hospitals pursuing vertical integration (Summer, 2010). For example, instead of acquisitions, the state could encourage contractual arrangements involving shared resources, protocols, and incentives; this would give hospitals and their collaborators more flexibility. Such arrangements have been termed vertical “relationships” instead of vertical integration (Walston et al., 1996). Prevalent in ACOs and other health home models, the federal government is encouraging these arrangements. Similarly, states could allow hospitals to enter into such arrangements with private sector entities without the threat of undue regulatory scrutiny.

Global budgets—which limit resources available to a hospital or health care system and establish benchmarks for performance and quality—hold promise for incentivizing collaboration and efficiencies across the continuum care while promoting the health of the broader community. The extent to which the global budgets adopted in Maryland and Massachusetts incentivize vertical integration will be important to document. Some of the SIM states are also designing global budget demonstrations. Because definitive research findings are not yet available on vertical in-

tegration in these new environments, states should be cautious when enacting any new legislation, rules, or regulations addressing vertical integration or related delivery system reforms.

Invest in Data Collection and Performance Metrics. By investing in health information infrastructure, data collection, and the development of measures to track progress in improving community health, states will be better equipped to monitor hospital community benefit activities and progress in addressing social and economic determinants of health. As a first step, states should collect electronic data on hospital community benefit activities for program planning, monitoring, and evaluation. New measures and interactive tools are also becoming available to states. For example, in 2014, HHS engaged the National Quality Forum to develop measures against which hospitals’ efforts to improve community health could be evaluated (Nash, 2014). *Community Health Status Indicators-2015* is an interactive web application on the CDC website that presents county profiles with key indicators of health outcomes; the tool can be used to track progress in addressing the social determinants of health. The health department in Howard County, Maryland, is investing in a system to aggregate population and demographic data by ZIP code and census tract for use in community needs assessments and health planning. Dignity Health, which operates hospitals and ancillary care facilities in 17 states, has partnered with Truven Health Analytics to develop a Community Need Index. The index assigns a score to each ZIP code in the country for each of five socioeconomic barriers that affect health: income, cultural/language, education, insurance, and housing (Dignity Health, 2015). Coupled with hospital performance measures developed in recent years through national public-private collaborations, data to monitor population health improvement at the local, regional, and state level will be critical to assessing the effectiveness of hospital community benefit policy and the effects of the evolving hospital business model on community health.

Concluding Thoughts

As anchor institutions, hospitals are inextricably tied to the economic and social fabric of their communities. In this important role, hospitals have a responsibility to their communities even as they realign their business models to respond to a rapidly changing environment that is moving away from fee-for-service reimbursement to payment based on value and quality. Harvard Business School Professor Michael Porter offers an important perspective for hospitals as they manage change, which he calls “shared value” (Porter & Kramer, 2011). Value creation, long recognized as central to successful business strategy, is the basic premise behind this concept. Porter and Kramer (2011) maintain that an institution’s competitiveness can be enhanced by creating shared value, which should focus on “identifying and expanding the connections between societal and economic progress” within the community.

To create shared value, ICIC (2011) suggests that hospitals can interact with their communities in the following ways to address the upstream determinants of health: “as a provider of products or services; real estate developer; purchaser; employer; workforce developer; cluster anchor; and community infrastructure builder.” ICIC cites the Johns Hopkins Institutions in Baltimore, who partnered with the Annie E. Casey Foundation and state and local governments to create East Baltimore Redevelopment, Inc. (EBRI) to construct new housing, life sciences and biotech labs and offices, retail space, a cultural center, and open public spaces. In addition, the Cleveland Clinic launched an ambitious drive to reduce smoking and obesity in Cleveland, which is expected to result in a healthier citizenry as well as healthier, more productive employees for the Clinic (ICIC, 2011). In De-

troit, the Henry Ford Health System—through a multi-institution partnership—has encouraged employees to live, work, and invest in the same community; helped establish a local business incubator; and used its purchasing power to persuade suppliers to relocate to Detroit (Zuckerman, Sparks, Dubb, & Howard, 2013). Hospital community benefit policy can be leveraged in these ways to transform communities and improve the health of the entire population.

Changing a mindset is difficult. In today’s resource-constrained environment, hospital leaders are likely to direct hospital community benefit dollars to the immediate needs of current patients or to reach targets for hospital quality.

State policymakers can play a pivotal role in encouraging hospital leaders to turn their attention outward to work with state agencies, local health departments, and community collaborators to develop a shared vision and process for addressing broader community needs. Tying hospital community benefit expenditures to CHNA implementation and evaluation will be important. Encouraging hospital leaders to incorporate community health improvement into institutional strategic plans will also help solidify the role of the hospital in promoting community health. Policymakers could also encourage hospital boards to introduce incentive-based compensation for hospital executives to reinforce the hospital’s commitment to the broader community. In these and other ways, hospitals, policymakers, and community stakeholders can partner to create shared value and, at the same time, help ensure the long-term profitability, effectiveness, and sustainability of hospitals.

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Endnotes

¹ For a summary of federal rulemaking, see the tenth issue brief in this series entitled *Hospital Community Benefits after the ACA: State Law Changes and Promotion of Community Health* (February 2015), pp. 3-4.

² CA, DE, FL, GA, IL, IN, ME, MD, MA, MS, MT, NV, NH, NM, NY, NC, OH, PA, RI, SC, TX, UT, VA, WA, WV. For more information on what these states have enacted, see Hilltop's *Hospital Community Benefit State Law Profiles* at http://www.hilltopinstitute.org/hcbp_cbl.cfm.

³ New Hampshire defines "health care charitable trusts" as "... a charitable trust organized to directly provide health care services..." (N.H. Rev. Stat. Ann. Tit. I, §§ 7:32- d).

⁴ Prevention and Wellness Funds are also called Prevention and Health Equity Trusts, Health and Prevention Trusts, Wellness Trusts, and Pooled Funding for Prevention (Prevention Institute, 2015).

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization 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. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

Hilltop's Hospital Community Benefit Program is a central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs. The program provides tools to state and local health departments, hospital regulators, legislators, revenue collection and budgeting agencies, hospitals, and community-based organizations to use as these stakeholders develop approaches that will best suit their communities and work toward a more accessible, coordinated, and effective community health system.

This is the eleventh issue brief in the series, *Hospital Community Benefits after the ACA*, published by the Program. The series began in January 2011 with *The Emerging Federal Framework* and has addressed numerous important policy issues surrounding hospital community benefit. These include additional requirements for tax-exempt hospitals established by the ACA; federal and state approaches to community benefit regulation; social and economic factors that shape health; and the importance of state-level regulation of hospital community benefit.

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analysis to advance the health of vulnerable populations

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