



## The Hilltop Institute

analysis to advance the health of vulnerable populations

### Hospital Community Benefits after the ACA State Law Changes and Promotion of Community Health

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#### Overview

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Hospital community benefit policy is evolving differently by state. Media reports in the early 2000s exposed egregious billing and debt collection practices by some hospitals<sup>1</sup> and prompted a number of states to enact legislation and policies addressing the provision of charity care and financial assistance, as well as practices related to patient charges, billing, and collection. Since passage of the Affordable Care Act (ACA)<sup>2</sup> in 2010 and subsequent rulemaking, state community benefit policy has increasingly moved beyond a focus on financial assistance policies to pursuing strategies that address the social determinants of health and promote community health.

In this issue brief, Hilltop's Hospital Community Benefit Program examines state-level community benefit<sup>3</sup> oversight by studying specific changes to community benefit statutes, regulations, and policies in 5 states selected from among the 40 states known to provide oversight of any type. These five states—Colorado, Illinois, Minnesota, New Hampshire, and New York—adopted changes during the period spanning four years before and

after adoption of the ACA (i.e., 2006 to 2014).<sup>4</sup> The changes enacted by these states illustrate the diverse ways in which state-level policy is evolving. These changes in state community benefit landscapes reflect the nature and scope of community benefit regulation prior to adoption of the ACA; differing state goals and objectives; the specific state entities that drive community benefit policy; and the strength and priorities of state health departments, hospital associations, and other advocacy/community groups.

Table 1 summarizes specific changes made by the five states. The table distinguishes between laws, regulations, and policies that a) affect provision of charity care, financial assistance, and/or charges, billing, and collection practices (i.e., traditional community benefit oversight) and b) promote community health improvement. Of these five states, not every state made changes in each category.

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**Table 1: Summary of Examined Statutory, Regulatory, and Policy Changes**

State	Summary of Change
<b>Changes Affecting Provision of Charity Care, Financial Assistance, and Charges, Billing, and Collection Practices</b>	
<b>Colorado</b>	Adopted two laws establishing, among other things, statewide eligibility standards for financial assistance for the uninsured; compliance monitoring of hospitals; and strict new requirements for correcting hospital billing errors and omissions
<b>Illinois</b>	Adopted new eligibility standards for property and sales tax exemption; mandated a charitable discount of 100 percent for patients below specified income levels; and established statewide standards for financial assistance applications
<b>Minnesota</b>	Instituted court-filed Hospital Agreements to establish “working standards” related to the provision of charity care, financial assistance, and charges, billing, and collection practices
<b>New Hampshire</b>	Considered but delayed a repeal of its Certificate of Need (CON) statute until 2016, and left untouched existing regulations requiring CON applicants to provide free care and remain accessible to individuals who are “medically underserved”
<b>Changes Promoting Community Health Improvement</b>	
<b>New Hampshire</b>	Included social and economic health determinants in a list of community health needs that may be reported as community benefit
<b>New York</b>	Adopted policies that integrated prevention, community health needs planning, and ACA hospital community benefit approaches into its State Health Improvement Plan (SHIP), <sup>5</sup> provided technical assistance to hospitals and health departments, and began reporting outcomes
<b>Minnesota</b>	Passed legislation requiring inclusion of state health improvement goals into the community benefit framework governing nonprofit hospitals but subsequently repealed that legislation

## Methodology

For this issue brief, Hilltop examined specific state law changes that varied in approach to community benefit regulation. The changes reflect varying state goals and objectives, employ a variety of policy tools (e.g., statutes, regulations, policy statements, and Certificate of Need [CON] procedures), emanate from different agencies within state governments, and occur in geographically diverse states. Based on these criteria, Hilltop selected five states: Colorado, Illinois, Minnesota, New Hampshire, and New York.

To identify changes in the state-level regulation of hospital community benefits for the purposes of this issue brief, Program staff drew upon accumulated knowledge from previous issue briefs; key statutes, regulations, and policies; and the [Community Benefit State Law Profiles](#) (*Profiles*).<sup>6</sup>

After carefully scrutinizing the *Profiles* and state laws and regulations, Program staff conducted an extensive literature review that included peer-reviewed journals and grey literature<sup>7</sup> to better understand the history of federal and state approaches to incentivizing community benefits and gain perspectives on recent community benefit developments.

Program staff also developed an interview protocol to guide interviews with state, hospital association, and community/advocacy group officials in the states that were selected for study. Staff conducted one-hour, semi-structured telephone interviews with two to five key informants from each of the five states during the period of June through December 2014. Key informants included high-level state officials (e.g., legislators, health department staff, and Attorney General’s Office staff), executives of state hospital associations, and staff from key advocacy groups repre-

senting consumers and other stakeholders. The interview protocol included questions that addressed 1) notable changes in community benefit law, regulations, policy, and/or practice that had occurred between 2006 and 2014; 2) the circumstances that led to the changes; 3) the processes for adopting and implementing the changes; and 4) post-implementation considerations. At each stage, informants were asked to identify stakeholders who were critical in driving or opposing the changes, factors that facilitated and/or impeded the changes, and the resources required to implement the changes.

**Study Limitations and Caveats.** Observations reported in this brief reflect select experiences of a limited number of states and interviews with a limited number of stakeholders in each of those states. The research describes notable changes—rather than every change—in the laws of the

states examined.<sup>8</sup> Efforts were made to select a varied group of states based on a review of the *Profiles* and the published and grey literature; however, only a small number of states were identified as having made changes to hospital community benefit law, regulation, and/or policy since the ACA was signed into law in 2010. Significant change may be underway in other states that were not identified through this research. It is likely that many states have been delaying action on community benefit policy—committing resources instead to implementation of insurance marketplaces and other reforms in the ACA—while they await final rules from the Internal Revenue Service (IRS) for implementing §9007 of the ACA, “Additional Requirements for Charitable Hospitals.” The IRS published the final rules on December 31, 2014 (IRS, 2014a), 79 Fed. Reg. 78953,<sup>9</sup> so significant state activity may occur in 2015 and beyond.

## Addressing Charity Care, Financial Assistance, and Billing Practices

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In 2013, before implementation of the major ACA coverage provisions, an estimated 41 million people were uninsured. Although the ACA is helping to expand coverage to millions of previously uninsured individuals, many—including undocumented persons and adults with low income in states that did not expand Medicaid—remain without coverage (Kaiser Family Foundation, 2014). Many uninsured individuals have limited financial resources, lack the resources to pay for hospital care, and thus will continue to need free or discounted hospital care. This is also the case for some insured individuals who have policies with high deductibles and/or copayments.

**Federal Approach.** Federal oversight of nonprofit hospital provision of charity care prior to 1969 is described extensively in an earlier issue brief, [The Emerging Federal Framework](#).<sup>10</sup>

In 1969, the IRS broadened the scope of hospital activities that could qualify for federal tax exemption. Rather than relying solely on the provision of charity care, the new standard required that nonprofit hospitals provide “community benefits” to retain their federal tax-exempt status

(Rev. Rul.69-545, 1969-2 C.B. 117). Although charity care continued to be an important component of community benefit, this ruling broadened the scope of eligible charitable activities to include activities that are “beneficial to the community as a whole.” The community benefit standard is still in effect today.

Over the past decade, Congress has scrutinized nonprofit hospitals’ community benefit activities. The Senate Finance Committee held two hearings (June 2004 and September 2006) to examine the federal tax exemptions of nonprofit hospitals. The minority staff of the Senate Finance Committee published two reports (2004 and 2007), which led to an examination of community benefit requirements. The 2007 report proposed that each nonprofit hospital develop and publicize its charity care program and report the percentage of total expenditures attributable to charity care (Lunder & Liu, 2009).

In 2008, the IRS redesigned Form 990, the informational return required of tax-exempt organizations. This revision included the addition of Schedule H for use by tax-exempt hospitals. Schedule H was designed to “combat the lack of

transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care” (IRS, 2007). It contains six parts, two of which are most relevant to this report: Part I: Charity Care and Certain Other Community Benefits at Cost, and Part II: Community Building Activities.<sup>11, 12</sup>

Section 9007 of the ACA establishes “Additional Requirements for Charitable Hospitals,” which stipulates that a hospital facility will not be treated as a tax-exempt charitable organization unless it meets that provision’s requirements related to community health needs assessment (CHNA); financial assistance policies; and limitations on charges to patients who are eligible for financial assistance and on billing and collection practices. The IRS’s Final Rules implementing these provisions were published on December 31, 2014.

**State Approaches.** States take various approaches to incentivizing and regulating the provision of charity care and financial assistance by hospitals, as well as imposing limitations on hospital charges, billing, and collection practices.

Twenty-five states have either conditional or unconditional requirements that tax-exempt hospitals provide charity care and/or community benefits.<sup>13</sup> The specific requirements vary by state. For example, California requires tax-exempt hospitals to provide “community benefits,” which it describes broadly as hospital activity “intended to address community needs and priorities primarily through disease prevention and improvement of health status” (Ca. Health & Safety Code §127345(c); Rosenbaum, Byrnes, & Rieke, 2013). Florida, on the other hand, requires only that tax-exempt hospitals provide charity care and serve Medicaid beneficiaries (Fla. Stat. §617.2002(2)).

Twenty states require hospitals to develop financial assistance policies.<sup>14</sup> Eight states mandate free care for at least some patients who are unable to pay,<sup>15</sup> and seven states require that hospital charges be based on a sliding fee scale that reflects the patient’s ability to pay.<sup>16</sup> Ten states have established uniform state standards for charity care eligibility.<sup>17</sup>

With regard to hospital charges, billing, and collection practices, the laws of 11 states expressly limit hospital charges for patients who are eligible for assistance pursuant to a hospital’s financial assistance policy (FAP).<sup>18</sup> The laws of several states also limit hospital billing and collection practices. For example, at least five states limit or prohibit hospitals from effectively forcing the sale or foreclosure of a patient’s primary residence due to nonpayment of a medical debt.<sup>19</sup>

Following is a detailed discussion of changes in laws, rules, or policies related to the provision of charity care, financial assistance, and hospital charges, billing, and debt collection practices in four of the five states selected for this issue brief.

**Colorado.** Colorado adopted two separate pieces of legislation—Senate Bill (SB) 12-134 and SB 14-50—both applicable to nonprofit and for-profit hospitals. These two pieces of legislation came into being as follows:

Members of two consumer groups, the Colorado Center on Law & Policy (CCLP) and the Colorado Consumer Health Initiative (CCHI) had longstanding concerns regarding the transparency of hospital charity care programs, hospital rates being charged to uninsured individuals, and hospital billing and collections practices. The two groups and the Colorado Hospital Association met to discuss these and other issues.

CCLP and CCHI worked with a state senator who introduced draft legislation, SB 12-134. While the bill was in the Senate, the Colorado Hospital Association continued to work with the parties, although it neither supported nor opposed the bill. SB 12-134, enacted in 2012 with bipartisan support as the Hospital Payment Assistance Program (Colo. Rev. Stat. §25-3-112), requires hospitals to make financial assistance information available on hospital websites, in patient waiting areas, before discharge, and in patient billing statements. The statute also requires hospitals to offer financial assistance to “qualified” uninsured patients with family income of less than 250 percent of the federal poverty level (FPL) and mandates that hospitals screen uninsured patients for financial assistance eligibility before initiating collection actions. In addition,

SB 12-134 establishes that the maximum amount charged to patients who are eligible for financial assistance may not exceed the lowest negotiated rate between the hospital and a private insurer.

SB 12-134 did not resolve all concerns, however. After its passage, CCHI fielded consumer calls and heard reports of excessive hospital charges and consumer accounts being sent to debt collectors, suggesting inconsistency in how hospitals were complying with the law. Concerned about patient privacy and hospital proprietary information, the Colorado Hospital Association sought clarity regarding which entity was going to monitor hospital compliance and enforce the statute. CCHI and CCLP approached the same state senator about amending SB 12-134 to address these and other concerns.

In 2014, Colorado enacted SB 14-50 to add the following requirements: patient notification and corrective action of hospital errors/omissions in supplying required information; a mechanism for consumer recourse; compliance monitoring of hospitals; notification of hospital errors/omissions to the state health department;<sup>20</sup> and hospital penalties for “knowing or willful” noncompliance. SB 14-50, which was supported by CCHI, CCLP, and the Colorado Hospital Association, also created a Hospital Financial Assistance Standards Committee. The Committee’s charges were to develop recommendations for uniform standards for the consistent implementation of SB 12-134 and SB 14-50 and to submit recommendations for rules to implement both pieces of legislation to the state Board of Health (a component of the Colorado Department of Public Health & the Environment). No rulemaking proceeding has yet been initiated, and the Committee—under the terms of SB 14-50—lapsed on December 31, 2014, leaving the statute in effect without guidance on how to comply.

**Illinois.** Illinois provides an example of a state that adopted new eligibility standards for tax exemption and established new statewide standards for financial assistance applications.

Between 2006 and 2014, Illinois significantly changed its charity care requirements. The Illinois community benefit landscape now includes

several atypical statutory and regulatory provisions that policymakers in other states may find informative. Two pieces of legislation—SB 2194 and SB 3261—adopted in 2012 achieve the following:

SB 2194 stipulates that a nonprofit hospital is eligible for tax exemption only if the value of charity care and certain other “qualified services or activities” provided equals or exceeds its estimated property tax liability. SB 2194 also allows investor-owned hospitals to receive a credit against state income taxes for providing free or discounted services.

SB 3261 mandates that hospitals provide a charitable discount of 100 percent of charges for patients below specified income levels and directs the Attorney General to draft rules addressing hospital financial assistance application requirements and presumptive eligibility criteria.<sup>21</sup>

These statutory provisions are unusual for several reasons: Illinois is one of only five states that have established broad mandatory minimum community benefit requirements for nonprofit hospitals.<sup>22</sup> Additionally, Illinois may be the only state that confers a credit against state income taxes to investor-owned hospitals for providing free or discounted services. Also, Illinois is one of only a few states that mandate a 100 percent charitable discount for persons below a specified income level. Finally, an amendment to SB 3261 mandates the Office of the Attorney General to develop rules requiring hospitals to include, among other things, specifically prescribed language in financial assistance applications. The final 2013 rules require that such applications include an opening statement advising applicants that they may be eligible for free or discounted care and that they are not required to provide their Social Security number. Each financial assistance application must also include a certification that the information provided is accurate, the text of which is prescribed by the rule (77 Ill. Adm. Code §4500.30(a), (h) (2014)).

These unusual statutes came into existence as follows. In 2004, the Illinois Department of Revenue denied an application for a charitable property tax exemption submitted by Provena Cove-

nant Medical Center for allegedly failing to provide sufficient charity care to persons in need (Provena Covenant Medical Center, 2010). This decision was ultimately upheld by the Illinois Supreme Court in 2010.<sup>23</sup> Illinois' concern about the adequacy of charity care was analogous to the focus of the 2004 and 2006 U.S. Senate Finance Committee hearings examining the federal tax exemptions of nonprofit hospitals.

The regulatory changes to Illinois law arose out of multiparty negotiations during the 2012 Illinois legislative session. Participating stakeholders sought different goals. For example, the Illinois Hospital Association desired certainty regarding the level of charity care required of hospitals by tax exemption standards. It also sought to avoid the negative effects of other proposed legislation, which would have resulted in a \$350 million reduction in Medicaid funding to hospitals and physicians (Westphal, Olsen, & Adams, 2012). Several labor unions, community advocacy groups, and other interested parties expressed dissatisfaction with the levels of charity care that were provided by some tax-exempt hospitals at the time. The Fair Care Coalition,<sup>24</sup> a loose coalition of advocacy groups, sought, among other things, standardized language required as part of each hospital's financial aid application, limits on information (e.g., Social Security numbers) that hospitals could demand from patients as a condition of applying for free or discounted care, and uniform standards for determining presumptive eligibility.

The Governor's staff convened at least one meeting to discuss a large package of health care-related bills (Lubell, 2012). In attendance were legislators and representatives of the Illinois Hospital Association, Office of the Attorney General, Department of Revenue, and some consumer groups. According to a key informant, the Office of the Attorney General and the Fair Care Coalition were "heavily involved" in negotiations related to financial assistance application requirements and the presumptive eligibility standards. After a series of discussions involving the Illinois Hospital Association, compromises were reached,<sup>25</sup> and the legislative package was enacted into law in 2012. Part of the compromise in-

cluded reducing a proposed \$350 million Medicaid cut to \$105 Million (Westphal et al., 2012).

Key informants reported that the 2012 changes have resulted in greater transparency and community engagement. Another outgrowth of the 2012 legislation is that the Governor's Office of Health Information and Transformation has formed several work groups, one of which is focused on population health integration.

**Minnesota.** In Minnesota, the Office of the Attorney General and the state's hospital association jointly developed "working standards" to address charity care, financial assistance policies, and hospital charges, billing, and collection practices. Those standards form the basis of court-approved binding agreements (i.e., Hospital Agreements) executed by the Attorney General's Office and each nonprofit hospital and hospital system.

According to a key informant, the working standards are intended to provide evidence of standardized best practices for dealing with debt collection and charity care issues. Minnesota's 18-page Hospital Agreement prohibits hospitals from charging an uninsured patient whose annual household income is less than \$125,000 an amount greater than the amount the hospital would be reimbursed by the private, third-party payer that is the hospital's greatest source of revenue (Minnesota Attorney General, 2012). The Hospital Agreement also generally prohibits hospitals and/or any debt collection agency or attorney the hospitals may employ from taking legal action to collect a medical debt or garnish wages or bank accounts unless specific conditions are met.

These detailed provisions arose from an initial 2005 agreement between the Office of the Attorney General and five hospital systems, all of which were members of the Minnesota Hospital Association. The Office of the Attorney General had investigated the systems with respect to their billing, debt collection, and charity care policies, and the parties subsequently initiated discussions about the feasibility of developing working standards to be included in court-approved binding agreements to be executed by the Attorney



General's Office and each nonprofit hospital or hospital system (Benson, 2005; Hatch, 2005). The original 2005 Hospital Agreement covered a two-year period. Eventually all nonprofit hospitals signed that first agreement, which was then renewed—without significant changes—for five-year terms in 2007 and 2012. According to key informants, as of August 2014, there were 90 identical, signed agreements between the Office of the Attorney General and the state's nonprofit hospitals.

The Hospital Agreements appear to accomplish what was intended, with the Attorney General's Office monitoring hospitals to ensure compliance when patients raise complaints. When interviewed in August 2014, a key informant speculated that the continued need for Hospital Agreements might be reassessed after the IRS issues final rules regarding charges, billing, and collection practices.

**New Hampshire.** New Hampshire has a broad general requirement that all “health care charitable trusts” (a term that includes nonprofit hospitals)<sup>26</sup> provide community benefits (N.H. Rev. Stat. Ann. Tit. I, §7:32-c).<sup>27</sup> The term “community benefit” is defined as including, but not limited to, charity care and financial or in-kind support of public health programs (N.H. Rev. Stat. Ann. Tit. I, §7:32-d (III) (1999); Rosenbaum et al., 2013).<sup>28</sup>

New Hampshire also requires nonprofit hospitals and other health care charitable trusts to submit written financial assistance plans as part of every CON<sup>29</sup> application. The relevant statute specifies that CON applications must include “at a minimum ... the degree to which the proposed project will be accessible to persons who are medically underserved,” including persons with disabili-

ties and those with low incomes (N.H. Rev. Stat. Ann. Tit. XI, §151-C:7 (III)). Regulations further state that a CON applicant's financial assistance plan must specify that 100 percent of uninsured individuals with household income less than or equal to 150 percent of the FPL are eligible for free care, subject to a reasonable and nominal payment by the patient of up to \$100, which is waived in cases of financial hardship (N.H. Code Admin. R. He-Hea 303.04(d)). The regulations also require that health care services be made available and accessible to 100 percent of the applicant's medically underserved population during all hours of business operation (N.H. Code Admin. R. He-Hea 303.04(d); (b)).

In 2012, the New Hampshire legislature voted to repeal most provisions of the CON law effective in 2015 (N.H. Rev. Stat. Ann. Tit. XI, §151:C). The regulations requiring free care and accessibility by persons who are “medically underserved” were not repealed. According to a state representative, legislative action to abolish the CON process was not directed at the CON free care and accessibility provisions. Instead, the 2015 repeal date was a result of a compromise: some legislators wanted to abolish CON procedures immediately, saying that market forces would be sufficient to reduce health care spending on facilities, while other legislators wanted the CON process to stay in place. In 2013, the CON issue resurfaced. With bi-partisan support, a “budget trailer bill” (House Bill 2) that delayed the repeal date until 2016 was passed. If all or part of the CON statute were to be repealed in 2016, it is unclear what—if any—action New Hampshire would take regarding the charity care standards embodied in the remaining CON regulations.

## Promoting Community Health Improvement

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The United States has the highest medical care costs (both per capita and as a percentage of gross domestic product) among major industrialized countries and lags behind in life expectancy, infant mortality, and other indicators of a healthy

life (Organisation for Economic Cooperation and Development, 2013).

Today, government agencies, public interest organizations, researchers, and health care providers—including hospitals—overwhelmingly agree

that factors other than medical care play important roles in shaping the health of communities. These factors include income, education, employment, community safety, the availability of healthy foods, the environment, access to recreational facilities, socioeconomic conditions, housing, social cohesion and supports, language, literacy, culture, and transportation options (U.S. Department of Health and Human Services [HHS], 2010; Weil, 2014; Cohen & Kabel, 2014; Robert Wood Johnson Foundation® [RWJF] Commission to Build a Healthier America, 2014; Institute of Medicine [IOM], 2011). These factors are often referred to as “social” or “social and economic” determinants of health.

Although it is true that many significant risk factors (e.g., obesity and tobacco use) are ultimately under the control of individuals, the risk factors themselves are influenced by circumstances that fall outside the health care domain (IOM, 2011). Investing in evidence-based health promotion and prevention activities can be an effective, proactive approach to creating healthier communities (Rosenbaum, Rieke, & Byrnes, 2014; IOM, 2012). Preventing avoidable disease is essential to improving the health of America’s communities.

**Federal Approaches.** At the federal level, there is recognition that “upstream” investments in prevention (i.e., addressing social and economic factors) can effectively promote both individual and community health. This recognition is evidenced in various ways. Healthy People 2020, which identifies health-related goals and objectives for the coming decade, highlights the importance of addressing health determinants in its four overarching goals (HHS, 2010):

1. Attain high-quality, longer lives free of preventable disease, disability injury, and premature death
2. Achieve health equity, eliminate disparities, and improve the health of all groups
3. Create social and physical environments that promote good health for all
4. Promote quality of life, healthy development, and healthy behaviors across all life stages

Similarly, the ACA includes provisions that focus on prevention and population wellness. For example, §4001 created a National Prevention, Health Promotion, and Public Health Council that is chaired by the Surgeon General.<sup>30</sup> Each year, the Council submits a report describing national progress in meeting specific prevention, health promotion, and public health goals—as defined in the National Prevention Strategy—to the President and relevant committees of Congress.

The IRS Final Rules also support improving community health; they specifically provide 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.” Thus, the term “health needs” includes interventions that improve or maintain community health (IRS, 2014a). This is consistent with the Schedule H definition of community benefit, which includes investments in community health improvement services (IRS, 2014b).

**State Approaches.** Of the five states examined for this brief, only two—New Hampshire and New York—have implemented community benefit frameworks that move beyond charity care, financial assistance, and billing practices to address upstream factors that promote community health improvement. Minnesota attempted to implement such a framework but has been unsuccessful thus far.

**New Hampshire.** In New Hampshire, the community benefit reporting structure facilitates and supports hospital investment in community health improvement activities. The state’s definition of “community benefit” includes:

- Donation of funds, property, services, and other resources that promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities, and services to vulnerable populations



- Allocation of funds, property, services, and other resources that contribute to community health care needs, as identified in a community benefit plan (N.H. Rev. Stat. § 7:32-d (1999)).

The state's "data-driven" *Community Benefits Reporting Form*, first adopted in 2008, currently contains a three-page "List of Potential Community Needs." Included in the list are the following social and economic factors: poverty, unemployment, homelessness, economic development, educational attainment, high school completion, housing adequacy, vandalism/crime, air quality, and water quality (New Hampshire Office of the Attorney General, 2009). Hospitals that engage in community benefit activities identify the community need that is addressed and report on the form unreimbursed costs for the previous year and projected unreimbursed costs for the upcoming year.

A key informant provided historical context for New Hampshire's community benefit reporting form. In the early 1990s, there was no law requiring the provision of community benefits in New Hampshire. In 1999, draft legislation was developed by a state senator and retired surgeon who believed that community benefit was an important policy issue to address. Although the original proposal established community benefit requirements for hospitals only, hospitals and the New Hampshire Hospital Association urged that community benefit requirements be established for a broader range of medical providers. The statute, adopted later that year, required all "health care charitable trusts"<sup>31</sup> to provide community benefits. Responsibility for developing appropriate annual reporting mechanisms was assigned to the existing Charitable Trusts Unit, which is part of the Office of the Attorney General. The original reporting form required health care charitable trusts to annually submit information in a narrative format to the Charitable Trusts Unit.

After the form had been in use for several years, the Office of the Attorney General partnered with the Harvard Business School and the New Hampshire Department of Health and Human Services to compile a report about the first four

years of implementation of the community benefit law. The state agencies determined that the original form's narrative format made it difficult to extract usable data and did not provide the information needed to answer the two questions most frequently asked by legislators and the media:

1. How much were health care charitable trusts spending on community benefits?
2. How much were Chief Executive Officers (of the health care charitable trusts) being paid?

With grant funding from the Endowment for Health, a New Hampshire foundation, the Charitable Trusts Unit and the New Hampshire Department of Health and Human Services engaged the Community Health Institute (CHI) in New Hampshire to help modify the original reporting form. CHI convened several focus groups that were attended primarily by representatives of nonprofit hospitals and other health care charitable trusts. Following several rounds of revisions, the current *Community Benefits Reporting Form*, described as more data-driven and without narrative reporting requirements, was implemented in 2008. All nonprofit hospitals must use this form for their state community benefit reporting, and the reports are publicly available on the Charitable Trusts Unit website. However, a key informant reported that there are no state-based definitions or accounting requirements for determining unreimbursed costs, and the taxonomy for reporting expenditures is not well defined.

**New York.** New York's policies have evolved beyond addressing charity care and financial assistance issues to integrating community needs planning and CHNA/implementation strategy approaches into its State Health Improvement Plan (SHIP), titled *Prevention Agenda 2013-2017* (New York State Department of Health [DOH], n.d.) The state incentivizes and promotes hospital community benefit initiatives that target community health improvement by expressly linking its Prevention Agenda to required hospital community benefit plans (referred to as "community service plans"). In 2012, the DOH issued a new Prevention Agenda and a Guidance Document requiring a connection between nonprofit hospi-

tal community service plans and the Prevention Agenda (DOH, 2012).

The Prevention Agenda specifies five state health priorities:

1. Prevent chronic diseases
2. Promote a healthy and safe environment
3. Promote the health of women, infants, and children
4. Promote mental health and prevent substance abuse
5. Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care-associated infections

New York requires that each tax-exempt hospital community service plan identify two Prevention Agenda priorities,<sup>32</sup> selected jointly with the local health department, and describe strategies to address the priorities in a three-year plan of action. Hospital priorities must match priorities identified by the local health department, thus incentivizing the two entities to collaborate (DOH, 2012). For each priority, the Prevention Agenda identifies specific goals and evidence-based and best practice interventions that can be implemented to meet those goals (DOH, 2012). One of the priorities—“Promote a healthy and safe environment”—directly advances community health improvement. However, because hospitals only have to address two state health priorities, there is no assurance that they will choose this one.

The Prevention Agenda intentionally aligns community service plan requirements with ACA community benefit requirements for IRS Form 990, Schedule H, as well as with Public Health Accreditation Board standards. DOH officials have stated that this alignment minimizes challenges to hospital compliance and facilitates adoption and implementation of the Prevention Agenda.

The DOH developed the Prevention Agenda in collaboration with stakeholders who were represented by an ad hoc committee that, in turn, reported to the state Public Health and Health Planning Council. The Council includes repre-

sentatives from the Healthcare Association of New York State (HANYS), the Greater New York Hospital Association (GNYHA), the New York Academy of Medicine (NYAM), and hospitals and hospital systems. Other key stakeholders include the New York Health Plan Association and consumer groups such as the American Cancer Society and Medicaid Matters. The ad hoc committee selected the five Prevention Agenda priority areas after an extensive consultation process, which eventually involved 140 organizations (DOH, 2014b). According to key informants, the hospital associations were generally supportive of the proposed Prevention Agenda, but officials expressed some concerns about expanding hospital community benefit requirements in ways that might unduly burden their members. One nationwide advocacy group was supportive of the process but sought more involvement by organizations at the community level, a key informant noted. Most of the consumer-oriented stakeholders involved in creating the Prevention Agenda were statewide advocacy groups.

The DOH uses its own programs to implement components of the Prevention Agenda. Additionally, it assists hospitals in identifying and selecting evidence-based hospital community benefit activities and applying for grants to fund implementation. The DOH received a grant from RWJF for supplemental technical assistance and consultation to assist with community service plan development.

A key implementation strategy in New York has been to provide technical assistance to hospitals and local health departments related to evidence-based practices and federal reporting requirements. Stakeholders were able to access grant support for these activities. For example, NYAM, whose president chaired the ad hoc committee, received a grant from the New York State Health Foundation to provide technical assistance to local health departments implementing the Prevention Agenda (NYAM, 2014). HANYS received a grant to develop a website featuring resources for hospitals and local health departments and to host webinars instructing hospitals and community organizations on evidence-based methods in community health improvement. Additional resources were provided by RWJF, which support-

ed development of brochures and other information available on the DOH and NYAM websites and the websites of other stakeholders. HANYS has also provided technical assistance to local health departments and hospitals in disseminating information about the Prevention Agenda to local schools, businesses, and community organizations. As a HANYS representative explained, this was helpful because hospitals and local health departments needed assistance in collecting and reporting evidence-based outcomes data. The DOH created and maintains an online “dashboard” to track indicators and long-term outcomes to support continuing evaluation of the Prevention Agenda.

A key informant indicated that Prevention Agenda goals are increasingly reflected in other statewide programs. For example, since the Prevention Agenda was adopted, state Medicaid Reform occurred, and four domains for funding were identified. One of these domains is population health, and it includes measures and priorities from the Prevention Agenda. The New York State Health Innovation Plan<sup>33</sup> submitted to the Center for Medicare and Medicaid Innovation is the state’s blueprint to extend many of the goals of the Medicaid Delivery System Reform Incentive Payment (DSRIP) program<sup>34</sup> to non-Medicaid markets and is aligned with the Prevention Agenda. (DOH, 2013, 2014a; Office of the Governor, 2014; HANYS, 2014).

**Minnesota.** Minnesota’s tax-exempt hospitals are required to report the unreimbursed costs of charity care and community benefits that they provide. For purposes of financial reporting, Minnesota law defines “community benefit” as the costs of charity care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education costs, and the cost of operating subsidized services (Minn. Stat. §144.699).

In contrast to New York and New Hampshire, Minnesota was unsuccessful in its attempt to incorporate state-established community health improvement goals into the community benefit

framework governing tax-exempt hospitals. A protracted budget battle in 2011 sparked the enactment of a two-year state budget that reduced the SHIP’s 2012-2013 funding by 70 percent; this reduction would necessarily reduce the scope of SHIP implementation to fewer counties (The Hilltop Institute, 2012). As explained by Minnesota Department of Health representatives, the Governor’s Office responded to the budget cut by proposing a rider/amendment to the budget bill, which would require the State Health Commissioner to develop a plan to implement evidence-based strategies from the SHIP as part of hospital community benefit programs and health maintenance organization collaboration plans (2011 Minn. Laws, 1<sup>st</sup> Sp. Sess., Ch. 9, H.F. 25 Art. 10, Sec. 4, Subd 2, statewide health improvement program (b)). The rider/amendment further required the Commissioner to convene an advisory board to “1) determine priority needs for health improvement in reducing obesity and tobacco use ... and 2) review and approve hospital community benefit activities” (2011 Minn. Laws, 1<sup>st</sup> Sp. Sess., Ch. 9, H.F. 25 Art. 10, Sec. 4, Subd 2, statewide health improvement program (b)). The Minnesota Hospital Association opposed the rider/amendment—most pointedly the requirement that the Commissioner “review and approve” hospital community benefit plans—and expressed its position that the new requirements were unnecessarily duplicative of existing federal requirements (Minnesota Hospital Association, 2012; The Hilltop Institute, 2012).

The rider/amendment did pass, after which the Minnesota Department of Health convened a series of town hall meetings to elicit input from stakeholders and the public. The Minnesota Hospital Association and its members continued to strongly oppose the rider/amendment, and in April 2012, the legislature voted unanimously to repeal it. The Governor approved the law’s repeal (H.F. 2237; The Hilltop Institute, 2012). Had the law not been repealed, Minnesota hospitals’ community benefit plans would have been subjected to new scrutiny by the Commissioner, who would have had a legislative directive to ensure that the plans were coordinated with the state-determined community health improvement goals of reducing tobacco use and lowering obesity rates.

Minnesota Department of Health officials have noted that, although the rider/amendment was repealed, it led to good faith conversations about coordinating the efforts of the Minnesota Department of Health, the Hospital Association, and the Minnesota Council of Health Plans to identify health needs across the state. In 2014, the Minnesota Department of Health issued *Advancing Health Equity in Minnesota*, a report that acknowledges and seeks to broaden the understanding that social, economic, and environmental factors play an important role in shaping

community health. In addition, ongoing discussions facilitated by the Center for Community Health (CCH) aim to develop a mechanism for coordinating and streamlining the CHNA processes of nonprofit health plans, hospitals and health systems, and public health agencies. A coordinating document is being developed through a steering committee led by CCH, with the goal of identifying opportunities for partnerships and streamlining fulfillment of CHNA requirements by applicable entities.

## Observations and Policy Considerations

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This issue brief examines specific changes in community benefit laws, regulations, and policies in five states in the four years before and four years after passage of the ACA (i.e., between 2006 and 2014). The following observations can guide policymakers in other states considering changes in the community benefit landscape.

States pursued a variety of approaches to address community benefit goals, depending on the state's own goals and priorities, prior activity in the state, which state entities drive community benefit policy, existing programs and infrastructure that might be used to leverage community benefit, the political environment, and key stakeholders. For example, Illinois and Colorado used legislation, Minnesota used legally binding agreements, New Hampshire used community benefit reporting forms and its CON regulatory framework, and New York linked its SHIP to its existing community benefit framework.

Leveraging community health benefit policy to pursue goals for community health improvement may be more likely to occur in states with strong leadership from the state health department. For example, the New York DOH played a central role in coordinating and guiding development of the Prevention Agenda 2013-2017 and incorporating hospital community benefit into this process. This example is in contrast to states such as Illinois and Minnesota—with respect to court-filed Hospital Agreements—where the Offices of the Attorneys General played major roles in driving aspects of community benefit policy. In those

two cases, the major emphasis of those Offices was on hospital financial assistance and charges, billing, and collection practices.

On the other hand, New Hampshire is an example of a state where the Charitable Trust Unit of the Office of the Attorney General successfully built a broad coalition of stakeholders across government agencies and community groups to implement a comprehensive community benefit strategy that addresses financial assistance policies and community health improvement. Key informants specifically cited longstanding relationships with stakeholders as a very important factor in fostering these collaborative efforts.

Extensive, collaborative stakeholder engagement also contributed to successful outcomes in New York, where an interlocking committee structure included major stakeholders occupying key roles. The DOH provided leadership and coordinated the process, which involved 140 organizations statewide. In Illinois, stakeholder involvement had a significant influence on the tax-exemption standards that were ultimately adopted.

As states pursue community health improvement, it will be important to promote use of evidence-based and evidence-informed programs and practices. These do not necessarily require legislation or regulation; as shown by New York, they can be embedded into existing policies through partnerships with state health officials, stakeholder groups, community agencies, and local funders.

Hospitals may benefit from technical assistance when complying with federal and state requirements and employing evidence-based practices. New York and New Hampshire sought funding from foundations to support implementation activities. Foundation support can serve as an imprimatur for state efforts, helping to convince others of the legitimacy and importance of the work.

Moving forward, it will be important for states to balance the need for community benefit policies that provide a safety net for uninsured and underinsured populations with investments in upstream community health improvements, such as education, employment, housing, and the environment. The health insurance marketplaces and other reforms authorized by the ACA have brought about significant reductions in the number of uninsured individuals. However, gaps in coverage will remain for individuals with high-deductible health

plans who experience a serious illness, certain disenfranchised populations (e.g., undocumented persons), and individuals with low income living in states that opt out of the Medicaid expansion.

The Final Rules published by the IRS on December 31, 2014, clarify that the health needs that a tax-exempt hospital may consider in its community health needs assessment “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 to address social, behavioral, and environmental factors that influence health in the community” (§1.501(r)-3). The long-awaited rules may bring about heightened activity aimed at promoting community health improvement in state legislatures and agencies in 2015.

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## Endnotes

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<sup>1</sup> For example, in 2003-2004, a series of *Wall Street Journal* articles exposed the facts that uninsured individuals were often not informed of the availability of financial assistance; hospitals generally charged uninsured patients far more than patients with insurance; and many hospitals engaged in “extreme measures,” such as obtaining liens on the family homes of former patients and levying personal bank accounts to collect overdue debts (Lagnado, March 13, 2003; March 17, 2003; October 30, 2003; September 21, 2004).

<sup>2</sup> “The Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, 124 Stat. 1028 (2010). These consolidated Acts are herein referred to as the Affordable Care Act (ACA).

<sup>3</sup> For the purpose of this issue brief, “community benefit” includes ACA provisions on hospital charges, billing, and collection practices.

<sup>4</sup> This timeframe captures changes made during development and implementation of IRS Form 990, Schedule H, the informational return that all tax-exempt hospitals must file on an annual basis, as well as changes made following ACA enactment.

<sup>5</sup> According to the Association of State and Territorial Health Officials, a SHIP is a planning guide developed for a particular state, the goal of which is to improve the health of that state’s population. It identifies health priorities specific to the needs of the state and the resources available to meet those needs. Interest in SHIP was stimulated by grant initiatives such as the Centers for Disease Control and Prevention’s National Public Health Improvement Initiative (NPHII), the Public Health Accreditation Board’s (PHAB’s) accreditation of public health departments, and the IRS’s 2013 Notice of Proposed Rulemaking regarding community health needs assessments.

<sup>6</sup> The Hilltop Institute’s *Community Benefit State Law Profiles*—which can be accessed at [http://www.hilltopinstitute.org/hcbp\\_cbl.cfm](http://www.hilltopinstitute.org/hcbp_cbl.cfm)—present a comprehensive analysis of each state’s community benefit landscape, as defined by its laws, regulations, and, in some cases, the policies and activities of state executive agencies. The Profiles organize these state-level legal frameworks by the major categories of federal community benefit requirements found in §9007 of the ACA, §501(r) of the Internal Revenue Code.

<sup>7</sup> “Grey literature” is literature that “is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers” (New York Academy of Medicine, n.d.).

<sup>8</sup> Thus, changes examined in Colorado and Illinois relate only to provision of charity care; financial assistance; and charges, billing, and collection practices, while changes addressed in New York pertain only to community health improvement.

<sup>9</sup> Read The Hilltop Institute’s *Bulletin* in which the Hospital Community Benefit Program briefly summarizes the IRS’s Final Rules on Additional Requirements for Charitable Hospitals under the ACA here: [http://www.hilltopinstitute.org/Bulletins/hilltopBulletin\\_HCBP\\_FinalRules.html](http://www.hilltopinstitute.org/Bulletins/hilltopBulletin_HCBP_FinalRules.html). Also read a *HealthAffairs* blog post by George Washington University Professor Sara Rosenbaum: <http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/>.

<sup>10</sup> This issue brief can be accessed here: <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief-January2011.pdf>

<sup>11</sup> Remaining parts are Part III: Bad Debt, Medicare, and Collection Practices; Part IV: Companies and Joint Ventures; Part V: Facility Information; and Part VI: Supplemental Information.

<sup>12</sup> The categories of hospital community benefit activities reportable under Part I of Schedule H are consistent with the reporting framework developed by the Catholic Health Association of the United States (CHA) (CHA, 2006), with one exception: unlike CHA’s Guidelines, Part I of Schedule H does not specifically include a “community building” category. Instead, Schedule H features a separate Part (II) for reporting community building activities.

<sup>13</sup> CA, DE, FL, IL, IN, ME, MD, MA, MS, MT, NC, NV, NH, NM, NY, OH, PA, RI, SC, TX, UT, VA, WA, and WV. GA requires that hospitals designated as “destination cancer hospitals” provide uncompensated charity care to GA residents. Lists of states provided in this brief reflect updated information as of December 31, 2014. An updated version of the *Profiles*, originally published in 2013, will be released in early 2015.

<sup>14</sup> CA, CO, IL, IN, MA, ME, MD, MT, NH, NM, NY, OK, PA, RI, TX, UT, VA, WA, WI, and WV.

<sup>15</sup> CA, ME, MD, NV, RI, TX, UT, and WA.

<sup>16</sup> IL, MA, MD, NH, NY, RI, and WA.

<sup>17</sup> CA, CO, IL ME, MD, NH, OK, RI, TX, and WA.

<sup>18</sup> CO, IL, MD, MS, NC, ND, NV, NJ, NY, OK, and TN.

<sup>19</sup> LA, MD, NY, OH, and RI.

<sup>20</sup> The state health department is responsible for monitoring and enforcing compliance with the new requirements.

<sup>21</sup> In Illinois, presumptive eligibility qualifies an individual for hospital financial assistance without further scrutiny if certain conditions are met. For example, an individual may be presumed eligible under a hospital's financial assistance policy if proof of financial assistance has already been established for another income-based benefit program, such as Medicaid (Ill. Admin. Code tit. 77 §4500 (2014)). Other presumptive eligibility criteria include homelessness, mental incapacitation, and patient death when there is no estate.

<sup>22</sup> The other states are NV, PA, TX, and UT.

<sup>23</sup> The Court's decision was based on determination, under state law, as to whether land owned by the hospital system was owned by a "charitable institution" and whether the property was used "exclusively" for charitable purposes. It is noteworthy that the Court's 30-page opinion failed to clearly specify a method for determining future eligibility for nonprofit hospital state property and sales tax exemptions. (More detailed discussion of this topic can be found in Somerville, Mueller, Boddie-Willis, Folkemer, & Grossman, 2012). Two years after the Provena decision, the absence of clear standards led to three more denied tax exemptions, while 20 hospitals had then-pending requests for property tax exemptions. The Illinois Hospital Association and its members strongly desired clarity regarding what level of charity care or "other qualified services or activities" was required for state tax exemption.

<sup>24</sup>The Fair Care Coalition (2012) describes itself as "a coalition representing patients, communities, taxpayers, researchers, and advocates."

<sup>25</sup> There appear to be no official statements explaining the provision of tax credits for investor-owned hospitals. It is conceivable that the state sought to use this as a policy lever to encourage more charity care. Alternatively, perhaps out-of-state investors were interested in acquiring failing Illinois nonprofit hospitals, and the state adopted this provision as an incentive.

<sup>26</sup> The New Hampshire definition of "health care charitable trusts" is "a charitable trust organized to directly provide health care services, including, but not limited to, hospitals, nursing homes, community health services, and medical-surgical or other diagnostic or therapeutic facilities or services" (N.H. Rev. Stat. Ann. Tit. I, §7:32 d-1).

<sup>27</sup> This requirement applies to entities that have total fund balances exceeding \$100,000 (N.H. Rev. Stat. Ann. Tit. I, §7:32 d-1).

<sup>28</sup> Other components of the statute are described in greater detail in the next section of this brief, *Promoting Community Health Improvement*.

<sup>29</sup> CON programs are intended to restrain health care facility costs and allow coordinated planning of new services and construction. Many CON programs began in 1974 in response to federal law. Only 36 states retain some type of CON program (National Conference of State Legislatures, 2014). A New Hampshire CON approval is required to construct or modify health care facilities, acquire new medical equipment (e.g., MRI, PET radiation therapy, cardiac catheterization), and offer new inpatient care beds or services. Capital expenditures for projects are subject to a threshold that is indexed annually by the Health Services Planning and Review Board (New Hampshire Department of Health and Human Services, 2012).

<sup>30</sup> The Council's membership comprises cabinet secretaries and directors of 20 federal departments and agencies.

<sup>31</sup> The definition of health care charitable trusts includes "nonprofit hospitals, nursing homes, community health services, medical-surgical facilities, diagnostic/therapeutic facilities, or other diagnostic or therapeutic facilities or services" with fund balances greater than \$100,000 (N.H. Rev. Stat. § 7:32-d(V) (1999)).

<sup>32</sup> One of the priorities must address a health disparity (DOH, 2012).

<sup>33</sup> In December 2014, New York received a \$100 million State Innovations Model Testing grant from the Centers for Medicare & Medicaid Innovation in support of the state's Health Innovation Plan.

<sup>34</sup> DSRIP, a program of the federal Centers for Medicare & Medicaid Services, implements the federal and New York state governments' \$8 billion investment in redesigning health care delivery to Medicaid recipients to facilitate performance-based payments. A particular focus is reducing unnecessary utilization of hospital inpatient beds and emergency services (Schuyler Center for Analysis and Advocacy, 2014).



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## About The Hilltop Institute

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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](http://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 tenth issue brief in a 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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