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analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA: *The State Law Landscape*

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Impetus

Section 9007 of the Affordable Care Act (ACA) expanded and clarified federal community benefit requirements for nonprofit hospitals by establishing new standards relating to community health needs assessment; financial assistance policies; and hospital charges, billing, and collection practices. These federal standards were enacted against a backdrop of varied, often dissimilar state community benefit laws, regulations, and policies that defined states' expectations of nonprofit hospitals—expectations relating to both the value these hospitals bring to their communities and the fairness of their business practices. Although recent community benefit analysis has mostly focused on the federal requirements of the ACA, nonprofit hospitals and hospital systems remain subject to state regulation, as well. This makes it necessary for nonprofit hospitals to conform their actions and policies to at least two (i.e., federal and state) distinct regulatory schemes. For a hospital system operating hospital facilities in multiple states, the regulatory structures of additional jurisdictions must also be considered. Not only is the system faced with ensur-

ing that its facilities comply with federal community benefit requirements, but it must also choose between (1) establishing individual jurisdiction-specific policies for facility-by-facility compliance with the community benefit standards of the state in which each facility is located or (2) attempting to devise a single set of policies that conform to the community benefit requirements of all states in which the system operates.

The Hilltop Institute's Community Benefit State Law Profiles (Profiles)¹ present a comprehensive analysis of each state's community benefit landscape, viewed through the lens of major categories of federal community benefit requirements articulated in §9007 of the ACA (§501(r) of the Internal Revenue Code (IRC)). The Profiles:

- Can serve as an analytical tool for assessing state regulatory schemes in the context of federal community benefit standards

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- Clarify similarities and differences in community benefit policies and the legal landscape from state to state
- Describe the baseline of each state’s regulatory framework that can be useful for tracking future state-level community benefit legislative, regulatory, and policy initiatives
- Facilitate policymakers’ consideration of their states’ community benefit requirements against those of other states and federal community benefit benchmarks

Although compilations of state community benefit laws are available elsewhere,² the Profiles

Background: The Federal Community Benefit Standard

“Community benefit” was first articulated by the Internal Revenue Service (IRS) in 1969 as the legal standard that nonprofit hospitals must satisfy in order to qualify for federal tax exemption. It replaced the IRS’s 1956 standard that required hospitals to provide charity care “to the extent of a [their] financial ability.” The community benefit standard requires a hospital to demonstrate that it promotes the health of “a class of persons that is broad enough to benefit the community” (IRS, 1969).³ Although charity care remains an important indicator that the hospital benefits its community, the 1969 ruling meant that charity care was no longer the only indicator (Miller, 2009). The 1969 community benefit standard remained essentially unchanged until 2009 (Davis, 2011), when the IRS introduced a new Schedule H to supplement financial data collected from all tax-exempt organizations via the

Methodology

The initial identification of community benefit laws in the 50 states was performed by law students affiliated with the *Network for Public*

break new ground by using the ACA’s federal community benefit requirements as a framework and context for comprehensive analysis of each state’s community benefit laws and regulations. Because they are often closely related to state community benefit requirements, the Profiles also examine state property, income, and sales tax exemptions available to nonprofit hospitals.

This brief presents the Profiles’ findings and begins the analysis needed for an understanding of the state community benefit landscape and its significance in the context of national health reform.

Form 990 informational return. In Part I of the 2008 Schedule H, “Charity Care and Certain Other Community Benefits at Cost,” the IRS specified exclusive categories of community benefit activities that would support federal tax exemption (IRS, n.d.a); these categories have remained unchanged for subsequent federal tax years (IRS n.d.a-e).

The ACA, enacted in 2010, established new standards that nonprofit hospitals must meet for federal tax exemption. These include conducting a community health needs assessment and developing an implementation strategy every three years; adopting and publicizing a financial assistance policy; and limiting charges, billing, and collections with respect to individuals eligible for financial assistance under the hospital’s financial assistance policy (FAP).

Health Law who used a data collection tool developed by Hilltop. The tool’s variables were designed to capture state law requirements simi-

lar to those of §9007 of the ACA (IRC §501(r)) and IRS “community benefit” reporting requirements, with three variables added to capture relevant state tax exemptions. Primarily for the purpose of confirming law students’ negative findings, Hilltop conducted an electronic survey of state hospital associations. Both the student-collected data and results of the hospital association survey were used as reference materials for an independent review and analysis of primary source materials—state community benefit laws and regulations—conducted by JD/MPH-credentialed Hilltop staff.

The Profiles classify states as including or not including legislative or regulatory community benefit requirements, organized into eight distinct topic areas. This binary classification approach led to interpretive challenges. Questions such as “If the law requires hospitals to provide commu-

nity benefits *only* if they seek a certificate of need, is that a community benefit requirement?” had to be answered consistently to ensure uniform interpretation across states. Hilltop developed classification criteria to address this need. Of course there are other, equally valid approaches to distinguishing between states that do or do not have such requirements; in many cases, differences in interpretive approach may account for variation in findings between studies that report, for example, how many states have community benefit requirements. In developing classification criteria for this study, Hilltop elected, in general, to construe the requirements broadly, so that each statutory and regulatory provision arguably amounting to a positive finding is flagged, and its limitations are explained. Specific classification criteria are detailed online in [About the Profiles](#).

Findings and Discussion

Community Benefit Requirement

Federal. No federal statute or regulation expressly defines nonprofit hospital “community benefits” or specifically recognizes categories of community benefits. The IRS identifies these categories on Schedule H and, in the accompanying instructions, provides definitions and guidance as to the kinds of contributions and activities that may be reported in each category (IRS, n.d.g.). Community benefits reportable on line 7 of Schedule H for tax reporting years 2008-2012 include a hospital’s unreimbursed costs related to: financial assistance, Medicaid, other means-tested government programs, community health improvement services and community benefit operations, health professions education, subsidized health services, research, cash and in-kind contributions for community benefit, and “other benefits.” Since 2011, the Schedule H Instructions have included express guidance that

“[s]ome community building activities may also meet the definition of community benefit” (IRS, n.d.f-g), meaning that qualifying community building activities may be reported in Part I, line 7e of Schedule H as “community benefit” rather than in Part II as “Community Building Activities.”⁴

State. In addition to the federal community benefit requirements, nonprofit hospitals must also comply with the community benefit standards of the state in which they are located, generally to protect state tax exemptions. State community benefit requirements may or may not align with federal community benefit requirements and may be more specific or more stringent than their federal counterparts. In that case, a nonprofit hospital’s compliance with the ACA’s community benefit standards may be insufficient for compliance with state law or to qualify for state tax exemption.

Twenty-three states require nonprofit hospitals to provide community benefits.⁵ Nine states have broad and unconditional community benefit requirements in law or regulation.⁶ Six require nonprofit hospitals to provide community benefits as a condition of certificate of need approval.⁷ Six require community benefits as an express condition of property tax exemption,⁸ three as a condition of hospital licensure,⁹ two as an express condition of sales tax exemption,¹⁰ and two as a condition of receiving partial state reimbursement for charity care expenses.¹¹

The nature of state community benefit requirements varies widely from state to state. California, for example, defines “community benefit” broadly as hospital activity “intended to address community needs and priorities primarily through disease prevention and improvement of health status” (Cal. Health & Safety Code §127345(c)). The statute includes as examples of community benefits: charity care; medical research; health professions education; child care; sponsoring food, shelter, and clothing for the homeless; and education, transportation, and other goods and services that help maintain a person’s health (Cal. Health & Safety Code §127345(c)). Rhode Island’s community benefit requirements include non-revenue producing programs available in the community (e.g., health screenings or transportation services), scientific or medical research, education activities, and forming linkages with community partners focused on improving community health and engaging in community health advocacy (23-17.14 R.I. Code R. §1.9). Maryland recognizes community benefit categories very similar to those of Schedule H, except for the state’s express inclusion of community building activities as a community benefit category (Maryland Health Services Cost Review Commission, 2012). In contrast, Florida recognizes only charity care and Medicaid participation as community benefits (Fla. Stat. §617.2002).

Minimum Community Benefit Requirement

Federal. Federal law does not specify the amount of community benefits that a nonprofit hospital must provide. The IRS employs a “facts and circumstances” test that takes into consideration all relevant circumstances in making its determination as to whether or not a hospital’s community benefit contributions are sufficient to support federal tax exemption (Lerner, 2009; CRS, 2008).

State. A handful of states require nonprofit hospitals to provide a specified, quantifiable minimum amount of community benefits. Since 2012, Illinois has required nonprofit hospitals, as a condition of property tax exemption, to provide charity care or other specified community benefits in amounts at least equivalent to their property tax liability (35 ILCS 200/15-86(c)). Utah similarly conditions property tax exemption on hospitals’ commensurately valued “gifts” to their communities (Utah State Tax Commission, 2011). More complex minimum community benefit requirements in Nevada,^{11a} Pennsylvania, and Texas are detailed in the Profiles.

Community Benefit Reporting Requirements

Federal. After the ACA was enacted in 2010, Schedule H was revised to reflect the new community benefit requirements codified in I.R.C. §501(r). These were designed, in part, to enhance “transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care” (IRS, 2007).¹²

State. Some states do not require state-level community benefit reporting by nonprofit hospitals.¹³ One state that does not expressly require nonprofit hospitals to provide community benefits nevertheless requires that they report any community benefits they do provide.¹⁴ Most states, however, require some form of nonprofit hospital community benefit reporting.¹⁵ States may adopt community benefit reporting requirements either to enhance transparency, as a tool

for determining a hospital's eligibility for tax exemption or other state-conferred preference or authorization, or for other policy-related purposes (Folkemer et al., 2011). States' community benefit requirements may be mandatory (e.g., California), voluntary (e.g., Massachusetts), or both mandatory and voluntary (e.g., Georgia).

Some states require community benefit reporting as a condition of securing state authorization or approval. For example, in Mississippi, South Carolina, and Virginia, community benefit reporting is a condition of certificate of need approval (Mississippi, 2010; S.C. Code of Regs. 61-15 §202C(1)(c); Va. Code §32.1-102.2(c); 12 Va. Admin. Code §§5-220-270(A) and 5-220-420(A). Utah and Illinois require hospitals to report community benefits in order to qualify for property tax exemptions (Utah, 2011; 35 Ill. Comp. Stat §200/15-86(c), and North Carolina requires community benefit reporting as a condition of tax-free bond financing (N.C. Gen. Stat. §§131A-21; 131A-7; N.C. Medical Care Commission, n.d.).

Required community benefit reporting consists of different data elements from state to state. Some states require only that hospitals report charity care expenditures.¹⁶ Typical of these are Maine, New Mexico, and South Carolina. Other states require more. For example, besides reporting charity care, Georgia requires reports of total gross revenues and bad debts" (Ga. Code §31-7-280). Vermont hospitals must submit a summary of their budgets that includes "revenue by source and quantification of cost shifting to private payers..." (Vt. Stat. Ann. tit. 18 §9405b(a)(5); Vermont Dept of Financial Regulation, 2012). Pennsylvania's reporting scheme requires nonprofit hospitals to include their federal returns with submission of their annual reports (10 Pa. Stat 379). California requires hospitals to report, "to the extent practicable," the *economic value* of community benefits provided (Cal. Health & Safety Code §127350). Minnesota requires hospi-

tals to submit charity and discounted care policies and patient contacts by income level (Minn. Stat. §144.698.1(5); Minn. R. §4650.0115).

Community Health Needs Assessment

Federal. The ACA requires that tax-exempt hospitals, at least every three years, conduct a community health needs assessment (CHNA) that takes into account the input of individuals who represent the broad interests of the community and of individuals with special public health knowledge or expertise. The CHNA must be made widely available to the public (I.R.C. §501(r)(3)(B)). The IRS has indicated its intention to provide, by regulation, that a written report of the CHNA must be posted on the hospital's open-access website until it is replaced by a subsequent CHNA (IRS, 2011). The IRS and Treasury have expressly indicated by proposed rule that, in the meantime, hospitals may continue to rely on the standards applicable to CHNA and implementation strategies that they articulated in Notice 2011-52 (IRS, 2012).

State. Only 11 states¹⁷ require by law or regulation that tax-exempt hospitals conduct CHNAs.¹⁸ Approaches adopted by these states differ significantly. Idaho's approach is less prescriptive than its federal counterpart and does not address public access; it requires tax-exempt hospitals with at least 150 beds to submit to a regulatory agency a report that provides, among other things, an "indication of the process the hospital has used to determine general community needs which coincide with the hospital's mission" (Idaho Code §63-602D(7)).

At least seven states expressly require public input in the CHNA process.¹⁹ These states' regulatory schemes differ with respect to the nature and extent of public input required. For example, California requires that hospitals consult with community groups and local government officials in identifying and prioritizing community needs (Cal. Health & Safety Code §127350(b)). Mary-

land nonprofit hospitals must consider the most recent community needs assessments developed by their state or local health department; they “may” also consult with community leaders, local health care providers, and others (MD. Code Ann. Health-Gen., §19-303(b)). New Hampshire and Texas both specify that the needs assessment process must include consultation with members of the public, community organizations, and local government officials. Texas further requires input from private business, insurance companies, and health science centers (N.H. Rev. Stat., Tit I, §7:32-f; Tex. Health and Safety Code Ann. §311.044(a)-(d)). In contrast, Vermont simply specifies that hospitals must have a protocol for “meaningful public participation” (Vt. Stat. Ann. tit. 18 §9405a, 9405b(a)(10)).

Implementation Strategy (Community Benefit Plan)

Federal. The ACA requires tax-exempt hospitals to adopt “an implementation strategy to meet the community health needs identified through [its CHNA]” (I.R.C. §501(r)(3)(A)(2)). The IRS has indicated that it will provide, by regulation, that an implementation strategy must, for each community health need identified by the CHNA, either describe how the hospital plans to meet the need or explain why it does not intend to meet the need. The IRS also intends to require governing body approval of a hospital’s written implementation strategy, and submission of a copy of the implementation strategy to the IRS with the hospital’s informational return (IRS, 2011).

State. The IRS has defined the ACA-required “implementation strategy” as “a written plan that addresses each of the community health needs identified through a CHNA for [the hospital] facility” (IRS, 2011). Although states use different terms (e.g., “community benefit plan”), comparable requirements typically relate to addressing gaps in clinical care access, prevention, and measures to ameliorate social and other determi-

nants that contribute to poor health status and outcomes in a hospital’s service area.

Ten states have laws that expressly require hospitals to develop community benefit plans.²⁰ Seven of these states have adopted standards that are more stringent than ACA requirements.²¹ California, Texas, New Hampshire, and New York require that hospitals’ community benefit plans include mechanisms to evaluate the plans’ effectiveness (Cal. Health & Safety Code 127355; Tex. Health and Safety Code Ann. §311.044; N.H. Rev. Stat. Ann. Tit. I, §7:32-e; N.Y. Pub. Health Law §2803-l(3)). California further requires that a hospital’s community benefit plan specify measurable objectives to be achieved within specific time frames (Cal. Health & Safety Code 127355). New Hampshire requires the inclusion of cost estimates (N.H. Rev. Stat. Ann. Tit. I §7:32-e), and Vermont requires that identified health care needs be integrated with the hospital’s long-term planning (Vt. Stat. Ann. tit. 18 §9405(a)).

Last year, the state of Washington adopted new implementation strategy standards that build on those of the ACA. The ACA requires a tax-exempt hospital to make its CHNA (but not its implementation strategy) “widely available to the public” and to include an explanation of why the hospital does not intend to meet any health need identified in its CHNA. Under the Washington law a hospital’s implementation strategy must be made “widely available to the public” and include “a brief explanation for not accepting recommendations for community benefit proposals identified in the assessment through the stakeholder consultation process” (Wash. Rev. Code §70.41.470). The law also requires “evidence-based” implementation strategies “when available,” or, alternatively, that innovative programs and practices be supported by evaluation measures (Wash. Rev. Code §70.41.470).

Financial Assistance Policy

Federal. Section 9007 of the ACA (I.R.C. §501(r)(4)) requires each tax-exempt nonprofit hospital to develop a written FAP and a written policy relating to emergency care. The FAP must include, at a minimum: eligibility criteria for financial assistance and whether such assistance includes free or discounted care; the basis for calculating patient charges; the method for applying for financial assistance; and, unless the organization has a separate billing and collections policy, the actions the organization may take in the event of nonpayment (I.R.C. §501(r)(4)).

In a June 2012 Notice of Proposed Rulemaking (NPRM), the IRS and Treasury proposed additional regulatory requirements for tax-exempt hospital FAPs: they must include eligibility criteria and the basis for calculating patient charges, specify all free care and discounts available under the hospital's FAP; identify the amounts (e.g., gross charges) to which the discounts are applied; and state that, after a patient is determined to be FAP-eligible, he or she will not be charged more for medically necessary or emergency services than the amounts generally billed (AGB) to patients with applicable insurance coverage. The FAP must also include a description of any required documentation and provide contact information for securing assistance with the FAP application process. The hospital's specification of "the actions the organization may take in the event of nonpayment" must include (either in its FAP or in a separate billing and collections policy) an explanation of all extraordinary collection actions the hospital may take, consistent with the requirements of §501(r)(6) (IRS, 2012).

State. State regulatory approaches vary widely. Nineteen states have laws requiring hospitals to develop a financial assistance policy.²² At least eight states mandate free care for at least some patients who are unable to pay.²³ Nine states have established uniform standards for charity care eligibility,²⁴ and seven states require hospital

charges for patients with lower incomes to be based on a sliding fee scale that reflects the patients' ability to pay.²⁵

Financial Assistance Policy Dissemination

Federal. The ACA requires tax-exempt hospitals' FAPs to include "measures to widely publicize the policy within the community to be served by the organization" (IRC §501(r)(4)(A)(v)). The IRS and Treasury have provided additional guidance in their 2012 NPRM: an FAP must include four types of measures in order to be considered "widely publicized." It must include a summary of publication measures or explain how a copy of the summary may be obtained. Publication measures must include: free paper copies of the FAP application form and a plain language summary of the FAP, available on request, both by mail and within the hospital facility, in English and in the primary language of any population with limited English proficiency constituting more than 10 percent of residents of the community the hospital serves. The FAP must also include a description of measures to inform and notify visitors to the hospital and the community served about the FAP, as well as measures for making the FAP, the FAP application form, and a plain language summary of the FAP (in English and other languages as described above) available on the hospital's website (IRS, 2012).

Although the NPRM states that FAPs include measures the hospital will take "to inform and notify visitors ... about the FAP through a conspicuous public display or other measure(s) reasonably calculated to attract the attention of visitors to the hospital facility" (IRS, 2012, p. 38152), it does not specifically identify locations at which hospital FAPs must be disseminated. Several states have followed a different approach, prescribing precise locations at which FAPs or notices concerning FAPs must be posted or otherwise made available.

State. The laws of at least 18 states²⁶ specify locations within the hospital where FAPs must be posted, distributed, or otherwise disseminated. In 17 states,²⁷ hospitals are directed to post FAP information in one or more public areas, such as a hospital's admissions department, billing offices, emergency rooms, or waiting areas. At least nine states²⁸ require information about charity and discounted care or an FAP summary to be included in patient bills. Five states²⁹ require that the hospital post its FAP or a summary of its FAP on the hospital's website. Texas is the only state that requires the publication of hospitals' charity care policies in a local newspaper. California requires that the written notice of a hospital's FAP include a statement that emergency room physicians in the hospital must also provide discounted emergency services to uninsured patients and patients with high medical costs (Cal. Health & Safety Code §127405(a)(1)(B)).

Limitations on Charges, Billing, and Collections

Federal. The ACA prohibits tax-exempt hospitals from charging FAP-eligible patients more than the "amounts generally billed" for the service when provided to individuals with applicable insurance coverage (I.R.C. §501(r)(5)). It also prohibits the use of "gross charges" and bars hospitals' use of "extraordinary collection actions" before making reasonable efforts to determine the patient's or the responsible party's eligibility under the hospital's FAP (I.R.C. §501(r)(6)). In their 2012 NPRM, the IRS and Treasury proposed acceptable methodologies for calculating "amounts generally billed," defined "gross charges," and clarified what actions are necessary to satisfy a hospital's duty to make a "reasonable effort" to determine an individual's FAP eligibility before initiating extraordinary collection actions. The NPRM defines "extraordinary collection action" broadly to include, among other things, selling patient debt to a third party; reporting adverse information to a credit agency; and taking any action requiring legal or

judicial process, such as establishing a lien, foreclosing an individual's property, seizing bank accounts, initiating a civil action, causing an individual's arrest, or garnishing an individual's wages (IRS, 2012).

State. Several states expressly limit hospital charges to FAP-eligible patients.³⁰ Some link these limitations to family income. For example, Illinois nonprofit and for-profit hospitals may collect no more than 25 percent of the family income of an FAP-eligible patient (210 ILCS 89/10(c)). New Jersey limits nonprofit and for-profit hospital charges to uninsured state residents who have gross family income below 500 percent of the FPL (N.J. Stat. §26:2H-12.52). Several other states limit charges based on rates charged to other payers. For example, Colorado limits nonprofit and for-profit hospital charges to an FAP-eligible patient to no more than the lowest negotiated rate the hospital charges a private health plan (Colo. Rev. Stat. §25-3-112(3)). In Oklahoma, hospitals may charge FAP-eligible patients no more than the greater of the Medicare rate or the hospital's cost of providing the service (Okla. Stat. tit. 63-§1-723.2). Similarly, New York limits uninsured patient charges to a sliding income scale-based percentage of the highest of the rates charged for the service to the hospital's highest volume payer, Medicaid, or Medicare (N.Y. Pub. Health Law §2807-k(9-a)). Although not a requirement of Minnesota law, all of the states' nonprofit hospitals have executed legally binding agreements with the Attorney General that, among other things, limit hospital charges for services not covered by health insurance. Pursuant to the agreement, a hospital may not charge a patient whose annual income is less than \$125,000 more than the amount of reimbursement the hospital has received for the same service from the hospital's largest nongovernment payer during the previous year (Minnesota Attorney General, 2012, ¶ 32).

Limitations on hospital billing and collection practices are also present in the laws of several states. At least five states³¹ limit or prohibit hospitals from effecting forced sales or foreclosures of a patient's primary residence due to nonpayment of a medical debt. As a condition of reimbursement from the Health Safety Net Trust Fund, Massachusetts hospitals may not seek legal execution against the personal residence or motor vehicle of a patient with low income without the express approval of the hospital's Board of Trustees (114.6 Code Mass. Reg. 13.08(1)). Illinois hospitals may not pursue legal action for nonpayment against uninsured patients who are clearly unable to pay and who have cooperated with the hospital in good faith (210 ILCS 88/35).

Kansas uniquely ties its hospital debt collection limitations to how a patient's medical condition affects his or her ability to work. If a patient's illness (or that of a family member) prevented the patient from working for over two weeks, a court may not order wage garnishment for payment of a medical debt until two months after his or her recovery (Kan. Stat. Ann. §60-231-(c)). Other restrictions limit the percentage of a person's wages that may be subjected to garnishment (Kan. Stat. Ann. §60-2310(b)).

Conclusion

The Community Benefit State Law Profiles identify state-level community benefit requirements relating to community health needs assessment, community benefit planning, financial assistance, and patient financial protections—all central features of federal community benefit requirements under the ACA. The associated analysis of state community benefit laws and regulation against these benchmark federal requirements—in effect, viewing state community benefit standards through the lens of the ACA—facilitates a better

Tax Exemption

Federal. For exemption from federal income tax pursuant to I.R.C. §501(a), a nonprofit hospital must meet the general federal criteria for charitable tax exemption set forth in I.R.C. §501(c) and related regulations, and satisfy the community benefit requirements for charitable hospitals set forth in I.R.C. §501 (r), relevant IRS revenue rulings (e.g., Rev. Rul. 69-545, 1969-2 C.B. 117), and, as a practical matter, in the NPRM (IRS, 2012) and IRS guidance (IRS, 2011). Neither property nor sales are taxed at the federal level.

State. Qualifying nonprofit hospitals in 42 states do not pay state income tax, property tax, or sales and use tax. In 32 of those states, qualifying nonprofit hospitals are exempt from all three types of tax.³² In six of the 42 states, nonprofits may qualify for exemption from state income and property tax, but the state does not levy a sales tax.³³ Five of the 42 states do not levy a corporate income tax but exempt nonprofit hospitals from state sales and property taxes.³⁴ In the eight states not included in the 42 mentioned above, no exemption from sales and use taxes is available to nonprofit hospitals.³⁵

To see a comparison table of all 50 Community Benefit State Law Profiles, go to http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm.

understanding of each state's community benefit landscape. The remarkable variation in state legislative and regulatory approaches to nonprofit hospitals' community benefit responsibilities presents implications and issues too numerous to fully explore here; Hilltop will continue its analysis of the Profiles' findings in an upcoming issue brief.

In some states, the new federal standards overlap or even duplicate community benefit policies

already in place; in others, the federal requirements exceed those at the state level. Conversely, some state community benefit standards are more stringent than their federal counterparts. Hospitals are expected to comply with both federal requirements and those of the state in which they are located, a circumstance that may present special challenges both for multi-state hospital systems and the agencies that monitor them.

The Profiles provide clear, focused information to support stakeholder analysis and facilitate comparison of the scope and breadth of their state's laws to those of other states. Moreover, they can serve as a framework for community benefit planning that takes into account both federal and state imperatives and promotes cross-state consideration of these issues.

As state policymakers and decision makers monitor and react to ACA implementation, there are numerous options and approaches they may wish to consider. States can assess whether federal community benefit standards are adequate to advance state policy goals, or if there are gaps that can be addressed by state-level regulation. Developing strategies for better connection and more complementary relationships between state and federal policies can optimize the value of both. As a strategy for improving the general understanding of how federal and state requirements interact at the state level, states may want to develop and make available to the public, state decision makers, and industry stakeholders community benefit "roadmaps" that crosswalk state and federal requirements.

After careful consideration of the implications of available options, states may decide to defer initiating state law or policy change until federal community benefit requirements are fully implemented and have been in place long enough to permit meaningful assessment of the combined effect of federal and existing state standards.

States may also consider deferring adjustments to their community benefit policies until the effects of ACA implementation can be fully appreciated, in terms, for example, of public and private coverage expansion, as well as of new federal initiatives to reduce hospital costs and improve quality. It is not yet clear how these changes may alter nonprofit hospitals' community benefit behavior.

Ultimately, states may decide to either preserve existing state requirements or develop new ones designed to advance state-specific needs and policies that are not accommodated by the federal community benefit framework. Conversely, existing state requirements can be adjusted for alignment with their federal counterparts in order to ameliorate hospitals' and states' administrative burdens associated, for example, with separate, sometimes duplicative federal and state reporting and monitoring systems.

Before initiating legislative changes, states may wish to explore non-regulatory approaches that encourage community engagement and collaborations with nonprofit hospitals to advance community benefit initiatives that are responsive to community goals and priorities.

The role of nonprofit hospitals in a post-ACA environment will be subject to redefinition in response to changes in care delivery and payment systems, as well as to the current consolidation trend in the hospital industry. When health reform's coverage initiative is fully implemented, hospitals will experience significant reimbursement differences as patient populations shift from uninsured to publicly insured status. All of these factors are likely to substantially affect hospital opportunities and responsibilities relating to community benefit, a circumstance that should not be overlooked as states reevaluate their community benefit laws and consider their options for the future.

The information in this brief is provided for informational purposes only and is not intended as legal advice.

The Hilltop Institute does not enter into attorney-client relationships.

Endnotes

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² These include: Community Catalyst's [Free Care Compendium](#) (2012) and [Health Care Community Benefits: A Compendium of State Laws](#) (November 2007; update expected Spring 2013); the Catholic Health Association's [Comparison of Recommendations Between the Catholic Health Association and VHA Inc.'s A Guide for Planning and Reporting Community Benefit and Community Benefit Mandated State Reporting Requirements](#) <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=2147487948> (2010) and [Community Benefit Voluntary Reporting by U.S. State](#) (2010). The Association for Community Health Improvement provides information about community benefit requirements in selected states in its [State Government Community Benefit and Charity Care Requirements & Reports](#) and [State Hospital Association Community Benefit Reports & Resources](#). See also Rosenbaum, S., Byrnes, M., & Rieke, A. (2013) [Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems](#)" and Catholic Health Association (2010) [Survey of State Laws/Oversight related to Community Health Needs Assessments and Implementation Strategies](#).

³ In 1969, Steven T. Miller (then IRS Deputy Commissioner for the Tax Exempt and Government Entities Division) explained that the IRS looks at five major factors in its "facts and circumstances" analysis of whether a hospital qualifies for federal tax exemption: "(a) A community board; (b) An open medical staff; (c) A full-time emergency room open to all regardless of ability to pay; (d) The admission of all types of patients including those able to pay for care either themselves or through third-party payers; and (e) How excess funds are used, such as for expansion and replacement of existing facilities and equipment, medical training, education, and research" (Miller, 1969). (The emergency room requirement was later modified by the IRS' Rev. Rul. 83-157, which indicated that a hospital that did not operate a full-time emergency room might nevertheless qualify for federal tax exemption under §501(c)(3)).

⁴ "Community building" refers to activities that benefit community health but do not involve the provision of medical care (Congressional Research Service [CRS], 2008). These activities address the root causes of poor health in areas such as education, employment, income, housing, community design, family and social support, community safety, and the environment (CDC, 2012; HHS, 2011; Institute of Medicine, 2011). For a full discussion of community building and related Schedule H reporting issues, see Somerville, M., Nelson, G., Mueller, C., Boddie-Willis, C., & Folkemer, D. (2012, October). *Hospital community benefit after the ACA: Community building and the root causes of poor health*. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ScheduleHIssueBrief5-October2012.pdf> and Barnett, K., & Somerville, M. (2012, October). *Hospital Community benefit after the ACA: Schedule H and hospital community benefit – Opportunities and challenges for the states*. Retrieved from <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ScheduleHIssueBrief4-October2012.pdf>

⁵ CA, DE, FL, IL, IN, ME, MD, MA, MS, MT, NV, NH, NM, NY, OH, PA, RI, SC, TX, UT, VA, WA, and WV.

⁶ CA, FL, IN, MD, ME, MT, NH, NV, and WA.

⁷ DE, MA, MS, NH, SC, and VA. (New Hampshire has two distinct community benefit requirements, one, of general application, is unconditional. The other is a condition of CON approval.)

⁸ IL, MS, PA, TX, UT, and WV.

⁹ MA, NM, and RI.

¹⁰ IL and PA.

¹¹ NY and OH.

^{11a} Text revised on April 16, 2013, to include Nevada.

¹² For a more complete analysis of Schedule H, see Barnett & Somerville (2012, October).

¹³ AK, AL, AR, AZ, CO, DE, FL, HI IA,KS ,KY, LA, MA, MI, MO, ND, NE, NJ, OH, OK, SD, and WY.

¹⁴ CT.

¹⁵ CA, CT, GA, ID, IL, IN, MD, ME, MN, MS, MT, NH, NV, NY, NM, NC, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, and WI.

¹⁶ GA, ME, NM, OR, SC, VA, WA, and WI.

¹⁷ CA, ID, IL, IN, MD, NH, NY, RI, TX, VT, and WA.

¹⁸ Although Massachusetts law does not require nonprofit hospitals to conduct CHNAs, the Attorney General's Voluntary Guidelines recommend that they conduct CHNAs every three years (Mass. Office of the Attorney General, 2009)

¹⁹ CA, MD, NH, NY, TX, VT, and WA.

- ²⁰ CA, IL, IN, MD, NH, NY, RI, TX, VT, and WA. Although Massachusetts law does not require nonprofit hospitals to develop community benefit plans or implementation strategies, the Voluntary Guidelines recommend that they do so (Massachusetts Attorney General, 2012).
- ²¹ CA, NH, NY, IN, TX, VT, and WA.
- ²² CA, CO, IL, IN, MA, ME, MD, MT, NH, NY, OK, PA, RI, TX, UT, VA, WA, WI, and WV. Except in NH and UT, the FAP requirement applies to both for-profit and nonprofit hospitals.
- ²³ CA, ME, MD, NV, RI, TX, UT, and WA.
- ²⁴ CA, CO, ME, MD, NH, OK, RI, TX, and WA.
- ²⁵ MA, NY, RI, WA, IL, MD, and UT.
- ²⁶ AL, CA, CO, IL, IN, ME, MD, MA, NJ, NH, NY, OH, PA, RI, TN, TX, VA, and WV.
- ²⁷ AL, CA, CO, IL, IN, ME, MD, MA, NJ, NH, NY, PA, RI, TN, VA, WA, and WV.
- ²⁸ AL, CO, IL, ME, NV, NJ, NY, RI, and VA.
- ²⁹ AL, CO, IL, RI, and VA.
- ³⁰ CO, IL, MD, MS, ND, NV, NJ, NY, OK, and TN.
- ³¹ LA, MD, NY, OH, and RI.
- ³² AR, AZ, CO, CT, FL, GA, HI, IA, ID, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, ND, NE, NJ, NM, NY, OH, PA, SC, UT, VA, VT, and WI.
- ³³ AK, DE, NH, NM, OR, and MT.
- ³⁴ NV, SD, TN, WY, and TX.
- ³⁵ AL, CA, LA, NC, OK, RI, WV, and WA.

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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 the 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. The program is funded for three years through the generous sponsorship of the Robert Wood Johnson Foundation (www.rwjf.org) and the Kresge Foundation (www.kresge.org).



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