



The Hilltop Institute

analysis to advance the health of vulnerable populations

Hospital Community Benefits after the ACA Addressing Social and Economic Factors that Shape Health

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Introduction

The Hilltop Institute's Hospital Community Benefit Program is a central, objective resource for state and local decision makers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs.

This brief is the ninth in the series, *Hospital Community Benefits after the ACA*. Earlier briefs address the requirements for tax-exempt hospitals established by §9007 of the Affordable Care Act (ACA)¹ and assessed federal and state approaches to community benefit regulation (Nelson, Somerville, Mueller, & Boddie-Willis, 2013; Somerville, Nelson, & Mueller, 2013; Folkemer, Spicer, Mueller, Somerville, Brow, Milligan, & Boddie-Willis, 2011). Another brief (Somerville, Nelson, Mueller, Boddie-Willis, & Folkemer, 2012) explores hospital "community building" activities that fall within categories specifically recognized by Schedule H, which supplements IRS Form 990, the informational return filed by

tax-exempt organizations (IRS, n.d.a.). That brief explains the importance of a wide range of IRS-recognized community building activities in addressing the root causes of poor health. Subsequent briefs and The Hilltop Institute [Community Benefit State Law Profiles \(Profiles\)](#)² address the ongoing importance of state-level regulation of hospital community benefits and present comprehensive analyses of each state's community benefit landscape as viewed through the lens of the major categories of federal community benefit requirements (Somerville, Nelson, & Mueller, 2013; Nelson, Somerville, Mueller, Boddie-Willis, 2013).

This issue brief continues the program's examination of state-level community benefit oversight by focusing on the ten states that require hospitals to develop implementation strategies: [California](#), [Illinois](#), [Indiana](#), [Maryland](#), [New Hampshire](#), [New York](#), [Rhode Island](#), [Texas](#), [Vermont](#), and [Washington](#). It identifies specific social and

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economic factors that shape community health and thus are of great importance to state and local policymakers. The implementation strategy requirements of California, Illinois, Indiana, New Hampshire, Rhode Island, and Texas were enacted prior to the ACA. Whether, how, and when these states will reassess state requirements in response to the ACA is unknown. Certain aspects of the state implementation strategy requirements of Maryland,³ New York,⁴ Vermont,⁵ and Washington⁶ were adopted post-ACA.

This brief begins by providing essential background information and describes the regulatory framework through which federal and state policymakers exercise oversight of hospital community benefits. Next, it describes current hospital-reported programs and initiatives that target spe-

Background

Today, there is broadening appreciation among researchers, government agencies, public interest organizations, foundations, and health care providers—including hospitals—that factors other than medical care play important roles in shaping individual and community health. 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], 2013; Institute of Medicine, 2011; Robert Wood Johnson Foundation® [RWJF] Commission to Build a Healthier America, 2014; Levi, Segal, & Kohn, 2011).

The conceptual model of population health employed by County Health Rankings & Roadmaps (CHR&R),⁷ a widely recognized and authoritative source of information on population health, assigns 40 percent of the responsibility for population health outcomes to social and economic

cific social and economic factors, as reflected in more than 500 state-required implementation strategies—or reports of implementation strategies—as well as the methodology Hilltop employed in that review. This review provides a baseline of currently reported activities, many of which may have been initiated prior to enactment of the ACA.

Based on the review, the brief identifies standard regulatory tools and characteristics of implementation strategies used by those states that could facilitate hospital investment in activities that address social and economic determinants. The final section offers conclusions, recommendations, and policy options for state and local policymakers and decision makers.

factors (UWPHI, 2014a; Booske, Athens, Kindig, Park, & Remington, 2010). Around the nation, state and local officials, parents, public health workers, communities of all sizes, and other entities, including some tax-exempt hospitals, are acting together to improve the health of communities by addressing social and economic factors where community residents live, learn, work, and play.

Below are a few examples of communities across the nation that are striving to create what RWJF is calling a “culture of health” to enable all individuals to lead the healthiest possible lives (Lavizzo-Mourey, 2014).

- A nonprofit hospital system in Ohio is tackling food insecurity by treating hunger as a health issue. In just three years it has provided 10.5 million meals to residents who are considered “food insecure” (Gearon, 2014).
- The *Green & Healthy Homes Initiative* is implementing a “cost-effective and integrated approach to housing interventions” by com-

bining federal and philanthropic investments in weatherization, energy efficiency, health, and safety to create more sustainable, affordable, and healthier homes. The 17 current sites include 15 cities, one county, and one Indian nation (Green & Healthy Homes Initiative, 2014).⁸

- The city of Providence, Rhode Island, established the Healthy Communities Office in 2012. Its goals are to lower chronic disease

rates by providing safe and convenient places for children to play, encourage walking rather than driving, and increase participation in federally funded meal programs for children (Healthy Communities Office, 2013).

It is against this backdrop of more than two decades of state regulation of community benefits that Hilltop undertook a review of state-level oversight of hospital activities targeting the social and economic factors that shape health.

The Federal/State Framework

IRS/Treasury oversight of community benefits, first articulated in 1969, specified that a hospital seeking exemption from federal taxation must demonstrate that it promotes the health of “a class of persons that is broad enough to benefit the community” (Rev. Rul. 69-545). That standard remained essentially unchanged until 2009 (Davis, 2011), when the IRS introduced a new Schedule H to supplement the financial data collected from all tax-exempt organizations via Form 990 (IRS, 2007). Part I of the 2013 Schedule H, “Charity Care and Certain Other Community Benefits at Cost,” is where hospitals report specific categories of community benefit activities that would support federal tax exemption (IRS, n.d.a.). Part II, labeled “Community Building,” is where hospitals list expenditures for non-clinical activities that address community health within the following nine categories:

- Physical improvements and housing
- Economic development
- Community support
- Environmental improvements
- Leadership development and training for community members
- Coalition building
- Community health improvement advocacy
- Workforce development
- Other⁹

For each item listed in Part II of Schedule H, a hospital must describe “how its community building activities ... promote the health of the communities it serves” (IRS, n.d.b.). This detail is not required of activities listed in Part I.

Notably, some activities related to health may not be reportable in either Parts I or II. Each year’s Schedule H Instructions delineate what may be reportable as community benefit in Part I and provide examples of community building activities that may be reportable in Part II. Additional guidance regarding “what counts” as community benefit can be found in materials prepared by the Catholic Health Association (2014).

States can separately establish community benefit standards for tax-exempt hospital licensees. These standards need not align with federal community benefit requirements and can be more specific and stringent than their federal counterparts. Thus, state policymakers seeking to encourage and promote tax-exempt hospital activities that address social and economic determinants may wish to assess their state’s existing community benefit regulatory framework.

All nonprofit hospitals seeking exemption from federal taxation must conform to the above-described federal requirements. Hospitals in states that do not specify the types of hospital

activities that support exemption from state taxation need only satisfy federal requirements. Policymakers in these states may wish to consider whether the federal regulatory scheme, including the community building categories specified, sufficiently advances state health goals and priorities. If it does not, then separate state requirements may be appropriate.

Hospitals in states that do specify separate state requirements must comply with both sets of directives in order to be eligible for both federal and state tax exemption. Policymakers in states that separately specify the types of hospital activities that support exemption from state taxes may want to review the existing state regulatory scheme to ensure that it is appropriately reflective of current state goals and priorities regarding social and economic factors that influence health.

Federal Implementation Strategies. Since its implementation in 2010, ACA §9007(a), as codified in I.R.C. §501(r)(3)(A)(ii), additionally requires each tax-exempt hospital to adopt “an implementation strategy to meet the community health needs identified through its Community Health Needs Assessment, or CHNA.” In their implementation strategies, tax-exempt hospitals identify, in response to needs identified in their CHNAs, the community benefit activities in which they are (or plan to be) engaged. Federally required implementation strategies are written plans (also called action guides) that formulate nonprofit hospitals’ proposed approaches for addressing the significant health needs in their communities (Spugnard, 2013).

Implementation strategies further the ACA’s goal of enhancing community benefit accountability because they specify the actions that a nonprofit hospital intends to take to address each significant community health need.

Community benefit transparency, another ACA goal, underlies the Schedule H reporting requirements and CHNA. It also underlies the requirement that federal implementation strategies are to be made publicly available. Pursuant to a still-pending 2013 Notice of Proposed Rulemaking (NPRM), a nonprofit hospital may either attach the implementation strategy to its Form 990 or provide on the Form 990 the URL(s) of the web page(s) where the implementation strategy is available (proposed rule §1.501(r)-3).¹⁰ The NPRM would further require that implementation strategies delineate the anticipated impact of proposed actions and describe a plan to evaluate the actual outcomes (IRS, 2013).

State Implementation Strategies. The laws of California,¹¹ Illinois,¹² Indiana,¹³ Maryland,¹⁴ New Hampshire,¹⁵ New York,¹⁶ Rhode Island,¹⁷ Texas,¹⁸ Vermont,¹⁹ and Washington²⁰ require that tax-exempt hospitals develop state implementation strategies (also referred to as community benefit plans, community service plans, or implementation plans) to satisfy state regulatory requirements. (In this brief, all such plans are referred to as state implementation strategies.)

Like federally required implementation strategies under ACA §9007, state implementation strategies further community benefit accountability and transparency. Also like their federal counterparts, they typically address the costs associated with the provision of charity and discounted care. In addition, they delineate community benefit activities that a hospital plans to take to respond to community health needs and describe activities in which a hospital is presently engaged, including those activities that address the social and economic factors that shape health.

Methodology

Using the Profiles, Hilltop identified the ten aforementioned states that require tax-exempt hospitals to develop implementation strategies. Some states require hospitals to develop and/or submit a report of the implementation strategy to a state entity, whereas others require hospitals to submit the implementation strategy itself.²¹

Hilltop reviewed more than 500 electronically available, state-required implementation strategies and reports to find reported activities that target social and economic measures. The goal was to assess the degree to which hospitals reported implementing community benefit and community building activities targeting education, income, employment, and community safety, each of which is a social and economic focus area identified by CHR&R. CHR&R is a widely regarded and familiar tool that employs specific factors and measures (available locally and which can be compared across county lines) in assessing the health of counties. Those factors and measures have been developed and subjected to input from experts. For these reasons Hilltop used the following CHR&R measures to guide its review: education (high school graduation rates), income (children living in poverty), employment (unemployment), and community safety (violent crime rates) (UWPHI, 2014a). Hilltop reviewed the most currently available hospital implementa-

tion strategy in electronic format. Most documents were dated 2011, 2012 or 2013, although a few were dated 2010 or older. The review and categorization of each reported hospital initiative or activity was performed by Hilltop using a data collection tool it developed.

Finally, Hilltop used the Profile of each of the ten states that require implementation strategies to identify state laws, regulations, and other requirements related to those strategies. Review and analysis of these primary source materials—including state community benefit laws, regulations, and reporting requirements—was conducted by JD/MPH and JD/PhD credentialed staff using standard approaches to statutory construction and interpretation.

State-level requirements for implementation strategies and implementation strategy reports generally predate the ACA. They differ from the federal approach and from each other in many respects. Comparing these various regulatory regimes provides opportunities to identify types of state policies, regulatory tools, and features of those tools that can facilitate hospital activities that address social and economic determinants.

Hospital-Reported Activities that Target Social and Economic Measures

A 2013 study of federal informational returns filed by tax-exempt hospitals found that they devote an average of 7.5 percent of their operating expenditures to community benefits. The largest portion of those expenditures represents unreimbursed costs for means-tested government pro-

grams—generally Medicaid shortfall. The next largest component is attributed to the cost of free and discounted care for individuals who are unable to pay for needed hospital services (Young, Chou, Alexander, Lee, & Raver, 2013).

Beyond these two community benefit categories, many tax-exempt hospitals provide additional benefits to their communities, most typically health fairs and screenings, which can be considered types of community health improvement services. A significant number of tax-exempt hospitals also provide community health education on such topics as tobacco cessation and obesity prevention (Catholic Health Association, 2012).

However, only a few of the numerous community benefit and community building activities reported in electronically available state implementation strategies address the CHR&R measures of education, income, employment, and community safety (UWPHI, 2014a). Income and education, in particular, are known to be two of the most important social factors that influence health (RWJF, 2011a; RWJF, 2011b; Center on Society and Health, 2014). Yet, as reported in electronically accessible state implementation strategies or reports of those strategies, very few hospital activities appear to address those important health measures.

Among the ten states that require development of state implementation strategies, California was the only state in which hospitals reported initiatives and programs addressing all four of these measures. Maryland and New York hospitals reported activities addressing high school gradua-

tion, unemployment, and violent crime rates. Hospitals in the remaining states reported activities addressing two or fewer of the four measures under review.

None of the reviewed state-required implementation strategies specified whether the reported initiatives were either evidence-informed or evidence-based. A fuller discussion of evidence-based initiatives can be found in the *Conclusions and Recommendations* section of this brief.

Examples of hospital activities addressing the social and economic measures of high school graduation, children in poverty, unemployment, and violent crime rates identified in this review include the following:

- Programs in Indiana and New York offer students college credit while in high school or provide scholarships to students seeking medical careers
- A collaboration among Maryland hospitals prepares individuals aged 18 to 21 years for entry-level jobs in the health care industry
- Initiatives at several California hospitals address gang prevention and youth violence, and one program reports that it promotes change in attitudes and beliefs regarding sexual violence among high school students and builds leadership and mentoring among youth

Use of State Regulatory Tools to Target Social and Economic Determinants

The regulatory schemes of several states that require implementation strategies clearly contemplate nonprofit hospital investment in activities that target social and economic factors. Those states use a variety of regulatory tools to articulate state expectations and thereby promote community benefit accountability. Policymakers in other states who are interested in encouraging nonprofit hospital investment in activities that

target social and economic determinants may consider using similar standard regulatory tools such as these. Examples of these tools are discussed below.

Express Policy Guidance. New York's current state health improvement plan, *The Prevention Agenda 2013-2017*, emphasizes the importance of addressing the social determinants of health

(New York State Department of Health [NYSDOH], 2012a). A 2012 guidance document “asks” that tax-exempt hospitals, local health departments, and community partners collaborate to develop state-required community health assessments, community health improvement plans, and hospital implementation strategies (referred to as community service plans) (NYSDOH, 2012b).

New York requires that implementation strategies focus on at least two of the five state *Prevention Agenda* priorities, at least one of which must address a health disparity. For example, one of the five priorities is “promote a healthy and safe environment” (NYSDOH, 2012b). Substantive goals established to effectuate this priority include 1) reducing exposure to outdoor air pollutants; 2) improving the design and maintenance of the built environment to promote healthy lifestyles; and 3) improving the design and maintenance of home environments to promote health and reduce illness (NYSDOH, 2012a).

The 2012 guidance document accompanying New York’s *Prevention Agenda 2013-2017* “incorporates state and local experience developing and implementing” prior policy and is also shaped by national accreditation of state and local public health agencies. Its language more explicitly supports hospital investment in activities that address social, economic, and environmental factors (NYSDOH, 2012b).

Statutes or Regulations. California and Maryland both define 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); Md Code Ann. Health-Gen. 19-303(a)(3)). The California statute provides the following examples of community benefits: child care; sponsoring food, shelter, and clothing for the homeless; and “education, transportation, and other goods and ser-

vices that help maintain a person’s health” (Cal. Health & Safety Code §127345(c)). This language appears to facilitate hospital investment in activities that address the social and economic factors that shape health. Maryland’s statute requires that each tax-exempt hospital’s implementation strategy (referred to as a community benefit report) describe the hospital’s efforts to track and reduce health disparities in its community (Md. Code Ann. Health-Gen. 19-303(c)(vii)).

Community Benefit Reporting Documents.

A few of the ten states mandating implementation strategies require that reports of those strategies be submitted on standardized forms. For example, New Hampshire’s Community Benefit Reporting Guide classifies “community building” activities as a category of reportable community benefits and defines them as activities “intended to address social and economic determinants of health” (New Hampshire Department of Justice, 2008). Such activities might include adopt-a-school efforts, mentoring programs, youth development initiatives, home safety assessment and installation, and welfare-to-work initiatives.

New Hampshire’s required community benefit reporting form reflects this expansive approach. The state supplies a chart that itemizes each community benefit reporting category, along with a list of potential community health needs. Included in the list of needs are socioeconomic factors such as poverty, unemployment, educational attainment, high school completion, vandalism/crime, homelessness, air quality, and water quality (New Hampshire Department of Justice, 2008). To report the amount of dollars invested, hospitals match the category of each community benefit initiative with the specific need it addresses.

In Maryland, the Health Services Cost Review Commission (HSCRC) is the government entity that oversees state-required hospital community benefits. Maryland’s community benefit report-

ing guidance classifies many hospital activities addressing social and economic factors as “community building,” which is a category of community benefit. Examples include, small business development, mentoring programs, school-based

programs on health care careers, and neighborhood watch groups, all of which may count as community benefit activities (HSCRC, 2013a). The activities themselves are reported on a pre-formatted table.

Facilitative Implementation Strategy Approaches

Similar to federally required implementation strategies under ACA §9007, state implementation strategies advance community benefit accountability and transparency. Like their federal counterparts, these strategies typically address the costs associated with providing charity and discounted care. They also delineate community benefit activities that a hospital plans to take to respond to significant health needs and describe existing activities in which a hospital is currently engaged, including those addressing the social and economic factors that shape health.

The more accountability and transparency a state incorporates into its implementation strategy requirements, the simpler it is for policymakers, health departments, community organizations, and the general public to assess the degree to which hospital activities target social and economic factors. As detailed below, there are several approaches that states can utilize to facilitate the goals of community benefit accountability and transparency.

Community Engagement. Questions regarding accountability and transparency may arise during the development phase of implementation strategies. Neither the ACA nor the 2013 NPRM require “real time” community engagement in the development of implementation strategies.²² However, at least four states do establish such requirements along with a mechanism designed to ensure that the required community engagement occurs. Washington directs hospitals to “consult” with community-based organizations, stakeholders, and local public health jurisdictions

in developing each implementation strategy. Hospitals, in their implementation strategies, must provide a brief explanation if they do not accept community benefit proposals identified through the stakeholder consultation process. (Wash. Rev. Code §70.41.470).

New Hampshire law contemplates that the views of the community served by the hospital, community groups, members of the public, and local government officials will be “solicited” during implementation strategy development (N.H. Rev. Stat. Ann. Tit. I, §§7:32-e (vi)). The implementation strategy report must include the means used to solicit the views of the community served, and must identify community groups, members of the public, and local government officials consulted on the development of the report.

Rhode Island specifies that the communities that are a focus of the strategy must be “involved” in the planning and implementation process (23-17.14 R.I. Code R. §11.5(b)(3)). If the state department of health receives “sufficient information” that a hospital has not complied with state community benefit requirements, including the requirement that communities are to be involved in the planning and implementation process, the department is authorized to hold a hearing and impose penalties (23-17.14 R.I. Code R. §11.5(b)(6)).

New York State “asks” nonprofit hospitals to “work with” local boards of health and community partners to complete their state-required implementation strategies. In connection with the

two *Prevention Agenda* priorities required to be included in the implementation strategy, hospitals must describe the organizations that participated and the stakeholder sessions that were held (NYSDOH, 2012b).

Policymakers in some states may decide to align with the present federal standard, which does not require direct community engagement during implementation strategy development. Officials and decision makers in other states may wish to consider whether community engagement in implementation strategy development should be required. Some questions to consider include the following (Nelson et al., 2013):

- What type(s) of engagement should be mandated?
- Should tax-exempt hospitals be “required” or merely “encouraged” to “consult” with non-hospital entities? If required, how will engagement be measured and enforced?
- Should engagement with some entities, such as local boards of health, be mandated?
- How much weight should hospitals give to views from nonhospital entities that have been “solicited” and to the “involvement” of outside groups?

Permitting maximum input from all sectors and the community at large certainly promotes community benefit accountability and transparency, but it must be weighed against considerations of administrative efficiency and avoiding duplicative requirements.

Filing with a State Entity. Federal requirements for filing federal implementation strategies differ from state requirements for filing state implementation strategies. Tax-exempt hospitals must either file copies of their federally required implementation strategies with Schedule H of IRS Form 990 or provide the URL(s) of the web page(s) on which the implementation strategy is

available to the public (proposed rule §1.6033-2(a)(2)(ii)(I)(2)). Of the ten states that require hospitals to develop state implementation strategies, nine require that those documents be filed with a state agency. Washington is the outlier in this regard, requiring that implementation strategies be made “widely available to the public” within the meaning of IRS regulations (Wash. Rev. Code §70.41.470(3)).

Electronic Availability. The current era of electronic accessibility would seem to facilitate community benefit transparency. However, the IRS does not make Form 990, Schedule H, or the associated implementation strategies available electronically.²³ Several states, including California, New Hampshire, and Vermont, do require that state implementation strategy reports—or the strategies themselves—be posted on a state website (Cal. Health & Safety Code §127350(d); N.H. Rev. Stat. Ann. Tit. I, §7:32-g; Vt. Stat. Ann. Tit. 18 §9405b(c)). Under Maryland law, the HSCRC is responsible for collecting hospital community benefit information from individual hospitals, which it compiles into a publicly available statewide Community Benefit Report (Md. Code Ann. §19-303(c)(1); (d)). This document is electronically available and contains a summary of statewide information, as well as information from individual hospital community benefit reports (HSCRC, 2013b). Although it is apparently not required by state law, Indiana and Texas also post implementation strategies on a state website.

New York and Washington expressly require that tax-exempt hospitals post their implementation strategies on the hospital’s website (N.Y. Pub. Health Law §2803; Wash. Rev. Code §70.41.470(3)(a)). Vermont requires posting on the hospital’s website as well as the state’s website (Vt. Stat. Ann. Tit. 18 §9405b(b);(c)).

Ease of Comparison. One advantage of transparency is the ease of comparing information about community benefit initiatives. IRS Form 990 and

Schedule H are standardized forms that facilitate some degree of comparison. Maryland and New Hampshire also have prescribed formats for reporting community benefit/community building activities.

Maryland requires hospitals to complete a pre-formatted table in which hospitals provide narrative information about their community benefit initiatives in the following categories: identified need, hospital initiative, primary objective of the initiative, single or multi-year duration, key partners, evaluation dates, outcome, and continuation and cost of initiative. The use of a standardized tabular format facilitates the comparison of different hospitals' initiatives.

As previously described, a pre-formatted table is also included in New Hampshire's required implementation strategy reports, which facilitates comparison of expenditures among hospitals; however, no narrative description is required.

Specificity. The level of detail—including the minimum information hospitals must supply—required in state implementation strategies and strategy reports varies from state to state. The laws of California, Indiana, Maryland, Rhode Island, and Texas appear to require tax-exempt hospitals to list all significant community benefit activities (Cal. Health & Safety Code 127350(d); Ind. Code §16-21-9-6; Md. Code Ann. Health-Gen. §19-303(c)(1); 23-17.14 R.I. Code R.

§11.5(b); Tex. Health and Safety Code Ann. §311.044). New Hampshire and Rhode Island further require hospitals to report activities that they anticipate undertaking in the near future (N.H. Rev. Stat. Ann., Tit. I §7:32-e); (23-17.14 R.I. Code R. §11.5(b)). In contrast, Vermont requires hospitals to describe at least three—but not necessarily all—initiatives that the hospital is currently undertaking or planning to undertake (Vt. Reg. H-2009-05 §4 (B)(2)).

Policymakers who seek to encourage hospital investment in activities that target social and economic determinants need to carefully assess the transparency of their state community benefit regulatory frameworks. Some decision makers may determine that the federal scheme is sufficient to advance state goals and objectives. Federal standards of community benefit transparency are an integral part of the federal regulatory scheme that recognizes the nine previously identified community building categories (IRS, n.d.a.). However, there is still some uncertainty regarding which types of activities “count” as community benefits. States seeking to encourage hospitals to engage in a broader range of activities to address social and economic factors may find that the degree of transparency established in the federal system is not sufficient to afford appropriate public understanding, oversight, and monitoring.

Conclusions and Recommendations

This brief focuses on the state-level regulation of hospital activities addressing social and economic factors that shape health, in the ten states that require hospitals to develop implementation strategies. The four factors specifically addressed are: income, education, employment, and community safety. But it is well established that other factors are also vitally important: availability of

healthy foods, the environment, access to recreational facilities, socioeconomic conditions, housing, social cohesion and supports, language, literacy, culture, and transportation. Because all of these factors are fundamental to healthy communities, they are likely of great importance to state and local policymakers, as well as to tax-exempt hospitals that are currently engaged in or plan-

ning activities targeting at least some of these social and economic determinants of health.

Baseline of Currently Reported Activities.

Hilltop’s review of more than 500 electronically available state-required implementation strategies and strategy reports found that only a few of the numerous community benefit and community building activities reported address the measures utilized by CHR&R—education (high school graduation rates), income (children living in poverty), employment(unemployment), and community safety (violent crime rates). Many of the documents reviewed report activities that predate IRS/Treasury-proposed rules for CHNA reports and implementation strategies; others are the first ones adopted under newly issued federal or state specifications. By comparing hospital data in future years with the baseline information Hilltop collected from the implementation strategies of the hospitals in the ten states discussed, it might be possible to assess whether hospitals will have shifted a greater portion of their community investments toward activities that target social and economic determinants after implementation of the ACA.

Use of Standard Regulatory Tools to Target Social and Economic Determinants. States are not required to defer to federal tax exemption standards, and they may establish their own requirements for nonprofit hospital property, income, and sales tax exemption. States have a variety of regulatory tools at their disposal, including policy pronouncements, statutory language, regulations, and reporting requirements. States that seek to encourage hospital community benefit investment in the broader range of social and economic or “upstream” factors can consider employing any of these approaches. In addition, requirements that facilitate transparency of state-mandated implementation strategies or reports of such strategies can make activities targeting so-

cial and economic factors more accessible to oversight and public view.

Community Engagement. At least four states currently require community engagement during the development phase of implementation strategies, which can promote accountability and advance transparency. Other states may want to consider whether such requirements would further state health goals and objectives without imposing undue burdens on hospitals.

Evidence-Based and Evidence-Informed Strategies. Some policymakers may determine that their existing state regulatory frameworks sufficiently advance state health goals and objectives. Others may wish to consider adopting, facilitating, implementing, promoting, and/or expanding policies that encourage community benefit investment in activities targeting social and economic determinants. Those policymakers may wish to give serious consideration to evidence-based and evidence-informed strategies. Adopting such strategies provides greater assurance that implemented interventions have been subjected to systematic review and found to be effective, which can promote efficient use of finite public and community benefit dollars (Centers for Disease Control and Prevention [CDC], 2014a).

One authoritative and widely respected source of evidence-informed policies and programs is *What Works for Health*, which is part of the CHR&R project (UWPHI, 2014e). UWPHI explains that the evidence ratings it assigns to health improvement strategies combine what is known from scientific study and the observations of unbiased experts. Each reviewed strategy is assigned its evidence rating based on the quantity, quality, and findings of available research.²⁴ CHR&R assesses strategies in terms of their effect on factor(s) that drive health outcomes rather than their direct effect on health (e.g., strategies

relating to the “income” health factor are assessed for their effect on income).²⁵

In addition, the *Guide to Community Preventive Services* (Guide)²⁶ compiled by the CDC is a globally respected public health resource for evidence-based policy recommendations relating to improved health, including some recommendations as they relate to social and economic determinants. The Guide was created to help inform the decision making of federal, state, and local officials and others. Based on systematic reviews of the scientific literature, it reflects the assessments of strategies reviewed by the HHS-created Community Preventive Services Task Force²⁷ and identifies population health interventions that “save lives, increase lifespans and improve quality of life” (CDC, 2014e).

Several other resources regarding evidence-based and evidence-informed population health strategies are listed under *Resources* at the end of this brief.

Many government entities, public health researchers, policy organizations, and others interested in addressing the social and economic determinants that affect health strongly support the use of evidence-based strategies, when possible (Rosenbaum, Riecke, & Byrnes, 2014;²⁸ New York Academy of Medicine, 2013). However, questions remain regarding whether an over-emphasis on evidence-based strategies can hinder innovation, adaptation to local contexts, and ultimately limit the evidence base. New York supports reliance on “promising practices” in addition to evidence-based strategies (NYSDOH, 2012b), and Washington permits “innovative programs and practices ... [that are...] supported by evaluation measures” (Wash. Rev. Code §70.41.470 (3)(b)).

Expanded Hospital Roles and Multi-Sector Collaborative Efforts. A recent report by the RWJF Commission to Build a Healthier America (2014) strongly emphasizes that the “mindset, mission and incentives for ... health care institutions must be broadened beyond treating illness to helping people live healthy lives.” As described throughout this brief, the places where Americans live, learn, work, and play have a major impact on health. Tax-exempt hospitals may find it effective to partner with entities beyond the health care system when addressing education, poverty, employment, community safety, transportation, housing, and other non-clinical determinants in order to implement cross-sector strategies to effectively address the array of social and economic factors that shape health (New York Academy of Medicine, 2013; RWJF, 2014; Trust for America’s Health, 2013). The active participation of community-based organizations, community members, and representatives from other sectors in both CHNA and implementation strategy development and implementation can increase the likely inclusion of activities that address a broad range of social and economic factors.

After thoughtfully considering the available options, some states may choose to delay making any changes to law or policy until the federal community benefit requirements and ACA implementation have been in place long enough to permit meaningful assessment of the altered health care landscape. Others may determine that specific conditions in their states and state health goals and policies warrant expanded attention to social and economic determinants at this time. All of these factors should be taken into account as states reassess their community benefit regulatory frameworks and evaluate options for addressing social and economic determinants as a means of improving community health.

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

¹ 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 referenced herein as the Affordable Care Act (ACA).

² The Profiles can be accessed at http://www.hilltopinstitute.org/hcbp_cbl.cfm. The Community Benefit State Law Profiles owe much to the work and support of Hilltop's research partners for that project. Hilltop expresses its appreciation for the contributions of Kathleen Hoke, JD, and Cristina Meneses, JD, MS, both of the Network for Public Health Law; to Network researchers Joshua Greenfield, JD, Lauren Klemm, JD, and Sage Graham, JD; to Patsy Matheny, LLC, who fielded a survey of state hospital associations on Hilltop's behalf; and to the individuals who responded to that survey.

³ Md. Code. Ann. Health-Gen. §19-303(c)(2)(vii).

⁴ See New York State Department of Health (2012a).

⁵ Vt. Stat. Ann. Tit. 18 §9405a

⁶ Wash. Rev. Code §70.41.470.

⁷ CHR&R is a collaboration of the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation.

⁸ Atlanta, GA; Baltimore, MD; Buffalo, NY; Chicago, IL; Cleveland, OH; Denver, CO; Detroit, MI; Dubuque, IA; Flint, MI; Jackson, MS; New Haven, CT; Oakland, CA; Philadelphia, PA; Providence, RI; Salt Lake County, UT; San Antonio, TX; and Spirit Lake Tribe Nation.

⁹ Instructions for IRS' 2014 Schedule H provide little guidance regarding activities deemed appropriate for filing in the "Other" category.

¹⁰ In its second quarter update to its 2013-2014 Priority Guidance Plan, the IRS specified its intent to work on final regulations during the period ending June 30, 2014. No date for the publication of final regulations has been made public.

¹¹ Cal. Health & Safety Code 127350(d); Cal. Health & Safety Code §127355

¹² 210 ILCS 76/15

¹³ Ind. Code §16-21-9-4; Ind. Code §16-21-9-6

¹⁴ Md. Code Ann. Health-Gen. §19-303(c)

¹⁵ N.H. Rev. Stat. Ann., Tit. I § 7:32-e

¹⁶ N.Y. Pub. Health Law §2803-1 (3)

¹⁷ 23-17.14 R.I. Code R. §11.5(b)

¹⁸ Tex. Health and Safety Code Ann. §311.044

¹⁹ Vt. Stat. Ann. tit. 18 § 9405b(a)(10); Vt. Stat. Ann. tit. 18 §9405a

²⁰ Wash. Rev. Code §70.41.470

²¹ With respect to implementation strategy development, neither the ACA nor the 2013 NPRM require that hospitals take into account input from public health experts or the public.

²² The 2013 NPRM would require that hospitals take into account "written comments received on the hospital facility's most recently conducted CHNA and [previous] *most recently adopted implementation strategy* (emphasis added) in assessing the health needs of its community" (proposed rule §1.501(r)-3(b)(5)(iii)). However, taking into account views related to a previously adopted implementation strategy is clearly different from affording an opportunity for community and/or health department input during ongoing implementation strategy development.

²³ Technically, hospitals' Form 990s are public information. However, in practice, locating and gaining access to these filings can be quite difficult and costly (Noveck & Goroff, 2013).

²⁴ UWPPI (2014b) explains that each reviewed strategy is assigned an evidence rating based on the quantity, quality, and findings of available research. Ratings include “Scientifically Supported,” “Some Evidence,” “Expert Opinion,” “Insufficient Evidence,” “Mixed Evidence,” and “Evidence of Ineffectiveness.”

²⁵ With respect to enhancing educational attainment, for example, *What Works for Health* recommendations include career academies, mentoring programs, and targeted programs to increase college enrollment. *What Works for Health* provides details regarding the programs it reviewed and rates these three programs as “Scientifically supported,” the highest rating (UWPPI, 2014c). Many evidence-informed strategies do not rely exclusively on government action. However, all *What Works for Health* recommendations designed to improve low incomes in populations require government action at the federal, state, or local level. Select examples include Increase in State Earned Income Tax Credits (rated “Scientifically Supported”) and Living Wage laws (rated as supported by “Some Evidence”) (UWPPI, 2014d). State and local policymakers are uniquely positioned to address poverty. Hospitals and individuals from other sectors can work collaboratively with state and local governments, but they are unlikely to significantly augment the incomes of low-income families absent government action.

²⁶ The Guide rates strategies reviewed as “Recommended,” “Recommended Against,” or “Insufficient Evidence.” It recommends, for example, several strategies in connection with violence reduction, such as “School-based programs to reduce violence” (CDC, 2014b) and “Early childhood home visitation to reduce child maltreatment” (CDC, 2014c). Specific details concerning the interventions reviewed, and the effectiveness and economic outcomes for these two programs and others, are set forth in the Community Guide.

²⁷ While HHS created the Task Force (Community Preventive Services Task Force, 2013), its members are appointed by the Director of the Centers for Disease Control and Prevention (CDC, 2014d).

²⁸ A recent *Health Affairs* Blog argues that the IRS should create “safe harbors” for hospital community benefit investments in health improvement that are “evidence-based” (Rosenbaum et al., 2014).

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About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan health research organization dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis. To learn more about The Hilltop Institute, please visit www.hilltopinstitute.org.

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

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analysis to advance the health of vulnerable populations

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