

SECTION I

Community Benefits Policy Issues and Concerns

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This section provides both an introduction to basic community benefits concepts as well as more technical information to assist the experienced health advocate. This section also contains a number of group exercises intended for use in community benefits trainings.

A. Defining Community Benefits

In any community benefits effort, an important step for your group is to reach a common understanding of the term community benefits. At a minimum, community benefits are something that a healthcare institution provides to the community above and beyond what it ought to provide as a normal part of quality care.

A more complete definition of community benefits might be:

The **unreimbursed goods, services, and resources** provided by **healthcare institutions** that address **community-identified health needs and concerns**, particularly those of people who are traditionally uninsured and underserved.

The bold terms deserve special attention.

- 1. Unreimbursed goods, services, and resources:** Community benefits are community-critical goods, programs, and resources an institution provides the public *without* expecting or receiving payment in return.
- 2. Healthcare institutions:** While most commonly associated with hospitals, community benefits may be provided by *all* healthcare institutions that serve your community. In developing a community benefits strategy, your community may consider all of the institutions that currently provide health care (e.g., HMOs, nursing homes).
- 3. Community-identified health needs and concerns:** An essential element of an effective community benefits program is defining the community that will be served. The traditional way to define community is as a geographical area, but community can also be defined in a number of other ways. An institution with specialty services or populations might define its community in a manner consistent with its areas of expertise such as women, children, a particular ethnic group, or persons with diabetes or AIDS. The target community could differ from the institution's traditional service area.
- 4. Particularly [the needs] of people who are traditionally uninsured and underserved:** Above all, effective community benefits programs must be focused on health needs and priorities developed through a process in which the institution is open to collaboration with the community, particularly those who are traditionally uninsured and underserved such as people with disabilities, low-income people, and people of color.

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The definition on the previous page is very basic and broad. Ideally, it provides a framework in which a community can self-determine the goods and services that will best address community health needs. But defining what should and should not be a community benefit requires some extra attention. Throughout the remainder of this section, we will examine each of these concepts more closely.

B. Health vs. Health Care

Too often health is equated with traditional services provided by doctors and hospitals. Is this perception accurate? Before your group begins to think about community benefits and what it will seek from local healthcare institutions, it may want to reexamine the concepts of “health” and “health care.”

Notice the great variety of answers you came up with. Of course, there is no “right” answer to this question. Each community will have different needs, concerns, and priorities. But the theme is clear. Traditional healthcare services might more accurately be described as “sick care.” In reality, 80 percent of “health” is determined by a complex mix of factors like education, income, environment, violence, and other factors not traditionally associated with “access to health care.” This broader view of health can and should be applied to community benefits. Institutional health resources can be used to address many of the issues you identified in your list, in addition to the important traditional services, with the goal of improving and promoting health.

C. Evaluating Community Benefits Activity

Understanding what it takes to be healthy and knowing your community’s priority health needs will become important when your group begins to craft an agenda for its work. It will also be important when your group begins to evaluate institutional community benefits programs. In the absence of community input or regulatory oversight, institutions have claimed a wide range of activities as community benefits. Some of the more questionable institutional community benefits claims include:

- employees’ personal United Way contributions
- setting up a maternity wing in a hospital serving an elderly population
- executives’ time served on the board of a local charity
- allowing community organizations to use hospital rooms for meetings

In these cases it is easy to determine that these activities should not constitute valid community benefits activity. Sometimes the answer is less obvious. For example, if your local hospital reported the list on the following page as its community benefits program, how would you respond and why?

✓ **GROUP EXERCISE: Which of the Following Are “True” Community Benefits?⁴**

In the box at the left, indicate whether you think each of the following items is or is not a community benefit and explain your answer in the space provided. If you aren’t sure, explain why. If your answer depends on certain conditions, please list them.

1. Requiring board members to meet annually with focus groups of the uninsured or vulnerable populations to discuss health needs

2. Providing cholesterol screenings at the mall

3. Donating to the Olympics

4. Supporting the symphony

5. Serving Medicaid patients

6. Providing a free clinic for the homeless

7. Providing free services to those who can afford to pay, but don’t

4. Based on an exercise developed by the Northwest Federation of Community Organizations.

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8. Supporting a religious institution, like a church

9. Convening a committee to study free-care policies

10. Paying livable wages to the hospital staff

11. Supporting medical education and research

12. Executive participation in a community benefits policy roundtable

13. Holding a “get to know you” open house

14. Running an emergency room

15. Providing interpreter services

16. Supporting a community youth recreation program

Is there such a thing as a “true” community benefit?

If one hundred people completed this exercise, there would probably be one hundred different answers. Because healthcare priorities differ among communities, the “appropriate” community benefits program will also differ. Answers will also vary because people have different perspectives within the community. Additionally, people will have had different experiences and relationships with local health institutions.

Look back at the list and consider the following:

Requiring board members to meet annually with focus groups of the uninsured or vulnerable populations to discuss health needs

IS a community benefit

- If the process is collaborative and leads to results.

IS NOT a community benefit

- If nothing results from the meetings, or the meetings are more public relations than substance. Community leaders should clarify what the goals of the meeting are, what their role will be in the process, and what follow-up and evaluation there will be.

Supporting the symphony

IS a community benefit

- If the community defines spirituality as a component of what it takes to be healthy, and sees the symphony as improving its quality of life.
- If resources are dedicated to scholarships for disadvantaged youths.

IS NOT a community benefit

- If the symphony is not closely enough related to the healthcare needs of the community.
- If the support is not specifically targeted to disadvantaged youths or a similar program.

Convening a committee to study free-care policies

IS a community benefit

- If people are empowered and supported to participate in the committee, the institution is forthcoming with data, and change results.

IS NOT a community benefit

- If no action results, and the committee is nothing more than a roundtable discussion.
- If the institution convenes a committee that is not inclusive of the community.

Supporting medical education and research

IS a community benefit

- If vulnerable communities rely heavily on the free goods and services provided by teaching and research facilities.
- If teaching institutions operate their education programs in the red.
- If research leads to breakthroughs that enable providers to serve the entire community better.

IS NOT a community benefit

- If these institutions do not provide opportunities for students and researchers to serve at-risk populations directly.
- If these institutions focus exclusively on research at the expense of communities with immediate health needs.
- If teaching hospitals train more specialists where there is a shortage in primary care physicians.

Executive participation in a community benefits policy roundtable

IS a community benefit

- If the community has a long-standing relationship with institution executives and they collaborate around policy positions.
- If the institution is seeking more information on how to better structure programs and incorporates this information into the program.

IS NOT a community benefit

- If the institution will not be providing any services to the community; it will only be discussing issues with policy experts.
- If there is no change in policy. If barriers are not removed. If the institution does not reach out into the community as a result of participation.
- If the community, particularly vulnerable populations, are not involved.

Holding a “get to know you” open house

IS a community benefit

- If genuine efforts to open lines of communication are made.

IS NOT a community benefit

- If it does not further community input: Was outreach done to vulnerable populations? How will time be spent? Will there be an opportunity for people to voice their concerns? Is the meeting place and time designed to be conducive to participation?

**Running an emergency room
(and other similar critical, but costly, services)**

IS a community benefit

- If a hospital staffs an emergency room, even though there is no legal requirement to do so.⁵

IS NOT a community benefit

- If the entire community agrees that this is an essential service that must be given to the most vulnerable populations.
- If emergency room services are reimbursed.

5. The laws in most states do not delineate what services (e. g., emergency care) hospitals need to provide in order to be licensed.

Providing interpreter services

IS a community benefit

- If translation services are generally not provided on a widespread basis.
- If the institution provides translation services over and above the norm.
- If the institution does not receive reimbursement for the translation services.

IS NOT a community benefit

- If the hospital only meets the minimum standards under the Civil Rights Law but no more.⁶
- If clear communication and informed consent are not possible without interpretive services. Anything essential to basic quality care should not be considered a community benefit.

Supporting a community youth recreation program

IS a community benefit

- If youth violence is a problem in the community and is a major cause of death or injury for young people. Finding activities for young people will help remedy a serious community health problem.

IS NOT a community benefit

- If youth recreation programs are too disconnected from health care to be considered a community benefit. While youth recreation programs are important, the health needs in the community may be so great that a different community benefit may be preferable.

6. 42 United States Code § 2000d. For a detailed discussion of how the Civil Rights Law requires translation services, see Jane Perkins et al., National Health Law Program, *Ensuring Linguistic Access in Healthcare Settings: Legal Rights and Responsibilities* (1998); available through the National Health Law Program by calling (202) 289-7661.

Is It Unreimbursed?

One factor communities may consider in deciding whether any good or service is a community benefit is whether the healthcare institution is being paid for that service. Some institutions may claim full credit for a program or service for which they receive partial or full payment. Some examples include the following:

- Cholesterol screenings at the mall administered by an HMO but funded by the American Cancer Society.
- Treating Medicaid recipients. Some hospitals would suggest that simply treating Medicaid patients is a community benefit in itself. While most would disagree with that proposition, states that have regulated community benefits generally allow hospitals to credit the difference between the cost of care and the payment received (often called the shortfall or unreimbursed portion) as a community benefit.⁷ But the *actual* cost of care can be unclear, since it includes all the things the hospital spends its money on—for instance, high executive salaries, fancy marble foyers and furniture, and money spent on mergers and acquisitions. So, whether this “shortfall” should be calculated as a community benefit depends on how the cost itself is calculated and what it includes.⁸ Additionally, keep in mind that more and more hospitals are giving discounts to private health plans as a result of managed care. Losses from these discounts are then shifted to other payers, including Medicaid and Medicare.

What Is NOT a Community Benefit?

To help grasp the concept of community benefits, it is useful to think about what types of activities are NOT community benefits. There were some items on the list that most people would probably agree were not community benefits. It may be noble for healthcare entities to support the Olympics. But does that support have local impact? Is it related to health care? Is it a priority need? Does it serve the traditionally uninsured and underserved? Likewise, providing free services (such as blood pressure monitoring) to those who can afford to pay for their own care may improve a hospital’s public relations, but does it serve those community members who are most in need of free services?

In analyzing your answers it may be useful to determine some common characteristics. The reasons behind your choices are the same criteria to use when examining the community benefits claims of healthcare institutions in your community. Essentially, you have defined the criteria for your community.

7. Four of the states that have community benefits laws require community benefits to be unreimbursed (California, Idaho, Indiana, and Texas). See the Resource Materials: Community Benefits Laws and Regulations for a list of these laws.

8. The community benefits law in Utah counts “[t]he reasonable value of unreimbursed care for patients covered by Medicare, Medicaid, or other similar government entitlement programs” as a community benefit. On the other hand, at least one state, Massachusetts, does not include Medicaid shortfalls as a community benefit.

D. The Argument for Institutional Responsibility

You now have a sense of what should and should not be a community benefit. But which institutions are responsible for providing community benefits and participating in community benefits processes? Traditionally, community benefits have been associated with nonprofit “general” or acute-care hospitals. Improving on this traditional “community benefits system” is the first necessary step, but at the same time other healthcare institutions can and should be engaged in community benefits processes.

Think of some of the health needs that individuals in your group have identified as important. Prescription drugs, dental care, mental health care, substance abuse care, and long-term care are examples of prevalent health needs. The common characteristic of all of these is that they are not strictly hospital-based services. Some needs such as mental health and substance abuse are only partially addressed by hospital care. In these two cases, hospital care must be combined and coordinated with public health programs that emphasize prevention. Other needs, such as dental and long-term care, are not hospital-based at all.

And as the healthcare industry creates different types of specialty institutions (for example, maternity and heart hospitals) will hospitals continue to offer the traditional range of services that they now offer in competition with these newer institutions?

Boutique, or niche, hospitals

are specialty, for-profit hospitals that are designed to offer a specific, profitable service such as ear, nose, and throat; maternity services; or cardiac surgery to low-risk, well-insured patients. Boutique hospitals undermine the ability of local nonprofit hospitals to provide needed services by: 1) cherry-picking low-risk, well-insured patients; and 2) offering only high-revenue services. Nonprofit hospitals are thus deprived the income generated from these high-revenue cases and are less likely to pay for vital, but money-losing, services for the community.

Community vigilance is also needed as hospitals continue to consolidate and often pare down or close facilities. According to research by Professor Alan Sagar at the Boston University School of Public Health, “hospitals that close, nationally, tend to be in communities with higher percentages of African-American or Latino-American residents.”⁹ In these instances it becomes even more important for community leaders to consider the various types of health institutions operating in their community that could provide resources to promote community health. In the context of community benefits, is relying exclusively on the resources of nonprofit hospitals the way to go?

9. Alan Sagar, Deborah Socolar, and Jasprit Deol, *Before It's Too Late: Why Hospital Closings Are a Problem Not a Solution* (June 2, 1997, 2nd ed.), 8. Available by request by e-mail: asager@bu.edu.

✓ GROUP EXERCISE: Which Local Healthcare Institutions Should Be Providing Community Benefits?

What kind of healthcare institutions are in your community? Which do you believe are legally required to provide community benefits? Which should be?

INSTITUTION	YES	NO
Nonprofit hospitals	<input type="checkbox"/>	<input type="checkbox"/>
For-profit hospitals	<input type="checkbox"/>	<input type="checkbox"/>
Nonprofit health insurers and HMOs	<input type="checkbox"/>	<input type="checkbox"/>
For-profit health insurers and HMOs	<input type="checkbox"/>	<input type="checkbox"/>
Banks	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacies	<input type="checkbox"/>	<input type="checkbox"/>
Mental health facilities	<input type="checkbox"/>	<input type="checkbox"/>
Doctors' offices	<input type="checkbox"/>	<input type="checkbox"/>
Nursing homes	<input type="checkbox"/>	<input type="checkbox"/>
Medical supply companies	<input type="checkbox"/>	<input type="checkbox"/>
Dentists	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency treatment centers	<input type="checkbox"/>	<input type="checkbox"/>
Drug companies	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

CONSIDER THE FOLLOWING

BANKS

Surprisingly, of all these institutions, only banks have an enforceable fifty-state obligation to their communities. Under the federal Community Reinvestment Act¹⁰ (often referred to as “CRA”), every bank must demonstrate that it is taking steps to serve its community, not just its customers.

There is no equivalent mandate for any type of healthcare institution. Only some of the various health institutions on the preceding list have enforceable community requirements in *some* states. Banks are classic bottom-line institutions. The existence of the CRA supports the interesting notion that a similar mandate could be applied to health institutions.

NONPROFIT INSTITUTIONS

The traditional and historic obligation of nonprofit healthcare institutions to provide community benefits is derived from several sources.

- **Nonprofit institutions are mission-driven.** By law they cannot be owned by any person or entity and are often thought of as “community institutions.”¹¹ In fact, one regulator declared that the public is the only true shareholder (or owner) of a nonprofit.¹² The community has a right to expect that its institutions will serve community needs.
- **Nonprofit healthcare institutions are created with an explicit charitable or social welfare mission to serve their community by providing health care or healthcare coverage to the community.** An argument can be made that nonprofit institutions are violating their missions by failing to meet the needs of the underserved adequately.
- **Nonprofit organizations have benefited from years of favorable governmental treatment, including tax breaks, tax exemptions, and other advantages.** For all these reasons, nonprofit healthcare institutions should be accountable to all of the people they were created to serve, particularly those who cannot otherwise afford health care.
- **Nonprofit healthcare institutions should provide community benefits in order to be good corporate citizens.**

10. 12 United States Code § 2901, et. seq.

11. Howard Oleck, “Proprietary Mentality and the New Non-Profit Corporation Laws,” *Cleveland State Law Review* 20, (1971): 145, 146.

12. Letter from California Corporations Commissioner Gary Mendoza to J. Kendall Anderson, May 6, 1994.

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The problem is that while this community obligation exists in the law, the standards for fulfilling it generally are vague. As a result, institutions create their own standards. Additionally, more has traditionally been expected from hospitals and less has been expected from nonprofit HMOs and nonprofit insurers. Some states have taken steps to correct this situation by defining the standards and process by which *all* nonprofit institutions must meet their public obligations. For example, in 1997, Pennsylvania enacted The Institutions of Purely Public Charity Act which outlines the obligations of all nonprofit corporations.¹³

FOR-PROFIT INSTITUTIONS

Even though your community benefits efforts likely will begin by focusing on nonprofits, there are other potential benefit providers in the community to consider. For-profit healthcare institutions should also have a community interest obligation to the public because:

- **Health care is a social good.** Health care is different from other for-profit industries because it is so basic and essential for ALL people. And while we would not expect the only car dealership within one hundred miles to give out free or reduced-cost cars to people who could not otherwise afford one, we do require hospitals to treat people in emergency situations regardless of ability to pay.¹⁴ The concept of “community benefits” applies this “social good” view of health care to nonemergency situations in an effort to improve community health as well as assure basic access to health care.
- **Market and industry changes make it necessary that for-profit institutions contribute to community health and community benefits.** In many communities, for-profit healthcare institutions are becoming more common, even dominant. Their strong position in many local markets creates an uneven playing field. While they have great resources, they generally service a smaller percentage of the at-risk population.¹⁵ This may shift responsibility to public and nonprofit institutions or more people may go unserved. From a public policy perspective, it makes sense to require for-profit institutions to provide free care and community benefits to the communities they serve in order to even the competition. Of course, there may be a greater community obligation for tax-exempt nonprofits than for tax paying for-profits. In order to level the playing field, a few state legislatures and regulators are taking cutting edge steps to restore balance:

For example, in Massachusetts all acute care hospitals and insurers must contribute to the Free Care Pool. The funds in the pool are then redistributed to disproportionate-share hospitals to help pay for the cost of providing free care.¹⁶

13. 10 Pa. Const. Stat. § 371, et. seq.

14. See the federal law, 42 United States Code § 1395dd.

15. See Julio Mateo, Jr. and Jaime Rossi, *White Knights or Trojan Horses? A Policy and Legal Framework for Evaluating Hospital Consolidations in California* (Consumers Union West Coast Regional Office, April 1999).

16. Mass. Gen. Laws, ch. 118G, §§ 18, 18A.

- **For-profit institutions should provide community benefits in order to be good “corporate citizens” of the community (discussed on page 15).**

The prime example of this concept is the Community Reinvestment Act, which puts community service requirements on banks. In the healthcare context, an example of the good corporate citizen rationale is contained in the Massachusetts Attorney General’s Community Benefit Guidelines for Health Maintenance Organizations.

Former attorney general Scott Harshbarger states reasons for extending community obligations to all HMOs regardless of for-profit or nonprofit status.

“The healthcare marketplace . . . is evolving quickly and dramatically. . . . In **Massachusetts**, HMOs have made major gains in recruiting new members, and as a result, have become a critical component in the delivery of healthcare services to a significant portion of consumers across the state. Given their increasingly important role in providing or arranging for the provision of health care in the Commonwealth, HMOs, irrespective of their model type or organizational status, have acknowledged their corporate responsibility to do all that they can to improve and maintain the health status of members of the communities they serve.”¹⁷

The HMO industry in Massachusetts eventually supported these guidelines, thereby acknowledging their corporate responsibility to the community.

THE CONVERSION OF NONPROFIT HEALTHCARE INSTITUTIONS TO FOR-PROFIT STATUS

Many for-profit institutions were once nonprofit. And today many nonprofits are considering merging, partnering with, or becoming for-profit companies. In every state, regulators such as attorneys general, insurance commissioners, or public health officials must approve these changes. Because of this heightened scrutiny, conversions and mergers offer opportunities to raise community benefits issues, to examine the community benefits record of converting institutions, and to think about community needs for the future. In many states, community activism has led regulators and legislators to impose community benefits conditions on converting for-profit institutions. Typically, regulators in these instances have required for-profit successors to provide community benefits at the same level as the selling nonprofit. These requirements have generally been imposed either as a condition of regulatory approval or pursuant to new laws meant to address conversion and merger trends.¹⁸

17. The Attorney General’s Community Benefit Guidelines for Health Maintenance Organizations, February 1996, 1.

18. A report entitled “Protecting Health, Preserving Assets,” which analyzes conversion laws, is available from Community Catalyst.

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It is important to note that community benefits gains can be made outside of the legislative arena. Regulators, such as an attorney general or commissioner of public health, can approve private agreements reached directly between a community coalition and an institution. Such certified agreements can be very effective if the community and/or regulator are given the appropriate role, resources, and power to monitor institutional behavior over the long term. (See page 23, “Key Elements of Institutional Responsibility.”) Overall, conversion and merger transactions are tremendous opportunities for advancing community health interests because community and regulatory leverage is so strong. Many for-profits view community benefits in this context as a cost of getting the deal done.

- For-profit Tenet Healthcare Corporation purchased nonprofit Deaconess Incarnate Word Health System (DIWHS) in Missouri in 1997. As a result of pressure from the community, Tenet agreed to maintain, as long as it owned the hospital system, the same aggregate level of free care and community benefits as DIWHS had provided. The parties agreed that the level was approximately \$5,231,582.
- In the last two years, six states have passed laws requiring for-profit acquirers to submit a community benefits plan or to maintain levels of free care.
- An additional four states put provisions into law requiring regulators to consider the acquirer’s commitment to free care as a factor relevant to the approval or disapproval of the transaction.
- In nine states, laws contain provisions requiring regulators to monitor the impacts of these transactions on health care.

NONHOSPITAL-BASED ENTITIES

Whether for-profit or nonprofit, there are many other institutions that can and should be held responsible for community benefits obligations, and some states and state regulators have taken that step.

- A law in Massachusetts requires *hospitals, HMOs, and insurers* to contribute to a free-care pool.¹⁹
- A law in Minnesota requires “any acute care institution or *outpatient surgical center*” to provide community benefits and file an annual report detailing its efforts.²⁰ In some states, for-profit specialty surgical centers, called “boutique hospitals,” are becoming increasingly common. The Minnesota community benefits law is an important tool for healthcare organizers in states that have a large number of boutique hospitals.

19. Mass Gen. Laws, ch. 118G, §§ 18, 18A.

20. Minn. Stat. § 144.698 (emphasis added).

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- Another law in Minnesota requires *insurance companies, including HMOs*, to file annual “action plans” with the insurance commissioner. The action plan “must include a detailed description of the health plan company’s policies and procedures for enrolling and serving high risk and special needs populations. This description must also include the barriers that are present for the high risk and special needs population and how the health plan company is addressing these barriers in order to provide greater access to these populations.”²¹
- In 1990, Utah passed a law called the Nonprofit Hospital and *Nursing Home Charitable Property Tax Exemption Standards* (emphasis added). Under the law, nonprofit nursing homes are required to provide community benefits, including free care and issue a report annually about its activities.²²
- In 1997, Maine passed a law requiring *hospital service plans* (a.k.a. Blue Cross and Blue Shield plans) to provide community benefits and report annually on their activities.²³

CONSIDER THE FOLLOWING

Many physician groups are closely affiliated with nonprofit and for-profit hospitals. The affiliation often will allow the physician group to use the hospital’s name in its advertising and marketing. Its doctors will have admitting privileges at the hospital and may even have offices located within a hospital’s campus. Yet while the hospital may be required to provide community benefits, these physician groups are not. For example, if an indigent patient is treated within a hospital by a doctor in an affiliated physician group, the patient will likely be billed by the physician group even if the patient is receiving “free care” from the hospital. Seeking payment from people qualified for free care doesn’t make much sense. Should physician groups, particularly those closely affiliated with hospitals, be required to provide free care to those indigent patients who qualify for free services from the hospital? Particularly for nonprofit institutions with a charitable mission, shouldn’t charitable obligations extend to any affiliated and partner organizations that benefit from the use of the valuable name and image of the hospital?

Also consider drug companies. In 1992, during hearings held by the U.S. Senate Special Committee on Aging, pharmaceutical companies agreed to set up a voluntary program to provide necessary medications free of charge to people who cannot afford them. Reports on the program’s effectiveness are unfavorable. But can the program be evaluated and made to work? Or can community leaders revitalize the debate of 1992?²⁴

21. Minn. Stat. § 62Q.07, Subd. 2(e).

22. Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards (December 18, 1990), Utah State Tax Commission.

23. 1997 Me. Laws 344.

24. For more information on the free prescription drug program, call Health Care For All at (617) 350-7279.

LOOKING FOR PUBLIC PROCESS AND OPPORTUNITY IN THE LAW

Most institutions described on the preceding pages must receive licenses from the state in order to operate. Licensing may also become relevant in the sale of an institution because some states require new licenses for changes in ownership. Looking at the law is useful, even if the law itself is weak. For example, hospital licensing laws in most states contain only broad and unspecific licensing requirements.²⁵ But whether you are focusing on hospital licensing or licensing laws for other institutions (e.g., nursing homes or HMOs), the key is to look for public process. Often the relevant regulator will be required to hold a public hearing or other public process prior to approval of the license.²⁶ If a public hearing is not automatic, there may be a mechanism for your group to request a public hearing or raise concerns about institutional behavior.²⁷ Licensing laws may also require annual or biennial performance reviews or license renewal.²⁸ Public hearings or other review processes, even if not specifically focused on community benefits, are good opportunities to raise questions publicly about a particular institution's community benefits activities. Because the state is approving or renewing an application, community leaders have increased leverage.

CONSIDER THE FOLLOWING

States often grant licenses and in return put demands and requirements on the regulated institutions.

- How do health institution licensing requirements and oversight processes compare to other industries in your state (e.g., liquor licenses, taxis, building contractors, hairdressers)? For many other types of industries, state licensing is very stringent. Is there an issue to raise here?
- There may be other laws that regulate health institutions and provide for public process. If the institution is a hospital or nursing home and is constructing a new building it may also need to get zoning approval.²⁹ If a public hospital is involved in any sale or other major change, there may be a county or city council process or at least the opportunity to try to get a public hearing. These regulatory handles may not yet be “tried and true” methods of making community benefits advances, but they have been used creatively and effectively by some communities.

25. Most hospital licensing laws have very basic requirements for institutions, such as submitting an application containing the names of the owners, establishing that they are of reputable and responsible character, and that they operate the hospital in a safe and efficient manner. See, for example, Ind. Code § 16-21-2-11; 210 Ill. Comp. Stat. § 85/6(a).

26. See R.I. Gen. Laws § 23-17-14.4(a) (within ten working days of receiving an application for an initial license or a license in connection with a change in ownership, the Department must notify and afford the public an opportunity to comment on the application).

27. A regulation of the Department of Public Health in Massachusetts allows a group of ten residents of the institution's service area to request a public hearing on a determination of need (same as certificate of need) application. See 105 Code of Massachusetts Regulations 100.603(B).

28. See Oreg. Rev. Stat. § 441.025(2) (each license must be renewed annually).

29. In Columbus, Ohio, community members were forced to express their concerns over the building of a new hospital at a planning commission meeting.

In Massachusetts, the **Neponset Valley Community Health Coalition** (NVHC) formed after it was announced that the Neponset Valley Health System (NVHS) would be sold to Columbia/HCA. Under the terms of the deal, Columbia had required NVHS to sign a confidentiality document, and thus, information was not forthcoming. But, NVHC used the Department of Public Health’s Determination of Need process (same as “certificate of need”) and the Attorney General’s public hearings to push Columbia for responses to its concerns. Ultimately, NVHS merged with nonprofit Caritas Christi Health Care System. NVHC continued to use the determination of need process to secure commitments on free care and services. It also worked out an agreement with Caritas whereby two of the six positions on the Caritas Board of Directors are chosen from the community.

E. Developing Your Group’s Definition of Community Benefits

The definition of community benefits presented at the beginning of this section on page 2 is very basic. After your group has had time to consider this baseline definition, identified its own criteria for “true community benefits,” and thought about the institutions in the community, you should return to this definition and refine the concept of community benefits to fit your community.

F. Community Benefits: Key Elements of Institutional Responsibility

There is a significant history to community benefits. Your group is building upon a foundation derived from the work and leadership provided by key institutions such as the Catholic Health Association, the W. K. Kellogg Foundation, and countless community organizations across the country. Additionally, certain policymakers, analysts, and regulators have played important roles in refining the concept of community benefits, and this section incorporates many of their ideas.³⁰ From a review of this history and the 14 existing community benefits laws and guidelines, we have put together a list of important issues you will want to consider in your work.

Because circumstances will be different for each community, not every community benefits effort will look the same or achieve the same results. Some efforts will follow formal regulations while others will be less formal; not all of these elements will be important or achievable in your work. But looking through the broad categories will give you a sense of the elements you will want to consider.

The following section is a more detailed look at the elements of institutional responsibility. You may treat it as a reference in case your group is facing a particular issue and needs a more detailed and in-depth discussion.

Community process is an overarching and critical component to community benefits efforts, so under each element, we have highlighted important process considerations.

1. The Definition of Community Benefits

We have crafted a working definition of community benefits for purposes of discussion and group thinking. It is an important conceptual framework for thinking about this work. Additionally, some states have defined the term legislatively. Often these definitions will include a list of specific types of services that can qualify as community benefits. Generally, these definitions also echo the themes of improving health status, disease prevention, charity and unreimbursed care, and improving health access to communities in need.

30. For example, Kevin Barnett of The Public Health Institute; Bradford Grey of the New York Academy of Medicine; Scott Harshbarger, former attorney General of Massachusetts; Paul Hattis, the Senior Medical Advisor to the Department of Community Benefit Programs of the Partners Healthcare System of Boston, Massachusetts; Mark Schlesinger of Yale University School of Medicine.

For example, the **California community benefits law** defines community benefits as “activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following”:

1. Charity and unreimbursed care
2. The unreimbursed cost of providing community-oriented wellness and health promotion programs; prevention services; adult day care; child care; medical research and education; nursing and other professional training; home-delivered meals; sponsorship of free food, shelter, and clothing to the homeless; and outreach clinics
3. Financial or in-kind support of public health programs
4. Donation of funds, property, or other resources that contribute to a priority of the community
5. Healthcare cost containment
6. Enhancement of access to healthcare or related services that contribute to a healthier community
7. Services offered without regard to financial return because they meet a community need in the service area of the hospital
8. Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person’s health.

Cal. Health & Safety Code § 127345(c)

2. The Health-Needs Assessment

It makes sense to study and agree on community health needs before trying to craft solutions.³¹ The needs assessment may also present an important opportunity to begin institution-community collaboration on a subject where there will likely be some agreement and consensus. Institutions sometimes claim the needs assessment as a community benefits activity. The needs assessment should not be the ultimate activity, but rather, a first step to identify where resources are needed. Your group may want to consider the following:

- Does the needs assessment make use of existing data from community health agencies?³²
- Will the assessment contain a component aimed at identifying barriers and systemic reasons for poor health status?
- Will the assessment be targeted enough (e.g., ethnic groups, traditionally uninsured and underserved people, neighborhoods, income levels) yet broad enough (e.g., the hospital service area, or community-wide) to give sufficient information to craft a focused community benefits plan?

31. The California, Connecticut, Indiana, Massachusetts, New Hampshire, Texas, and Utah community benefits laws and guidelines require a community health-needs assessment.

32. For an explanation on how to analyze health data, see “Using Data: A Guide for Community Health Activists,” published by The Access Project.

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- Will the assessment inventory and reexamine existing community benefits efforts by the institution and by other institutions?
- Should collaboration and sharing of expenses among institutions be encouraged?
- How often will an assessment be conducted?



Process Issues: Community organizations should be involved in the planning and implementation of any health-needs assessment. The assessments, whenever possible, should have qualitative (data collection through interviews, focus groups, and surveys) and quantitative (statistical public health data) aspects. Key questions for the planning stage include how the community will be involved in answering the following questions:

- What type of data will be collected?
- Who will be interviewed, surveyed, etc.?
- What will the interviews and surveys consist of?
- Who will conduct the surveys?
- How will barriers to care be identified?
- Who will analyze and write the assessment?

After the data-collection phase is complete, there is another important process issue. Community groups should seek to have public review and comment of the assessment before it is finalized.³³ Community members should consider the following questions when reviewing the final assessment:

- Does the assessment square with community perception of unmet need?
- Do interviewees feel the assessment accurately reflects their views?
- How were needs prioritized?
- How were data analyzed and presented?

3. The Community Benefits Plan

It is important to remember that no two community benefits efforts will look the same. Below are some of the potential components of an institutional community benefits plan. Community leaders can advocate for a less formal version of some of these components as part of a negotiated agreement. In this situation, groups should determine which of these is a priority. Legislative proposals, on the other hand, should address as many of the components as possible:

³³ The California, Massachusetts, New Hampshire, and Texas community benefits laws and guidelines discuss public participation in the community health-needs assessment.

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A community benefits mission statement. Seven states require institutions to create new mission statements or amend existing ones to reflect a commitment to serving community interests in their community benefits laws. This can be very effective since the mission will likely have to be approved by the board of directors, thereby involving the highest levels of institutional power in a community benefits effort. Also, in the case of nonprofits there is a legal duty for the board of directors to govern the institution in order to fulfill its mission. So, explicitly adding a community benefits component to the institution's mission can be effective from a legal perspective for enforcement purposes.

For example, in **Massachusetts, St. Elizabeth's Medical Center** community benefits mission statement reads, "St. Elizabeth's Medical Center . . . is committed to serving the entire community, including the uninsured, underinsured, poor, and disadvantaged. We are dedicated to providing accessible, high-quality healthcare services to all within our culturally diverse community, particularly our host communities of Allston and Brighton; the well-being of our community by providing excellence in healthcare through preventative health, education, and wellness services; and collaborating with our community in identifying and responding to issues by fulfilling the physical, spiritual, emotional, and social needs of the people we serve." *Commitment to Care, Commitment to Community*, St. Elizabeth's Medical Center of Boston Third Annual Community Benefits Report, 1997–1998, 4.



Process Issues: Again the ever present issue of community process should be considered. Will the community be involved in creating that mission statement? At a minimum, will the community have an opportunity to review and comment on it? The attorney general is charged with enforcing charities and it is difficult for the community to be in a legal position to enforce the law. Even so, it will be easier for the attorney general to enforce (and for the community to encourage the attorney general to enforce) if the healthcare entity has a clear community benefits component in its mission statement.

A clear definition of plan beneficiaries. Who is this plan meant to serve? Of course, the plan should focus on those that are traditionally at risk for poor health, but the plan should be more specific than that. Focusing on a clearly defined and identifiable segment of the community makes it easier to evaluate and measure the effect of a community benefits program or service. Measurable outcomes will mean that community leaders and institutions will be better able to determine the strengths and weaknesses of a particular community benefit and make corrections. A clear definition of plan beneficiaries will also ensure that resources are targeted to needs.

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Beneficiaries can be defined in several different ways:

- by geography
- by race/ethnicity
- by income
- by demographic groups such as children or the elderly
- by disease affinity groups (e.g., people with AIDS or diabetes)³⁴

A list of measurable objectives, goals, and time frames. The plan should be very clear on what the institution hopes to accomplish, how it will achieve those goals, and how long it will take to do so.³⁵

Explanation of the institutional and community process by which the goals and objectives were chosen. Five of the existing community benefits laws reinforce the idea of community-institution collaboration by requiring institutions to detail the process it used or will use to consult the community. Requiring an explanation of the internal institutional process is also helpful to ensure that, for example, the board of directors approved the objectives, potentially giving more institutional priority to the success of the plan.

Explanation of the institution's plan for outreach and notice to the public at large of its community benefits efforts and any new programs and services that are available.

A detailed institutional and community benefits budget. How much of its budget is the institution committing to this effort? Is it getting any reimbursement for the community benefits it is providing? What is its level of bad debt and is that detailed separately from the level of charity care? In the Catholic Health Association's Social Accountability Budget, the following items are part of the budget: patient costs to charges, traditional charity care, unpaid costs of public programs, nonbilled services, education and research, and fund raising.³⁶ The budget should also include other costs such as outreach workers, needs assessment, and community process.

An annual report. The report should detail all of the elements described in this section, The Community Benefits Plan. Additionally, it should be widely available to the public, and the hospital should notify the public that the report is available.

34. The California, Connecticut, Massachusetts, New Hampshire, Texas, and Utah community benefits laws and guidelines contain provisions explaining how the "community" should be defined.

35. The California, Indiana, Massachusetts, and Texas community benefits laws and guidelines require the community benefits plan to state measurable objectives within specified time frames.

36. See the Resource Materials for a sample community benefits budget produced by the Catholic Health Association.

The **Indiana community benefits law** states, “Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is: 1) public information; 2) filed with the state department; and 3) available to the public on request from the department. This statement shall be posted in prominent places throughout the hospital, including the emergency room waiting area and the admissions office waiting area. The statement shall also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital.”³⁷

All community benefits plans should be submitted by a certain date. For example, nonprofit hospitals in California must submit an annual report of their community benefits plan no later than 150 days after the hospital’s fiscal year has ended.³⁸

4. Evaluation Methods and Process for Ongoing Planning and Modification of a Plan

Community involvement in priority setting, decisionmaking, evaluation, and modification of the community benefits plan is crucial to program success. Institutions should seek and communities should encourage an approach that builds upon the assets of the community in order to leverage existing and new resources to maximum impact. Constituency and community leaders bring a wealth of information, not only about health needs but also about barriers to access, particular cultural differences, outreach techniques, and existing community infrastructure.³⁹



Process Issues:

- Does the program supplement and not seek to replace existing community health assets such as clinics, and so forth?
- How will participation by community and constituency leaders be structured?
- Will there be a collaborative approach, such as a community benefits committee with diverse and broad representation, or will there be an opportunity to review the plan via a public hearing?

37. Ind. Code § 16-21-9-7(c).

38. Cal. Health & Safety Code § 127350(d). California also allows hospital systems to file a single report. Cal. Health & Safety Code § 127350(d).

39. The California, Connecticut, Indiana, Massachusetts, New Hampshire, New York, and Texas community benefits laws and guidelines require public participation in program design and priorities. For example, the Massachusetts Hospital Guidelines provide: “In order to form a bridge to community leaders and representatives of the medically underserved, hospitals should establish a Community Benefits Advisory Group, or other similar mechanism, which includes members of the population to be served and which reflects the racial, cultural, and ethnic diversity of the community.” Attorney General’s Community Benefit Guidelines for Nonprofit Acute Care Hospitals, June 1994, 8.

5. Accountability and Enforcement

The community has a tremendous role to play in long-term monitoring. Whether there are laws or guidelines to enforce and a regulator to push, or a less formal negotiated agreement, community vigilance will be necessary. Some of the tasks groups will need to attend to are:

- review annual reports (where they are required) or periodically seek new and updated information on institutional activities
- continue to monitor health access and community benefits from the community perspective
- continue to assess community health needs
- continue communication with the institution(s)
- continue to work to expand participation and increase base of support

Keeping abreast of this information will give the group tools to use to enforce community benefits obligations, whether or not there is a specific law and penalties. Inadequate annual reports, insufficient community benefits activity, and other community dissatisfaction can be the subject of:

- media reports
- formal written reports issued by community groups
- formal or informal communication with regulators
- formal letters or interviews with institutional leaders and board members

If there is some formal regulatory oversight, or formal oversight is achievable through laws or regulation, then you may want to consider the following issues when evaluating new or proposed laws or regulations:

Which regulator is charged with monitoring and enforcement?⁴⁰ Public health officials will have the most relevant health information and expertise, but other regulators may be more appropriate depending on the type of institution and circumstances. It may be more efficient to attach oversight responsibilities onto existing regulatory responsibilities and processes. For example, if HMOs have to file annual financial reports with the commissioner of insurance, perhaps the commissioner may be the appropriate overseer. Consider making efficient use of existing resources and frameworks.

40. Nearly all the community benefits laws and guidelines name a state official to oversee the community benefits process. The state regulators represent a variety of different offices: public health officials (California, Connecticut, Minnesota, New York, Texas), attorneys general (Massachusetts, New Hampshire, Pennsylvania), the tax department (Idaho, Utah, West Virginia), the state department (Indiana), or the Superior Court (Georgia).

How will a violation be brought to the attention of the regulator? Regular reporting is the easiest method to ensure that the regulator gets up-to-date information to evaluate. But community leaders may want to consider seeking some mechanism by which members of the community can raise issues independently of an annual report. (Of course, any annual report should be available and subject to public scrutiny.)

What penalties are in place for healthcare entities that violate community benefit requirements? This piece of enforcement is one of the key areas where many of the laws fall short. Only four states have penalties for noncompliance—Indiana, New Hampshire, Pennsylvania, and Texas.⁴¹



Process Issues:

- Once the plan is in place, monitoring and ensuring accountability become critical for the community and regulators. Paying attention to these issues now will help to give community leaders the power and resources necessary in the future to ensure that community benefits will continue effectively.
- Is it clear in the plan/law/agreement what the role of the community will be over the long term? For example, will there be a proactive community benefits committee? Or will there be a less formal reactive role for the community in a periodic review process?
- Once the role is clear, what infrastructure exists or should be created within the community to ensure that that role will be fulfilled? For example, if your coalition is an ad hoc coalition, you may want to consider what sort of role it can play in long-term monitoring.
- Tying into the two questions above, what specific authority or power will the community have? Again, the range can be very broad.
- Lastly, what funding and resources should the institution provide or the community seek in order to maintain this effort or infrastructure? Another component of effective long-term monitoring is institutional infrastructure. Who in the institution will be in charge of community benefits? Is it someone who carries significant weight and decisionmaking authority? How or will the board of directors be involved? In the absence of a formal community benefits committee, how will the community communicate effectively with the institution?

41. In Indiana and Texas, hospitals are assessed a penalty not to exceed \$1,000 for each day they fail to file a community benefits annual report. Ind. Code § 16-21-9-8; Tex. Health & Safety Code § 311.047. In Pennsylvania a penalty not to exceed \$500 is imposed on any entity that does not file an annual report. 10 Pa. Cons. Stat. §379(I). In New Hampshire, healthcare charitable trusts may be fined \$1,000 plus attorneys' fees and costs for not providing an annual report. N.H. R.S.A. §7:32-gIII.

6. A Baseline Standard for Contribution

In addition to a community benefits budget, there is also the issue of a base standard for contribution. This is one of the most contentious issues your group will face, particularly if you are considering a legislative agenda. Only two of the laws/guidelines set standards or factors to consider on this question.⁴²

7. Specific Obligations for All Health Institutions

For groups considering a legislative campaign, an additional issue might be determining the types of institutions that should provide community benefits. Traditionally, communities think of nonprofit hospitals when they think of community benefits. However, some of the most recent community benefits laws apply to institutions such as nursing homes (Utah) and outpatient surgical centers (Minnesota). For-profit hospitals and other institutions in a number of states are also subject to free-care and community benefits requirements because of new conversion laws (Connecticut, District of Columbia, Rhode Island, and Washington). Moreover, in at least four states, Blue Cross/Blue Shield plans are now subject to some community benefits review pursuant to new laws, most of which were the result of restructuring or conversion activity (California, District of Columbia, Maine, and Rhode Island).

8. Free Care

For millions of uninsured people, free care represents critical and last-resort access to health care. Yet there are no federal laws, and state laws mandating how, when, and how much free care healthcare institutions must provide are nonexistent or weak. Because free care is such a critical part of community benefits, it requires extra attention. Understanding free care and improving access to free care will likely be a priority in your community for any one of a number of reasons. Perhaps you live in a small town and the town's largest employer has recently closed its doors, leaving hundreds unemployed and uninsured. Or the local public hospital that provides 80 percent of services to the underserved and uninsured is about to be sold to a large for-profit hospital chain. Or people in your community who have relied on free care for years suddenly find that the local hospital has changed its policy and services are no longer available.

42. Only the Pennsylvania and Texas laws provide a financial benchmark, but neither should be considered a model. See Tex. Health & Safety Code Ann. § 311.042; 10 Pa. Cons. Stat. § 375(D).

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Community leaders/coalitions have successfully brought about change in the free-care policies of individual hospitals or even state law by simply raising the issue to the public's attention. Because these free-care campaigns highlight need, and the expense of treating health needs that have gone unaddressed, they have often been the impetus for a look at the issue of community benefits. Free-care campaigns that have expanded to community benefits often examine issues such as institution-community relations, nonhospital-based services, primary care, and prevention and health resource allocation on a broader scale. Raising free-care issues as a precursor to or highlight during a community benefits campaign is strategically effective. Once hospitals and health institutions are explicitly and financially responsible for care for the uninsured they tend to develop an interest in lower-cost preventative services and programs for the uninsured. For a hospital in particular, the drive to lower costs becomes a tremendous incentive to think proactively about community benefits and public health initiatives to benefit the underserved.

You can read more about Free Care in the Resource Material section at the back of the book.