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# Transforming Hospital Community Benefit: Increasing Community Engagement and Health Equity Investment in Connecticut

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## Executive Summary

This paper seeks to inform state and local efforts to strengthen the connection between hospital community benefit programs and health equity investments in Connecticut. It begins with a brief **overview** on the status of health equity in Connecticut and a framework for understanding the underlying connections between health, policy, and social and economic health determinants. It includes a **comparative analysis** of the state and federal frameworks governing community benefit for Connecticut hospitals, with a special focus on transparency and opportunities for health equity investment. It concludes with **recommendations** on public policies and institutional practices to increase transparency, community accountability, and evaluation for health equity impact.

**Recommendation 1:** Require all hospitals and MCOs to provide community benefit as a condition of licensure.

**Recommendation 2:** Redefine community benefit to require greater targeting of high-need populations.

**Recommendation 3:** Create an Office of Health Strategy to align data collection and facilitate effective investment in strategies that eliminate health disparities.

**Recommendation 4:** Strengthen community benefit reporting standards.

**Recommendation 5:** Evaluate for health equity impact using both process and outcome measures.

**Recommendation 6:** Set robust standards for community engagement, particularly of communities impacted by health inequities.

**Recommendation 7:** Establish a minimum threshold for financial investment in interventions that address health disparities, including the social and economic determinants of health.

**Recommendation 8:** Strengthen the connection between hospital financial assistance policies and community benefit to end economic inequities perpetuated by provider billing practices.

**Recommendation 9:** Encourage hospitals and MCOs to focus internal resources on building capacity and relationships around health equity practice.

**Recommendation 10:** Build community knowledge and capacity to engage in community benefit, community health, and health equity planning.

**Recommendation 11:** Name and address the history, legacy, and present-day implications of racial, gender, and other forms of discrimination that shape opportunities to be healthy.

## I. Introduction

American health care is at a crossroads. The national momentum gained in the wake of the Patient Protection and Affordable Care Act's (hereinafter "ACA")<sup>1</sup> 2010 passage has been stifled, with basic health care programs under attack in Washington and state houses around the country. Public health, primary care, housing, and key social service programs face funding cuts, threatening the core services and financial supports millions of low-income people to meet their basic human needs. In the not-so-distant future, these cuts in federal funding will cause upheaval in state houses around the country, as governments grapple with how they ought to prioritize spending in an era of doing more, for potentially more people, with less.

"In today's America, people live in two distinctly different worlds. ... You don't need to travel far, or at all, to see the neighborhoods that have been left in the past. Some of our largest hospital systems are in the same urban communities that are burdened by these staggering mortality statistics — you can literally stand in the hospital lobby, open the doors, and gaze outside upon a neighborhood that experiences 1950s-quality health outcomes. You can travel even further backward on the health quality timeline by riding a few subway stops or walking a few neighborhood blocks."

*Defeating the ZIP Code Health Paradigm: Data, Technology, and Collaboration Are Key," Health Affairs*

At the same time, a new consensus is emerging about the significance of underlying community characteristics like poverty, racism and segregation, education and employment, transportation, housing, and environmental exposure to pollutants for determining how long people live and how healthy they are while they are alive.<sup>2</sup> Health departments, providers, and community activists around the country are embracing this broader vision of what matters for health to move beyond clinical care and address these "social and economic determinants" in their communities.

How can state and local policymakers, community advocates, and health care entities navigate these countervailing pressures? And how—in an age of shrinking budgets and growing inequality—ought they mitigate the damage caused by public and private institutional policies that have embodied and perpetuated America's legacy of racism, sexism, and other forms of discrimination?<sup>3</sup>

While answers to these questions will become apparent over the next few years, there are efforts underway at the local and state level to realign health care spending to invest in the broader determinants of health. The ACA included several health care financing incentives, delivery system reforms, and regulatory requirements that have prompted health care organizations—payors, health systems, and providers—to think more strategically about their roles in influencing the health of their broader communities, not just the patients or beneficiaries they serve.<sup>4</sup>

**Hospital community benefit programs, mandated by the ACA for all hospitals with a federal tax exemption, are one example of local initiatives communities can harness to address broader health determinants and, potentially, health equity.<sup>5</sup>** The ACA introduced new

mandates about financial policies and formalized requirements related to hospitals' community health needs assessments (hereinafter "CHNAs") and implementation planning with the goal of increasing transparency, creating pathways for community and public health input, and encouraging the targeting of financial resources to local health priorities.<sup>6</sup> What is less clear, however, is the extent to which hospitals are using community benefit to address health equity and engage communities currently impacted by health disparities and economic inequity.

This paper seeks to inform state and local efforts to strengthen the connection between hospital community benefit programs and health equity investments in Connecticut. It begins with a brief **overview** on the status of health equity in Connecticut, followed by a **comparative analysis** of the state and federal frameworks governing community benefit for Connecticut hospitals. It concludes with **recommendations** on public policies and institutional practices to increase transparency, community accountability, and evaluation for health equity impact. It is our hope that it provides a valuable framework for Connecticut policymakers, hospitals, and advocates with a shared interest in taking practical steps towards achieving health equity, so that all of Connecticut's residents may live their longest, healthiest lives.

## Methodology

To understand the status of public policies governing Connecticut hospitals, we analyzed existing federal and state laws and guidance, focusing on provisions relating to health equity, community engagement, and public reporting.<sup>7</sup> For insight into current hospital practices and spending, we reviewed community benefit reports compiled by the Connecticut Office of the Healthcare Advocate (hereinafter "OHA"); the Connecticut Office of Health Care Access (hereinafter "OHCA"); and the Connecticut Department of Health's (hereinafter "DPH") 2012, 2014, and 2016 State Facilities Plans and Supplements. We also reviewed the Connecticut Hospital Association's publicly available materials on community benefit along with a sample of Connecticut hospital CHNAs and implementation strategies. For Connecticut-specific health equity data, we relied primarily on DPH's most recent State Health Assessment<sup>8</sup> and State Health Improvement Plan<sup>9</sup>, conducted in 2014 as part of Healthy Connecticut 2020. Finally, we reviewed academic articles and the gray literature for studies and analyses of community benefit financial trends and emerging practices related to community benefit investments and partnerships.<sup>10</sup>

## INEQUITY VS. DISPARITY: WORKING DEFINITIONS

### Health Disparities

Differences in health outcomes between groups within a population.

### Health Inequities

Differences in health that are avoidable, unfair, and unjust. Affected by social, economic, and environmental conditions.

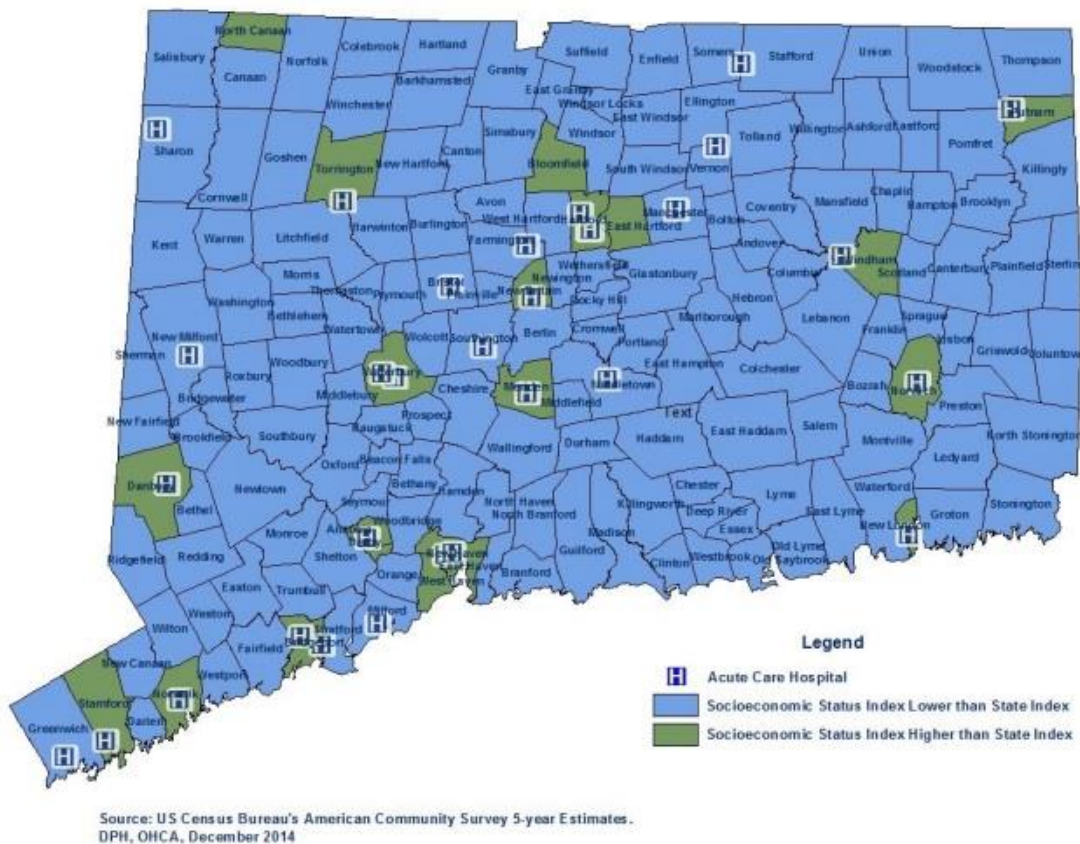
### Health Equity

Attainment of the highest level of health for all people, through efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

## II. Health Equity in Connecticut: An Overview

At first glance, Connecticut compares favorably to other states in terms of overall health status and economic well-being. It reliably ranks in the top ten states for overall health<sup>11</sup> and is consistently one of the wealthiest in terms of per capita and median income.<sup>12</sup> Connecticut as a whole experiences the second lowest rate of premature deaths compared to the rest of the country.<sup>13</sup>

While this would normally be cause for celebration, these benefits and health outcomes do not accrue evenly. Connecticut residents currently experience the third highest rate of income inequality<sup>14</sup> in the country along with disparities in education, income, and opportunity—all factors that influence health (see **Figure 2**). This is particularly true for residents of Connecticut’s larger towns and urban communities, which tend to be more racially and ethnically diverse and home to higher numbers of lower-income people than the rest of the state.<sup>15</sup>

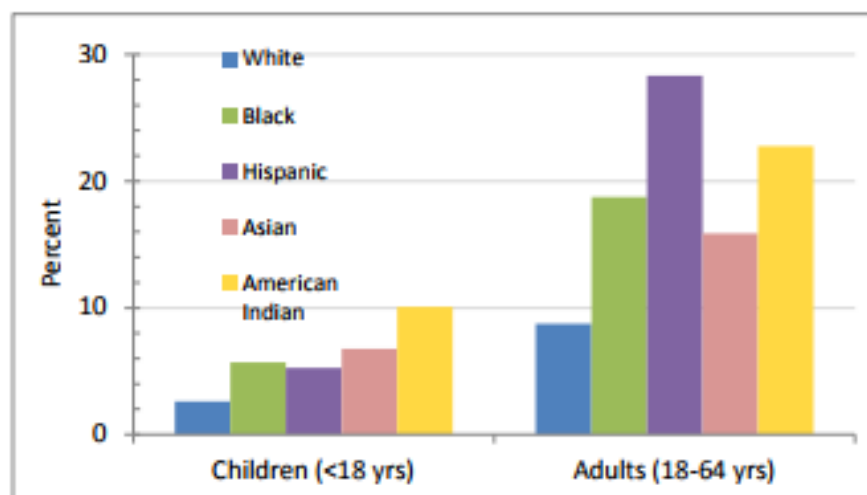


**Figure 2: Socioeconomic Status Index, by Town** (Source: Department of Public Health. [Statewide Healthcare Facilities and Services Plan – 2014 Supplement](#) [2014], Figure 15)

These disparities contribute to poorer health outcomes and higher premature death rates for the state’s racial and ethnic minorities. For example:

- Black men and women die prematurely of cancer and heart disease than whites and other ethnic/racial groups.<sup>16</sup>

- Black and Hispanic residents experience higher rates of high blood pressure<sup>17</sup> and diabetes<sup>18</sup> than whites experience and are more likely to have preventable hospital stays or emergency room visits.<sup>19</sup>
- In 2016, Black children experience were twice as likely to have lead poisoning, even though overall rates of lead poisoning decreased in the state as a whole.<sup>20</sup>
- Black and Hispanic mothers, particularly those living in Connecticut’s larger urban centers, are more likely to give birth to low-weight babies.<sup>21</sup>
- Non-white children and adults across all races and ethnicities are disproportionately more likely to be uninsured, compared to whites (see **Figure 3**).<sup>22</sup>



Note: All racial groups are non-Hispanic.

Source: US Census Bureau, American Community Survey, 1-Year Estimates, 2012, B27001 Files.

**Figure 3: Uninsured Children and Adults in Connecticut** (Source: State Health Assessment, 2014)

These inequities in health may also contribute to economic inequities. One DPH study found that:

“In 2012, Black non-Hispanics generated higher total charges due to more visits and with more severe conditions. **The total excess hospital costs in Connecticut for Black non-Hispanics and Hispanics relative to Whites were \$218 million and \$39 million, respectively.** The comparatively higher hospital costs generated suggest that substantial savings could be realized through disparity reduction.”<sup>23</sup> (Emphasis added)


Particularly for uninsured and underinsured people, extraneous medical bills like the ones described above can also have long-term implications for financial health, feeding additional cycles of economic insecurity and poverty.<sup>24</sup> Disparities add costs for private and public insurers, too:

“**[R]acial disparities in health will cost US health insurers approximately \$337 billion** [nationally, between 2009 and 2018], including \$220 billion for Medicare due to higher rates of chronic diseases among African Americans and Hispanics and the aging of the population.”<sup>25</sup> (Emphasis added)

With a growing percentage of Connecticut residents who identify as racial and ethnic minorities, there is more at risk now from health inequities than ever before in terms of human lives and financial cost.<sup>26</sup>

### III. The Community Benefit Framework: A Foundation for Hospital Investment in Community Health and Equity

Hospitals have a vital role to play in addressing these existing health disparities. As local anchor institutions, hospitals' fates are irrevocably tied to those of their communities.<sup>27</sup> As medical providers, their emergency rooms are frequently ground zero for understanding gaps in community services and preventive care. And as mission-oriented institutions, non-profit hospitals in particular have a role to play in addressing the root causes of poor health in their communities. In fact, federal tax law requires tax-exempt hospitals with 501(c)(3) status to provide **“programs or activities that provide treatment and/or promote health and healing as a response to identified community**



**COMMUNITY BENEFIT PROGRAMS ARE PROGRAMS OR ACTIVITIES THAT PROVIDE TREATMENT AND/OR PROMOTE HEALTH AND HEALING AS A RESPONSE TO IDENTIFIED COMMUNITY NEEDS.**  
Catholic Health Association

#### ACA REQUIREMENTS FOR TAX-EXEMPT HOSPITALS

1. **Community health needs assessment (CHNA)** every three years with public health and community input to identify priority health needs, and develop annual implementation strategies to address them
2. Write and widely publicize **financial assistance, emergency care, and collections policies**
3. **Fairly charge patients** who qualify for financial assistance the amounts generally billed to patients with health insurance
4. Make a **reasonable effort** to determine whether patients are eligible for financial assistance before initiating “extraordinary” collection actions

**needs,” beyond the medical care hospitals provide to their patients.<sup>28</sup>**

The Internal Revenue Services (IRS) and Treasury Department, which oversee these rules and requirements, define **community benefit** broadly to include promoting access to clinical care for low- and moderate-income people, along with “community health improvement services” that can include social and economic health determinants.<sup>29</sup>

#### A. The Federal Approach to Community Benefit

Over the past ten years, two major federal developments have reshaped hospital community benefit programs. First, in 2008, the IRS began requiring private tax-exempt hospitals to file detailed financial information about their community benefit policies and investments along with their annual Form 990 tax returns.<sup>30</sup> This new form, the Schedule H, required organizations

operating tax-exempt hospitals to break down their community benefit spending by category.<sup>31</sup> Prior to the ACA, Schedule H's primary function was to give regulators, researchers, and the public insight into hospitals' total community benefit spending and their allocations across the various categories.

The second major development occurred in 2010, when the ACA became law.<sup>32</sup> The ACA added new protocols related to financial assistance and emergency care policies; billing and collections, including charges; and community benefit planning.<sup>33</sup> Hospital facilities report how they are complying with these policies annually through Schedule H, in addition to providing financial information.<sup>34</sup> There are significant penalties for hospitals that flout these requirements, including monetary penalties for failing to conduct a CHNA and disciplinary procedures for other violations.<sup>35</sup> Hospitals found to have engaged in willful and egregious non-compliance may have their tax-exempt status revoked.<sup>36</sup>

The IRS released final rules implementing these ACA requirements in December 2014.<sup>37</sup> The final rules emphasized three main policy goals: 1) **increasing transparency** about hospital community benefit performance, policies, and investments, including financial programs aimed at helping patients gain access to care; 2) **improving protections against medical debt and hospital overcharging** for low-income, uninsured, and other patients with financial barriers to care; and 3) **standardizing a formal strategic process for planning and implementation of community benefit programs**, based on best practices in the public health and hospital sectors.<sup>38</sup>

The federal rules offer some guardrails about community engagement and investment in unmet health needs that hold promise for health equity:

- **Hospitals must show that community benefit programs and activities respond to an identified community need**, which can be established through a CHNA; by documentation, including a request from a public health agency or community group; or by collaborating in community health improvement activities or programs with other tax-exempt or government organizations.<sup>39</sup>
- **The IRS includes programs and activities that address disparities in access or health outcomes** as examples of programs that clearly meet community benefit objectives.<sup>40</sup>
- **Hospitals must define the “community served” by their CHNAs to include low-income, minority, and medically underserved residents living in their geographic service areas.**<sup>41</sup> By definition, this includes populations experiencing health disparities or facing barriers to medical care due to insurance status, language barriers, geographic distance, or other financial barriers.<sup>42</sup>
- **Hospitals must proactively seek and consider input from governmental public health agencies and community representatives**, including members or representatives of the medically underserved, low-income, and minority populations in the hospital's geographic service area.<sup>43</sup>

Hospitals are not required or expected to address all of the needs that are uncovered through the CHNA. Once a hospital has catalogued the significant health needs of the community, it may use any reasonable criteria to select priorities to address in the next three years.<sup>44</sup> Once these steps are completed, hospitals must **document the process in a written report (the “CHNA report”) that**



**is adopted by a board-authorized body and shared widely with the public.** This CHNA report has to provide a detailed narrative that allows lay readers to understand the steps the hospital undertook to complete the CHNA, along with the priority health needs it plans to address, what resources it has or will make available, and an evaluation of the prior CHNA’s interventions and strategies.<sup>45</sup> Hospitals must make the CHNA report widely available to the public, including on a website, along with two subsequent CHNA reports.<sup>46</sup>

Once the CHNA report is complete, tax-exempt hospitals must develop an **annual implementation strategy** that describes the steps they will take to address one or more of the priority health needs identified in the CHNA.<sup>47</sup> These strategies must be filed with the hospital’s 990, with sign-off from the hospital board.<sup>48</sup>



“THE CHNA CAN BE A USEFUL TOOL TO ADDRESS HEALTH DISPARITIES AND INEQUITIES. THROUGH EXAMINATION OF EVIDENCE-BASED ADVERSE DETERMINANTS OF HEALTH, IT IS POSSIBLE TO STRATEGIZE TO ELIMINATE PERSISTENT AND PERVASIVE HEALTH INEQUITIES, IMPROVE HEALTH OUTCOMES, AND DIMINISH FINANCIAL COSTS.”

Connecticut Hospital Association, Guidelines for Conducting a Community Health Needs Assessment

## B. Connecticut’s Approach to Community Benefit

States, municipalities, and other political jurisdictions are free to set additional requirements for hospital community benefit to achieve public policy goals that address specific needs in their states and communities, and many do. At first blush, Connecticut’s statute appears to be more expansive than the federal standard since it applies to all hospitals, including for-profits, and to managed care organizations (MCOs). However, the provision of community benefit is voluntary.<sup>49</sup> While the statute outlines a set of “guidelines” and reporting requirements for hospitals and MCOs that choose to provide community benefit, these lack the force of law.

**Connecticut law defines community benefit simply as “any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital.”**<sup>50</sup> Unlike the federal approach, Connecticut does not define specific categories of community benefit, nor does it collect core community benefit information through unified reporting. Instead, data relevant to community benefit spending is scattered across various reporting forms and agencies for hospital uncompensated care, hospital bed funds (financial gifts made by individuals or estates to hospitals for the purposes of covering the costs of care for people who cannot afford to pay)<sup>51</sup>, debt collection and charity care policies, and voluntary community benefit reports.<sup>52</sup>

Connecticut’s statute states that hospitals and MCOs with voluntary community benefit programs should incorporate the following elements:

- **Publicly adopt** a community benefits policy statement that outlines the institution's commitment to a formal community benefit program;
- Assign internal responsibility for developing and implementing the community benefit program, including **resource allocation and evaluation**;
- Get **meaningful participation** from communities within the institution's geographic service area in defining the target population and priority needs, developing and implementing the program;
- **Prioritize public health needs** outlined in the most recent version of the state health plan prepared by the Department of Public Health;
- **Assess existing health care needs and resources** of the institution's targeted populations and **develop a program** based on these findings; and
- **Prepare a report** documenting this process, outlining the community benefit services to be offered, and providing a community benefit budget that includes administrative costs and expenses.<sup>53</sup>

These guidelines are, in themselves, a good statement of process and principle. However, Connecticut offers very little in the way of guidance or support to hospitals attempting to conduct a thorough community benefit process, and does not collect detailed information that would allow community members to understand and compare how local hospitals are doing. In many ways, the federal requirements appear to serve as the real barometer for Connecticut hospitals.

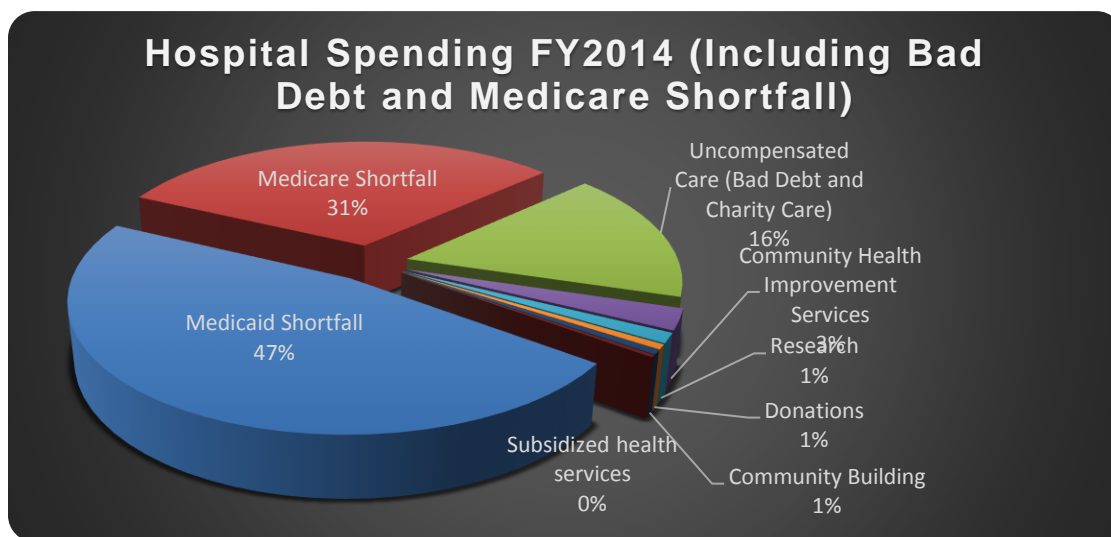
### **C. Are Hospitals Using Community Benefit to Inform Health Equity Decision-making and Investment?**

Both Connecticut and federal approaches grant hospitals a great deal of flexibility with regard to community benefit spending. Neither sets a mandatory minimum expenditure on community benefit, instead focusing on the process hospitals must use to gather data and input to inform their CHNA. Both allow hospitals to target their community benefit spending, programming, and outreach to neighborhoods and demographic groups that have experienced historical disadvantages, barriers to care, or health disparities.<sup>54</sup> Both give hospitals ultimate control to decide which community need, if any, to address. Unless states have enacted stronger rules, hospitals also decide where to set the contours of their financial assistance and collections policies. Because of this flexibility, it is important for regulators and community partners to remain engaged and informed about local hospital community benefit programs.

Total community benefit spending and allocations across categories of spending, such as financial assistance or community health improvement services, are imperfect proxies for measuring hospital commitments to health equity. However, they do indicate hospital priorities, at some level, in meeting unmet needs. Nationally, several early analyses of federal community benefit spending have looked at data just prior to and following passage of the ACA. These studies showed wide variations in terms of how much money hospitals allocated to community benefit.<sup>55</sup> For Fiscal Year 2009, the bulk of community benefit spending reported in Schedule H—about 85 percent—flowed to financial assistance and Medicaid shortfall.<sup>56</sup> By Fiscal Year 2011, following the passage of the ACA, hospitals reported spending an average of 9.67 percent of total expenses on community benefit, with about 56 percent flowing to access initiatives. Only .41 percent went to community health improvement services.<sup>57</sup> **While these two data points are insufficient to establish a trend,**

**the pattern of hospital spending still seems oriented towards access, rather than to the social and economic determinants that contribute to poor health.**<sup>58</sup>

Comparable financial analyses of hospital community benefit spending for the same period do not exist for Connecticut hospitals. This is due partially to challenges with the state reporting requirements<sup>59</sup> and inconsistencies between the state and federal reporting standards for uncompensated care and Medicare shortfall (see **Figure 4**).<sup>60</sup> Despite these discrepancies, the public data that is available at the state level follows a similar theme: hospitals allocate the bulk of their community benefit spending to shore up access programs like financial assistance and Medicaid shortfall, with minimal spending on community health improvement services.<sup>61</sup>



**Figure 4: Connecticut Hospital Community Benefit, Bad Debt and Medicare Shortfall Spending for Fiscal Year 2014 as a Percentage of Total Expense** (Sources: Connecticut Hospital Association and OHCA Hospital Annual reports.<sup>62</sup>)

In addition to the financial filings, qualitative reviews of recent CHNA reports indicate that Connecticut hospitals still overwhelmingly focus their community benefit investments on prevention and clinically based services. In state agency reviews of hospital CHNA reports, coupled with hospital surveys from 2007/2008, 2014, and 2016, hospitals overwhelmingly selected health priorities that focused on prevention and access to clinical health services such as smoking, obesity, and mental health/substance use.<sup>63</sup> Relatively few Connecticut hospitals flagged issues like housing, transportation, safety, and economic challenges in their CHNAs (see **Figure 5**).<sup>64</sup>

At one level, these findings are not surprising. National surveys have found that, despite growing understanding among hospital leaders about the importance of social and economic determinants of health, hospitals are still in the early stages of developing capabilities to tackle the social and economic determinants in a strategic, focused way.<sup>65</sup> Only about one-third have a fully functional, “well-defined process for connecting people to social needs resources” for any community member (as opposed to a smaller patient panel), and fewer than half report fully functional connections with community organizations that address social needs.<sup>66</sup> While the CHNA requirement and community benefit process could allow hospitals to play a leadership role in identifying local needs and focusing social determinants spending, there is clearly more work to be done to bring them up to speed.<sup>67</sup>

Health Needs	Number of Assessments Identifying this Health Need	
	2014 Review (2008-2014 CHNAs) <sup>1</sup>	2016 Review (2012-2016 CHNAs) <sup>2</sup>
Overweight, Obesity, Nutrition, Physical Activity	16	23
Substance Abuse <sup>3</sup>	12	21
Mental Health <sup>3</sup>	12	20
Chronic Disease	18	19
Respiratory Health	5	13
Access to Care (general)		12
Safety		9
Maternal and Child Health	5	9
Tobacco Use		8
Gaps in Primary Care	13	7
Healthy Aging	4	7
HIV/AIDS		5
Sexually Transmitted Infections (STIs) (excluding HIV/AIDS)		5
Gaps in Mental Healthcare	7	4
Housing	4	

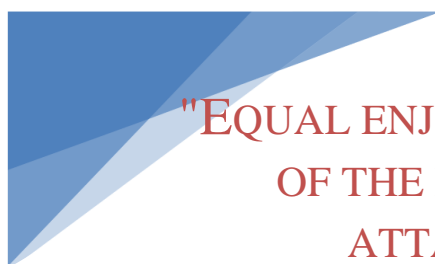
<sup>1</sup> The 2014 review includes 21 CHNAs completed between 2008 and 2014.

<sup>2</sup> The 2016 review includes 26 CHNAs completed between 2012 and 2016. One CHNA identified in this review pertained specifically to cancer care, rather than community health more generally. One hospital did not identify priority health areas in the CHNA; their priority health areas will be included in their CHIP which is currently under development. Some CHNAs were conducted as a collaboration among multiple hospitals. Priority health needs from these collaborative CHNAs are counted once

<sup>3</sup> 19 CHNAs identified substance abuse and mental health together as health priorities.

**Figure 5 : Top Health Needs Identified through CHNA Process, Connecticut, 2008-2014 vs. 2012-2016** (Source: Connecticut Department of Public Health, [Statewide Healthcare Facilities and Services Plan – 2016 Supplement](#), Table 4.5)

#### IV. Recommendations: Making Community Benefit an Engine for Health Equity



**"EQUAL ENJOYMENT  
OF THE HIGHEST  
ATTAINABLE  
STANDARD OF  
HEALTH IS A HUMAN  
RIGHT AND A  
PRIORITY OF THE  
STATE."**

Connecticut General Assembly Public Act No.  
08-171

Early analysis appears to show that hospital community benefit spending on programs that address the root causes of health inequities account for just a small fraction of hospital expenses.<sup>68</sup> It is unclear whether hospitals are using their CHNAs to guide their community benefit investments towards the highest-need communities.

Connecticut policymakers have an opportunity to go further here. States frequently serve as laboratories for innovation in law and policy, and may be better positioned to support and drive meaningful reforms, gather stakeholders, and identify local and regional challenges and solutions to making health equity investments an easy choice. Although care must be taken in

drafting legislation or policy guidance to avoid the creation of conflicting or duplicative requirements, there are opportunities for state and local policymakers to expand or tailor community benefit to target health equity. The following recommendations identify opportunities for state policymakers to create consistent approaches and to formalize requirements for hospitals that target health disparities. They are intended to reinvigorate discussions about sharpening community benefit to be a more effective tool for health equity change—not in a punitive way, but to support and drive the types of multisector partnerships<sup>69</sup> and deep community engagement that leads to transformation.<sup>70</sup>

### **RECOMMENDATION 1: Require all hospitals and MCOs to provide community benefit as a condition of licensure.**

We recommend that policymakers make community benefit mandatory for hospitals and MCOs, regardless of tax status.<sup>71</sup> While federal community benefit obligations have historically been framed as a distinguishing function and feature of non-profit healthcare, the stubborn persistence of health disparities concentrated in certain communities supports an argument that for-profit hospitals<sup>72</sup> should routinely be required to assess and address community health needs at some level—particularly those that serve communities with low socioeconomic status or high health disparities (see Figure 2). There is some precedence for this in the state’s Certificate of Need (CON) and conversion laws, wherein OHCA and the Office of the State Attorney General can impose conditions on hospitals seeking transfers of ownership or conversion to for-profit status to maintain charity care levels or conduct some “look-alike” community benefit activities.<sup>73</sup> However, these settlement agreements are time-limited. Similarly, the concept of including MCOs in community benefit requirements is intriguing. Strengthening MCO requirements for community benefit could complement many of the state’s initiatives to use payment incentives to drive investment in social and economic determinants. At the very least, hospitals should be encouraged to include MCOs, accountable care organizations, and other payers in their community health improvement tables.

Among the states with which it shares a border—New York, Rhode Island, and Massachusetts—Connecticut has taken what is arguably the most relaxed and least comprehensive approach to community benefit law and governance.<sup>74</sup> Even a bright spot of innovation—that Connecticut’s existing statute goes beyond the federal standard by including for-profit hospitals and MCOs in its scope—is dulled by the lack of clarity in the existing statute and the fact that the requirements are voluntary. One option would be to make community benefit mandatory for all hospitals and MCOs as a condition of state licensure. To date, nine states mandate the provision of community benefit unconditionally, and an additional 16 require community benefit to be provided as a condition of some other status (licensure, tax exemption, etc.).<sup>75</sup> Neighboring Rhode Island requires community benefit as a condition of licensure for all hospitals.<sup>76</sup>

Alternatively, if policymakers wish to keep the program voluntary, Massachusetts offers a worthy model of a voluntary program with robust public reporting and oversight by the Attorney General, with increasing coordination with the state Department of Public Health.<sup>77</sup>

### **RECOMMENDATION 2: Redefine “community benefit” to require greater targeting of high-need populations.**

Policymakers should revise Connecticut’s community benefit definition to encourage more targeting to communities experiencing health disparities.<sup>78</sup> Given the prevalence of health disparities in Connecticut among low-income people and non-white racial and ethnic populations, the current definition is insufficient to direct resources to areas of greatest need. We recommend that the definition be rewritten as follows:

“Any voluntary A program that includes activities to promote preventive care, to increase access to care, and to improve the health status and reduce racial, ethnic, linguistic and cultural disparities in health for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital[.]”<sup>79</sup>

Policymakers should provide clear definitions and examples of community benefit and community building categories, inclusive of investments in social and economic health determinants, that are consistent with what is required of tax-exempt hospitals through the Form 990. Bad debt, Medicare shortfall, and offsets from hospital bed funds should be expressly excluded from being reported as community benefit. These reforms should lend clarity to hospitals and MCOs that currently struggle to characterize their community health and access initiatives as community benefit under state law.

## Principles for Health Equity

- **Reach out to and work with the communities most impacted by the problem.** While there is much to learn about health equity from a scientific perspective, a critical first step is to engage the communities known to be experiencing health disparities in understanding the barriers they face and in naming crafting solutions.
- **Gather data to understand how disparities affect different demographic groups in a local community, and identify any other factors that are influencing the community’s health.** This includes social and economic factors—education opportunities, job pipelines, income and wealth status, community and family safety, social inclusion and community cohesion, environment.
- **Work with community partners and other stakeholders to identify concrete, local opportunities to address the root causes of poor health.** Where possible, push solutions that address the social, economic, and environmental determinants of health.
- **Over-invest in targeted communities** to compensate for the additional barriers and lack of opportunity that people experiencing health inequities have to be healthy.

Adapted from National Academies of Sciences, Engineering, and Medicine. [Communities in Action: Pathways to Health Equity](#). The National Academies Press (2017). See also [Defining Health Equity](#), Health Equity Institute at San Francisco State University.

### **RECOMMENDATION 3: Create an Office of Health Strategy to align data collection and facilitate effective investment in strategies that eliminate health disparities.**

Currently, the Office of the Healthcare Advocate, the Office of Health Care Access, and the Department of Public Health all have some reporting or programmatic relationship to community benefit and community health planning. Numerous other state initiatives are also prioritizing health

equity and the elimination of health disparities.<sup>80</sup> Agencies routinely reported difficulty accessing consistent, timely data on health disparities. For example, Connecticut’s 2020 State Health Assessment cited challenges with procuring local health data and data for “specific populations, such as residents of rural areas, sexual minorities, veterans, and racial and ethnic minorities such as American Indians and Asian Americans.”<sup>81</sup> It also reported difficulty accessing data on social and economic health determinants outside of the health care system, including data on “patient safety standards, trauma screening by primary care and behavioral health providers, enforcement of housing codes, and collaboration among housing code enforcement agencies.”<sup>82</sup> An Office of Health Strategy similar to the one proposed by the Health Care Cost Containment Study<sup>83</sup> could serve as a convener, clearinghouse and portal for sharing relevant data and identifying ongoing gaps inside and outside of the health care sector.<sup>84</sup> **We recommend that policymakers create an Office of Health Strategy with the following goals:**

- **Break down existing siloes** by convening providers, payers, and community partners from a variety of sectors, such as health care, transportation, housing, and food security to identify common barriers and share best practices.<sup>85</sup> This could include identifying and eliminating duplicative reports, assessments, and initiatives, thereby freeing up human and financial resources.
- **Encourage collaboration and data sharing** across state agencies and initiatives on community health, community benefit, and health care financing and utilization, including human and social services agencies. This includes continuing to build on promising practices, such as the integration and leveraging of public health data and hospitals’ private CHNA data in the 2014 and 2016 supplements to the state facilities plans.<sup>86</sup>
- **Build a community of practice** among agencies, providers, payers, public health, and community residents and organizations that are of and/or represent the communities most directly impacted by health disparities.
- **Integrate community benefit data and processes with strategic clinical initiatives to encourage investment in the social and economic determinants of health.**<sup>87</sup> Working with providers and payers, the Office of Health Strategy could conduct research to determine how interventions to address social and economic health determinants influences health outcomes and health care spending.<sup>88</sup> It could also monitor, evaluate, and encourage provider, payer, and public health investments in local and regional health disparities.<sup>89</sup> The Office could support expanded use of Connecticut’s first-in-the-nation Health Equity Index, which uses geo-mapping to identify “hot spots” where social and economic health determinants are particularly burdensome to communities.<sup>90</sup>
- **Work with community organizations, public health, and service agencies to make the data widely available and accessible to the public.** This could include talking with community organizations and members about what data would be most relevant to their lives and work, and making data readily available on public websites without requiring an additional outreach step. It may also include creating explanatory documents and educational materials to simplify data sets and build capacity among community partners to engage with data in ways that position them to take action on key issues that contribute to health inequities.

#### **RECOMMENDATION 4: Strengthen community benefit reporting standards.**

Connecticut policymakers should amend and require community benefit reporting for all hospitals and MCOs to allow for greater insight into hospital spending and approaches to community benefit. Currently, privately owned tax-exempt hospitals submit their IRS Form 990s and all required attachments, including their audited financials and implementation strategies, to the state.<sup>91</sup> But state hospitals, for-profit hospitals and MCOs are not required to file the 990. This approach creates a blind spot in the data collected and summarized by the state, and could indicate that—in practice, if not in policy—the bulk of community benefit is borne by non-profit hospitals instead of the larger category of providers and payers envisioned by the statute. Specifically, Connecticut policymakers should:

- **Require all hospitals and MCOs to file annual community benefit reporting forms and supplemental information as described in Recommendation 2.** All health care entities should also be required to publicly post their annual implementation strategies on their websites and file them with state regulators.<sup>92</sup> OHCA currently maintains a partial listing of hospital CHNAs and implementation strategies on its website, but these should be available for all hospitals and MCOs.
- **Require health care entities to make their CHNA reports and annual implementation strategies widely available to the public.** Currently, Connecticut law simply requires hospitals and MCOs to make these documents available to the public upon request.<sup>93</sup>
- **Separate charity care and bad debt in hospitals' uncompensated care reporting.** Currently, Connecticut requires hospitals to report annually on their uncompensated care expenditures.<sup>94</sup> However, Connecticut allows hospitals to file this information using inflated chargemaster rates rather than cost, and to combine bad debt with charity care. By contrast, the Form 990 Schedule H requires hospitals to report both of these numbers at cost. It also draws distinctions between bad debt (in which patients who may still be low-income are likely pursued through the collections process) and charity care (in which patients are deemed unable to pay their bills and have the debt forgiven). Hospital and OHCA reporting on uncompensated care—currently mandated for all hospitals and separate from the community benefit guidelines—should be refined to distinguish between bad debt and charity care, and to require hospitals to report these numbers at cost, rather than charges.

The Office of Health Care Access (OHCA) should also routinely collect, organize, and analyze community benefit and uncompensated care data in publicly searchable formats to allow the public to gauge hospital commitments to community benefit and health equity. Specifically, OHCA should:

- **Create a database, updated at least annually and searchable by hospital facility and MCO as well as by community benefit service, with multi-year data that allows for trend analyses and comparisons across hospitals and MCOs and community benefit type.** Connecticut law currently requires OHCA or its designee to report every other year with a summary and analysis of the community benefit reports they receive from MCOs and hospitals.<sup>95</sup> This is too infrequent. As of this writing, the DPH website included a community benefit dashboard for 2013<sup>96</sup>, along with community health needs assessments, implementation strategies, and 990 reports for many Connecticut hospitals. The Connecticut



Hospital Association does post CHNAs in one place on its website, but more frequent, uniform public reporting with coded categories would enable researchers, policymakers, and the public to better gauge hospital performance related to community benefit.<sup>97</sup>

- **Require OHA and OHCA to post hospital financial assistance, collections, and hospital bed fund policies online in a searchable format, similar to California’s Fair Care Pricing portal.**<sup>98</sup> This will aid members of the public, community-based organizations, and others in identifying financial programs that can help uninsured and underinsured Connecticut residents find timely access to care in their area.

**RECOMMENDATION 5: Evaluate for health equity impact using both process and outcome measures.**

Policymakers should work with stakeholders, including community and public health entities and providers, to identify appropriate metrics for tracking how community benefit investments have led to improvements in health equity indicators (outcomes measures), as well as engagement and involvement of the communities directly impacted by health inequities (process measures). The CDC recommends that health equity evaluations include both sets of measures to understand how the people most directly impacted by health disparities experienced the problem and the intervention, and to ensure that they have a role in defining whether interventions were a success.<sup>99</sup> Health equity outcomes metrics could be tagged to health equity indicators such as those identified in Healthy Connecticut 2020.<sup>100</sup> Process measures could look at who was engaged and how the intervention was planned, as described below in Recommendation 6.<sup>101</sup>

**Table 1: Sample Priority Principles for Community Engagement**

1. **Sharing Power:** Inclusion and mitigation of power differentials in the community health improvement process
2. **Transparency:** Includes setting clear expectations for participants on how their input will inform decision-making and regular feedback throughout the process
3. **Accommodation:** Designing community engagement and outreach efforts to overcome barriers to participation such as language, literacy, community capacity, community tensions, transportation, childcare, venue location and accessibility
4. **Facilitation:** Incorporating effective, skilled, culturally competent facilitation into meeting design
5. **Grasstops and Grassroots Representation:** Engaging formal and informal decision-makers from the community, along with community representatives and members who represent the broad interests of the community served

**Source:** Massachusetts Determination of Need Community Engagement Guidelines

**RECOMMENDATION 6: Set robust standards for community engagement, particularly of communities impacted by health inequities.**

Connecticut policymakers should establish a core set of principles for robust community engagement throughout the community benefit process—from the initial data collection in the

CHNA report, to developing an implementation strategy, to allocating funds for community benefit services and programs. Community engagement criteria should emphasize the need for intentional outreach and inclusion of communities at greatest risk for experiencing health disparities, with a focus on populations that have experienced major obstacles to health associated with socio-economic disadvantages and historical and contemporary injustices.<sup>102</sup>

Two states, Massachusetts and Minnesota, have recently adopted standards to formalize and evaluate community engagement in public health and hospital initiatives that are instructive. The Minnesota Department of Public Health adopted a Community Engagement Plan (hereinafter “the Plan”) with aggressive goals for increasing community engagement from 2016-2019 with specific targets and deadlines for building engagement from people experiencing health disparities, both in terms of total numbers engaged in DPH initiatives and in the depth of their engagement.<sup>103</sup> For example, the Plan includes targets for increasing representation from racial and ethnic minorities on public health advisory bodies. At the same time, the Plan outlines targets for increasing community input in the initial and development phases of projects, to shared decision-making and co-creation of goals.<sup>104</sup>

This year, the Massachusetts Department of Public Health adapted several validated, preexisting community engagement standards for hospitals and other health care entities to use in its revamped Determination of Need (hereinafter “DON”) process.<sup>105</sup> As of January 2017, health care entities applying for a DON must demonstrate a connection between their proposed projects and “community-based health initiative” (hereinafter “CHI”) goals that specifically focus on social and economic health determinants in the communities impacted by their proposals.<sup>106</sup> As part of the evidence base, DON applicants must show their work on community engagement by completing and submitting a **self-assessment and stakeholder assessment of community engagement** efforts to date.<sup>107</sup> For larger initiatives, the DON applicant must submit a separate **community engagement plan** to govern the applicant’s ongoing community engagement throughout the DON process. Hospitals can submit the community engagement processes they undertook for their CHNAs and implementation strategies as evidence of community engagement that achieves these higher bars.<sup>108</sup> However, the state health department reserves the right to develop a corrective action plan for community engagement based on pre-established priorities (see **Table 1**).<sup>109</sup> This effectively raises the bar for community engagement and creates some common language and values for how it should be done.

**RECOMMENDATION 7: Establish a minimum threshold for financial investment in interventions that address health disparities, including the social and economic determinants of health.**

Connecticut policymakers should consider options for establishing a minimum spending threshold focused on social and economic health determinants. At least one bill offered in the 2017 session would have amended Connecticut’s community benefit statute to require hospitals (but not MCOs) to adopt measures that address the social determinants of health in their community benefit implementation strategies.<sup>110</sup> Policymakers could require hospitals and MCOs to provide a minimum percentage of either their total community benefit spending or their total budget to intentionally address health disparities or social and economic determinants identified in the hospital’s own CHNA, requested by the community, or in DPH’s State Health Improvement

Plan.<sup>111</sup> Alternatively, policymakers could require hospitals to devote a certain number of programs or activities focused on addressing social and economic determinants.

Connecticut policymakers could also require hospitals and MCOs to set aside an annual percentage of their community benefit expenditures in a common pool. These funds could be reallocated based on pre-determined guidelines, such as regional or state priorities related to health disparities, creative interventions in social and economic spheres outside of clinical care settings, or to bolster investment in higher-need, lower-resourced communities that may lack the resources needed to adequately address disparities. This approach might provide some needed ballast to the state, given Connecticut's income inequality and its clustering of lower-income, higher-need populations in certain urban and rural communities. The revised Determination of Need (DON) process adopted this year by the Massachusetts Department of Public Health includes a similar mechanism. DON applicants must select and fund a "community-based health initiative" that addresses a social determinant of health or another DPH priority.<sup>112</sup> In addition, each DON applicant must contribute to a new statewide pool of funding for community-based health initiatives "that responds to the historically unequal distribution of CHI resources across the Commonwealth." These contributions are capped based on the total value of the DON project, and are split so that the bulk of the dollars stay in the local community.<sup>113</sup>

**RECOMMENDATION 8: Strengthen the connection between hospital financial assistance policies and community benefit to end economic inequities perpetuated by provider billing practices.**

Over 15 percent of Connecticut residents between the ages of 18 and 64 had medical debt in 2015.<sup>114</sup> Given the long-term financial impacts of medical debt for low- and moderate-income households, Connecticut policymakers should build on existing state requirements to require all hospitals to have robust financial assistance and collections policies and should explore opportunities to expand these protections to other provider practices, particularly physician and diagnostic providers involved in ACOs and other risk-sharing arrangements. These policies are a critical, if overlooked, component of a hospital's potential investment in the economic determinants of health and are, in most cases, within a hospital's power and control to address. Yet while the federal community benefit rules encourage nonprofit hospitals to examine financial barriers to care as part of the CHNA, it is unclear to what extent hospitals are using the CHNA process to evaluate whether their own billing and collections policies are erecting barriers to care for their patients that perpetuate cycles of economic inequity. The National Consumer Law Center's Medical Debt Model Act includes a range of recommendations for state policymakers, from establishing a set baseline for eligibility to creating a private right of action for consumers who are harmed by egregious debt collection practices.<sup>115</sup>

**RECOMMENDATION 9: Encourage hospitals and MCOs to focus internal resources on building capacity and relationships around health equity practice.**

Hospitals and MCOs can tailor many of the recommendations above to improve their internal community benefit planning and practices. Community benefit staff, board members, clinicians, frontline staff, and leadership all have roles to play in creating awareness within their institutions about health disparities and in reinforcing commitments to combat them locally.<sup>116</sup> Hospitals and MCOs should consider taking the following steps to build a culture of health equity within their institutions:

- Educating and securing a commitment from boards of directors to share data, collaborate, and invest in health equity solutions alongside community and public health partners and other providers, including market competitors
- Supporting innovation in community benefit by tying executive pay to improvements over set time periods on identified health equity markers
- Adopting hiring practices and investing in employment pipelines that support and create economic opportunity for populations that have historically experienced disparities
- Using contracting clout to extend hospital financial assistance and debt collection practices to physician practices and other providers of clinical services, such as diagnostics
- Hiring community benefit professionals, community health workers, and others with demonstrated community engagement skills and experience
- Maintaining communications and routinely reach out to community leaders and members throughout the CHNA and implementation process
- Identifying and supporting the development of community health leaders from target populations, including through roles on the community advisory board<sup>117</sup>
- Connecting the dots among revenue cycle, strategic planning, and community benefit teams to ensure hospital billing and collections policies do not exacerbate economic inequities or establish barriers to care
- Using geomapping, or “hotspotting,” to identify relationships between high rates of preventable hospital utilization and relevant social and economic health determinants
- Including questions in the CHNA process that address the social and economic determinants of health
- Collaborating with public health and other agency partners working on social and economic determinants, like transportation and housing

## A Framework for Healthcare Organizations to Achieve Health Equity

Make health equity a **strategic** priority through leadership commitment and funding.

Develop **governance structures and workflows** that support health equity work.

Deploy **specific strategies** to address the multiple determinants of health.

Decrease institutional racism within the organization through creating culturally appropriate spaces, accepting health insurance, and **reducing implicit bias** among staff.

Develop **partnerships with community organizations** to improve health and equity.

**Source:** Institute for Healthcare Improvement.

## **RECOMMENDATION 10: Build community knowledge and capacity to engage in community benefit, community health, and health equity planning.**

Community members, coalitions, and organizations also have roles to play in ensuring that Connecticut community benefit programs are achieving their full potential to address health disparities. The following list includes some initial steps community partners can take, in addition to advocating for the recommendations listed above.

- **Get acquainted with local hospital CHNAs and financial assistance policies.** The public CHNA reports are a treasure trove of information about local community health needs and perceptions and can provide useful information about the hospital's priorities for the coming years. The CHNA report also includes information about the hospital's outreach efforts, prioritization process, and partnerships that can provide a solid background for those seeking to connect with the institution for the first time. Similarly, even a quick review of a hospital's financial assistance policy can illuminate opportunities for improvement and areas of excellence.<sup>118</sup>
- **Invite yourself to the table.** Community residents, coalitions, and organizations should proactively seek to build relationships with hospitals and MCOs. Community organizations frequently have skills and deep roots in the community that can augment the hospital's networks, which can be a valuable asset for hospitals that have struggled to make inroads with population groups experiencing health disparities, language or other barriers. And community residents are able to bear witness in real time to their own lived experiences, adding value and insight that no data set can duplicate.
- **Explore opportunities to serve on community benefit advisory bodies and committees.** To ensure that participation is meaningful, community organizations can engage and equip community members impacted by health inequities to participate in community health planning and discussions. They can also encourage hospital staff to observe best practices for supporting community members in this process.
- **Build alliances with advocates from other sectors.** Now, with proposed federal and state budget cuts to funding for housing, community development, food security, and health care, it is more critical than ever that community partners and advocates develop alliances and common agendas to ensure that revenues remain for core building blocks of shared prosperity, such as health care and education. These cuts will likely exacerbate existing disparities in health and economic status. While there is no magic solution to these problems—particularly in states like Connecticut facing significant fiscal challenges—a united front and common messaging can help build public awareness about the long-term consequences.

## **RECOMMENDATION 11: Name and address the history, legacy, and present-day implications of racial, gender, and other forms of discrimination that shape people's opportunities to be healthy.**

Achieving health equity requires active, intentional work to mitigate and eradicate the social and economic factors that contribute to health disparities.<sup>119</sup> In many communities, establishing the trust that is necessary to build successful health equity interventions will require acknowledging and

reckoning with the roles that racism, sexism, and other forms of bias have played in creating generational poverty through the systematic denial of equal opportunities for quality education, housing, jobs, transportation, and even food to communities of color, women, and others. This may include a potential reckoning with the role one's own institution or community of origin has played in promoting or benefitting from these policies. This is painful—but necessary—work for which no single sector of society can or should bear sole responsibility. Common tables such as those envisioned by the hospital CHNA process offer one opportunity for community members and local hospitals to reckon with their shared history and set the table for a more just and equitable future. We encourage providers, policymakers, and community members to be open to using a social/racial justice and equity framework that acknowledges this painful history and rights the course by addressing the ways in which it lives on today.

## **V. CONCLUSION**

We are in a time of great uncertainty and great need. The foundations of our health care system are shifting, with federal lawmakers proposing harmful budget cuts and tax reforms that will slash the safety net programs that make life possible for millions of people. Yet delaying action to achieve health equity is not an option. These crises present an even greater imperative to adopt public policies and institutional priorities that can target scarce resources to areas and populations experiencing the greatest inequities. The question is not whether, from a moral and economic perspective, Connecticut can afford to allow these inequities to exist. The question is how long it can afford not to address them. Connecticut has significant work to do to remedy the health and economic inequities that present a “poison pill” for so many people of color, women, immigrants, low-income people, LGBTQ people, and others. Community benefit represents a unique opportunity to unite health care providers, public health, and community members affected by health disparities around the identification of solutions, not just problems. It is our hope that this paper provides concrete steps for policymakers, providers, and advocates to take to advance the cause of health equity, together.

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<sup>1</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 42 U.S.C. § 18001 et seq (2010).

<sup>2</sup> Wyatt, R., et al. [Achieving Health Equity: A Guide for Health Care Organizations](#). Institute for Healthcare Improvement White Paper, 2016.

<sup>3</sup> Ibid, pp. 6 and 9. In addition to genocide against Native peoples, slavery, and segregation, ongoing discrimination in housing, education and economic opportunity, public budgetary policy and patterns of investment have had significant impacts on health outcomes for many racial and ethnic minorities. Other population groups also face barriers to health, including low-income people, women, veterans, LGBTQ people, people living with disabilities, and people who are homeless. For example, households with annual incomes under \$115,000 have higher risks of premature mortality, or early death, when controlling for other factors, and this risk increases as income decreases. To date, the science is unclear about how these various social identities overlap and interact to drive mortality or wellness. What is clearer is that many people fall into multiple groups, and that these “social identities ...intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression.”

<sup>4</sup> See, e.g., Grogan, C. [“How the ACA Addressed Health Equity and What Repeal Would Mean,”](#) *Journal of Health Politics, Policy and Law*. Duke University Press (June 29, 2017); and Heiman, H., and Artiga, S. [“Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.”](#) Kaiser Family Foundation (November 4, 2015).

<sup>5</sup> Chen, M., et al. [“Hospitals’ Engagement in Population Health: Moving Past the Medicine and Into the Community,”](#) *Health Affairs Blog* (April 5, 2016).

<sup>6</sup> Folkemor, D., et al. [Hospital Community Benefits after the ACA: The Emerging Federal Framework](#), The Hilltop Institute, UMBC (January 2011). See also Eckstein, E., and Hattis, P. [Hospitals Investing in Health: Community Benefit in Massachusetts](#). Community Catalyst (October 2016).

<sup>7</sup> Specifically, we looked for terms including “health equity,” “health disparities,” “barriers to care,” “community health,” and specific mentions of social and economic determinants of health. We reviewed the Internal Revenue Service (IRS) [Revenue Ruling 69-545](#) (1969); the IRS [Schedule H Form](#) and the [Schedule H Instructions](#) for the Form 990 for Fiscal Year 2016; and the statutory language and [implementing rules](#) for Section 501(r) of the Internal Revenue Code, which codifies the Affordable Care Act’s requirements for tax-exempt hospitals. At the state level, we reviewed Connecticut’s community benefit statute, policy guidance, and agency reports related to hospital community benefit, hospital billing and collections, public health planning and assessment, and hospital financial reporting on uncompensated care.

<sup>8</sup> Connecticut Department of Public Health. [Healthy Connecticut 2020. 1: State Health Assessment](#) (2014). (Hereinafter “State Health Assessment.”)

<sup>9</sup> Connecticut Department of Public Health. [Healthy Connecticut 2020. 2: State Health Improvement Plan](#) (2014). (Hereinafter “State Health Improvement Plan.”)

<sup>10</sup> A comparative analysis of hospital uncompensated care spending and community benefit programs and expenditures was beyond the scope of this research project. However, a closer review of this data for Connecticut hospitals may yield additional insight on ways hospitals are rising to meet local community challenges and opportunities for additional work or partnership with public health and community advocates.

<sup>11</sup> [“Best States: Public Health Rankings.”](#) *U.S. News & World Report*.

<sup>12</sup> See Thompson, D. [“What on Earth Is Wrong with Connecticut?”](#), *The Atlantic* (July 5, 2017).

<sup>13</sup> State Health Assessment, p. 35. See also Connecticut Department of Public Health, [Statewide Healthcare Facilities and Services Plan, 2016 Supplement](#) (2017), p. 64 (stating that “[b]arriers to opportunities to live a healthy life may be disproportionately concentrated among certain population groups, including but not limited to racial and ethnic minorities, low-income populations, those with lower educational attainment and older adults. The influences of socioeconomic factors on health patterns and outcomes are often intertwined and demonstrably result in health disparities.”). (Hereinafter “Statewide Facilities Plan, 2016 Supplement.”)

<sup>14</sup> McNichol, E. [“How State Tax Policies Can Stop Increasing Inequality and Start Reducing It,”](#) *Center on Budget and Policy Priorities* (December 15, 2016).

<sup>15</sup> For example, 36.2 percent of New Haven’s population is black non-Hispanic, followed by 30.7 percent white non-Hispanic, 25.9 percent Hispanic, and 4.6 percent Asian non-Hispanic. The Hispanic population accounts for more than 40 percent of the population in Hartford and Bridgeport. See State Health Assessment, p. 27. At the same time, even Connecticut’s highest-income areas can have pockets of need and disparity. For example, Fairfield County continues to

experience deep pockets of poverty and inequality. See Krasselt, K. "[Fairfield County's Income Inequality Worst in Nation](#)," *CT Post* (February 1, 2017).

<sup>16</sup> State Health Assessment, p. 35, Figures 26 and 27.

<sup>17</sup> Connecticut Department of Public Health. [Statewide Healthcare Facilities and Services Plan – 2014 Supplement](#) (2014), p. 58, Figure 11. (Hereinafter "Statewide Healthcare Facilities Plan, 2014 Supplement.")

<sup>18</sup> *Ibid.*

<sup>19</sup> Older White adults, people with chronic conditions, and people living within close proximity to an acute care hospital were also at greater risk for preventable hospitalizations and ED visits. Statewide Healthcare Facilities Plan – 2014 Supplement, p. 64, Table 24. See also State Health Assessment, p. 37 (stating that "In 2011, black non-Hispanics appeared to experience greater hospitalization rates for all of the leading causes of hospitalizations compared to white non-Hispanics and Hispanics. The hospitalization rate for black non-Hispanics for heart disease was 37 percent higher than that for white non-Hispanics, and hospitalizations for mental disorders were 34 percent higher for black non-Hispanics relative to white-non-Hispanics.").

<sup>20</sup> Connecticut Department of Public Health. [Healthy CT 2020: State Health Improvement Plan Year Two Annual Report](#) (2016), p. 5 and Appendix B.

<sup>21</sup> State Healthcare Facilities Plan – 2016 Supplement, p. 68, Figure 4.1. The significant of low birth weight is that it may predispose babies to obesity and other chronic illnesses later in life. See "[Low Birthweight](#)," March of Dimes.

<sup>22</sup> State Health Assessment, p. 149, Figure 258.

<sup>23</sup> State Healthcare Facilities Plan – 2016 Update, p. 2 (citing Dalal, M., et al. "[Quantifying the Potential Benefits of Health Equity in Connecticut: Disparities in Hospital Charges and Costs among Blacks and Hispanics compared to Whites, 2005-2012](#)," Connecticut Department of Public Health, Community Health and Prevention Section).

<sup>24</sup> See Karpman, M., and Caswell, K. "[Past-Due Medical Debts among Non-elderly Adults, 2012-2015](#)," Urban Institute (March 2017); and \_\_\_\_\_, "[The Color of Debt: Credit Card Debt by Race and Ethnicity](#)," Demos.

<sup>25</sup> Institute for Healthcare Improvement, p. 9.

<sup>25</sup> Hospitals cannot count a program or activity as community benefit if it is primarily a marketing campaign; limited to hospital employees or affiliated physicians; is required as part of the regular compliance for all health care providers; or is unrelated to health or the hospital's mission. [IRS Revenue Ruling 69-545, p. 17](#). See also Catholic Health Association, "[About Community Benefit](#)."

<sup>26</sup> Connecticut's minority population has grown dramatically over the last 30 years, from 10 percent in 1980 to 32 percent in 2015. Today, 70 percent of Connecticut residents identify as white non-Hispanic. The remaining 30 percent break down as follows: 14.2 percent Hispanic, 9.4 percent black non-Hispanic, 4.1 percent Asian non-Hispanic, and 2.3 percent of another race or multi-racial background). See Nair, A. "[Connecticut State Innovation Model State Health Profile, Preliminary Findings Presented to the Population Health Council](#)," Connecticut Department of Public Health (September 22, 2016), Slide 4.

<sup>27</sup> Zuckerman, D. "[Hospitals As Anchor Institutions: Linking Community Health and Wealth](#)," Democracy Collaborative (February 28, 2013).

<sup>28</sup> IRS Schedule H [Instructions](#), Form 990 (2016). See also "[Community Benefit Categories and Definitions](#)," Catholic Health Association.

<sup>29</sup> Categories of spending are as follows: charity care/financial assistance; losses sustained from serving Medicaid beneficiaries and other means-tested government health programs; community health improvement programs; subsidized health services; health professions education; research; and community benefit operations. Hospitals may also claim cash and in-kind contributions they make to other organizations to carry out programs in these categories. Full definitions and examples for these categories can be found in the Schedule H Instructions. These numbers are reported at cost, not charges. See Schedule H Form 990 Instructions.

<sup>30</sup> See Miller, S. [Community Benefit and Nonprofit Hospitals: Full Remarks before the Office of the Attorney General of Texas; Charitable Hospitals: Modern Trends, Obligations, and Challenges](#), Internal Revenue Service Tax Exempt and Government Entities Division Commissioner Remarks (January 12, 2009).

<sup>31</sup> See [IRS Form 990, Schedule H](#).

<sup>32</sup> In this age of hyper-partisanship, it is worth noting that the community benefit requirements were initially championed by US Republican Senator Charles Grassley (R-IA), who was later joined by US Senator Jeff Bingaman (D-NM) in offering the text that became Section 9007 of the ACA.

<sup>33</sup> Internal Revenue Service, [Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return](#) (December 31, 2014).



<sup>34</sup> Note that many hospital systems file a joint Schedule H, so the financial information they report is aggregated across their facilities. By contrast, Schedule H requires hospitals to file facility-specific information about their financial assistance and emergency care policies, charging and debt collection practices, and CHNAs.

<sup>35</sup> See Section 9007 of the [Patient Protection and Affordable Care Act](#) and 26 Code Fed Regs. § 53-4959-1.

<sup>36</sup> The first case of a hospital losing its tax-exempt status for failure to comply occurred earlier this year, in 2017. The hospital in question was a dual status hospital that had failed to complete a community health needs assessment. See Wyland, M., "[Hospital Loses Tax Exemption for Noncompliance with ACA](#)," *Nonprofit Quarterly* (August 18, 2017).

<sup>37</sup> See Preamble, "[Additional Rules for Charitable Hospitals](#)."

<sup>38</sup> *Ibid.*

<sup>39</sup> See IRS Form 990, Schedule H Instructions, p. 17.

<sup>40</sup> These include improving access to health services; enhancing public health; advancing increased general knowledge; or relieving or reducing either government burden or other community efforts. Examples include programs that support core public health functions, like immunizations and emergency preparedness; that reduce geographic, financial, or cultural barriers to accessing health services; and that address "public health priorities such as eliminating disparities in access to health care services or disparities in health status among different populations." See IRS Form 990, Schedule H Instructions, p. 17.

<sup>41</sup> Under the federal rules, non-profit hospitals determine how they define their "community served" for purposes of the CHNA, and they can apply all facts and circumstances—with one critical exception. To prevent hospitals from cherry-picking and, arguably, to encourage hospitals to target their community benefit investments to higher-need communities, the rules prohibit hospitals from defining their communities in ways that exclude low-income, minority, and medically underserved residents living in their geographic service areas. This definition includes uninsured patients and patients who rely on the hospital's financial assistance policy to cover the cost of their care. 26 Code Fed. Reg. § 1.501(r)-3(b)(3).

<sup>42</sup> *Ibid.*

<sup>43</sup> 26 Code Fed. Reg. § 1.501(r)-3(b)(5).

<sup>44</sup> 26 Code Fed. Reg. § 1.501(r)-3(b)(4). Examples of the kinds of factors a hospital may consider in its decision are the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.

<sup>45</sup> 26 Code Fed. Reg. § 1.501(r)-3(b)(6)(i)(F).

<sup>46</sup> 26 Code Fed. Reg. § 1.501(r)-3(b)(6)-(7). See also Catholic Health Association, "[Summary of Community Health Needs Assessment and Implementation Strategy Requirements](#)," (January 2015) (summarizing the final rules on community health needs assessments).

<sup>47</sup> 26 Code Fed. Reg. § 1.501(r)-3(c).

<sup>48</sup> *Ibid.* The hospital board may also authorize another body to sign off on the implementation strategy.

<sup>49</sup> Conn. Gen. Stat. § 19a-127k et seq. See also Lembo, K. [Hospital and Managed Care Organization Community Benefit Report, 2007-2008 Biennium](#), State of Connecticut Office of the Healthcare Advocate (August 18, 2009), p. 4 (stating that "The statutory structure of CT Public Act 08-184 makes the establishment of a 'community benefits program' voluntary. A voluntary community benefits program must operate within guidelines that are established under subsection (c) of § 19a-127k. This provision essentially states that an entity with a community benefits program that does not have corresponding guidelines governing it, is not obligated to report on its program." (Hereinafter "OHA 2007-2008 Biennium Report."))

<sup>50</sup> Conn. Gen. Stat. § 19a-127k(a)(1).

<sup>51</sup> Conn. Gen. Stat. § 19a-509b(f).

<sup>52</sup> All Connecticut hospitals—not just tax-exempt hospitals—must file their policies on charity care, reduced cost services, and debt collection practices annually with the Office of the Healthcare Advocate and include information about the number of applicants and recipients who received financial assistance in a given year. See Conn. Gen. Stat. § 19a-649 (regarding uncompensated care); Conn. Regs. § 19a-643-206. Current filings and examples of hospital annual reports can be found at OHCA's [website](#), with information on each hospital's audited financials, charity care and hospital bed funds broken down by hospital.

<sup>53</sup> Conn. Gen. Stat. § 19a-127k.

<sup>54</sup> See 26 Code Fed. Reg. § 1.501(r)-3(b).

<sup>55</sup> Nationally, it may still be too early to tell whether the new federal requirements have prompted hospitals to realign their community benefit spending to address health equity. Most of the available reporting data is based on Fiscal

Years 2011 and 2012, when final rules had not been issued. The most recent 990H data is based on FY2014. For example, while private tax-exempt hospitals spent an average of 7.5 percent of their annual expenses on community benefit for FY2009, there was a twenty-point spending gap between hospitals in the top and bottom deciles. Young G., et al. "[Provision of Community Benefits by Tax-exempt US Hospitals.](#)" *New England Journal of Medicine* (2013). 368(16):1519–1527.

<sup>56</sup> Ibid.

<sup>57</sup> Internal Revenue Service, Department of the Treasury. "[Report to Congress on Private Tax-exempt, Taxable, and Government-Owned Hospitals.](#)" (January 2015).

<sup>58</sup> While rationales driving hospital community benefit investments will remain unclear without further study, one early analysis found that hospitals serving communities with lower socioeconomic status and greater health needs tended to invest more in access programs aimed at connecting patients to clinical care, such as financial assistance and Medicaid shortfall, than did hospitals that served better-resourced communities. At the same time, these hospitals spent about the same as other hospitals on community health improvement services, even though their communities experienced a higher level of demand for such services. The study concluded that: "[H]ospitals appear more inclined to respond financially to the health needs of their community when these needs can be met primarily by providing clinical care services within the confines of the hospital itself." Singh, S., et al. "[Analysis of Hospital Community Benefit Expenditures' Alignment with Community Health Needs: Evidence from a National Investigation of Tax-Exempt Hospitals.](#)" *American Journal of Public Health*, (May 2015).

<sup>59</sup> See OHA 2007-2008 Biennium report, p. 4; see also Lembo, K., [Office of the Healthcare Advocate 2009 Annual Report](#), Department of Public Health Office of the Healthcare Advocate (2009), p. 11.

<sup>60</sup> Federally, Schedule H requires hospitals to separate out bad debt and charity care in their reporting. (While hospitals write off both types of patient accounts, only charity care—forgiven debt for patients deemed unable to pay—is included as community benefit. Bad debt can lead to serious financial consequences for low- and moderate-income patients, and the IRS has expressly prohibited hospitals from reporting it as community benefit. IRS Form 990, Schedule H Instructions, pp. 2-3.) But Connecticut's hospital financial reporting requirements allow hospitals to include both amounts in one lump sum as uncompensated care. See, e.g., "[Connecticut Acute Care Hospital Uncompensated Care Trend Analysis FY 2012-FY 2014.](#)" Office of Health Care Access (reporting a combined uncompensated care number for all hospitals).

<sup>61</sup> \_\_\_\_\_. "[Statewide Financial Assistance, Certain Other Community Benefits and Community Building Activities at Hospitals in Connecticut.](#)" Department of Public Health Office of Health Care Access (comparing selected community benefit spending data for private tax-exempt hospitals from FY2012 and FY2013).

<sup>62</sup> It is critical to note that the data supplied by the Connecticut Hospital Association includes two categories of spending that are not community benefit under federal rules: Medicare shortfall and bad debt. Removing these categories from the chart results in significantly less money attributed to community benefit. See Connecticut Hospital Association, "[Connecticut Hospitals by the Numbers.](#)" (Accessed September 2017); see also "[Statewide Hospital Expense Data Fiscal Years 2011-2014, Connecticut's Acute Care Hospitals.](#)" (Accessed September 2017).

<sup>63</sup> See Connecticut Office of the Healthcare Advocate, "[2007-2008 Connecticut Community Health Benefits Report, Appendix II.](#)" (Accessed September 2017); see also Connecticut Department of Public Health, [Statewide Healthcare Facilities and Services Plan – 2014 Supplement](#) (February 2015), pp. 78-79.

<sup>64</sup> Some health assessments also identified the social determinants of health, including community socioeconomic disadvantage, housing conditions (e.g., lead exposure) and social cohesion and integration as priority health concerns. Connecticut Department of Public Health, [State Health Care Facilities and Services Plan – 2016 Supplement](#), (August 2017), p. 98.

<sup>65</sup> Lee, J., and Korba, C. [Social Determinants of Health: How Are Hospitals and Health Systems Investing in and Addressing Social Needs?](#) Deloitte Center for Health Solutions. See also Singh, et al.

<sup>66</sup> Ibid, p. 13.

<sup>67</sup> See Daly, R. "[Amid Criticism, Hospitals Fund Social Determinants Spending.](#)" Healthcare Financial Management Association (July 26, 2017).

<sup>68</sup> Rosenbaum, S. "[Hospital Community Benefit Spending: Leaning In on the Social Determinants of Health.](#)" *Milbank Quarterly*, Op-Ed (June 2016).

<sup>69</sup> See Mays, G., et al. "[Preventable Death Rates Fell Where Communities Expanded Population Health Activities through Multisector Networks.](#)" *Health Affairs* (November 2016).

<sup>70</sup> Many of these recommendations, which were developed separately based on reviews of other state policies and procedures, echo those made by the Office of the Healthcare Advocate in the 2007-2008 Biennium Report.

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<sup>71</sup> See OHA 2007-2008 Biennium Report, p. 13.

<sup>72</sup> See Kaiser Family Foundation, "[Hospitals by Ownership Type](#)," (accessed September 2017) (breaking down hospitals by privately owned tax-exempt hospitals, for-profit, and publicly owned hospitals).

<sup>73</sup> See discussion in Garcia, R. "[Three CT Hospitals Get Greenlight to Go For-Profit](#)," Universal Health Care Foundation of Connecticut Health Care Hub Blog (July 27, 2016). See also Conn. Gen. Stat. § 19a-486 et seq. (regarding Attorney General role in hospital conversions) and Conn. Gen. Stat. § 19a-613 and Conn. Regs. § 19a-638-1 et seq. (regarding Office of Health Care Access role in Certificate of Need).

<sup>74</sup> See The Hilltop Institute, "[Community Benefit State Law Profiles Comparison](#)" (comparing state community benefit laws across several policy measures, including enforcement and scope).

<sup>75</sup> Ibid.

<sup>76</sup> See The Hilltop Institute, "[Rhode Island](#)," *State Community Benefit Profiles*.

<sup>77</sup> See The Hilltop Institute, "[Massachusetts](#)," *State Community Benefit Profiles*; also see Massachusetts Office of the Attorney General, "[Community Benefits Provided by Nonprofit Hospitals and HMOs](#)," (searchable public website that includes community benefit reporting requirements, voluntary guidelines, and reports from regulated entities). The Attorney General is in the process of revising the community benefit guidelines. "[AG Healey Convenes Health Care Experts for Advisory Task Force on Hospital, HMO Community Benefits Guidelines](#)," Press Release, Office of Massachusetts Attorney General Maura Healey (April 19, 2017).

<sup>78</sup> Conn. Gen. Stat. §19a-127k(a)(1).

<sup>79</sup> See OHA 2007-2008 Biennium Report, p.13.

<sup>80</sup> Ibid.

<sup>81</sup> State Health Assessment, p. 2.

<sup>82</sup> Ibid.

<sup>83</sup> Garcia, R. "[Create an Office of Health Strategy - The Time Has Come](#)," Universal Health Care Foundation of Connecticut Health Care Hub Blog (April 12, 2017).

<sup>84</sup> "[An Act Establishing the Office of Health Strategy and Improving the Certificate of Need Program](#)," Substitute for Governor's S.B. No. 795 (Session Year 2017).

<sup>85</sup> Deloitte report.

<sup>86</sup> Statewide Healthcare Facilities Plan 2014 Supplement, pp. 50 et seq.

<sup>87</sup> Carlson, B. [Partnering with Accountable Care Organizations for Population Health Improvement](#), Centers for Disease Control and Prevention (June 2015).

<sup>88</sup> See, e.g., Taylor, L. et al. "[Leveraging the Social Determinants of Health: What Works?](#)," PLOS ONE (2016) (calling for additional research to develop a comprehensive understanding of which social interventions impact health outcomes and to explore alternative methods of investing financial resources in social services).

<sup>89</sup> This includes creating greater synergy between public health and hospital assessment processes. \_\_\_\_\_, "[Community-Based Health Needs Assessment Activities: Opportunities for Collaboration Between Public Health Departments and Rural Hospitals](#)," ASTHO (2017).

<sup>90</sup> [Health Equity Index](#), Connecticut Association of Health Directors.

<sup>91</sup> Conn. Gen. Stat. § 19a-649(c).

<sup>92</sup> "Communities may be able to obtain their hospitals' implementation strategies by getting copies of attachments to Schedule H, but that places a high burden on communities, who often lack the means to secure, search, and understand Schedule H information. Posting the implementation strategy and thereby making it widely available would seem to be a logical extension of the effort to ensure greater transparency in hospital responsiveness to communities." Rosenbaum, S. "[Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement](#)," Economic Studies at Brookings (March 2016).

<sup>93</sup> Conn. Gen. Stat. §19a-127k(d).

<sup>94</sup> Conn. Gen. Stat. §19a-649.

<sup>95</sup> Conn. Gen. Stat. §19a-127k(e).

<sup>96</sup> [Connecticut Acute Care Hospital Financial Data](#) and [FY 2012-2013 Community Benefit Dashboard](#), Department of Public Health, Office of Health Care Access.

<sup>97</sup> The Connecticut Hospital Association routinely issues reports that include bad debt and Medicare shortfall as community benefit. These two categories are excluded from the federal community benefit reporting structure. See, e.g., "[Community Health](#)," Connecticut Hospital Association.

<sup>98</sup> California Office of Statewide Health Planning and Development, "[Healthcare Financial Assistance Policies and Application Forms for California Hospitals](#)."

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<sup>99</sup> Davis, R., and Gervin, D. "[CDC Evaluation Coffee Break: Evaluating Health Equity](#)," Centers for Disease Control and Prevention Presentation, June 2015.

<sup>100</sup> Ibid.

<sup>101</sup> Ibid.

<sup>102</sup> See, for example, the National Prevention Strategy, highlighting the need to Focus on communities at greatest risk. Hall, M., et al. "[Policy Approaches to Advancing Health Equity](#)," *Journal of Public Health Management Practice* (2015). Also, the federal Office of Minority Health's National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care emphasize direct engagement and feedback loops with the community. Like, R. "[Engaging the Community to Eliminate Disparities in Health and Health Care](#)," *Hospitals & Health Networks* (February 27, 2014).

<sup>103</sup> [Community Engagement Plan, 2016-2019](#). Minnesota Department of Public Health.

<sup>104</sup> Ibid.

<sup>105</sup> [Community Engagement Standards for Community Health Planning Guidelines](#), Massachusetts Department of Public Health (January 2017).

<sup>106</sup> Ibid.

<sup>107</sup> Ibid.

<sup>108</sup> Ibid.

<sup>109</sup> Ibid. This is a higher threshold for community engagement than what is specified in the state's voluntary community benefit guidelines. As of this writing, the Massachusetts Attorney General is revisiting those guidelines to better align them with the DPH process and recommendations.

<sup>110</sup> "[An Act Concerning Community Benefit Plans](#)," Proposed Bill No. 117, Connecticut General Assembly (January 2017 Session).

<sup>111</sup> [https://www.cga.ct.gov/2017/phdata/tmy/2017SB-00117-R000307-Universal\\_percent20Healthcare\\_percent20Foundation\\_percent20of\\_percent20Connecticut\\_percent20-TMY.PDF](https://www.cga.ct.gov/2017/phdata/tmy/2017SB-00117-R000307-Universal_percent20Healthcare_percent20Foundation_percent20of_percent20Connecticut_percent20-TMY.PDF)

<sup>112</sup> The DON Health Priorities are six common social determinants of health: 1) Social Environment 2) Built Environment 3) Housing 4) Violence and Trauma 5) Employment 6) Education. Current EOHHS/DPH Focus Issues Statewide trends and overall burden of morbidity and mortality point to: 1) Substance use disorders (SUDs) 2) Housing Stability/Homelessness 3) Mental illness and mental health 4) Chronic disease with a focus on Cancer, Heart Disease and Diabetes. [Determination of Need Community-Based Health Initiative Guideline](#), Massachusetts Department of Public Health (January 2017).

<sup>113</sup> The DON regulations cap an applicant's maximum contribution at a percentage of the value of the underlying project (5 percent for most). They also require hospitals to divide these funds between local community-based health improvement initiatives, which receive the bulk of the funding, and a state pool. A state advisory board is being established to guide investments from the statewide pool.

<sup>114</sup> Karpman, M., "Past-Due Medical Debts."

<sup>115</sup> Bosco, J., et al. [Model Medical Debt Protection Act](#), National Consumer Law Center (August 2017).

<sup>116</sup> See McCarthy, D., et al. "[If All Health Care Is Local, What Does It Take to Improve?](#)" The Commonwealth Fund Blog (July 27, 2017); and Trocchio, J., and Curtis, J. "[Community Benefit: Hallmarks for Assessing a Solid Program](#)," *Journal of the Catholic Health Association of the United States* (May-June 2012).

<sup>117</sup> Garret, D., et al. "[Medicaid ACO Checklist for Advocates](#)," Community Catalyst (April 2017).

<sup>118</sup> \_\_\_\_\_. "[Hospital Financial Assistance Policies: A Quick Reference Guide](#)," Community Catalyst.

<sup>119</sup> Braveman, P. et al. [What Is Health Equity? And What Difference Does a Definition Make?](#), Robert Wood Johnson Foundation Report (May 2017).