

Hospitals Investing in Health: Community Benefit in Massachusetts

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*Report authored by
Enid Eckstein, EMHL
Paul A. Hattis, MD, JD, MPH*

COMMUNITY CATALYST



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FOREWORD

In Massachusetts and across the nation, we now understand that good health requires more than health care. Each day brings greater recognition of the impact that social and economic determinants such as housing, employment, and education have on the health of our communities. As we increasingly focus on addressing the factors that influence health, an immediate question is how can our hospitals help?

To answer that question, we must first consider the millions of dollars that Massachusetts tax-exempt hospitals already distribute to address community health needs. Those contributions result from hospitals' community benefit obligations to maintain tax-exempt status, as part of the community health initiatives required by the state's determination of need process, or as payments provided to municipalities in lieu of taxes. They represent a vital resource for community health, and Massachusetts' history of leadership on issues related to hospital community benefits has given us a unique resource in the robust information available to the public from the attorney general's reporting system. The data from those reports provides an important window into hospital contributions' potential impact on community health. Ensuring that the data paints a complete and accurate picture of hospital contributions is essential to tracking progress and impact across the Commonwealth.

Hospitals Investing in Health: Community Benefit in Massachusetts serves as a catalyst for broader conversations in Massachusetts about how to ensure that hospital contributions are leveraged for greatest community health impact. It examines hospital community benefit spending, the determination of need program, and the payments in lieu of taxes that are important investments in community health. The report's findings, recommendations, and conclusions are the product of thorough review of data and conversations with public officials, health care experts, and community leaders. The report concludes there is more at stake than simply tracking the amounts contributed by hospitals. Those investments, as part of a larger obligation to the community, demand greater coordination in their oversight and utilization, require regular evaluation to understand their value and impact, and include an obligation for greater transparency and community engagement so residents reap appropriate returns from the tax exemption afforded to Massachusetts hospitals.

Hospital community benefits are in the DNA of Community Catalyst. We have promoted their importance since our inception in 1998, and we have supported community groups in multiple states as they have engaged their local hospitals in deeper collaboration. As a national organization, we see that the implications of this report go beyond the boundaries of Massachusetts. We hope it will be as a catalyst for change here in Massachusetts, in other states, and in Washington D.C. Accordingly, Community Catalyst and several local organizations—the Massachusetts Public Health Association, the Center for Community Health Education Research and Service, the Massachusetts Communities Action Network, the Dudley Street Neighborhood Initiative, the Chinese Progressive Association, Health Law Advocates, and Health Care For All—endorse the report's recommendations.



We believe this report fills an important knowledge gap by providing a consumer perspective on the current state of hospital contributions to community health. Our organizations, and the communities we represent, have a direct stake in how these resources are allocated and overseen. We stand ready to engage with leaders and communities across the Commonwealth in the review and revision of the determination of need regulations and the attorney general's voluntary community benefit guidelines. Those programs, as drivers of hospital investment in community health, are the starting point for ensuring that our hospitals partner with the communities they serve and use their vast influence—as neighbors, employers, purchasers, and care providers—to address health and economic well-being.

EXECUTIVE SUMMARY

In 1994, Massachusetts became an early leader in state accountability when it established voluntary guidelines for the provision of hospital community benefits. The attorney general's guidelines asked hospitals to report their resource commitments and to provide a summary of their community benefit activities. Subsequent enhancements of the guidelines in 2002 and 2009 placed greater emphasis on planning, through the development of formal needs assessment processes, active community engagement, and increased transparency. Federal oversight has also become more robust with the enactment of the Patient Protection and Affordable Care Act. Newly revised rules for hospital community benefits were issued by the IRS in 2014, and they have created renewed attention and thinking about the role community benefit spending can play in community health improvement.

There has been greater recognition that social factors and inequities play an important role in affecting health status. Across the country hospitals are moving outside their walls to join efforts that address the social and economic conditions in their communities. A changing reimbursement system is creating incentives for hospitals to address the underlying factors that impact the health of their communities, including nonmedical determinants of health. Today the “triple aim”—to improve population health, enhance quality of care, and implement overall system cost reduction—is a common goal among health care providers and those who work in the field of public health.

Massachusetts hospitals spend millions annually on community benefits, yet there is little formal analysis or evaluation of the effectiveness of those investments or whether they provide meaningful benefits to the communities they serve. This report provides an overview of the current Massachusetts hospital landscape through the lens of the attorney general's accountability framework for community benefits, the Massachusetts Department of Public Health's determination of need process, and some aspects of local payment in lieu of taxes programs—with Boston as our most detailed example. Overall, we find an often fragmented and distant oversight approach, which can encourage wasteful duplication of efforts and results in lack of coordination and alignment among hospitals' community health improvement efforts. There are also few metrics to determine whether programs are dedicating a sufficient level of resources to those efforts or have adopted effective approaches to addressing underlying community health needs.

Community benefit spending by most Massachusetts hospitals has not changed significantly since Massachusetts's health care reform was enacted in 2006. The report also finds community benefit contributions statewide to be uneven across hospitals. A significant number of hospitals spend considerably less than the targeted 3 percent of total patient expenses recommended by the attorney general's guidelines. Some hospitals provide little investment in community health initiatives, even though they have significant resources. Despite the expectations of community engagement, there are a limited number of efforts featuring the types of hospital community partnerships that create sustained transformative change in population health and long-term changes in communities.

This report is particularly timely in that the Massachusetts attorney general and the Massachusetts Department of Public Health have decided to re-examine and amend the community benefit guidelines and determination of need regulations, which serve as the critical oversight framework for hospital performance and accountability. Municipalities continue to struggle to balance their budgets

and will likely seek sustained commitments from their local tax-exempt hospitals. An important goal of this report is to stimulate the thinking of the health care community, policymakers, community organizations, and activists about this unprecedented opportunity for strategic cooperation in utilizing the community benefit paradigm to address population health. Another goal of this report is to assist community members, who are key stakeholders of community benefit processes and partners in population health improvement efforts, as they examine the contributions and activities undertaken by hospitals.

We hope this report will lead to a dialogue on how communities and hospitals can better partner with each other to make meaningful investments aimed at addressing long-term inequities. Those partnerships should work to improve population health outcomes and get the “biggest bang” at whatever level of resources a tax-exempt hospital can commit. We also hope this report is useful in exploring whether the current structure of hospital-supported health improvement efforts is strategically designed to effectively address community health needs and inequities. From an accountability perspective, we are heartened that this report’s publication is occurring at a time when both the state attorney general and the Department of Public Health have indicated strong interest in improving the effective government oversight of their respective community benefit programs and the community health improvement projects supported by the determination of need process.

With an eye toward these aims, this report makes recommendations in five areas. The recommendations address the future direction of how the Commonwealth oversees hospital community benefits and the need for coordination with the determination of need process. They also highlight the need for greater evaluation of community health improvement activities to ensure they can generate positive population health outcomes.

INTRODUCTION

With the nation and the Commonwealth confronting increasing economic inequality, awareness is growing that the social determinants of health and equity drive health care outcomes.¹ These determinants include the conditions in which people are born, grow, live, work, and age—conditions that are shaped by the distribution of money, power, and resources at the global, national, and local levels, and that are themselves influenced by policy choices.² Life expectancy and other key outcomes vary greatly by race, gender, geography, and socioeconomic status.

Overwhelming evidence from the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, and other sources suggests that social, economic, and environmental factors are more significant predictors of health than access to care. The County Health Rankings, published annually by the Robert Wood Johnson Foundation and the University of Wisconsin's Population Health Institute found that 40 percent of the factors contributing to length and quality of life are social and economic.³ These are followed by health behaviors (30 percent), clinical care (20 percent), and the physical environment (10 percent).⁴ Identification of differences in health outcomes and key determinants is a critical first step toward reducing inequalities between populations. Disparities in health care access and quality also result in increased health care costs.⁵ According to a 2009 study by the Joint Center for Political and Economic Studies, eliminating health care disparities for minorities from 2003 to 2006 would have reduced direct medical expenditures by \$229.4 billion and indirect costs associated with illness and premature death by approximately \$1 trillion.⁶

The challenges are great. Forty-five million Americans live in poverty, between 700,000 and 800,000 people in Massachusetts among them.⁷ In 2011, Massachusetts had the fourth-highest measured income inequality among states, following only Connecticut, New York, and Florida.⁸ The Brookings Institution, in its ranking of cities with the greatest gap between the top 1 percent and the bottom 99 percent, ranked Boston fourth in the nation in 2013 and third in 2014;⁹ in 2016, Boston has the distinction of being the city with the greatest income inequality in the nation.¹⁰

Ever since 1989, when the pioneering Hospital Community Benefit Standards Program, developed at New York University,¹¹ redefined “community benefit standards” for hospitals to include an *affirmative obligation to take on a broader responsibility for population health at a community level, including addressing societal inequities*, policy experts and stakeholders have been struggling with how best to effectuate an accountability scheme that incorporates these goals and expectations. That policy discussion recently found its reflection nationally in a part of the Patient Protection and Affordable Care Act (ACA) that revised some requirements for the grant of federal tax-exempt status to non-profit hospitals. To claim tax-exempt status, a hospital must provide community benefit work that is transparent, concrete, and measurable. It must be both responsive and accountable to identified community needs.¹² Recently promulgated IRS guidelines clarify the ACA's expectations for greater community engagement by hospitals to address population health needs. These new rules recognize that community benefits are more than charity care; they also include the need to “prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”¹³ Hospitals can use community benefit dollars to address “upstream” factors of health. How states and localities alter their own community benefit requirements in

response to these new rules remains to be seen, but the rules provide a policy lens through which to evaluate the Massachusetts system.

For both our nation and our state, struggles with rising health care costs, as well as the goals of improving quality and outcomes, have resulted in a shift away from a hospital-centric view of health care toward one that places a greater emphasis on community and population-based care. The call by the federal Centers for Medicare and Medicaid (CMS) for a triple aim—to improve population health, enhance quality of care, and implement overall system cost reduction—is driving change. Nonetheless, in our state especially, hospital systems continue to play essential roles, working with their clinical partners in managing the health of (and spending for) covered populations. Success in this population health management paradigm will likely depend upon providers working hard to create and sustain meaningful partnerships with community groups and other local stakeholders.

Fortunately, Massachusetts has long been a national leader in health reform. The state was the first to establish guidelines for the provision of community benefits by hospitals, in 1994, and 12 years later it led the way in expanding health insurance coverage through the passage of Chapter 58. Subsequent passage of the ACA, with its strong emphasis on public health and community benefits, took further steps toward a new paradigm for hospitals—in a reformed system aimed not just at delivering health care but at improving health for all. The changes brought by health care reform, both in Massachusetts and nationally, along with the growing awareness that unmet health needs still plague far too many, require that we reassess the effectiveness of the hospital community benefit paradigm and explore its continuing potential as a key component of health care reform.

This report is timely in that the Massachusetts Office of the Attorney General and the Massachusetts Department of Public Health have indicated an interest in re-examining their oversight structures for hospital performance and accountability tied to their respective community benefit and determination of need programs. An important goal of this report is to stimulate the thinking of the health care community, policymakers, community organizations, and activists about this unprecedented opportunity for strategic cooperation as a means to utilize the community benefit paradigm to address population health.

To that end, this report explores the current state of Massachusetts hospital community benefit programs. We hope that the report will stimulate a statewide dialogue on community benefit processes and their intersection with other investments for improving population health as a means to focus on how communities and hospitals can better partner with each other. These partnerships can work to improve population health outcomes and get the “biggest bang” for whatever level of resources an exempt hospital can commit. Accordingly, this report poses questions as to whether the current structure of these programs adequately addresses community health care needs and inequities. Finally, the report makes recommendations regarding the future direction of the Commonwealth’s oversight of hospital community benefit efforts and some parallel issues tied to the determination of need process, as well as offering suggestions aimed at improving the overall evaluation process for community health improvement activities and their link to population health outcomes.

I. THE HISTORY OF COMMUNITY BENEFIT REGULATION

Both federal and state regulation of the tax exemption of hospitals have a long history. Starting in 1894, the federal government required that for hospitals to receive an exemption from taxes, they had to provide free or reduced care to patients who were unable to pay.¹⁴ In 1956 an IRS ruling stipulated that tax-exempt hospitals “organized and operated exclusively for non-profit charitable purposes, must provide some amount of free or charity care, to the extent of their financial ability.”¹⁵ In 1969 the IRS shifted its focus from charity care to community benefits, requiring hospitals to “promote the health of persons broadly enough to benefit the community.”¹⁶ In theory, this created the possibility for hospitals to move from a strict hospital-centered and health-care-driven definition toward activities that could be considered of broader benefit to the community, such as support for community services, education, training, and research. However, the lack of clarity and accountability of the federal community benefit standards led a number of states to take action around hospital tax exemption.

In Massachusetts, a series of *Boston Globe* articles in the early 1990s brought attention to the relationship of hospitals to their communities. In May 1993, a report commissioned by the Boston Department of Health and Boston City Hospital, “Report on the Financial Resources of Major Hospitals in Boston,”¹⁷ sparked a broad discussion on the obligations of non-profit hospitals. Public reaction to the report led to a call for greater accountability and transparency in hospital operations. In response, the Massachusetts attorney general created a Community Benefit Task Force and in 1994 promulgated voluntary guidelines, which itemized specific community benefits and established reporting requirements for hospitals. It is important to note that the Massachusetts guidelines, unlike those of some other states, continue to be voluntary; while they set forth a number of expectations (including expenditure targets that are discussed in detail in the next section), hospitals are not legally required to adhere to those guidelines.

In 1996, hospitals filed their first reports with the attorney general’s office. In those initial years after guideline promulgation, the attorney general’s office did not generate any comprehensive or summary analysis of the submissions, nor did it rule on the adequacy of the reports.^{18 19} The guidelines were updated in 2002 with more specific requirements, including development of a Community Health Needs Assessment (CHNA) and a mandate that hospitals conduct these CHNAs while working with community groups in order to build partnerships between hospitals and communities. The new regulations required tax-exempt hospitals to report on their organizational leadership, community health needs assessment, target population, community involvement, community benefit plans, programs, and community benefit expenditures including charity care. The reporting form also included an optional section that allowed hospitals to report community services programs and charitable activities that could not be counted as community benefit programs. These changes were designed to create greater transparency and to enable the public and the hospitals to compare what all the reporting hospitals were doing. One development included the public posting of community benefit reports and summaries on a new attorney general’s website.²⁰

At the federal level, in 2004 and 2006 the U.S. Senate Finance Committee held hearings to investigate whether the nation’s tax-exempt hospitals were properly accounting for their charitable activities. The committee, chaired by Senator Charles Grassley (Iowa-R), questioned whether tax-

exempt hospitals deserved the billions of dollars in tax breaks they received from federal, state, and local governments; the amount was estimated to be \$12 billion in 2004.²¹ Senator Grassley's committee called upon the IRS to develop a supplemental reporting form to require more uniform reporting. Following the hearings, the Government Accounting Office concluded that "non-profit hospitals may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for proving benefit commensurate with their tax exempt status."²² The report and the Senate hearings led to redesign of the IRS reporting process and to the adoption of Schedule H.²³ The Schedule H "community benefit" definition encompasses not only hospital-based care, training, and research but also "community health improvement" activities provided by a hospital to community entities.

While Congress and the administration focused on Schedule H and the community benefit obligation of tax-exempt hospitals, the Massachusetts attorney general convened a new task force to review community benefit reporting requirements. The task force revised the voluntary guidelines, with the revised guidelines taking effect on October 1, 2009. These were designed to increase accountability, to encourage stronger community engagement during all phases of community benefit planning (not simply reporting), and to better align hospitals' and health management organizations' community benefit activities with the State Health Improvement Plan (SHIP).²⁴ (See Appendix C for a comparison of IRS 990 and Massachusetts reporting guidelines.)

The 2009 guidelines also called for hospitals to develop a mission statement and an implementation plan with short-term and long-term goals to address the improvement of health indicators. They required hospitals to target benefits not only to their own patients but also to the unmet health needs of disadvantaged populations from communities that they serve. Under the guidelines hospitals could count as "community benefit" only those activities that address the needs of their target population.

Perhaps the most notable requirement was the refinement of the triennial Community Health Needs Assessment, which mandated "regular involvement of the community, including planning and implementation of the plan."²⁵

The Affordable Care Act of 2010 created new federal community benefit obligations for tax-exempt hospitals in terms of both financial assistance and community needs assessments. Under the ACA, community benefit expenditures were defined as:

- Financial assistance to those eligible under the hospital's policy
- Expenditures connected with the Medicaid participation of hospitals that receive less than the reasonable cost of care
- Health professions education and health research
- Expenditures on community health improvement including community-building activities such as economic development, mentoring programs, creating employment opportunities, coalition building, workforce development, leadership development and training for community members, and community-based environmental improvements.

In the words of Sara Rosenbaum of the George Washington University: “Hospitals are being held to new standards (and) are expected to bring a greater focus to population health in the communities they serve.”²⁶

In December 2014, the IRS issued a set of final rules on hospital community benefits. These regulations affect all tax-exempt and government-operated hospitals, which make up more than 80 percent of U.S. hospitals.²⁷ The rules state that:

- The CHNA report must include an evaluation of the impact of any actions taken to address significant needs identified in the hospital’s most recent CHNA.
- The health needs that a hospital may consider in its report include not only access to care but also prevention of illness, adequate nutrition, and the addressing of social, behavioral, and environmental factors that influence health in the community.

II. OVERALL COMMUNITY BENEFIT SPENDING IN MASSACHUSETTS

In evaluating hospital community benefits in Massachusetts, it is useful to understand both how much is being spent and what it is being spent on. The current study examines overall community benefit spending by Massachusetts’s hospitals, including charity care, for the fiscal years (FY) 2008 through 2015. The analysis relies on data from hospitals’ annual reports to the attorney general.²⁸ The attorney general defines “community benefit expenditures” as: direct and associated community benefit expenditures, determination of need expenditures, corporate sponsorships, employee voluntarism, and charity care. The hospitals’ annual reports are available on the attorney general’s website and include a breakdown of spending, in predetermined categories, for all Massachusetts acute care hospitals—for-profit and tax-exempt—that report to the attorney general. Excluded from this data are psychiatric and rehabilitation hospitals, the Shriners Hospital (which did not report during those years), and Cambridge Health Alliance and Boston Medical Center, neither of which reported during this period.²⁹

For FY 2015, Massachusetts acute care hospitals reported spending an estimated \$570 million on community benefits. This represents a decrease from FY 2014, when the same hospitals reported an estimated aggregate \$626 million in community benefit spending;³⁰ the drop resulted primarily from reduced spending on charity care. There was also wide variation among hospitals with respect to total community benefit spending. It is important to note that although some states mandate a specific minimum amount of community benefit spending (as indicated in Appendix E), the Massachusetts attorney general’s guidelines do not stipulate a specific dollar amount. However, since their initial promulgation in 1994,³¹ the guidelines have suggested a target spending threshold for hospitals to consider. Hospitals with audited total patient care expenses (TPE) under \$200 million have a target of “up to” 3 percent of TPE on community benefits, while hospitals with audited TPE over \$200 million have a suggested target level of between 3 percent and 6 percent of such expenses.³² The attorney general’s guidelines stress that these are only target levels and there is flexibility based on financial circumstances.

TABLE 1

FY 2015 Total Tax-Exempt Massachusetts Hospital Community Benefit Spending as a Percentage of Total Patient Expenses

HOSPITAL ANNUAL TOTAL PATIENT EXPENSES (TPE)	NUMBER OF HOSPITALS SPENDING <3% TPE FOR COMMUNITY BENEFITS	NUMBER OF HOSPITALS SPENDING >3% TPE FOR COMMUNITY BENEFITS
Less than \$200 million	20	4
More than \$200 million	14	10

Source: Analysis of data from Massachusetts attorney general's website:
http://www.cbsys.ago.state.ma.us/cbpublic/public/hccdownloadreportdatanew.aspx?report_year=2015.

In FY 2015, only about 17 percent of all reporting tax-exempt hospitals with under \$200 million in annual TPE met the suggested 3 percent threshold (Table 1). Even 58 percent of all the tax-exempt hospitals with *over* \$200 million in annual TPE fell short of the 3 percent mark. Twenty-one tax-exempt hospitals spent 2 percent or less of TPE on community benefits in FY 2015. Eight hospitals reported spending over 4 percent of their TPE on community benefits. Two hospitals, Holyoke Medical Center and Morton Hospital, reported spending over 10 percent of their TPE on community benefits. (See Appendix A for 2015 gross spending on community benefits.) Interestingly, two *for-profit* hospitals, Steward's St. Elizabeth's Hospital and Morton Hospital, which continued to file community benefit reports with the attorney general under the terms of a hospital conversion, reported spending more than 4 percent on community benefits—in addition to paying property, sales, and income taxes.

Overall average gross spending on community benefits as a percentage of TPE has not changed dramatically over the last five years, with an average of 3.4 percent of TPE over the time period shown. (Table 2 and Figure 1 provide a summary of total community benefit spending from FY 2008 through FY 2015.)

TABLE 2

Total Community Benefit Spending of All Massachusetts Hospitals Reporting to the Attorney General, FY 2008–FY 2015

FISCAL YEAR	TOTAL OF COMMUNITY BENEFIT SPENDING	STATEWIDE TOTAL PATIENT EXPENDITURES	% OF TOTAL PATIENT EXPENSE EXPENDITURES
2008	\$435,169,713	\$14,727,003,559	2.95%
2009	\$485,342,174	\$16,024,979,709	3.03%
2010	\$580,073,349	\$17,015,383,774	3.41%
2011	\$622,435,557	\$17,337,444,897	3.59%
2012	\$656,065,124	\$17,849,986,642	3.68%
2013	\$652,214,080	\$18,450,131,514	3.54%
2014	\$626,502,007	\$18,732,696,544	3.34%
2015	\$564,726,076	\$18,506,622,940	3.05%*

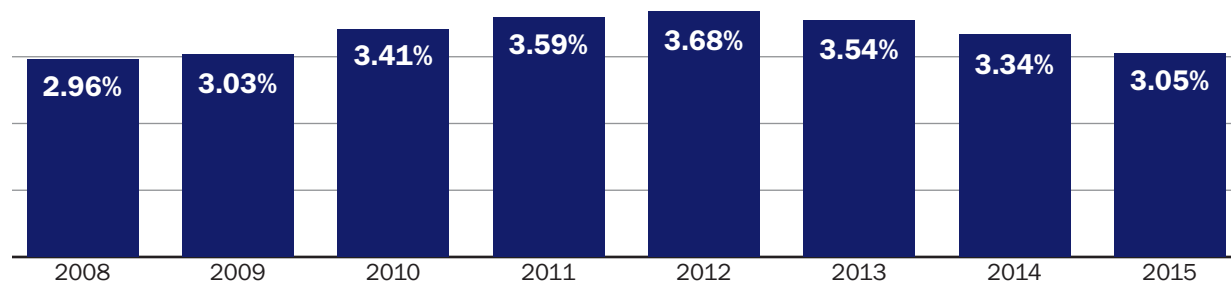
*The \$564,726,076 in 2015 varies from the total reported by the attorney general because MetroWest and St. Vincent's did not report total patient expenses for 2015, and QMC closed during this period. We have also excluded their community benefit spending from this table for that year.

Source: Analysis of data from the Massachusetts attorney general's website.

The year-to-year trend is demonstrated in Figure 1.

FIGURE 1

Total Community Benefit Spending as Percentage of Total Patient Expenses, FY 2008–FY 2015



Source: Analysis of data from the Massachusetts attorney general's website:
http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

WHAT ARE COMMUNITY BENEFIT DOLLARS SPENT ON?

The bulk of community benefit spending can be broken down into two major categories: charity care and direct community benefit spending, including funding for community health initiatives. Hospitals also expend funds on administrative support for community benefits, determination of need payments, corporate sponsorships, and other leveraged resources, which are all reported in the “other” category. (See Appendix D for comparison of federal and state regulations on what is permissible when calculating community benefit expenditures.)

Table 3 provides a dollar breakdown of the community benefit dollar and the distribution of charity care spending and direct community benefit spending from 2008 to 2015.

TABLE 3

Community Benefit Spending Analysis, FY 2008–FY 2015

FISCAL YEAR	NET CHARITY CARE	DIRECT COMMUNITY BENEFIT SPENDING	OTHER COMMUNITY BENEFIT SPENDING	TOTAL COMMUNITY BENEFIT SPENDING
2008	\$152,555,750	\$157,487,235	\$125,126,729	\$435,169,713
2009	\$171,910,154	\$190,193,945	\$123,238,075	\$485,342,174
2010	\$306,433,489	\$201,886,118	\$71,753,741	\$580,073,349
2011	\$321,243,214	\$217,842,321	\$83,350,022	\$622,435,557
2012	\$356,044,638	\$216,812,710	\$83,207,776	\$656,065,124
2013	\$335,133,933	\$236,004,146	\$81,076,001	\$652,214,080
2014	\$322,758,719	\$228,814,873	\$74,928,415	\$626,502,007
2015*	\$247,260,872	\$243,356,011	\$74,109,193	\$564,726,076

*The 2015 data does not include MetroWest or St. Vincent’s Hospital since they did not report TPE, and QMC closed during this period.

Source: Analysis of data from the Massachusetts attorney general's website:
http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

Charity Care Spending

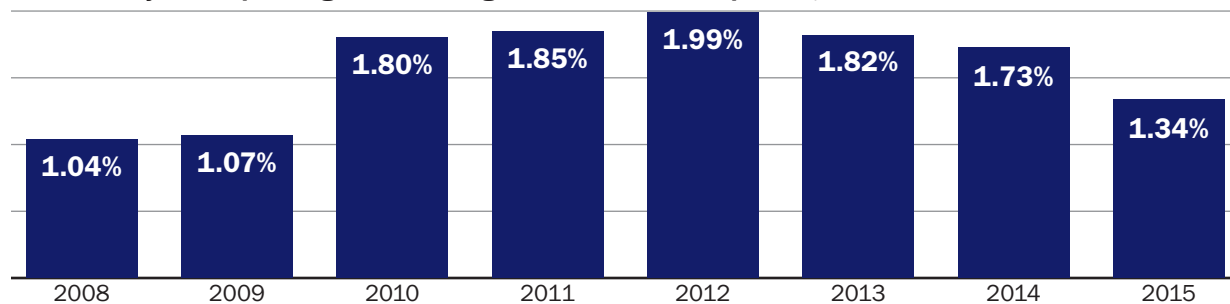
Hospital community benefit spending is part of an important safety net for the uninsured and the underinsured who cannot afford to pay hospital bills. Since 2008, Massachusetts charity care³³ has tended to vary in absolute dollar amounts as well as a percent of total community benefit spending. As noted in Table 3, aggregate charity care has varied from a low of \$152 million in FY 2008 to as much as \$356 million in FY 2012. As shown in Figure 2 below, charity care as a percentage of TPE has varied between 1 and 2 percent in aggregate statewide. In FY 2015, there was a dramatic drop in net charity care spending compared with prior years, with a \$75 million decrease in spending from \$322 million in FY 2014 to \$247 million in FY 2015. (Even with the charity care expenditures of the two excluded hospitals that did not report TPE, and the closure of Quincy Medical Center, then the drop in charity care would be closer to \$70 million).

It is not known whether the 2015 decline in charity care spending will continue. Part of the decrease in charity care spending is possibly attributable to the continuing decrease in the uninsured in Massachusetts with the 2014 expansion of the ACA. However, the significant increase in Medicaid enrollment that took place because of the MA Connector website challenges in the fall of 2013 through 2014 quite likely impacted the amount of measured charity care in FY 2015.

Figure 2 represents spending on charity care as a percentage of total patient expenses.

FIGURE 2

Total Charity Care Spending as Percentage of Total Patient Expenses, FY 2008–FY 2015



Source: Analysis of data from the Massachusetts attorney general's website:
http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

With the expansion of health insurance coverage under Chapter 58 and the ACA, there has been an assumption that the need for uncompensated care will decrease and that hospitals can shift their community benefit spending to other purposes. Whether that assumption holds true remains unclear. For example, recently proposed regulations that cut state support for the Health Safety Net and raise income eligibility levels would likely put more pressure on hospitals to provide more charity care. Also, while the expansion of health insurance coverage should reduce the aggregate need for uncompensated care, many low-income patients, particularly those who are undocumented, continue to rely on uncompensated care. A 2016 report from the Blue Cross Blue Shield of Massachusetts Foundation entitled “Health Care Access and Affordability in Massachusetts” also found that one in five Massachusetts residents had difficulty paying medical bills and one in four reported an unmet health need in 2015.³⁴ All of this suggests that there may be an expanding group of underinsured

people in Massachusetts who will be unable to pay the increasing deductibles and copayments expected under their insurance plans.

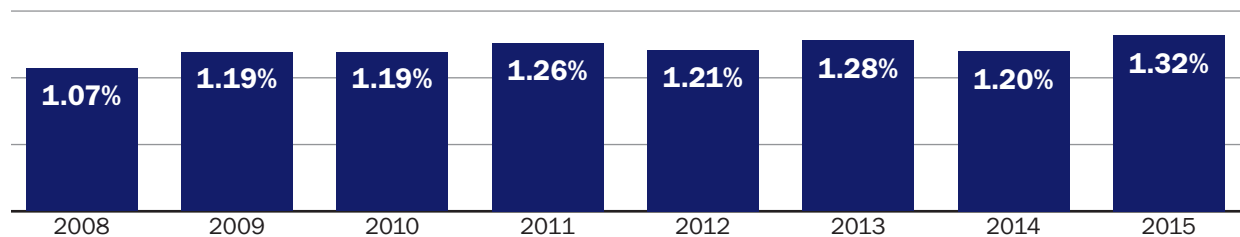
Direct Community Benefit Spending

The other major category of expenditures in community benefits (42.7 percent of the total in FY 2015) is what can be called “direct community benefit” spending. The attorney general defines a “community benefit program” as a program, grant, or initiative developed with community representatives or based on a community health needs assessment for a target population identified by the hospital through its community assessment and identified in its community benefit plan.³⁵ Direct community benefit spending can include preventive care, health screening, outreach health education through community health workers, early childhood wellness programs, and community-based training and counseling programs designed to improve the health of disadvantaged populations.³⁶ Direct community benefit activities and spending can be part of integral relationships that exist between a hospital and its community organization partners. According to the guidelines, hospitals’ direct community benefit spending generally, “goes to community-based programs that support the hospitals Community Benefits Plan and address the needs of underserved populations or other needs,” whereas “associated expenses” can include depreciation on movable equipment that a community benefit program buys or leases or a share of the fixed depreciation on space that a program uses.³⁷ In FY 2015, for the Massachusetts hospitals included in this report, \$243 million was spent on such direct community health initiatives.³⁸ Hospitals also may report other community service expenditures but these do not count toward the community benefits total.

Below, Figure 3 shows Massachusetts hospitals’ total annual spending on direct community benefits as a percentage of total patient expenses. Total direct community benefit spending has slowly but steadily increased in absolute dollars over the last seven years. However, as can be seen in Figure 3, as a percentage of total patient expenses, direct community benefit spending is essentially flat. It has varied only between 1.2 and 1.3 percent of total patient expenses over the last five years.

FIGURE 3

Direct Community Benefit Spending as Percentage of Total Patient Expenses, FY 2008–FY 2015



Source: Analysis data from the Massachusetts attorney general's website:
http://cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

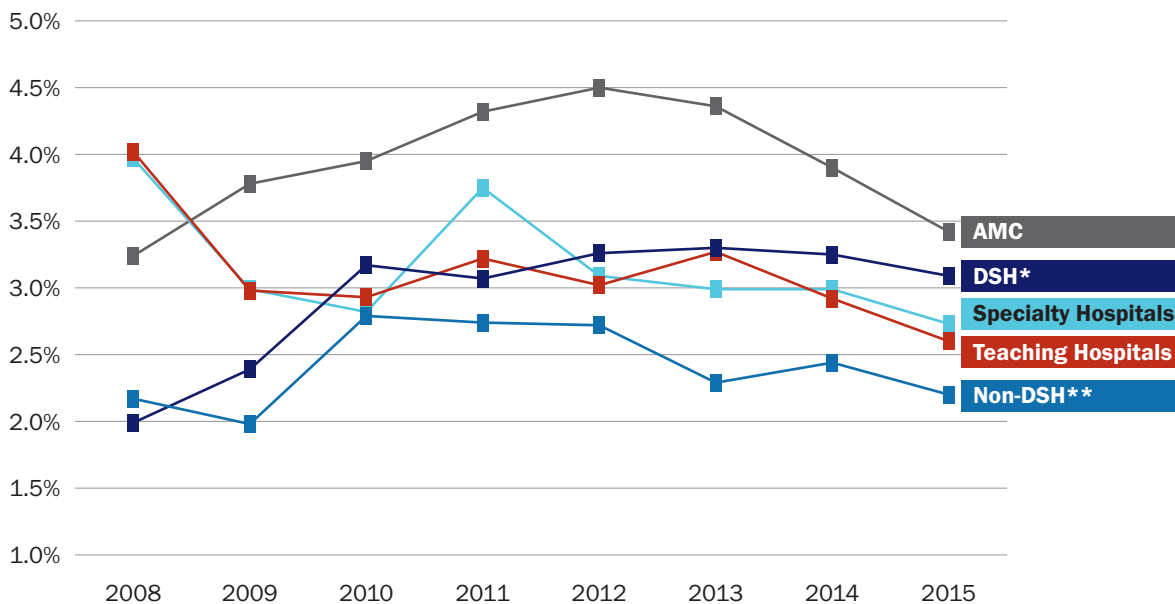
Although the data show relatively little change in the total percentage of spending for direct community benefits, there is great variation among tax-exempt hospitals in regard to that spending.

A total of 22 tax-exempt hospitals, which represents 46 percent of all hospitals, actually spent *less than one half of one percent* (0.5 percent) of TPE on direct community benefits. And 35 tax-exempt hospitals, which represent 73 percent, spent less than 1 percent. The spending of a few hospitals pulls up the state aggregate proportion of direct community benefit spending as a percentage of TPE. (Specific details about individual hospitals appear in Appendix A.) Northeastern University researcher Gary Young and his colleagues arrived at a similar conclusion in a report, published in the *New England Journal of Medicine*, that noted significant variability of community benefit expenditures among hospitals. Using a federal IRS accounting approach, which allows greater expense eligibility in “countable community benefits” than does the Massachusetts scheme, their analysis also indicated that hospitals overall spent very little on direct community health improvement.³⁹

Perhaps it is also useful to look at community benefit spending from a “hospital cohort” perspective. Figure 4 provides a breakdown of direct community benefit spending by hospital cohort designations (as utilized by the Health Policy Commission in its 2016 report on community hospitals) for the same period. Figure 4 shows total community benefit spending by cohort, and Figure 5 shows each cohort’s spending for direct community benefits.

FIGURE 4

Total Community Benefit Spending by Hospital Cohort as Percentage of Total Patient Expenses, FY 2008–FY 2015

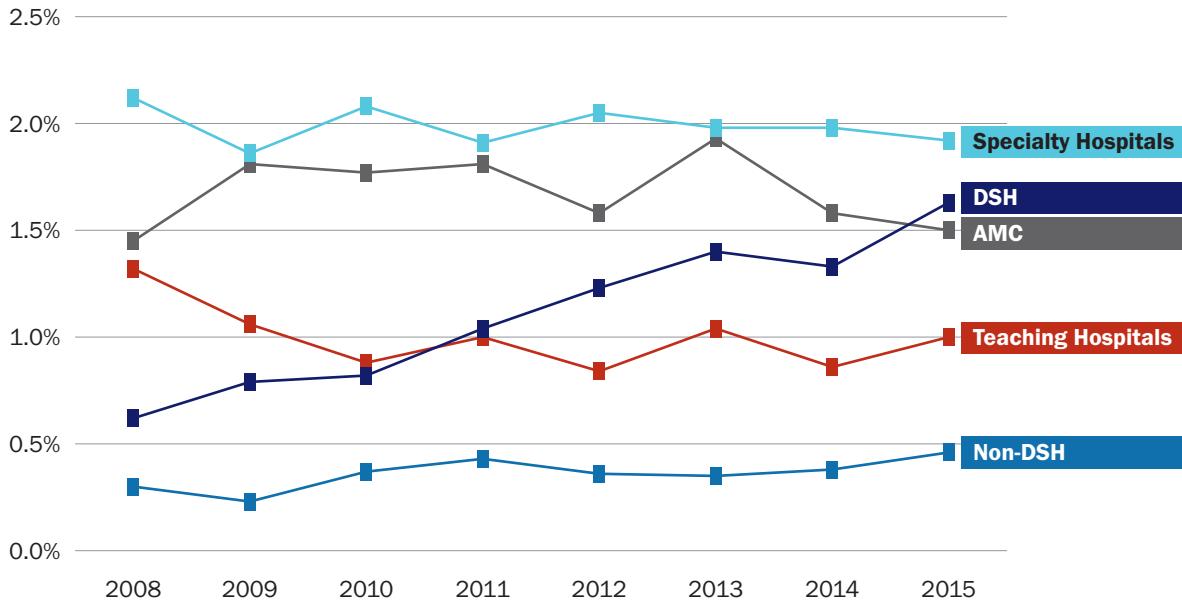


* Community DSH hospitals are those community hospitals that receive at least 63 percent of their gross patient service revenue from government payers.
 ** Community Non-DSH hospitals are non-specialty acute hospitals that are not AMCs or teaching hospitals, and receive less than 63 percent of their gross patient service revenue from government payers.

Sources: Hospital designations are from Massachusetts Health Policy Commission Report, *Community Hospitals at a Crossroads*, January 2016, which utilizes the 2013 cohorts. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>. Analysis of data from the Massachusetts attorney general's website: http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

FIGURE 5

Direct Community Benefit Spending by Hospital Cohort as Percentage of Total Patient Expenses, FY 2008–FY 2015



Sources: Hospital designations are from Massachusetts Health Policy Commission Report, Community Hospitals at a Crossroads, January 2016. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>. Analysis of data from the Massachusetts attorney general's website: http://www.cbsys.ago.state.ma.us/cbpublic/public/hccdownloadreportdatanew.aspx?report_year=2015.

When analyzing hospitals by cohort, one apparent outlier group is the non-DSH community hospitals. On average, they dedicate the least amount of resources overall to total community benefit spending and also spend the least as a group on direct community benefits.⁴⁰ These hospitals tend to be in suburban communities or in smaller cities, and they tend to have a relatively high proportion of commercial payers and a relatively low demand for charity care. To date, in aggregate this cohort has not demonstrated a reallocation of community benefit dollars toward spending on direct community benefit activities in their local area.

III. CURRENT STATE OF COMMUNITY BENEFIT REPORTING

As noted previously, there are similarities in the attorney general's guidelines and the IRS rules: both require health care entities to conduct a community health needs assessment (CHNA), define the community claimed by the facility, develop a plan to implement community benefits, and implement that plan. The Massachusetts guidelines additionally require hospitals to file annual reports on the prior year's activities, the needs assessment, a definition of the population targeted, and names of community partners consulted.

DEFINITION OF "COMMUNITY"

The attorney general and the IRS require hospitals to define the geographic area and specific population/patient categories the hospital serves. Hospitals can "define" specific populations—such as individuals with disabilities, children, and the LGBT population as their community of focus. Hospitals can also indicate geographic areas that go beyond traditional service boundaries to reach medically underserved areas.⁴¹ Outside Boston, hospitals define their community as the surrounding geographic area that forms a part or all of their primary service area. In Boston, specialty hospitals such as Dana-Farber and Boston Children's claim specific neighborhoods as well as note they engage in some activities with an aim of benefiting a statewide population. Boston hospitals have a high degree of overlapping geographic areas, yet some neighborhoods are less well served than others.⁴²

COORDINATION

The 2014 IRS rules encourage greater coordination among regional entities to maximize population coverage and effectiveness. In most communities, each hospital independently operates its own community benefit program, focusing largely on its immediate service area. In some areas hospitals have begun coordinating their community benefit planning. Several western Massachusetts hospitals have joined together in a joint CHNA and community benefit planning process to maximize resources and effectiveness.⁴³ Hospitals in the Worcester area are working on a joint community health assessment. In Boston, members of the Conference of Boston Teaching Hospitals (COBTH) meet to share information and have begun to look at common health status data. To date, however, they have not created a common community benefit plan for the Boston area, nor have their needs assessments been conducted on the same timetable, making coordination difficult. However, the COBTH hospitals recently reported alignment of their Community Health Needs Assessment process timetables, which may enable greater cooperation.⁴⁴

UNIFORM REPORTING AND ACCOUNTABILITY

An essential component of the attorney general reporting process is the brief descriptions of the programs, services, and training that constitute allowable community benefit activities. Hospitals generally provide a short description of a program, the number of people served, and local partners, as well as categorizing the type of program. The categories hospitals use include direct service,

community education and participation, service and outreach to the underserved, health professional staff training, and capacity building, among others.

Unfortunately, it is difficult to fully understand or evaluate community benefit programs from the hospital reports. Lack of uniform reporting is a concern nationally and also characterizes the reporting in Massachusetts. Cross-hospital comparisons are difficult since the attorney general does not provide specific instruction to hospitals to ensure uniform coding of programs. Despite the 2016 update from the attorney general,⁴⁵ this lack of uniform coding also makes it hard to determine which programs deliver direct medical services within a community and which are designed to build community capacity and create long-term systematic change. Some hospitals focus on a handful of key initiatives, such as tobacco cessation, opioid addiction, violence prevention, and healthy eating; others have dozens of programs covering a wide range of projects and health goals. Often there is no way to know which programs are viewed as most strategic in nature and core to a hospital's community benefit efforts, or if the programs are integral to the hospital's mission and strategic plan.

The impact of the programs is also difficult to determine. The attorney general asks hospitals to “articulate measurable goals for each community benefit program.”⁴⁶ Hospitals can set either operational or outcome goals, depending on the nature of the program, and are also encouraged to develop both short-term and long-term goals for each of their projects. In practice, most hospitals just list the program's goals and report the number of persons served by each activity. The attorney general's reporting rules do not require hospitals to indicate the amount of funds spent on each project, making it difficult to determine the size or importance of the effort. While some hospitals conduct their own evaluations of projects, those are the exception. There is generally no expectation for an overall evaluation process to determine the effectiveness or extent of these programs. This systematic lack of evaluation of the effectiveness of community benefit data is not unique to Massachusetts; organizations elsewhere have raised similar concerns.^{47 48}

MEANINGFUL COMMUNITY ENGAGEMENT

The new IRS rules stress community engagement but do not delineate how this is to be achieved. This emphasis on community engagement comes at a time of increasing national recognition that it is an integral building block for community health improvement. As communities often have firsthand knowledge of the underlying social, racial, and economic barriers to public health improvement, prestigious organizations such as the Health and Medicine Division of the National Academies emphasize that the next generation of prevention must focus on building relationships with communities and must be derived from the community's assessments of its needs and priorities.⁴⁹

Despite the growing recognition of the importance of community engagement, challenges remain for integrating it as a core principle for most hospitals' organized efforts. The Health Research and Educational Trust, with support from the Public Health Institute and the American Hospital Association, recently published a report on a national survey of hospital “approaches to population health.” The report found that 50 percent of hospitals nationwide used outside resources (consultants) to conduct their Community Health Needs Assessments⁵⁰—about the same percentage as in Massachusetts.⁵¹ The consultant is hired directly by the hospital and reports to the hospital. While outside consultants can play a valuable role in helping to facilitate the CHNA process, using a

consultant does not necessarily create an ongoing partnership between community organizations and the hospital. However, there are an increasing number of resources available to help hospitals with this aspect of their community benefit approach. For example, the George Washington University School of Public Health recently developed a set of principles to guide community engagement and enhance the CHNA process.⁵²

Community engagement can take place in many arenas. The Community Health Needs Assessment process, when viewed from a longitudinal perspective, should include preplanning, continuous and ongoing planning activities, implementation, and evaluation—all steps providing multiple opportunities for community engagement. Often, when hospitals submit their community benefit reports, they simply list the names of the community organizations they consulted but do not indicate the level of continuing engagement with the named groups in establishing priorities or implementation of the plan. A concern of some community leaders is that they have sometimes been involved in the initial needs assessment process to talk about areas of concern but not in any other phase of community benefit planning, implementation, or evaluation.⁵³

The IRS takes a very broad approach to the definition of “community” and encourages hospitals to consider input from a broad array of sectors. The 2014 regulations state: “Hospitals must solicit and take into account any input from persons knowledgeable about the community.” The regulations suggest that a diverse array of community stakeholders be engaged with the hospitals.⁵⁴ An author’s review of recent submissions of hospital community benefit reports⁵⁵ shows that many hospitals submit a listing of dozens of organizations as community partners without giving a sense of the depth or longitudinal nature of those relationships. At the same time, few representatives are listed from certain stakeholder groups, including grassroots organizations, smaller religious congregations, immigrant rights organizations or leaders, housing activists, civil rights and disability rights organizations, and labor or workforce representatives. Inclusion of these groups could offer a broader perspective on the needs and assets of the community. Furthermore, the changing demographics of the state make continual updating of community representation necessary.

The IRS also specifies that input must be solicited and used in setting program priorities. Although many hospitals have community benefit advisory committees that meet on a regular basis, it is not clear from the community benefit reports what, if any, ongoing community participation exists in the setting of priorities or in post-CHNA implementation of the plan. Under the current reporting scheme, it is difficult to determine the extent of any long-range transformative partnerships between community organizations and the hospital. Despite the fact that community organizations often know firsthand the barriers to health care and can help determine how they might be overcome, the community benefit process is challenging for both the hospital and community organizations. Hospitals can be confronted with a lack of stability in their own staff, changes in leadership, and funding challenges—all challenges to building stable relationships with community organizations. Furthermore, community organizations do not always understand the complexity of hospital organizations and decision-making structures, and have their own funding challenges.

Community engagement is not a one-way process. Community organizations have a responsibility to advocate for their community’s needs. Many community organizations have little understanding of the community benefit/determination of need process and how they would approach it. The

attorney general's guidelines encourage community response to the annual community benefit reports. Individuals and community organizations also have the right to make public comments on the community benefit process, implementation, and level of community engagement.⁵⁶ Unfortunately, discussions to date with officials from the attorney general's office have given little indication that this is happening in a regular fashion.

COMMUNITY OUTREACH

For their community outreach, most hospitals report having used surveys (paper and electronic), focus groups, questionnaires, internet applications, and individual interviews. Many of the CHNAs relied on Department of Public Health data, CDC data, and local public health data. A number of hospitals used community meetings and a community organizer to build larger "town hall" meetings to discuss the CHNA and community needs. One used a web-based computer game to solicit input. These techniques enable hospitals to gather input from a multitude of voices. Hospitals solicit broad input, but it is not clear from the reports how well this is integrated and how extensive and effective community partnerships currently are for these institutions.

ALIGNMENT WITH STATE AND LOCAL HEALTH DEPARTMENTS AND THEIR PLANS

Local health departments are well placed to maximize investments in public health initiatives and to give perspectives on public health issues. Coordination of hospital community benefit planning, Massachusetts Department of Public Health/determination of need planning, and local public health department planning is at best uneven. Seamless coordination exists in some areas, but in other communities, cooperation is lacking. This can result in duplication of effort and a failure to achieve optimal use of strategic resources. As the Commonwealth continues to grapple with rising health care costs and shared population risk, the need for overall population health planning will increase. There is a strong suggestion of a need for better alignment with efforts tied to statewide and well as local public health plans to reduce the health burdens from chronic disease. Important elements of addressing population health needs are community engagement, diverse voices, and the development of a system to evaluate (1) the coordination of hospital efforts tied to state or local plans, (2) resource commitments to these plans, and (3) process and outcome impacts from community benefit efforts.

THE VALUE OF THE TAX EXEMPTION

One of the continuing policy questions surrounding the discussion of community benefits is how best to economically value what hospitals contribute to their communities with their "charitable" efforts. Clearly, it has been challenging to obtain a clear answer in dollars and cents terms. What hospital activities should count and how to assess the financial value of various hospital charity care or health improvement activities has been a continuing controversy. Finally, as tax-exempt hospitals are awarded their tax-exempt status, an additional question arises as to how much community benefit is sufficient to justify the exemption. A few states have decided to pursue mandating a minimal level

of community benefit spending in measurable terms⁵⁷ (see Appendix E). As noted, Massachusetts recommends but does not require a specific dollar amount of community benefit spending.

For some, the question of whether there should be a minimum dedication of resources to community benefits grows out of the reality that there is significant variability among hospitals in the level of resources they commit to community benefits. About 70 percent of all Massachusetts tax-exempt hospitals failed to devote resources of at least 3 percent of TPE in 2015—the target level suggested by the attorney general’s guidelines. Of interest, we note that this target level is less than academic studies’ estimated average value of tax exemption awarded to hospitals. For example, Nancy Kane from the Harvard School of Public Health estimates that tax exemption allows hospitals to forgo expenses in the range of 4 percent to 6 percent of total operating expenses. In 2000, Kane & Wubbenhorst, in a national sample, looked at the value of tax exemption as compared with hospital charity care plus varying estimates of levels of bad debt⁵⁸ (they did not include direct community benefit spending because of a lack of uniform definition). Their estimate of taxes forgone was limited to federal income taxes plus state and local sales, income, and property taxes. Similar to our observation based on the current attorney general’s data, they found that a significant majority of hospitals in their study did not have levels of charity care and bad debt expense that rose to the value of their estimated forgone taxes. They also found wide variability among hospitals in the levels of resources dedicated to community benefit spending under their definition.

A more recent study by Sara Rosenbaum and colleagues at the George Washington School of Public Health used a different methodology to estimate that the potential value of tax-exempt hospitals’ tax exemption in 2011 was about \$24.6 billion.⁵⁹ That estimate includes not only the hospitals’ direct savings on federal and state taxes but also their ability to raise money through tax-exempt donations and municipal bonds.

Massachusetts hospitals’ federal tax exemption, according to the GWU study, is the highest in the nation on a per hospital basis. On average, it was projected to be about \$15.5 million per tax-exempt hospital per year. Massachusetts hospitals’ state tax exemption was projected to be an average of \$5.1 million per tax-exempt hospital—for a total of over \$20 million of exemption per hospital per year.⁶⁰ The study noted that Massachusetts hospitals account for 5 percent of the total dollar value of non-profit tax exemptions granted in the US, even though its hospitals’ share of community benefit spending is only 3 percent of all spending nationally.

The GWU study estimated the 2011 combined total tax exemption for Massachusetts hospitals at nearly \$1.27 billion, of which \$316 million was lost state income, sales, and property taxes, and \$961 million was lost federal income tax.⁶¹ The study also noted that about 48.5 percent of the total federal taxes exempted nationally could be attributed to forgone income taxes from hospitals (no specific percentage for Massachusetts hospitals was published in the study’s federal exemption breakdown). Using this percentage, Rosenbaum *et al.* estimated that Massachusetts hospitals collectively saved about \$466 million in 2011 federal corporate income taxes. Roughly, for 2011 the GWU researchers’ method yields about \$782 million in forgone income, sales, and property taxes for exempt Massachusetts hospitals.⁶²

Interestingly, hospitals’ profit margins have essentially doubled since 2011, according to data from the Center for Health Information and Analysis.⁶³ And with subsequent growth in hospital purchases

subject to sales tax and the value of property holdings, the calculated gap between the dollar value of community benefits and the value of forgone taxes has likely grown considerably since 2011.

Finally, something that has not been studied fully, to our knowledge, is the overall financial strength of hospitals and its relationship over time to the extent of total or direct community benefit spending in Massachusetts. We think that there are useful questions to explore here in the years to come. It would be advisable to consider the answers to those questions before undertaking an overt effort to establish more definite expectations about a minimum hospital resource commitment to community benefit spending.

IV. OTHER HOSPITAL EXPENDITURES THAT CAN IMPROVE COMMUNITY HEALTH

In addition to community benefit obligations, hospitals in Massachusetts expend other funds that potentially contribute to community health improvement. These expenditures, pursuant to the Massachusetts Department of Public Health's determination of need regulations and the City of Boston's payment in lieu of tax program, are worth consideration as significant opportunities for coordination and impact on community health and health equity.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH AND DETERMINATION OF NEED SPENDING

The Massachusetts Department of Public Health (MDPH), as part of its determination of need (DoN) process, requires hospitals proposing expansion or construction to provide some dedicated resources for community-based health initiatives. The regulation also includes a provision for any 10 taxpayers to participate in a review of the DoN through the formation of a Ten Taxpayer group.

The DoN was established by the legislature in 1971 to encourage equitable geographic and socioeconomic access to health care services, help maintain standards of quality, and constrain overall health care costs by eliminating duplication of expensive technologies, facilities, and services.⁶⁴ Similar laws were passed across the country, but many of these laws were eventually scaled back or repealed. Though the basic Massachusetts scheme has been maintained since 1971, an important update in 2012 gave the newly created Health Policy Commission and the attorney general some "interventional" rights with respect to cost growth issues.⁶⁵ The DoN process requires hospitals seeking approval to include a plan to address primary and preventive care, known as Community Health Initiatives (CHI), with a requirement that up to 5 percent of the DoN application amount be devoted to CHI. CHI embrace a wide definition of public health, emphasizing not only medical health but also the underlying racial and social disparities and the need to build sustainable community capacity.⁶⁶

From FY 2008 to FY 2015, Massachusetts hospitals reported to the attorney general actual total spending of about \$64 million in CHI benefits.⁶⁷ Funds are distributed through MDPH to area community health networks and community coalitions. In 1992, MDPH, created community health network areas as a way to foster cooperation in public health planning among providers and other community health care organizations.⁶⁸ The MDPH required the network areas to use surveillance and other population health data for their health planning activities and mandated Community Health Needs Assessments to provide guidance to community planning efforts and utilization of MDPH funds. Over the years, MDPH has developed specific network area priorities designed to improve the health status of vulnerable populations and build community capacity to address social determinants of health. The community health network areas are responsible for implementing these priorities locally. Priorities include the elimination of racial and ethnic health and health care disparities; the promotion of wellness in the home, school, workplace, and community; and the management and prevention of chronic disease.

The DoN funds support a wide array of projects, from farmers’ markets and access to healthy food to violence prevention programs to community organizing. About a third of Massachusetts hospitals contribute via the DoN process in any given year, but in terms of dollars, the bulk of DoN commitments originate from hospitals with larger DoN applications. Since the DoN funds are linked to hospital expansion or new large capital projects, from a geographic point of view CHI funds are not distributed equally across the state, and so a policy question has arisen as to whether at least a portion of these dollars should also be shared beyond the areas local to the hospitals.

Hospitals are required to report on the progress of their funding and projects but, as is the case with community benefit spending, there is little evaluation of the effectiveness of DoN health improvement investments. To date, the regulations have not provided a mechanism for oversight of CHI activities or spending, nor are there any meaningful penalties should a hospital or other organization not deliver on its commitments. In the event a hospital fails to follow through on its commitments, current regulations essentially limit MDPH action to revocation of the holder’s license—a penalty not likely to be applied. As MDPH notes in its own analysis, “To date there has been no data driven or coordinated disbursement of the CHI investments, [resulting in] small uncoordinated investments across many issues and flexible standards of community engagement.”⁶⁹ There is no way to determine whether these investments have advanced population health outcomes.

Table 4 illustrates actual DoN spending during this period.

TABLE 4

Determination of Need Spending by Hospitals, FY 2008–FY 2015

FISCAL YEAR	TOTAL DoN SPENDING
2008	\$7,288,546
2009	\$7,713,342
2010	\$7,842,469
2011	\$9,137,006
2012	\$10,855,809
2013	\$8,230,948
2014	\$7,079,216
2015	\$6,182,199
TOTAL	\$64,326,536

Source: Analysis data from the Massachusetts attorney general’s website: http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=19&report_year=2013&type=browse.

Note that a review of Massachusetts Department of Public Health DoNs awarded during the same period shows different amounts reported per year. This could be explained by different accounting methods and/or MDPH’s counting of the total projected spending of the DoN from its inception.

The department has made known its intent to fundamentally refine its approach to DoNs, and in late August 2016 proposed regulations were issued. These proposed regulations seek to realign the determination of need process with the shift in payment incentives, the changing structure of health care delivery, and the shift toward health care systems taking on both financial risk and accountability for population health. The revisions position the DoN process as a “significant executive branch tool that can be realigned to advance the state’s public health and health care reform goals.”⁷⁰ Importantly

for CHI, the draft regulations attempt to support an improved process for aligning CHI spending with community-level population health priorities and call for the development of standards for community engagement.

PROPERTY TAX EXEMPTION AND PILOT PAYMENTS

Municipalities rely heavily on property tax revenue. In 2015, 67 percent of Boston's income was from property taxes, yet 52 percent of all property is tax exempt,⁷¹ due to the presence of major academic medical centers and hundreds of educational institutions.⁷² The Boston Municipal Bureau reports that Boston's total taxable property value for fiscal 2016 is \$128 billion, a \$17.3 billion, or 15.6 percent, increase over the previous year's value.⁷³ The high proportion of tax-exempt properties shifts the burden to residential property owners and businesses, and creates challenges for local governments. Under Massachusetts' "Prop 2½" law, the remaining taxable base can grow by no more than 2.5 percent per year, creating intense pressure on municipal leaders.

Across the country, state and local governments have long sought ways to get revenue from non-profits. In several states, municipalities have initiated property tax challenges against hospitals. In the early 1970s the City of Boston began to collect voluntary payment in lieu of tax (PILOT) contributions from tax-exempt institutions in an effort to relieve the strain on residential and commercial taxpayers. In 2010, then Mayor Thomas Menino established a task force to realign the PILOT program to more effectively capture lost property tax revenue. The new program assessed large Boston health care and educational institutions a fee of 25 percent of what the nonprofit's property would yield if taxable. Implemented in 2011, the Boston program, while still voluntary, is thought to be the most far-reaching of its kind in the country, with the strictest standards.⁷⁴ It is important to note that PILOT funds do not have to be used for community health purposes and conceptually are more often thought of as payments to offset the costs of key infrastructure supports, such as road improvements around hospitals, city services, and snow removal. Contributions become part of the city's general operating budget.

Boston's PILOTs apply to all non-profits with property holdings of over \$15 million. The Boston PILOT Task Force, responsible for the 2011 program, recognized early on that institutions prefer "in-kind contributions" to direct cash payments. It therefore adopted a community benefit approach: up to 50 percent of the assessed PILOT payment can be paid via a noncash contribution of "community benefits" that directly benefit Boston residents, support the city's mission and priorities, are quantifiable, and offer opportunities for collaboration with the city.⁷⁵ The city annually reviews applications for the offset. Institutions are required to describe their programs and quantify the funds expended.⁷⁶ The most recent hospital report posting on the PILOT website is 2013, so it is not apparent which community benefit activities are currently part of the offset or whether these are activities the hospital currently provides in some form. The chart in Table 5 compares Boston hospitals' direct community benefit spending, property tax obligations, total exempt value, PILOT contribution, less the community benefit credit offset, cash payment to the city and total funds expended by the hospital.⁷⁷ Hospital direct community benefit spending can apply to many communities, not just the city of Boston area. The chart provides a snapshot of community benefit

spending and PILOT spending for Boston hospitals. The current PILOT program operates on a five-year cycle, so properties were assessed at the 2011 rate.

TABLE 5

Comparison of Boston Acute Care Hospitals' Tax Obligations, Direct Community Benefit Spending, and PILOT Payments, FY 2015

HOSPITAL	DIRECT CB SPENDING AS REPORTED TO THE AGO	PROPERTY TAX OBLIGATION IF TAXED	TOTAL EXEMPT VALUE	REQUESTED PILOT CONTRIBUTION	LESS CB CREDIT	CASH PAYMENT PAID	TOTAL FUNDS EXPENDED BY HOSPITAL
BIDMC	\$13,606,537	\$25,239,552	\$813,129,901	\$5,021,590	\$2,510,795	\$2,510,795	\$16,117,332
Boston Children's Hospital	\$31,626,346	\$20,507,771	\$660,688,500	\$2,734,805	\$2,051,104*	\$683,701	\$32,310,047
Brigham and Women's	\$21,599,340	\$9,836,098	\$794,517,135	\$5,454,645	\$2,727,322	\$2,727,322	\$24,326,662
Dana-Farber	\$2,477,279	\$7,702,191	\$248,137,603	\$1,487,307	\$743,654**	\$743,653	\$3,220,932
Faulkner	\$1,955,211	\$5,026,195	\$161,926,400	\$912,119	\$456,060	\$456,059	\$2,411,270
Mass Eye and Ear	\$615,407	\$3,628,827	\$116,908,100	\$632,645	\$316,323	\$316,323	\$931,730
Mass General	\$53,807,298	\$55,457,390	\$1,786,642,729	\$12,065,700	\$6,032,850	\$6,032,850	\$59,840,148
New England Baptist	\$544,932	\$4,174,320	\$134,481,973	\$741,744	\$370,872	\$370,872	\$915,804
Tufts Medical Center	\$5,871,392	\$12,448,421	\$401,044,500	\$2,760,852	\$1,380,426	\$1,018,053	\$6,889,445
TOTAL	\$132,103,742	\$144,020,765	\$5,117,476,841	\$31,811,407	\$14,538,302	\$14,859,628	\$146,963,370

Note: Boston Medical Center was not included in this group because they do not report to the Attorney General but do make a PILOT payment. Boston hospitals other than acute care hospitals participate in the PILOT program, but do not report community benefit expenditures to the attorney general. Spaulding Hospital and Franciscan Children's Hospital pay a PILOT but were not part of this study. The data in this chart use the FY 2015 PILOT and the FY 2015 community benefit figures. The city's fiscal year begins July 1 whereas the hospitals' begins October 1.

*Half of Boston Children's Hospital cash PILOT was a direct cash contribution to the Boston Public Schools and the Boston Public Health Commission as an exceptional opportunity credit.

**Dana-Farber received a credit toward the PILOT for hiring previously unemployed Boston residents as part of the Mayor's Credit for Hire program.

In FY 2015, PILOT assessments for all Boston health care facilities in this study totaled \$31,811,407. The city credited a combined 46 percent back to the hospitals as a community benefit credit; the remainder was collected by the City of Boston in cash payments that summed to \$14,859,628, although not all hospitals paid in full. In 2015, the total property tax revenue collected for the city was about \$1.8 billion,⁷⁸ so the direct cash payments were equal to only 0.8 percent of Boston's total tax revenue. Other towns and cities in Massachusetts face similar challenges and questions—especially when the value of city-provided services (e.g. police, fire, road maintenance, etc.) seem to be substantially greater than the PILOT cash payments. Many Massachusetts communities receive some PILOT payments from area hospitals, but there is no consistent approach. Many hospitals make no such contributions or make infrequent minimal donations. In many communities, municipal leaders annually coax contributions from local hospitals, many of which are not in cash but are specific services.

Of additional interest is that for-profit hospitals in Massachusetts do pay property taxes and in many instances provide community benefits as well. Table 6 indicates the amounts that for-profit hospital systems contribute to local communities via property taxes and direct community benefit spending. Several for-profit hospitals provide more in direct community benefit spending and municipal taxes than similarly sized tax-exempt hospitals.

TABLE 6

For-Profit Hospital Tax Payments and Total Contribution to Municipalities, FY 2015

HOSPITAL	DIRECT COMMUNITY BENEFIT SPENDING	PROPERTY TAX	TOTAL \$ DEDICATED LOCALLY
Carney	\$615,557.00	\$1,418,849.00	\$2,034,406.00
Good Samaritan	\$1,109,580.00	\$2,471,509.29	\$3,581,089.29
St. Anne	\$1,172,591.00	\$1,001,809.33	\$2,174,400.33
Nashoba Valley	\$5,000.00	\$380,355.26	\$385,355.26
Holy Family/Methuen	\$873,274.00	\$775,965.12	\$1,649,239.12
Holy Family/Merrimack	Included in Holy Family above	\$324,550.68	\$324,550.68
Morton	\$1,532,510.00	\$1,211,600.08	\$2,744,110.08
St. Elizabeth's	\$6,709,365.00	\$3,302,716.49	\$10,012,081.49
St. Vincent	\$3,428.00	\$4,263,046.89	\$4,263,214.20
MetroWest Framingham	\$73,036.00	\$773,300.37	\$846,336.37
Natick	Included in MetroWest	\$261,173.12	\$272,567.71
Norwood	\$137,224.00	\$932,466.00	\$1,069,690.00
TOTAL	\$12,231,565.00	\$17,117,341.63	\$29,357,040.53

Source: Town's Tax Assessor Databases. Includes information provided by Steward Healthcare on Steward hospital holdings. The assessment date in all cities and towns is January 1 of each year.

In sum, while PILOT payments provide real cash dollars to municipalities, questions remain whether they are sufficient to ease municipal burdens or whether their oversight is as consistently applied to all hospitals. About 10 years ago, the Massachusetts Department of Revenue conducted an inventory of PILOT payments and some overall assessment of the value of non-profit institutions.⁷⁹ Since then, there has been no known analysis of the loss of revenue to the state's communities that results from the tax exemption for non-profit hospitals. There is no consistent system for elected officials and residents to determine if they are receiving their fair value back—in the form of PILOTs, direct community benefits, or otherwise—in exchange for these exemptions. Likewise, there is little transparency or useful data available to elected and policy leaders to inform decisions on how to best balance municipal budgets and provide services to residents.

V. RECOMMENDATIONS

A number of government agencies oversee community benefits at Massachusetts hospitals. At the federal level, the IRS provides rules and reporting requirements for tax-exempt organizations. At the state level, the Office of the Attorney General offers voluntary guidelines for community benefits, and the Department of Public Health oversees a separate determination of need process. In some municipalities, hospitals also contribute through the PILOT process. There can also be local oversight efforts tied to PILOT programs in some municipalities. In addition, the Massachusetts Health Policy Commission and the Center for Health Information and Analysis (CHIA) track and report data that can be both relevant and important to community benefit oversight.

Each of these governmental agencies has different processes, reporting requirements, timetables, and data metrics, which make effective hospital comparisons and overall transparency difficult. The multiple layers of oversight and reporting can especially burden smaller, less-well-resourced hospitals. Most glaring in this whole area is the reality that the IRS Schedule H requires one set of data and reporting and the attorney general community benefit reporting requires another set of metrics covering essentially the same activities. CHIA utilizes yet another separate set of metrics to analyze hospital performance and expenses.

The lack of an integrated system not only creates challenges for providers but also, perhaps even more importantly, makes it very difficult for community groups and elected officials to use the data. The recently promulgated IRS rules and reporting requirements can serve as a catalyst for the state to review its current community benefit reporting process so as to better align with the changing landscape.

The following recommendations seek to create a more integrated, transparent process that puts population health front and center and provides for strategic use of existing hospital community benefit resources and DoN funds to address long-term population health needs. They also include some specific recommendations tied to the overall financial commitments and categories of community benefit spending. Some of these recommendations can be incorporated into the attorney general's voluntary hospital community benefit guidelines or the determination of need regulations. Others imply a dialogue among stakeholders with an aim of reorienting the content and direction of community benefit programs in light of national changes that emphasize population health planning and accountability for overall health. Massachusetts has a unique opportunity to weave these multiple strands into one integrated approach to population health.

These recommendations are organized into the following categories:

1. Building on the strong base provided by the current Massachusetts attorney general's voluntary guidelines
2. Alignment of existing guidelines with the IRS guidelines
3. The determination of need process and the Massachusetts Department of Public Health
4. Development of a common statewide approach on community benefit and population health
5. Evaluation of community benefit practices and spending

1 Build on the base provided by the attorney general's voluntary guidelines

The Massachusetts attorney general's voluntary guidelines were adopted over 20 years ago and set a national standard and direction for hospital community benefits. Over the years these guidelines have been revised and expanded; hospitals have generally complied with the evolution of the reporting requirements. The current voluntary guidelines and reporting system offer a valuable degree of data transparency for consumers and community organizations that is not available from the IRS reporting requirements.⁸⁰ In particular, the attorney general's electronic reporting platform allows for a searchable database and greater ease of public access. Additionally, the inclusion of *for-profit* hospitals' reporting on community benefits is critical, due to the enhanced transparency value that it creates, since these data are not available under the current IRS reporting structure.

There are, however, some areas where transparency of community benefit activities could be strengthened to better promote public understanding. The following suggestions are intended to strengthen some of the attorney general's current reporting requirements:

- Insure that all tax-exempt hospitals report to the attorney general—including those that historically were government-owned but are no longer. Currently there are several hospitals that do not report to the attorney general even though they file federal 990s and complete Schedule H as tax-exempt organizations.
- Require all hospitals to include prospective *implementation plans* for the upcoming year and an annual evaluation of the prior year's plan as part of their report to the attorney general.
- Require all hospitals to post prominently on their website their annual community benefit report, current-year implementation plan, and triennial community health assessment, as well as their financial assistance and credit and collections policies (see below for more detail on the IRS requirements).
- Develop a stricter uniform coding system for “direct community benefit programs.” While the attorney general issued a much-needed update in February 2016, the current system allows for considerable individual interpretation in categorizing community benefit activities, making comparison across hospitals difficult.
- Require hospitals to clarify whether the services they provide are (1) medical services, (2) programs designed to change individual behavior or risk factors, or (3) programs that specifically address underlying social determinants of health from a general population perspective. A standardized, clearly delineated breakdown on spending in different categories will provide a better understanding of spending patterns and provide valuable data on the extent to which hospitals may be shifting spending to broader population health needs.
- Require financial reporting to be at the individual project or program level. The current reporting system does not require hospitals to specify what level of funding is invested in each program, making it difficult to determine the hospital's priorities for community benefit activities. Boston hospitals that make PILOT program payments already report specific activity funding when they report individual program spending.

- Require all hospitals to hold annual public meetings discussing their implementation plans for community benefits and, at a minimum, invite community organizations that they name as being part of the implementation process.
- Establish a timetable for the attorney general to issue periodic reports of best practices by hospitals. The current guidelines discuss the potential of such reports, but to date there have been none. Several current Massachusetts examples of cross-hospital and regional collaborations could be showcased. The attorney general could establish an advisory committee comprising representatives from hospitals, consumers, health care plans, community leaders, and unions to review best practices.
- Require hospitals not only to list the community organizations and individuals involved in the community engagement process in the CHNA but also to develop specific categories of organizations for engagement so stakeholders can evaluate to what extent a diverse group of community organizations/leaders are engaged in the actual plan development, its implementation, and annual review.
- Require hospitals to list all tax-exempt properties, which will enable communities to evaluate the balance between community benefit spending and property tax relief granted.
- Given the number of hospitals that do not meet the voluntary community benefit threshold of 3 percent of total patient expenses, the attorney general should explore establishing a report card that includes this financial commitment level and a listing of the individual hospital's dedication of resources in comparison to it, as part of summary reporting to the public. A similar threshold comparison on the report card for direct community benefit spending should also be considered as a means to make this issue more transparent to the public and foster discussion of it.

2 Align attorney general guidelines with federal guidelines and existing state rules

There are several areas where aligning the attorney general's guidelines with the federal rules would both strengthen the state guidelines and reduce areas of confusion or redundancy in terms of hospital compliance.

- **Regional planning:** It would be valuable to incorporate IRS language encouraging regional CHNA planning and implementation. The final IRS rules clarify that joint planning activities are not only permissible but encouraged, as long as a joint CHNA report complies with all applicable CHNA development and reporting requirements on a facility-specific basis. The rules also permit joint strategies to be updated annually, spelling out which prioritized health needs will and will not be addressed during the triennial CHNA cycle. The IRS rules refer to two types of joint activities: multi-facility collaborations and collaborations between hospital facilities and public health agencies. In both cases, the key is the commonality of the community and adoption of the CHNA report and implementation strategies by the hospital. Many Boston area hospitals share geography and could benefit from a joint process.
- **Language on health needs:** It would be valuable, as well, to incorporate IRS language on health needs. These include “the need to address financial and other barriers to accessing care, to prevent

illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. §1.501(r)-3.” The final IRS rule makes clear that a CHNA can assess not only significant unmet needs for health care but also significant *health needs* arising from economic barriers to care, social conditions such as inadequate access to proper nutrition and housing, and “the mitigation of social, environmental, and behavioral factors that influence health, or emergency preparedness.”

- **Gathering community input:** The IRS rules stress that hospitals must consult with “persons representing the broad interests of the community” as part of the community health needs assessment process. Among those to be included are employee organizations, grassroots organizations, local public health departments, school districts, consumer advocacy and social justice organizations, and—most important—community members who are from medically underserved, low-income, and minority populations, or organizations that represent them. Community engagement, required by the IRS, the Office of the Attorney General, and the Massachusetts Department of Public Health, demands a comprehensive approach across all facilities, departments, and agencies. There needs to be a core set of principles for community engagement that includes engagement throughout the implementation process, not just during the initial CHNA. Those principles should be consistent with the DoN community engagement expectations as detailed further below. Ideally those principles could emerge from a joint attorney general and MDPH discussion.
- **Hospital billing and collections:** Currently, the attorney general’s community benefit guidelines encourage, but do not require, hospitals to adopt consumer-friendly credit and collections policies, and Massachusetts Health Safety Net (HSN) regulations stipulate billing and collection practices and procedures that hospitals and health centers must follow. Yet medical debt still presents a problem for Massachusetts families—and there is evidence that this burden is growing. This year, hospitals must implement new federal requirements for tax-exempt hospitals to develop financial assistance, billing, and collections policies; to make these documents widely available; and to limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients. Under the federal requirements these protections are extended to third-party collection agencies. Some of the specifics—presumptive eligibility for financial assistance, limiting charges to patients who qualify for financial help, and notification and language access requirements—will be new for Massachusetts hospitals. We recommend that the attorney general build on existing state guidelines and federal requirements for hospital billing and collections to protect low- and moderate-income families from medical debt and promote best practices among Commonwealth hospitals. Additionally, hospitals could be encouraged to use their community health needs assessments—or similar processes—to gather data and community input on how best to tailor financial assistance programs and policies to meet the needs of the communities they serve.

3 Align the determination of need process with community benefit planning and oversight

Currently there are multiple approaches to public health planning and community initiatives. As the Massachusetts Department of Public Health has issued revised DoN regulations, this is an opportune

time to discuss how to optimize the value of CHI spending and related community engagement processes. Under an improved CHI process, there should be both a clearer articulation of population health and spending priorities for funded activities and a greater longitudinal presence of diverse and representative community organizations and voices in the CHI process.

Many of the above community engagement recommendations for the attorney general's community benefit guidelines may be applicable to the newly proposed Department of Public Health regulations. Accordingly:

- The MDPH should provide greater oversight to CHI processes with an aim of carrying out a more robust set of activities and resource commitments tied to key state health priorities. The specific system commitments and their progress should be reviewed by the state as well as by well-defined local community groups that help to review activities and commitments on an annual basis.
- In the event that hospitals are not in compliance with their CHI plans or community processes, there should be specific penalties and/or expectations of additional resource commitments for CHI efforts.
- Hospitals with a DoN obligation should be encouraged, as appropriate, to align their CHI plans with their existing community benefit plans to maximize the strategic use of their resources.
- CHI investments should be standardized through enhanced coordination and oversight to optimize investments in population health and develop evaluation metrics to assess program effectiveness. MDPH should create an annual report on CHI investments and program progress and to share best practices.
- A single standard of community engagement should be applied: Both the community benefits and the DoN process require specific levels of community engagement. There should be common principles applied across all organizations that define expectations for an effective community engagement process. In many instances, it would make the most sense to think that the same community engagement structure for the oversight of community benefit commitments could serve this oversight role with respect to CHI commitments as well.
- MDPH needs to insure that there is some level of geographic equity for receiving the value that flows from CHI spending. Most hospital development occurs in large urban areas. More remote and lesser-resourced areas often do not obtain public health benefit from DoN funds; accordingly, the CHI funding formula should identify some amount of pooled resources that can flow to these communities.

4 Develop a common statewide approach on community benefits and population health

The work of multiple agencies touches upon concepts of population health: the Massachusetts Department of Public Health, the Health Policy Commission, the attorney general, and CHIA, as well as many local public health commissions and other stakeholders such as statewide advocacy organizations.

- The lack of hospital CHNA coordination in most communities, or any form of collaborative effort in carrying out community benefit activities, flies in the face of the strategic utilization of scarce resources. Efforts to encourage coordination should be undertaken as described above. Collaboration with the Massachusetts Department of Public Health, which has responsibility for oversight of determination of need spending, should result in emphasizing community health improvement and engagement with local coalitions. New York State now requires that each of its hospital community service plans (community benefit plans) include two state-identified priorities selected jointly with the local health department.⁸¹ As MDPH develops its sub-regulations for the DoN, there will be an opportunity to delineate state-identified health priorities, which can become the focus for activities across the state.
- New Health Policy Commission accountable care organization (ACO) certification criteria require an ACO to carry out at least one program that addresses a social determinant issue in their enrolled population. Because hospitals are active participants in ACOs, it may make sense that ACO efforts to improve population health should intersect or build upon hospital community benefit activities. There are likely synergistic opportunities to combine social-determinant-focused efforts for ACO enrollees with broader geographically targeted population health efforts. This may be especially true for Medicaid ACOs.
- The various statewide reporting metrics should be aligned, using acceptable standard measures for revenues and expenses, to improve analysis of community benefit spending and its impact. For example, CHIA utilizes operating revenue, total expenses, and standard financial ratios in its reporting, while the attorney general utilizes total patient expenses and Chapter 224 calls for measurement of total health care expenditures. It would be useful if all systems integrated common metrics to allow seamless comparison.

5 Evaluate community benefit practices and spending to meet community and population health needs

- Convene a technical group of all interested parties to agree on appropriate evaluation metrics for a community benefit program. Metrics should cover both process and outcomes and should encompass all aspects of community benefit program efforts, including community engagement efforts.
- Create a pilot evaluation process to determine the effectiveness of those metrics for specific community benefit programs. Massachusetts hospitals spend millions of dollars on a wide variety of programs. There is no common metric to determine the effectiveness of these programs. Most hospitals report program outcomes, but few report population health outcomes.

VI. CONCLUSION

In this era of health system reform we have an unprecedented opportunity to leverage existing resources to create a more effective and efficient community benefit model. The Massachusetts community benefit approach is 20 years old. Though leaders have made positive changes to make the program more accessible, much more can be—and needs to be—done. The new federal rules have increased the interest among community organizations and others to advocate for an improved state oversight scheme that focuses on how community benefits can build healthier communities and address the underlying social determinants of health.

Hospitals need to support broad-based prevention strategies rather than focus only on direct services and narrow notions of health education and charity care. Given the amount of money that our state's hospitals currently expend on community benefits, it is critical to measure the effectiveness of these expenditures. Better evaluation can help hospitals be more effective as they adopt strategic community benefit activities and help determine whether they successfully address underlying social determinants of health and advance equality.

Hospital community benefit implementation plans provide a new opportunity for community leaders to organize and advocate for an ongoing relationship with their local hospitals. Community leaders want greater transparency and understanding of the community benefit program and its outcomes. Hospitals can strategically address long-term population health needs by a critical review of their existing community benefit spending and effectiveness. State government can optimize its hospital accountability and related processes, many of which flow out of the awarding of tax exemption, DoN approval, or even ACO certification through appropriate levels of interagency coordination. Municipalities can also partner and coordinate with area hospitals, health departments, and community groups on shared priorities. Together, hospitals, community leaders, elected officials, and state policy leaders can write the next chapter for hospital community benefits in Massachusetts.

APPENDICES

Appendix A. FY 2015 Community Benefit Expenditures

HOSPITALS	TOTAL PATIENT EXPENSES (TPE)	DIRECT COMMUNITY BENEFIT SPENDING/TPE	TOTAL CHARITY CARE SPENDING/TPE	TOTAL COMMUNITY BENEFIT/TPE
Anna Jaques Hospital	\$108,962,919	0.14%	1.51%	1.68%
Athol Memorial Hospital	\$22,211,828	1.61%	1.42%	3.22%
Baystate Franklin Medical Center	\$89,917,771	0.37%	1.09%	1.97%
Baystate Mary Lane Hospital	\$28,516,125	0.61%	1.46%	2.09%
Baystate Medical Center	\$900,187,680	0.98%	1.03%	2.59%
Baystate Noble Hospital	\$57,246,048	0.13%	0.84%	0.98%
Baystate Wing Hospital	\$86,346,095	0.60%	0.80%	1.44%
Berkshire Medical Center	\$324,816,942	1.82%	0.76%	4.29%
Beth Israel Deaconess Hospital/Needham	\$68,904,557	0.28%	1.09%	1.46%
Beth Israel Deaconess Medical Center	\$1,045,247,568	1.30%	1.54%	3.43%
Brigham and Women's Hospital	\$1,573,679,065	1.37%	1.69%	3.57%
Boston Children's Hospital	\$885,477,395	3.57%	1.17%	5.09%
Boston Medical Center	DID NOT REPORT			
Cape Cod Healthcare	\$558,049,971	2.38%	1.07%	3.76%
Carney Hospital	\$91,622,563	0.67%	1.90%	2.71%
Clinton Hospital	\$23,017,786	0.39%	2.08%	2.47%
Cooley Dickinson Hospital	\$144,819,886	0.43%	1.08%	1.90%
Dana-Farber Cancer Institute	\$577,158,034	0.43%	2.04%	3.53%
Emerson Hospital	\$184,173,047	0.24%	1.46%	1.83%
Fairview Hospital	\$39,634,160	3.43%	0.78%	4.47%
Faulkner Hospital	\$202,066,217	0.97%	1.42%	2.40%
Good Samaritan Medical Center	\$227,403,876	0.49%	1.45%	1.95%
Hallmark Health System	\$224,282,500	0.89%	0.94%	3.38%
Harrington Memorial Hospital	\$112,544,375	0.60%	0.74%	1.35%
HealthAlliance, Inc.	\$138,771,633	0.39%	1.11%	1.55%
Heywood Hospital	\$92,457,384	0.91%	1.43%	2.65%
Holy Family Hospital & Medical Center	\$179,159,733	0.49%	1.36%	2.47%
Holyoke Medical Center, Inc.	\$100,017,221	13.02%	0.92%	13.94%
Jordan Hospital	\$193,513,214	0.63%	1.42%	2.75%
Lahey Clinic Medical Center	\$724,814,784	0.32%	1.20%	1.57%
Lawrence General Hospital	\$224,957,563	5.26%	1.02%	6.64%
Lowell General Hospital	\$382,026,883	0.51%	1.93%	3.12%
Marlborough Hospital	\$67,534,339	0.39%	1.84%	2.23%
Martha's Vineyard Hospital	\$69,662,813	0.41%	0.69%	1.46%
Massachusetts Eye and Ear Infirmary	\$172,929,936	0.36%	1.24%	1.62%
Massachusetts General Hospital	\$2,191,093,139	2.46%	1.46%	4.62%
Mercy Medical Center	\$248,285,432	1.17%	1.10%	2.30%

continued

continued

HOSPITALS	TOTAL PATIENT EXPENSES (TPE)	DIRECT COMMUNITY BENEFIT SPENDING/TPE	TOTAL CHARITY CARE SPENDING/TPE	TOTAL COMMUNITY BENEFIT/TPE
MetroWest Medical Center	DID NOT REPORT			
Milford Regional Medical Center	\$172,685,839	0.62%	2.39%	3.22%
Milton Hospital	\$74,044,976	0.25%	1.29%	1.64%
Morton Hospital & Medical Center	\$35,261,192	4.35%	3.02%	10.39%
Mount Auburn Hospital	\$281,386,036	0.43%	1.14%	1.72%
Nantucket Cottage Hospital	\$39,284,607	0.61%	0.82%	1.85%
Nashoba Valley Medical Center	\$46,252,637	0.01%	1.21%	1.30%
New England Baptist Hospital	\$199,348,444	0.27%	1.08%	1.36%
Newton-Wellesley Hospital	\$369,585,024	0.32%	1.94%	2.33%
North Shore Medical Center	\$415,169,552	0.61%	1.23%	2.36%
Northeast Hospital Corporation	\$327,447,300	0.34%	1.09%	1.50%
Norwood Hospital	\$140,611,558	0.10%	1.42%	1.75%
Saint Anne's Hospital	\$196,008,425	0.60%	1.09%	2.06%
Saint Vincent Hospital	DID NOT REPORT			
Signature Healthcare Brockton Hospital	\$238,785,432	0.11%	2.36%	2.51%
South Shore Hospital	\$444,571,528	0.73%	0.91%	1.78%
Southcoast Hospitals Group	\$645,847,561	1.77%	1.03%	2.92%
St. Elizabeth's Medical Center	\$204,901,695	3.27%	1.44%	4.93%
Sturdy Memorial Hospital	\$149,409,031	0.38%	1.24%	1.62%
Tufts Medical Center	\$577,167,383	1.02%	1.42%	2.63%
UMass Memorial Medical Center	\$1,272,863,031	0.38%	1.05%	1.51%
Winchester Hospital	\$256,415,408	0.40%	1.05%	1.67%

Appendix B. Health Policy Commission Cohort Designations Status 2013

AMC

- Beth Israel Deaconess Medical Center
- Brigham and Women's Hospital
- Massachusetts General Hospital
- Tufts Medical Center
- UMass Memorial Medical Center
- Boston Medical Center*

COMMUNITY DSH

- Athol Memorial Hospital
- Cape Cod Healthcare, Inc.
- Falmouth Hospital
- Steward Good Samaritan Medical Center
- Clinton Hospital
- Fairview Hospital
- Baystate Franklin Medical Center
- Harrington Memorial Hospital
- HealthAlliance, Inc.
- Heywood Hospital
- Steward Holy Family Medical Center
- Holyoke Medical Center, Inc.
- Lawrence General Hospital
- Signature Healthcare Brockton Hospital
- Marlborough Hospital
- Martha's Vineyard Hospital
- Mercy Medical Center
- Morton Hospital & Medical Center
- Noble Hospital
- North Shore Medical Center
- Southcoast Hospitals Group
- Steward Saint Anne's Hospital
- Sturdy Memorial Hospital
- Baystate Wing Hospital

COMMUNITY NON-DSH

- Anna Jaques Hospital
- Steward Norwood Hospital
- Cooley Dickinson Hospital
- Beth Israel Deaconess Hospital/Needham
- Beth Israel Deaconess/Milton
- Emerson Hospital
- Hallmark Health System
- Beth Israel Deaconess/Plymouth
- Lowell General Hospital
- Baystate Mary Lane Hospital
- MetroWest Medical Center
- Milford Regional Medical Center
- Nantucket Cottage Hospital
- Steward Nashoba Valley Medical Center
- Newton-Wellesley Hospital
- Northeast Hospital Corporation
- South Shore Hospital
- Winchester Hospital

SPECIALTY

- Boston Children's Hospital
- Dana-Farber Cancer Institute
- Massachusetts Eye and Ear Infirmary
- New England Baptist Hospital

TEACHING

- Steward Carney Hospital
- Baystate Medical Center
- Berkshire Medical Center
- Faulkner Hospital
- Lahey Clinic Medical Center
- Mount Auburn Hospital
- Saint Vincent Hospital
- Steward St. Elizabeth's Medical Center

HOSPITAL COHORT DEFINITIONS

Hospital DSH status can fluctuate from year to year. This report uses the Health Policy Commission 2016 report designations, which used the 2013 Cohort designations.

AMCs—Academic Medical Centers—are acute hospitals with extensive research and teaching programs. They serve as principal teaching hospitals for their respective medical schools and have extensive resources for tertiary and quaternary care, with a case mix index greater than 5 percent above the statewide average.

Teaching hospitals are those that host at least 25 full-time equivalent medical residents per one hundred inpatient beds but do not otherwise meet the requirements to be considered AMCs.

Community Non-DSH hospitals are all non-specialty acute hospitals that are not AMCs or teaching hospitals.

Community DSH hospitals are those community hospitals that receive at least 63 percent of their gross patient service revenue from government payers.

Specialty hospitals are those that serve a unique patient population or provide a unique set of services.

*BMC did not file a community benefit report and is not included in the breakdown.

Source: Massachusetts Health Policy Commission Report, Community Hospitals at a Crossroads, January 2016. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>

Appendix C. Comparison of IRS Guidelines and Attorney General’s Guidelines for Community Benefit Calculation

ITEM	IRS SCHEDULE H: FORM 990	MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL
Charity care at cost	Yes	Yes
Unreimbursed Medicaid costs	Yes	No
Community health improvement services and community benefit operations	Yes	Yes: Including determination of need expenditures, employee voluntarism, and other leveraged results
Health professions education	Yes	No
Research	Yes	No
Cash in-kind contribution to community groups	Yes	Yes
Bad debt	Information requested	Can report if suggested debt collection practices are followed
Corporate sponsorships	Presumably included in contributions to community groups	Can report if suggested debt collection practices are followed

Source: Massachusetts Division of Health Care Finance and Policy, Study of the Reserves and Surpluses of Insurers in Massachusetts, May 2010, p 57. Accessed at <https://www.scribd.com/document/31506835/Hospital-Reserves>.

Appendix D. Limitations of This Report

This report relies extensively upon data that Massachusetts hospitals provide to the Massachusetts attorney general as part of the requisite annual community benefit reports. While the IRS Schedule H could have been also used, the study relies specifically on reporting to the attorney general. The Massachusetts attorney general uses reports from hospitals and from Schedule H to quantify community benefits. All Massachusetts hospitals report (with the exceptions described below), and therefore this data provides a method of cross-hospital comparison. Unlike under the federal Schedule H, the Massachusetts guidelines require for-profit hospitals to report. In comparison to the federal government, Massachusetts excludes some categories in its count of community benefits. Two major health care entities, Boston Medical Center and Cambridge Health Alliance, do not report. These two hospitals are DSH hospitals and serve underserved populations; their reporting might change the overall numbers in some instances. Hospitals report total patient expenses, and the attorney general uses these as a metric of community benefit spending. In the 2015 data set, two hospitals MetroWest and St. Vincent’s, did not report total patient expenses. It is important to note the loss of two hospitals, North Adams Regional and Quincy Medical Center during the 2014-2015 period.

The Partners HealthCare system, in addition to each of its affiliated hospitals, also reports to the attorney general as a system. Its financial reporting includes both Partners hospitals’ contributions as well as some that the system makes on its own. Given that this report focuses on hospital community benefit programs, it excludes those contributions reported at the system level, as they are already reflected in the individual hospital filings. In some cases, hospitals do not report full data; for that reason, the hospital-by-hospital comparisons may be missing data in a specific year. Prior to 2009, the reporting categories were slightly different, so in some instances 2008 data were excluded.

Appendix E. States with Financial Community Benefit Requirements*

ILLINOIS

Illinois specifies a minimum level of charity care or other “health services to low-income or underserved individuals” that a non-profit hospital must provide to qualify for property and sales tax exemption. Effective in 2012, an Illinois statute requires that non-profit hospitals seeking property tax exemption provide charity care or other specified services or activities at levels at least equivalent to what the hospital otherwise would be required to pay in property taxes. S.B. 2194, codified at 35 ILCS 200/15-86(c) (2012), <http://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=003502000HArt.+15&ActID=596&ChapterID=8&SeqStart=35900000&SeqEnd=40700000>.

NEVADA

Nevada requires that non-profit and for-profit hospitals that have at least 100 beds and are located in a county that has at least two licensed hospitals annually provide care for indigent inpatients in an amount that represents at least 0.6 percent of the hospital’s net revenue for the preceding fiscal year. Nev. Rev. Stat. §439B.320 (<https://www.leg.state.nv.us/NRS/NRS-439B.html>). If the amount of treatment a hospital provides to indigent patients is less than 0.6 percent of its net revenues for the previous year, the county will deduct the shortfall from payments otherwise owed to the hospital. (Nev. Rev. Stat. §439B.340(2)(c), <https://www.leg.state.nv.us/NRS/NRS-439B.html>.)

PENNSYLVANIA

Pennsylvania law permits most non-profit hospitals to choose from among seven alternative community benefit standards in order to qualify as a tax-exempt “institution of purely public charity.” Six of these standards specify a minimum level of community benefits. One of the requirements is “Providing goods or services to all who seek them without regard of their ability to pay if the institution a) has a written policy to this effect, b) has published this in a reasonable manner, and c) provides these uncompensated goods or services equal to at least 75% of net operating income, but not less than 3% of total operating expenses.” (10 Pa. Stat. §375(d)(1)(i)(C), <http://www.dos.pa.gov/BusinessCharities/Charities/Resources/Pages/The-Institutions-of-Purely-Public-Charity-Act.aspx#Vks9JU2FPq4>.)

TEXAS

Texas has three alternative standards, and hospitals must meet one of them. Two of the three set a minimum level of contribution that a hospital must provide.

1. Charity care and government-sponsored indigent health care (shortfall) at a level that is “reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system;”

* Source: Community Benefit State Law Profiles: A 50-State Survey of State Community Benefit Laws through the Lens of the ACA. Hilltop Institute, The Hilltop Institute, UMBC. Available at http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm.

2. Charity care and government-sponsored indigent health care (shortfall) provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax;
3. Charity care and community benefits provided in a combined amount equal to at least 5 percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least 4 percent of net patient revenue. Texas Tax Code Ann. §§11.1801(a), <http://www.statutes.legis.state.tx.us/Docs/TX/pdf/TX.11.pdf>; Tex. Health and Safety Code Ann. §§ 311.031(2) & (8); 311.045, <http://www.statutes.legis.state.tx.us/DocViewer.aspx?K2DocKey=odbc%3a%2f%2fTCAS%2fASUPUBLIC.dbo.vwTCAS%2fHS%2fS%2fHS.311%40TCAS2&QueryText=311.042&HighlightType=1>.

UTAH

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Community benefits are at a crossroads in Massachusetts and nationally. We hope this report will increase the impact of community benefit on community health and lead to more sustainable long-term hospital-community partnerships. We know those partnerships are the key to tackling the underlying disparities in our communities and improving health for all of us.



Because we all should have a say
in decisions that affect **our health**