Testimony Supporting H.B. No. 6550: An Act Concerning the Office of Health Strategy's Recommendations Regarding Various Revisions to Community Benefits Programs Administered by Hospitals

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Public Health Committee

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Dear Senator Daugherty Abrams, Representative Steinberg, and esteemed members of the Public Health Committee,

My name is Dashni Sathasivam and I am testifying today on behalf of Health Equity Solutions, where I serve as the Manager of Policy & Outreach. Health Equity Solutions is a nonprofit organization with a statewide focus on promoting policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

Health Equity Solutions **strongly supports** this proposed legislation to strengthen Connecticut's community benefit program requirements. **Tying community benefit spending to needs identified by communities in community health needs assessments (CHNAs) is a promising strategy for advancing health equity.** This strategy aligns community investments with initiatives that address underlying barriers to health. Greater community benefit program spending has been associated with lower hospital readmission rates,[1] which can lead to tangible reductions in health care costs and signify improved health.

Over 14 states (including: OR, CA, ID, MA, WA, RI, IL, NV, PA, TX, UT, MD, ME, and VT) have passed laws outlining community benefit spending requirements and/or reporting standards that go beyond the federal IRS standards. Connecticut has an opportunity to learn from the experiences of other states and leverage community benefit programs as a tool to advance equity.

The community benefit program was designed as a required accountability mechanism for nonprofit hospitals to contribute to the wellbeing of their communities in lieu of their contributions to state and federal income and property taxes that would otherwise fund local resources and the education system.[2] Since triannual CHNAs are already a federally required process and recognized as a tool for

[1] Chaiyachati, K. H., Qi, M., & Werner, R. M. (2020). Nonprofit hospital community benefit spending and readmission rates. Population health management, 23(1), 85-91.

[2] Rubin DB, Singh SR, Young GJ. Tax-exempt hospitals and community benefit: new directions in policy and practice. Annu Rev Public Health. 2015;36:545–57.

health equity [3, 4, 5] linking these existing programs adds accountability without adding burden. In other words, this proposal ties community benefit to data on and input already gathered from the hospital's community.

Currently, the largest share of community benefit dollars are spent on financial community benefits, with these dollars going directly back to the hospital to make up for the costs of care provided to un- and under-insured people [6] Examples of spending on non-financial community benefits include lead abatement initiatives, supportive housing, legal aid, community health advocacy, and coalition building.[7]

Community benefit spending, as reported on the IRS 990 Form H, has gone down across the country since the enactment of the Affordable Care Act (ACA). Much of this reduction in community benefit spending reflects higher insurance coverage rates following the passage of the ACA and a corresponding decrease in the need for subsidized and free healthcare. However, other areas such as non-financial community benefit spending have not increased to make up for this reduction.[8]

The range of spending on non-financial community benefits among Connecticut hospitals is meant to depend, in part, on the social, economic, and health needs of the population served by each hospital. Developing a unique spending floor requirement based on previous trends in spending, priorities identified in the CHNA, and each hospital's financial performance provides a minimum threshold that is tailored and responsive to a hospital's individual circumstances. This approach increases transparency and is calibrated to avoid any undo burden on our hospitals. For example, this process accounts for hospitals' proportion of uninsured patients, which has been linked to lower community health improvement spending.[9]

Effectively, **H.B. 6550 proposes aligning existing processes for a more coordinated, impactful, and community-responsive approach that recognizes and further supports hospitals in serving as "anchor institutions" that work to help address costly health inequities in their communities.**[10]

We also support the proposals in H.B. 5575 and H.B. 5991 to improve transparency and community engagement for for-profit hospitals because they offer similar opportunities to address the social and economic factors that drive inequities in health outcomes.

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[3] Ainsworth D, Diaz H, Schmidtlein MC. Getting more for your money: designing community needs assess-ments to build collaboration and capacity in hospital system commu-nity benefit work. Health Promot Pract. 2013;14(6):868–75.
[4] Cain CL, Orionzi D, O'Brien M, Trahan L. The power of community voices for enhancing community health needs assessments. Health Promot Pract. 2016;18(3):437–43.
[5] Mathews AL, Coyle BS, Deegan MM. Building community while comply-ing with the Affordable Care Act in the Lehigh Valley of Pennsylvania. Prog Community Health Partnersh. 2015;9(1):101–12.
[6] *FY 2018 tax returns from Connecticut nonprofit hospitals*
[7] Catholic Health Association. (2020). *Community Benefit Categories and Definitions*. https://www.chausa.org/docs/default-source/community-benefit/guide-for-planning-2020/cb_guide-for-planning_2020_categories_and_definitions.pdf?sfvrsn=0
[8] Genevieve Kanter et al., *Association of State Medicaid Expansion with Hospital Community Benefit Spending*, JAMA NETWORK OPEN (May 29, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766544.
[9] Geri Cramer et al., *The Progress of U.S. Hospitals in Addressing Community Health Needs*, 107 AM. J. PUB. HEALTH 2 (2017), 255-261.
[10] https://www.brookings.edu/wp-content/uploads/2016/07/Rosenbaum-PDF-Layout-FINAL-1.pdf

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The pandemic and related disproportionate rates of COVID-19 infection and death experienced by Black, Latino, and American Indian communities have demonstrated the need for and value of local resources to maintain health in times of vulnerability.[11,12] Setting aside a minimum amount of community benefit dollars to address health disparities and social determinants of health ensures that nonprofit hospitals' reinvestments stay local and help to financially support needed community resources. As it stands, Connecticut sees a robust level of investment via community benefit spending programs. These proposed changes strengthen clarity and create a reporting system so that the impact of these programs can be better understood. At present, it can be challenging to parse the human impact of these programs because of the IRS-focused reporting structure.

Clear and detailed information through standardized reporting requirements improves nonprofit hospitals' accountability to the communities they serve and better highlights their investments in them. Currently, the IRS defines community benefit spending categories; however, the federal guidance is ambiguous.[13] As a result, it is difficult to compare community benefit programs across hospitals, fully understand which programs and partners were included, or identify hospitals' work to support community health. The proposed reporting standards for CHNAs and community benefit programs are critical for improving transparency and targeting disparities unique to each hospital's service area through the inclusion of outcome metrics, demographic data, standard processes of identifying and prioritizing community needs, and a definition of what it means to solicit meaningful community input and feedback.

We respectfully recommend the following:

- **Define "meaningful participation"** to set a standard for soliciting community input and engagement for CHNAs and community benefit programs. The IRS offers a sweeping description of "Input Representing the Broad Interests of the Community,"[14] leaving the program without a common or measurable definition of how communities are engaged to participate in these processes. Clarifying this element will ensure these processes are comparable across hospitals.
- **Specify demographic data reporting requirements** to include population-level data already collected by hospitals on demographic factors associated with health disparities, including race, ethnicity, primary language, disability status, sexual orientation, and gender identity. Demographic data should be reported utilizing the standard categories already reported to the state through other reporting systems and structures and in adherence with data standards. This data can serve as basis for partnership and collaboration with community-based

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[11] Putterman, A. (2020, April 8). Black and Latino residents hit particularly hard by COVID-19 in Connecticut, as experts fear disparities will widen. *Hartford Courant*. https://www.courant.com/coronavirus/hc-news-coronavirus-covid-19-racial-disparities-0407-20200408-jsrg2au2fnab5fbxhpu4ioqmb4-story.html

[12] Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169.
DOI: http://dx.doi.org/10.15585/mmwr.mm6934e1external icon

[13] https://www.healthaffairs.org/do/10.1377/hblog20161201.057691/full/

[14] https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

organizations skilled and engaged in addressing social determinants of health through culturally and linguistically appropriate approaches.[15]

- **Solicit public feedback via an annual public comment period** on the OHS summary and analysis of community benefits program reports. This ensures an opportunity for communities and stakeholders to provide input and serves as an accountability and transparency mechanism to respond to stakeholder recommendations whether or not they are adopted. In other words, this is a relatively simple way of creating a sustained feedback loop among hospitals, the Office of Health Strategy, and consumers.

Stronger community benefit standards, as proposed in H.B. 6550, can help to elevate opportunities for all Connecticut residents to attain their optimal health. The spending floor, reporting standards, and our suggested changes promote fairness and transparency. They also promote health equity by encouraging upstream investments to alleviate social and economic inequities (e.g. housing and food insecurity, uninsurance) that drive disparate health outcomes (e.g. maternal mortality, diabetes, life expectancy) for Black, Indigenous, Latino(a), Asian, and other people of color in our state.

Thank you for the opportunity to testify in support of H.B. 6550 I can be reached with any questions at dashni@hesct.org or 860.937.6432.

[15] Carroll-Scott, A., Henson, R. M., Kolker, J., & Purtle, J. (2017). The role of nonprofit hospitals in identifying and addressing health inequities in cities. *Health Affairs*, *36*(6), 1102-1109.