UNIVERSAL HEALTH CARE
Foundation of Connecticut

**Testimony in Support of House Bill 6550: An Act Concerning the Office of Health Strategy's Recommendations Regarding Various Revisions to Community Benefits Programs Administered by Hospitals**

**Universal Health Care Foundation of Connecticut**
**March 8, 2021**

Chairs and members of the Public Health Committee, thank you for the opportunity to submit testimony in support of House Bill 6550: An Act Concerning the Office of Health Strategy's Recommendations Regarding Various Revisions to Community Benefits Programs Administered by Hospitals.

At Universal Health Care Foundation, we envision a health system that is accountable and responsive to the people it serves, that supports our health, takes excellent care of all of us when we are sick, at a cost that doesn't threaten our financial security. We support this bill because it requires that hospitals are accountable to the communities they serve by investing in community health and well-being.

In exchange for non-profit status, non-profit hospitals are asked to reinvest in their communities with the goal of focusing on community health needs, as opposed to simply providing direct medical services to patients. Currently, however, most of the community benefit spending that hospitals report is primarily charity care and Medicaid and Medicare shortfalls – known as financial community benefit – rather than community investment.

The majority of community benefit spending is not spent explicitly on community needs, but on Medicaid and Medicare shortfalls and uncompensated care. In 2018, Connecticut hospitals spent $1.053 billion on community benefits, but 93.82% of this was for Medicaid shortfalls and uncompensated care.

In contrast, hospitals spent, of their overall community benefit spending, only 2.18% on community services promoting community health, 0.66% on community building projects, and 1.61% on donations to community organizations, according to data on the Connecticut Hospital Association website. This breakdown of spending does not show that hospitals are prioritizing the needs of their communities. Instead, hospitals are labeling the uncompensated care costs that they would be spending regardless as community benefit.

Hospitals are also not required to focus on underserved populations and do not have to target the concerns identified in their Community Health Needs Assessments (CHNA) with their community benefit spending. This lack of specification allows hospitals to not direct their spending at underserved populations or the social determinants of health,

where there is likely the most need in the community, as a report by Community Catalyst about community benefit in Connecticut points out.

Connecticut currently has no minimum requirement for community benefit spending. Establishing a community benefit and community building spending floor would create accountability for hospitals to invest in their communities. Non-profit hospitals do not pay property taxes to their communities, causing these communities to lose revenue that could support community services like education or infrastructure. As a result, hospitals should be obligated to invest in the well-being of their communities, if they are exempt from taxes.

Creating a spending floor for community benefit would also ensure that communities across Connecticut receive comparable investments from their health systems. According to a state report, in 2014, out of 30 acute care hospitals in Connecticut, 18 are located in communities with health outcomes worse than state averages. This reality illustrates the fact that hospitals are frequently located in communities that have unmet health needs and that could benefit from hospital investment. The community building spending floor holds hospitals accountable to community investment.

Greater transparency is also needed around community benefit programs. This bill requires that community benefit reports are available to the public and that OHS must publish a yearly analysis of these reports. While the IRS defines types of community benefit spending, hospitals are able to interpret these definitions for themselves, creating discrepancies between hospital reports and making it difficult for communities to hold hospitals accountable to their proposed investments. Uniform reporting to OHS and OHS' analysis of the reporting are important to be able to hold hospitals accountable.

The civil penalty in this bill is critical because it enforces the requirement of hospitals filing information about their community benefit programs. Without this penalty, hospitals would be able to ignore responsibility and not fulfill their obligation of investing in community health. When hospitals hold non-profit status, they enter into a bargain with their communities. The state must be able to enforce hospital accountability in this bargain.

Other states have implemented guidelines similar to those proposed. Rhode Island and Massachusetts require that CHNAs discuss health objectives identified on the state level, as a way to encourage addressing the social determinants of health. Texas and Oregon require that hospital community benefit spending programs address the priorities determined in their CHNAs. In California, Washington, and Rhode Island, hospitals must intentionally assess the needs of underserved communities and communities of color. Six states – Illinois, Nevada, Pennsylvania, Texas, Utah, and Oregon – have minimum levels for spending. Maine, Massachusetts, Vermont, and Washington have specific requirements for eliciting feedback on CHNAs from stakeholders.

**We propose several recommendations to strengthen this bill.**

First**, hospitals should be required to collect data on race, ethnicity, primary language, sexual orientation, and gender identity in relation to their CHNAs and their community benefit reporting**.

Racial inequities in health outcomes are prevalent. For example, per a report from the Connecticut Health Foundation, babies with Black mothers have four times the rate of infant mortality than babies born to white mothers. Black men are twice as likely to die from prostate cancer than white men. Hispanic and Black residents in Connecticut are more than twice as likely than white residents to have diabetes and are also more likely to develop severe complications. Those who speak languages other than English also see health disparities and inequities.

LGBTQ+ individuals experience barriers to health insurance and providers, and number of health disparities. LGBTQ+ individuals are at an increased risk of suicide, depression, other mental health problems, HIV and STDs, substance use disorders, and decreased likelihood of cancer screenings, according to information on HealthyPeople.gov.

Due to the increased health risks associated with these different populations, it is important that hospitals are aware of these data to determine how to best serve their communities. Having hospitals collect data on race, ethnicity, primary language, sexual orientation, and gender identity can better our understanding of health inequities and disparities and help hospitals develop priorities for community benefit spending. Without this data we would not be able to evaluate if strategies to reduce disparities are working. This information is also important to help hospitals reduce cultural and linguistic barriers to more effectively engage with their community

**This bill should also include:**

- **requirements for community stakeholder engagement in the creation of community needs assessments,**
- **creation of a definition of "meaningful engagement" of community members, and**
- **solicitation of community feedback at an annual public hearing or in a comment period for the OHS community benefit report.**

These provisions ensure that community stakeholders cannot be left out of the process, ensuring greater hospital accountability, and recognizes that community members are the experts on their communities. Community benefit spending is irrelevant if it does not address the community's needs and concerns.

Nonprofit hospitals have a responsibility to invest in the health of their communities due to their tax-exempt status. However, Connecticut is currently unable to hold hospitals accountable. This legislation ensures that hospital community benefit spending fulfills its actual purpose. We urge you to support this proposal and our recommended changes because they are crucial to holding hospitals accountable to their communities. Thank you.