

HEALTH LAW

Hospitals' Obligations to Address Social Determinants of Health

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Abstract

Federal health care reform has expanded medical insurance to millions of people, altering the role that hospitals play in improving community health. However, current federal and state community benefit policy is an ineffective tool for ensuring that hospitals address the social determinants of health afflicting their communities. Policy shifts and other incentives that promote improved population health outcomes can encourage health care organizations to do the same.

Hospitals' Responsiveness to Community Needs

In the early 19th century, hospitals emerged as welfare institutions, or as branches of cities' almshouses.¹ The municipal almshouse served as a haven for its elderly, unemployed, ill, disabled, delinquent, minors, and incompetent. In the words of Charles Rosenberg, the internal composition of the almshouse "inevitably reflected the diversity of misfortunes afflicting its clients."¹ Physicians became widely engaged to care for clientele at almshouses, where staff positions were sought after as valuable learning and teaching opportunities. Thus, at no point when the hospital first emerged, was "public medicine" detached from medical careers or "distinguishable from the more pervasive problem of dependency."¹ However, beginning in the early 20th century, the welfare hospital for the "rootless and dependent"¹ gradually transformed into a market institution, potentially profitable and powered by patient payments.^{1,2} Simultaneously, physicians became increasingly employed by national medical networks and academic institutions whose clientele were less marked by dependency.² As a result, market forces in today's medical system may be opposed to the charitable interests of hospitals' past.

Nevertheless, nongovernmental nonprofit hospitals retain remnants of their historical mission—a "charitable purpose."³ In 2019, the American Hospital Association reported that 56% of community hospitals in the United States are organized as nongovernment nonprofit organizations, and, government hospitals included, nearly 80% of community hospitals enjoy tax-exempt status.⁴ In return, they are exempt from billions in state and federal tax liability (an estimated \$24.6 billion in 2011⁵). Courts typically describe the indirect subsidy as a quid pro quo that charitable hospitals receive for alleviating a substantial government burden through the care they provide.^{6,7} In other words, the tax

revenue lost through exemption may be considered offset by the hospitals' contributions to society.

Are current legal standards adequate to ensure that hospitals fulfill the role for which massive subsidies are granted? Consistent with the goal of the Affordable Care Act (ACA) to "support innovative medical care delivery methods designed to lower the costs of health care generally,"⁸ hospitals may consider spending less of their charitable budgets on the cost of uncompensated clinical care and more on the social determinants of health. According to Thomas Frieden, "interventions that address social determinants of health have the greatest potential public health benefit."⁹ Easterling and McDuffee report that modern health care consumers' socioeconomic backgrounds create a diverse "mix of resources, opportunities, obstacles and threats which determine to a great extent the level of health that can be achieved."¹⁰ Emphasizing this point in a June 2018 address to the American Medical Association House of Delegates, the US Surgeon General, Jerome Adams, urged physicians to resist responding to national health with clinical solutions alone.¹¹ Cogently, he iterated that today's most urgent health issues—whether "opioid addiction or unwanted pregnancies, gun violence or suicide, heart disease or cancer"—share risk factors.¹¹ Solving them requires addressing the root causes of poor community health. While ACA-enacted tax exemption requirements encourage hospital accountability in community health improvement,¹² hospitals that seek to provide innovative care that lowers costs may need to go above and beyond what is required.

Federal Community Benefit Standards Following Health Reform

Before Medicare and Medicaid were implemented in 1966,^{13,14} the Internal Revenue Service (IRS) required nonprofit hospitals to provide free or discounted care to indigent and uninsured patients to qualify for exemptions (the "charity" care standard).¹⁵ Upon the federal programs' drastic reduction of the uninsured and consequentially diminished need for [charity care](#), the IRS relaxed its standard such that hospitals could maintain exempt status if they provided "community benefit."¹⁶

Community benefit following Medicare and Medicaid. Under a broader standard, expenditures recognized by the IRS as providing community benefit include unreimbursed research, health professions education and training, unpaid costs of public programs, and other community health improvement activities, in addition to free or discounted care provided under the traditional charity care standard.¹⁷ Significantly, federal law does not set a minimum amount of benefits; rather, the IRS considers the "facts and circumstances"¹⁸ of each case to determine whether a hospital's contributions are sufficient for tax exemption.^{18,19} Following suit, 23 states enacted legislation requiring nonprofit hospitals to provide community benefits.²⁰

Community benefit following the ACA. Like Medicare and Medicaid, the ACA has reduced the number of America's uninsured, extending coverage to an estimated 20 million individuals since its enactment.²¹ Unlike the preceding programs, the ACA's enactment was not accompanied by more lenient tax-exemption standards. Instead, the IRS added regulations to Internal Revenue Code that require charitable hospitals at least once every 3 years to conduct a community health needs assessment (CHNA) and adopt an implementation strategy that includes a description of how the hospital plans to meet identified needs and incorporates input from community representatives.^{22,23} However, the new regulations do not identify particular mechanisms for addressing community needs, nor do they mandate any specific infrastructure for intervention. To monitor CHNA compliance, the IRS uses Form 990 Schedule H, which requires hospitals to report their community benefits.¹⁷ For hospitals that fail to comply, a \$50 000 excise tax is imposed,²⁴ and tax-exempt status may be revoked.²⁵ However, only 2 hospitals have lost tax-exempt status in consequence.^{26,27} According to an estimate of community benefit spending in 2009 based on Schedule H data, before the enactment of the ACA, tax-exempt hospitals spent about 7.5% of their total operating budgets on community benefits.^{28,29} Post-ACA estimates reflect only a modest increase, at 8.5% in 2012 and 8.1% in 2014.^{29,30}

Rethinking Community Benefit to Address Community-Based Social Issues

Tax-exempt hospitals continue to spend the most community benefit resources on unreimbursed care, not community health improvement.⁵ Although federal health care reform has freed up hospitals' financial resources, one potential explanation for this spending trend is, according to Gary Young and colleagues, that "many hospitals may lack the infrastructure and competencies necessary for effectively engaging in community health initiatives."²⁸ However, population health is substantially determined by community-based issues that fall outside the purview of basic clinical care. Known as [social determinants of health](#), these factors include education, income security, neighborhood safety, food access, and presence of support networks, among others.¹⁰ Thus, instead of addressing a diminishing need for charity care, more community benefit expenditures should address community-based issues that expose people to illness and injury.

According to Kenneth McLeroy and colleagues, multiple models of community-based interventions for health promotion currently exist.³¹ However, 3 specific categories of community-based projects may particularly strengthen public health while building community capacity to address health-related issues. Because individual behaviors are the result of multiple social influences at varying levels, interventions in any model must mobilize social influences, which may include family support, social networks, neighborhood characteristics, organizational policies and practices, community factors, public policy, the physical environment, and culture.³¹ In a "setting" model, the community may be understood as the geographical setting where interventions are

implemented, and the purpose of projects is to change individual behavior in order to reduce the population's risk of disease.³¹ "Setting" projects may use mass media to convey community-wide initiatives, include educational strategies and public policy, and engage community committees or advisory groups that provide input in developing interventions for specific target groups or in tailoring programs to community characteristics. In a second model, the community is understood as the "target of change," such that the goal of projects is to create "healthy community environments through broad systemic changes in public policy and community-wide institutions and services" by using interventions to improve characteristics that are thought to be related to poor public health.³¹ For example, community indicators may include poor air quality, limited amount of park space per capita, and number of residents living below the federal poverty level. Finally, in a model often utilized for health promotion, interventions engage the community as a resource, based on the "belief that a high degree of community ownership and participation is essential for sustained success in population-level health outcomes."³¹ Such programs align a community's existing resources with a strategically targeted set of identified health-related priorities. Often, these methods may involve external resources or actors that seek to achieve health outcomes by working through an array of community institutions and across different sectors.

Socially-oriented state policy enhancements. One way that community-based interventions may be achieved is through more stringent state regulation that requires hospitals to exceed federal requirements.²⁰ Such methods can be understood as broad, setting, or resource-based models that seek to influence organizational or institutional behavior to improve state-wide health. For example, California requires community benefit activities to address community priorities specifically and primarily through disease prevention and health status improvement.³² The relevant statute lists approved activities, including health education, prevention, and social services, which are offered without cost because they meet identified needs in the hospital's service area.³³ The California Hospital Association provides notable examples of services that meet state standards in a guide for community benefit planning.³⁴ For example, San Diego's City Heights Wellness Center, a joint project of 2 local hospitals, offers multilingual cooking classes to combat high rates of diabetes and obesity, tailored to the unique needs of its culturally diverse community.^{34,35} Recognizing that California's homeless population has particular difficulty accessing health care—especially up-to-date immunizations for children—Cedars-Sinai Hospital dispatches mobile units to homeless shelters in Los Angeles.^{34,36} Similarly, the Street Nurse Program at Sutter Medical Center in Sacramento connects the "fragile homeless population" surrounding the medical center with on-demand medical care or advice.³⁷ Nurses personally drive patients to the clinic or help them access other services. Working in close partnership with another Sutter program, hospital personnel build relationships with local homeless persons and eventually help them access services such as housing, medical care, and substance use treatment.³⁷

Other states may place additional requirements on the CHNA process, adding public input requirements or stricter standards for implementation plans. In Vermont, hospitals must identify a “process for achieving openness, inclusiveness, and meaningful public participation”³⁸ in community benefit planning and publicize yearly progress on proposed initiatives.³⁹ Texas and California require hospitals to include community groups or organizations and government officials in prioritizing needs⁴⁰⁻⁴³ and to identify goals to be achieved over a specific timeline.⁴³⁻⁴⁵ Washington State requires hospitals to publicize geographic and population descriptions of areas they serve if not already provided in the IRS-mandated CHNA. Descriptions must include information such as “leading causes of death, levels of chronic illness, and descriptions of the medically underserved, low-income, and minority, or chronically ill populations in the community.”⁴⁶ According to McLeroy and colleagues, effective community-based interventions require an “insider’s understanding” and “careful assessment of community structures” in advance of implementation.³¹ Presumably, hospitals that abide by these more stringent requirements will be in a better position to identify and address community-specific needs and prioritize them when developing implementation strategies. Furthermore, higher legal standards may incentivize more exacting community benefit planning among hospitals that seek to maintain their tax-exempt status.

Nonregulatory Approaches to Community Benefit

Aside from regulatory interventions, hospitals may engage in federal initiatives or [accountable care organizations](#) (ACOs) that advance community benefit through innovative delivery models. Such models employ a “resource” approach to community-based interventions, because the federal government or a health care organization plays the role of an external actor working in order to align various community resources to advance population-level health priorities using an established infrastructure. Examples of such efforts include the federal Accountable Health Communities Model (AHCM), the federal Next Generation ACO Model, Vermont Blueprint for Health, and OneCare Vermont.

Accountable Health Communities Model. AHCM is a federal model employed by hospitals that seek to reduce clinical spending by addressing the social determinants of health, including “housing instability, food insecurity, utility needs, interpersonal violence and transportation” through clinical-community connections.⁴⁷ The program promotes clinical screening for unmet social needs and assists patients in accessing the appropriate community services.⁴⁸ Significantly, funding is not invested in community programs. Rather than dispersing funding across services, AHCM creates infrastructure that aligns different sectors, ensuring services’ availability and responsiveness to beneficiaries’ needs.⁴⁸

Next Generation ACO Model. Next Generation is a federal model built upon experiences from the Pioneer ACO Model and Medicare Shared Savings Program. ACOs are groups of

health care providers, including hospitals, payers, and physicians and other caregivers, who collaborate to give high-quality, coordinated care. Through coordination, health care organizations can ensure that patients get appropriate care while avoiding unnecessary spending and ineffective treatments.⁴⁹ Currently, 51 ACOs are participating in Next Generation.⁵⁰ The model offers [Medicare ACOs](#) (groups of providers serving original Medicare beneficiaries) opportunities to test whether financial incentives, paired with tools supporting patient engagement and care management, can reduce spending and improve health outcomes for Medicare beneficiaries.⁵⁰

By providing hospitals with fixed funding per beneficiary and requiring hospitals to assume financial risk if spending exceeds fixed amounts, the model advances a national goal of value-based (instead of volume-based) payment, disincentivizes providing costly clinical care, and incentivizes prevention.⁵¹ As previously discussed, preventive measures to address the social determinants of health at the community level may have the greatest effect on public health. Health care organizations, seeking to improve health outcomes while reducing spending, may consider such preventive measures in developing intervention strategies.

Federal, state, and organizational collaboration: OneCare Vermont. In partnership with the federal Centers for Medicare and Medicaid Services and the State of Vermont, OneCare Vermont (an ACO) seeks to promote effective treatment models and derive greater value from a fragmented health care system. The collaboration is a good example of federal, state, and organizational efforts converging to improve community health and may provide a solution for hospitals that believe they lack the infrastructure or resources to proving meaningful community benefit on their own.

Extending the federal Next Generation Medicare model to Medicaid beneficiaries and Blue Cross/Blue Shield members, OneCare is accountable for beneficiaries at 10 of Vermont's 14 hospitals, 21 of its 40 nursing homes, and a majority of primary and specialty care practices.⁵² Like AHCM, OneCare's ACO model seeks to create infrastructure that connects health care organizations with other community social services in order to appropriately outsource care. To do so, OneCare relies on services available through Vermont's state-led Blueprint for Health, which focuses on collaboration for "providers across the spectrum of care"⁵³ and directly invests in community health teams and initiatives, such as patient-centered medical homes, home support services, opioid addiction treatment programs, and healthy living workshops.⁵⁴ OneCare offers coordinators additional funding, training, and resources to collaborate with hospitals, including analytic tools for panel management, performance tracking, and communication.^{52,55}

Shifting towards value-based payment, OneCare rewards cost containment and quality benchmarks by allowing providers to retain excess capital if their expenditures for care fall below the amount budgeted by OneCare.^{52,56} In Vermont's all-payer ACO model,

insurers and hospitals alike contribute additional funding to OneCare for care coordination of high-risk beneficiaries.⁵² OneCare then distributes funding between Blueprint community organizations and hospitals in fixed payments per patient. Because hospitals assume financial risk if their clinical expenditures exceed the fixed payments, the model encourages effective collaboration with community partners beyond the hospitals' walls, driving down costs within them.

Moving Beyond Individual-Focused Care to Support Community Health

Federal health reforms such as the ACA have reduced the national need for charity care, creating opportunities for state governments and health care organizations to intervene upstream in poor population health through community-based initiatives. State legislatures may establish regulation when federal standards are insufficient or take a back seat as new federal policy takes shape. Hospitals, lacking appropriate infrastructure, may choose to participate in initiatives that align state, federal, and organizational efforts.

Realizing individual and shared health care goals requires partnership. In the words of US Surgeon General Adams, providers must be "at the table together, sharing lessons learned, and challenging each other to do more, to do it better, and to do it together."¹¹ Providers must also be willing to accept financial risk to be truly accountable for the communities they serve. Value-based, collaborative approaches can maximize community health benefits by incentivizing smarter, more effective health care decisions.

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Citation

AMA J Ethics. 2019;21(3):E248-258.

DOI

10.1001/amajethics.2019.248.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.