



Community Benefit in California: A New Chapter

Brief on Governor Newsom's Budget Proposal
February 2022

AUTHOR

Kevin Barnett, DrPH, MCP
Center to Advance Community
Health & Equity

REVIEWERS

Mary A. Pittman, DrPH
Matthew Marsom
Ann Whidden, MPH
Public Health Institute



PHI generates and promotes research, leadership and partnerships to build capacity for strong public health policy, programs, systems and practices.



The Center to Advance Community Health & Equity (CACHE), a program of the Public Health Institute, uses evidence-informed tools and technical assistance to support strategic approaches to health improvement in communities where health inequities are concentrated.

Overview

On January 10, 2022, California Governor Gavin Newsom released his proposed 2022-2023 budget launching the California budget process for the year. Included in the budget was an administration proposal that 1) requires that non-profit hospitals demonstrate how they are making investments in local health efforts, specifically community-based organizations that address the social determinants of health, and 2) proposes a statutory change to *“direct that 25-percent of a non-profit hospital’s community benefit dollars go to these efforts, while giving the Department of Health Care Access and Information enforcement authority over these requirements.”*¹ Like many other stakeholders, the Public Health Institute was surprised to learn of this proposal. This brief is intended to summarize the implications of this proposed change, in the context of the history of community benefit funding.

Community benefit is a legal term for expenditures made by non-profit hospitals to fulfill their charitable obligations as tax-exempt health care institutions. While there is no financial threshold requirement at the federal level or in the state of California, it is generally expected that the total of non-hospital community benefit expenditures is at least equal to the value of their tax exemption.

This proposal has substantial implications, given recent expenditure profiles. In 2019, 180 California nonprofit hospitals reported a total of over \$6 billion² in community benefit expenditures, \$2.9 billion of which were attributed to coverage of Medicaid shortfalls, and another \$861 million to financial assistance for uninsured patients, representing approximately 60% of all community benefit spending. Cash and in-kind contributions to community groups was over \$505 million, approximately 8.4% of total community benefit spending. Another \$301.5



million of expenditures was reported in the community health improvement services (CHI) and operations category. A conservative estimate of \$200 million of the total in this category directed to CHI services (i.e., not to operations) yields another 3.3% of total charitable expenditures directly to communities. Depending upon criteria yet to be established, some proportion of the cost of other government means-tested programs and community building expenditures may also be qualified expenditures. Twenty five percent of the total of \$6 billion in community benefit spending yields a total of over \$1.5 billion. Given a rough estimate of qualified spending of approximately \$700-800 million, application of this requirement could double current expenditures focusing on the social determinants of health (SDoH) flowing into communities. That said, it is important to acknowledge the persistent limitations in access to primary care and services to address the current crisis in behavioral and mental health for lower income Californians. While building a positive future requires us to move our health investments upstream, we must also address the immediate health care needs of those who are most vulnerable.

Community Benefit Expenditure Categories	Expenditures	Category % of Total
Medicaid shortfalls	2,934,002,398	48.5
Financial assistance at cost	861,494,780	14.2
Health professions education shortfalls	629,030,722	10.4
Cash/in-kind services to community groups	505,502,949	8.4
Subsidized health services	326,752,732	5.4
Community health improvement services/operations	301,564,992	4.9
Cost of other government means-tested programs	249,472,778	4.1
Research	221,462,619	3.6
Community building	27,874,045	0.4
Total	6,048,158,014	100.0

The COVID pandemic increased public awareness of the profound socioeconomic and health inequities in our society, and movement towards risk-based payment in health care all highlight the need for increased spending to prevent illness and support optimal health. While health education and support to encourage adoption of health behaviors is critically important, there is growing awareness that a

significant proportion of Californians do not have a livable wage and struggle daily with inadequate and often unhealthy living conditions, and limited access to affordable healthy food, transportation, childcare, early childhood education, and other goods and services. These and other factors comprise the social determinants of health, a significant proportion of which is driven by historical structural racism manifested in both public policies and institutional practices that limit opportunities for residents of BIPOC communities.

The frequent inability to meet one's basic needs and live with persistent prejudicial treatment has a corrosive effect over time on both physiological and psychological health. There is an imperative to correct these structural inequities. The establishment of a new requirement for nonprofit hospitals to substantially reallocate their community benefit expenditures in these areas will, nevertheless, present an array of challenges that merit thoughtful consideration and tailoring to ensure successful achievement of associated objectives. It should also be a dialogue that is expanded to include other institutions across sectors that bear similar responsibilities.

This brief includes a short overview of relevant community benefit history and outlines issues to be addressed to achieve the desired outcomes of the Governor's proposal.

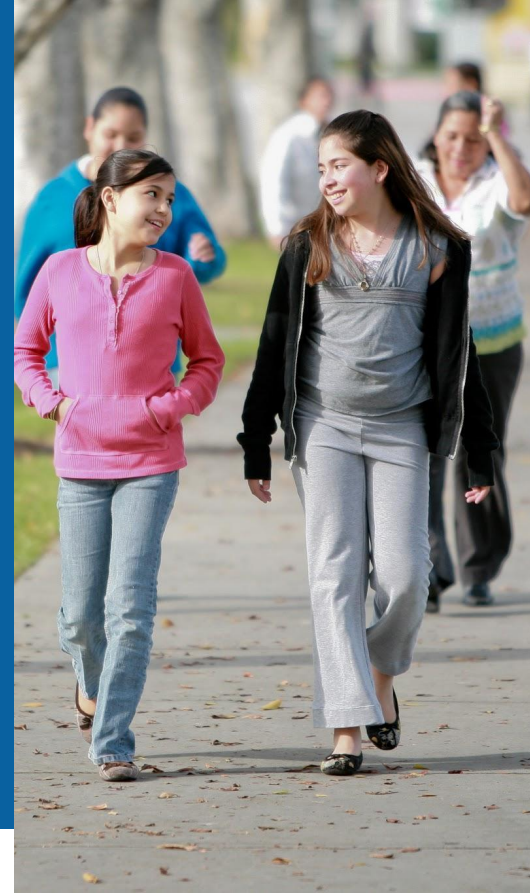




Community Benefit Background

The first expansion in the definition of community benefit for nonprofit hospitals by the federal government was the issuance of IRS Ruling 69-545³ in 1969. The ruling expanded the definition of charity beyond charity care to include the *promotion of health*. Health promotion was deemed “as one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community.” This expanded definition emerged in the wake of the passage of Medicare and Medicaid legislation, reflecting an optimism that expanded coverage would reduce the demand for charity care for uninsured populations, creating the opportunity for hospital allocation of a prevention dividend. As it turns out, while coverage expanded substantially, so did costs, and a persistent and growing class of uninsured required charity care services.


A similar optimism emerged four decades later with the passage of the Affordable Care Act, which included a requirement to conduct community health needs assessments (CHNAs) and develop Implementation Strategies (IS), federalizing requirements already in place in states such as California.⁴ Among the guidelines for reporting was a requirement to define the geographic parameters of their community benefit responsibilities, but a prohibition to do so “in a manner excludes medically underserved, low-income, or minority populations who live in the geographic areas from which it draws its patients (unless such populations are not part of the hospital facility’s target population or affected by its principal functions) or otherwise should be included based on the method the hospital facility uses to define its community.”⁵ While the language



appeared to encourage a focus on equity, the guidance is confusing. Using their reasoning, a hospital with a primarily commercially insured population may reason that such populations are not part of their target population, particularly if there is a proximal safety net hospital. As for the promise of a prevention dividend, it was again swamped by a significant expansion in reporting of Medicaid shortfalls, driven by a spike in demand for medical services among previously uninsured populations. With the Governor's proposal to further expand Medicaid in 2022-2024 to cover the remaining uninsured, the potential to shift spending to upstream prevention may be affected by shortfalls associated with a spike in demand for costly acute care services.

The passage of California's SB 697 in 1994 was one of two types of state statutes passed in the 90s and early 2000s. States such as Texas, Utah, Pennsylvania, and Illinois passed statutes with minimum financial thresholds for community benefit spending; other states like California, New York, and others passed statutes coined as "reporting" laws; without spending thresholds, but with requirements to conduct community health needs assessments (CHNAs) every three years and submit annual reports of what they implemented to address priority identified unmet health needs. For states with general financial spending thresholds, research indicates⁶ that it has resulted in an increase in reported expenditures on direct patient care, but lower levels of expenditures in categories such as community health improvement services. In practical terms, it is less complicated for institutions with a core competency in acute care delivery to document net costs of expenditures in those areas than lead or participate in the design, implementation, and evaluation of comprehensive prevention strategies. With a global spending requirement, it is likely that the orientation to "hitting a number" has contributed to a de-emphasis on the quality and strategic value of expenditures.

With reporting laws, a key purpose of a CHNA is to educate health care professionals on priority health needs at the level of population and geography, informing the design of interventions that make optimal use of limited charitable resources. Nonprofit hospitals have been encouraged to partner with other hospitals, local public health agencies, and community-based organizations in conducting CHNAs to work towards common priorities for shared investment. There are numerous examples of robust CHNAs where multiple hospitals and LHJs have come together to conduct comprehensive analyses. In moving from assessment to implementation, however, while there are no comprehensive analyses of practices, extensive experience clearly indicates that genuine

A woman with curly brown hair, wearing a dark blue zip-up hoodie with light blue accents on the cuffs and hood, stands in front of a construction site. She is holding a pair of glasses in her hands. The background shows a concrete foundation with rebar protruding, surrounded by trees and a clear sky.

“There is ample evidence where health inequities are concentrated. In urban areas, one need only to focus in neighborhoods that were historically redlined; they are still the areas with concentrations of poverty, poor quality housing, a lack of access to affordable healthy foods.”

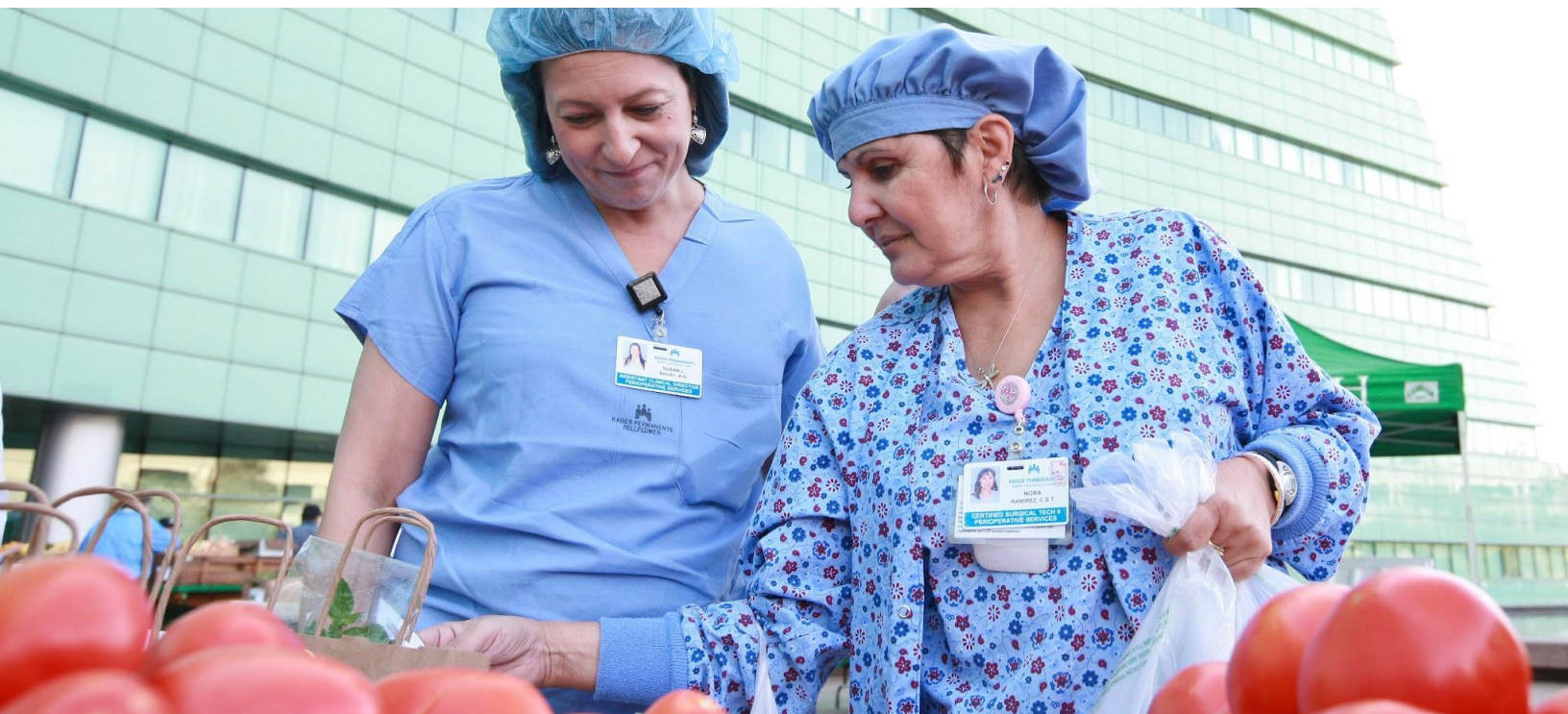
collaboration in the implementation of community benefit programming holds great promise but is the exception, rather than the rule. There is little evidence of alignment of interventions for greater social impact across hospitals competing for commercially insured populations in the same geographic area. Of equal concern, but with important exceptions, there is significant room for improvement in focusing community benefit expenditures in sub-geographic areas where health inequities are concentrated, and in addressing the upstream determinants of these inequities.

In summary, much of the focus of community benefit statutes has been on *how much* hospitals spend, rather than how they a) *align with others* to scale interventions to produce measurable impacts at scale; b) *focus interventions* in specific sub-geographic areas where health inequities are concentrated; and c) address upstream drivers of chronic disease and health inequities. There is ample evidence where health inequities are concentrated. In urban areas, one need only to focus in neighborhoods that were historically redlined; they are still the areas with concentrations of poverty, poor quality housing, a lack of access to affordable healthy foods, etc. In short, it's not rocket science – we know where we should be investing both public and private sector assets; we just haven't made the commitment to date.

Recent State Community Benefit Policy Innovation

Some states have taken steps to revise community benefit statutes in recent years with a focus on increasing expenditures in upstream prevention. In Massachusetts, which established voluntary reporting guidelines for both nonprofit hospitals and nonprofit health plans in 1994, the Office of the Attorney General provided additional guidelines to take effect in 2019 to encourage a more collaborative and community-driven approach. Hospitals were encouraged to focus community benefit spending in six priority areas: built environment, social environment, housing, violence, education and employment, with objectives to reduce chronic disease (with a Focus on Cancer, Heart Disease and Diabetes) and reduce homelessness, mental illness, and substance use disorders. The strategy recommended stronger community engagement and targeting to highest risk communities and required robust reporting.⁷

Oregon passed HB 3076⁸ in 2019 (effective 1/1/21), establishing minimum spending “floors” of community benefit spending for individual hospitals, and affiliated clinics, or groups of hospitals and clinics under the same ownership. The spending “floors” are based upon a formula that considers historical community benefit spending, operating revenue and annual margins, as well as demographic characteristics in their service areas. The new statute encourages increased spending on the social determinants of health,⁹ and provides explicit authorization to count expenditures in the community building category. In 2021, Illinois passed Senate Bill 1840¹⁰, which calls on hospitals to describe their actions to address health inequities, reduce disparities, and improve community health. The state of Washington passed House Bill 1272¹¹ in 2021, which requires detailed reporting on specific community health improvement activities that cost more than \$5,000, including, but not limited to the type of activity, the method of delivery, the target population(s), and the outcome metrics to be used. Last, but not least, California passed Assembly Bill 1207 in 2021¹², which requires nonprofit hospitals to submit an equity report each year that includes “an analysis of health status and access to care disparities on the basis of specified categories, including age, sex, and race, and a health equity plan to reduce disparities.” It also requires the new Department of Health Access and Information to convene a Health Care Equity Measures Advisory Committee to assist in the development of reporting guidelines.



Challenges and Opportunities

Effective implementation of the Governor’s Budget 25% proposal requires attention to the following:



Establish an Incentive to Fund and Report Community Building Activities

The IRS, reflecting a lack of knowledge of basic public health concepts, determined in 2010 that the category of community building activities was beyond the scope of what hospitals could report as community benefits. At the same time, language in their revised 990H requirements **permits reported spending** in this category *if a public sector agency has identified an issue as a priority concern*. The focus on SDoH in the Governor’s proposal will serve as an incentive for hospitals to report activities they may not have pursued or reported previously that focus on building community resilience. On a related note, the State may encourage an emerging focus among hospitals to provide grants and low interest loans to accelerate investments in areas such as affordable housing, healthy food financing, and small business development. Grants for these purposes fit well into the community building category, but it may serve as a significant incentive if, for example, a hospital were able to report a small portion (e.g., 2-5%) of low/no interest pre-development loans as part of their 25% requirement.

Increase Clarity and Consistency in Reporting of Services and Activities

Establishing the SDoH as the focus of qualifying expenditures will require a clearer delineation of the wide range of subcategories of services and activities than is currently provided for hospitals. The Community Health Services and Operations category, for example, will need to carve out operations as a separate reporting category, and there is a need to determine whether some of currently reported services/activities are

secondary and tertiary prevention, and not focused on the SDoH. Similarly, in 2010 workforce development was added as a subcategory to the original community building category,¹³ and some hospitals reported costs of recruitment of specialists, rather than limiting reported costs to recruitment of providers (e.g., primary care) that explicitly build capacity to increase access among Medicaid populations. California also allows nonprofit hospitals to report Medicare shortfalls. Large teaching hospitals may report substantial shortfalls in this category, given the volume of tertiary and quaternary care provided to older adults. This would make the shift to 25% SDoH a much larger number for these hospitals. Rural hospitals may also bear a significant burden, given both small margins and the need for a larger proportion of their community benefit spending in the category of subsidized services.¹⁴ Last, but not least, the COVID pandemic has contributed to a dramatic increase in behavioral health and mental health illness in our communities; a profound challenge that existed prior to the pandemic, given poor reimbursement rates and limited access to providers, particularly among Medicaid populations. While investment in the SDoH will certainly contribute over time to a reduction in associated crises for those at risk, there is an immediate need for a significant increase in access to direct services. Greater clarity, specificity, consideration of implications, and sensitivity to the diversity of the sector is needed to minimize confusion and to minimize unintentional negative impacts.

Establish an Inclusive Advisory Structure

It would be of critical importance for the Department of Healthcare Access to establish an advisory group or oversight body to develop clear guidance for priorities in areas such as this, and to provide guidance for community-based organizations and diverse partners to address social determinants of health, for community engagement, to support evaluation of those investments, and to encourage policy development to scale and sustain positive outcomes at the local and regional level. Such a body should capture both expertise and lived experience in health inequities and involve community-based organizations representing those most impacted by health inequities. Guidance from hospitals and health care associations will also be critical to ensure the definition of categories for SDoH and the education and sharing of successful practices is readily available.



“The experience of the last two years has caused many hospital leaders to consider new approaches that offer the potential to leverage assets across sectors.”

Strengthen Community Engagement and Coordination Capacity

Many communities across the state and in other states are building capacity for coordinated action and investment to promote health at the local level. The California Accountable Communities for Health Initiative¹⁵ provides one such example. The shift to greater investment in community partners and in social determinants of health will be most effective in transforming community conditions if it is carried out under the auspices of or in close coordination with broader community partnerships that can identify local priorities, most vulnerable communities, and most effective strategies to meet community needs. Implementing this new approach for greater direct community investment in SDoH could, for example, be more effective if carried in the setting of an accountable community for health or similar county level collaborative initiative.

Use Existing Data to Support an Evidence-Informed Focus on Equity

Hospitals are gradually building analytic capacity as part of their preparation to assume increasing financial risk to keep people healthy and out of preventable emergency room and inpatient facilities. Current analyses focus on individual patients or panels of patients served by individual providers. While this analytic approach provides important insights for proactive care coordination, it overlooks the interplay between health behaviors and environment within specific sub-geographies. As noted earlier in this brief, we know that there are neighborhoods and communities across the country where socioeconomic and health inequities are concentrated. We cannot effectively address the dynamic between behavior and environment by focusing on one patient at a time. GIS analyses of Prevention Quality Indicators (PQIs) *down to the census tract level* highlight rates of preventable ED/inpatient utilization five to ten times higher than county averages, providing clear guidance for the design and implementation of comprehensive strategies that align patient care coordination with place-based investments to address SDoH. The state of California has these utilization data and the capacity to develop powerful visuals that provide clear guidance for equity focused and aligned strategies.

Many provider and payor partnerships in California counties are building Community Information Exchanges (CIEs) towards a more systematic

approach to referrals of patients to social support services. This work is closely aligned with the implementation of the state CalAIM program and the development of Enhanced Case Management (ECM) strategies for Medi-Cal enrollees with complex health and social needs. The development of data platforms, as well as payment for 14 categories of Community Supports as in lieu of services (ILOS) that Medi-Cal managed care plans can use for over 40,000 enrollees offers great potential to reduce the demand for downstream treatment of illnesses in emergency room and inpatient settings. Hospitals can serve as key players in helping to build the capacity of community-based organizations to provide proactive supports for these populations. Such investments would ideally be part of a shared risk and gainsharing financing strategy with health plans, hospitals, and community partners based upon reductions in high cost and preventable medical service utilization. As such, it would be appropriate to include hospital investments to build CBO capacity to address the social needs of populations as reportable community benefits.

Take into Consideration Inequities in the Healthcare Marketplace

Just as there are profound socioeconomic and health inequities in our communities, there are parallel inequities in the healthcare marketplace, driven primarily by physical location, as well as public perceptions of relative accessibility. Hospitals in or near low-income communities bear a more significant burden of care for uninsured and publicly insured populations, both in terms of lower reimbursement rates, as well as higher rates and acuity for a broad spectrum of health problems. These hospitals tend to have lower margins, higher percentages of financial assistance and Medicaid shortfalls, and less capacity to allocate funds for preventive services and associated investments. Ironically, as institutions, they may have the greatest sensitivity and understanding of the need for investment in the SDoH, and the least capacity to do so. The Governor's proposal will need to accommodate these practical realities in order to avoid punishing hospitals that are already bearing a disproportionate financial burden in serving low income populations. It may be appropriate to consider incentives for cost sharing and strategy alignment among nonprofit hospitals in market areas to support those carrying significantly higher burdens of care for low-income populations. This is not to suggest that nonprofit hospitals should "walk away" from communities currently served; many of which may not be the most challenged, but nevertheless include a substantial population of low-income residents. Rather, they can and should continue to work in these communities, while exploring alignment with otherwise competing providers and payors, as well as with

other sector stakeholders to implement strategies in the most challenged neighborhoods.

Imperative to Build Hospital Transformation Capacity

Hospitals and health systems were faced with an existential challenge before the COVID pandemic, which is how to expand their scope of work beyond providing high quality acute care services, playing an important role as health improvement organizations. Decades of fee-for-service payment in the U.S. have served as an impediment to addressing health in a more comprehensive manner, reinforcing an ever upward cycle of payments for high-cost clinical treatment of preventable conditions. The evolution to risk-based reimbursement requires hospitals and health systems to build structures, functions, and skills to play an important role in improving health and eliminating health inequities in communities. This is a work in progress that will benefit from public sector facilitation and support, establishing incentives that reinforce positive innovations, and where necessary, requirements that scale innovations. Implementation of this new reporting requirement would optimally *recognize and reward internal capacity building* that reflects a commitment to serving as health improvement organizations. Along these lines, it may be worth considering a stepwise process that offers an alternative to the 25% mandate. Steps might include establishing a framework that ensures clarity and consistency in reporting, creating a statewide database, establishing differential targets that accommodate the diversity of the sector, and creating incentives for those institutions that demonstrate a commitment to meeting the challenge. Efforts by states (e.g., RI, CT, OR, DE) in recent years to set targets for primary care spending offer insights to what may be possible and what to avoid.¹⁶ PHI will examine these issues and opportunities in more detail in an upcoming brief, including collaborative strategies for investment and reallocation of savings secured by reducing the demand for treatment of preventable conditions in emergency room and inpatient settings.

Opportunity to Leverage Existing Assets and Build a More Diverse Health Workforce

The Governor's proposal includes \$350 million to further expand the community health worker/promotor (CHW/P) workforce by 25,000 in California, building on federal funds from multiple agencies to expand efforts to address vaccine hesitancy in communities across the country. In most

cases, the recent federal funding streams do not address the issue of sustainability, in part driven by urgency to simply deploy CHWs/Ps into the field. Nevertheless, there is an unprecedented opportunity to develop systems of care across providers and payors, with CHWs/Ps collecting data to establish evidentiary baselines at the individual, family, and community level from which to document reductions in preventable utilization and measurable improvements in health status and quality of life. There are existing models¹⁷ where CHWs/Ps are based with CBOs, with contractual relationships with individual providers and payors to serve specific geographic areas. This type of model supports both evidence-based care coordination and a place-based approach to health improvement that supports identification, advocacy and action to address SDoH at the community level.

Regardless of the model of CHW/P engagement, it will be important for the State of California to support approaches that involve risk and potential returns for providers, payors, and other key community stakeholders. Hospital expenditures in the development of these systems is consistent with the intent of this proposal to build community capacity. There is also an opening to build targeted workforce opportunities in all community investments, from housing and healthy food financing to childcare and development.

Connect the Dots

The Governor's proposal includes \$300 million to build public health infrastructure, including \$200 million for local health departments to "strengthen priority areas identified during the pandemic" and "expand local partnerships with health care delivery systems and community-based organizations, including faith-based organizations to drive systems change."¹⁸ This element of the proposal is aligned with Recommendation 3.9 of the Meeting the Demand for Health report from the California Future Health Workforce Commission in 2018, which calls for the establishment of a State fund pool available to local and regional jurisdictions with hospital matching funds (50% for rural; 100% for urban).¹⁹ Funds could be used in part to engage senior local public health staff with a core responsibility to establish an evidence base and systems level framework to align and focus hospital community benefit expenditures in sub-geographic areas where health inequities are concentrated. Securing matches from hospitals, and potentially from health plans for State funds could more than double the proposed allocation, expanding local health department capacity and creating the environment for sustainable funding supported by the private sector.

As noted in the historical summary, while there is and has been collaboration among hospitals and local public health agencies in conducting CHNAs, there are few examples where such alignment carries forward in the planning and implementation of interventions to address agreed upon priorities. It is not a surprise that such “parallel play” occurs in the community benefit practices of nonprofit hospitals; the competitive marketplace has fostered a broad array of organizational behaviors over recent decades that serve as obstacles to genuine, sustained collaboration. That said, the experience of the last two years has caused many hospital leaders to consider new approaches that offer the potential to leverage assets across sectors.

Build Shared Ownership for Health

Addressing the profound health inequities in the state of California (and across the country) will require renewed commitment from organizations, institutions, and communities across sectors. While our historically flawed health care finance and delivery “system” has certainly contributed to health inequities, they are a symptom of a far wider and deeper set of societal prejudicial policies and practices. As such, it is important to look well beyond our nonprofit hospitals as we seek to reverse the dynamics that have been in play for the past century. The emergence of hospital, health system, and health plan investment in areas such as affordable housing, healthy food financing, and supporting minority owned businesses is an important step towards acknowledgment that these institutions have a broader role to play in building health and well-being in our communities. Clearly, others have a similar role to play – we should be challenging financial institutions and large employers across sectors to think and act in a manner that sees their employees and the communities in which they live as investments. Their productivity and well-being are supported by living wages, access to affordable childcare and preschool, quality K-12 institutions, healthy living conditions, and safe neighborhoods. It is no longer acceptable for health care institutions to limit their responsibilities to the provision of high quality medical services. Similarly, it is no longer acceptable for the business sector to see their only responsibility as producing optimal returns for shareholders. There is much we can accomplish by leveraging expertise and assets across sectors to address the profound inequities in our communities and build a positive future for all Californians.

Work is needed on the ground in each of our communities that is focused on the common good. Health and well-being in all communities requires a livable wage, full access to affordable childcare and early childhood

development, safe and healthy housing and neighborhoods, dependable transportation to necessary goods and services, quality K-12 education, and affordable healthy food. Each and every employer, both large and small in our communities have a role to play in helping to achieve these basic and essential goals. Setting goals to increase investment in addressing the social determinants of health is a worthy cause—and an imperative for all of us to achieve equitable health and well-being outcomes necessary for a vibrant and productive society.





References

[1] Governor's Budget Summary 2022-2023, January 10, 2022, Page 134 (<https://www.ebudget.ca.gov/FullBudgetSummary.pdf>)

[2] Data drawn from Community Benefit Insight (<https://www.communitybenefitinsight.org/>), an online searchable platform with data submitted to the IRS as part of nonprofit hospital annual 990 Schedule H reporting requirements.

[3] Rev. Rul. 69-545, 1969-2 C.B. 117 (<https://www.irs.gov/pub/irs-tege/rr69-545.pdf>)

[4] Community Health Needs Assessment for Charitable Hospital Organizations – Section 501(r)3 (<https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>)

[5] IRS Section 5019(r)3, Community Served.

[6] Singh SR, Young GJ, Loomer L, Madison K. State-level community benefit regulation and nonprofit hospitals' provision of community benefits. *J Health Polit Policy Law*. (2018) 43:229–69. doi: 10.1215/03616878-43 03516.

[7] <https://www.mass.gov/files/documents/2018/02/07/Updated%20Hospital%20Community%20Benefits%20Guidelines.pdf>

[8] <https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/HB3076/Enrolled>

[9] Section 10

[10] (<https://www.ilga.gov/legislation/BillStatus.asp?DocNum=1840&GAID=16&DocTypeID=SB&SessionID=110GA=102>)

[11] (<https://app.leg.wa.gov/billsummary?BillNumber=1272&Year=2021&Initiative=false>)

[12] https://leginfo.legislature.ca.gov/faces/billPdf.xhtml?bill_id=202120220AB1204&version=20210AB120491CHP

[13] As delineated in the 1997 monograph “The Future of Community Benefit,” K. Barnett, Public Health Institute

[14] Subsidized services by definition are those services for which there are no other sources for residents within a region. Common examples of subsidized services are burn wards, dental services, blood banks, and related services where reimbursement rates do not cover costs.

[15] <https://cachi.org/>

[16] <https://www.milbank.org/2020/11/how-states-are-increasing-their-investment-in-primary-care/>

[17] One example is the Pathways Community Hub model (<https://pchi-hub.com/>), which has been endorsed by CMS and is being implemented in multiple states.

[18] CHEAC memo summarizing the Governor's Budget Proposal, January 10th 2022

[19] <https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf>, pg. 172

“There is an unprecedented opportunity to develop systems of care across providers and payors.”



www.phi.org/CommunityBenefit