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Harvard Law School

HOSPITAL COMMUNITY BENEFIT:
Addressing Nutrition as a Primary Community Health Need

EXECUTIVE SUMMARY

To maintain federal tax-exempt status, nonprofit hospitals must meet specific standards with respect to initiatives undertaken and/or supported by the hospital to benefit the community as a whole. In 2010, the Affordable Care Act (ACA) directed nonprofit hospitals to take several steps to achieve compliance with new federal tax reporting requirements. These steps include conducting a community health needs assessment (CHNA) at least once every three years and subsequently adopting an implementation strategy. Individual states have concurrent authority to regulate non-profit tax exemptions for state taxes, and many states also employ state-level community benefit requirements for hospitals.

These community benefit requirements present a valuable partnership opportunity for community-based food and nutrition service (FNS) providers and hospitals to improve population health and reduce healthcare costs. Research shows that access to nutritious food is a core component of individual and community health, particularly in preventing and ameliorating chronic illness. However, initiatives that aim to provide access to nutritional counseling and/or food to populations with specific health risks and conditions are often divorced from healthcare program and funding infrastructures, and have traditionally depended on grants and philanthropic support to sustain themselves. In implementing the ACA's requirements, the Internal Revenue Service (IRS) issued a Final Rule which allows hospitals to count measures taken to address community food insecurity as qualifying community benefit activities. Thus, hospital efforts to meet community benefit standards with nutrition-focused initiatives offer an important opportunity for integration of hospitals' and FNS providers' work to support and improve community health.

In light of these developments, FNS providers should:

1. **build relationships with local hospitals;**
2. **seek to be included in the hospital CHNA process and help to identify food as a priority community need;**
3. **connect and build relationships with other nonprofits and Community-Based Organizations (CBOs) involved in the CHNA process to ensure that meeting community nutrition needs is a key feature of the hospital's implementation plan; and**
4. **look for opportunities to use community benefit dollars to fund joint hospital and FNS provider projects that improve the health of the community by addressing food insecurity and other nutrition-related challenges.**

The Center for Health Law & Policy Innovation provides information and technical assistance on issues related to health reform, public health, and food law. This document should not be considered legal advice. For specific legal questions, consult with an attorney.

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The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

Since 2013, CHLPI has been engaged in policy work aimed at increasing integration of food and nutrition interventions into healthcare for those living with HIV or other chronic health conditions. CHLPI previously released *Food is Medicine: Opportunities in Public and Private Healthcare for Supporting Nutritional Counseling and Medically-Tailored, Home-Delivered Meals*. This issue brief continues to explore the topic, focusing on the use of hospital Community Benefit dollars as a key resource for supporting food and nutrition interventions.

We gratefully acknowledge the generous support and insight provided by the M•A•C AIDS Fund and members of the food and nutrition services community in making this paper possible. *Hospital Community Benefit: Addressing Nutrition as a Primary Community Health Need* is written by Sarah Downer, Robert Greenwald, Emily Broad Leib, Malinda Ellwood, Matthew Kien-Meng Ly, Ryan Tonkin, and Thea Sebastian.

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Introduction

The Patient Protection and Affordable Care Act (ACA) instituted a number of new initiatives and requirements aimed at controlling healthcare costs and improving quality, many of which focus on the prevention and treatment of chronic disease.[1] Among other provisions aimed at improving population health, the ACA strengthened requirements for hospital community benefit programs.[2] Introduced in 1969 by the Internal Revenue Service (IRS) as the standard hospitals must meet to maintain their nonprofit federal tax-exempt status, community benefit is defined as a group of activities that demonstrate a hospital's promotion of community health as a whole.[3] To maintain nonprofit status, all hospitals must plan, undertake and report a certain quantity of these activities.[4] Some examples of community benefit activities from Massachusetts include: initiatives by the Beth Israel Deaconess Hospital to provide financial counseling, benefit enrollment assistance, and payment planning to the underserved and uninsured in its community;[5] Fallon Community Health Plan's partnership with Merrimack Food Bank, Inc. to alleviate hunger and provide adequate nutrition to homebound elderly and disabled individuals;[6] and Winchester Hospital's partnership with Checker Cab to provide transportation in order to help patients with financial difficulties or transportation issues return home from the hospital.[7]

On December 31, 2014, the Internal Revenue Service issued a Final Rule implementing the ACA's requirements for tax-exempt hospitals.[8] According to the IRS's Final Rule and the ACA, all hospitals seeking federal tax-exempt status are now required to:

1. conduct a Community Health Needs Assessment every three years;
2. include input from individuals who represent the broad interests of the community in developing the CHNA;
3. adopt an implementation strategy to meet the needs identified in the CHNA.[9]

These strengthened requirements for hospital community benefit programs present an exciting opportunity for FNS providers to partner with hospitals in new ways in order to improve the health of the community. Prior to the ACA, hospitals traditionally fulfilled community benefit requirements by providing charity care for the uninsured and underinsured.[10] However, the IRS's Final Rule makes it clear that a variety of activities geared toward improving community health can fall under the purview of community benefit, including actions taken to address "the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."[11]

Hospitals have natural incentives to partner with FNS providers. People with acute and chronic illnesses often have difficulty obtaining and preparing adequate food.[12] Thus, the provision of medically-tailored meals and other food and nutrition interventions play a crucial role in keeping medically vulnerable people healthy.[13] In addition, since malnourished patients are more likely to be readmitted to hospitals and incur higher healthcare costs than well-nourished patients, the provision of food and adequate nutrition can significantly reduce hospital costs.[14] In one study, for example, researchers found that provision of medically-tailored, home-delivered meals reduced both the frequency and length of hospitalizations for high-needs patients.[15]

Despite the health benefit of these services, FNS providers are typically independent from the healthcare system and not supported by healthcare payers. The primary organizations that now provide services like medically-tailored, home-delivered meals are nonprofit organizations, the majority of which receive foundation and donor support but (with some exceptions) not Medicaid/Medicare, other insurance dollars, or funding from hospitals.[16] As a result, many of these programs can only serve specific client populations as designated by individual grants or disease-based funding streams (such as individuals living with HIV/AIDS).[17] Accessing hospital community benefit dollars could provide these organizations with crucial support for much-needed and highly-effective services.

This issue brief proceeds as follows. First, it gives an overview of both federal and state hospital community benefit requirements, including recent changes enacted as part of the ACA. Second, the issue brief offers recommendations for

FNS providers who are seeking to establish partnerships with hospitals. At a high level, FNS providers should: (1) build relationships with local hospitals; (2) seek to be included in the hospital CHNA process; (3) connect and build relationships with other nonprofits and CBOs involved in the CHNA process; and (4) look for opportunities to use community benefit dollars to fund joint hospital and FNS provider projects.

The Community Benefit Standard

Origin

Since 1894, when the U.S. government created a tax exemption for charitable organizations, nonprofit hospitals have been eligible to qualify for tax-exempt status.[18] Historically, in order to qualify, nonprofit hospitals needed to provide some level of free or reduced-cost medical services to patients who were unable to pay.[19] This was known as the "charity care standard."[20] In 1969 the Internal Revenue Service (IRS) established a new community benefit standard that broadened the tax-exemption requirements beyond charity care alone. In particular, nonprofit hospitals were to "promot[e] the health of a class of persons … broad enough to benefit the community."[21]

There has never been a minimum value of community benefit that a nonprofit hospital has to provide, nor any guidance as to what percentage of a hospital's resources must be spent on community benefit activities. Instead, the IRS employs a "facts-and-circumstances approach" to assess whether a hospital is tax-exempt.[22] In general, the IRS gives hospitals "broad latitude to determine the services and activities that constitute community benefit."[23] As a result, hospitals vary widely in how much they spend on community benefit. Total expenditures range from 1% to as much as 20% of total hospital operating expenditures.[24]

In general, hospitals tend to allocate most of their community benefit to offsetting reported Medicaid losses and providing upfront financial assistance to patients (also known as charity care), and a much smaller percentage (less than 1% of overall hospital operating expenses) for community health improvement activities and contributions to community groups to carry out community benefit programs.[25]

The ACA's Impact on the Community Benefits Standard

The years leading up to the passage of the ACA saw an increased demand for transparency, consistency and the facilitation of government monitoring of hospital compliance with community benefit standards.[26] In addition, advances in public health clarified the critical role of social factors in population and individual health.[27] Section 9007 of the ACA laid out a process for determining the scope of the hospital's activities directed toward meeting the community benefit standard.[28] With the introduction of the triennial CHNA process, the ACA's provisions regarding the hospital community benefit standard reflected a stronger commitment to a population-centric approach to health that takes a community's social determinants of health into account.[29]

Interested members of the public may view a hospital's CHNA, implementation plan, and community benefit activities by examining its federal tax filings, as these are required to be reported on the Schedule H attachment to tax Form 990.[30] Schedule H also defines the kinds of hospital activities that qualify as community benefit.[31] Community benefit activities include activities that (1) improve access to health services; (2) enhance public health; (3) advance increased general knowledge; and (4) relieve a government burden to improve health.[32]

Defining "Community"

In order to conduct the required CHNA every three years, a hospital must first define its "community." On December 31, 2014, the IRS issued a Final Rule that allows hospitals to "take into account all of the relevant facts and circumstances" to define community, including "the geographic area served by the hospital facility, target populations served (for example, children, women, or the aged), and principal functions (for example, focus on a particular specialty area or targeted disease)."[33] Notably, a hospital may not exclude medically underserved, low-income, or minority populations living in its geographic region in the definition of "community," even if these individuals have not sought care at the facility in the past.[34] The term "medically underserved" includes populations "at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers."[35]

The definition of community *must* therefore include vulnerable populations, and hospitals are encouraged to identify health needs in the community not only for the community at large, but also for "particular neighborhoods or populations experiencing health disparities."[36]

Conducting the Assessment

Having defined "community" for the purposes of conducting a CHNA, a hospital must conduct a Community Health Needs Assessment at least once every three years.[37] The CHNA is incredibly important, as it is the approved basis for demonstrating community needs, which must correlate with any community benefit activities undertaken by the hospital.[38]

A CHNA can be conducted in a variety of ways, and individual hospitals vary in how they develop their assessments. For example, some hospitals may distribute questionnaires to members of the defined community, hold community stakeholder meetings, conduct individual interviews, or use other methods to engage community members. Hospitals *must* solicit input from "(1) at least one state, local, tribal, or regional government public health department…with knowledge, information, or expertise relevant to the health needs of the community; (2) members of medically underserved, low-income, and minority populations in the community or individuals or organizations representing the interests of such populations; and (3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy."[39] In addition to including individuals in these required categories in the CHNA process, hospitals may also encourage participation from a broad range of people living in or serving the community, including but not limited to healthcare consumers, CBOs, school districts personnel, and private businesses.[40]

The range of issues that can be considered as constituting "community health" for CHNA purposes is quite broad. They can include "financial and other barriers to care, the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."[41] These needs must be identified and prioritized, and hospitals must identify resources (including programs, organizations, and facilities) that are available to address the identified health needs.[42]

Finally, hospitals are required to produce an officially authorized CHNA report that includes:

1. the definition of community and a description of how the community was defined;
2. a description of the CHNA process;
3. an account of how the hospital solicited input and accounted for the input received from community stakeholders;
4. a prioritized description of the identified health needs; and
5. a list of resources available to address those needs.[43]

Hospitals must also make their CHNAs "widely available to the public," which, at a minimum, includes posting a copy on a

website and having a copy available for inspection at the hospital upon request.[44]

Implementation Strategy

After conducting a CHNA, a hospital must adopt an "implementation strategy," which describes how the hospital will meet the needs described in the assessment or identifies needs that the hospital will not address and explains why it does not intend to address them.[45] Where the hospital intends to meet an identified need, the implementation strategy must provide a description of how the hospital intends to meet the need, and include an account of the steps the hospital plans to take.[46] The plan must also include an assessment of projected impact, a means of evaluating this impact, details on the resources to be allocated and mention of any planned collaboration between the hospital and other organizations.[47] Subsequent CHNA reports must include impact evaluations of activities undertaken in accordance with previous CHNA implementation plans.[48]

Where the CHNA identifies significant health needs that the hospital does not plan to address, the implementation strategy has to provide some specific reasons why the hospital does not plan to address these needs.[49] These reasons could include resource constraints, the presence of other facilities or organizations that are adequately addressing the need, lack of experience or competency to effectively address the need, the low priority nature of the need, or lack of identified effective interventions.[50]

State Community Benefit

Because taxes are assessed at both the state and federal levels, hospitals may also need to abide by state regulations governing nonprofit status. Hospitals can derive significant financial benefit from state-level nonprofit designations, notably through relief from income, property and sales taxes. Because state and federal requirements are not always identical, a hospital may be designated as a nonprofit in one system, but not in the other. In general though, the financial benefit from income, property and sales tax breaks means that most nonprofit hospitals are interested in attaining both designations.

States have the authority not only to require that nonprofit hospitals provide community benefit, but also to define this requirement differently from federal requirements. The community benefit requirements implemented by states are widely diverse. Generally, there are eight types of state community benefit requirements.[51] These include requiring (1) community benefit; (2) minimum community benefit; (3) community benefit reporting; (4) Community Health Needs Assessments; (5) community benefit plans and implementation strategies; (6) financial assistance policies; (7) dissemination of financial assistance policies; and (8) limitations on charges, billing and collections.[52] States have implemented various combinations of these requirements, from having no requirements at all to having all eight types of requirements listed above.[53] Notably, requirement types (1) to (5) are most relevant to FNS providers and are further detailed in the table below.

Table 1. State Community Benefit Requirements Relevant to Food and Nutrition Service Providers[54]

State Law Requirement	Description
1. Community Benefit	23 states have community benefit requirements.[55] This requirement is either conditional or unconditional. For example, in Utah, the provision of charity care is a condition of a certificate of public review.
2. Minimum Community Benefit	5 states have mandatory minimum community benefit requirements.[56] For example Illinois requires community services valued at least as high as what the hospital would otherwise pay in property taxes.

3. Community Benefit Reporting	29 states have reporting requirements.[57] This is higher than the number of states with benefit requirements because in certain cases the reporting requirement is conditional on voluntary benefit provision. That is, although benefit are not required, if they are nevertheless provided, then they must also be reported.
4. Community Health Needs Assessments	11 states have Community Health Needs Assessment requirements.[58] Some states, such as Idaho, require an assessment but do not require the provision of benefit.
5. Community Benefit Plans / Implementation Strategies	10 states have benefit plan/implementation strategy requirements.[59] Idaho is the only state which requires an assessment but *does no*t require a benefit plan or implementation strategy.

For more information on state community benefit requirements, please visit http://www.hilltopinstitute.org/hcbp_cbl.cfm.[60] The Hilltop Institute's Community Benefit website includes an interactive Community Benefit State Law profiles comparison, a 50-state survey of state community benefit laws, and a number of community benefit issue briefs.[56]

Opportunity to Improve Population Health and Increase Awareness of Food and Nutrition Needs through New Community Benefit Requirements

Both federal and state community benefit requirements offer substantial opportunities for FNS providers to create partnerships with hospitals to better serve the needs of the community.

Suggested Actions and Recommendations

Hospital community benefit requirements offer an opportunity for CBOs such as FNS providers to gain access to new resources and become more integrated into the provision of healthcare. FNS providers can help hospitals meet new ACA requirements around costs and quality. For those seeking to build partnerships and programs that support food and nutrition services, CHLPI recommends the following:

1) FNS providers should build relationships with local nonprofit hospitals. To prepare for productive dialogue and future partnership, FNS providers and their range of programs and services should be familiar to key hospital staff. Building relationships with hospital administrators and providers can take time, but there are significant potential benefits to creating a channel of communication that will allow FNS providers to share knowledge and expertise about the nutritional status and needs of their client populations.

Before meeting with hospitals, FNS providers should have a thorough understanding of the hospital's existing CHNA, implementation strategy, and community benefit activities. This information is publicly available and, at a minimum, can be found in the hospital's Schedule H form attached to Federal Tax Form 990.[62] FNS providers should also be prepared to present relevant client demographic data and, where possible, highlight the economic impact of their services on healthcare costs for clients who are likely to be hospital patients.

2) FNS providers should seek to be included in the hospital CHNA process and help to identify food as a priority community need. FNS providers are well-positioned to educate medical providers and hospital staff about the link between food insecurity and exacerbation or onset of chronic health conditions. They should offer to be involved in the hospital's upcoming CHNA process in order to be a strong voice for their clients, many of whom will identify as part of the minority and/or vulnerable groups of individuals that hospitals *must* consider in developing their CHNA and subsequent implementation plan.

3) FNS providers should connect and build relationships with other nonprofits and CBOs involved in the CHNA process to ensure that meeting community nutrition needs is a key feature of the implementation plan. Hospitals will have to consider and prioritize many community needs when developing CHNAs and creating implementation plans. Coalitions of CBOs that voice support for inclusion of a FNS as a priority need can have a large influence on how hospitals will distribute community benefit resources.

4) FNS providers should ultimately look for opportunities to use community benefit dollars to fund joint hospital and FNS provider projects that improve the health of the community by addressing food insecurity and other nutrition-related challenges. FNS providers and hospitals can leverage each other's expertise and strengths to have a significant impact on community health. FNS providers can offer services on-site at the hospital or alternatively serve as a satellite site for screenings and other health activities conducted by hospital staff. They can distribute educational and other health materials, offer clients assistance with obtaining health coverage, and encourage clients to visit providers regularly for preventive (as opposed to acute) care. Hospitals can refer patients to FNS providers, thus expanding providers' client base, and can financially support provision of FNS for their patients. Hospitals and FNS providers can also collaborate to study the impact of providing a certain range of coordinated services to individuals with diet-related health conditions. Community benefit resources can be used to fund these promising joint food and nutrition initiatives that target key segments of the hospital's defined community.

Successful Partnerships

Many hospitals have identified the need for access to affordable, healthy food in their CHNAs, even if they do not incorporate projects addressing this need in their implementation plans and community benefit programs.[63] In a brief survey of hospital CHNAs in Massachusetts, for instance, nearly all hospitals acknowledged the role of adequate nutrition as a community need important to maintaining one's health.[64] A common theme among hospital CHNAs in Massachusetts is that "basic needs insecurity," described in part as a lack of access to healthy food, is an area of concern for their communities.[65] An analysis of the community benefit programs revealed that of the 68 hospitals listed on the Massachusetts Attorney General website, 53 addressed nutrition in some way as part of their community benefit programs.[66] Because hospitals have identified access to nutrition as such a fundamental need, projects to support such needs should be a mainstay of every hospital community benefit program. Building off of their CHNAs, many hospitals have successfully incorporated numerous food projects into their community benefit programs, partnering with CBOs to achieve their goals.[67] Descriptions of several such partnerships can be found in Appendix A.

Conclusion

FNS providers have a large role to play in prompting hospitals to support food and nutrition interventions as part of community health promotion. New community benefit requirements for hospitals offer opportunities for FNS providers to be a strong voice for the importance of these interventions in their communities and partner with hospitals to leverage resources for the largest possible community impact. All FNS providers should be aware of nonprofit hospital community obligations and should strive to become part of the formal CHNA development process and play a role in the subsequent implementation plan.

Appendix A- Examples of Successful Partnerships

Selected Model Partnerships

Anna Jaques Hospital (Newburyport, MA)	Anna Jaques Hospital, in Newburyport, MA, supports a number of food and nutrition initiatives.[68] Notably, Anna Jaques Hospital is one of two main sponsors of the Newburyport Farmer's Market.[69] Recognizing that healthy eating can help people reduce risk for certain diseases and cancers, staff "attend and present at the Farmer's Market to ensure that the community has access to healthy, affordable food choices."[70]
Baystate Mary Lane Hospital (Springfield, MA)	Baystate Mary Lane Hospital, located in Springfield, MA, has a Mobile Food Pantry program.[71] The program partners the hospital with the Food Bank of Western Massachusetts and Hillside Village to distribute food to vulnerable community members once a month.[72]
Carney Hospital (Dorchester, MA)	Located in Dorchester, MA, Carney Hospital has a number of programs to improve nutrition access and education.[73] For example, in 2013, Carney Hospital "provided diabetic patients and community members with vouchers to buy fruits and vegetables at local Farmer's Markets."[74] The program distributed vouchers totalling $6,000 to 67 patients.[75]
Holyoke Medical Center (Holyoke, MA)	Holyoke Medical Center, of Holyoke, MA, conducts an annual "Community Food Drive" to help the community meet the needs of the hungry.[76] In 2013, the program worked with River Valley Counseling Center's Food Pantry to identify the members of the community most in need and to collect and donate over 300 pounds of food.[77]
Indiana University Health Bloomington Hospital (Bloomington, IN)	Indiana University's Bloomington Hospital serves as an excellent illustration of the potential for partnerships between hospitals and CBOs to support food and nutrition programs. Bloomington Hospital's "Positive Link" program is the "preeminent provider of comprehensive prevention and holistic social services for those impacted by HIV in south central Indiana."[78] Despite receiving limited funding, Positive Link has developed over 50 partnerships and a service region covering nearly one-third of the state of Indiana devoted to providing services to the HIV/AIDS community.[79] In partnership with Hoosier Hills Food Bank and Community Kitchen, Positive Link provides nutritional assistance to food insecure patients through their Nutrition Links program.[80] Hoosier Hills Food Bank provides shelf-stable groceries while Community Kitchen provides home-delivered meal service.[81]
New England Baptist Hospital (Roxbury Crossing, MA)	New England Baptist Hospital, in Roxbury Crossing, MA, supports food and nutrition initiatives to promote food access and education.[82] In their "Combating Hunger" program, the hospital partnered with the Action for Boston Community Development Parker Hill/ Fenway Neighborhood Service Center and the Mission Hill Elementary School to combat hunger.[83] The program provided food to more than 200 families per month during holidays and school vacations.[84]
St. Elizabeth's Medical Center (Brighton, MA)	Located in Brighton, MA, the St. Elizabeth's Medical Center supports a number of initiatives aimed at improving food access and education.[85] For example, the hospital piloted a Healthy Meals Program where they partnered with City Fresh Foods to provide discharged patients with chronic heart failure with low sodium meals for 30 days.[86] Another example is the hospital's Farmers Market Voucher Program.[87] The program provides diabetic patients with "vouchers that can be used at local farmers markets to buy fresh fruits and vegetables."[88]
UMass Memorial Hospital (Worcester, MA)	UMass Memorial Hospital partnered with the Regional Environmental Council to develop and support a community garden in a food insecure neighborhood.[89] Produce from the 20-bed garden is made available to residents and farmers' markets.[90] UMass Memorial Hospital's funding supports five inner-city youth employees to manage the garden.[91]

Endnotes

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[39] Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954, 78963 (Dec. 31, 2014) (26 C.F.R. Parts 1, 53, 602).

[40] *Id.* at 78966.

[41] *Id.* at 78963.

[42] *Id.* at 78962-3.

[43] *Id.* at 78966.

[44] *Id.* at 78968.

[45] *Id.* at 78969.

[46] *Id.* at 79003.

[47] *Id.* at 78969.

[48] *Id.*

[49] *Id.* at 79003.

[50] *Id.*

[51] Types provided by The Hilltop Institute. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[52] *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[53] *Id.*

[54] *Id.*

[55] California, Delaware, Florida, Illinois, Indiana, Maine, Maryland, Massachusetts, Mississippi, Montana, Nevada, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, and West Virginia. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[56] Illinois, Nevada, Pennsylvania, Texas, and Utah. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[57] California, Connecticut, Georgia, Idaho, Illinois, Indiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, north Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[58] California, Idaho, Illinois, Indiana, Maryland, New Hampshire, New York, Rhode Island, Texas, Vermont, and Washington. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[59] California, Illinois, Indiana, Maryland, New Hampshire, New York, Rhode Island, Texas, Vermont, and Washington. *See Community Benefit State Law Profiles Comparison*, The Hilltop Institute, http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm (last visited Apr. 14, 2015).

[60] The Hilltop Institute's community benefit homepage can be found at http://www.hilltopinstitute.org/hcbp_cbl.cfm.

[61] *Id.*

[62] Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78954, 78969 (Dec. 31, 2014) (26 C.F.R. Parts 1, 53, 602); *see also* Schedule H (Form 990), Hospitals, Internal Revenue Service, *available at* http://www.irs.gov/uac/About-Schedule-H-Form-990.

[63] *See Utilization of Community Benefit to Improve Health Food Access in Massachusetts*, Health Care Without Harm, 25-8 (2015), *available at* https://noharm-uscanada.org/sites/default/files/documents-files/3088/Community%20BenefitBenefit%20Improve%20Healthy%20Food%20Access%20in%20Mass_FINAL.pdf.

[64] *Id.*

[65] *The Attorney General's community benefit guidelines for non profit hospitals,* Massachusetts Attorney General (2009), *at* www.mass.gov/Cago/docs/healthcare/hospital_guidelines.pdf.

[66] *Id.*

[67] *See Utilization of Community Benefit to Improve Health Food Access in Massachusetts*, Health Care Without Harm, 29-31

(2015), *available at* https://noharm-uscanada.org/sites/default/files/documents-files/3088/Community%20BenefitBenefit%20Improve%20Healthy%20Food%20Access%20in%20Mass_FINAL.pdf.

[68] *Id.*

[69] Anna Jaques Hospital – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=2&report_year=2013.

[70] *Id.*

[71] Baystate Mary Lane Hospital – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=45&report_year=2013.

[72] *Id.*

[73] See *Utilization of Community Benefit to Improve Health Food Access in Massachusetts*, Health Care Without Harm, 46 (2015), *available at* https://noharm-uscanada.org/sites/default/files/documents-files/3088/Community%20BenefitBenefit%20Improve%20Healthy%20Food%20Access%20in%20Mass_FINAL.pdf.

[74] Carney Hospital – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=18&report_year=2013.

[75] *Id.*

[76] Holyoke Medical Center – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=36&report_year=2013.

[77] *Id.*

[78] *HIV/AIDS Positive Link*, Bloomington Hospital, http://iuhealth.org/bloomington/about/community-health/hiv-aids-positive-link/ (last visited Apr. 14, 2015).

[79] Telephone Interview with Jill Stowers, Clinical Lead Manager of Community Health at Indiana University Health Blooming (Nov. 28, 2013); Positive Link nomination for Jackson Healthcare Charitable Services Awards (2013).

[80] *Client Services*, Bloomington Hospital, http://iuhealth.org/bloomington/about/community-health/hiv-aids-positive-link/client-services/ (last visited Apr. 14, 2015).

[81] *Id.*

[82] *See Utilization of Community Benefit to Improve Health Food Access in Massachusetts*, Health Care Without Harm, 48 (2015), *available at* https://noharm-uscanada.org/sites/default/files/documents-files/3088/Community%20BenefitBenefit%20Improve%20Healthy%20Food%20Access%20in%20Mass_FINAL.pdf.

[83] New England Baptist Hospital – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=58&report_year=2013.

[84] *Id.*

[85] *See Utilization of Community Benefit to Improve Health Food Access in Massachusetts*, Health Care Without Harm, 31, 49 (2015), *available at* https://noharm-uscanada.org/sites/default/files/documents-files/3088/Community%20BenefitBenefit%20Improve%20Healthy%20Food%20Access%20in%20Mass_FINAL.pdf.

[86] St. Elizabeth's Medical Center – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=75&report_year=2013.

[87] *Id.*

[88] *Id.*

[89] UMass Memorial Medical Center – FY2013 Community Benefit Standard Summary, *available at* http://www.cbsys.ago.state.ma.us/cbpublic/public/hccstandardnew.aspx?org_id=113&report_year=2013.

[90] *Id.*

[91] *Id.*