CONNECTICUT
Health Strategy

Hospitals' Community Benefit Summary and Analysis Report FY 2023

Report pursuant to Conn. Gen. Statute §19a-127k

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Commissioner

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Acronyms

ACA.....Patient Protection and Affordable Care Act
CGS.....Connecticut General Statutes
CHNA.....Community Health Needs Assessment
ECA.....Extraordinary Collection Action
EMCP.....Emergency Medical Care Policy
FAP.....Financial Assistance Policy
FPG.....Federal Poverty Guidelines
FPL.....Federal Poverty Level
FY..... Filing Year
GAO.....Government Accountability Office
HHC.....Hartford HealthCare
HHCMG.....Hartford HealthCare Medical Group
HRS.....Hospital Reporting System
IRC.....Internal Revenue Code
IRS.....Internal Revenue Service
NEMG.....Northeast Medical Group
OHS.....Office of Health Strategy
PHE.....Public Health Emergency
REL.....Race, Ethnicity, and Language
SCHIP.....State Children's Health Insurance Program
SDOH.....Social Determinants of Health
YNHH.....Yale New Haven Hospital
YNHHS.....Yale New Haven Health Services

Executive Summary

About this report

Connecticut General Statute §19a-127k, requires all nonprofit hospitals in Connecticut to submit a Community Benefits Annual Status Report each year to the Connecticut Office of Health Strategy (OHS). OHS is responsible for producing an annual report that includes analyses, findings, and recommendations on Connecticut acute care nonprofit hospitals' community benefit programs and other hospital investments addressing community needs.

Nonprofit hospitals are required to provide goods and services to benefit the community in order to remain exempt from federal, state and local taxes. The Internal Revenue Service (IRS) requires nonprofit hospitals to report on these investments each year. Hospitals also provide community building and other activities that promote community health, in addition to community benefits as defined by federal law.

This report presents a summary analysis for tax filing year (FY) 2023 of financial allocations from 23 acute care nonprofit hospitals as reported to the IRS for community benefits and community-building activities. The report also analyzes other expenses on activities addressing community needs identified through a Community Health Improvement Plan (CHIP), as reported by hospitals to OHS through an annual status report. The report provides an overview of hospitals' financial assistance policies as financial assistance to patients represents a critical component of community benefit. All data and policies are self-reported by the hospitals.

Key Findings

- **Total Community Benefits and Investments**: Hospitals reported a combined net total of **$2.05 billion** in Community Benefits, Community Building and CHIP expenses in FY 23. The net total includes the sum of all Community Benefit, Community, Building and CHIP expenses ($2.99 billion) minus the CHIP expenses that overlap with Community Benefit and Community Building ($931.6 million).

- **CHIP Expenses**: CHIP activities reported to OHS overlap with IRS-reported community benefits and community building expenditures. Hospitals reported a total of $946.4 million in CHIP activities, which include:
  - $931.4 million reported as Community Benefits (per IRS definitions)
  - $123,309 reported as Community Building (per IRS definitions)
  - $14.8 million in addition to Community Benefit and Community Building activities

Breakdown of Financial Calculations

Expense Categories	Total Reported Expenses	CHIP Overlap with Community Benefit and Community Building	Net Total
Community Benefit	$2,032,405,305.00	$931,446,564.31	$2,032,405,305.00
Community Building	$8,043,432.00	$123,309.00	$8,043,432.00
CHIP activities	$946,399,496.31		14,829,623.00
Totals	$2,986,848,233.31	($931,569,873.31)	**$2,055,278,360.00**

Community Benefit

- **Expenditures:** Hospitals reported a total of $2.03 billion in community benefit expenditures, representing 12.64% of total hospital expenses. During the same period, all 23 nonprofit acute care hospitals collectively reported $16.3 billion in total revenue and $16.07 billion in total expenses.
- **Growth from 2016:** From 2016 to 2023, the total community benefit expense for acute care nonprofit hospitals increased by $258 million (a 14.57% increase), rising from $1.7 billion to $2.03 billion. However, as a percentage of total hospital expenses, the community benefit expense declined by 3%.
- **Top three community benefit expenditures:** Hospitals reported the following top expenditures: 1. Unreimbursed Medicaid Costs totaled $1.24 billion (61%); 2. Health Professions Education totaled $298 million (14.6%); 3. Financial Assistance or charity care totaled $283 million (14%).
- **Unreimbursed costs of treating Medicaid patients –** Hospitals reported $1.24 billion in unreimbursed Medicaid costs in FY 2023, making up 61% of total community

benefit expenditures. The most significant change was a $166 million increase in unreimbursed costs for treating Medicaid patients, which accounted for 64% of the total spending increase ($166 million out of $258 million).

  - In FY 2023, OHS updated its methodology for calculating hospital Medicaid costs as part of the Hospital Financial Stability reporting. As a result, the Medicaid payment-to-cost ratio was 0.87 compared to 0.62 in FY 2022 indicating a higher reimbursement of hospital costs. However, unreimbursed Medicaid costs saw a slight increase, rising to $1.2 billion in FY 2023, up from $1.07 billion in FY 2022. Further details on the revised methodology can be found In the **Unreimbursed Medicaid Costs** section of this report.

- **Financial Assistance (Charity Care) –** Hospitals provided $283 million in financial assistance (charity care), representing 14% of total community benefit expenditures. However, charity care has decreased by $61.8 million (17.9%) since 2016. Over the same period, hospitals saw an increase in bad debt, with nearly $120 million in unrecovered payments attributed to patients who would have qualified for charity care but did not receive assistance for various reasons.
  - **Financial Assistance Policies:** Most hospitals offer financial assistance or free care for households earning under 250% of the Federal Poverty Line (FPL). Some hospitals also offer discounted care for households with annual incomes up to 550% of the FPL. However, financial eligibility standards vary across hospitals. For example, Middlesex, St. Mary's, St. Francis Medical, and Johnson Memorial hospital's offer free care to individuals under 200% of the FPL which is an annual income of $29,160 for a single individual. In comparison, a minimum wage worker's annual salary is over $31,000.

Community Building

- **Community Building Investments**: In FY 2023, hospitals reported $8 million in community building investments, focused on activities addressing social determinants of health and local public health initiatives, such as childcare, violence prevention programs, and disaster readiness.

Community Needs and CHIP Activities

- **Identified Community Needs:** Connecticut hospitals identified a range of community needs in their current CHNA including in categories such as behavioral

health, access to care, preventative health, chronic disease management, maternal and child health, food security and quality, access to housing, workforce development, and violence prevention.

- **Hospital Investments in CHIP:** Hospitals reported a total of $946.4 million in investments addressing these needs, much of which overlaps with community benefit or community building activities:

Area of Focus	Amount	Number of Hospitals
Access to Care*, Reducing Barriers, & Healthcare Disparities	$771.7 million	14
Behavioral Health (Mental Health & Substance Use)	$151.3 million	18
Preventive Health (Disease Prevention & Wellness)	$11.3 million	14
Chronic Disease Management	$1.8 million	9
Maternal Wellness & Child Health Improvement	$5.5 million	5
Food Security & Quality	$1.01 million	3
Access to Housing	$264K	3
Workforce Development	$1.55 million	2
Violence Prevention	$1.4 million	1
Culturally Competent Care	$321K	1

***Of this total, $525.9M was from unreimbursed costs of treating Medicaid patients**

Data reviewed in this report comes from hospital and health system submissions to the IRS and to OHS through various reporting requirements. OHS has not validated this data.

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Community Benefits Background

Federal Oversight

Nonprofit hospitals must provide community benefits to maintain their tax-exempt status and support the health of the communities in the regions they serve. [1,2,3] Nonprofit hospitals with 501(c)(3) status benefit from exemptions on federal income taxes, as well as certain state and local taxes on net income, property, and purchases. They can also secure favorable borrowing terms like those available to government entities, and eligible donations to these hospitals are tax-deductible for donors on their federal income tax returns.[4] There is no federally mandated minimum or maximum community benefit spending requirement.

Currently, nonprofit hospitals must meet three federal requirements to obtain or maintain their tax-exempt status.[5, 6]

1. Be organized and operated to achieve a charitable purpose
2. Demonstrate one to six factors outlined by the IRS, colloquially known as community benefit
3. Comply with requirements in the Patient Protection and Affordable Care Act (ACA) including conducting a Community Health Needs Assessment (CHNA) every 3 years

In addition, the IRS stipulates six factors that hospitals must fulfill to maintain tax exempt status. These factors include:

1. Operate an emergency room open to all, regardless of ability to pay
2. Maintain a board of directors that represent the community

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[1] §501(c)(3) of the Internal Revenue Code
[2] The Hilltop Institute. (n.d.). What are hospital community benefits?. Retrieved from https://hilltopinstitute.org/wp-content/uploads/publications/WhatAreHCBsTwoPager-Sept2019.pdf
[3] Catholic Health Association. (n.d.). Community benefit overview. Retrieved from https://www.chausa.org/communitybenefit/community-benefit
[4] Committee for a Responsible Federal Budget. (n.d.). Federal tax benefits for nonprofit hospitals. Retrieved from https://www.crfb.org/papers/federal-tax-benefits-nonprofit-hospitals
[5] Rev. Rul. 69-545, 1969-2 C.B. 117
[6] Rev. Rul. 83-157, 1983-2 C.B. 94

3. Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians)
4. Provide care to all patients able to pay, including those who do so through Medicare and Medicaid
5. Use surplus funds to improve facilities, equipment, and patient care
6. Use surplus funds to advance medical training, education, and research

In addition to the IRS requirements, the Affordable Care Act barred certain excessive billing and debt collection practices and added requirements to hospitals' emergency medical care and financial assistance policy (FAP). ACA requires each hospital facility to conduct a Community Health Needs Assessment (CHNA) and establish a Community Health Improvement Plan (CHIP), also known as implementation strategy.[7]

The CHNA identifies community health priorities and strengths. The CHIP, also known as Implementation Strategy, outlines the hospital's plans to address identified health needs. The latest CHNA cycle for Connecticut nonprofit hospitals was in FY 2021/2022, with updates expected in FY 2024/2025.

Hospital organizations use Schedule H (Form 990) to provide information about their activities, policies, and community benefits provided. Schedule H, Part I (Form 990) consists of community benefit categories that require expense data and are further segmented into the following categories:

A. Financial assistance and means-tested government programs formed by the following subcategories:
   - Financial assistance at cost, also known as charity care
   - Unreimbursed Medicaid costs
   - Costs of other means-tested government programs, such as State Children's Health Insurance Programs
B. Total other benefits formed by the following subcategories:
   - Community health improvement services and community benefit operations
   - Health professions education
   - Subsidized health services
   - Research

[7] Internal Revenue Service. (2022). *Instructions for Schedule H (Form 990)*. Retrieved from https://www.irs.gov/instructions/i990sh#:~:text=%2F29%2F15.-,Purpose%20of%20Schedule,operated%20during%20the%20tax%20year

- Cash and in-kind contributions for community benefit

In Parts II and III of Schedule H, hospitals may report additional expenses as potential community benefit. Expenditures reported in Parts II and III must be justified to the IRS by hospitals. OHS is unable to verify whether these expenses are accepted by the IRS as community benefits. These categories include:

- Community building activities (e.g. workforce development, economic development, housing programs)
- Bad debt from patients who would have qualified for financial assistance
- Medicare shortfall (the gap between Medicare reimbursement and the actual cost of services).

The U.S. Government Accountability Office (GAO) analyzed federal regulations for nonprofit hospitals and concluded that, despite the added requirements from the Affordable Care Act (ACA), there remains ambiguity around which community benefit activities hospitals must perform to maintain their tax-exempt status.[8]

The GAO also found that the IRS has not consistently enforced these standards, even for hospitals reporting no community benefit spending. IRS evaluations often depend on secondary data and self-reported information from hospitals, with a few cases being referred for potential ACA violations.[9] In June 2024, the IRS announced that it will conduct audits of 35 nonprofit hospitals with a focus on community benefit compliance.[10] For more information regarding the legal requirements for non-profit hospitals and historical evolution of the Community Benefit Standard, read this 2024 Congressional Research Services Report.[11]

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[8] U.S. Government Accountability Office. (2020, September). Tax administration: Opportunities exist to improve oversight of hospitals' tax-exempt status (Report No. GAO-20-697). Retrieved from https://www.gao.gov/products/gao-20-697

[9] *Ibid*

[10] Rosenberg, T. R., & Arroyo, E. (2024, August 13). IRS audits & ongoing scrutiny of nonprofit hospitals – Key background & action steps. Sheppard, Mullin, Richter & Hampton LLP. The National Law Review. https://www.natlawreview.com/article/irs-audits-ongoing-scrutiny-nonprofit-hospitals-key-background-action-steps

[11] Liu, E. C. (2024, April 15). Legal requirements for Section 501(c)(3) hospitals (CRS Report No. R48027). Congressional Research Service. https://crsreports.congress.gov/product/pdf/R/R48027

Connecticut Oversight

Connecticut law further defines community benefit programs under Connecticut General Statutes (C.G.S.) 19a-127k(a)(2) as activities and services that:

- Promote preventive health care
- Improve health equity by reducing health disparities
- Overall, improve the health status of people in the region served by the hospital

Connecticut requires all short-term acute care nonprofit hospitals to submit an Annual Status Report to the Office Health Strategy (OHS). These reports provide OHS additional information regarding expenses hospitals are attributing to the activities supporting their Community Health Improvement Plan (CHIP) intended to address health needs identified through a Community Needs Health Assessment.

The Annual Status Report is due annually, and includes:

- A description of major updates regarding community health needs, priorities, and target populations, if any
- A description of progress made regarding the hospital's actions in support of its Implementation Strategy/CHIP
- A description of any major changes to the proposed Implementation Strategy/CHIP and associated hospital actions
- A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's Implementation Strategy/CHIP

OHS is responsible for publishing an annual summary and analysis report, soliciting public comments, identifying key stakeholders, and making recommendations to the Department of Public Health for the State Health Improvement Plan.

National Landscape

Nationally, hospital community benefits have gained more attention since the COVID-19 pandemic, highlighting the opportunity for states and hospitals to enhance community benefit activities that directly improve health outcomes. Some states are exploring policy changes, ranging from increasing community benefit spending to address social needs to establishing minimum standards for hospital contributions.

Community Benefits Background

A central question in the national conversation is whether nonprofit hospitals are providing meaningful benefits in exchange for the substantial tax exemptions they receive. A 2024 study published in the Journal of the American Medical Association, using data from 2021 (the most recent year available), found that 55% of the total tax benefits came from state and local taxes.[12] The study suggested that, since more than half of the total tax benefit comes from state and local taxes, efforts to enhance nonprofit hospitals' accountability should also focus at the local level. The study also provides a standardized estimation roadmap to help stakeholders assess and report the value of these tax benefits more effectively.

Another study by the Lown Institute, a non-partisan healthcare think tank, analyzed 2020 data and identified a fair share deficit of $25.7 billion among nonprofit hospitals. The Lown Institute created the fair share standard based on research into the valuation of nonprofit tax exemptions.[13] Under fair share standard, hospitals should allocate at least 5.9% of their overall expenditures to community benefits. The Lown Institute's methodology for establishing what counts as a community benefit only includes certain categories that directly contribute to community health: subsidized health services, community health improvement, cash and in-kind donations, and community building activities. Other categories, such as unreimbursed costs of treating Medicaid patients, are excluded from their analysis.[14]

The study revealed that, on average, hospitals allocated 3.87% of their overall expenditures to community benefit investments. As a result, four in five hospitals failed to meet the minimum community benefits expenditure threshold required to fulfill the fair share criteria under this methodology.[15]

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[12] Bai, G., Yehia, F., Anderson, G. F., & Hyman, D. A. (2024). Estimation of tax benefit of US nonprofit hospitals. JAMA, 332(20), 1732–1740. https://doi.org/10.1001/jama.2024.13413.
[13] Lown Institute. (2023, April 11). 2023 Fair Share Spending. Lown Institute Hospital Index. https://lownhospitalsindex.org/2023-fair-share-spending/
[14] *Ibid.*
[15] *Ibid.*

What are other states doing?

Community benefits occupy an important role in improving health outcomes and addressing factors that lead to poor health. Table 1 shows what some other states are doing to improve community benefits reporting and access to financial assistance.

Connecticut requires annual reporting from short-term acute care nonprofit hospitals through a mandatory report. The reports must reflect progress towards strategies that address community needs and promote community health and health equity, including funding allocations for these activities. In contrast to a reporting-only requirement, some states have set minimum community benefit spending thresholds, mandated uniform financial assistance policies, and required hospitals to report on tax exemptions claimed.

Table 1 Comparative Analysis of Community Benefit Policies

State	Requires annual reporting	Minimum thresholds for hospital community benefits spending	Requires hospital coordination with local officials	Financial penalties for noncompliance with community benefit obligations	Minimum standards for financial assistance policy	Report on the number of tax exemptions claimed by hospital
CT	☑					
MA	☑					
NH	☑		☑	☑	☑	
NY	☑		☑	☑	☑	
IL	☑	☑	☑		☑	
MD	☑				☑	☑
OR	☑	☑		☑	☑	
CA	☑				☑	

Community Benefits Background

In California, the Hospital Fair Pricing Policies Act establishes, as a condition of licensure, minimum standards to be used in determining eligibility for free or discounted care under a hospital's charity care and discounted care policies.[16] Illinois' law requires nonprofit hospitals to spend the amount of their property tax on services that address the health are needs of low-income or underserved communities, and in Maryland, state law requires hospitals to report the types of tax exemptions claimed.[17, 18]

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[16] California Department of Health Care Access and Information. (n.d.). *Hospital Fair Billing Program: Laws and Regulations*.
[17] Illinois General Assembly. (n.d.). *35 ILCS 200/ Property Tax Code, Article 15: Exemptions*.
[18] Health Services Cost Review Commission. (2022, December). *Maryland Hospital Community Benefit Report: FY 2021.*

Data Analysis

This section will look at hospitals' expenditure and investments broken down by:

- Total Community Benefit expenses as reported to the IRS, Form 990, Schedule H
- Total Community Building expenses as reported to the IRS, Form 990, Schedule H
- Total expenditures to address identified community needs otherwise known as Community Health Improvement Plan (CHIP) activities

Hospitals reported a combined net total of **$2.05 billion** in Community Benefits, Community Building and CHIP expenses in FY 23. These three categories are not mutually exclusive. The analysis below includes a review of CHIP activities that overlap with what hospitals report as community benefit or community building activities to the Internal Revenue Services (IRS). Hospitals reported $946.4 million in CHIP activities of which:

- $931.4 million was reported as Community Benefits (per IRS definitions)
- $123,309 was also reported as Community Building (per IRS definitions)
- $14.8 million was neither and in addition to what was reported as Community Benefit or Community Building activities

Connecticut's Nonprofit Hospital Community Benefit Reported to the IRS

Community Benefits Multi-Year Analysis (FY 2016 – FY 2023)

This section provides an overview of community benefits expenses reported to the IRS from FY 2016 through 2023 by all 23 acute care nonprofit hospitals in Connecticut. Figure 1 illustrates the net total community benefit expense in Connecticut over the past eight observed filing years as reported to the IRS. Notably, the 2023 total community benefit expense is roughly $258 million (14.56%) higher than the previous year (2022) and the highest since FY 2016.

Figure 1. Community Benefit Expenses reported to the IRS (2016-2023)

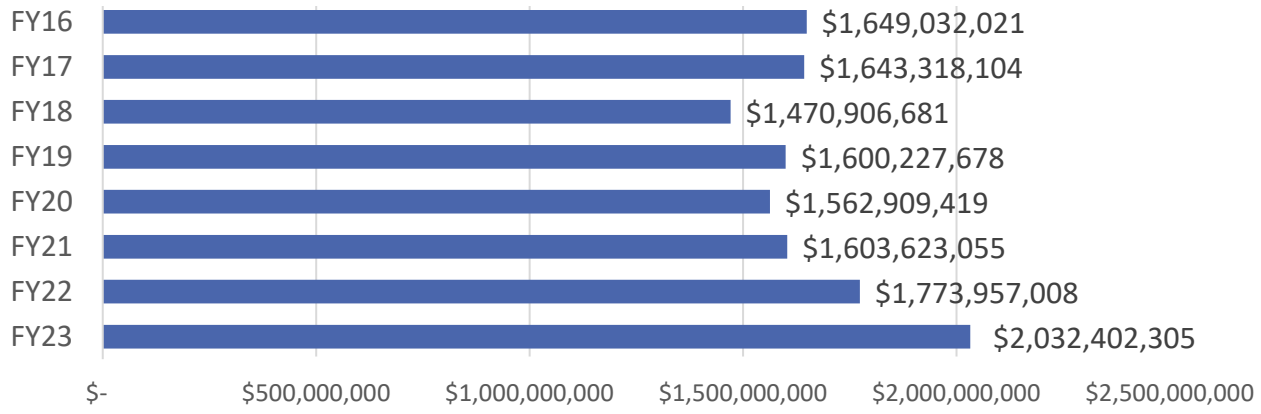
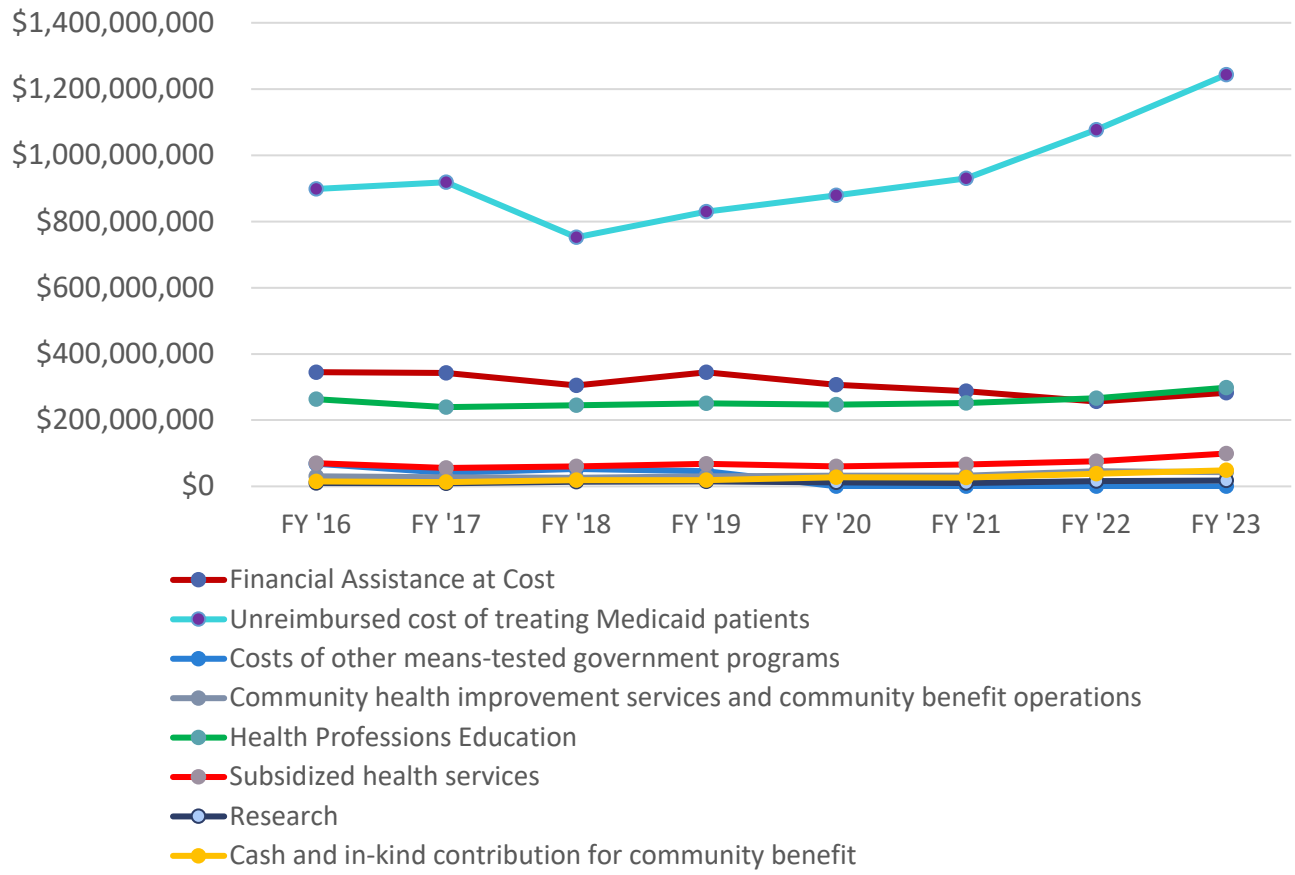


Figure 2 shows community benefit expenses reported to the IRS by category from 2016 to 2023. In 2023, the overall increase in expenses was primarily driven by a $166 million rise in unreimbursed cost of treating Medicaid patients, compared to the previous filing year. Meanwhile, spending on financial assistance at cost (charity care) has steadily declined since 2016, while subsidized health services gradually increased since 2020.

Figure 2. Community Benefit Expenses reported to the IRS (2016-2023)



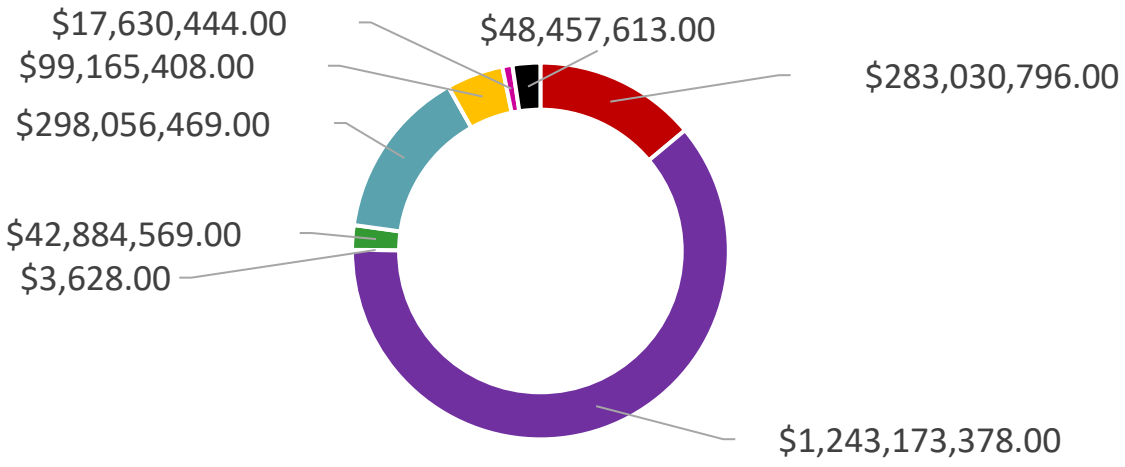
Appendix B: Community Benefit expenses reported to the IRS (FY 2016-2023) shows the exact dollar amount for each of the eight IRS 990 Schedule H, Part I categories by filing year (2016-2023). **Appendix C: Community Benefit expenses reported to the IRS by Hospital (FY 2016-2023)** shows the total community benefit reported to the IRS by hospital and by filing year (2016-2023).

Community Benefits Reported to the IRS (FY 2023)

In 2023, Connecticut acute care nonprofit hospitals reported to the IRS a total of $2.03 billion in community benefits. **Figure 3** illustrates the net community benefit expenses that were reported to the IRS in 2023. The top three expenses reported include:

1. $1.2 billion of community benefit expenses were hospital reported unreimbursed costs of treating Medicaid patients
2. $298 million in Health Professions Education
3. $283 million in Financial Assistance (charity care)

Figure 3. Community Benefits Expenses reported to the IRS by category (2023)



Legend: Community Benefit Category	Total Expenses Reported to the IRS
Unreimbursed cost of treating Medicaid patients	$1,243,173,378
Health Professions Education	$298,056,469
Financial Assistance at Cost	$283,030,796
Subsidized health services	$99,165,408
Cash and in-kind contribution for community benefit	$48,457,613
Community health improvement services and community benefit operations	$42,884,569

■ Research	$17,630,444
■ Costs of other means-tested government programs	$3,628
Total	$2,032,402,305

Unreimbursed Medicaid Costs

Hospitals report unreimbursed costs of treating Medicaid patients to the IRS as part of their community benefits; however, the detailed calculations each hospital uses to determine these unreimbursed costs are not available to OHS. In FY 2023, OHS adopted a new methodology to more accurately represent hospital Medicaid costs as part of its Annual Report on the Financial Status of Connecticut's Short-Term Acute Care Hospitals. This revised approach accounts for all Medicaid revenue received by hospitals, aligns eligible patient care expenses with federal Medicare standards, and ensures that only user fees specifically allocated to Medicaid revenue are recorded as Medicaid expenses.

Key components of the revised methodology include:[19]

- Inclusion of All Medicaid Payments – This calculation incorporates all Medicaid service payments and supplemental payments, such as Disproportionate Share Hospital (DSH) payments and Graduate Medical Education (GME) payments, in addition to standard reimbursements.
- Refined User Fee Allocation – Only user fees applied to Medicaid revenue are included, excluding fees associated with revenue from other payers.
- Allowable Cost Adjustments – The methodology relies on the Medicare Cost Report, which excludes certain non-patient care expenses such as advertising, lobbying, and parking.
- In FY 2023, Medicaid payments covered a higher proportion of hospital costs than previously reported. The statewide Medicaid payment-to-cost ratio in FY 2023 was 0.87 (87 cents per dollar), an increase from 0.78 (78 cents per dollar) under the previous methodology. Despite this change, hospitals reported a slight increase in unreimbursed Medicaid costs, totaling $1.2 billion in FY 2023, compared to $1.07 billion in FY 2022.

[19] Office of Health Strategy. (2024). *Annual report on the financial status of Connecticut's hospitals: FY 2023*. State of Connecticut

OHS is unable to determine whether the $1.2 billion in unreimbursed Medicaid costs reported by hospitals is consistent with this new methodology. However, given the timing of the data collection for this report, and the release of the new Financial Stability Report methods, we assume that this number represents the previous method of calculating so-called Medicaid underpayment.

Connecticut Nonprofit Hospitals Compared to National Data

To understand how Connecticut hospitals' community benefit expenses compare to national data, OHS reviewed the IRS' "Report to Congress on Private Tax-Exempt, Taxable and Government-Owned Hospitals" published in 2024.[20] The report is retrospective, with the most recent data available from filing year 2020. **Table 2** includes both national and Connecticut community benefit data for FY 2020.

National data includes the sum of all nonprofit hospitals' expenditures (which includes acute and non-acute care hospitals across the nation), while Connecticut data only includes nonprofit acute care hospitals. The leftmost column includes the community benefit categories used by the IRS. The next three columns (in green) are the national and Connecticut data as a percentage of total community benefit expense, as well as the difference (delta Δ) between the two. The three remaining columns (in yellow) are formatted similarly but focus on community benefit as a percentage of total hospital expenses.

Key highlights:

- In FY 2020, the total Community Benefit expenses reported by Connecticut hospitals represented 12% of hospitals' total expenditures; in contrast, total Community Benefit expenses reported by all non-profit hospitals nationwide represented 9.5% of hospitals' total expenditures.

[20] Tax Exempt & Government Entities Division, Internal Revenue Service. (2024). Report to Congress on private tax-exempt, taxable and government-owned hospitals.

Data Analysis

- Connecticut hospitals reported a higher percentage of Medicaid-related costs as part of Community Benefits, 56.2%, when compared to the total Medicaid-related costs reported by all U.S. nonprofit hospitals at 44%
- Connecticut hospitals reported more financial assistance as part of their community benefit at almost 20% when compared to the 16.5% reported nationally.
- Subsidized health services (e.g., essential but unprofitable services like behavioral health or trauma care) account for only 3.83% of community benefit spending in Connecticut, compared to 11.45% nationally—a significant 7.62% difference

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Table 2. Community Benefit IRS Data – National Benchmarks Compared to Connecticut (FY 2020)

Type of Community Benefit	Percent of Total Community Benefit Expense			Percent of Total Expenses		
	National	Connecticut	Difference	National	Connecticut	Difference
Financial assistance at cost	16.52%	19.61%	3.09%	1.57%	2.35%	0.78%
Unreimbursed cost of treating Medicaid patients	44.01%	56.21%	12.20%	4.18%	6.74%	2.56%
Costs of other means-tested government programs	1.10%	0.02%	-1.08%	0.10%	0.00%	-0.10%
Community health improvement services and community benefit operations	4.33%	2.08%	-2.25%	0.41%	0.25%	-0.16%
Health professions education	14.89%	15.78%	0.89%	1.42%	1.89%	0.47%
Subsidized health services	11.45%	3.83%	-7.62%	1.09%	0.46%	-0.63%
Research	4.76%	0.74%	-4.02%	0.45%	0.09%	-0.36%
Cash and in-kind contributions for community benefit	2.95%	1.74%	-1.21%	0.28%	0.21%	-0.07%
Total Community Benefits	100%	100%	0%	9.50%	12.00%	2.50%

Community Building Reported to the IRS (FY 2023)

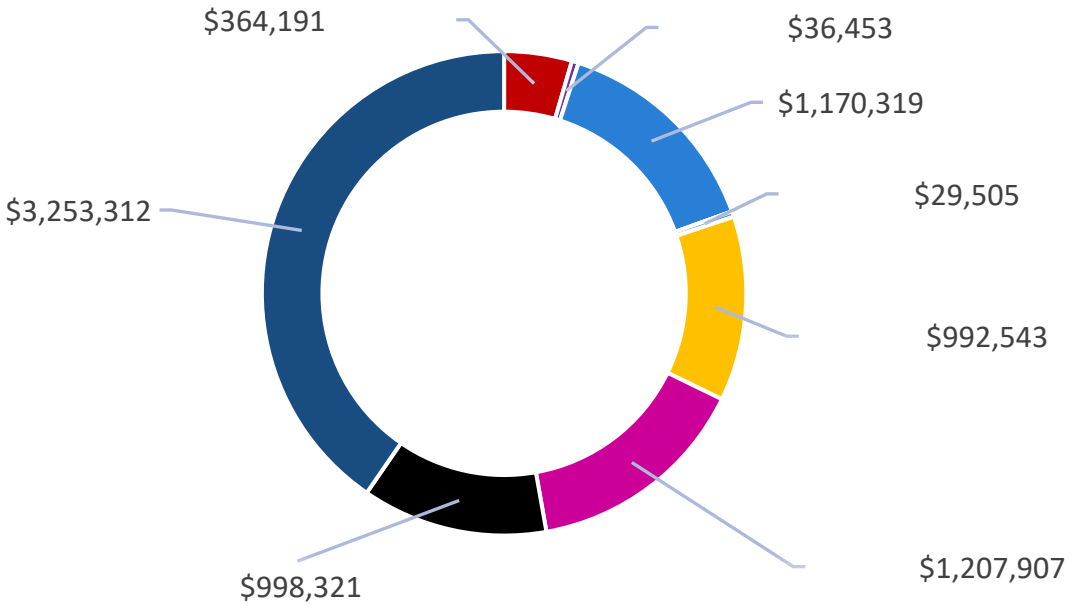
This section examines the total community building expenses reported to the IRS by all 23 acute care nonprofit hospitals in FY 2023. Community Building activities help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health such as education, air quality, and access to nutritious food. This is different from Community Benefits, which are activities that provide treatment or promote health and healing as a response to identified community needs. Community benefit programs have a special focus on disadvantaged populations and must be available to the broad community.

The data source used to analyze this section is Schedule H, Part II, of the IRS 990 form submitted by hospitals. Activities reported in Part II (community building) of Schedule H cannot be reported in Part I (community benefit) and vice versa. It is important to note that community building expenses do not automatically count as community benefit. Each hospital must provide justification to the IRS. However, OHS does not have information on whether these expenditures were accepted by the IRS as community benefit expenses.

In 2023, Connecticut acute care nonprofit hospitals reported a total of $8 million in community building expenses to the IRS (Figure 4). The top three expenses reported include:

- $3.2 million in "Other" community building activities-Examples include spending on food security, nutrition and other social determinants of health not covered by other community building categories
- $1.2 million in community health improvement advocacy - Examples include but are not limited to efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation
- $1.1 million in community support - Examples include but are not limited to child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness efforts beyond regulatory requirements

Figure 4. Community Building Expenses reported to the IRS (2023)



Legend: Community Building Category	**Total Expenses Reported to the IRS**
■ Other	$3,253,312
■ Community health improvement advocacy	$1,207,907
■ Community Support	$1,170,319
■ Workforce development	$998,321
■ Coalition building	$992,543
■ Physical improvements and housing	$364,191
■ Economic development	$36,453
■ Leadership development and training for community members	$29,505
■ Environmental improvements	$0
Total	$8,043,432

Community Health Improvement Plan Expenses Data Analysis (FY 2023)

This section examines hospital expenditures on activities aimed at addressing identified community health needs, as outlined in each CHIP. Acute care nonprofit hospitals report this information annually to OHS through a status report.

OHS analyzes these expenditures to determine how they align with the definitions of community benefit and community building as established by the IRS. Importantly, OHS includes in its analysis any hospital expenditures that do not meet the IRS criteria for community benefit or community building but are still directed toward CHIP activities. This section is organized into four subsections:

- Total Investments in CHIP Activities- A breakdown of total hospital investments in activities addressing identified health needs per their CHIP, amounting to $946.4 million
- Additional CHIP Expenditures that are not included in Community Benefit or Community Building- An analysis of CHIP expenditures that fall outside the IRS definitions of community benefit and community building, totaling $14.8 million out of $946.4 million
- Overlap with Community Benefit Expenditures reported to the IRS- An analysis of CHIP expenditures that also qualify as community benefit expenses reported to the IRS, totaling $931.4 million out of $946.4 million
- Overlap with Community Building Expenditures- An analysis of CHIP expenditures that overlap with community building expenses as reported to the IRS, totaling $123,309 out of $946.4 million

Total CHIP Expenditures reported to the Office of Health Strategy (FY 2023)

All 23 acute care nonprofit hospitals reported a combined $946.4 million towards community health improvement plan activities addressing an identified community health need. Data comes directly from the annual status reports submitted by each hospital to OHS and each facility's CHIP.

Data Analysis

Table 3 outlines expenditures reported to OHS by hospital, while Appendix A: Table 17. CHIP expenses by Identified Community Health Need by hospital (FY 2023) breaks down spending by community health need. OHS groups these needs into key categories: behavioral health, access to care, preventative health, chronic disease, maternal and child health, food security and quality, access to housing, workforce development and violence prevention.

Key Highlights:

- Top three hospitals by CHIP spending (as percentage of total hospital expenditures):
    - Stamford Hospital: 18.62%
    - Bridgeport Hospital: 13.61%
    - Yale New Haven Hospital: 12.05%

- Total funds towards community health needs:
    - Access to care: $771.7M (14 hospitals) – Focused on reducing healthcare barriers and improving care coordination. Of this total, $525.9M was from unreimbursed costs of treating Medicaid patients
    - Behavioral health: $151.3M (18 hospitals) – Funding for mental health services, substance use treatment, and community-based programs.
    - Preventative health: $11.3M (14 hospitals) – Promoting healthy lifestyles, disease prevention, and early screenings
    - Chronic disease: $1.8M (nine (9) hospitals) – Supporting chronic disease management
    - Maternal and child health: $5.5M (five (5) hospitals) – Focused on maternal wellness and child health improvement
    - Food security and quality: $1.01M (three (3) hospitals) – Efforts to improve access to nutritious food
    - Access to housing: $264K(three (3) hospitals) – Addressing housing stability as a health factor
    - Workforce development: $1.55M (two (2) hospitals) – Programs to strengthen the healthcare workforce
    - Violence prevention: $1.4M (one (1) hospital) – Initiatives aimed at reducing community violence
    - Culturally competent care: $321K (one (1) hospital) – Enhancing care for diverse populations

Table 3. CHIP Expenses by Hospital (FY 2023)

Hospital	CHIP Expenses that also count as community benefit	CHIP Expense that also counts as community building	Additional CHIP Expenses	Total CHIP expenses	CHIP Expenses as share of hospital's total expenditures
Backus	$1,013,148.61	$0	$-	$1,013,148.61	0.20%
Bridgeport	$118,600,628.00	$0	$3,515,697.00	$122,116,325.00	13.61%
Bristol	$24,366.00	$0	$-	$24,366.00	0.02%
Central Connecticut	$645,646.98	$0	$-	$645,646.98	0.10%
Charlotte Hungerford	$877,501.00	$0	$-	$877,501.00	0.44%
Connecticut Children's	$3,162,109.00	$0	$1,192,575.00	$4,354,684.00	0.87%
Danbury	$99,447.00	$35,720	$1,657,271.00	$1,792,438.00	0.21%
Day Kimball	$745,730.00	$0	$-	$745,730.00	0.57%
Greenwich	$48,817,007.00	$0	$3,468,682.00	$52,285,689.00	9.78%
Griffin	$24,811,086.00	$0	$-	$24,811,086.00	10.18%
Hartford	$7,390,565.98	$0	$-	$7,390,565.98	0.30%
Johnson Memorial	$23,075.00	$0	$23,333.00	$46,408.00	0.07%
Lawrence + Memorial	$52,792,186.00	$0	$391,556.00	$53,183,742.00	11.44%
Middlesex	$24,944,132.64	$0	$-	$24,944,132.64	5.14%
MidState	$590,997.99	$0	$-	$590,997.99	0.13%
Norwalk	$58,909.00	$83,881	$791,640.00	$934,430.00	0.21%
Sharon	$20,214.00	$3,708	$2,500.00	$26,422.00	0.04%
St. Francis	$215,760.00	$0	$149,874.00	$365,634.00	0.04%
St. Mary's	$88,304.00	$0	$243,630.00	$331,934.00	0.10%
St. Vincent's	$10,521,278.00	$0	$-	$10,521,278.00	1.65%
Stamford	$143,168,935.63	$0	$-	$143,168,935.63	18.62%
Windham	$488,891.48	$0	$-	$488,891.48	0.37%
Yale New Haven	$492,346,645.00	$0	$3,392,865.00	$495,739,510.00	12.05%
Total	**$931,446,564.31**	**$123,309**	**$14,829,623.00**	**$946,399,496.31**	**5.89%**

Additional CHIP expenses

This subsection highlights expenditures towards CHIP activities that are not reported as Community Benefit or Community Building by the hospital. Hospitals report that these expenditures help address community health needs as outlined in their community health improvement plans. These activities are funded through external funds and do not use hospitals' operating budgets.

Only four (4) hospitals reported CHIP expenses under this category. Table 4 shows allocations towards CHIP activities that do not meet the federal Community Benefit or Community Building criteria. A total of $14.8 million out of $946.4 million in reported expenses falls under this category.

Key Highlights:

- Bridgeport Hospital reported the largest amount to activities that do not meet the IRS Community Benefit criteria, with $3.5M allocated, followed by Greenwich ($3.4M), and Yale New Haven Health ($3.3M).
- Danbury hospital reported $1.6 million, followed by Connecticut Children's Medical Center (Connecticut Children's) ($1.1M).
- Norwalk Hospital reported $791,640, followed by Lawerence + Memorial ($391,556)
- St. Mary reported $243,630 while St. Francis reported $149,874 towards CHIP activities that do not meet the IRS Community Benefit definition.

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Table 4 CHIP expenses not meeting IRS Community Benefit or Community Building criteria

Hospital	CHIP Expenses not meeting IRS criteria
Bridgeport	$3,515,697.00
Connecticut Children's	$1,192,575.00
Danbury	$1,657,271.00
Greenwich	$3,468,682.00
Johnson Memorial	$23,333.00
Lawrence + Memorial	$391,556.00
Norwalk	$791,640.00
Sharon	$2,500.00
St. Francis	$149,874.00
St. Mary's	$243,630.00
Yale New Haven	$3,392,865.00
Total	**$14,829,623.00**

CHIP expenses that overlap with Community Benefit

In 2023, Connecticut acute care nonprofit hospitals reported a total of $2.03 billion in Community Benefit activities to the IRS. As a share of expenses reported to the IRS, $931.4 million out of the $2.03 billion was allocated towards CHIP activities meeting the IRS Community Benefit definition. Table 5 shows this overlap. The data is broken down to align with the categories the IRS uses to define Community Benefit.

Key Highlights:

- Out of a total of 2.03 billion million in Community Benefit expenses reported to the IRS, 45.8% ($931.4 million) supported CHIP activities
- The unreimbursed cost of treating Medicaid patients accounts for the largest share of total CHIIP expenses that qualify as Community Benefit at $531.76 million out of $931.4 million.
    - Only Bridgeport, Greenwich, Griffin, Lawrence + Memorial, Middlesex and Yale New Haven claimed unreimbursed cost of treating Medicaid patients as expenditures towards CHIP activities addressing a community need.
- Community Health Improvement Services and Community Benefit Operations account for a disproportionate share of CHIP expenditures relative to total Community Benefit spending because Stamford Hospital miscategorized over

$36M in expenses that do not align with IRS definitions and is not clear how those dollars are addressing their identified needs as outlined in their CHIP

- Several categories show lower levels of investment when considering CHIP expenses as a share of total Community Benefit expenditure:

  - Subsidized Health related expenses on CHIP activities totaled $20 million (20% of total Community Benefit expenditures)
  - Health Profession Education related expenses on CHIP activities totaled $14.9 million (5% of total Community Benefit expenditures)
  - Cash and in-kind contributions related expenses on CHIP activities totaled $5.5 million (11% of total Community Benefit expenditures)

Table 5. CHIP Expenses as share of hospitals' total Community Benefit expenses

Community Benefit Category	Total Community Benefits Expenses reported to the IRS	Expenses allocated towards CHIP meeting IRS definition	CHIP Expenses as share of hospitals' total Community Benefit expenditures
Financial Assistance at Cost	$283,030,796.00	$193,056,701	68%
Unreimbursed costs of treating Medicaid patients	$1,243,173,378.00	$531,761,004	43%
Costs of other means-tested government programs	$3,628.00	$0	0%
Community health improvement services and community benefit operations	$42,884,569.00	$166,140,957	387%
Health Professions Education	$298,056,469.00	$14,929,236	5%
Subsidized health services	$99,165,408.00	$20,013,081	20%
Research	$17,630,444.00	$0	0%
Cash and in-kind contribution for community benefit	$48,457,613.00	$5,545,584.88	11%
Total	**$2,032,402,305.00**	**$931,446,564.31**	**45.8%**

Table 6 presents the total community benefit expenses reported to the IRS, the total expenses allocated to CHIP activities that meet the IRS' community benefit definition, and the proportion of CHIP expenditures relative to total community benefit expenditures reported to the IRS by Hospital.

Key Highlights:

- Griffin Hospital stands out, allocating 100% of its reported community benefit expenses to CHIP activities, representing 10.18% of the total hospital's expenditures.
- Stamford Hospital reported CHIP expenditures that exceeded its total community benefit expenses (134.5%), suggesting additional investments beyond those categorized under the IRS Community Benefit criteria.
- Other hospitals with a high proportion of their community benefit expenses allocated to CHIP activities include Yale New Haven Hospital (72.9%), Bridgeport Hospital (81.3%), and Greenwich Hospital (89.0%).
- Several hospitals allocated less than 5% of their community benefits expenses reported to the IRS towards CHIP activities. These hospitals include:
    - St. Francis (0.2%)
    - Danbury (0.1%)
    - Norwalk (0.1%)
    - Bristol (0.1%)
    - Central Connecticut (1.1%)

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Table 6. Community Benefit Expenses reported to the IRS and CHIP expenses meeting IRS Community Benefit criteria as reported to OHS

Hospital	Community Benefit Expenses reported to the IRS (Form 990, Part I)	Expenses supporting CHIP activities that meet IRS Community Benefit criteria (Annual Status Report)	Expenses supporting CHIP as share of Total Community Benefit Expenditures
Backus	$48,902,548	$1,013,149	2.1%
Bridgeport	$145,839,705	$118,600,628	81.3%
Bristol	$26,524,298	$24,366	0.1%
Central Connecticut	$60,703,320	$645,647	1.1%
Charlotte Hungerford	$10,128,276	$877,501	8.7%
Connecticut Children's	$140,561,689	$3,162,109	2.2%
Danbury	$101,851,121	$99,447	0.1%
Day Kimball	$18,215,075	$745,730	4.1%
Greenwich	$56,070,872	$48,817,007	87.1%
Griffin	$24,811,086	$24,811,086	100.0%
Hartford	$185,889,110	$7,390,566	4.0%
Johnson Memorial	$7,546,467	$23,075	0.3%
Lawrence + Memorial	$85,368,011	$52,792,186	61.8%
Middlesex	$70,813,446	$24,944,133	35.2%
MidState	$44,261,391	$590,998	1.3%
Norwalk	$53,069,773	$58,909	0.1%
Sharon	$11,030,347	$20,214	0.2%
St. Francis	$99,796,785	$215,760	0.2%
St. Mary's	$33,236,505	$88,304	0.3%
St. Vincent's	$66,689,726	$10,521,278	15.8%
Stamford	$106,468,937	$143,168,936	134.5%
Windham	$16,451,819	$488,891	3.0%
Yale New Haven	$618,171,998	$492,346,645	79.6%
Total	**$2,032,402,305**	**$931,446,564**	**45.8%**

CHIP expenses that overlap with Community Building

This subsection analyzes the expenditures on CHIP activities that meet the IRS' community building definition. Only three hospitals reported CHIP expenditures that meet the IRS

definition for community building, totaling $123,309. These hospitals include Danbury, Norwalk and Sharon. Out of the $123,309 claimed toward implementation strategies:

- $73,640 supported coalition building
- $49,669 supported community health improvement advocacy

Table 7 presents the total community building expenses reported to the IRS, the total expenses allocated to CHIP expenses that meet the IRS' community building definition, and the proportion of CHIP expenditures relative to total community building expenditures reported to the IRS.

Key Highlights:

- In 2023, Connecticut's acute care nonprofit hospitals reported a total of $8.05 million in community building expenses to the IRS. However, only $123,309 (2%) of this expenditure was allocated toward CHIP activities that align with the IRS' Community Benefit criteria, as reported to the Office of Health Strategy (OHS)
- Danbury Hospital had the highest proportion of its community building expenses allocated to CHIP activities (35%, or $37,428 of $100,729)
- Sharon Hospital followed, allocating 25.4% ($3,708 of $14,588)
- Norwalk Hospital reported higher total community building expenses ($863,672) than Danbury and Sharon, but allocated only 9.71% ($83,881) to CHIP activities
- 19 out of 23 hospitals (83%) reported zero CHIP expenditures related to community building, despite reporting community building expenses to the IRS
- Yale New Haven Hospital had the highest total community building expenses ($3.67 million) but did not allocate any of it toward CHIP activities

The low proportion of community building expenditures allocated to CHIP activities suggests that while hospitals are investing in community building initiatives as reported to the IRS, the majority may not address an identified health need.

Table 7. Community Building Expenses and CHIP expenses meeting criteria (FY 2023)

Hospital	Community Building Expenses reported to the IRS (Form 990, Part I)	Expenses supporting CHIP activities that meet IRS community building criteria (Annual Status Report)	Expenses supporting Implementation Strategy as share of Total Community Building Expenditures
Backus	$81,836	$0	0%
Bridgeport	$31,612	$0	0%
Bristol	$0	$0	0%
Central Connecticut	$236,936	$0	0%
Charlotte Hungerford	$49,131	$0	0%
Connecticut Children's	$1,772,148	$0	0%
Danbury	$100,729	$35,720	35%
Day Kimball	$0	$0	0%
Greenwich	$522,242	$0	0%
Griffin	$0	$0	0%
Hartford	$400,302	$0	0%
Johnson Memorial	$0	$0	0%
Lawrence + Memorial	$760	$0	0%
Middlesex	$183,812	$0	0%
MidState	$21,775	$0	0%
Norwalk	$863,672	$83,881	9.71%
Sharon	$14,588	$3,708	25.42%
St. Francis	$0	$0	0%
St. Mary's	$30,400	$0	0%
St. Vincent's	$24,672	$0	0%
Stamford	$0	$0	0%
Windham	$44,184	$0	0%
Yale New Haven	$3,673,752	$0	0%
Total	**$8,052,551**	**$123,309.00**	**2%**

Financial Assistance Policy and Bad Debt

IRC section §501(r)(4) requires tax-exempt hospitals to have a Financial Assistance Policy (FAP). While the federal government does not require minimum requirements for financial assistance eligibility, hospitals must establish criteria for free or discounted care and make those criteria publicly available.

Hospitals may justify their bad debt as community benefit if the debt is reasonably attributable to patients eligible under the organization's Financial Assistance Program (FAP).[21] To do this, the IRS requires hospitals to provide a clear methodology and rationale for including bad debt as a community benefit. However, the IRS prohibits hospitals from reporting bad debt as uncompensated care in Part I of Schedule H, which includes charity care and unreimbursed Medicaid costs. Instead, bad debt must be documented with justification in Part VI of Schedule H to be counted as community benefit.

If the IRS accepts a hospital's rationale, bad debt can count as a community benefit for certain Financial Assistance Policy-eligible individuals. However, it is unclear whether those individuals applied for financial assistance in the first place, applied and did not qualify for unknown reasons, or if the hospital took any collection-related actions against those individuals on debt that may ultimately be written off.

Hospitals do not report the number of financial assistance applications submitted, approved, or denied nor do they report the number of Extraordinary Collection Actions (ECAs) initiated. As a result, OHS cannot determine if the number of patients receiving charity care is higher or lower than those facing ECAs.

Table 8 shows hospitals that have documented bad debt attributed to patients that would have been eligible under the organization's Financial Assistance Policy (FAP) but did not receive financial assistance.

Financial Assistance Policy and Bad Debt

Key Highlights:

- Since 2016, hospitals reported a total of $119,965,952, 4% of the total bad debt, as debt attributable to FAP-eligible individuals.
- From 2016 to 2018, it remained at or below $9 million annually; however, it increased sharply from 2019 onward, from $15.3 million in 2019 to $26.2 million or 6% of the total bad debt in 2023.
- Stamford Hospital reported the highest bad debt attributable to FAP-eligible individuals, totaling $72.6 million since 2016—60.5% of all reported bad debt attributable to FAP. The hospital had not reported bad debt before 2019, but its bad debt grew significantly between 2019 and 2023, reaching $20.1 million in 2023.
- More than half of hospitals (59%)—13 out of 22—have not reported any portion of bad debt as a community benefit in any year.
- Notably, Bridgeport, Hartford, Yale New Haven, and St. Francis hospitals—some of the largest in the state—didn't report any bad debt attributable to FAP-eligible individuals.

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Table 8. Total bad debt attributable to Financial Assistance Policy (2016-2023)

Hospital	2016	2017	2018	2019	2020	2021	2022	2023	Total
Backus	$2,184,007	$0	$0	$0	$0	$0	$0	$0	$2,184,007
Bridgeport	$0	$0	$0	$0	$0	$0	$0	$0	$0
Bristol	$552,416	$713,430	$734,906	$1,511,080	$2,232,019	$2,204,992	$2,111,660	$2,491,748	$12,552,251
Central Connecticut	$0	$0	$0	$0	$0	$0	$0	$0	$0
Charlotte Hungerford	$0	$0	$0	$0	$0	$0	$0	$0	$0
Connecticut Children's	$0	$1,222,649	$583,148	$1,491,835	$1,241,832	$776,849	$1,315,952	$718,201	$7,350,466
Danbury	$1,287,818	$1,156,186	$510,371	$670,095	$0	$0	$0	$0	$3,624,470
Day Kimball	$370,259	$256,391	$283,124	$283,456	$159,731	$156,471	$159,094	$686,529	$2,355,055
Greenwich	$0	$0	$0	$0	$0	$0	$0	$0	$0
Griffin	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hartford	$0	$0	$0	$0	$0	$0	$0	$0	$0
Johnson Memorial	$0	$0	$0	$0	$0	$0	$0	$0	$0
Lawrence + Memorial	$0	$0	$0	$0	$0	$0	$0	$0	$0
Middlesex	$1,099,358	$1,355,744	$1,605,884	$1,727,323	$1,475,366	$1,714,841	$2,076,863	$2,181,850	$13,237,229
MidState	$0	$0	$0	$0	$0	$0	$0	$0	$0
Norwalk	$1,888,503	$1,984,320	$402,370	$437,479	$0	$0	$0	$0	$4,712,672
Sharon	$0	$0	$0	$0	$0	$0	$0	$0	$0
St. Francis	$0	$0	$0	$0	$0	$0	$0	$0	$0
St. Mary's	$1,330,172	$0	$0	$0	$0	$0	$0	$0	$1,330,172
St. Vincent's	$0	$0	$0	$0	$0	$0	$0	$0	$0
Stamford	$0	$0	$0	$9,235,549	$11,494,354	$14,443,023	$17,357,551	$20,089,153	$72,619,630
Windham	$0	$0	$0	$0	$0	$0	$0	$0	$0
Yale New Haven	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	**$8,712,533**	**$6,688,720**	**$4,119,803**	**$15,356,817**	**$16,603,302**	**$19,296,176**	**$23,021,120**	**$26,167,481**	**$119,965,952**

Table 9 shows the data on bad debt attributable to FAP from FY 2016 to FY 2023. In FY 2016, Connecticut's nonprofit hospitals accrued approximately $8.7M bad debt attributable to FAP. As shown in Table 9, bad debt attributable to FAP has continued to rise since 2018, reaching $26M in FY 2023.

Table 9: Bad Debt Attributable to Financial Assistance Policy FY 2016 - FY2023

Filing Year	Total Bad Debt attributable to FAP	% Change Over Year
2016	$8,712,533.00	
2017	$6,688,720.00	-23.23%
2018	$4,119,803.00	-38.41%
2019	$15,356,817.00	272.76%
2020	$16,603,302.00	8.12%
2021	$19,296,176.00	16.22%
2022	$23,021,120.00	19.30%
2023	$26,167,481.00	13.67%
Total	**$119,965,952.00**	

Financial Assistance Policy Analysis

All of the hospitals included in this report had a Financial Assistance Policy (FAP) with eligibility requirements for free and discounted care based on the Federal Poverty Guidelines (FPG) in place.[22]

FAPs generally stated income requirements were based on gross earnings, with a few exceptions. Several of the hospitals indicated in their FAPs additional considerations when providing financial assistance, such as catastrophic medical expenses or medical indigence. The 2023 Federal Poverty Guidelines for the contiguous states, including Connecticut, are provided in Table 9.

For example, an individual living alone is considered a household size of one (1), whereas two parents and two children are considered a household of four (4). A household size of

[22] U.S. Department of Health and Human Services. (2023). Annual update of the HHS poverty guidelines. Federal Register, 88(12), 3424–3425. https://www.federalregister.gov/documents/2023/01/19/2023-00885/annual-update-of-the-hhs-poverty-guidelines

four (4) may qualify for discounted care if their household income is at or below $83,250, or 300% of the Federal Poverty Level (FPL) depending on the hospital's policy.

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Table 10. Federal Poverty Guidelines for the contiguous states (2023)

Household Size	2023 FPL	125%	200%	250%	300%	400%	500%	550%	800%	999%
1	$ 14,580	$ 18,225	$ 29,160	$ 36,450	$ 43,740	$ 58,320	$ 72,900	$ 80,190	$ 116,640	$ 145,654.20
2	$ 19,720	$ 24,650	$ 39,440	$ 49,300	$ 59,160	$ 78,880	$ 98,600	$ 108,460	$ 157,760	$ 197,002.80
3	$ 24,860	$ 31,075	$ 49,720	$ 62,150	$ 74,580	$ 99,440	$ 124,300	$ 136,730	$ 198,880	$ 248,351.40
4	$ 30,000	$ 37,500	$ 60,000	$ 75,000	$ 90,000	$ 120,000	$ 150,000	$ 165,000	$ 240,000	$ 299,700.00
5	$ 35,140	$ 43,925	$ 70,280	$ 87,850	$ 105,420	$ 140,560	$ 175,700	$ 193,270	$ 281,120	$ 351,048.60
6	$ 40,280	$ 50,350	$ 80,560	$ 100,700	$ 120,840	$ 161,120	$ 201,400	$ 221,540	$ 322,240	$ 402,397.20
7	$ 45,420	$ 56,775	$ 90,840	$ 113,550	$ 136,260	$ 181,680	$ 227,100	$ 249,810	$ 363,360	$ 453,745.80
8	$ 50,560	$ 63,200	$ 101,120	$ 126,400	$ 151,680	$ 202,240	$ 252,800	$ 278,080	$ 404,480	$ 505,094.40

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Free care

OHS compiled hospitals' maximum household income requirements for free care (100% discount), are found in Table 10. The first column lists the single hospital health system or hospitals associated with a multi-hospital health system. The four major health systems across all their respective hospitals had the same FAP and are therefore denoted by the health system. For example, the hospitals within Yale New Haven Health Services used the same FAP. The second column indicates the maximum percentage above the FPL at which patients qualify for free care.

Table 11. Health System/Hospital's Household Income Ceilings for Free Care for an Individual and a Family of Four (2023)

Health System/Hospital	FPL Free Care	Individual Income	Family of 4 Income
Nuvance Health Network	300%	$43,740	$90,000
Bristol	250%	$36,450	$75,000
Connecticut Children's	250%	$36,450	$75,000
Day Kimball	250%	$36,450	$75,000
Griffin	250%	$36,450	$75,000
Hartford Health Care	250%	$36,450	$75,000
Stamford	250%	$36,450	$75,000
Yale New Haven Health Services	250%	$36,450	$75,000
Middlesex	200%	$29,160	$60,000
Trinity Health of New England	200%	$29,160	$60,000

At 200% of the FPL, an individual must earn at or below $29,160 to qualify for free care (Tables 9 and 10). Under Connecticut's Medicaid income eligibility, an individual with no children must have an annual income at or below 138% FPL at or $20,121.[23]

[23] Connecticut Department of Social Services. (2022, March 1). *Connecticut HUSKY Health Program annual income guidelines.*

Additionally, in 2023 the Connecticut minimum wage was $15.00.[24] A Connecticut resident earning a minimum wage annual salary of $31,200 would exceed the 200% FPL threshold ($29,160) used by Middlesex Hospital, St. Mary's Hospital, St. Francis Hospital, and Johnson Memorial Hospital.

Discounted Care

As shown in Table 11, discounted charity care eligibility varies by hospital and health system. In 2023, Yale New Haven Health Services and Hartford HealthCare offered the most generous income thresholds, providing discounted care to households earning up to 550% of the FPL.

Table 12. Health System/Hospital's Household Income Ceilings for Discounted Care for an Individual and a Family of Four (2023)

Health System/Hospital	FPL Discounted Care	Individual Income	Family of 4 Income
Yale New Haven Health Services	550%	$80,190	$165,000
Hartford HealthCare	550%	$80,190	$165,000
Connecticut Children's	500%	$72,900	$150,000
Middlesex	500%	$72,900	$150,000
Bristol	400%	$58,320	$120,000
Griffin	400%	$58,320	$120,000
Nuvance Health Network	400%	$58,320	$120,000
Rockville	400%	$58,320	$120,000
Stamford	400%	$58,320	$120,000
Trintiy Health of New England	400%	$58,320	$120,000
Waterbury	400%	$58,320	$120,000
Day Kimball	250%	$36,450	$75,000

[24] Connecticut Department of Labor's Office of Research. (n.d.). State of Connecticut - Minimum Wage Information. https://www1.ctdol.state.ct.us/lmi/ctminimumwage.asp

For example, under Yale New Haven Health Services' policy, a family of four earning up to $165,000 (550% FPL) would be eligible for discounted care. However, that same family would not qualify for discounted care at hospitals who required a lower FPL threshold for such assistance.

Total Bad Debt reported to the Internal Revenue Service

Bad debt refers to situations where a nonprofit hospital provides services expecting payment but does not receive it. When the hospital believes payment is unlikely, it can write off the debt from its account receivable. This differs from charity care, where the hospital did not expect to receive payment because the patient met the hospital's Financial Assistance Policy (FAP). OHS reviewed hospitals' IRS Form 990s and found that Connecticut nonprofit hospitals have written off more bad debt in the last three years, than they have provided charity care to patients (Figure 5).

Figure 5. Bad Debt vs Charity Care (2016-2023)

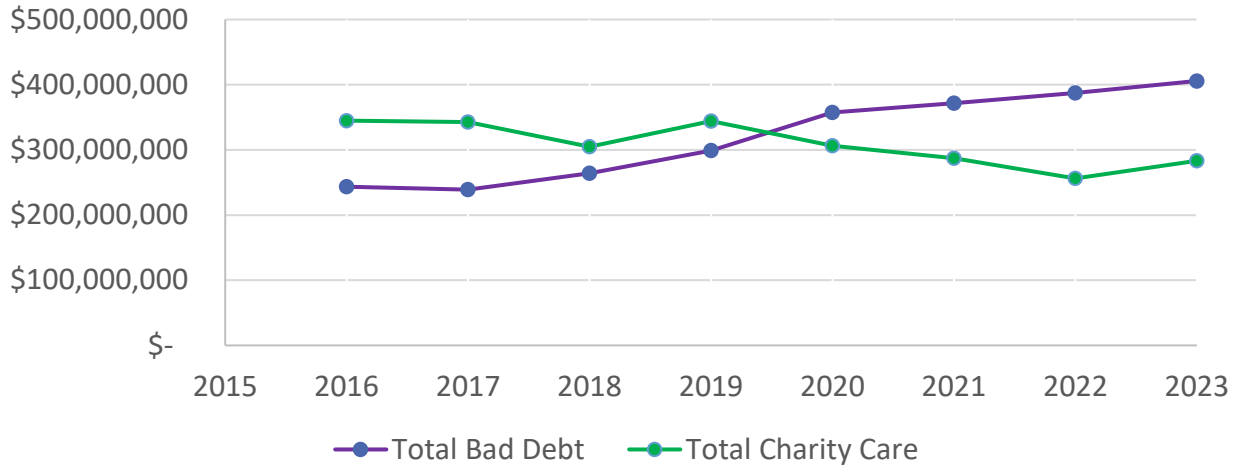

Figure 5 shows the data on bad debt and charity care from 2015-2023. In 2016, Connecticut's nonprofit hospitals provided approximately $350 million in charity care, and reported approximately $243 million in total bad debt. As shown in Table 12, bad debt has continued to rise since 2018, while charity care has gone down.

In 2023, bad debt and charity care increased to $405 million and $283 million, respectively. Notably, charity care rose in FY 2023 for the first time since 2019. Between 2016 and 2023, hospitals reported a total of $2.1 billion in bad debt. Table 12 also shows the year-over-year percentage change in total bad debt. Appendix D provides a breakdown of total bad debt by hospital.

Table 13. Total Bad Debt year-over-year percentage change (2016-2023)

Filing Year	Total Bad Debt	% Change Over Year
2016	$226,043,629	-
2017	$235,643,272	4.25%
2018	$260,879,729	10.71%
2019	$297,523,376	14.05%
2020	$357,295,411	20.09%
2021	$371,816,203	4.06%
2022	$387,214,683	4.14%
2023	$405,739,126	4.78%
Total	**$2,542,155,4292**	

Emergency Medical Care Policy

In addition to having a financial assistance policy, hospitals must have an Emergency Care Policy (EMCP). An EMCP at minimum must:

- Establish a written policy for a hospital facility that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are FAP-eligible.
- The policy prohibits the hospital facility from engaging in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.
- The policy requires the hospital facility to provide the care for emergency medical conditions that the hospital facility is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations.[25]

All the Connecticut nonprofit acute care hospitals satisfied the requirement to have an Emergency Medical Care Policy within their FAPs or as a separate document.

[25] Electronic Code of Federal Regulations. (n.d.). *Title 42: Public health. Chapter IV: Centers for Medicare & Medicaid Services, Department of Health and Human Services.* Retrieved March 4, 2025, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G

Debt Collection Recovery Summary

Regardless of how bad debt is written off by hospitals, it does not mean that debt goes away for the patient or their family. For initial nonpayment, nonprofit hospitals may take punitive action against patients, known as extraordinary collection actions (ECA).

Federal rules require hospitals to wait at least 120 days before initiating any ECA, notify the patient at least 30 days before initiating ECA, and suspend the ECA while financial assistance applications are pending and until the decision is made. Patients have up to 240 days to apply for financial assistance after an initial bill is provided the hospital may initiative a collection action before that period expires. The ECAs hospitals are allowed to take against patients include:[26]

- Selling an individual's debt to another party, such as a collections agency
- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus
- Deferring or denying, or requiring payment before providing medically necessary care because of an individual's previous nonpayment
- Actions that require a legal or judicial process, including but not limited to:
    - Placing a lien on an individual's property
    - Foreclosing on an individual's real property
    - Attaching or seizing an individual's bank account or any other personal property
    - Commencing a civil action against an individual
    - Causing an individual's arrest
    - Causing an individual to be subject to a writ of body attachment
    - Garnishing an individual's wages

[26] U.S. Department of the Treasury, Internal Revenue Service. (n.d.). Billing and collection (26 C.F.R. § 1.501(r)-6). Electronic Code of Federal Regulations. https://www.ecfr.gov/current/title-26/chapter-I/subchapter-A/part-1/subject-group-ECFR062882ac6495890/section-1.501(r)-6

Hospitals can take ECAs, such as selling a patient's debt—even if payments are current—reporting debt to credit bureaus (which can hurt credit scores) or pursuing legal actions like wage garnishment or placing liens on homes.[27, 28]

This report does not include data on how many individuals face ECAs, or the types used, because that information is not available to OHS. Tables 12-16 summarize each hospital's debt recovery rates by health system. For more details on ECAs, see the Hospital Reporting System (HRS) Report 18 on OHS' web portal, which outlines hospital collection policies and agent information.

Note: Governor Lamont signed legislation[29] that prohibits health care providers and hospitals in Connecticut from reporting a person's medical debt to a credit rating agency for use in credit reports and it also voids any medical debt reported to a credit rating agencies. This law went into effect on July 1, 2024; therefore, it has no impact to the data reported in this report. In addition to this step, the Lamont administration, working in partnership with the national nonprofit organization Undue Medical Debt, has erased $30 million of medical debt for nearly 23,000 residents.[30]

Key Highlights

- Danbury Hospital had high recovery rates, particularly due to Simko Law Firm's performance, which had the highest recovery rate at 80.4%.
- Norwalk Hospital driven by LoveJoy and Rimer's efforts had a 36% recovery rate.

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[27] Lodge, M. (2024). What happens when medical bills go to collection? https://time.com/personal-finance/article/what-happens-when-medical-bills-go-to-collection/

[28] Sanders, B. (2023). Executive charity. https://www.sanders.senate.gov/wp-content/uploads/Executive-Charity-HELP-Committee-Majority-Staff-Report-Final.pdf

[29] Office of Governor Ned Lamont. (2024). Governor Lamont signs law prohibiting medical debt from being reported to credit rating agencies. https://portal.ct.gov/governor/news/press-releases/2024/05-2024/governor-lamont-signs-law-prohibiting-medical-debt-from-being-reported-to-credit-rating-agencies

[30] Officer of Governor Lamont (2024). https://portal.ct.gov/governor/news/press-releases/2024/12-2024/governor-lamont-announces-nearly-23k-residents-will-have-30-million-in-medical-debt-erased?language=en_US

- Hospitals from the Yale New Haven Health system have a diverse range of collection agencies, and their collection rates range from 0% to 22%.
- Hospitals from Hartford Healthcare Health System have three collection agencies and their collection rates range from 1.3% to just over 6%.
- Hospitals from Trinity Healthcare Health System have a few collection agencies. Their collection rates range from 9% to just over 18%.

Table 14. Hartford Healthcare Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Backus	Arcadia	5%
	Arstrat	3%
	Nair and Levin	6%
Central Connecticut	Arcadia	5%
	Arstrat	2%
	Nair and Levin	5%
Charlotte Hungerford	Arcadia	6%
	Arstrat	2%
	Nair and Levin	7%
Hartford	Arcadia	4%
	Arstrat	2%
	Nair and Levin	4%
MidState	Arcadia	5%
	Arstrat	2%
	Nair and Levin	6%
St. Vincent's	Arcadia	3%
	Arstrat	1%
	Nair and Levin	3%
Windham	Arcadia	5%
	Arstrat	2%
	Nair and Levin	6%

Table 15. Trinity Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Johnson Memorial	American Adjustment Bureau	18%
Saint Francis	Nair and Levin	8%
	American Adjustment Bureau	14%
Saint Mary's	American Adjustment Bureau	18%
	Parallon	9%

Table 16. Nuvance Health System

Hospital	Contracted Collection Agent	Recovery Rate
Danbury	Credit Center Incorporated	22%
	Simko Law Firm	80%
	American Adjustment Bureau	13%
Norwalk	Credit Center Incorporated	21%
	LoveJoy and Rimer	36%
	American Adjustment Bureau	6%
	Credit Management Company	0%
	Eastern Collections	0%
Sharon	Collection Bureau of the Hudson Valley	11%
	SOS	33%

Table 17. Single Hospital Health System

Hospital	Contracted Collection Agent	Recovery Rate
Bristol	American Adjustment Bureau	11%
Connecticut Children's	American Adjustment Bureau	16%
Day Kimball	Sherloq	11%
Griffin	Arcadia	12%
	American Adjustment Bureau	25%
Middlesex	Arcadia	7%
Stamford	ROI	5%
	Mark Sank & Associates	0%
	Law Offices Howard Lee Schiff	0%
	MAF	7%
	RSI	3%

Table 18. Yale New Haven Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Bridgeport	American Adjustment Bureau	7%
	Arcadia	6%
	Links	5%
	DCM Bankruptcy	1%
	DCM Probate	4%
	BDM International Collections	22%
	Sunbelt International Collections	6%
Greenwich	American Adjustment Bureau	10%
	Arcadia	8%
	Links	7%
	DCM Bankruptcy	0%
	DCM Probate	10%
	BDM International Collections	42%
	Sunbelt International Collections	17%
Lawrence + Memorial	American Adjustment Bureau	10%
	Arcadia	9%
	Links	7%
	DCM Bankruptcy	0%
	DCM Probate	11%
	BDM International Collections	15%
	Sunbelt International Collections	18%
Yale New Haven	American Adjustment Bureau	7%
	Arcadia	6%
	Links	5%
	DCM Bankruptcy	1%
	DCM Probate	4%
	BDM International Collections	22%
	Sunbelt International Collections	6%

Community Boards

The IRS requires nonprofit hospitals' governing boards to include members from the community and requires that those members should represent over 50% of the governing board. If less than 50%, the IRS notes hospitals may be serving private interests rather than the public's interest. Moreover, those members from the medical or administrative staff should not participate in questions of inurement, or private benefit to those members of staff. For example, a nonprofit hospital CEO should not be deciding their own compensation.

The IRS standard for board of directors does not have requirements on socioeconomic status for those members who are drawn from the community. In review of the 23 nonprofit hospitals' community boards, OHS found no instances in which members from the community constituted less than 50% of membership. Additionally, no hospitals reported that compensation policies applied to these community members. Instances of board members receiving payment were rare, and those who were compensated were typically medical or administrative staff rather than community representatives.

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Recommendations

Community Benefit reporting requirements, as outlined in §19a-127k, must be defined in statute, meaning all recommended changes would require legislative action. To enhance analysis, OHS recommends:

- Expanding hospital reporting to include Form 990, Schedule H calculations and worksheets, increasing transparency on methodologies, ratios, and beneficiary counts to standardize assessments across hospitals.
- Requiring hospital reporting to include financial assistance screening outcomes, including applications submitted, approved, and denied, as well as the number of Extraordinary Collection Actions (ECAs) initiated. This data can help assess whether hospitals provide adequate charity care or rely too heavily on ECAs. Increased transparency will also enable policymakers to evaluate financial assistance programs and ensure compliance with community benefit obligations.
- Requiring hospital reporting of unreimbursed Medicaid cost calculations to OHS using the state's revised methodology, introduced in the FY 2023 Financial Stability Report. This updated approach calculates the statewide Medicaid payment-to-cost ratio at 0.87 (or 87 cents per dollar), providing a more accurate measure than previously reported by hospitals. The methodology accounts for all Medicaid revenue received, aligns eligible patient care expenses with federal Medicare standards, and ensures that only user fees allocated to Medicaid revenue are recorded as Medicaid expenses. Aligning with this methodology ensures a more accurate and standardized representation of Medicaid costs and reimbursements.

Other Considerations

Connecticut currently offers state and local tax relief to nonprofit hospitals based on the federal standard for community benefit. However, the state could consider aligning state and local tax exemptions with its own standards to promote hospital spending linked directly to community needs. Potential state-level standards to establish a more consistent system could include:

- Setting minimum spending requirements for community benefit activities and for financial assistance policies, ensuring hospitals allocate sufficient resources to address local health disparities and meet community needs

- Strengthening the link between community benefit expenses and interventions that improve health outcomes, so that funds are directed to activities that improve community health
- Restricting punitive actions against patients with medical debt, ensuring that hospitals prioritize patient well-being over aggressive debt collection practices.
- Ensuring surplus funds for medical training, education, and research align with long-term community needs
- Requiring hospitals to report on the value of the tax exemptions claimed, promoting transparency and accountability in how hospitals use the substantial tax benefits they receive
- Further defining community benefits to better align hospital spending with community needs. For example, Connecticut could consider including community-building activities, such as affordable housing and economic development, as eligible benefits. This could incentivize hospitals to direct more funds toward these initiatives. Through the Certificate of Need process, OHS has already imposed conditions requiring Bridgeport Hospital to increase its overall community benefit spending by at least 1% annually, excluding Medicaid shortfalls from the baseline calculation[31]

Examples from Other States:

- Maryland and Illinois: Enacted laws allowing low-income patients enrolled in need-based programs to automatically qualify for free care without applying
- Oregon and California: Established minimum community benefit spending levels based on hospitals' historical expenses. In Oregon, the state collaborates with hospitals every two years to set the minimum, using a three-year average of unreimbursed care, an operating margin multiplier, and net patient revenue
- New Jersey: Requires hospitals spending less than 12% of their operating budget on community benefits to pay a $3 daily per-bed fee to local governments, supporting services typically funded through taxes

[31] Bridgeport Hospital, Yale New Haven Health Services Corp., Milford Hospital, and Milford Health and Medical, Inc. (2019). Agreed Settlement: Transfer of ownership of Milford Hospital to Bridgeport Hospital (Docket Number: 18-32270-CON). Connecticut Office of Health Strategy. https://portal.ct.gov/ohs/-/media/ohs/con/1832270-con-finalv1.pdf

Federal Initiatives

The U.S. General Accountability Office (GAO) recommended to Congress, in 2020, that they should consider specifying in the Income Revenue Code (IRC) what services and activities it considers sufficient benefit. As of February 2025, Congress has not enacted legislation to clarify community benefit under the IRC. Clearly outlining such activities and services would improve the IRS ability to oversee tax-exempt hospitals.[32]

In that same report, the GAO made several recommendations to the Commissioner of Internal Revenue to improve oversight of tax-exempt hospitals:

- Update Form 990: Revise Form 990, including Schedule H and its instructions, to ensure that information demonstrating a hospital's community benefits is clear and easily identifiable by Congress and the public, including details on community benefit factors.
- Assess Reporting by Individual Facility: Evaluate the benefits, costs, and tax law implications of requiring tax-exempt hospital organizations to report community benefit expenses on Schedule H by individual facility rather than by the organization as a whole, and take appropriate action based on the findings.
- Implement a Compliance Review Process: Establish a well-documented process to identify hospitals at risk of noncompliance with the community benefit standard, ensuring that hospitals' community benefit activities are consistently reviewed.
- Create Specific Audit Codes: Develop specific audit codes to help identify potential noncompliance with the community benefit standard, improving oversight and accountability

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[32] U.S. Government Accountability Office. (2020, Sept. 17). Tax administration: Opportunities exist to improve oversight of hospitals' tax-exempt status (GAO Publication No. GAO-20-679). https://www.gao.gov/products/gao-20-679

Methodology

Sources

This report uses a variety of sources to achieve an objective review of hospitals' community benefit. These sources include, but are not limited to:

1. The IRS' Form 990 including both the hospitals' submissions to OHS and the IRS' 2023 Instructions for the Schedule H
2. Hospitals' CHNAs and Implementation Strategies from 2021/2022
3. Hospitals' Financial Assistance Policies and Emergency Medical Care Policies
4. Hospitals' Annual Status Reports
5. OHS Annual Report on the Financial Status of Connecticut's Short-term Acute Care Hospitals FY 2022

Hospitals Reviewed

This report consists of nonprofit hospitals licensed as an acute care facility located within the geographic borders of Connecticut. In total, 23 Connecticut acuter care nonprofit hospitals are included.

Hospitals excluded from this report are those that are out-of-state, campus, or government hospitals, those not licensed as acute care, or hospitals that do not meet the Connecticut definition of hospital in Connecticut General Statutes §19a-127k, which defines hospital as it relates to community benefit programs in Connecticut.

Data Analyzed

CHNA and CHIP Data

OHS reviewed the 2021/2022 cycle CHNA and CHIP reports conducted by nonprofit acute care hospitals. Community needs documented in this analysis include identified needs from the 2021/2022 cycle, and the health needs hospitals indicated they were addressing in current strategies. Activities to address health needs in the Implementation Strategy were included if they were marked as in progress, or if the hospital indicated that they planned to work on it.

Nonprofit Hospitals' Community Benefit Expenses

Connecticut nonprofit, acute care hospitals' expense data was obtained from their IRS Form 990, Schedule H submissions to OHS. Hospitals' IRS Form 990 submissions may be found on OHS' public web portal: Financial Documents Page (ct.gov). OHS reviewed filing years 2016 – 2023 (eight years), staying consistent with a starting year of 2016 from previous community benefit work, and to capture years pre-pandemic. When hospitals did not document dollar amounts with a community benefit category, OHS coded as nonapplicable and did not assume that the data was missing or 0. Calculations were conducted among the hospitals that reported dollar figures and determined by the valued %. Some numbers may not add up due to rounding.

State and National Comparison

OHS obtained the IRS report that provides national community benefit data through a Freedom of Information Act request. To give context to the national and Connecticut data, OHS compared the two IRS data sets as: 1) a percentage of total community benefit expense, and 2) total community benefit expense as a percentage of hospitals' total expense. The IRS notes that their numbers may not add up due to rounding.

Hospitals' Annual Status Reports

OHS reviewed the Annual Status Reports submitted by hospitals in October 2024. This report provides expense data from hospitals attributed to activities that support their CHIP activities. These expenses are categorized as community benefit, community building, or as expenses that did not count as either. The data is compared to what hospitals submitted in their IRS Form 990.

Financial Assistance Policy, Emergency Medical Care Policy, and Billing and Collections Data

Financial Assistance Policies, Emergency Medical Care Policies, billing and collections practices (sometimes all in the same document) were pulled from hospitals' submissions to OHS. These submissions may be found on OHS' public web portal: Financial Documents Page (ct.gov).

Methodology

OHS documented nonprofit and for-profit hospitals' policies against federal requirements codified in Internal Revenue Code 501(r)(4). Since all hospitals included the Federal Poverty Guidelines (FPG) as criteria for eligible patients to receive financial assistance, OHS documented the Federal Poverty Level ceilings hospitals documented for either free or discounted care.

Extraordinary Collection Action (ECA) data from collection agents and their recovery rates were obtained from Hospital Reporting System Report 18. These reports may be found on OHS' public web portal: Hospital Reporting System - Reports (ct.gov).

Connecticut Nonprofit Hospitals' Community Boards

OHS obtained nonprofit hospitals' community board data in the IRS Form 990, Parts I and VII for filing year 2023. OHS noted all board members documented in Form 990, regardless of when their term on the board expired, if they were members of the hospital medical or administrative staff, and the number that were independent. The IRS requires at least 50% of the governing board drawn from the community not be associated with administrative or medical staff. OHS reviewed this data as governing boards have the final say on community benefit, such as adopting a Community Health Needs Assessment and Implementation Strategy.

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Glossary

1. **Bad debt:** consists of services for which a tax-exempt hospital anticipated but did not receive payment.[33]
2. **Cash and in-kind contributions for community benefit:** are funds and in-kind services donated to community organizations or to the community at large for a community benefit purpose.[34] An example is event sponsorship, or contributions for providing technical assistance, or evaluation of community coalition efforts.
3. **Community benefit operations:** are costs associated with assigned staff and community health needs and/or assets assessment, as well as other costs associated with community benefit strategy and operations.[35] An example is the costs related to the Community Health Needs Assessment and developing the Implementation Strategy.[36]
4. **Community Building:** are the activities that help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health, such as education, air quality, and access to nutritious food.[37]
5. **Community health improvement services** are activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services don't generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.[38] Examples of a community health improvement service if it addresses a community health need and meets a community benefit objective are exercise classes, screenings (blood pressure, behavioral health, hearing, etc.), clinics for the

[33] Robert Wood Johnson Foundation & RTI International. (n.d.). Terms and glossary. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.glossary
[34] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4
[35] *Id.*
[36] *Id.*
[37] Robert Wood Johnson Foundation and RTI International. (n.d). Community benefit spending 101. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.cb101
[38] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

underinsured or uninsured, assistance to enroll in public programs like Medicaid, or programs and activities that address social determinants of health (as long as they are not also documented as community building).[39]

6. **Costs from other means-tested programs:** is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments. [40] An example of another means-tested government program is a State Children's Health Insurance Program (SCHIP).
7. **Extraordinary collection actions:** actions taken by a hospital after the facility has made a reasonable effort to determine whether an individual is eligible for assistance under the hospital organization's financial assistance policy (FAP).[41] Examples of ECAs include but are not limited to selling an individual's debt to another party, such as a collection agency, reporting adverse information about an individual to consumer credit reporting agencies/bureaus, deferring or denying medically necessary care because of non-payment, suing a patient to: put a lien on property, foreclose on real property, or garnishing wages.
8. **Financial assistance policy:** is a widely publicized document that applies to all emergency and medically necessary care, addresses the financial assistance available to patients, criteria and eligibility for financial assistance, the basis for calculating amounts charged, the method for applying for financial assistance, the collections process, and a list of providers that are included and excluded from financial assistance.[42]
9. **Filing year:** may include different months depending on the hospital and refers to a hospital's fiscal year. Most hospitals use a fiscal year from October 1 – September 30; some hospitals in the data set used a calendar year, and in one case a condensed year due to a change in tax status.

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[39] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4

[40] *Id.*

[41] Internal Revenue Service. (n.d.-a). Billing and Collections – Section 501(r)(6). https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6

[42] Internal Revenue Service. (n.d.-b). Financial Assistance Policies (FAPs). https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps

10. **Health professions education:** are educational programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees and other health professionals when that education is necessary for a degree, certificate, or training that is required by state law, accrediting body or health profession society.[43] An example of health professions education includes the direct costs of stipends, fringe benefits of interns, residents, and fellows in accredited graduate medical education programs.[44]
11. **Financial assistance at cost (charity care):** is free or discounted health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the organization's financial assistance policy.[45] The IRS states charity care excludes bad debt. An example of charity care is providing an eligible patient a 50% discount on their medical bill.
12. **Medicaid (the reported unreimbursed costs from Medicaid)**: is the shortfall created when a facility receives payments that are less than the cost of caring for public program beneficiaries. This payment shortfall is not the same as a contractual allowance, which is the full difference between charges and government payments.[46] An example is when a hospital treated a patient with Medicaid, and there is a negative difference between the hospital's costs incurred for treating the patient and the payment received. While the IRS suggests a standard method for calculating shortfall, it also allows hospitals to use their own methodologies. Hospital-specific methodologies are not available for review.
13. **Research:** is any study or investigation the goal of which is to generate increased generalizable knowledge made available to the public, and the cost is funded by a tax-exempt or government entity, or internally with exceptions.[47] An example

[43] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4
[44] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf
[45] Catholic Health Association. (2015). Community benefit categories and definitions: a guide for planning & reporting community benefit. 293–320. https://www.chausa.org/docs/default-source/community-benefit-guide-2015/2015-cb-guide-categories-definitions.pdf?sfvrsn=4
[46] *Id.*
[47] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

provided by the IRS is an evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols.

14. **Subsidized health services** are clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs.[48] An example of subsidized health services could be psychiatric inpatient beds.

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[48] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

Appendix A: CHIP expenses by Identified Community Health Need by hospital (FY 2023)

Hospital	Identified Community Health Need in Implementation Strategy	Community Need Category	CHIP Expense	Total
Backus	Promote Healthy Behaviors and Lifestyles	Preventative Health	$73,460	$1,013,149
	Improve Health Equity, Coordination of Services, and Access to Care	Access to Care	$407,723	
	Reduce the Burden of Chronic Disease	Chronic Disease	$312,772	
	Enhance Community-Based Behavioral Health Services	Behavioral Health	$219,194	
Bridgeport	Community Health and Wellbeing	Preventative Health	$172,603	$122,116,325
	Access to Care	Access to Care	$121,429,073	
	Behavioral Health	Behavioral Health	$338,858	
	Child Wellbeing	Maternal & Child Health	$69,504	
	Healthy Living	Preventative Health	$106,287	
Bristol	Behavioral Health and Substance Misuse	Behavioral Health	$706	$24,366
	Chronic Disease Management	Chronic Disease	$4,250	
	Access to Care	Access to Care	$16,863	
	Senior Health and Services	Access to Care	$2,547	
Central Connecticut	Enhance Community Behavioral Health Services	Behavioral Health	$482,631	$645,647
	Promote Healthy Lifestyles and Behaviors - Address Chronic Disease	Chronic Disease	$83,199	
	Improve health equity/Access to care/SDoH	Access to Care	$79,818	
Charlotte Hungerford	Better Meet the Social and Mental Well-Being of Those We Serve	Behavioral Health	$84,510	$877,501
	Expand Access to Culturally Responsive Care	Culturally competent care	$321,372	
	Address Health through Housing	Access to Housing	$130,844	
	Reduce Food Insecurity and Increase Access to Healthy Food	Food security and quality	$70,277	
	Improve Community Health in Partnership with Others	Preventative Health	$270,499	

Appendix A

Hospital	Identified Community Health Need in Implementation Strategy	Community Need Category	CHIP Expense	Total
Connecticut Children's	Access to Nutritious Foods	Food security and quality	$820,496	$4,354,684
	Educational and Occupational Opportunities	Workforce Development	$941,613	
	Access to Healthcare	Access to Care	$1,192,575	
	Safe Neighborhood and Violence Prevention	Violence Prevention	$1,400,000	
Danbury	Chronic Disease Prevention and Promotion of Well-Being	Chronic Disease	$436,412	$1,792,438
	Prevention of Mental Health Issues and Substance Use Disorders	Behavioral Health	$1,356,026	
Day Kimball	Inadequate Transportation as a Barrier to Healthcare Access	Access to Care	$636,663	$745,730
	Fall Prevention	Preventative Health	$58,593	
	Behavioral Health	Behavioral Health	$50,474	
Greenwich	Community Health & Wellbeing	Preventative Health	$0	$52,285,689
	Access to Care & Services	Access to Care	$51,329,950	
	Behavioral Health: Healthy Minds	Behavioral Health	$787,210	
	Healthy Living	Preventative Health	$168,529	
Griffin	Mental Health	Behavioral Health	$63,701	$24,811,086
	Heart Health	Chronic Disease	$230,610	
	Maternal and Infant Health	Maternal & Child Health	$27,627	
	Substance Use & Misuse	Preventative Health	$30,691	
	Access to Care	Access to Care	$24,458,455	
Hartford	Mental Health Outreach	Behavioral Health	$477,231	$7,390,566
	Staff Recruitment	Workforce Development	$609,502	
	Access to Care	Access to Care	$6,303,834	
Johnson Memorial	Obesity	Chronic Disease	$46,408	$46,408
Lawrence + Memorial	Community Health & Wellbeing	Preventative Health	$113,628	$53,183,742
	Access to Care	Access to Care	$52,496,619	
	Behavioral Health	Behavioral Health	$6,689	
	Healthy Living	Preventative Health	$566,806	

Appendix A

Hospital	Identified Community Health Need in Implementation Strategy	Community Need Category	CHIP Expense	Total
Middlesex	Mental Health & Substance Use, Prioritizing Opioids Use Disorder	Behavioral Health	$14,812,104	$24,944,133
	Healthy Living & Chronic Illness Management and Prevention	Preventative Health	$7,933,580	
	Maternal Child Health & Family Services with a Focus on Minimizing Disparities	Maternal & Child Health	$2,198,449	
MidState	Enhance Community Behavioral Health Services	Behavioral Health	$426,600	$590,998
	Promote Healthy Lifestyles and Behaviors/Address Chronic Disease	Preventative Health	$92,923	
	Improve health equity/Access to care/Social Determinants of Health	Access to Care	$71,474	
Norwalk	Chronic Disease Prevention and Promotion of Well-Being	Chronic Disease	$632,491	$934,430
	Preventing Mental Health Issues and Substance Use Disorders	Behavioral Health	$301,939	
Sharon	Chronic Disease Prevention and Promotion of Well-Being	Chronic Disease	$14,575	$26,422
	Prevention of Mental Health Issues and Substance Use Disorders	Preventative Health	$11,847	
St. Francis	Trauma and Mental Health as it relates to Neighborhood Safety	Behavioral Health	$121,878	$365,634
	Increase Social Cohesion by Improving Stable Housing	Access to Housing	$121,878	
	Increase Social Cohesion by Improving Access to Healthy Foods	Food security and quality	$121,878	
St. Mary's	Outreach and Community Trust - Competent Care	Preventative Health	$165,967	$331,934
	Systems Change - Mental Health	Behavioral Health	$165,967	
St. Vincent's	Reduce the Burden of Chronic Disease, and Promote Healthy Behaviors and Lifestyles (Healthy Lifestyles)	Preventative Health	$1,083,171	$10,521,278
	Improve Access to Care (Access to Care)	Access to Care	$8,328,169	
	Enhance Behavioral Health Services (Behavioral Health)	Behavioral Health	$832,367	
	Strengthen Communities and Families (Child Wellbeing)	Maternal & Child Health	$277,570	
Stamford	Access to Health & Social Services	Access to Care	$520	$143,168,936
	Behavioral Health	Behavioral Health	$130,659,880	
	Access to Primary and Preventive Services	Access to Care	$12,497,219	
	Housing	Access to Housing	$11,317	

Appendix A

Hospital	Identified Community Health Need in Implementation Strategy	Community Need Category	CHIP Expense	Total
Windham	Promote Health Behaviors and Lifestyles	Preventative Health	$51,756	$488,891
	Improve Health Equity, Coordination of Services, and Access to Care	Access to Care	$175,235	
	Reduce the Burden of Chronic Disease	Chronic Disease	$131,449	
	Enhance Community-Based Behavioral Health Services	Behavioral Health	$130,453	
Yale New Haven	Community Health & Wellbeing	Preventative Health	$365,422	$495,739,510
	Access to Care	Access to Care	$492,297,977	
	Behavioral Health	Behavioral Health	$1,770	
	Child Wellbeing	Maternal & Child Health	$3,005,416	
	Healthy Living	Preventative Health	$68,925	

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Appendix B: Community Benefit expenses reported to the IRS (FY 2016-2023)

Community Benefit Category	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Financial Assistance at Cost	$344,844,514	$342,741,512	$304,728,594	$344,298,104	$306,485,259	$287,077,698	$256,221,292	$283,030,796
Unreimbursed cost of treating Medicaid patients	$898,481,395	$918,436,011	$752,298,844	$829,856,416	$878,499,462	$930,183,118	$1,076,538,948	$1,243,173,378
Costs of other means-tested government programs	$68,369,260	$41,339,920	$52,577,205	$46,194,252	$256,459	$17,858	$36,025	$3,628
Community health improvement services and community benefit operations	$30,157,773	$27,283,014	$25,851,331	$30,672,119	$32,465,889	$32,178,059	$45,749,387	$42,884,569
Health Professions Education	$263,704,838	$239,297,743	$244,594,057	$251,128,821	$246,558,450	$251,782,512	$265,924,277	$298,056,469
Subsidized health services	$69,824,157	$55,565,017	$59,986,430	$67,709,063	$59,865,586	$65,779,762	$75,980,410	$99,165,408
Research	$9,925,901	$9,299,774	$13,901,341	$14,537,834	$11,616,198	$10,441,344	$15,724,789	$17,630,444
Cash and in-kind contribution for community benefit	$15,186,659	$12,823,612	$18,514,959	$18,833,462	$27,162,116	$26,162,704	$37,781,880	$48,457,613
Total Community Benefit (Part I)	**$1,700,494,497**	**$1,646,786,603**	**$1,472,452,761**	**$1,603,230,071**	**$1,562,909,419**	**$1,603,623,055**	**$1,773,957,008**	**$2,032,402,305**

Appendix C: Community Benefit expenses reported to the IRS by Hospital (FY 2016-2023)

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Backus	$28,291,128	$33,471,727	$28,893,515	$26,860,895	$34,302,895	$36,491,499	$43,112,270	$48,902,548
Bridgeport	$79,102,397	$89,760,920	$63,030,991	$78,852,425	$103,803,268	$112,057,147	$134,073,187	$145,839,705
Bristol	$24,529,493	$21,745,130	$20,078,419	$26,941,731	$25,124,045	$29,394,229	$32,432,732	$26,524,298
Central Connecticut	$53,577,257	$57,268,714	$47,374,720	$43,701,235	$50,118,006	$48,869,554	$55,907,820	$60,703,320
Charlotte Hungerford	$18,477,207	$15,382,864	$15,043,042	$15,526,376	$5,200,784	$9,546,958	$12,898,152	$10,128,276
Connecticut Children's	$85,726,133	$81,792,633	$92,910,735	$95,384,407	$87,866,460	$91,556,624	$112,695,864	$140,561,689
Danbury	$88,400,803	$84,091,144	$79,417,975	$82,803,142	$80,531,151	$83,001,760	$89,007,110	$101,851,121
Day Kimball	$10,858,337	$12,081,995	$11,203,588	$6,918,063	$11,631,642	$11,139,046	$9,445,299	$18,215,075
Greenwich	$47,913,431	$46,595,448	$58,796,195	$48,728,950	$58,955,477	$54,664,800	$57,577,523	$56,070,872
Griffin	$10,208,725	$12,902,480	$10,464,059	$15,067,506	$16,753,304	$23,995,846	$28,669,111	$24,811,086
Hartford	$150,828,453	$126,468,070	$111,917,239	$126,889,724	$137,030,506	$126,303,762	$137,235,416	$185,889,110
Johnson Memorial	$4,007,975	$7,045,362	$4,058,683	$4,366,249	$3,365,740	$4,316,706	$5,141,895	$7,546,467
Lawrence + Memorial	$38,625,033	$48,271,688	$3,564,192	$41,326,603	$53,118,507	$53,988,573	$70,245,138	$85,368,011
Middlesex	$72,537,865	$69,221,995	$50,894,041	$61,418,225	$52,272,141	$67,067,571	$72,606,343	$70,813,446
MidState	$29,099,243	$20,726,754	$26,883,877	$31,605,649	$31,252,030	$25,739,575	$32,419,488	$44,261,391
Norwalk	$41,759,613	$47,388,646	$39,191,423	$43,786,059	$41,908,657	$44,861,783	$48,552,246	$53,069,773
Sharon	$0	$1,939,228	$3,296,231	$4,631,395	$6,527,472	$8,032,507	$12,271,675	$11,030,347
St. Francis	$92,765,722	$108,165,882	$79,370,558	$75,494,155	$87,516,901	$88,759,309	$85,170,097	$99,796,785
St. Mary's	$29,494,286	$31,720,619	$22,880,122	$19,366,486	$29,380,784	$27,076,614	$32,625,865	$33,236,505
St. Vincent's	$102,536,211	$95,676,298	$106,768,111	$100,486,195	$35,075,690	$33,924,486	$38,862,177	$66,689,726
Stamford	$71,646,357	$76,601,089	$69,524,017	$78,290,440	$69,894,284	$74,231,663	$78,518,877	$106,468,937
Windham	$12,558,447	$8,984,419	$3,878,836	$10,980,415	$6,126,919	$9,258,165	$10,934,108	$16,451,819
Yale New Haven	$556,087,905	$546,014,999	$521,466,112	$560,801,353	$535,152,756	$539,344,878	$573,554,615	$618,171,998
Total	**$1,649,032,021**	**$1,643,318,104**	**$1,470,906,681**	**$1,600,227,678**	**$1,562,909,419**	**$1,603,623,055**	**$1,773,957,008**	**$2,032,402,305**

Appendix D: Total Bad Debt reported to the IRS (FY 2016-2023)

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Backus	$8,148,488	$6,788,033	$6,897,000	$7,571,797	$11,414,722	$12,945,709	$14,590,813	$13,867,621
Bridgeport	$15,691,920	$15,545,225	$13,097,196	$17,937,092	$19,092,076	$16,239,951	$20,479,613	$27,750,000
Bristol	$2,209,665	$2,853,719	$2,939,623	$6,044,318	$6,386,438	$7,281,546	$7,530,602	$8,886,073
Central Connecticut	$6,729,000	$5,489,000	$7,640,000	$6,243,411	$13,948,280	$16,156,013	$19,830,054	$17,146,220
Charlotte Hungerford	$2,054,040	$2,559,232	$2,033,000	$3,527,245	$4,656,221	$5,673,073	$7,010,247	$5,540,829
Connecticut Children's	$1,605,446	$4,354,151	$2,082,672	$3,817,147	$3,177,467	$2,774,460	$4,669,829	$2,565,002
Danbury	$6,524,062	$8,369,265	$8,534,892	$11,357,543	$8,305,667	$6,846,883	$13,654,712	$8,041,659
Day Kimball	$3,460,363	$2,396,181	$3,196,626	$2,730,880	$4,283,289	$4,195,867	$4,960,324	$5,208,266
Greenwich	$15,919,399	$10,751,757	$14,602,003	$16,442,469	$13,562,439	$11,889,490	$12,390,419	$15,240,000
Griffin	$524,574	$434,067	$774,954	$816,998	$706,945	$862,799	$748,776	$618,700
Hartford	$4,677,909	$12,487,000	$17,510,000	$8,029,866	$34,758,726	$40,074,286	$47,640,257	$46,876,125
Johnson Memorial	$1,261,634	$2,354,604	$2,329,620	$2,536,488	$2,133,056	$1,878,436	$2,069,359	$940,788
Lawrence + Memorial	$9,904,254	$12,186,865	$2,386,277	$6,140,000	$9,787,201	$7,539,315	$10,818,183	$13,240,000
Middlesex	$10,993,577	$13,557,441	$16,058,848	$17,273,230	$14,753,657	$17,148,415	$20,768,625	$21,818,497
MidState	$2,744,000	$4,785,000	$3,889,000	$3,763,659	$10,239,225	$10,543,764	$11,874,689	$11,482,125
Norwalk	$4,228,622	$4,443,170	$6,819,833	$8,749,584	$6,483,848	$5,635,877	$7,406,852	$6,916,632
Sharon		$1,116,838	$2,284,495	$1,368,255	$1,900,161	$412,764	$1,015,098	$1,511,723
St. Francis	$14,575,173	$12,097,274	$19,148,353	$24,044,016	$19,913,903	$13,997,251	$13,427,708	$9,383,227
St. Mary's	$1,900,245	$6,668,222	$7,767,190	$10,875,277	$10,131,955	$6,479,349	$8,019,526	$11,557,539
St. Vincent's	$8,350,781	$6,264,015	$7,130,409	$7,694,558	$22,342,164	$22,884,508	$20,877,588	$33,738,166
Stamford	$37,347,560	$39,312,823	$33,696,973	$39,859,945	$46,366,898	$62,987,451	$75,698,000	$79,435,166
Windham	$4,324,000	$2,562,000	$1,693,000	$2,612,601	$4,398,412	$4,468,900	$4,244,526	$4,724,768
Yale New Haven	$62,868,918	$58,267,390	$78,367,765	$88,086,997	$88,552,661	$92,900,096	$57,488,883	$59,250,000
Total	**$226,043,630**	**$235,643,272**	**$260,879,729**	**$297,523,376**	**$357,295,411**	**$371,816,203**	**$387,214,683**	**$405,739,126**