State of Connecticut
Community Benefit Report

December 2021

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Acronyms

ACA	Patient Protection and Affordable Care Act
APCD	All-Payer Claims Database
CHNA	Community Health Needs Assessment
GAO	Government Accountability Office
HEC	Health Enhancement Communities
IRC	Internal Revenue Code
IRS	Internal Revenue Service
OHS	Office of Health Strategy
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

The purpose of this document is to provide the reader with an overview of hospital community benefit, present findings on community benefit services and activities from 2016 to 2020, and offer recommendations to enhance community benefits and improve health.

Findings:

- Connecticut nonprofit hospitals' community benefits have decreased over the five observed years
  - In 2020, community benefit across the state was $144 million less than in 2016
  - As a percentage of total expense, community benefit dropped from 15.83% in 2016, to 12.00% in 2020
- Five of the eight community benefit categories in the Schedule H decreased between 2019 and 2020
- Unreimbursed costs from Medicaid accounted for greater than 50% of the benefit to communities every year observed
  - 72% of hospitals documented greater than 50% in 2020
  - 32% of hospitals documented greater than 75% in 2020
- Financial assistance at cost, also known as charity care, was at its lowest point in 2020 during the observed period
  - Half of hospitals provided less charity care in 2020 than in 2019
- Three independent hospitals provided more community health improvement services and community benefit operations than several Connecticut health systems
- Cash and in-kind contributions over the observed five years hit its highest mark in 2020, and 63% of Connecticut nonprofit hospitals documented a cash or in-kind donation in 2020

Recommendations:

- Require enhanced reporting from nonprofit hospitals that participate in community benefit service and activities
- Require nonprofit and for-profit hospitals to submit an annual report to OHS with updates on the hospital's community benefit services and activities
- Support hospitals with their community benefit data needs by making additional data available from the All-Payer Claims Database (APCD), while ensuring compliance with federal and state privacy and use laws
- Promote hospital partnership with community health collaboratives on community benefit services and activities
- Explore with hospitals how to include more community building as part of their community benefit
- Support GAO recommendations for Congress and Executive action, including providing further specificity on the services/benefits considered "community benefit," updating and clarifying relevant portions of IRS Form 990, and enacting changes to help facilitate the identification of noncompliance

Purpose

The purpose of this document is to provide the reader with an overview of hospital community benefit, present findings on community benefit services and activities from 2016 to 2020, and offer recommendations to enhance community benefits and improve health.

This report does not include data for hospitals located outside of Connecticut, or hospitals classified as for-profit or government facilities.

This report satisfies the reporting requirement outlined in Connecticut General Statutes §19a-127k, found in Appendix A.

Overview

Community Benefit

Nonprofit hospitals are charitable, tax-exempt organizations, and make up 80% of hospitals in Connecticut. Pursuant to 501(c)(3) and 501(r) of the Internal Revenue Code (IRC), and Internal Revenue Service (IRS) Revenue Ruling 69-545, hospitals may be relieved of paying federal and state corporate income taxes, local sales taxes, and local property taxes, and instead provide what is known as community benefit. The Hilltop Institute, a nonpartisan research organization, defines hospital community benefit as the "initiatives and activities undertaken by nonprofit hospitals to improve health in the communities they serve."[1]

The federal government charges the IRS with overseeing hospitals' community benefit program compliance. In addition to the requirements set forth in Section 501(c)(3) of the IRC of 1954 to be considered a charitable organization, in 1969 the IRS released Revenue Ruling 69-545 which outlines the six factors hospitals may demonstrate for community benefit in order to qualify for a tax exemption:

1. Operating an emergency room open to all, regardless of ability to pay
2. Maintaining a board of directors drawn from the community
3. Maintaining an open medical staff policy
4. Providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare
5. Using surplus funds to improve facilities, equipment, and patient care
6. Using surplus funds to advance medical training, education, and research

Demonstration of these factors is determined by a community benefit standard. In regard to this standard, the IRS states "no one factor is determinative in considering whether a nonprofit hospital meets the community benefit standard [and] the IRS weighs all the relevant facts and circumstances in evaluating these factors. Additional factors, such as whether a hospital provides financial assistance to those not able to pay, are relevant in determining whether the hospital is providing a benefit to the

[1] "What Are Hospital Community Benefits?" *The Hilltop Institute Hospital Community Benefit Program*, The Hilltop Institute, University of Maryland, https://hilltopinstitute.org/wp-content/uploads/publications/WhatAreHCBsTwoPager-Sept2019.pdf.

community."[2] In 2009, the IRS introduced the Schedule H for 501(c)(3) tax-exempt hospitals to complete annually in their Form 990. Hospitals use the Schedule H to document evidence that they are demonstrating community benefit and are in compliance with federal requirements.

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), adding new requirements for hospitals to be labeled a 501(c)(3) organization. These requirements were codified in Section 501(r) of the IRC, and require hospitals to:[3]

1. Complete a Community Health Needs Assessment and adopt an Implementation Strategy every three years
2. Have a written financial assistance policy (FAP) and emergency medical care policy
3. Limit the amount charged for any emergency or other medically necessary care to a FAP-eligible individual to not more that the amount generally billed to individuals who have insurance covering such care
4. Make a reasonable effort to determine whether an individual is eligible for assistance under the FAP before engaging in collection action against that individual

This report does not include the 501(r) requirements submitted in the Form 990 Schedule H, or the associated Community Health Needs Assessment (CHNAs) and Implementation Strategies. CHNAs and Implementation Strategies are required to be completed and made public every three years, but there is no definite link between the activities performed by the hospital, and the dollar amount tied with those activities in the Schedule H. Further reviewed in the Recommendations section, OHS would like to work with hospitals to better understand the link between their CHNAs and Implementation Strategies, with their Form 990 Schedule H submissions. A separate analysis was conducted and made public by the Office of Health Strategy (OHS) regarding CHNAs and Implementation Strategies produced by Connecticut hospitals. A majority of Connecticut hospitals are slated to produce updated CHNAs and Implementation Strategies in 2022.

The State of Connecticut, represented by OHS, has an interest in nonprofit hospitals' community benefit programs, as it is Connecticut communities that are the recipients of the benefit from those facilities that participate in the tax exemption. Additionally, three of the four tax benefits - state corporate income tax, local property tax, and local sales tax - are taxes that the state and municipalities would otherwise collect. This report seeks to promote transparency regarding which services and activities are being considered hospital community benefit, and how the associated expenditures made by hospitals are positively impacting the communities and addressing needs.

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[2] "Charitable Hospitals - General Requirements for Tax-Exemption under Section 501(c)(3)." *Internal Revenue Service*, 31 Aug. 2021, https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

[3] "Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)." *Internal Revenue Service*, 7 Sept. 2021, https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r.

Recognized Community Benefit Services and Activities

The IRS requires hospitals that want to apply or sustain their tax exemption to annually submit the Form 990, which documents community benefit in Schedule H. The IRS definitively recognizes services and activities listed in Part I of the Schedule H as "community benefit." Part I, Financial Assistance and Certain Other Community Benefits at Cost, is composed of the following sections and categories:

1. Financial Assistance and Means-Tested Government Programs
    a. Financial assistance at cost
    b. Medicaid
    c. Costs of other means-tested government programs
2. Other Benefits
    a. Community health improvement services and community benefit operations
    b. Health professions education
    c. Subsidized health services
    d. Research
    e. Cash and in-kind contributions for community benefit

This report includes analysis for Part I data, and the definitions with expanded information about the eight categories (i.e., the Medicaid category is the unreimbursed costs from Medicaid), are found in the Methodology section. Parts II and III are not included in this report, as it is up to the IRS' discretion if the justification is enough for the activities to be counted as community benefit.

Methodology

Process

Data used for this report comes from the IRS Form 990, and the majority is derived from the Schedule H. Nonprofit hospitals submit their Form 990s to OHS annually. These annual submissions were used for filing years[4] 2016 to 2020, the latter being the most recent year available.

Definitions

1. **Financial assistance at cost** is also known as charity care and is the cost of free or discounted services to people meeting the hospital's criteria for receiving financial assistance. This excludes "bad debt," which are the uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay
2. **Medicaid**, which is the unreimbursed costs from Medicaid, is the difference between the hospital's costs incurred for treating Medicaid patients and the payment received
3. **Costs from other means-tested programs** is the difference between the hospital's costs incurred for treating these patients and the payment received. The IRS offers the State Children's Health Insurance Program (SCHIP) as an example of other means-tested programs
4. **Community health improvement services and community benefit operations** are activities or programs, subsidized by the hospital, which have a goal of improving community health

[4] Filing year depends on the submitting hospital, but is most commonly from October 1 to September 30. Hospitals also submitted using the calendar year (January 1 – December 31), or in one case, a condensed year when their tax status changed.

5. **Health professions education** are the unreimbursed costs incurred on training programs for being licensed to practice as a health professional
6. **Subsidized health services** are clinical services provided to patients despite causing a financial loss to the hospital after incorporating the payments received from programs that are not means-tested, like commercial insurance
7. **Research** is any study or investigation with a goal of generating knowledge to the public that is unfunded
8. **Cash and in-kind contributions for community benefit** are donations to other organizations to provide any of the seven community benefits described above

Hospital Inclusion

To qualify for inclusion in this report, hospitals had to submit a Form 990 to OHS at least once between filing years 2016 and 2020. In total, 27 Connecticut hospitals are included in this report, and 21 of 22 eligible hospitals submitted their forms in 2020.

Below in Figure 1, hospitals marked with a green box include data for that hospital in the corresponding year column, while those hospitals marked with a gray box were not included because the hospital (1) had a change in tax-status, or (2) was acquired and no longer submitted a separate Form 990. One hospital is marked with a red box, indicating the hospital did not submit their Form 990 to OHS.

Legend

Hospital Included	
Hospital Not Included	
Noncompliant (not included)	

Figure 1

Hospital	*2016*	*2017*	*2018*	*FY19*	*FY20*
Backus	Included	Included	Included	Included	Included
Bridgeport	Included	Included	Included	Included	Included
Bristol	Included	Included	Included	Included	Included
Charlotte Hungerford	Included	Included	Included	Included	Included
Central Connecticut	Included	Included	Included	Included	Included
Connecticut Children’s	Included	Included	Included	Included	Included
Danbury	Included	Included	Included	Included	Included
Day Kimball	Included	Included	Included	Included	Included
Greenwich	Included	Included	Included	Included	Included
Griffin	Included	Included	Included	Included	Included
Hartford	Included	Included	Included	Included	Included
Johnson Memorial	Included	Included	Included	Included	Included
Lawrence + Memorial	Included	Included	Included	Included	Included
Manchester	Included	Not Included	Not Included	Not Included	Not Included
Middlesex	Included	Included	Included	Included	Included
MidState	Included	Included	Included	Included	Included
Milford	Included	Included	Included	Included	Not Included
Norwalk	Included	Included	Included	Included	Included
Rockville	Included	Not Included	Not Included	Not Included	Not Included
St. Francis	Included	Included	Included	Included	Included
St. Mary’s	Included	Included	Included	Included	Included
St. Vincent’s	Included	Included	Included	Included	Included
Sharon	Not Included	Included	Included	Included	Noncompliant
Stamford	Included	Included	Included	Included	Included
Waterbury	Included	Not Included	Not Included	Not Included	Not Included
Windham	Included	Included	Included	Included	Included
Yale New Haven	Included	Included	Included	Included	Included

Findings

Nonprofit Hospitals’ Community Benefit (2016-2020)

Over the five observed filing years (2016-2020), nonprofit hospitals’ community benefit decreased in Connecticut, as shown in Table 1, which visualizes total community benefit in the state. Total community benefit across the state hit a high of $1.7 billion in 2016, and accounted for $1.5 billion in 2020 - a difference of approximately $144 million.

Table 1

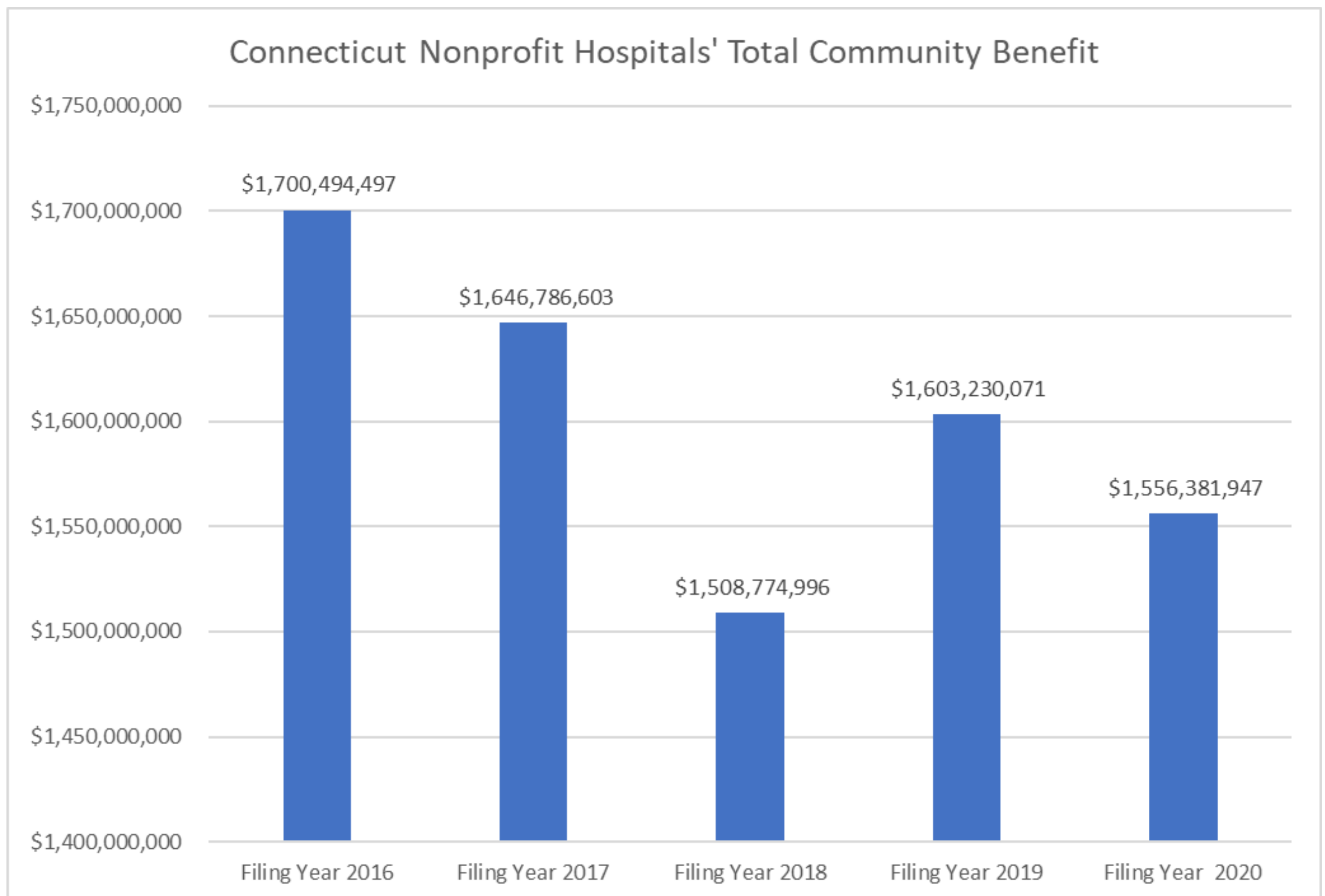

Table 2 provides additional details on the totals, broken out by two sections: total financial assistance and means-tested government programs, and total other benefits; which are composed of the eight categories the IRS deems community benefit. Five of the eight community benefit categories decreased between 2019 and 2020 and are further explored in this report.

Table 2

Connecticut Nonprofit Hospitals' Total Community Benefit

Schedule H	Filing Year 2016	Filing Year 2017	Filing Year 2018	Filing Year 2019	Filing Year 2020
Financial Assistance at cost	$ 344,844,514	$ 342,741,512	$ 320,130,774	$ 344,298,104	$ 305,303,119
Medicaid	$ 898,481,395	$ 918,436,011	$ 767,371,699	$ 829,856,416	$ 875,100,015
Costs of other means-tested government programs	$ 68,369,260	$ 41,339,920	$ 52,577,205	$ 46,194,252	$ 256,459
Total Financial Assistance and Means-Tested Government Programs	$ 1,311,695,169	$ 1,302,517,443	$ 1,140,079,678	$ 1,220,348,772	$ 1,180,659,593
Community health improvement services and community benefit operations	$ 30,157,773	$ 27,283,014	$ 26,876,482	$ 30,672,119	$ 32,446,636
Health professions education	$ 263,704,838	$ 239,297,743	$ 246,193,398	$ 251,128,821	$ 246,558,450
Subsidized health services	$ 69,824,157	$ 55,565,017	$ 61,368,647	$ 67,709,063	$ 57,939,838
Research	$ 9,925,901	$ 9,299,774	$ 13,901,341	$ 14,537,834	$ 11,616,198
Cash and in-kind contributions for community benefit	$ 15,186,659	$ 12,823,612	$ 20,355,450	$ 18,833,462	$ 27,161,232
Total Other Benefits	$ 388,799,328	$ 344,269,160	$ 368,695,318	$ 382,881,299	$ 375,722,354
Total Community Benefit	**$ 1,700,494,497**	**$ 1,646,786,603**	**$ 1,508,774,996**	**$ 1,603,230,071**	**$ 1,556,381,947**

Table 3 shows community benefit as a percentage of total expense. Total expense is how much a hospital spent in the filing year. Community benefit observed as a percentage of hospitals' total expense has similarly decreased over the observed five years (Table 3). In 2016, community benefit accounted for 15.83% of total expense, and in 2020 accounted for 12.00%. Similarly, seven of the eight community benefit categories decreased as a percentage of total expense between 2019 and 2020. The single category that saw an increase as a percentage of total expense was cash and in-kind contributions for community benefit.

Table 3

Connecticut Nonprofit Hospitals' Community Benefit as a % of Total Expense

Schedule H	**Filing Year 2016**	**Filing Year 2017**	**Filing Year 2018**	**Filing Year 2019**	**Filing Year 2020**
Financial Assistance at Cost	3.21%	3.29%	2.83%	2.86%	2.35%
Medicaid	8.36%	8.81%	6.79%	6.91%	6.75%
Costs of other means-tested government programs	0.64%	0.40%	0.47%	0.38%	0.00%
Total Financial Assistance and Means-Tested Government Programs	12.21%	12.50%	10.09%	10.15%	9.10%
Community health improvement services and community benefit operations	0.28%	0.26%	0.24%	0.26%	0.25%
Health professions education	2.45%	2.30%	2.18%	2.09%	1.90%
Subsidized health services	0.65%	0.53%	0.54%	0.56%	0.45%
Research	0.09%	0.09%	0.12%	0.12%	0.09%
Cash and in-kind contributions for community benefit	0.14%	0.12%	0.18%	0.16%	0.21%
Total Other Benefits	3.62%	3.30%	3.26%	3.19%	2.90%
Total Community Benefit	**15.83%**	**15.80%**	**13.35%**	**13.34%**	**12.00%**

Table 4 provides community benefit as a percentage of total community benefit expense. OHS calculated the total community benefit for each of the eight categories to understand how much each category comprises of the total community benefit expense.

Table 4 shows that Medicaid is the biggest portion of community benefit in Connecticut, accounting for over 50% in each of the five years. Additionally, in 2020, the Medicaid category is at its highest percentage of total community benefit over the five years considered. However, the second largest portion, financial assistance at cost, is at its lowest percentage of total community benefit.

The first section, Total Financial Assistance and Means-Tested Government Programs, shows over the five years 75% or more of community benefit is derived from unreimbursed costs from Medicaid or charity care.

Table 4

Connecticut Nonprofit Hospitals' Community Benefit as % of Total Community Benefit Expense

Schedule H	**Filing Year 2016**	**Filing Year 2017**	**Filing Year 2018**	**Filing Year 2019**	**Filing Year 2020**
Financial Assistance at Cost	20.28%	20.81%	21.22%	21.48%	19.62%
Medicaid	52.84%	55.77%	50.86%	51.76%	56.23%
Costs of other means-tested government programs	4.02%	2.51%	3.48%	2.88%	0.02%
Total Financial Assistance and Means-Tested Government Programs	77.14%	79.09%	75.56%	76.12%	75.86%
Community health improvement services and community benefit operations	1.77%	1.66%	1.78%	1.91%	2.08%
Health professions education	15.51%	14.53%	16.32%	15.66%	15.84%
Subsidized health services	4.11%	3.37%	4.07%	4.22%	3.72%
Research	0.58%	0.56%	0.92%	0.91%	0.75%
Cash and in-kind contributions for community benefit	0.89%	0.78%	1.35%	1.17%	1.75%
Total Other Benefits	22.86%	20.91%	24.44%	23.88%	24.14%
Total Community Benefit	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Table 5 presents the incremental change, known as a delta (Δ), between the two most recent filing years, 2019 and 2020. At high level, it illustrates that spending in five of the eight community benefit categories decreased between 2019 and 2020. In total, community benefit decreased by $46.8 million. The two categories driving this decrease are other means-tested government programs, and financial assistance at cost. Other means-tested government programs, which do not include Medicaid or Medicare, documented a 99% drop ($45,937,793) between 2019-2020. In 2019, St. Vincent's Medical Center documented $45,918,014 in this category, and in 2020 documented $0. Notably, St. Vincent's was affiliated with Ascension Healthcare in 2019, and transferred ownership to Hartford Healthcare in 2020.

Financial assistance at cost decreased $38.9 million between 2019 and 2020, which was primarily driven by Yale New Haven Hospital. Similar to other means-tested government programs, this decrease is further reviewed in this report.

Table 5

Connecticut Nonprofit Hospitals' Community Benefit, 2019-2020 Delta (Δ)

Schedule H	Filing Year 2019	Filing Year 2020	2019-2020 Δ
Financial Assistance at cost	$ 344,298,104	$ 305,303,119	$ (38,994,985)
Medicaid	$ 829,856,416	$ 875,100,015	$ 45,243,599
Costs of other means-tested government programs	$ 46,194,252	$ 256,459	$ (45,937,793)
Community health improvement services and community benefit operations	$ 30,672,119	$ 32,446,636	$ 1,774,517
Health professions education	$ 251,128,821	$ 246,558,450	$ (4,570,371)
Subsidized health services	$ 67,709,063	$ 57,939,838	$ (9,769,225)
Research	$ 14,537,834	$ 11,616,198	$ (2,921,636)
Cash and in-kind contributions for community benefit	$ 18,833,462	$ 27,161,232	$ 8,327,770
Total Community Benefit	**$ 1,603,230,071**	**$ 1,556,381,947**	**$ (46,848,124)**

Community Benefit Breakdown

Starting with the largest portioned category of community benefit in 2020 (Medicaid), and working down to the lowest portion of community benefit (costs of other means-tested government programs), this report gives an overview analysis of each category. The following legend is used to denote hospitals' system affiliaton, or if they are independent.

Legend

Legend
Independent
Hartford Healthcare
Trinity Health of New England
Nuvance Health
Yale New Haven Health Services

Medicaid

As noted earlier in this report, over half of nonprofit hospitals' community benefit came from Medicaid, which is the unreimbursed costs from Medicaid (Table 4). In 2020, unreimbursed costs from Medicaid accounted for $875 million (56.23%) of total community benefit, an increase of $45.2 million from 2019 (Tables 2 and 4). Table 6 displays each hospital's accounted unreimbursed costs from Medicaid in 2020, and the data shows that Yale New Haven reported approximately 29% of the unreimbursed costs, or $250.6 million.

To better understand the role of the largest documented benefit to communities, Table 7 provides each hospitals' Medicaid category as a percentage of the hospitals' total community benefit. In 2020, 72% of nonprofit hospitals documented over 50% of their benefit as unreimbursed costs from Medicaid (Table 7). Notably, seven hospitals (32%) documented greater than 75%:

1. MidState (93%)
2. Johnson Memorial (92%)
3. Backus (90%)
4. Day Kimball (85%)
5. Charlotte Hungerford (83%)
6. Stamford (82%)
7. Central Connecticut (76%)

Table 6

	Medicaid		
1	Yale New Haven	$	250,681,551
2	Hartford	$	65,781,699
3	Bridgeport	$	60,574,668
4	Connecticut Children's	$	59,635,416
5	St. Francis	$	58,480,901
6	Stamford	$	57,561,953
7	Danbury	$	45,956,702
8	Central Connecticut	$	37,998,428
9	Backus	$	30,721,281
10	MidState	$	28,954,338
11	Norwalk	$	26,258,697
12	St. Vincent's	$	25,220,391
13	Lawrence + Memorial	$	23,526,046
14	Middlesex	$	22,914,376
15	St. Mary's	$	20,501,072
16	Greenwich	$	18,748,851
17	Bristol	$	10,355,377
18	Day Kimball	$	9,843,309
19	Griffin	$	9,538,898
20	Windham	$	4,449,499
21	Charlotte Hungerford	$	4,302,647
22	Johnson Memorial	$	3,093,915
	Total	**$**	**875,100,015**

Table 7

	Medicaid as a % of Community Benefit	
1	MidState	93%
2	Johnson Memorial	92%
3	Backus	90%
4	Day Kimball	85%
5	Charlotte Hungerford	83%
6	Stamford	82%
7	Central Connecticut	76%
8	Windham	73%
9	St. Vincent's	72%
10	St. Mary's	70%
11	Connecticut Children's	68%
12	St. Francis	67%
13	Norwalk	63%
14	Bridgeport	58%
15	Danbury	57%
16	Griffin	57%
17	Hartford	48%
18	Yale New Haven	47%
19	Lawrence + Memorial	44%
20	Middlesex	44%
21	Bristol	41%
22	Greenwich	32%
	Total	**56%**

Financial Assistance at Cost

The second largest category of community benefit was financial assistance at cost, also known as charity care. From 2016-2020, charity care accounted for approximately 19-21% of community benefit in Connecticut (Table 4). 2020 recorded the lowest year for financial assistance at cost for patients, a drop of roughly $38.9 million compared to 2019 (Tables 4 and 5).

Table 8 highlights the total amount of financial assistance at cost/charity care that each hospital documented in 2020. Yale New Haven Hospital (YNHH) documented 52% of charity care in 2020, followed by the other three Connecticut based Yale New Haven Health Services (YNHHS) hospitals. The four Connecticut YNHHS hospitals made up 80% of total charity care in 2020.

Table 8

Financial Assistance at Cost

	Hospital		Amount
1	Yale New Haven	$	161,659,284
2	Greenwich	$	32,134,461
3	Bridgeport	$	30,646,402
4	Lawrence + Memorial	$	21,009,311
5	Danbury	$	12,280,362
6	Stamford	$	9,931,793
7	Hartford	$	6,628,811
8	Norwalk	$	4,789,842
9	St. Francis	$	4,160,770
10	St. Vincent's	$	4,041,270
11	Middlesex	$	2,733,869
12	Central Connecticut	$	2,616,317
13	Bristol	$	2,510,054
14	Backus	$	2,388,836
15	St. Mary's	$	1,907,127
16	Griffin	$	1,428,115
17	MidState	$	1,384,500
18	Connecticut Children's	$	1,110,829
19	Windham	$	933,694
20	Charlotte Hungerford	$	695,552
21	Johnson Memorial	$	245,168
22	Day Kimball	$	66,752
	Total	**$**	**305,303,119**

Considering the documented decline in charity care, OHS put together Table 9, which provides each hospitals' financial assistance at cost/charity care in 2019, 2020, and the delta (Δ) between those two years. Table 9 shows that half of Connecticut hospitals provided less charity care in 2020 than they did in 2019. While YNHH documented the highest amount of charity care in 2020 found in Table 8, it also recorded the principal decline between 2019 and 2020 ($43.6 million) as shown in Table 9. Of the four YNHHS hospitals in Connecticut, only YNHH documented a decline, while Bridgeport, Greenwich, and Lawrence + Memorial documented the largest increases between 2019 and 2020.

Table 9

Financial Assistance at Cost

Hospital	2019	2020	Δ
Bridgeport	$ 19,484,717	$ 30,646,402	$ 11,161,685
Greenwich	$ 27,596,389	$ 32,134,461	$ 4,538,072
Lawrence + Memorial	$ 17,660,000	$ 21,009,311	$ 3,349,311
Central Connecticut	$ 2,147,186	$ 2,616,317	$ 469,131
Stamford	$ 9,486,340	$ 9,931,793	$ 445,453
Griffin	$ 1,063,058	$ 1,428,115	$ 365,057
Backus	$ 2,039,587	$ 2,388,836	$ 349,249
Hartford	$ 6,355,972	$ 6,628,811	$ 272,839
Windham	$ 857,732	$ 933,694	$ 75,962
Bristol	$ 2,446,213	$ 2,510,054	$ 63,841
MidState	$ 1,381,694	$ 1,384,500	$ 2,806
Johnson Memorial	$ 280,419	$ 245,168	$ (35,251)
Day Kimball	$ 111,880	$ 66,752	$ (45,128)
Middlesex	$ 2,797,053	$ 2,733,869	$ (63,184)
Charlotte Hungerford	$ 820,371	$ 695,552	$ (124,819)
Connecticut Children's	$ 1,386,682	$ 1,110,829	$ (275,853)
St. Mary's	$ 2,682,204	$ 1,907,127	$ (775,077)
St. Francis	$ 5,036,794	$ 4,160,770	$ (876,024)
Danbury	$ 15,928,791	$ 12,280,362	$ (3,648,429)
St. Vincent's	$ 8,553,832	$ 4,041,270	$ (4,512,562)
Norwalk	$ 9,612,703	$ 4,789,842	$ (4,822,861)
Yale New Haven	$ 205,280,418	$ 161,659,284	$ (43,621,134)
Total	**$ 344,298,104**	**$ 305,303,119**	**$ (38,994,985)**

Health Professions Education

Health professions education are the unreimbursed costs incurred on training programs for being licensed to practice as a health professional. Table 10 provides the documented health professions education for each hospital in 2020. YNHH reported approximately 40% of the total unreimbursed costs from health professions education ($97.1 million). Only three hospitals did not document health professions education: Bristol, Johnson Memorial, and Stamford.

Table 10

Health Professions Education

1	Yale New Haven	$	97,126,948
2	Hartford	$	39,181,760
3	St. Francis	$	23,065,259
4	Connecticut Children's	$	20,947,229
5	Danbury	$	15,502,811
6	Middlesex	$	10,439,224
7	Bridgeport	$	9,040,353
8	Central Connecticut	$	8,694,366
9	St. Mary's	$	6,723,879
10	Norwalk	$	6,400,020
11	Greenwich	$	3,456,140
12	St. Vincent's	$	2,093,491
13	Lawrence + Memorial	$	1,824,817
14	Griffin	$	1,546,097
15	Windham	$	217,674
16	Backus	$	152,551
17	Day Kimball	$	127,402
18	Charlotte Hungerford	$	9,980
19	MidState	$	8,449
20	Bristol	$	-
21	Johnson Memorial	$	-
22	Stamford	$	-
	Total	**$**	**246,558,450**

For filing year 2020, five Schedule H categories comprised 8.32% of the remaining community benefit (Table 4):

1. Subsidized health services (3.72%)
2. Community health improvement services and community benefit operations (2.08%)
3. Cash and in-kind contributions for community benefit (1.75%)
4. Research (0.75%)
5. Costs of other means-tested government programs (0.02%).

Subsidized Health Services

Subsidized health services are clinical services provided to patients despite causing a financial loss to the hospital after incorporating the payments received from programs that are not means-tested. Table 12 displays each hospitals' subsidized health services in 2020, which accounts for $57.9 million of community benefit.

Over half of subsidized health services in 2020 came from three hospitals: Middlesex, Yale New Haven, and Bristol. Table 2 shows that between 2016 and 2020, the high for subsidized health services was $69.8 million (2016), and the low was $55.5 million (2017).

Table 11

Subsidized Health Services

#	Hospital		Amount
1	Middlesex	$	12,427,548
2	Yale New Haven	$	10,559,689
3	Bristol	$	9,674,885
4	Hartford	$	4,145,491
5	Greenwich	$	3,991,249
6	Griffin	$	3,743,994
7	Norwalk	$	2,980,460
8	Danbury	$	2,687,528
9	Lawrence + Memorial	$	1,812,981
10	St. Vincent's	$	1,737,264
11	Day Kimball	$	1,589,993
12	Bridgeport	$	1,248,753
13	Central Connecticut	$	454,641
14	MidState	$	449,477
15	Windham	$	308,306
16	Backus	$	127,579
17	Charlotte Hungerford	$	-
18	Connecticut Children's	$	-
19	Johnson Memorial	$	-
20	St. Francis	$	-
21	St. Mary's	$	-
22	Stamford	$	-
	Total	**$**	**57,939,838**

Community Health Improvement Services and Community Benefit Operations

Community health improvement services and community benefit operations are the activities or programs subsidized by the hospital, which have a goal of improving community health. This is the first category discussed that is focused on improving a community's health, and not focused on the programs provided to individuals when they arrive at the hospital or increase staff training. Table 4 shows this category has increased as a percentage of community benefit over the five observed years, and Table 2 depicts 2020 as having the highest dollar allotment ($32.4 million) since 2016 ($30.1 million).

Table 12 gives each hospitals' recorded community health improvement services and community benefit operations in 2020, and highlights that improvement dollars range from $4,000 to $13 million. The largest amount of dollars expended came from YNHH, which provided 40% of the category ($13 million). The next three largest contributors to community health improvement are independent hospitals. Table 13 groups hospitals together by their system affiliation, or for the purposes of this report, groups independent hospitals together. Middlesex, Bristol, and Connecticut Children's together provided more community health improvement services and community benefit operations than several health systems (Table 13).

Table 12

Community Health Improvement Services and Community Benefit Operations

	Hospital		Amount
1	Yale New Haven	$	13,076,450
2	Middlesex	$	2,972,813
3	Bristol	$	2,583,729
4	Connecticut Children's	$	2,388,599
5	Bridgeport	$	2,038,670
6	St. Vincent's	$	1,968,274
7	Lawrence + Memorial	$	1,380,597
8	Hartford	$	1,251,044
9	St. Francis	$	1,064,265
10	Backus	$	912,648
11	Greenwich	$	528,488
12	MidState	$	455,266
13	Central Connecticut	$	354,254
14	Griffin	$	311,880
15	Windham	$	210,829
16	St. Mary's	$	201,270
17	Stamford	$	199,013
18	Norwalk	$	197,248
19	Charlotte Hungerford	$	191,137
20	Danbury	$	129,319
21	Johnson Memorial	$	26,657
22	Day Kimball	$	4,186
	Total	**$**	**32,446,636**

Table 13

Community Health Improvement by Grouping

Hospital		Amount
Yale New Haven	$	13,076,450
Bridgeport	$	2,038,670
Lawrence + Memorial	$	1,380,597
Greenwich	$	528,488
YNHHS Total	**$**	**17,024,205**
Middlesex	$	2,972,813
Bristol	$	2,583,729
Connecticut Children's	$	2,388,599
Griffin	$	311,880
Stamford	$	199,013
Day Kimball	$	4,186
Independent Total	**$**	**8,460,220**
St. Vincent's	$	1,968,274
Hartford	$	1,251,044
Backus	$	912,648
MidState	$	455,266
Central Connecticut	$	354,254
Windham	$	210,829
Charlotte Hungerford	$	191,137
HHC Total	**$**	**5,343,452**
St. Francis	$	1,064,265
St. Mary's	$	201,270
Johnson Memorial	$	26,657
Trinity Total	**$**	**1,292,192**
Norwalk	$	197,248
Danbury	$	129,319
Nuvance Total	**$**	**326,567**

Table 14 further dissects the data by providing the percentage of total expense this category comprises in 2020. The same three independent hospitals – Middlesex, Bristol, and Connecticut Children's – documented the highest percentage of community health improvement services when considering their total expense. Conversely, the three lowest as a percentage of total expense are: Stamford (0.03%), Danbury (0.02%), and Day Kimball (0.004%).

Table 14

	Community Health Improvement Services and Community Benefit Operations	Total Expense	%
Bristol	$ 2,583,729.00	$ 144,256,122.00	1.79%
Middlesex	$ 2,972,813.00	$ 419,235,331.00	0.71%
Connecticut Children's	$ 2,388,599.00	$ 371,945,837.00	0.64%
St. Vincent's	$ 1,968,274.00	$ 437,484,072.00	0.45%
Yale New Haven	$ 13,076,450.00	$ 3,353,235,179.00	0.39%
Lawrence + Memorial	$ 1,380,597.00	$ 394,935,731.00	0.35%
Bridgeport	$ 2,038,670.00	$ 743,751,393.00	0.27%
Backus	$ 912,648.00	$ 409,399,267.00	0.22%
Windham	$ 210,829.00	$ 117,311,906.00	0.18%
Griffin	$ 311,880.00	$ 195,522,569.00	0.16%
MidState	$ 455,266.00	$ 356,518,886.00	0.13%
St. Francis	$ 1,064,265.00	$ 864,716,976.00	0.12%
Greenwich	$ 528,488.00	$ 461,249,484.00	0.11%
Charlotte Hungerford	$ 191,137.00	$ 170,403,135.00	0.11%
Central Connecticut	$ 354,254.00	$ 478,209,539.00	0.07%
St. Mary's	$ 201,270.00	$ 293,354,475.00	0.07%
Hartford	$ 1,251,044.00	$ 1,843,108,359.00	0.07%
Norwalk	$ 197,248.00	$ 408,192,474.00	0.05%
Johnson Memorial	$ 26,657.00	$ 76,006,533.00	0.04%
Stamford	$ 199,013.00	$ 593,512,414.00	0.03%
Danbury	$ 129,319.00	$ 721,766,095.00	0.02%
Day Kimball	$ 4,186.00	$ 113,599,072.00	0.004%
Total	**$ 32,446,636.00**	**$ 12,967,714,849.00**	**0.25%**

Cash and In-Kind Contributions for Community Benefit

Cash and in-kind contributions for community benefit are donations in the form of cash or staff time to organizations. Over the observed five years, this category was at its highest in 2020 ($27.1 million), up $8.3 million from 2019 (Table 2). Table 15 highlights each hospital's cash and in-kind contributions made in 2020. The data shows that 63% of hospitals made donations of some kind, with Hartford Hospital documenting 66% ($18 million) of the total contributions. Eight hospitals, including the two affiliated with Nuvance Health, did not make cash or in-kind contributions in 2020.

Table 15

Cash and In-Kind Contributions for Community Benefit

	Hospital	Amount
1	Hartford	$18,062,552
2	Lawrence + Memorial	$ 3,564,755
3	Stamford	$ 2,201,525
4	Yale New Haven	$ 2,048,834
5	St. Francis	$ 432,006
6	Middlesex	$ 275,056
7	Bridgeport	$ 254,422
8	Griffin	$ 108,173
9	Greenwich	$ 96,288
10	St. Mary's	$ 47,436
11	Connecticut Children's	$ 46,800
12	St. Vincent's	$ 15,000
13	Windham	$ 6,917
14	Charlotte Hungerford	$ 1,468
15	Backus	$ -
16	Bristol	$ -
17	Central Connecticut	$ -
18	Danbury	$ -
19	Day Kimball	$ -
20	Johnson Memorial	$ -
21	MidState	$ -
22	Norwalk	$ -
	Total	**$27,161,232**

Research

Research is any study or investigation with a goal of generating knowledge to the public that is unfunded. Table 16 highlights each hospital's unfunded research in 2020, which in aggregate accounted for $11.6 million by seven hospitals. Two hospitals make up approximately 66% of this category: Danbury ($3.9 million) and Connecticut Children's ($3.7 million). From 2016-2020, research spanned from a low of $9.3 million (2017), to a high of $14.5 million (2019) as shown in Table 2.

Table 16

Research

	Hospital	$	Amount
1	Danbury	$	3,974,429
2	Connecticut Children's	$	3,737,587
3	Hartford	$	1,979,149
4	Norwalk	$	1,282,390
5	St. Francis	$	313,700
6	Middlesex	$	252,796
7	Griffin	$	76,147
8	Backus	$	-
9	Bridgeport	$	-
10	Bristol	$	-
11	Central Connecticut	$	-
12	Charlotte Hungerford	$	-
13	Day Kimball	$	-
14	Greenwich	$	-
15	Johnson Memorial	$	-
16	Lawrence + Memorial	$	-
17	MidState	$	-
18	St. Mary's	$	-
19	St. Vincent's	$	-
20	Stamford	$	-
21	Windham	$	-
22	Yale New Haven	$	-
	Total	**$**	**11,616,198**

Costs of Other Means-Tested Government Programs

The lowest community benefit documented in 2020 was costs of other means-tested government programs, which does not include Medicaid or Medicare, but could be the State Children's Health Insurance Program. In 2020, Middlesex Hospital was the only facility to document in this category, totaling $256,459.

Community Benefit – Weighted Averages

To better understand nonprofit hospitals' community benefit in 2020, OHS grouped eligible hospitals, and then analyzed their community benefit data by using weighted averages. For additional detailed findings on total community benefit, average community benefit, and median community benefit, see Appendix B. Weighted averages take into account the relative importance of factors, whereas averages do not. Using an average may be helpful, but treating the largest hospital in the state the same as the smallest hospital in the state will lead to skewed results. To help with this challenge, OHS used publicly available information such as hospitals' licensed beds, total expenses, and net incomes to better understand the impact those factors have on hospitals' community benefit services and activities.

As noted, hospitals were grouped by their system affiliation, and for the purposes of this report, the independent hospitals were grouped together. With these groupings, OHS used each hospital's relative factor and determined the percentage they make up in the grouping, then multiplied the total community benefit spending for that grouping by the percentage to obtain a weighted average. The results from this analysis are as shown:

Connecticut hospitals' community benefit in 2020, weighted by licensed beds:

1. Yale New Haven Health Services - $387.1 million
2. Hartford Healthcare – $94.3 million
3. Trinity Health of New England – $61 million
4. Nuvance Health – $57.8 million
5. Independent Hospitals - $48.5 million

Connecticut hospitals' community benefit in 2020, weighted by total expense:

1. Yale New Haven Health Services - $387.6 million
2. Hartford Healthcare - $89.6 million
3. Trinity Health of New England - $68.5 million
4. Nuvance Health - $66.5 million
5. Independent Hospitals – $56.7 million

Connecticut hospitals' community benefit in 2020, weighted by net income:

1. Yale New Haven Health Services - $377.5 million
2. Hartford Healthcare - $84.7 million
3. Trinity Health of New England - $66.7 million
4. Independent Hospitals – $63.3 million
5. Nuvance Health - $61.9 million

Weighting licensed beds and total expense provided similar rankings within the grouping, while net income put independent hospitals in front of those affiliated with Nuvance Health. Yale New Haven Health Services, regardless of which weighting factor was used, provided more community benefit on average compared to their peers. In Appendix B, this report provides the grouping totals, averages, and medians, which provide different results than the weighted averages.

National Comparison to Connecticut Hospitals

Section 9007(e)(1) of the ACA, Public Law 111-148 provides that the Secretary of the Treasury submit annually community benefit services and activities associated dollars for tax-exempt (nonprofit), taxable, and government-owned hospitals to Congress. The IRS has been submitting this report annually, but has not released anything in 2021. Therefore, this report uses the 2020 IRS filing, which includes data from filing year 2016 shown in Table 17. Table 17 presents the same IRS data (Schedule H) observed in this report, but formatted slightly different based on the IRS' table. The data is broken out by the national benchmark (National), Connecticut data (Connecticut), and the delta (Δ) between the two. The three columns in green represent percent of total community benefit, and those in yellow denote community benefit as a percentage of total expense. This report has mostly been focused on data for filing year 2020, but given limitations with available data at the national level, is providing filing year 2016 data. Filing year 2016 in Connecticut was the largest sum of community benefit, and is compared to the 2016 national data. The IRS notes that percentages may not add up to 100% due to rounding.

Table 17

Community Benefit IRS Data - National Benchmarks Compared to Connecticut - Filing Year 2016						
Type of Community Benefit	Percent of Total Community Benefit Expense			Percent of Total Expense		
	National	Connecticut	Δ	National	Connecticut	Δ
Total Community Benefits	100%	100%	0%	9.42%	15.83%	6.41%
Total financial assistance and means-tested government programs	64.19%	77.14%	12.94%	6.05%	12.21%	6.16%
Financial assistance at cost	16.82%	20.28%	3.46%	1.58%	3.21%	1.63%
Medicaid	45.64%	52.84%	7.20%	4.30%	8.36%	4.06%
Costs of other means-tested government programs	1.73%	4.02%	2.29%	0.16%	0.64%	0.48%
Total other benefits	35.81%	22.86%	-12.94%	3.37%	3.62%	0.25%
Community health improvement services and community benefit operations	3.92%	1.77%	-2.15%	0.37%	0.28%	-0.09%
Health professions education	15.48%	15.51%	0.03%	1.46%	2.45%	0.99%
Subsidized health services	8.82%	4.11%	-4.71%	0.83%	0.65%	-0.18%
Research	4.85%	0.58%	-4.26%	0.46%	0.09%	-0.37%
Cash and in-kind contributions for community benefit	2.74%	0.89%	-1.85%	0.26%	0.14%	-0.12%

Percent of Total Community Benefit Expense

In 2016, compared to the average percentage of total community benefit expense by nonprofit hospitals across the United States, those in Connecticut provided more total financial assistance and means-tested government programs, and less total other benefits. Looking first at total financial assistance and means-tested government programs, Connecticut hospitals' Medicaid surpassed the national average by 7.20%, and provided 3.46% more financial assistance at cost/charity care. The costs of other means-tested government programs category, which dropped 99% for Connecticut hospitals in 2020, exceeded the benchmark by 2.29% in 2016.

For total other benefits in 2016, Connecticut nonprofit hospitals fall short 12.94% compared to nonprofit hospitals across the United States. Both subsidized health services, and unfunded research are below the national benchmark by 4.71% and 4.26%, respectively. Community health improvement services and community benefit operations also lag the national benchmark, by 2.15%. Only health professions education exceeds the national average, being 0.03% higher.

Percent of Total Expense

In 2016, Connecticut nonprofit hospitals' community benefit as a percent of total expense exceed the national benchmark by 6.41%. The Medicaid category is the principal reason for being above, documented at 4.06% more than the benchmark, followed by financial assistance at cost/charity care at 1.63% higher, and costs of other means-tested government programs at 0.48% higher.

Total other benefits also exceed the benchmark by 0.25%. However, only one category in this section exceeds the benchmark - health professions education (0.99% higher than the national benchmark). The other four categories, fell short of the national benchmark by less than 0.5% in each category.

2021 IRS Report

OHS looks forward to the next iteration of this report from the IRS which will include data for filing year 2017. Once the IRS report becomes publicly available, OHS will release the 2017 comparison of the national benchmark and Connecticut nonprofit hospitals.

Recommendations

Based on the findings included in this report, OHS has incorporated several state and federal recommendations that will help enhance transparency and accountability, promote meaningful engagement of the community, produce stronger linkages between community benefits and identified health needs, and make available data to support hospitals.

State Recommendations

1. **Require enhanced reporting from nonprofit hospitals that participate in community benefit services and activities.**

OHS recommends increasing transparency on community benefit services and activities, including Community Health Needs Assessments (CHNAs) and Implementation Strategies, so that OHS, communities, and other stakeholders may better understand the benefit being afforded to communities. In addition to codifying the submission of the CHNA and corresponding Implementation Strategy for each nonprofit hospital to OHS within thirty days of making it public,[5] the following items are proposed to be added as requirements in the current community benefit statute, §19a-127k:

a. *The names of the senior hospital administrators who are overseeing community benefits*. This information will allow stakeholders to understand which senior hospital administrators have ownership and responsibility providing benefit to communities.

b. *Demographics of the population being focused on and why.* OHS is facilitating the standardization of the collection of race, ethnicity, and language (REL) data across certain state entities and health care providers that have electronic health records pursuant to Public Act 21-35. Greater alignment of these standards, as well as the ability to aggregate

[5] Nonprofit hospitals, pursuant to CFR 1.501(r)(3), are required to make their community health needs assessment "widely available to the public."

and disaggregate, are critical in the evaluation of health disparities and promoting health equity.

c. *Description of the health status and health disparities affecting the population*. This information will provide further detail on individuals' health and set the practice standard across Connecticut to create alignment opportunities amongst hospitals, the state government, and other stakeholders. Identification of health disparities will allow appropriate targeting of funding and resources, as well as data behind the most prominent health issues and disparities across the state.

d. *Who from communities are meaningfully being engaged to participate in Community Health Needs Assessments as well as Implementation Strategies, and hospitals' definition of meaningful participation.* Enacting this recommendation gives opportunity to determine a standard, best-practice definition and approach by hospitals, and creates transparency on who is contributing to CHNAs and Implementation Strategies, e.g., diverse members from the community, faith-based organizations, community-based organizations, health departments, schools, tribal nations, local municipalities, state agencies, foundations, etc.

e. *A description of barriers to achieving or maintaining health, with a focus on root causes impacting the health of our communities, namely social determinants of health (SDOH) and health inequities*. SDOH are the conditions in which people are born, grow, live, work and age. Health inequities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. SDOH have been shown to exert the most powerful and sustained influence on health and the distribution of disease, illness, injury, disability and premature death.[6] Data shows health inequities have led to people of color faring worse across many measures of health status.[7] The importance of health inequities is highlighted by recent action from the Biden Administration,[8] the Centers for Disease Control and Prevention,[9] and the Office of Minority Health.[10]

f. Recommendations from hospitals with input from community members and health-inclined multi-sector organization on how to remove barriers to redress root causes to poor health. Multi-faceted causes to poor health require collaboration between community members, hospitals, the government, and multi-sector organizations. Working collectively on the

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[6] Hood, Carlyn M, et al. "County Health Rankings: Relationships Between Determinant Factors and Health Outcomes." *American Journal of Preventive Medicine*, vol. 50, no. 2, Feb. 2016, pp. 129–135., https://doi.org/https://www.sciencedirect.com/science/article/pii/S0749379715005140?via%3Dihub.

[7] Nambi Ndugga and Samantha Artiga. "Disparities in Health and Health Care: 5 Key Questions and Answers." *KFF*, Kaiser Family Foundation , 11 May 2021, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

[8] Executive Order. No. 13985, 2021. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.

[9] "Racism and Health." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 20 Oct. 2021, https://www.cdc.gov/healthequity/racism-disparities/index.html.

[10] "Our Work Today." *About the Office of Minority Health*, US Department of Health and Human Services Office of Minority Health, https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=1.

identified needs and solutions will create focus, alignment, and bring together the efforts and resources that have traditionally been in silos for decades.

g. *The community health needs and health disparities identified, how they were prioritized, which needs were chosen to be addressed, and how the chosen align with the Department of Public Health's State Health Improvement Plan.* This allows stakeholders to better understand the needs in communities, across Connecticut, and with the government to create alignment opportunities. Moreover, it provides transparency on how needs were prioritized and chosen to be addressed, and how that process relates to the input provided for the CHNA.

h. *Evidence (i.e., in-process and outcome metrics) that shows how the Implementation Strategies are working to address identified needs on an ongoing basis.* This allows stakeholders to understand if strategies to improve community needs, especially social determinants of health and health inequities, are having an impact. Measures across the state also provide hospitals, the government, and other stakeholders the opportunity to learn what interventions are working, and those interventions which are not having the desired impact.

i. *How the hospital solicited feedback on the Implementation Strategies and revisions that were made.* This allows stakeholders to understand how hospitals are continually improving their communities as part of community benefits, and how partnerships between multi-sector organizations, community members, and the government are working.

2. Require nonprofit and for-profit hospitals to submit an annual report to OHS with updates on the hospital's community benefit services and activities.

This new reporting will allow OHS to understand how community benefit services and activities are related to the dollars spent. This report focuses on community benefit dollars, since the CHNAs and Implementation Strategies currently do not link those activities with the dollars documented in the Form 990 Schedule H. By understanding the connection, OHS will have a more complete picture of how benefits are being attributed. Moreover, this new reporting will allow OHS to understand how needs are changing, how Implementation Strategies are working in practice, and how OHS may further support hospitals in addressing the root causes of identified health needs.

Currently, only nonprofit hospitals are submitting their community benefit activities to OHS. For-profit hospitals also provide expenditures considered community benefit as demonstrated in the IRS' report to Congress. For-profit information will give OHS better insight into how nonprofit hospitals that receive tax relief for doing community benefit, compare to for-profit hospitals that do not receive such relief. Additionally, for-profit hospitals may be compared to a national benchmark like the nonprofit hospitals, and it will provide an understanding of what is being done for communities that do not have nonprofit hospitals.

3. Support hospitals with their community benefit data needs, by making additional data available from All-Payer Claims Database, while ensuring compliance with federal and state privacy and use laws.

The All-Payer Claims Database (APCD) is a large database housed within OHS that includes medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers. In accordance with federal and state privacy and use laws, making data available from the APCD

to hospitals for use in their community benefits programs could aid them in conducting their CHNAs and preparing and undertaking their implementation strategies. This statewide healthcare utilization data may help identify trends or prevalence of community health conditions and other factors that can contribute to barriers to access and health disparities, as well as health outcomes.

4. **Promote hospital partnership with community health collaboratives on community benefit services and activities.**

In addition to the above state recommendations, OHS urges hospitals that have not already done so, to partner their community benefit services and activities with local health collaboratives, and where applicable, Health Enhancement Communities (HECs). HECs are comprised of multi-sector organizations (e.g., community-based organizations, faith-based organizations, hospitals, health departments, FQHCs, schools, etc.) and community residents, working together to create an impact with the government to the multi-factorial root causes that contribute to poor health, namely social determinants of health and health inequities. Hospitals partnering their community benefit activities with health collaborations and the government open the door to greater impact. Interventions that are multi-pronged (systems, programs, policies, and cultural norms), focused on root causes to the needs identified, and have the people who live in communities involved in the work, provide an opportunity to tear down silos and work together to improve people's health.

HECs are currently being supported by Federal grants from the CDC and OMH, and working to address social determinants of health like food insecurity or transportation, and health inequities like maternal morbidity and mortality for Black and Latina women. All of these needs were identified in the last round of CHNAs.

5. **Explore with hospitals how to include more community building as a part of their community benefit**

Community building, while not considered community benefit without the hospital demonstrating to the IRS how the activities promote the health of the communities it serves, is an important category given how these activities improve a community's health or safety. Some examples of community building activities may include but are not limited to:[11]

1. Physical improvements such as housing, or removing harmful building materials (e.g., lead abatement), neighborhood improvement and revitalization, housing for vulnerable population upon inpatient discharge, housing for seniors, and parks and playgrounds to improve physical activities

2. Economic development activities such as assisting in small business development and creating employment opportunities in areas with high joblessness rates

3. Community supports such as child care, mentoring programs, neighborhood support groups, violence prevention, disaster readiness and public health emergency preparedness and

[11] "Community Benefit Spending 101." *Community Benefit Insight*, Robert Wood Johnson Foundation, RTI International, Public Health Institute, https://www.communitybenefitinsight.org/?page=info.cb101.

community disease surveillance "beyond what is required by accrediting bodies or government entities."

4. Environmental improvements to address "environmental hazards that affect community health such as alleviation of water or air pollution," the safe removal or treatment of garbage and waste products, and other activities to protect the community from environmental hazards (other than expenses made to comply with legal requirements)
5. Leadership development and training for community members such as training in conflict resolution, civil, cultural, or language skills, and medical interpreter skills
6. Coalition building such as community coalitions to address health and safety issues
7. Community health improvement advocacy such as efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation
8. Workforce development, including recruiting physicians and other health professionals to underserved areas

Table 18 displays the thirteen hospitals that provided community building activities in 2020. In total, $7.7 million was expended, and 75% of that was provided by Yale New Haven Hospital ($3.4 million), and Connecticut Children's ($2.4 million). Over the five observed years, these two hospitals have been the primary drivers of community building activities in Connecticut.

Community building activities are a pathway for hospitals to address social determinants of health and health inequities identified in their CHNAs. Therefore, OHS would like to explore with hospitals how to include more community building in their community benefit services and activities.

Table 18

Community Building

	Hospital	Amount
1	Yale New Haven	$ 3,416,953.00
2	Connecticut Children's	$ 2,463,106.00
3	Danbury	$ 730,018.00
4	Greenwich	$ 572,397.00
5	Hartford	$ 299,314.00
6	St. Mary's	$ 66,880.00
7	St. Vincent's	$ 64,124.00
8	Lawrence + Memorial	$ 58,664.00
9	MidState	$ 40,820.00
10	Backus	$ 18,597.00
11	Bridgeport	$ 15,514.00
12	Middlesex	$ 12,756.00
13	St. Francis	$ 7,013.00
	Total	**$ 7,766,156.00**

Federal Recommendations

The United States Government Accountability Office (GAO) was tasked with auditing the IRS' ability to oversee nonprofit hospitals' community benefit programs. In October 2020, the GAO released a report to the public recommending Congress and the IRS make changes to improve oversight of community benefit programs.[12] Notably, the GAO found that the IRS "does not have a well-documented process to ensure that those [community benefit] activities are being reviewed." Moreover, the "IRS was unable to provide evidence that it conducts reviews related to hospitals' community benefits because it does not have codes to track such audits."

The GAO made one recommendation for Congressional action:

1. **Congress should consider specifying in the IRC what services and activities it considers sufficient community benefit**

The Internal Revenue Code (IRC) and the standard the IRS uses to see if community benefit was demonstrated is described in the Overview section of this report. The GAO report shows several hospitals provided $0 in charity care, even though they are considered charitable organizations. Even more hospitals documented less than one percent in community benefit spending. OHS and hospitals would benefit if the federal government was more specific with what counts, and how much should be attributed to those services and activities.

The GAO made four recommendations for Executive action:

2. **The Commissioner of Internal Revenue should update Form 990, including Schedule H and instructions where appropriate to ensure that the information demonstrating the community benefits a hospital is providing is clear and can be easily identified by Congress and the public, including the community benefit factors**
3. **The Commissioner of Internal Revenue should assess the benefits and costs, including the tax law implications, of requiring tax-exempt hospital organizations to report community benefit expenses on Schedule H by individual facility rather than by collective organization and take action, as appropriate**
4. **The Commissioner of Internal Revenue should establish a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard that would ensure hospitals' community benefit activities are being consistently reviewed**
5. **The Commissioner of Internal Revenue should establish specific audit codes for identifying potential noncompliance with the community benefit standard**

The GAO included in their report a letter from the IRS which enclosed their responses to the GAO's recommendations. The IRS did not comment on the Congressional recommendation, but agreed with the four recommendations for Executive action.

OHS supports the above recommendations and finds they will be beneficial, especially recommendation two (2). This recommendation if implemented will make the information on the Schedule H that

[12] *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status*, United States Government Accountability Office, 19 Oct. 2020, https://www.gao.gov/products/gao-20-679.

demonstrates the six community benefit factors clearer. This allows hospitals, community members, and the government to better understand if community benefit is being demonstrated.

Of the five recommendations, only recommendation four (4) has been implemented, and is considered closed by the GAO. The agency notes “In April and July 2021, IRS updated the guidance for reviews under the ACA Hospital Review group. This group performs compliance reviews of tax-exempt hospital organizations at least once every three years to determine if they are compliant with community benefit standard of Rev. Rul. 69-545 in addition to the requirements outlined in § 501(r). Those updates add instructions for employees to document case files with relevant facts and circumstances considered during their review that determine whether the hospital organization satisfies the community benefit standard for exemption. These actions will help IRS ensure it is effectively reviewing hospitals' community benefit activities.”

Appendix A

Sec. 19a-127k. Community benefits programs. Penalty. (a) As used in this section:

(1) "Community benefits program" means any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital in accordance with guidelines established pursuant to subsection (c) of this section;

(2) "Managed care organization" has the same meaning as provided in section 38a-478;

(3) "Hospital" has the same meaning as provided in section 19a-490.

(b) On or before January 1, 2005, and biennially thereafter, each managed care organization and each hospital shall submit to the Healthcare Advocate, or the Healthcare Advocate's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

(c) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the organization's or hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas in developing and implementing the program and in defining the targeted populations and the specific health care needs it should address. In doing so, the governing body or management of the organization or hospital shall give priority to the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7; and

(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.

(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the biennial report required by subsection (b) of this section the status of the program, if any, that the organization or hospital established. If the managed

care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the results of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (c) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.

(e) The Healthcare Advocate, or the Healthcare Advocate's designee, shall, within available appropriations, develop a summary and analysis of the community benefits program reports submitted by managed care organizations and hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, 2005, and biennially thereafter, the Healthcare Advocate, or the Healthcare Advocate's designee, shall make such summary and analysis available to the public upon request.

(f) The Healthcare Advocate may, after notice and opportunity for a hearing, in accordance with chapter 54, impose a civil penalty on any managed care organization or hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.

Appendix B

Total community benefit documented by grouping in 2020:

1. Yale New Haven Health Services - $751 million
2. Hartford Healthcare - $351.5 million
3. Independent Hospitals - $263.5 million
4. Nuvance Health - $122.4 million
5. Trinity Health of New England - $120.2 million

Average hospital community benefit documented by grouping in 2020:

1. Yale New Haven Health Services - $187.7 million
2. Nuvance Health - $61.2 million
3. Trinity Health of New England - $50.2 million
4. Independent Hospitals - $43.9 million
5. Hartford Healthcare – $40 million

Median hospital community benefit documented by grouping in 2020:

6. Yale New Haven Health Services - $81.3 million
7. Nuvance Health - $41.9 million
8. Independent Hospitals – $38.6 million
9. Hartford Healthcare - $34.3 million
10. Trinity Health of New England - $29.3 million

Table 19 provides by nonprofit hospital, the amount of total community benefit documented in 2020.

Table 19

	Total Community Benefit	
1	Yale New Haven	$ 535,152,756.00
2	Hartford	$ 137,030,506.00
3	Bridgeport	$ 103,803,268.00
4	Connecticut Children's	$ 87,866,460.00
5	St. Francis	$ 87,516,901.00
6	Danbury	$ 80,531,151.00
7	Stamford	$ 69,894,284.00
8	Greenwich	$ 58,955,477.00
9	Lawrence + Memorial	$ 53,118,507.00
10	Middlesex	$ 52,272,141.00
11	Central Connecticut	$ 50,118,006.00
12	Norwalk	$ 41,908,657.00
13	St. Vincent's	$ 35,075,690.00
14	Backus	$ 34,302,895.00
15	MidState	$ 31,252,030.00
16	St. Mary's	$ 29,380,784.00
17	Bristol	$ 25,124,045.00
18	Griffin	$ 16,753,304.00
19	Day Kimball	$ 11,631,642.00
20	Windham	$ 6,126,919.00
21	Charlotte Hungerford	$ 5,200,784.00
22	Johnson Memorial	$ 3,365,740.00
	Total	**$ 1,556,381,947.00**

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