CONNECTICUT
Health Strategy

Hospitals' Community Benefit Summary and Analysis Report FY 2024

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

June 1, 2026

Table of Contents

Acknowledgements v
Authors v
Acronyms v
Executive Summary 1
About this report 1
Key Findings 2
Community Benefits Background 5
Federal Oversight 5
Connecticut Oversight 8
Data Analysis 10
Connecticut's Nonprofit Hospital Community Benefit Reported to the IRS 11
Community Benefits Multi-Year Analysis (HFY 2016 –HFY 2024) 11
Community Benefits Reported to the IRS (HFY 2024) 13
Unreimbursed Medicaid Costs 14
Community Building Reported to the IRS (HFY 2024) 15
Other Investments (Implementation Strategies) to meet identified needs (HFY 2024) 17
Other Investments: Additional Implementation Strategy expenses 19
Other Investments (Implementation Strategy) expenses that overlap with Community Benefit 20
Other Investments (Implementation Strategy) expenses that overlap with Community Building 24
Financial Assistance Policy and Bad Debt 26
Key Highlights 27
Financial Assistance Policy Analysis 29
Free care 29
Discounted Care 31
Total Bad Debt reported to the Internal Revenue Service 31
Emergency Medical Care Policy 33
Debt Collection Recovery Summary 34

Key Highlights 36
Community Boards 40
National Landscape 41
What are other states doing? 41
Notable Legislative Activity 41
Recommendations 44
Enhancing Analysis 44
Alternative Strategies 45
Strengthening Community Benefit in Connecticut 45
Federal Accountability 46
Methodology 47
Sources 47
Hospitals Reviewed 47
Data Analyzed 47
CHNA and Other Investments (Implementation Strategy) Data 47
Nonprofit Hospitals' Community Benefit Expenses 48
Hospitals' Annual Status Reports 48
Financial Assistance Policy, Emergency Medical Care Policy, and Billing and Collections Data 48
Connecticut Nonprofit Hospitals' Community Boards 49
Glossary 50
Appendix A: Other Investments (Implementation Strategy) by Identified Community Health Need by hospital (HFY 2024) 54
Appendix B: 59
Appendix C: Community Benefit expenses reported to the IRS by Hospital (HFY 2016-2024) 60
Appendix D: Federal Poverty Guidelines for the contiguous states (2024) 62
Appendix E: Total Bad Debt reported to the IRS (HFY 2016-2024) 63

Table of Figures/Tables

Figure 1. Community Benefit Expenses reported to the IRS (2016-2024) 11
Figure 2. Community Benefit Expenses reported to the IRS (2016-2024) by category 12
Figure 3. Community Benefits Expenses reported to the IRS by category (2024) 13
Figure 4. Community Building Expenses reported to the IRS (2024) 16
Table 1. Other Investments (Implementation Strategy) Expenses by Hospital (2024) 18
Table 2 Other Investments (Implementation Strategy) that do not meet IRS Community Benefit or Community Building criteria 19
Table 3. IS Expenses as share of hospitals' total Community Benefit expenses 22
Table 4. Community Benefit Expenses reported to the IRS and IS expenses meeting IRS Community Benefit criteria as reported to OHS 23
Table 5. Community Building Expenses and IS expenses meeting criteria (2024) 25
Table 6. Total bad debt attributable to patients who were eligible for Financial Assistance Policy but did not receive it (2016-2024) 28
Table 7 Health System/Hospital's Household Income Ceilings for Free Care for an Individual and a Family of Four (2024) 30
Table 8. Health System/Hospital's Household Income Ceilings for Discounted Care for an Individual and a Family of Four (2024) 31
Figure 5. Bad Debt vs Charity Care (2016-2024) 32
Table 9. Total Bad Debt and Charity Care year-over-year percentage change (2016-2024) 32
Table 10. Hartford Healthcare Health System Debt Recovery Rate 37
Table 11. Trinity Health System Debt Recovery Rate 37
Table 12. Nuvance Health System Debt Recovery Rate 38
Table 13. Single Hospital Health System Debt Recovery Rate 38
Table 14. Yale New Haven Health System Debt Recovery Rate 39
Table 15. Comparative Analysis of Community Benefit Policies 42

Acknowledgements

The Connecticut Office of Health Strategy expresses appreciation to the individuals and organizations who provided invaluable contributions to advance this work. We extend sincere thanks to the Connecticut hospitals who submit the data analyzed in this report.

Authors

Carlos Sosa-Lombardo
Elisa Neira-Hamada, LMSW

Acronyms

ACA.....Patient Protection and Affordable Care Act
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
HFY.....Hospital's Fiscal 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
OHS.....Office of Health Strategy
REL.....Race, Ethnicity, and Language
YNHH.....Yale New Haven Hospital

Executive Summary

About this report

Connecticut General Statute §19a-127k requires all nonprofit hospitals in Connecticut to submit an Annual Status Report 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 their communities 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 the hospital's fiscal year (HFY) 2024 of financial allocations from 23 acute care nonprofit hospitals as reported to the IRS for community benefits and community-building activities. The report analyzes other expenses including activities addressing community needs identified through a Community Health Needs Assessment (CHNA) every three years. The report also provides an overview of hospitals' financial assistance policies as these policies represent a critical component of community benefit.

It is also important to note that this report is a compilation of information provided by the hospitals that has not been independently verified. This includes what hospitals reported as a significant portion of their Community Benefit contributions as being necessary to cover unreimbursed Medicaid costs. Federal reporting submitted by hospitals and State calculation of the unreimbursed costs of treating Medicaid patients differ. The two measures used, IRS Form 990 Schedule H and the State's calculation of the percentage of cost of treating Medicaid patients that is covered by Medicaid payments, include different factors and cannot be directly compared. See **Unreimbursed Medicaid Costs** for additional information.

Key Findings

Total Community Benefits and Investments: Hospitals reported a combined net total of $2.18 billion in Community Benefits and Community Building expenses and other community investments in HFY 24. This includes $2.13 billion in Community Benefit expenses, $13.5 million in Community Building activity expenses and $42.3 million in Other Investments that primarily support community needs identified by hospitals.

Breakdown of Financial Calculations

Expense Categories	Total Reported Expenses	Other investments that overlap with Community Benefit and Community Building	Net Total
Community Benefit	$2,132,546,333.00	$868,304,798.22	$2,132,546,333.00
Community Building	$13,586,314.00	$83,721.00	$13,586,314.00
Other community investments	$910,705,674.50		$42,317,155.28
Totals	$3,056,838,312.50	($868,388,519.22)	**$2,188,449,803.28**

Community Benefit and Community Building Activities are federally defined. Other investments are activities that primarily support community needs identified by hospitals that may overlap with Community Benefit or Building activities. The $42.3 million in Other Investments reported to OHS do not qualify as community building or community benefit expenditures under IRS regulations.

Community Benefit Expenditures

Expenditures: Hospitals reported $2.18 billion in community benefit expenditures, representing 13% of total hospital expenses. During the same period, all 23 nonprofit acute care hospitals collectively reported $17.29 billion in total revenue and $16.81 billion in total expenses.

- **Growth from 2023:** the total community benefit expense for acute care nonprofit hospitals increased by $150 million (a 7.4% increase), rising from $2.03 billion to $2.18 billion.
- **Top three community benefit expenditures:** Hospitals reported the following top expenditures: 1. Unreimbursed Medicaid Costs totaling $1.17 billion (55%); 2. Health Professions Education totaling $313.8 million (14.7%); 3. Financial Assistance or charity care totaling $308.5 million (14.4%).
- **Unreimbursed costs of treating Medicaid patients:** Hospitals reported $1.17 billion in unreimbursed Medicaid costs, accounting for 55% of total community benefit expenditures for fiscal year 2024. This represents a $69 million decrease, or 5.6% reduction, in unreimbursed Medicaid costs compared to HFY 2023**.** See **Unreimbursed Medicaid Costs** for additional detail**.**
- **Financial assistance (charity care):** Hospitals provide charity care when the patient meets the hospital's Financial Assistance Policy. In 2024, charity care rose from $283.0 million to $308.5 million. Notably, charity care rose for the second time since 2019. The overall increase in charity care expenditure occurred during a period marked by Medicaid unwinding.
- **Financial assistance policies:** Most hospitals offer financial assistance or free care for households earning less than 250% of the Federal Poverty Level (FPL). However, financial eligibility standards vary across hospitals, and some set the threshold for free care at 200% of FPL or $30,120. An individual working full-time at minimum wage, earning $32,635 per year, would not qualify for free care at these hospitals.

Community Building

Community Building Investments: In HFY 2024, hospitals reported $13.6 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.

Other Investments (Implementation Strategies) Addressing Community Needs

Connecticut hospitals identified a range of community needs in their Community Health Needs Assessment (CHNA). These needs were categorized into broader 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 to address identified needs: Hospitals reported a total of $910.7 million in investments addressing community needs identified through their CHNA process. Most of this investment, $868.3 million, also qualifies as Community Benefit investment under federal guidelines. Of the $868.3 million total, hospitals attribute 65% to unreimbursed costs for treating Medicaid patients, which are reported as community benefit investments addressing identified community needs.

Area of Focus	Amount	Number of Hospitals
Access to Care, Reducing Barriers, & Healthcare Disparities	$830,072,465.70	21
Behavioral Health (Mental Health & Substance Use)	$29,745,869.03	15
Preventive Health (Disease Prevention & Wellness)	$6,133,064.00	15
Other	$5,286,573.01	13
Food Security & Quality	$1,550,872.50	12
Maternal Wellness & Child Health Improvement	$6,641,666.26	12
Chronic Disease Management	$1,158,273.00	12
Workforce Development	$15,182,698.00	8
Access to Housing	$13,304,310.00	6
Culturally Competent Care	$1,061,301.00	4
Violence Prevention	$568,582.00	2
Total	**$910,705,674.50**	

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

The IRS also 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

---

[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

2. Maintain a board of directors that represents the community
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 policies (FAP). The ACA requires each hospital facility to conduct a Community Health Needs Assessment (CHNA) and establish an Implementation Strategy (IS), also referred to as Community Health Improvement plan (CHIP) by hospitals in Connecticut.[7]

The CHNA identifies community health priorities and strengths. The IS, 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 HFY 2021/2022 with updates expected in HFY 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

[7] Internal Revenue Service. (n.d..). Community health needs assessment for charitable hospital organizations - Section 501(r)(3). Retrieved form https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

B. Total other benefits formed by the following subcategories:
   - Community health improvement services and community benefit operations
   - Health professions education
   - Subsidized health services
   - Research
   - 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 has no mechanism 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 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.

[8] U.S. Government Accountability Office. (2020). 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*

Information regarding these audits is not yet available.[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 Service Report.[11]

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 Implementation Strategy (IS)/Community Health Improvement Plan (CHIP) intended to address health needs identified through a Community Health Needs Assessment but OHS does not verify this information.

The Annual Status Report 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/IS
- A description of any major changes to the proposed Implementation Strategy/IS and associated hospital actions

[10] Rosenberg, T. R., & Arroyo, E. (2024). 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

- A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's Implementation Strategy/IS

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.

Data Analysis

The main data sources used to inform analysis of Connecticut hospitals' community benefit expenditures and investments for this report include:

- Federal data as reported by hospitals to the IRS using Schedule H, Form 990 detailing community benefit expenses and community building expenses.
- State data as reported by hospitals to OHS through an Annual Status Report documenting investments made by hospitals to address community needs identified through the Community Health Needs Assessments (CHNAs).

Numbers included in the narrative of this report have been rounded for clarity and ease of presentation. Minor discrepancies occur when aggregating totals or calculating percentages. All tables contain complete, unrounded numbers.

Limitations

The community benefit expense data presented in this report are entirely based on figures reported by hospitals to the IRS, without underlying calculations or documentation. OHS reviews hospitals' IRS filings to compile this report but cannot perform independent calculations or validations based on those filings.

Hospitals submit Schedule H (Form 990) to the IRS, following federal instructions that include worksheets for calculating unreimbursed Medicaid costs and other community benefit categories. However, those worksheets and calculation details are not available to OHS, and hospitals may use their own methodologies when determining totals. As a result, figures derived from IRS filings represent self-reported, aggregated data. See **Federal Oversight** for greater detail.

Separately, hospitals submit an annual status report form to OHS documenting how they are investing resources to address community needs identified in their Community Health Needs Assessments (CHNAs) and Implementation Strategies (IS) to address prioritized health needs. These submissions complement the federal community benefit framework and provide OHS with additional narrative and programmatic information, but do not include detailed financial calculations. See **Connecticut Oversight** for greater detail.

Data Analysis

Federal reporting submitted by hospitals and State calculation of the unreimbursed costs of treating Medicaid patients differ. The two measures used, IRS Form 990 Schedule H and the State's calculation of the percentage of cost of treating Medicaid patients that is covered by Medicaid payments, include different factors and cannot be directly compared. See **Unreimbursed Medicaid Costs** for additional information.

The data analysis that follows is based on hospitals' federal Community Benefit reporting and should be interpreted with these limitations in mind.

Connecticut's Nonprofit Hospital Community Benefit Reported to the IRS

Community Benefits Multi-Year Analysis (HFY 2016 –HFY 2024)

This section provides an overview of community benefits expenses reported to the IRS from HFY 2016 through 2024 by all 23 acute care nonprofit hospitals. **Figure 1** illustrates the net total community benefit expense in Connecticut over the past nine observed hospitals fiscal years as reported to the IRS. Notably, the 2024 total community benefit expense is roughly $100 million (4.93%) higher than the previous year (2023) and the highest since HFY 2016. For HFY16–HFY19, this graph includes hospitals that have since closed or consolidated and therefore are no longer required to submit reports.

Figure 1. Community Benefit Expenses reported to the IRS (2016-2024)

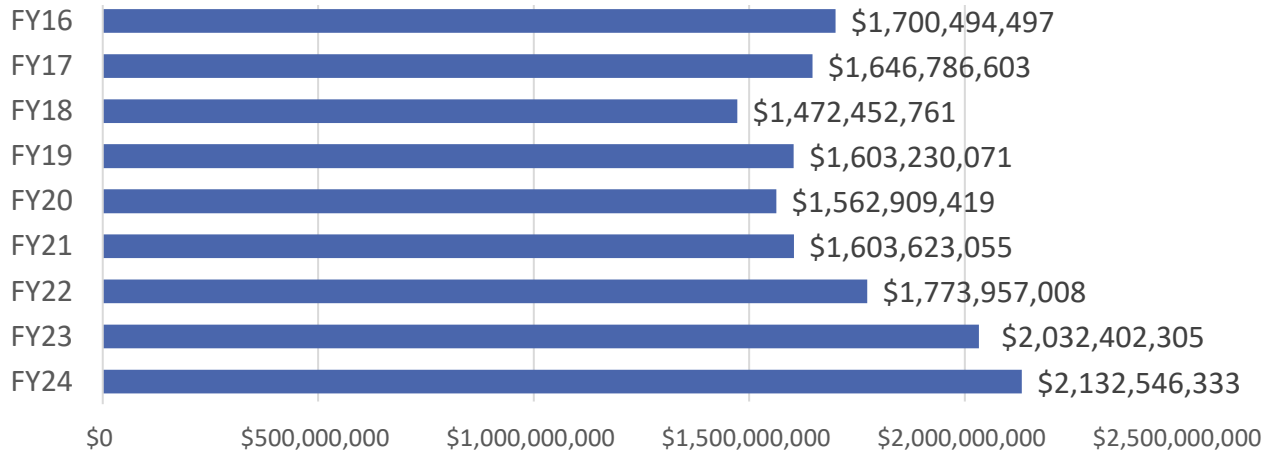
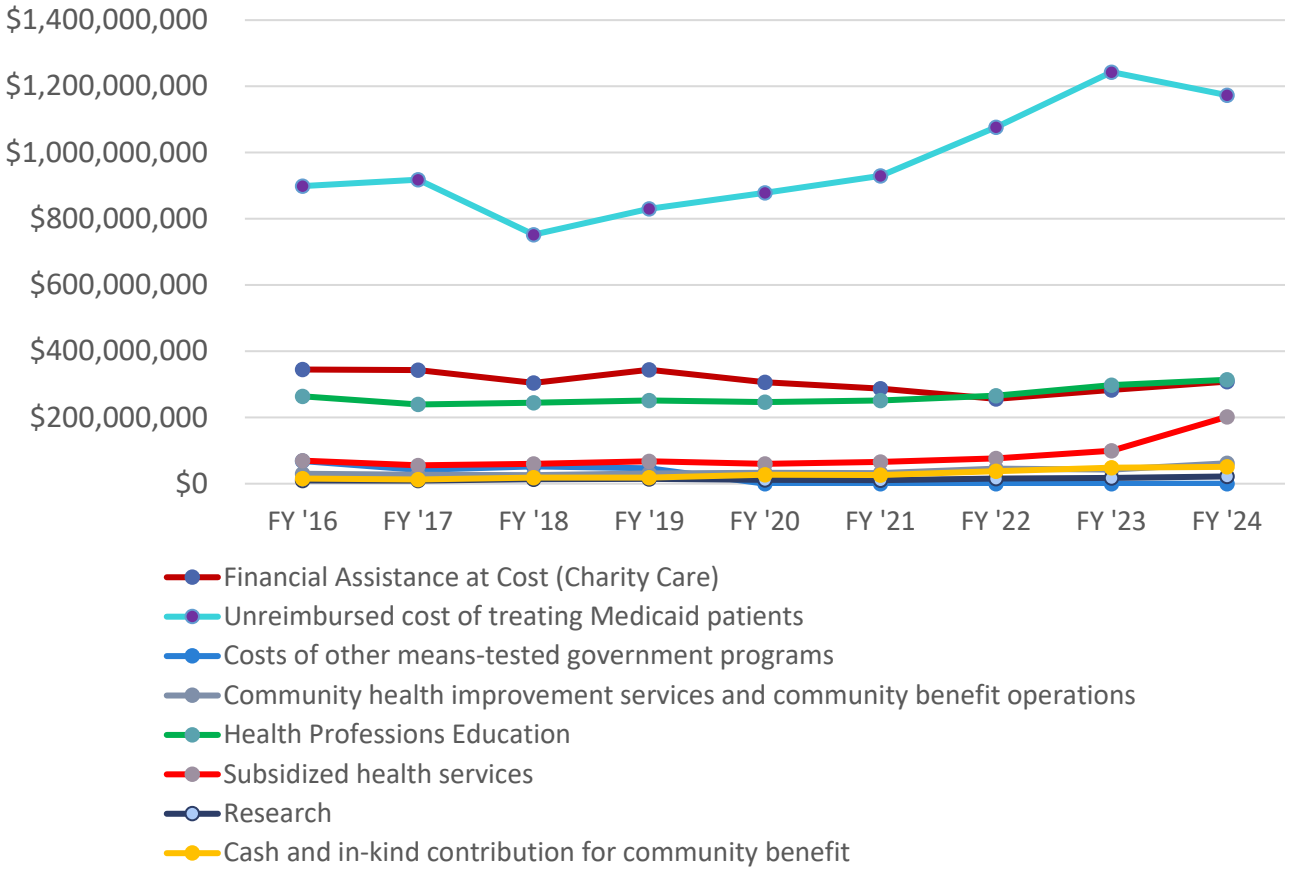


Figure 2 presents community benefit expenses reported to the IRS by category, from 2016–2024. According to IRS Schedule H filings, the 2024 year-over-year increase was driven

largely by a $103 million increase in Subsidized Health Services and a $25 million increase in Financial Assistance or Charity Care. However, Charity Care remains well below where it was in 2016. Charity Care investments were $344.8 million in 2016, compared to $308.5 million in 2024. Figure 2 also shows a $69 million decrease in what hospitals reported as unreimbursed costs for treating Medicaid patients.

Figure 2. Community Benefit Expenses reported to the IRS (2016-2024) by category



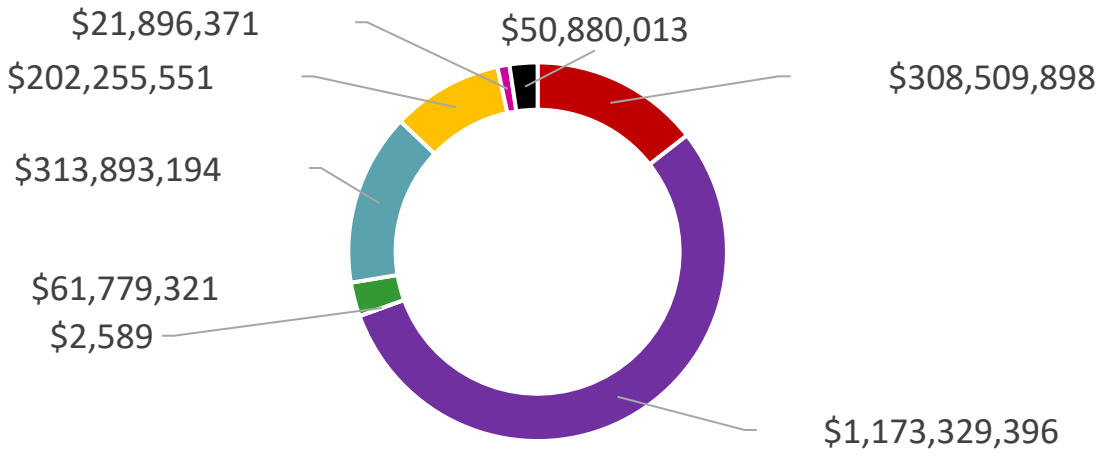
Appendix B: Community Benefit expenses reported to the IRS (HFY 2016-2024) shows the value reported for each of the eight IRS 990 Schedule H, Part I categories by hospital fiscal year (2016-2024). **Appendix C: Community Benefit expenses reported to the IRS by Hospital (HFY 2016-2024)** shows the total community benefit reported to the IRS by hospital and by hospital fiscal year (2016-2024). The Community Benefit Dashboard, an interactive online tool designed to provide greater access to hospital community benefit data, also provides details by hospital and health system.

Community Benefits Reported to the IRS (HFY 2024)

In 2024, Connecticut's acute care nonprofit hospitals reported to the IRS a total of $2.13 billion in community benefits. **Figure 3** illustrates the net community benefit expenses that were reported to the IRS in 2024. The top three expenses reported include:

1. $1.17 billion out of $2.13 billion of community benefit expenses were reported as unreimbursed costs of treating Medicaid patients
2. Over $313.8 million invested in Health Professions Education
3. $308.5 million in Financial Assistance (charity care)

Figure 3. Community Benefits Expenses reported to the IRS by category (2024)



Community Benefit Category	Total Expenses Reported to the IRS
Unreimbursed cost of treating Medicaid patients	$1,173,329,396
Health Professions Education	$313,893,194
Financial Assistance at Cost	$308,509,898
Subsidized health services	$202,255,551
Cash and in-kind contribution for community benefit	$50,880,013
Community health improvement services and community benefit operations	$61,779,321
Research	$21,896,371
Costs of other means-tested government programs	$2,589
Total	$2,132,546,333

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. OHS uses a different methodology to calculate a Medicaid payment to cost ratio that more accurately reflects Medicaid coverage of expense. The statewide Medicaid payment to cost ratio for fiscal year 2024 as published in the OHS Annual Report on the Financial Status of Connecticut Short Term Acute Care Hospitals indicates that Medicaid covers $0.87 of the expense of treating Medicaid patients. This 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.

Unreimbursed Medicaid costs represent a substantial share of hospitals' reported Community Benefit expenditures. The Internal Revenue Service (IRS) provides guidance for calculating and reporting these costs through Schedule H, Form 990. However, the State of Connecticut does not have access to the underlying calculations or worksheets hospitals use to determine Medicaid underpayment. Schedule H reports only an aggregate figure for unreimbursed Medicaid expenses, without detail on the assumptions or methodologies used to derive that amount.

As a result of these methodological differences, Medicaid payments may be more fully captured in the OHS analysis than in the unreimbursed Medicaid cost amounts hospitals report to the IRS. Current data submission requirements do not provide OHS with sufficient detail to determine specifically how each hospital has calculated the unreimbursed Medicaid costs reported to the IRS.

OHS is also unable, based on available data, to determine the specific amount of overstatement the aggregate $1.17 billion reported to the IRS may include. The State's calculation that Medicaid covers $0.87 cents on the dollar of Medicaid expenses suggests this difference is significant, even considering the hospitals' reported decrease in unreimbursed Medicaid costs compared to fiscal year 2023.

Community Building Reported to the IRS (HFY 2024)

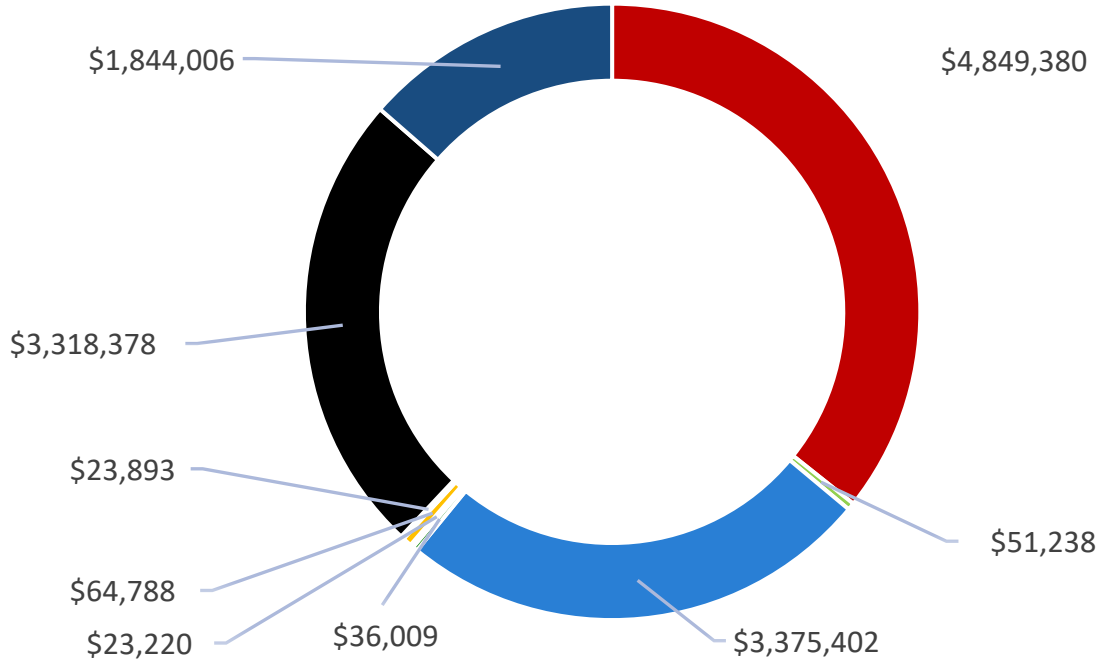
This section examines the total community building expenses reported to the IRS by all 23 acute care nonprofit hospitals in FY 2024. Community Building activities help build the capacity in the community to address health needs and often address the upstream factors and social determinants that impact 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 2024, Connecticut acute care nonprofit hospitals reported a total of $13.6 million in community building expenses to the IRS (Figure 4). In comparison, last HFY, hospitals reported a total of $8 million. The top three expenses reported for HFY 2024 include:

- $3.3 million in community support -Examples include but are not limited to childcare and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness efforts beyond regulatory requirements
- $4.8 million in physical improvements and housing - Examples include but are not limited to housing rehabilitation for vulnerable populations, removing harmful building materials (e.g., lead abatement), neighborhood improvement and revitalization, housing for vulnerable populations upon inpatient discharge, housing for seniors, and parks and playgrounds to improve physical activities
- $3.3 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

Figure 4. Community Building Expenses reported to the IRS (2024)



Community Building Category	Total Expenses Reported to the IRS
Other	$3,318,378
Community health improvement advocacy	$23,893
Community Support	`$3,375,402
Workforce development	$1,844,006
Coalition building	$64,788
Physical improvements and housing	$4,849,380
Economic development	$51,238
Leadership development and training for community members	$23,220
Environmental improvements	$36,009
Total	$13,586,314

Other Investments (Implementation Strategies) to meet identified needs (HFY 2024)

This section examines hospital expenditures on activities aimed at addressing identified community health needs, as outlined in the Implementation Strategy of each hospital. Acute care nonprofit hospitals report this information annually to OHS through a status report. Some of these expenditures overlap with the expenditures that hospitals report to the IRS through the 990 Form, Schedule H.

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 Implementation Strategy activities.

In total, $910.7 million out of $2.18 billion are expenses or investments directly tied to Implementation Strategy addressing a community need:

- $868.3 million out of $910.7 million overlap with Community Benefit expenditures reported to the IRS
- $83,721 out of $910.7 million overlap with Community Building expenditure reported to the IRS
- $42.3 million out of $910.7 million are additional investments that are not Community Benefit or Community Building

Table 1 outlines expenditures reported to OHS by hospital, while **Appendix A: Implementation Strategies expenses by Identified Community Health Need by hospital (HFY 2024)** 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.

Table 1. Other Investments (Implementation Strategy) Expenses by Hospital (2024)

Hospital	IS Expenses that also count as community benefit	IS Expense that also counts as community building	Additional IS Expenses	Total IS expenses	IS Expenses as share of hospital's total expenditures
Backus	$1,211,180.00	$0.00	$0.00	$1,211,180.00	0.2%
Bridgeport	$112,899,231.91	$0.00	$8,668,657.79	$121,567,889.70	13%
Bristol	$0.00	$0.00	$24,096.36	$24,096.36	0.01%
Central Connecticut	$716,790.00	$0.00	$0.00	$716,790.00	0.1%
Charlotte Hungerford	$1,020,015.39	$0.00	$0.00	$1,020,015.39	0.5%
Connecticut Children's	$21,864,753.00	$0.00	$0.00	$21,864,753.00	4%
Danbury	$389,897.50	$0.00	$2,689,206.57	$3,079,104.07	0.3%
Day Kimball	$53,199.00	$0.00	$0 .00	$53,199.00	0.04%
Greenwich	$47,021,389.80	$0.00	$767,622.75	$47,789,012.55	9%
Griffin	$22,524,048.00	$48,002.00	$0.00	$22,572,050.00	8%
Hartford	$9,202,018.98	$0.00	$0.00	$9,202,018.98	0.4%
Johnson Memorial	$32,000.00	$0.00	$70,000.00	$102,000.00	0.2%
Lawrence + Memorial	$48,629,584.07	$0.00	$519,363.94	$49,148,948.01	10%
Middlesex	$24,629,837.24	$0.00	$0.00	$24,629,837.24	5%
MidState	$794,018.00	$0.00	$0.00	$794,018.00	0.2%
Norwalk	$266,877.00	$8,583.00	$764,448.00	$1,039,908.00	0.2%
Sharon	$173,811.00	$2,185.00	$44,012.00	$220,008.00	0.3%`
St. Francis	$380,000.00	$0.00	$620,000.00	$1,000,000.00	0.1%
St. Mary's	$115,190.00	$0.00	$13,000.00	$128,190.00	0.04%
St. Vincent's	$14,219,638.00	$24,951.00	$0.00	$14,244,589.00	2%
Stamford	$112,763,931.69	$0.00	$23,916,427.96	$136,680,359.65	16%
Windham	$511,441.00	$0.00	$0.00	$511,441.00	0.4%
Yale New Haven	$448,885,946.64	$0.00	$4,220,319.91	$453,106,266.55	10%
Total	**$868,304,798.22**	**$83,721.00**	**$42,317,155.28**	**$910,705,674.50**	**5%**

Other Investments: Additional Implementation Strategy expenses

This subsection highlights expenditures towards IS 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 Implementation Strategy/Community Health Improvement Plans. These activities are funded through external funds and do not use hospitals' operating budgets.

Only twelve (12) hospitals reported IS expenses under this category. **Table 2** shows allocations towards IS activities that do not meet the federal Community Benefit or Community Building criteria. A total of $42.3 million out of $910.7 million in reported expenses falls under this category.

Key Highlights:

Stamford Hospital reported the largest investment in activities that do not meet the IRS Community Benefit criteria, with almost $24 million allocated. Stamford Hospital was followed by Bridgeport Hospital ($8.6 million), and Yale New Haven Hospital ($4.2 million) reporting investments that did not meet the IRS criteria.

Table 2 Other Investments (Implementation Strategy) that do not meet IRS Community Benefit or Community Building criteria

Hospital	Other Investments not meeting IRS criteria
Bridgeport	$8,668,657.79
Bristol	$24,096.36
Danbury	$2,689,206.57
Greenwich	$767,622.75
Johnson Memorial	$70,000.00
Lawrence + Memorial	$519,363.94
Norwalk	$764,448.00
Sharon	$44,012.00
St. Francis	$620,000.00
St. Mary's	$13,000.00
Stamford	$23,916,427.96
Yale New Haven	$4,220,319.91
Total	**$42,317,155.28**

Other Investments (Implementation Strategy) expenses that overlap with Community Benefit

In 2024, Connecticut acute care nonprofit hospitals reported a total of $2.13 billion in Community Benefit activities to the IRS. Hospitals reported $868.3 million out of the $2.13 billion towards IS activities meeting the IRS Community Benefit definition. Hospitals calculate these amounts using the Annual Status Report Form provided by OHS and identify which Implementation Strategy activities also meet the Community Benefit definition.

Table 3 shows this overlap. The data is broken down to align with the categories the IRS uses to define Community Benefit and indicates a wide range of alignment with identified community needs. For example, nearly all (76%) Community health improvement services and community benefit operations investments met the IRS community benefit definition.

The percentages presented in the Key Highlights differ from those shown in **Table 3** because they represent two distinct measures. Table 3 displays Implementation Strategy (IS) expenses as a share of each Community Benefit category reported to the IRS (i.e., the proportion within each category). In contrast, the Key Highlights describe the distribution of IS-related Community Benefit expenditures across categories (i.e., each category's share of the total $868.3 million in IS expenditures meeting the IRS definition). As a result, percentages in the Key Highlights will not match those in Table 3.

Key Highlights:

- **Unreimbursed Medicaid costs:** Hospitals identified the unreimbursed cost of treating Medicaid patients as *both* the largest share of total Community Benefit investment ($1.17 billion of $2.13 billion) *and* the largest single component of Implementation Strategy expenses meeting the IRS definition of community benefit.
    - Hospitals reported $563.3 million in unreimbursed Medicaid costs associated with IS activities, representing 65% of all other investments meeting the IRS definition
    - While all Connecticut hospitals reported unreimbursed Medicaid costs to the IRS, only seven hospitals reported Implementation Strategy expenses

addressing an identified community need (Yale New Haven Hospital accounts for 57% of the total $563.3 million)

- These expenditures included the following categories:
  - Access to care, reducing barriers and health disparities (98.6%)
  - Behavioral health (1.2%)
  - Maternal wellness and child health improvement (0.2%)

- **Other community benefit categories:** Hospitals reported investment that met the IRS Community Benefit definition in several other categories.
  - Financial assistance at cost (25% of all other investments meeting IRS criteria for community benefit)
  - Community health improvement services and community benefit operations (5%)
  - Subsidized health services (2%)
  - Health professions education and cash or in-kind contributions (<2%)
  - Cash and in-kind contributions for community benefit (<1%)
  - Research (<1%)

Table 3. IS Expenses as share of hospitals' total Community Benefit expenses

Community Benefit Category	Total Community Benefits Expenses reported to the IRS	Expenses allocated towards IS meeting IRS definition	IS Expenses as % of Category Total
Financial Assistance at Cost	$308,509,898.00	$218,532,483.85	71%
Unreimbursed costs of treating Medicaid patients	$1,173,329,396.00	$563,369,765.00	48%
Costs of other means-tested government programs	$2,589.00	$0.00	0%
Community health improvement services and community benefit operations	$61,779,321.00	$46,823,568.87	76%
Health Professions Education	$313,893,194.00	$17,107,462.90	5%
Subsidized health services	$202,255,551.00	$13,889,941.42	7%
Research	$21,896,371.00	$1,116,972.00	5%
Cash and in-kind contribution for community benefit	$50,880,013.00	$7,464,604.18	15%
Total	**$2,132,546,333.00**	**$868,304,798.22**	41%

Table 4 presents the total community benefit expenses reported to the IRS, the total expenses allocated to Other Investments (Implementation Strategy activities) that meet the IRS' community benefit definition, and the proportion of IS expenditures relative to total community benefit expenditures reported to the IRS by Hospital. By showing the proportion of Implementations Strategy (IS) expenditures relative to total community benefit spending, the table presents the extent to which hospitals are directing their reported community benefit resources toward activities intended to address community health needs identified through the CHNA process.

Key Highlights:

- Griffin and Stamford Hospitals stand out, allocating almost 100% of its reported community benefit expenses to IS activities

- Other hospitals with a high proportion of their community benefit expenses allocated to IS activities include Greenwich Hospital (84%) and Bridgeport Hospital (81%)
- Several hospitals allocated less than 1% of their community benefits expenses reported to the IRS towards IS activities

Table 4. Community Benefit Expenses reported to the IRS and IS expenses meeting IRS Community Benefit criteria as reported to OHS

Hospital	Community Benefit Expenses reported to the IRS (Form 990, Part I)	Expenses supporting IS activities that meet IRS Community Benefit criteria (Annual Status Report)	Expenses supporting IS as share of Total Community Benefit Expenditures
Backus	$46,871,00.00	$1,211,180.00	3%
Bridgeport	$139,727,694.00	$112,899,231.91	81%
Bristol	$29,806,394.00	$0	0.%
Central Connecticut	$75,674,848.00	$716,790.00	1%
Charlotte Hungerford	$14,494,456.00	$1,020,015.39	7%
Connecticut Children's	$143,682,043.00	$21,864,753.00	15.%
Danbury	$154,618,788.00	$389,897.50	0.2%
Day Kimball	$15,527,121.00	$53,199.00	0.3%
Greenwich	$55,927,174.00	$47,021,389.80	84%
Griffin	$22,528,933.00	$22,524,048.00	99%
Hartford	$221,794,048.00	$9,202,018.98	4%
Johnson Memorial	$5,326,630.00	$32,000.00	0.6%
Lawrence + Memorial	$86,759,999.00	$48,629,584.07	56%
Middlesex	$81,164,563.00	$24,629,837.24	30%
MidState	$35,913,346.00	$794,018.00	2%
Norwalk	$89,212,576.00	$266,877.00	0.3%
Sharon	$24,416,364.00	$173,811.00	0.7%
St. Francis	$109,911,738.00	$380,000.00	0.4%
St. Mary's	$32,528,268.00	$115,190.00	0.4%
St. Vincent's	$55,696,941.00	$14,219,638.00	25%
Stamford	$113,071,841,00	$112,763,931.69	99%
Windham	$12,388,399.00	$511,441.00	4%
Yale New Haven	$565,503,169.00	$448,885,946.64	79%
Total	**$2,132,546,333.00**	**$868,304,798.22**	**41%**

Other Investments (Implementation Strategy) expenses that overlap with Community Building

In 2024, Connecticut acute care nonprofit hospitals reported $13.6 million in Community Building activities to the IRS. Hospitals allocated $83,721 (0.6%) of that total towards IS activities meeting the IRS Community Building definition. Hospitals calculate these amounts using the Annual Status Report Form provided by OHS and identify which Implementation Strategy activities also meet the Community Building definition. The low proportion of community building expenditures allocated to IS 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 5** presents the total community building expenses reported to the IRS, the total expenses allocated to IS expenses that meet the IRS' community building definition, and the proportion of IS expenditures relative to total community building expenditures reported to the IRS.

Key Highlights:

- Only four hospitals reported IS expenditures that meet the IRS definition for community building (Griffin, Norwalk, Sharon and St. Vicent's)
- CT Children's Medical Center had the highest total community building expenses ($7 million) but did not allocate any of those resources toward IS activities that met IRS criteria

Table 5. Community Building Expenses and IS expenses meeting criteria (2024)

Hospital	Community Building Expenses reported to the IRS (Form 990, Part I)	Expenses supporting IS activities that meet IRS community building criteria (Annual Status Report)	Expenses supporting Implementation Strategy as share of Total Community Building Expenditures
Backus	$231,998.00	$0.00	0.00%
Bridgeport	$27,456.00	$0.00	0.00%
Bristol	$0.00	$0.00	0.00%
Central Connecticut	$330,289.00	$0.00	0.00%
Charlotte Hungerford	$56,877.00	$0.00	0.00%
Connecticut Children's	$7,302,304.00	$0.00	0.00%
Danbury	$55,877.00	$0.00	0.00%
Day Kimball	$0.00	$0.00	0.00%
Greenwich	$536,739.00	$0.00	0.00%
Griffin	$79,126.00	$48,002.00	60.67%
Hartford	$1,034,310.00	$0.00	0.00%
Johnson Memorial	$0.00	$0.00	0.00%
Lawrence + Memorial	$11,313.00	$0.00	0.00%
Middlesex	$158,248.00	$0.00	0.00%
MidState	$38,068.00	$0.00	0.00%
Norwalk	$53,385.00	$8,583.00	16.08%
Sharon	$2,586.00	$2,185.00	84.49%
St. Francis	$0.00	$0.00	0.00%
St. Mary's	$0.00	$0.00	0.00%
St. Vincent's	$24,951.00	$24,951.00	100%
Stamford	$0.00	$0.00	0%
Windham	$116,482.00	$0.00	0%
Yale New Haven	$3,526,305.00	$0.00	0%
Total	**$13,586,314.00**	**$83,721.00**	**0.6%**

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.

Bad debt refers to services a tax-exempt hospital expected to be paid for but ultimately was not. This differs from financial assistance/charity care, where the hospital did not anticipate payment because the patient qualified under the hospital's financial assistance policy and was determined to be unable to pay.

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).[12] 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 FAP-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.

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

Table 6 shows hospitals that have documented bad debt attributed to patients that would have been eligible under the organization's FAP but did not receive financial assistance.

Key Highlights

- Since 2016, hospitals reported a total of $129.4 million as debt attributable to FAP-eligible individuals who did not receive financial assistance. It rose sharply between 2019 and 2023. In 2024, it fell significantly to $5 million, a decrease of $21 million (80%) from the previous year
- Stamford Hospital reported the highest bad debt attributable to FAP-eligible individuals who did not receive financial assistance, totaling $72.6 million since 2019. The hospital had not reported any before 2019, but its bad debt attributed to FAP-eligible individuals who did not receive financial assistance grew significantly between 2019 and 2023, reaching $20.1 million in 2023. In 2024, Stamford didn't report any bad debt attributed to FAP-eligible individuals who did not receive financial assistance
- More than four out of five hospitals (82%) - 19 out of 23 – did not report any portion of bad debt attributable to FAP eligible individuals who did not receive financial assistance in HFY 2024, including some of the state's largest hospitals

Table 6. Total bad debt attributable to patients who were eligible for Financial Assistance Policy but did not receive it (2016-2024)

Hospital	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total
Backus	$2,184,007	$0	$0	$0	$0	$0	$0	$0	$0	$2,184,007
Bristol	$552,416	$713,430	$734,906	$1,511,080	$2,232,019	$2,204,992	$2,111,660	$2,491,748	$2,563,996	$15,116,247
Connecticut Children's	$0	$1,222,649	$583,148	$1,491,835	$1,241,832	$776,849	$1,315,952	$718,201	$1,215,706	$8,566,172
Danbury	$1,287,818	$1,156,186	$510,371	$670,095	$0	$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	$129,218	$2,484,273
Manchester	$2,300,726	$0	$0	$0	$0	$0	$0	$0	$0	$2,300,726
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	$1,283,598	$14,520,827
Milford	$300,473	$162,099								$462,572
Norwalk	$1,888,503	$1,984,320	$402,370	$437,479	$0	$0	$0	$0	$0	$4,712,672
Rockville	$1,504,520	$0	$0	$0	$0	$0	$0	$0	$0	$1,504,520
St. Mary's	$1,330,172	$0	$0	$0	$0	$0	$0	$0	$0	$1,330,172
Stamford	$0	$0	$0	$9,235,549	$11,494,354	$14,443,023	$17,357,551	$20,089,153	$0	$72,619,630
Total	**$12,818,252**	**$6,850,819**	**$4,119,803**	**$15,356,817**	**$16,603,302**	**$19,296,176**	**$23,021,120**	**$26,167,481**	**$5,192,518**	**$129,426,288**

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.[13]

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 2024 Federal Poverty Guidelines for the contiguous states, including Connecticut, are provided in **Appendix D: Federal Poverty Guidelines for the contiguous states (2024)**.

Under these guidelines 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 four (4) may qualify for discounted care if their household income is at or below $93,600, or 300% of the Federal Poverty Level (FPL) depending on the hospital's policy.

Free care

OHS compiled hospitals' maximum household income requirements for free care (100% discount), in **Table 7**. 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.

[13] 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

Table 7 Health System/Hospital's Household Income Ceilings for Free Care for an Individual and a Family of Four (2024)

Health System/Hospital	FPL Free Care	Individual Income	Family of 4 Income
Nuvance Health Network	300%	$45,180	$93,600
Bristol	250%	$37,650	$78,000
Connecticut Children's	250%	$37,650	$78,000
Day Kimball	250%	$37,650	$78,000
Griffin	250%	$37,650	$78,000
Hartford Health Care	250%	$37,650	$78,000
Stamford	250%	$37,650	$78,000
Yale New Haven Health Services	250%	$37,650	$78,000
Middlesex	200%	$30,120	$62,400
Day Kimball	200%	$30,120	$62,400
Trinity Health of New England	200%	$30,120	$62,400

At 200% of the FPL, an individual must earn at or below $30,120 to qualify for free care (**Appendix D: Federal Poverty Guidelines for the contiguous states (2024)**). Under Connecticut's Medicaid income eligibility, an individual with no dependents must have an annual income at or below 138% FPL at or $20,783.[14]

Additionally, in 2024 the Connecticut minimum hourly wage was $15.69.[15] A Connecticut resident earning a minimum wage annual salary of $32,635 would exceed the 200% FPL threshold ($30,120) for free care used by Middlesex Hospital, St. Mary's Hospital, St. Francis Hospital, and Johnson Memorial Hospital.

[14] Connecticut Department of Social Services. (2024, October 1). *Connecticut HUSKY Health Program annual income guidelines.*

[15] 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

Discounted Care

As shown in **Table 8**, discounted charity care eligibility varies by hospital and health system. In 2024, 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 8. Health System/Hospital's Household Income Ceilings for Discounted Care for an Individual and a Family of Four (2024)

Health System/Hospital	FPL Discounted Care	Individual Income	Family of 4 Income
Yale New Haven Health Services	550%	$80,830	$171,600
Hartford HealthCare	550%	$80,830	$171,600
Connecticut Children's	500%	$75,300	$156,000
Middlesex	500%	$75,300	$156,000
Bristol	400%	$60,240	$124,800
Day Kimball	400%	$60,240	$124,800
Griffin	400%	$60,240	$124,800
Nuvance Health Network	400%	$60,240	$124,800
Rockville	400%	$60,240	$124,800
Stamford	400%	$60,240	$124,800
Trinity Health of New England	400%	$60,240	$124,800

For example, under Yale New Haven Health Services' policy, a family of four earning $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 and Bad Debt

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 five years, than they have provided charity care to patients (**Figure 5**). Charity care is reported under the Financial Assistance at Cost category in IRS Form 990, Schedule H.

Figure 5. Bad Debt vs Charity Care (2016-2024)

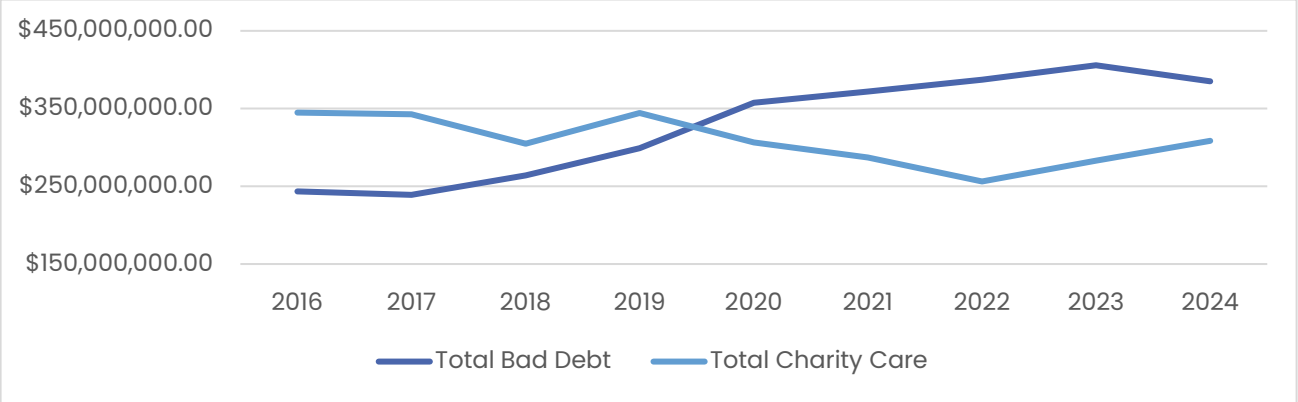


Figure 5 shows the data on bad debt and charity care from 2016-2024. In 2016, Connecticut's nonprofit hospitals provided approximately $344 million in charity care, and reported approximately $243 million in total bad debt. As shown in **Table 9**, bad debt rose between 2018 and 2023 and charity care expenditure gradually increased after 2022, growing to more than$308 million in 2024. The overall increase in charity care expenditure occurred during a period marked by Medicaid unwinding. Between 2016 and 2024, hospitals reported a total of $2.9 billion in total bad debt and a total of $2.7 billion in charity care. Bad debt decreased by five percent to $385 million in 2024, the first decrease since 2017.

Table 9. Total Bad Debt and Charity Care year-over-year percentage change (2016-2024)

Financial Assistance Policy and Bad Debt

Fiscal Year	Total Bad Debt	% Change Over Year	Fiscal Year	Total Charity Care	% Change Over Year
2016	$243,435,616	-	**2016**	$344,844,514	-
2017	$239,000,105	-2%	**2017**	$342,741,512	-1%
2018	$264,208,955	11%	**2018**	$304,728,594	-11%
2019	$299,056,304	13%	**2019**	$344,298,104	13%
2020	$357,295,411	19%	**2020**	$306,485,259	-11%
2021	$371,816,203	4%	**2021**	$287,077,698	-6%
2022	$387,214,683	4%	**2022**	$256,221,292	-11%
2023	$405,739,126	5%	**2023**	$283,030,796	10%
2024	$385,034,975	-5%	**2024**	$308,509,898	9.00%
Total	**$2,952,801,378**		Total	**$2,777,937,667**	

Appendix E: Total Bad Debt reported to the IRS (HFY 2016-2024) provides a breakdown of total bad debt by hospital. The Connecticut Hospital Community Benefit Dashboard includes data on both charity care/financial assistance at cost and bad debt for each of the state's 23 short term acute care nonprofit hospitals.

Emergency Medical Care Policy

In addition to having a financial assistance policy, hospitals must have an Emergency Medical 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.[16]

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.

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 initiate a collection action before that period expires. The IRS established specific rules regarding ECAs that hospitals may take against patients who fail to pay their medical bills. Each of the 23 hospitals analyzed in this report has a debt collection policy that outline the types of action they may pursue, which can include what is allowable under the IRS rules.

For more details on ECAs, see the Hospital Reporting System (HRS) Report 18 on OHS' web portal, which has hospital collection policies and agent information for each of the 23 hospitals analyzed in this report

As per IRS guidelines, these actions can include:[17]

- Selling an individual's debt to another party, such as a collection agency

[16] 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

[17] 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

- 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

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.[18, 19]

This report does not include data on how many individuals face ECAs, or the types used, because that information is not available to OHS. **Table 10** through **Table 14** summarize each hospital's debt recovery rates by health system. The debt recovery rate for some legal firms may exceed 100% because they can place ECAs that can take several years to resolve. Recoveries recorded in a given fiscal year often reflect collections on placements from prior years rather than the current year alone.

[18] 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/

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

Note: Governor Lamont signed legislation[20] 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 agency. 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 has erased $198 million of medical debt for nearly 160,000 residents as of December 2025.[21]

Key Highlights

- Norwalk Hospital had high recovery rates, particularly due to LoveJoy and Rimer's performance, which had the highest recovery rate at 951.45%.
- Danbury Hospital, driven by Simko Law Firm's efforts, had a 803.34% recovery rate.
- Hospitals from the Yale New Haven Health system have a diverse range of collection agencies, and their collection rates range from 0% to 45.4%.
- Hospitals from Hartford Healthcare Health System have three collection agencies and their collection rates range from 2.34% to just over 7.42%
- Hospitals from Trinity Healthcare Health System utilize several different collection agencies. Their collection rates range from 9% to just over 17.5%.

[20] 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

[21] Office of Governor Ned Lamont. (2025). Governor Lamont announces additional 40,000 Connecticut residents to have medical debt erased: Letters being mailed this week under third round of the Lamont administration's medical debt erasure initiative [Press release]. CT.gov.

Table 10. 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 11. Trinity Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Johnson Memorial	American Adjustment Bureau	17.50%
Saint Francis	Nair and Levin	10.89%
	American Adjustment Bureau	11.93%
Saint Mary's	American Adjustment Bureau	9%
	Parallon	15%

Table 12. Nuvance Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Danbury	Credit Center Incorporated	7.46%
	Simko Law Firm	803.34%
	American Adjustment Bureau	11.63%
Norwalk	Credit Center Incorporated	31.53%
	LoveJoy and Rimer	951.45%
	Eastern Collections	0%
Sharon	Collection Bureau of the Hudson Valley	22.25%
	SOS	1.76%

Table 13. Single Hospital Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Bristol	American Adjustment Bureau	11.75%
Connecticut Children's	American Adjustment Bureau	7.5%
Day Kimball	Sherloq	13%
	Michalik, Bauer, Silvia, & Cicarillo LLP	33%
Griffin	Parallon	11.06%
	American Adjustment Bureau	22.27%
Middlesex	Arcadia	6.72%
Stamford	ROI	0%
	Mark Sank & Associates	36.2%
	Law Offices Howard Lee Schiff	0%
	MAF	0%
	RSI	2.3%

Table 14. Yale New Haven Health System Debt Recovery Rate

Hospital	Contracted Collection Agent	Recovery Rate
Bridgeport	American Adjustment Bureau	6.4%
	Arcadia	4.9%
	Links	4.1%
	DCM Bankruptcy	0.7%
	DCM Probate	5.6%
	BDM International Collections	37.9%
	Sunbelt International Collections	3.0%
Greenwich	American Adjustment Bureau	9.5%
	Arcadia	7.8%
	Links	4.5%
	DCM Bankruptcy	0.0%
	DCM Probate	15.8%
	BDM International Collections	22.1%
	Sunbelt International Collections	20.1%
Lawrence + Memorial	American Adjustment Bureau	8.8%
	Arcadia	6.6%
	Links	5.3%
	DCM Probate	6.7%
	BDM International Collections	35.0%
	Sunbelt International Collections	45.4%
Yale New Haven	American Adjustment Bureau	6.1%
	Arcadia	5.3%
	Links	4.6%
	DCM Bankruptcy	0.5%
	DCM Probate	3.9%
	BDM International Collections	27.0%
	Sunbelt International Collections	21.8%

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.

National Landscape

What are other states doing?

Community benefits occupy an important role in improving health outcomes and addressing factors that lead to poor health. **Table 15** shows policies that other states implemented for community benefits reporting and access to financial assistance requirements.

Notable Legislative Activity

In New York, a new law approved in 2025 requires hospitals to submit the supporting information used to complete Schedule H (detailing how the community benefit expenses were calculated).[22] Indiana also passed new legislation, requiring every nonprofit hospital to report the entire Schedule H portion of the prior year's federal Form 990, including itemized/worksheet-level supporting data for all community benefit categories. This allows them to better understand how they are calculating the expenditure reported through Schedule H. Hospitals that fail to report the forms required are fined ten thousand ($10,000) per day for which the forms are past due.[23] Indiana's legislature introduced a new bill in January 2026 , (House Bill 1335), which if approved, will require nonprofit hospitals to spend more on community benefits than the hospital's estimated tax exemption value.

[22] Jozic, A., & LeDonne, J. (2025). New hospital community benefit reporting required in NYS—effective October 1, 2025. The Bonadio Group. https://www.bonadio.com/article/new-hospital-community-benefit-reporting-required-in-nys-effective-october-1-2025/
The Bonadio Group

[23] LegiScan. (2025). Indiana House Bill 1004 (Enrolled): Health care matters (2025 Regular Session) [Bill text]. Retrieved February 6, 2026, from https://legiscan.com/IN/text/HB1004/id/3221328

Table 15. 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	Requires submitting calculations used for 990, Schedule H
CT	☑					
MA	☑					
NH	☑		☑	☑	☑	
NY	☑		☑	☑	☑	☑
IL	☑	☑	☑		☑	
MD	☑				☑	
OR	☑	☑		☑	☑	
CA	☑				☑	
IN	☑			☑	☑	☑

Connecticut continues to require 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.

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.[24] Illinois law requires nonprofit hospitals to spend the amount of their property tax on services that address the health care needs of low-income or underserved communities, and in Maryland, state law requires hospitals to report the types of tax exemptions claimed.[25, 26]

[24] California Department of Health Care Access and Information. (n.d.). *Hospital Fair Billing Program: Laws and Regulations*.

[25] Illinois General Assembly. (n.d.). *35 ILCS 200/ Property Tax Code, Article 15: Exemptions*.

[26] Health Services Cost Review Commission. (2022, December). *Maryland Hospital Community Benefit Report: FY 2021.*

Recommendations

Enhancing Analysis

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

- Requiring hospital reporting of unreimbursed Medicaid cost calculations to OHS using the state's revised Medicaid payment-to-cost ratio methodology, introduced in the Annual Report on Connecticut Hospitals' Financial Stability HFY2023. 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.
- 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. New York and Indiana require hospitals to submit these documents which provide a clearer view into how hospitals compute and report on their Schedule H spending**.**
- 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.

Alternative Strategies

Benchmarking best practices and policy across the country, OHS has identified additional practices worth further exploration:

- **Maryland and Illinois:** Enacted laws allowing low-income patients enrolled in need-based programs to automatically qualify for free care without having to submit an application
- **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

Strengthening Community Benefit in Connecticut

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.[27] Over the five-year reporting period, Bridgeport Hospital consistently exceeded the 1% annual net community benefit increase required, achieving increases of 29%, 15%, 141%, 5%, and 8% from FY 2020 through FY 2024, respectively.

Federal Accountability

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 December 2025, Congress has not enacted legislation to clarify community benefit under the IRC. Clearly outlining such activities and services would improve the IRS's ability to oversee tax-exempt hospitals.[28]

[27] 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

[28] 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' 2024 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 2024

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 acute 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 Other Investments (Implementation Strategy) Data

OHS reviewed the 2021/2022 cycle CHNA and IS/CHIP processes 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 /CHIP were included as "Other Investments" 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 fiscal years 2016 – 2024 (nine 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.

Hospitals' Annual Status Reports

OHS reviewed the Annual Status Reports submitted by hospitals in October 2025. This report provides expense data from hospitals attributed to activities that support their IS 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).

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.

Methodology

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 fiscal year 2024. 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.

Glossary

1. **Bad debt:** consists of services for which a tax-exempt hospital anticipated but did not receive payment.[29]
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.[30] 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.[31] An example is the costs related to the Community Health Needs Assessment and developing the Implementation Strategy.[32]
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.[33]
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.[34] Examples of a community health improvement service if it addresses a

[29] Robert Wood Johnson Foundation & RTI International. (n.d.). Terms and glossary. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.glossary
[30] 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
[31] *Id.*
[32] *Id.*
[33] Robert Wood Johnson Foundation and RTI International. (n.d). Community benefit spending 101. Community benefit insight. https://www.communitybenefitinsight.org/?page=info.cb101
[34] Internal Revenue Service. (2022). Instructions for Schedule H (Form 990). https://www.irs.gov/pub/irs-pdf/i990sh.pdf

community health need and meets a community benefit objective are exercise classes, screenings (blood pressure, behavioral health, hearing, etc.), clinics for the 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).[35]

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. [36] An example of another means-tested government program is a State Children's Health Insurance Program (SIS).
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).[37] 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.[38]

---

[35] 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

[36] *Id.*

[37] 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

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

9. **Fiscal 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.

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.[39] 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.[40]

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.[41] 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.[42] 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

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

[41] 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

[42] *Id.*

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.[43] An example 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.[44] An example of subsidized health services could be psychiatric inpatient beds.

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

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

Appendix A: Other Investments (Implementation Strategy) by Identified Community Health Need by hospital (HFY 2024)

Hospital	Community Need Category	IS Expense	Total
Backus	Access to Care	$161,216.00	$1,211,180.00
	Chronic Disease	$359,293.00	
	Behavioral Health	$152,455.00	
	Food Security & Quality	$5,080.00	
	Other	$370,224.00	
	Workforce Development	$162,912.00	
Bridgeport	Access to Care	$120,867,430.05	$121,567,889.70
	Behavioral Health	$352,032.51	
	Maternal & Child Health	$43,997.88	
	Preventive Health	$304,429.26	
Bristol	Access to Care	$6,596.36	$24,096.36
	Behavioral Health	$15,000.00	
	Chronic Disease	$2,500.00	
Central Connecticut	Access to Care	$448,785.00	$716,790.00
	Other	$268,005.00	
Charlotte Hungerford	Access to Care	$326,988.60	$1,020,015.39
	Access to Housing	$124,227.00	
	Behavioral Health	$37,939.00	
	Food Security & Quality	$70,720.00	
	Maternal & Child Health	$11,704.39	
	Other	$279,214.40	
	Preventive Health	$169,222.00	

Appendix A

Hospital	Community Need Category	IS Expense	Total
Connecticut Children's	Access to Care	$969,812.00	$21,864,753.00
	Access to Housing	$11,615,672.00	
	Food Security & Quality	$90,336.00	
	Violence Prevention	$473,582.00	
	Workforce Development	$8,715,351.00	
Danbury	Access to Care	$382,607.00	$3,079,104.07
	Access to Housing	$1,000.00	
	Behavioral Health	$1,376,831.00	
	Chronic Disease	$14,512.00	
	Food Security & Quality	$889,523.57	
	Maternal & Child Health	$120,720.00	
	Other	$264,583.50	
	Preventive Health	$18,296.00	
	Workforce Development	$11,031.00	
Day Kimball	Access to Care	$33,612.00	$53,199.00
	Chronic Disease	$1,068.00	
	Maternal & Child Health	$2,675.00	
	Other	$1,258.00	
	Preventive Health	$14,586.00	
Greenwich	Access to Care	$46,610,384.16	$47,789,012.55
	Behavioral Health	$835,268.39	
	Chronic Disease	$82,417.00	
	Preventive Health	$260,943.00	
Griffin	Access to Care	$21,882,366.00	$22,572,050.00
	Behavioral Health	$389,957.00	
	Chronic Disease	$74,073.00	
	Maternal & Child Health	$67,280.00	
	Other	$910.00	
	Preventive Health	$157,464.00	

Appendix A

Hospital	Community Need Category	IS Expense	Total
Hartford	Access to Care	$813,348.33	$9,202,018.98
	Access to Housing	$1,192,411.00	
	Behavioral Health	$49,107.00	
	Culturally Competent Care	$1,038,436.00	
	Food Security & Quality	$30,000.00	
	Other	$1,427,823.99	
	Preventive Health	$4,650,892.66	
Johnson Memorial	Chronic Disease	$102,000.00	$102,000.00
Lawrence + Memorial	Access to Care	$48,370,254.00	$49,148,948.01
	Behavioral Health	$59,508.97	
	Chronic Disease	$81,572.00	
	Food Security & Quality	$90,235.07	
	Maternal & Child Health	$456,715.00	
	Preventive Health	$90,662.97	
Middlesex	Access to Care	$8,487,159.27	$24,629,837.24
	Behavioral Health	$13,873,812.96	
	Food Security & Quality	$44,233.08	
	Maternal & Child Health	$2,196,429.93	
	Preventive Health	$28,202.00	
MidState	Access to Care	$198,936.00	$794,112
	Behavioral Health	$585,811.00	
	Culturally Competent Care	$9,365.00	
	Preventive Health	$906.00	
Norwalk	Access to Care	$714,077.00	$1,039,908.00
	Behavioral Health	$6,642.00	
	Chronic Disease	$10,453.00	
	Culturally Competent Care	$500.00	
	Maternal & Child Health	$40,155.00	
	Other	$173,725.00	

Appendix A

Hospital	Community Need Category	IS Expense	Total
	Preventive Health	$50,616.00	
	Workforce Development	$43,740.00	
Sharon	Access to Care	$401.00	$220,008.00
	Access to Housing	$1,000.00	
	Behavioral Health	$16,818.00	
	Chronic Disease	$5,385.00	
	Food Security & Quality	$4,187.00	
	Maternal & Child Health	$35,728.00	
	Other	$25,124.00	
	Preventive Health	$122,499.00	
	Workforce Development	$8,866.00	
St. Francis	Access to Housing	$370,000.00	$1,000,000.00
	Chronic Disease	$425,000.00	
	Food Security & Quality	$110,000.00	
	Violence Prevention	$95,000.00	
St. Mary's	Access to Care	$115,190.00	$128,190.00
	Culturally Competent Care	$13,000.00	
St. Vincent's	Access to Care	$5,880,605.00	$14,244,589.00
	Behavioral Health	$26,355.00	
	Food Security & Quality	$210,560.00	
	Maternal & Child Health	$96,492.00	
	Other	$1,601,347.00	
	Preventive Health	$262,116.00	
	Workforce Development	$6,167,114.00	
Stamford	Access to Care	$124,241,201.45	$136,680,359.65
	Behavioral Health	$12,429,471.08	
	Other	$9,687.12	
Windham	Access to Care	$149,775.00	$511,441.00
	Food Security & Quality	$1,712.00	

Appendix A

Hospital	Community Need Category	IS Expense	Total
	Maternal & Child Health	$6,410.00	
	Other	$279,860.00	
	Workforce Development	$73,684.00	
Yale New Haven	Access to Care	$449,411,721.48	$453,106,266.55
	Behavioral Health	$124,671.12	
	Preventive Health	$2,229.11	
	Food Security & Quality	$4,285.78	
	Maternal & Child Health	$3,563,359.06	

Appendix B: Community Benefit expenses reported to the IRS by category (HFY 2016-2024)

Community Benefit Category	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
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	$308,509,898
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	$1,173,329,396
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	$2,589
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	$61,779,321
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	$313,893,194
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	$202,255,551
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	$21,896,371
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	$50,880,013
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**	**$2,132,546,333**

Appendix C: Community Benefit expenses reported to the IRS by Hospital (HFY 2016-2024)

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
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	$46,871,000
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	$139,727,694
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	$29,806,394
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	$75,674,848
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	$14,494,456
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	143,682,043
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	$154,618,788
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	$15,527,121
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	$55,927,174
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	$22,528,933
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	$221,794,048
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	$5,326,630
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	$86,759,999
Manchester	$18,491,286	$0	$0	$0	$0	$0	$0	$0	$0
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	$81,164,563
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	$35,913,346
Milford	$4,335,694	$3,468,499	$1,546,080	$3,002,393	$0	$0	$0	$0	$0
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	$89,212,576
Rockville	$8,293,133	$0	$0	$0	$0	$0	$0	$0	$0
Sharon	$0	$1,939,228	$3,296,231	$4,631,395	$6,527,472	$8,032,507	$12,271,675	$11,030,347	$24,416,364
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	$109,911,738

Appendix C

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
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	$32,528,268
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	$55,696,941
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	$113,071,841
Waterbury	$20,342,363	$0	$0	$0	$0	$0	$0	$0	$0
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	$12,388,399
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	$565,503,169
Total	**$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**	**$2,132,546,333**

Appendix D: Federal Poverty Guidelines for the contiguous states (2024)

Household Size	2024 Federal Poverty Line	150%	200%	250%	300%	400%	500%	550%	800%	999%
1	$15,060	22,590.00	$30,120	$37,650	$45,180	$60,240	$75,300	$82,830	$120,480	$150,449.40
2	$20,440	30,660.00	$40,880	$51,100	$61,320	$81,760	$102,200	$112,420	$163,520	$204,195.60
3	$25,820	38,730.00	$51,640	$64,550	$77,460	$103,280	$129,100	$142,010	$206,560	$257,941.80
4	$31,200	46,800.00	$62,400	$78,000	$93,600	$124,800	$156,000	$171,600	$249,600	$311,688.00
5	$36,580	54,870.00	$73,160	$91,450	$109,740	$146,320	$182,900	$201,190	$292,640	$365,434.20
6	$41,960	62,940.00	$83,920	$104,900	$125,880	$167,840	$209,800	$230,780	$335,680	$419,180.40
7	$47,340	71,010.00	$94,680	$118,350	$142,020	$189,360	$236,700	$260,370	$378,720	$472,926.60
8	$52,720	79,080.00	$105,440	$131,800	$158,160	$210,880	$263,600	$289,960	$421,760	$526,672.80

Appendix E: Total Bad Debt reported to the IRS (HFY 2016-2024)

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
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	$17,648,308
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	$25,970,000
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	$10,239,545
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	$19,087,838
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	$7,542,601
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	$4,341,806
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	$9,041,859
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	$4,600,307
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	$14,710,000
Griffin	$524,574	$434,067	$774,954	$816,998	$706,945	$862,799	$748,776	$618,700	$365,858
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	$46,411,513
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	$830,211
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	$11,930,000
Manchester	$10,662,336	$0	$0	$0	$0	$0	$0	$0	$0
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	$12,835,982
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	$12,533,630
Milford	$3,982,595	$3,356,833	$3,329,226	$1,532,928	$0	$0	$0	$0	$0
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	$5,396,637
Rockville	$1,985,773	$0	$0	$0	$0	$0	$0	$0	$0
Sharon	$0	$1,116,838	$2,284,495	$1,368,255	$1,900,161	$412,764	$1,015,098	$1,511,723	$799,762
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	$11,057,434
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	$10,406,015
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	$15,007,578

Appendix E

Hospital	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
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	$78,780,497
Waterbury	$761,283	$0	$0	$0	$0	$0	$0	$0	$0
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	$4,277,594
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	$61,220,000
Total	**$243,435,616**	**$239,000,105**	**$264,208,955**	**$299,056,304**	**$357,295,411**	**$371,816,203**	**$387,214,683**	**$405,739,126**	**$385,034,975**

CONNECTICUT
Health Strategy

Public Comments Summary

Public Comments: Community Benefit Report FY24

Pursuant to Conn. Gen. Statute §19A-127k

June 1, 2026

Acronyms

Table of Contents

Executive Summary 3
Criteria used for revisions 3
Feedback included in the revised report 3
Feedback not included in the revised report 4
Additional recommendations 6

Executive Summary

This document summarizes the public comment received regarding the FY 2024 Community Benefit Summary and Analysis Report. The Office of Health Strategies (OHS) received public comments from:

- Commission on Racial Equity in Public Health, Connecticut General Assembly
- Connecticut Children's Medical Center
- Connecticut Hospital Association
- Connecticut's Office of the Healthcare Advocate
- Day Kimball Hospital
- Health Equity Solutions
- Middlesex Health
- Stamford Health
- Trinity Health of New England

OHS revised the FY 24 Community Benefit Summary and Analysis Report based on some feedback received. Not all public recommendations were incorporated—either due to data limitations, structural integrity of the report, or the scope of authority. This executive summary synthesizes the most salient themes and cross-references them with report inclusion status.

Criteria used for revisions

Recommendations that propose changes to the report's methodology or overall structure will not be incorporated. Additionally, original recommendations included in the report will not be revised based on public comment.

However, recommendations that enhance clarity or provide additional context will be considered. Corrections addressing factual errors or inaccuracies will also be incorporated where appropriate.

Feedback included in the revised report

It was recommended that OHS revise the FY 2024 Community Benefit Summary and Analysis report to include:

- Clarification between the combined total investments ($2.18 billion) and the Community Benefit investments ($2.13 billion).
    - Response: OHS revised the document to include this clarification on page 2
- Reflect the new Free and Discounted care policy of Day Kimball Health.
    - Response: Revised Tables 7 & 8 to reflect the new Free and Discounted care policy of Day Kimball Health

- Avoid attributing recovery rates above 100% to property lien or other specific collection actions unless supported by Connecticut-specific evidence.
    - Response: OHS revised the document to reflect this feedback

Feedback not included in the revised report

The following recommendations were not included because they either propose changes to the report's methodology or overall structure:

- The distinction between IRS Schedule H and the State's Medicaid payment-to-cost ratio calculations are different measures and cannot be directly compared. This distinction should be maintained through the report.
    - Response: The distinction is clearly outlined in the document on various pages (pages 1, 11, 12, 15)
- Revise the Key Findings to emphasize that hospitals increased total Community Benefit spending, charity care, subsidized health services, and community building investments in FY 2024.
    - Response: This is already part of the Key Findings (page 3)
- The report should make clear that Connecticut Hospitals follow the federal Schedule H instructions when reporting Medicaid shortfall.
    - Response: The report already outlines such information (pages 1, 11, 12, 15)
- On OHS's Annual and 12 Month Filing Reports webpage and related HRS reporting materials, OHS uses distinct terminology for this separate reporting framework. OHS describes the Annual Reporting Filing and Twelve Months Actual Filing as hospital financial data filings completed largely through the HRS portal, and identifies Report 550 as 'Summary of Charges, Payments, Statistics and Uncompensated Care.' The community benefit report should use those accepted terms. If OHS elects to present information from HRS Report 550 or any Medicaid supplemental schedule, it should clearly label it as HRS/Twelve Months Actual Filing information, not as an alternative Medicaid shortfall calculation for Schedule H purposes.
    - Response: OHS will not include this feedback because it will add new technical terms that will confuse readers. The report is already clear regarding the data source.
- The report, however, should not use unrelated HRS data to cast doubt on federally reported Schedule H amounts or suggest that the $1.17 billion Medicaid shortfall figure is overstated. Without hospital-specific Schedule H worksheets and without applying Schedule H conventions, OHS has no basis to recalculate or critique hospitals' Schedule H Medicaid shortfall for purposes of a community benefit report.

  - Response: OHS already makes it clear the difference between the two measures (Schedule H vs payment-to-cost ratio calculation)

- The report should more prominently highlight that charity care increased from approximately $283.0 million in 2023 to $308.5 million in 2024, an increase of approximately $25 million or nearly 9%. This is an important patient-centered outcome and should be reflected in the Key Findings.
  - Response: This is already part of the Key Findings section (page 2)
- The report should more accurately describe hospital financial assistance policies. The report should recognize hospitals' ongoing efforts to improve screening, awareness, and enrollment in available assistance, while also acknowledging that coverage expansions, pandemic-era coverage policies, coverage for certain undocumented children, and increased exchange enrollment likely reduced the number of patients who otherwise would have relied on charity care compared with 2016.
  - Response: OHS does not collect data regarding hospitals' efforts on financial assistance screening, awareness and enrollment and cannot document changes in these efforts. The report already notes a correlation between reduced Medicaid recipients and the increased charity care and subsidized health.
- Retitle Table 6 as "Total Hospital Bad Debt Attributable to Patients Who Were Not Identified for Financial Assistance."
  - Response: OHS will not revise the name of the table with the proposed language because it is less accurate than the existing title
- Clarify that total bad debt and charity care are distinct metrics; total bad debt includes commercial, self-pay, and accounts above FAP eligibility thresholds.
  - Response: The report already differentiates between the two metrics in the respective sections
- Revise the recovery-rate discussion to state that recoveries recorded in a given fiscal year often reflect collections on placements from prior years, which can result in recovery rates greater than 100%; Avoid attributing recovery rates above 100% to property liens or other specific collection actions unless supported by Connecticut-specific evidence.
  - Response: The document already clarifies that recoveries recorded in a given fiscal year often reflect collections on placements from prior years (page 36). OHS removed the property lien as an example of such ECAs.
- Clarification that: 1) implementation strategy expenses are not required to qualify as community benefit or community building under IRS rules; 2) Community benefit and community building expenses are not required to be tied to a hospital's implementation

strategy; 3) Differences across hospitals may reflect local needs, priorities, interventions and funding sources.

  - Response: OHS provides definition of these terms and outlines the federal and state requirements in the document (pages 6 to 10).

- Regarding implementation strategy expenditures, the report should emphasize statewide totals and explanatory context rather than hospital-by-hospital comparisons that may be misinterpreted.

  - Response: OHS provided hospital-by-hospital comparisons for transparency and accountability

- In this year's report, there is no data shown about individual hospitals' unreimbursed Medicaid.

  - Response: The report directs readers to use the Community Benefit Dashboard for more detailed individual level hospital data

- The FY2024 report identifies important positive trends: total bad debt decreased, and bad debt attributable to patients eligible for financial assistance but not receiving it declined significantly. These improvements should be highlighted more prominently. At the same time, the report should acknowledge that medical debt is also driven by broader insurance market trends, including underinsurance, high-deductible health plans, and rising patient cost-sharing. Bad debt should not be framed primarily as a function of hospital financial assistance or billing practices.

  - Response: The trend has already been highlighted in the respective sections. Bad debt is not framed as a function of hospital financial assistance or billing practices.

Additional recommendations

These supplemental recommendations have been provided through public comment for future consideration by policymakers:

- Use a collaborative stakeholder process before recommending new state reporting requirements or analyses related to Schedule H worksheets, HRS Report 550 data, Medicaid payment-to-cost ratios, tax-exempt value, or other federal community benefit categories.

- Hospitals should submit their Schedule H (Form 990), along with any other additional worksheets used in calculating the numbers reported. Other states have implemented similar policies. Adopting such policies in Connecticut could bring transparency to the process, allowing for more clarity and accuracy in OHS' analysis.

- Hospitals must report financial assistance screening outcomes, including applications submitted, approved, denied, and ECAs initiated. This data should be disaggregated to the

greatest extent possible, including by race, ethnicity, gender, income, zip code, and language. Doing so could provide a more comprehensive assessment of hospital financial assistance policies and assist in identifying interventions that could be beneficial to Connecticut residents.

- Strengthen Connecticut's state-level reporting and accountability requirements beyond federal nonprofit hospital rules.
- Develop agreed-upon definitions and standardized data components where possible, while allowing for local community needs. Future reporting processes may include: 1)determining comparative meaning, trends, and better insight into issues facing consumers and hospitals; 2) highlighting, and seeking to replicate, best practices by the 23 hospitals; 3) providing informed community insight about hospital spending priorities to inform patient and insurance responsibilities to hospitals; 4) obtaining clear next steps to maximize hospital community benefit impact to achieve progress toward more affordable, accessible, quality health care.
- Create a better collaborative roadmap between hospitals and communities; begin with selective comparative metrics.
- Future annual Connecticut Hospital Community Benefit Summary and Analysis Reports must be a more informative vehicle upon which hospitals communicate more clearly and effectively how they work together with communities to develop and deliver community benefits, and to help communities understand the value of other significant investments, such as the recently announced billion dollar building investment by Hartford HealthCare.
- Require or encourage consistent year-over-year reporting that links CHNA needs, implementation strategies, community benefit spending, and outcomes.

These supplemental recommendations have been provided through public comment for future consideration by policymakers to enhance Community Benefit policies:

- The State should set minimum spending requirements for community benefit activities and financial assistance policies to ensure sufficient funding is allocated to community needs and assign oversight responsibility to a state agency such as the Office of the Attorney General to ensure compliance with spending targets or standards.
- Nonprofit designation should require operating according to standards aligned with nonprofit rather than for-profit industries. As such, improving transparency while enhancing hospital financial assistance data collection and setting minimum spending targets is a reasonable next step.
- Connecticut lacks meaningful oversight and consistent standards for hospital billing, debt collection, and financial assistance. Create and oversee fair statewide guardrails for billing,

debt collection, and financial assistance programs, with oversight from the Attorney General's Office.

- Standardize financial assistance eligibility, applications, and screening processes; streamline documentation by using existing public benefit eligibility such as WIC or SNAP where appropriate. Adopt common-sense protections for payment plans, screening before collections, sale of debt, interest, liens, foreclosures, and wage garnishment.
- Require all hospitals to meet common-sense financial assistance and billing guardrails consistent with Senate Bill 3.