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Community Benefit in California Hospitals:
A Landscape Review

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AUTHORS
Linda Cummings, PhD; Marsha Regenstein, PhD;
Jennifer Trott, MPH; Jacqueline Baños, MPH

About the Authors

Linda Cummings, PhD, is a health services research consultant.

Marsha Regenstein, PhD, is a professor in the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health.

Jennifer Trott, MPH, is a lead research scientist in the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health.

Jacqueline Baños, MPH, is a senior research associate in the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health.

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About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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Executive Summary

Nonprofit hospitals in California are exempt from paying federal and state taxes if they meet certain standards defined by the Internal Revenue Service, Affordable Care Act, and state law. These standards include an obligation to finance a set of community-focused, charitable activities known as "community benefit."

This report provides a landscape review of community benefit scope and practice in California nonprofit hospitals. It is based on a review of the national literature, California community benefit regulations and legislation, community health needs assessments (CHNAs) and community benefit plans submitted by California nonprofit hospitals, available financial data on community benefit spending, and interviews with 49 stakeholders.

Key Findings

- **What are the most common community health priorities identified by California's nonprofit hospitals?** More than nine in 10 nonprofit hospitals (92%) list access to care as a community benefit health priority. Mental health / behavioral health is also a common priority, chosen by 84% of hospitals. More than half of hospitals (57%) mention economic security, and half (50%) include housing and homelessness as a priority.
- **How much do California nonprofit hospitals spend on community benefit?** According to Community Benefit Insight, US hospitals reported over $93 billion in community benefit spending in 2020, of which $8.7 billion was attributed to hospitals in California. The largest category of spending nationally and in California, by far, was related to Medicaid (or Medi-Cal) shortfall — and the proportion of spending attributed to Medicaid shortfall has increased markedly in the last decade, particularly in California.
- **What is the value of the taxes not collected from California's nonprofit hospitals?** Empirical estimates of the collective value of community benefit in California — the total of nonprofit hospitals' uncollected tax liability — are not publicly available. Several stakeholders and experts estimate it at $2.6–$2.8 billion in 2020. However, previous studies indicate it could be much higher.
- **What are the common themes in the academic literature about the impact of community benefit spending across the country?** Academic experts have examined the amount, scope, and impact of community benefit dollars in several major empirical studies over the last decade. A number of scholars have concluded that the impact of community benefit spending is not commensurate to the value of the tax benefit.
- **What did California stakeholders say about the impact of community benefit spending in the state?** Interviewees who participated in this study were starkly divided in their assessments of community benefit's impact on community health in California. Interviewees within the hospital industry took great pride in their community benefit programs, indicating that their community benefit contributions far exceed current requirements under federal and state tax law. By contrast, most nonhospital industry interviewees expressed significant concerns around alignment of specific spending decisions with broader public health needs, transparency regarding spending decisions and calculation methods, and measurement of outcomes from community benefit initiatives.

A number of stakeholders believe state policymakers should explore a set of community benefit policy options that could increase alignment with other health initiatives, improve the availability of information, and facilitate measurement that helps ensure resources dedicated to community benefit are achieving their intended purpose.

Methodology

The methodology for this report consisted of:

- A review of community benefit requirements nationally and at the state level as well as a summary of Internal Revenue Service (IRS) requirements for a hospital to be designated as a charitable organization under the Affordable Care Act.
- A literature review of the current state of knowledge about community benefit from peer-reviewed articles and other publications.
- A scan of California hospital community health needs assessments (CHNAs) and community benefit plans.
- Hour-long interviews with 49 community benefit experts and key stakeholders, including 14 from the hospital industry in California. (See Appendix A for more information about these interviews, including development of the interview guide.)

Overview and Current Oversight of Community Benefit Spending

As of 2021, California had 358 community hospitals, the majority of which (207) were nonprofits.[1] Nonprofit hospitals are tax-exempt under Section 501(c)(3) of the Internal Revenue Code as organizations that operate for religious, charitable, scientific, or educational purposes.[2] These hospitals have an obligation to invest in the health and well-being of their communities in exchange for valuable tax exemptions. This obligation is fulfilled by financing a set of activities known as "community benefit."

Community benefits are programs and services designed to improve health in communities and increase access to health care. IRS Form 990, Schedule H instructions define community benefit as activities or programs that respond to community health needs and that seek to achieve one or more of the following objectives: improving access to health services, enabling people with low income to afford health care, enhancing public health, advancing generalizable knowledge, educating health professionals, and relieving the government burden to improve health.

The IRS identifies eight categories of community benefit reportable on tax-exempt hospitals' IRS Form 990, Schedule H: financial assistance at cost (also known as charity care), Medicaid shortfall, costs of other means-tested government programs, community health improvement services and community benefit operations, health professions education, subsidized health services, research, and cash and in-kind contributions for community benefit. Additional benefits captured on Form 990 Schedule H are community-building activities (see Table 3).

Federal Community Benefit Requirements

Community Benefit Standard

Under long-standing federal tax policy, organizations in the US can be deemed tax-exempt when they support a societal mission rather than a profitmaking enterprise. The Internal Revenue Service (IRS) has issued periodic rulings defining community benefit but has stopped short of prescribing financial thresholds that would clarify the contours of the nonprofit tax benefit. In 1956, the IRS issued a revenue ruling requiring nonprofit (tax-exempt) hospitals that operated "exclusively for religious, charitable, scientific or educational purposes" to provide charity care "to the extent of their financial ability."[3] The IRS eventually moved to a broader mandate to support "a charitable purpose such as the promotion of health"[4] and a set of six factors that characterize a hospital's community benefit standard.[5] These factors are:

- Operate an emergency room open to all, regardless of ability to pay
- Maintain a board of directors drawn from the community
- Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians)
- Provide care to all patients able to pay, including those who do so through Medicare and Medicaid
- Use surplus funds to improve facilities, equipment, and patient care
- Using surplus funds to advance medical training, education, and research[6]

The most recent IRS reporting requirements associated with community benefit went into effect in 2009 through a new Schedule H worksheet that accompanied nonprofit organizations' tax filings under Form 990.

Affordable Care Act Requirements for Community Benefit

IRS requirements related to community benefit were changed with the passage of the Affordable Care Act (ACA) and accompanying regulation in 2014.[7] Four new provisions were established that require nonprofit hospitals to:

- Conduct a community health needs assessment at least once every three years, accompanied by yearly plans to implement community benefit priorities.
- Maintain a written financial assistance policy that reflects the organization's criteria to determine whether patients are eligible for free or reduced care, and what steps the hospital will take for patient nonpayment of hospital bills.
- Set a limit on charges so that people eligible for financial assistance are charged no more than insured patients.
- Set billing and collection limits, with restraints on hospitals taking "extraordinary collection actions" before determining whether the patient meets eligibility for financial assistance under the hospital's policy.[8]

California Community Benefit Requirements

California is among a number of states that have specific laws or rules for community benefit requirements that extend beyond current federal requirements. Examples of the ways various states regulate community benefit include specifying how community benefit activities are defined, setting a minimum threshold for community benefit spending, and instituting reporting requirements pertaining to community benefit or the community health needs assessment or both.[9]

California statute defines community benefit as an activity "intended to address community needs and priorities primarily through disease prevention and improvement of health status" and provides examples of reported and unreported activities that fall within the category of community benefit. In 1994, the passage of Senate Bill 697 established this language along with reporting requirements for hospitals to complete a periodic community health needs assessment and annual community benefit plan — preceding by several years federal IRS requirements instituted after the passage of the Affordable Care Act.[10]

The California Department of Health Care Access and Information (HCAI) is the agency that manages community benefit reporting at the state level. In 1996, HCAI (then named the Office of Statewide Health Planning and Development) began collecting and reviewing CHNAs and community benefit plans. In 2019, the department was charged with enhancing the transparency and comparability of community benefit by developing regulations to standardize hospital data collection and reporting.[11]

Beginning in 2024, HCAI plans to post on its website hospital expenditures for community benefit, specifying the amount attributable to charity care, the unpaid cost of government-sponsored health care programs, and community benefit programs and activities. HCAI will also list hospitals that fail to report community benefit spending. In addition, HCAI is currently incorporating new requirements that hospitals report community benefit financial data separately for vulnerable populations, which are defined under AB 1204.[12]

Current Community Benefit Processes and Outcomes

Conducting a Community Health Needs Assessment

Every three years nonprofit, nonpublic hospitals and health systems in California must conduct a community health needs assessment (CHNA) to identify community health priorities and to identify the health priorities the hospital will address. California community benefit law requires hospitals to identify unmet community needs in the CHNA for improvement and maintenance of the health status of the community.[13] IRS regulations specify that the hospital must define its community, solicit input from members of the community, and provide written documentation of the CHNA in a report adopted by an authorized body of the hospital. Both the IRS and California code permit hospitals, at their discretion, to develop their CHNA in coordination with other hospital facilities, the public health department, or other organizations. Hospitals must make the CHNA report widely available to the public, although the study team's research indicates that these documents are not always available or easily found on hospitals' websites.[14]

The majority of nonprofit hospitals (92%) indicate that access to care is a community benefit health priority. Mental health / behavioral health is also a common priority, with 84% of hospitals across California including it in their community benefit plan. More than half of hospitals (57%) mention economic security as a priority, and half (50%) included housing and homelessness as a priority. Additional priorities mentioned in community benefit plans include chronic diseases, community health and safety, food security and nutrition, and a focus on specific populations, such as senior or older adult health, and maternal and child health.

Developing a Community Benefit Plan

Following the CHNA process, nonprofit hospitals and health systems in California are also required to develop a community benefit plan, in consultation with the community, that describes how the hospital will address the health priorities identified in the CHNA. The plan is designed at the individual facility level, although some hospitals that are part of a system may submit an identical community benefit plan for two or more facilities if they are located in the same region or have overlapping service areas. New plans are submitted annually to HCAI.

The hospitals' processes for selecting priorities to focus on in the annual community benefit plans are less straightforward than for the CHNA process. The priorities in the community benefit plan are selected from the needs identified in the CHNAs. In some instances, senior leadership, sometimes involving a board committee, are directly involved in decisions about the priorities selected for the plans. In other cases (e.g., the priorities did not markedly change from year to year), senior leadership and the board are briefed and approve the community benefit plan after it is already developed.

Several stakeholders reported that hospitals allocate a specified community benefit budget. In other cases, stakeholders described a largely retrospective process at the end of a reporting period when staff identify current or recent ventures, collected from different departments, that can be categorized as community benefit. Large hospital systems, like Kaiser, conduct health improvement programs and support research and educational efforts that extend beyond the catchment area of a member hospital.

A summary of priorities reported to HCAI for 2021 is included in Table 1 (see Appendix B for more information on the community benefit plans analysis).[15]

Table 1. Community Benefit Health Priorities, 2021 Community Benefit Plans (*N* = 223)

HEALTH PRIORITIES	HOSPITALS INDICATING PRIORITY (*N*)
Access to Care	92% (206)
Mental and Behavioral Health	84% (187)
Economic Security	57% (126)
Housing and Homelessness	50% (112)
Chronic Diseases	45% (101)
Community Health and Safety	36% (81)
Food Security and Nutrition	28% (63)
Specific Populations	25% (55)

Source: *2021 Hospital Community Benefit Plans*, California Health and Human Services Agency, last updated 2023.

Community Benefit Spending

Information on actual community benefit spending is available from a variety of sources, including the hospital industry through community benefit plans; studies and reports published on the topic; federal tax documents submitted to and published by the IRS; and other federal or state financial reporting documents. Despite these sources, measuring the current value of nonprofit hospitals' community benefit spending is a challenging task, in part because precise formulas for calculation of community benefit are not easily accessible to the public. Furthermore, in California, like in the vast majority of states, there is no threshold or set amount that nonprofit hospitals are required to spend on community benefit activities in exchange for their tax-exempt status.

According to an analysis by KFF, hospitals spent about $16 billion on charity care in 2020, and less on community health improvement.[16] According to Community Benefit Insight, a website that aggregates information about tax-exempt hospitals, US hospitals across the country reported over $93 billion in community benefit spending in 2020, of which $8.7 billion was attributed to hospitals in California.[17] Major categories of that spending are summarized in Table 2. The largest category of spending nationally and in California, by far, was related to Medicaid (Medi-Cal) shortfall, with about $40 billion attributed to Medicaid shortfall, and about $3.8 billion in community health improvement and community benefit operations (see Table 2).[18] Recent analyses commissioned by the American Hospital Association concluded that reported hospital community benefit spending exceeded the value of the tax exemption nine times over.[19] The largest component of this spending is attributable to Medicaid shortfall.

Table 2. Hospital-Reported Community Benefit Spending, US and California, 2020

	TOTAL US COMMUNITY BENEFIT SPENDING		CALIFORNIA COMMUNITY BENEFIT SPENDING	
SPENDING CATEGORY*	$	%	$	%
Medicaid Shortfall	$40,504,468,229	43.4%	$4,936,238,825	56.5%
Financial Assistance at Cost	$15,458,030,169	16.6%	$969,538,854	11.1%
Health Professions Education	$14,093,453,462	15.1%	$928,821,384	10.6%
Subsidized Health Services	$10,797,809,308	11.6%	$411,199,274	4.7%
Research	$4,401,855,327	4.7%	$368,280,491	4.2%
Community Health Improvement and Community Benefit Operations	$3,829,095,704	4.1%	$334,581,123	3.8%
Cash and In-Kind Contributions to Community Groups	$2,693,208,106	2.9%	$452,559,701	5.2%
Costs of Other Means-Tested Government Programs	$1,028,768,631	1.1%	$297,055,619	3.4%
Community Building	$593,847,894	0.6%	$31,641,801	0.4%
Total	**$93,400,536,830**	**100%**	**$8,729,917,072**	**100%**

* See Table 3 for community benefit spending category definitions and examples.

Sources: "State Analysis: California" (2020), Community Benefit Insight (CBI); and "State Analysis: National" (2020), CBI. Accessed June 27, 2024.

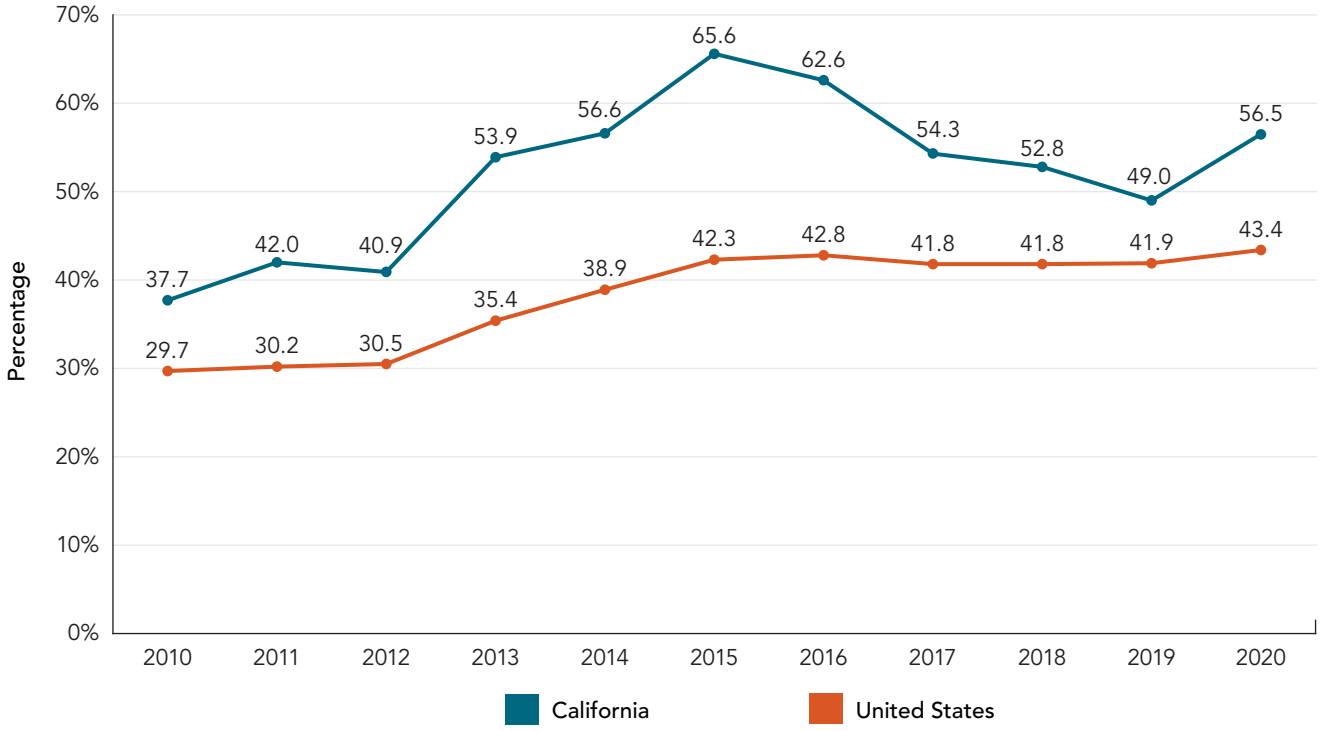
Medi-Cal Shortfall

As noted above, hospitals report an estimate of the difference between what they receive from Medi-Cal for patient services and the cost of providing these services to patients covered by Medi-Cal. The difference is referred to as Medi-Cal shortfall (or Medicaid shortfall).

Medicaid shortfall has grown significantly since the passage of the ACA, when more US residents became eligible for Medicaid through coverage expansions. Nationally, there has been a shift from community benefit spending on financial assistance programs to Medicaid shortfall. From 2010 to 2018, spending on financial assistance decreased by 6.8 percentage points, and spending on Medicaid shortfall increased by 7.2 percentage points.[20]

The increase among California hospitals has been substantially higher: In 2010, California nonprofit hospitals reported spending 37.7% of community benefit on Medi-Cal shortfall; by 2020, that number was 56.5% — an 18.8 percentage point increase (see Figure 1). This means that the proportion of community benefit spending associated with Medi-Cal shortfall increased 50% over 10 years.

Figure 1. Percentage of Community Benefit Spending on Medi-Cal Shortfall Among US and California Nonprofit Hospitals, 2010–20



Source: Author analysis of "State Analysis: National" (2010–20), Community Benefit Insight (CBI) and "State Analysis: California" (2010–20), CBI.

Other Expenditure Categories

Other major community benefit expenditure categories are described and illustrated in Table 3.

Table 3. Community Benefit Spending Category Definitions and Examples

COMMUNITY BENEFIT CATEGORY	SPENDING CATEGORY DEFINITION AND EXAMPLES
Medicaid	The amount incurred by tax-exempt hospitals that represents the difference between what care costs and what is paid by Medicaid. This is sometimes referred to as Medi-Cal or Medicaid shortfall.
Financial Assistance at Cost	Free or discounted health services provided to people who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include bad debt, self-pay or prompt pay discounts, or contractual adjustments with any third-party payers.
Health Professions Education	Programs for physicians, interns and residents, medical students, nurses and nursing students, pastoral care trainees, and other health professionals when education is necessary to retain a state license or certification by a board in the individual's health profession specialty. **Examples.** Medical residency programs; continuing medical education lectures and training for physicians, physical therapists, ultrasound technicians, social workers, paramedics, dietary technicians and other health care professionals; nursing clinical experience; registered nurse preceptorship programs
Subsidized Health Services	Subsidized health services are clinical services provided despite a financial loss to the tax-exempt hospital. A service meets an identified community need if it is reasonable to conclude that if the organization no longer offered the service: ▸ The service would be unavailable to the community and ▸ The community's capacity to provide the service would be below the community's need or ▸ The service would become the responsibility of the government or another tax-exempt organization Depending on the individual community, examples could include inpatient programs such as neonatal intensive care or addiction recovery, and outpatient programs such as satellite clinics designed to serve low-income communities or home health programs. **Examples.** An ambulatory clinic staffed with medical residents to provide primary and specialty care for uninsured and underinsured community members; providing emergency medical services and behavioral health services when there is limited access in the community; offering a program that screens for and treats children with disabilities and developmental disorders
Research	Any study or investigation designed to increase general knowledge and made available to the public. For example, research can include behavioral or sociological studies related to health, delivery of care, or prevention, or studies related to changes in the health care delivery system. **Examples.** Clinical, epidemiological, and health care services and delivery research conducted by a hospital research department

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Table 3. Community Benefit Spending Category Definitions and Examples (continued)

COMMUNITY BENEFIT CATEGORY	SPENDING CATEGORY DEFINITION AND EXAMPLES
Community Health Improvement and Community Benefit Operations	Community health improvement services are activities or programs subsidized by the tax-exempt hospital, carried out or supported for the express purpose of improving health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services. **Community health improvement examples.** Hospital community wellness program providing free diabetes screenings and health and wellness education; hospital breastfeeding program that provides access to lactation consultants, nurse training, and patient education; providing mental health education to hospital partners and community organizations; screening older adults for cognitive, behavioral, and psychosocial issues. Community benefit operations are activities associated with community health needs assessments (CHNAs), community benefit program administration, and the organization's activities associated with fundraising or grant-writing for the organization's community benefit programs. Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. **Community benefit operations examples.** Community benefit consultants; consultants and operations to support the CHNA process; staff salaries, benefits, and expenses; other administrative staff and support; software subscriptions
Cash and In-Kind Contributions to Community Groups	In-kind contributions are donations of items or services. In-kind contributions for community benefit include the cost of staff hours donated by the organization to the community while on the organization's payroll, indirect cost of space donated to tax-exempt community groups, and the financial value of donated food, equipment, and supplies. Cash contributions should not include donations made by employees; loans, advances or contributions to the capital of another organization; or unrestricted gifts to another organization that are not to be used to provide community benefit. **Examples.** Donations of clothing, shoes, hygiene products to people experiencing homelessness in the community; cash donations and grant funds awarded to community organizations that support hospital health priorities; hospital midwives' time to support a prenatal clinic for vulnerable pregnant people; staff time for participation in conferences, collaboratives, or other partnership meetings related to the hospital's health priorities
Costs of Other Means-Tested Government Programs	Other means-tested programs are government-sponsored health programs where eligibility for benefits or coverage is determined by income or assets.
Community Building	Community-building activities protect or improve the community's health or safety and cannot be reported on Schedule H as a community benefit under Part I. Beginning with the 2011 Schedule H, the IRS clearly indicated that some community-building activities may also meet the definition of community benefit. Activities that demonstrate evidence-based results in improving health better meet the definition of community benefit. Community-building activities help build the capacity of the community to address health needs and often address the "upstream" factors and social determinants that impact health such as education, air quality, and access to nutritious food. It should be noted that the financial reporting of community-building activities may be embedded under community health improvement. **Examples.** Creating a community resource hub for well-being information; supporting a community-based program to address financial, housing, and economic needs in the community; offering a student volunteer program for students planning to attend medical school from under-resourced communities; offering summer internships for youth in the community; participation in a cross-sector collaborative to support access to housing and resources for people experiencing homelessness

Sources: Definitions of community benefit spending categories obtained from "Terms and Glossary," Community Benefit Insight, 2023. Examples of community benefit spending categories obtained from author analysis of community benefit plans from *2021 Hospital Community Benefit Plans*, California Health and Human Services Agency, last updated 2023.

The Value of Community Benefit from a Tax Perspective

The collective value of community benefit in the US — the total of nonprofit hospitals' uncollected tax liability by virtue of their tax-exempt status — was estimated at $28.1 billion in 2020.[21] The study team attempted to identify California's portion of this estimate; however, empirical estimates of the value of the tax exemption for California nonprofit hospitals are not publicly available. Several stakeholders and experts who were interviewed for this report estimated the value of the tax exemption for California nonprofit hospitals to be in the $2.6–$2.8 billion range in 2020. KFF, which generated the $28.1 billion estimate, does not make available the state-level data used to formulate their estimate of nationwide community benefit tax liability. In another study, the Lown Institute — a nonpartisan think tank that studies community benefit, among other health policy issues — reviewed data from 75 California hospitals and estimated a combined tax exemption of nearly $2.3 billion for 2020.[22] Given the relatively small number of hospitals in their estimate, Lown's numbers indicate that the tax benefit could be higher than $2.8 billion.

Perspectives on Community Benefit: Findings from the Literature

Community benefit scholars have questioned the amount, scope, and impact of community benefit dollars. A landmark study of community benefit spending, published in the *New England Journal of Medicine* by Gary Young and others in 2013, shined a light on national practices.[23] At the time of the study (using 2009 data), IRS data indicated that hospitals dedicated an average of 7.5% of operating revenues to community benefit, with substantial variation among hospitals. The study found little to explain the wide swings in variation, raising questions regarding how hospitals, given their limited resources for such endeavors, decide which community benefits to provide.

Other studies have generally confirmed Young's findings. Though community benefit spending has shifted over the years across various categories, the estimate for the percentage of community benefit spending devoted to the category of community health improvement declined over the past decade, from 5.3% in 2009 to 4.1% in 2020.[24] The decrease does not seem to be linked with poorer hospital financial performance.

Several studies have called into question the adequacy of community benefit spending, relative to the value of the tax benefit. For example, researchers from Johns Hopkins University compared charity care provision across government-owned, nonprofit, and for-profit hospitals and found that nonprofits spent less proportionately on community benefit.[25] In a July 2023 Perspectives piece in the *New England Journal of Medicine*, Dr. Ge Bai, a leading public finance expert and key contributor to the community benefit literature, posed the question "Do nonprofit hospitals deserve their tax exemption?"[26]

A 2022 study from the Lown Institute also calls this point into question. Lown created a metric called "fair share" spending, which calculated the value of the tax break compared to the amount of community benefit claimed on Schedule H reporting for 2020. Lown categorized hospitals as being in a "fair share deficit" if their community benefit spending was lower than the value of the benefit. Across the US, the Lown Institute estimates that 77% of hospitals were in a fair share deficit, which represented over $14 billion in underspending.[27] The hospital industry strongly disputes these claims, in part because Lown excluded Medicaid shortfall and

health professions education and research from its fair share calculations.

The US Government Accounting Office (GAO) has weighed in on the issue of oversight of community benefit, calling for a number of improvements to the IRS's auditing and tracking to identify potentially noncompliant hospitals, some of which report little to no community benefit expenditures.[28] According to the GAO, although the IRS referred nearly 1,000 hospitals to the audit division for potential violations of the requirements of the ACA, it was not possible to determine whether these referrals were associated with community benefit. It was also not clear whether the IRS conducted reviews on the 30 hospitals identified by the GAO that reported zero community benefit spending.

Perspectives on Community Benefit: Findings from California Stakeholder Interviews

As part of this study, 49 stakeholders across a variety of settings were asked to provide their perspectives on how well community benefit processes and practices work in California (see Appendix A). Depending on the role of the person or the organization in terms of community benefit, interviewees were asked about engagement in the community benefit process, including participation in the development of the CHNA and community benefit plans, coordination with other statewide or regional health improvement initiatives, measures for evaluating community benefit's impact, and a range of other questions. Interviewees included experts from the field and academic researchers with published studies on community benefit, whose views are referenced in the discussion of the literature above.

Overview of Findings

Interviewees who participated in this study were starkly divided in their assessments of community benefit's impact on community health. Interviewees within the hospital industry took pride in their community benefit programs, indicating that their community benefit contributions far exceed current requirements under federal and state tax law. Conversely, academic researchers and nonhospital stakeholders in California interviewed for this study questioned whether the value of the tax break hospitals receive is justified by community benefit's impact on community health. Many nonhospital industry interviewees, across sectors, had concerns about the way that community benefit dollars are allocated including, among other issues, the fact that expenditures to improve community health are very small relative to Medi-Cal shortfall and other reported expenditure categories.

Several themes and key takeaways emerged from the interviews, with many mentioning concerns about how well hospital community benefit investments align with community or public health priorities. Many outside the hospital industry also frequently raised the issue of data transparency and were interested in having clearer information about how community benefit dollars are used and how they compare to the tax benefits provided. Another theme heard across many different stakeholder groups was the need for better ways to evaluate community benefit's impact locally, regionally, and across the state. These themes of alignment, transparency, and measurement of impact are discussed in the following sections.

Alignment

Many interviewees reported close working relationships between hospitals, public health, and community-based organizations to develop the CHNA, jointly sharing local and regional data with hospitals, often using the same consultants over

time to prepare the CHNA. Community benefit managers described an established process for developing the CHNA. Representatives from community organizations participate in focus groups and questionnaires and provide input on community health priorities. Despite this collaboration and community input, nonhospital stakeholders articulated a desire for hospitals to do more to align their community benefit investments and programs to address those community health needs and improve community health.

Discussions with interviewees regarding how the community benefit plans were developed, how resources were allocated, and how plans were evaluated were less straightforward than descriptions of the CHNA process. Hospitals are not required to collaborate with other community organizations to determine the amount or allocation of hospital community benefit resources. Although there is a well-established process for community participation in the CHNA, there seems to be little involvement by those outside the hospital or health system in the investments directed at community needs.

Several interviewees from the public health sector expressed interest in a more established role with hospitals around community benefit. There is no specific, formal alignment around community benefit between the California Department of Public Health and the 61 local public health offices. Several hospitals described a strong, collaborative partnership with a public health department that provided community health data and helped to facilitate community participation in the CHNA process (e.g., focus groups, interviews, and surveys). In other cases, there appears to be minimal or no involvement by the public health office in developing a hospital's CHNA.

Several stakeholders also noted opportunities to better align local community benefit activities with regional and state population health priority setting and resource allocation decisions. For example, hospitals and public health departments are on different cycles for identifying community health priorities, with public health developing new community health assessments every five years, whereas hospitals are on a three-year CHNA cycle. Moreover, aligning funding decisions at the local, regional, and/or statewide level may increase impact on shared priorities such as access to care, economic security, and mental and behavioral health. Many stakeholders that participated in this study suggested that some level of coordination between statewide initiatives and local community benefit plans could present an opportunity to increase community benefit's impact.

Transparency

A common issue raised in the stakeholder interviews was one of transparency, in part because of the size of the tax benefit and the need to establish the value of community benefit relative to forgone public revenue. Stakeholders outside of the hospital industry described their concerns about the availability of information about hospital community benefit spending, including the quality and consistency of federal and state data reporting, comprehensiveness of information to inform the public about community benefit activities, decisionmaking at the hospital level about community benefit spending and priorities, methods used to calculate community benefit spending, and the public's ability to assess whether a hospital's community benefit spending compares to the tax benefit it receives as a nonprofit, charitable entity.

Hospital interviewees indicated that they were aware of calls for greater transparency and understood that it was challenging for the public to decipher all of the details of their community benefit giving from the community benefit reports. Hospital representatives also raised critiques of IRS Schedule H

reporting, saying that some of the instructions were open for interpretation or less clear than they should be. At the same time, hospital-based stakeholders noted that they currently comply with federal and state regulations, and provide information in sufficient detail for the public to understand their priorities, community benefit investment strategies, and commitment to community improvement.

Community benefit experts raised the point that because Schedule H allows financial reporting at the health system level, and the community benefit plans require far less detailed reporting at the hospital level, it is nearly impossible to see what types of investments, in what communities, and at what level of investment, is taking place in any given community. Several interviewees also pointed out that it is not currently possible to track where individual hospitals in more affluent neighborhoods (which often have a favorable payer mix and financial profile) direct their community benefit investments, both for uncompensated and charity care, Medi-Cal shortfall, and community health improvement services.

According to many interviewees outside of the hospital sector, the state's requirement for transparency is quite narrow. Submission of a community benefit plan that is publicly available on a hospital or health system's website constitutes full compliance with the state transparency requirement under current HCAI regulation. HCAI does not have the authority or the technical ability — without obtaining substantial additional information — to determine whether the plans reflect activities and priorities identified in the CHNA, or whether the plan is actually responsive to the community's health needs.

Measuring Financial and Health Impacts

Hospital interviewees universally expressed a sense of responsibility to their community and portrayed community benefit as part of their mission. Nevertheless, many nonhospital stakeholders, like those working or collaborating with hospitals on community benefit, described an interest in quantifying a hospital's community benefit obligations. Among stakeholders, there was a range of perspectives on how well nonprofit hospitals meet these obligations.

Hospital-based stakeholders described a multitude of programs and practices listed in their community benefit plans as responses to priorities selected from the CHNA, such as contributions to senior services, postpartum support programs, and food banks. Nonhospital stakeholders pointed also to programming and local support provided through a range of community benefit activities; some described these activities as a collection of "kitchen sink" or marketing activities that include sponsoring public health billboards, allowing use of hospital conference rooms, and donating car seats.

Hospitals described their community benefit investments as exceeding the value of the tax exemption. Because Medi-Cal shortfall represents the largest portion of community benefit spending, many interviewees were interested in learning more about how Medi-Cal shortfall was calculated. Some nonhospital stakeholders did not consider Medi-Cal shortfall as a benefit to the community but instead viewed shortfall as a way for hospitals to pay themselves back for low rates relative to other payers. Additionally, some stakeholders had similar concerns about the significant spending on hospital facility improvement or health professional education in the name of community benefit, which they did not interpret as directly benefiting the community. Likewise, nonhospital industry interviewees were consistent in their concerns about the way that community benefit dollars are allocated — among other issues, with expenditures to improve community health very small relative to Medicaid shortfall and other reported expenditure categories.

The issue of quantifying impacts of community benefit dollars was also discussed with interviewees. Although hospital stakeholders highlighted several community benefit activities undertaken to address community health priorities, hospitals did not identify a process for evaluating impact. Federal and California law do not require hospitals to demonstrate that they met their goals or had a substantial impact in their communities. When asked about tracking community benefit activities and their impact over time (i.e., patterns or outcomes over several years or CHNA cycles), many stakeholders indicated that they could not speak to trends in community needs over time and how activities have evolved accordingly. Stakeholders involved with the CHNA and community benefit plan processes, especially those with several years of experience, explained that as hospitals identified priorities in their community benefit plans from their CHNA, they were being responsive to the perceived needs of the community at the time of the assessment, which could have changed from a previous assessment period.

In many cases, hospital interviewees described tracking utilization, such as attendance at a health fair or number of appointments at a mobile clinic. They did not, however, identify existing internal systems or methods to track individual or community-level outcomes as a result of the community benefit activity. Some hospitals and hospital systems indicated an interest in exploring ways to track outcomes and measure impact of their community benefit activities. In some cases, hospital stakeholders and collaborative groups were considering establishing data collection tools to utilize hospital data, and to identify a set of metrics to track the impact of their community benefit activities.

Conclusion

The community benefit landscape in California is complex, involving a wide range of stakeholders over a vast geographic area. This landscape review of community benefit in California is not an exhaustive study of community benefit's impact or implementation in the state. Some aspects of community benefit are not addressed in this report, which focuses primarily on key issues described in the research literature, raised by interviewees, or both.

Most stakeholders who participated in the study believe state policymakers can and should improve the processes and ultimately the value that community benefit activities provide to California communities. Exploring a set of options that could increase alignment with other health initiatives, improve the availability of information, and support better measurement may help ensure resources dedicated to community benefit are achieving their intended purpose.

Appendix A. Study Methods

This report provides a landscape view on the current state of community benefit among nonprofit hospitals in California. The findings are informed by qualitative interviews as well as a review of community benefit literature and research.

Stakeholder Interviews

Researchers conducted 45- to 60-minute virtual interviews with 49 stakeholders from the field from November 2022 to June 2023. Certain stakeholders were interviewed more than once. Stakeholders represented a variety of sectors including advocacy organizations, community organizations, consumer advocates, hospital facilities, hospital systems, think tanks, state and local public health officials, and other national and state community benefit field experts (see Table A1). Interviewees worked in different regions and geographies throughout California, including rural and urban areas. Some interview participants included national experts working outside of California in the community benefit field. The sample of interview participants was recruited using snowball sampling and a purposeful search of media accounts and gray literature. Interviews were recorded with permission and transcribed. Legislative and elected officials were not interviewed for this study.

Researchers developed an interview guide in which interviewees were asked about their organization's involvement with community benefit activities, experiences working with organizations that engage in community benefit activities, the alignment between community benefit activities and other community-focused efforts to improve health and address equity in the state, and ways that community benefit dollars can be leveraged for maximum impact to improve the health of communities in California. Interviewees engaged in community benefit activities were also asked about the development of and their roles in the community health needs assessment, community benefit plans, how health priorities were determined, and how the interviewees were involved in understanding the needs of their community.

This study was deemed exempt by The George Washington University Institutional Review Board.

Literature Review

Findings from this report were also informed by a review of the literature related to community benefit, including literature before and after the ACA's community benefit requirements. Peer-reviewed articles, research reports, and other reports from policy and research organizations were evaluated to gauge the state of community benefit in California for this report. The authors' review of the state of community benefit includes an environmental scan of the community benefit requirements in California, as well as recent policy, legislative, and regulatory action related to community benefit. To understand how California fits into the national context of community benefit, researchers examined community benefit requirements and regulatory action in other states.

Interviews as well as research collected from the literature review and environmental scan were analyzed and organized into the themes and findings described in this report.

In addition to the literature review, researchers conducted an analysis of the community benefit plans HCAI's database for the year 2021. Refer to Appendix B for more information about the community benefit plans analysis.

Table A1. Community Benefit Stakeholder Interviews by Sector

SECTOR	WHO IS INCLUDED	NUMBER OF INTERVIEWS
Community Organizations and Interest Groups	Community partnerships, nonprofits, labor unions	9
Government Entities	Regulatory government institutions	4
Hospitals	Regional and state hospital associations, hospital systems, individual hospitals	14
Public Health	Local and state public health agencies, public health officers / health officers, regional public health groups	9
Policy and Research	Research institutes, policy analysis organizations, think tanks, community benefit field experts	13
Total		**49**

Source: Authors' analysis of stakeholder interview participants.

Note: In many cases, stakeholders worked in more than one sector (e.g., a community benefit field expert also spoke to their experience working in hospital community benefit). This table reflects the primary sector the person represented at the time of the interview.

Appendix B. Community Benefit Plans Analysis

In addition to stakeholder interviews and a review of the literature, researchers analyzed hospital community benefit plans from the community benefit database maintained by the California Department of Health Care Access and Information (HCAI).[29] Researchers used the 2021 community benefit plan data set, as it was the most complete, most recent set of plans available on HCAI's website. There were 226 community benefit plans in the data set, representing unique hospital facilities. However, only 223 plans were included in the analysis because some hospitals did not provide the relevant information on their community benefit reports for the purposes of this analysis (i.e., the community benefit plan did not include health priorities). Hospital names were recorded according to HCAI's documentation in the data set and by verifying the hospital or hospital facility name in the community benefit plan.

To conduct the analysis, researchers documented the health priorities hospitals identified and prioritized, or indicated they would address from their community health needs assessment (CHNA). Researchers recorded only the priorities hospitals indicated they would address through their community benefit activities for each unique hospital facility and community benefit plan (i.e., if a hospital identified 10 health needs through their CHNA, but indicated they would address only five, only the five priorities were documented). Given the variability in how hospitals sorted the health priorities (i.e., some hospitals listed the health priorities in no particular order or in alphabetical order, whereas other hospitals ranked health priorities), researchers did not account for prioritization. After documenting the health priorities from the community benefit plans, researchers identified common themes or commonly referred to priorities. Researchers identified eight common themes or priorities. These themes were summarized to capture the variation in language used by hospitals in their community benefit plans. See Table B1 for how these themes were defined according to the language used by hospitals. Please note that although each hospital facility is required to submit a community benefit plan, the same community benefit plan was submitted and used for different facilities.

Table B1. Community Benefit Plans Analysis Table Key

SUMMARIZED HEALTH PRIORITY	WHAT IS INCLUDED (INEXHAUSTIVE LIST)
Access to Care	Access to care; access to health care / health care; health care / health care access; health care access and delivery; access to primary care, specialty care, transitions of care; access to treatment; access to coordinated, linguistically appropriate, culturally competent care and services; access to care and coverage; preventive practices; system navigation; continuum of care; health literacy and education; screenings; access to dental care, oral health; lack of knowledge of health care services; coordination of care; transitions of care
Chronic Diseases	Chronic disease(s); obesity, diabetes, Healthy Eating Active Living (HEAL) (when mentioned with diabetes or obesity); overweight; weight; cardiovascular disease; heart disease; high blood pressure; Alzheimer's and dementia; cancer; stroke; respiratory illnesses; preventing, managing, and treating chronic diseases
Economic Security	Workforce development, employment, economic security, access to basic needs, education, education as a means of escaping poverty, social determinants of health, poverty
Food Security and Nutrition	Food access, food insecurity, food security, Healthy Eating Active Living (HEAL) (when mentioned alone), healthy lifestyles, nutrition, food stability, nutrition and physical activity, access to basic needs (when food is specifically mentioned)
Housing and Homelessness	Housing, homelessness, stable housing, housing instability, housing security, affordable housing / housing affordability, housing and health care for homeless population(s), ending homelessness, homeless issues, improving health care for homeless population, access to basic needs (when housing is specifically mentioned)
Mental Health	Mental health, behavioral health, social and emotional well-being, behavioral health / mental health services and access, substance use, substance misuse, drug use and related services, abuse services, tobacco
Community and Health and Safety	Violence prevention, violence-free communities, public safety, community wellness and safety, green spaces, social isolation, resiliency, social needs, community-based wellness and activity centers, transportation and traffic, safety from violence and trauma, injury prevention, injury and disease prevention, unintentional injury and violence, community and social support, community outreach and education
Specific Populations	Older adult health, senior health, aging, aging concerns, maternal health, child health, infant health, adverse childhood experiences, childhood harm
Other	This category was used to mark when hospitals indicated a priority that did not fit into the above categories. Examples include birth indicators, disabilities, climate health, environmental sustainability, HIV/AIDS/STIs, etc.

Note: Many hospitals referred to their ongoing response efforts to COVID-19 as part of their community benefit plan activities, but it was not frequently listed as a part of the health priorities.

Source: Authors' analysis of hospital community benefit plans from HCAI's data set of hospital community benefit plans from 2021. *2021 Hospital Community Benefit Plans*, California Health and Human Services Agency, last updated 2023.

Endnotes

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5. A subsequent ruling by the IRS in 1983 modified the inclusion of an emergency room, if state or local health planners determined that those services were not needed in that community.
6. "**Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status**," GAO-20-679, US Government Accountability Office (GAO), October 19, 2020.
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11. ***Hospital Community Benefits Plans: Public Transparency Program*** (PDF), HCAI, February 1, 2023.
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13. *Report to the Legislature*, HCAI.
14. "**Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3)**," IRS, last reviewed or updated July 2023.
15. ***2021 Hospital Community Benefit Plans***, HCAI, last updated 2023. This number includes nonprofit hospitals as well as other hospitals that report community benefit plans to HCAI.
16. Jamie Goodwin, Zachary Levinson, and Scott Hulver, "**The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020**," KFF, March 14, 2023.
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26. Ge Bai, Sunjay Letchuman, and David A. Hyman, "**Do Nonprofit Hospitals Deserve Their Tax Exemption?**," *New England Journal of Medicine* 389, no. 3 (July 20, 2023): 196–97.

27. "**Fair Share Spending**," Lown Institute, accessed April 11, 2023.

28. "Tax Administration," GAO.

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