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UNDERSTANDING NONPROFIT HOSPITAL COMMUNITY BENEFITS: A MIXED METHODS APPROACH

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ABSTRACT

Nonprofit hospitals are required to provide "community benefits" in exchange for their tax exemption and they have been required to report on these benefits to the Internal Revenue Service (IRS) via Form 990/Schedule H since 2009. Few studies have focused on the community benefit categories of *Community Health Promotion, Contributions to Community Groups,* and *Community Building Activities* (hereafter "Community-Oriented Categories") collectively. Additionally, there is a dearth of research examining *why* Schedule H was designed as it was and *why* Community Health Needs Assessments (CHNAs) have not led to greater investment in Community-Oriented Categories. Through an explanatory sequential mixed-methods design, this study seeks to expand on past literature and fill these gaps. In Paper 1, multivariate and univariate multiple regression analyses are used to examine three potential drivers of community benefit spending in fiscal year 2016: organizational-level characteristics, state CHNA policy, and Medicaid expansion. While all three potential drivers were significantly associated with Total Community Benefit Spending, only two organizational-level variables were significantly associated with higher Community-Oriented Categories of spending: log total revenue ($\beta = 1.09$) and profit margin ($\beta = 2.26$). Paper 2 follows up on Paper 1 and uses historical analysis to better understand how Schedule H was created and why it does not hold nonprofit hospitals accountable for certain types of spending. Paper 3 furthers this understanding by analyzing interviews with nonprofit hospital CHNA staff and other key stakeholders in the CHNA/Schedule H reporting processes.

INTRODUCTION TO DISSERTATION

Nonprofit hospitals in the United States have been criticized by lawmakers, scholars, and journalists for providing insufficient benefits to their surrounding communities (Bai et al., 2021; Diamond, 2017; Grassley, 2008). This criticism exists despite the requirement that nonprofit hospitals provide community benefits in exchange for their tax-exempt status and have been required since 2009 to report the type and amount spent on community benefits to the Internal Revenue Service (IRS) via Form 990 Schedule H (hereafter "Schedule H") (Internal Revenue Service, 2007; Rosenbaum et al., 2016). Since 2009, many studies have examined publicly available tax data to better understand reported community benefit spending. However, few studies have focused primarily on the categories of community benefit which most closely relate to the social determinants of health and, to this author's knowledge, no other studies have conducted interviews to better understand the relationship between CHNAs and community benefit spending. This study adds to the existing body of literature by examining drivers of nonprofit hospital community benefit spending; the history of the creation of Schedule H; and the relationship between Community Health Needs Assessments and community benefit spending.

Nonprofit hospitals in the United States have been required to provide "benefits to the community" since 1969 however these benefits were not tracked at the federal level until 2009 when the IRS designed Schedule H. Prior to 2009, "community benefits" were loosely defined and interpreted by nonprofit hospitals differently (Folkemer et al., 2011; Grassley 2008). In 2009, however, the IRS standardized the definition of "community benefit" through the delineation of seven categories: *charity care, unreimbursed costs for means-tested government programs, subsidized health services, community health improvement, research, health*

professions education, and contributions to community groups (Internal Revenue Service, 2019a). There is an additional category, *community building activities*, that is tracked by the IRS and can be counted as a community benefit if properly justified (Internal Revenue Service, 2019a; Rosenbaum et al., 2014). This study argues that some categories of community benefit actually benefit the community more directly than others. These categories include *community health improvement, contributions to community groups* and *community building activities.* This study will shine light on how the seven categories were decided upon and also raise questions regarding the inclusion of all seven categories. Specifically, this study argues for the category *unreimbursed Medicaid* to be reported separately as it is calculated and budgeted for differently than the other categories. Additionally, while the argument to include *unreimbursed Medicaid* as a community benefit stems from the belief that hospitals "lose money" on Medicaid patients, this argument is complicated by a lack of transparent hospital pricing and other factors creating a complex shell game of funding and taxation.

The categories of community benefit were largely derived from the Catholic Health Association's preexisting community benefit requirements (Folkemer, et al., 2011; Trocchio, 2017). In the seminal study on nonprofit hospital community benefit tax data, scholars found highest spending, on average, was designated toward *unreimbursed costs of means-tested government programs* with significant spending variation among nonprofit hospitals (Young et al., 2013). Additionally, studies have found relatively low investment in categories such as *community health improvement, contributions to community groups,* and *community building activities* (Rosenbaum et al., 2016; Young et al., 2018). These three categories that receive comparatively low investment, are examined throughout this study as important opportunities to address the social determinants of health.

Following the 2009 requirement to report community benefits on Schedule H, the 2010 Affordable Care Act mandated that nonprofit hospitals conduct and publicize CHNAs and Implementation Plans every three years beginning in 2014 (Internal Revenue Service, 2014). The goal of CHNAs is to evaluate the health needs of the community served by the hospital and make a plan to address identified needs (Carroll-Scott et al., 2017). CHNA policy therefore requires hospitals to go beyond their traditional role of providing medical care and assigns them with the "…formal role in measuring, prioritizing, and responding to broader community health needs…" (Rosenbaum et al., 2016). CHNA policy has the potential to aid hospitals in directing their community benefit spending towards needed community health improvement.

Nonprofit hospitals and community benefit policy have the potential to be powerful tools in addressing the social determinants of health. The requirement to report community benefits via Schedule H as well as the CHNA requirement demonstrate lawmakers' interest in promoting increased transparency and intentionality with regard to nonprofit hospital community investment. Despite these advancements, we continue to see low spending in the categories that most directly address the social determinants of health (Rosenbaum et al., 2016; Young et al., 2018). This lack of investment is arguably rooted in current community benefit policy and the broad discretion it affords nonprofit hospitals in determining both how much to spend and what to spend on (Rosenbaum et al., 2013). While CHNAs are designed to guide nonprofit hospital spending toward the most needed activities and services, there is no mandate that spending be aligned with findings from these assessments.

To explore the landscape of nonprofit hospital community benefits and make recommendations for policy revision, this study uses explanatory sequential mixed-methods design where quantitative data are collected and analyzed and used to inform a second,

qualitative phase (Creswell & Clark, 2017). The first phase of this study, presented in Paper 1, used data obtained primarily from the website, Community Benefit Insight, a software tool that has cleaned and aggregated Schedule H tax data and combined it with data from sources such as the Centers for Medicare and Medicaid Services and the American Hospital Association. Multivariate regression analysis was used to examine the relationship between potential drivers of community benefit spending and certain categories of spending. Key independent variables included nonprofit hospital religious affiliation, academic affiliation, total revenue, state Medicaid expansion status and state-level CHNA policy. Key dependent variables included spending on Total Community Benefits, Community-Oriented Categories, *research, charity care*, and *unreimbursed Medicaid*. Paper 1 led to questions regarding the delineation of the seven categories of community benefit—why were these seven categories chosen and why is there no minimum spending requirements? Paper 2 sought to answer these questions through historical analysis where primary documents including reports, testimony, and letters are analyzed. Lastly, to answer questions regarding the link between actual community need and nonprofit hospital community benefit spending decisions, Paper 3 uses multiple case study methodology and in-depth semi-structured interviews with nonprofit hospital staff and other key stakeholders to understand the relationship between CHNA processes and Schedule H reporting.

Theoretical Frameworks

Paper 1 uses the lens of New Institutional Theory (NIT) to understand the link between nonprofit hospital organizational factors and community benefit spending decisions. Specifically, NIT furthers our understanding of organizational behavior being driven by social pressures and environmental constraints (Byrd & Landry, 2012). Moreover, NIT informs us that environmental pressures cause organizations in the same field (such as nonprofit hospitals) to resemble one

another, a concept known as "isomorphism" (DiMaggio & Powell, 1983). One type of isomorphism particularly explored in this study is "coercive isomorphism" in which "…formal and informal pressures are exerted on organizations by other organizations upon which they are dependent…" (DiMaggio & Powell, 1983). Nonprofit hospitals face coercive isomorphic pressures from the federal government through IRS requirements and state governments through state-specific community benefit policy. These pressures drive community benefit spending decisions and we therefore see nonprofit hospitals resemble one another.

NIT also posits that organizations may make decisions based on the desire to appear legitimate, even when these decisions sacrifice organizational efficiency, as legitimacy is key to resource procurement and organizational survival (Barley & Tolbert, 1997). This desire to maintain legitimacy can be seen in the nonprofit hospital example through decisions to spend on community benefits that protect nonprofit hospital legitimation in certain subfields. One example is nonprofit hospitals in the subfield of academic medical centers may spend more on the community benefit category of *research* to maintain their legitimacy and survival in the subfield. In contrast, a nonprofit hospital in the subfield of religious hospitals may place greater importance on community benefit expenditures such as *charity care* to appear legitimate. The quantitative findings in Paper 1 examine the association between organizational factors and categorial community benefit spending and through the lens of NIT these associations are better understood.

Paper 3 examines the relationship between CHNAs and community benefit spending through the lens of "decoupling." As mentioned previously, NIT states that organizations strive to be perceived as legitimate in their field (DiMaggio & Powell, 1983). To be perceived as legitimate, organizations must appear to follow institutionalized rules, even when these rules are

not "organizationally efficient" (Meyer & Rowan, 1977). When these rules are inefficient, organizations sometimes employ the practice of "decoupling" their formal policies from actual practices (Meyer & Rowan, 1977). This theory is helpful when examining the relationship between CHNAs and Community Benefit Spending as we see nonprofit hospital policy reflect the importance of conducting CHNAs however we do not see community benefit spending increase in the categories that most closely align with those findings.

Overview of the Three Papers

Paper 1

The goal of Paper 1 is to examine why there is significant community benefit spending variation among nonprofit hospitals with an eye toward three potential drivers of this variation: organizational factors, state-level policy, and Medicaid expansion. The specific research questions are: (1) How (if at all) are organizational factors such as profit margin, religious or academic affiliation associated with Total Community Benefit spending and spending on specific categories of community benefits? (2) What is the impact of state-level community benefit policy and CHNA regulations on Total Community Benefit spending and spending on Community-Oriented Categories? (3) How (if at all) is Medicaid expansion status associated with Total Community Benefit spending, spending on *unreimbursed costs for means-tested government programs* and spending on *charity care*?

To answer these questions, 2016 data from the website Community Benefit Insight was analyzed. Community Benefit Insight combines publicly available tax data with data from sources such as the American Hospital Association and the Centers for Medicare and Medicaid Services as a tool for researchers and the public. Through the use of multivariate and univariate multiple regression analysis, I examine significant predictors of five types of community benefit

spending: *Total Community Benefit spending; charity care spending; research spending; Community-Oriented spending;* and *unreimbursed Medicaid spending*. Significant predictors of greater *Total Community Benefit spending* included academic affiliation (β =.13), log total hospital revenue (β = 1.05), community benefit state laws (β = .23), CHNA state laws (β = .13), and multi-hospital CHNAs (β = .09). Significant predictors of greater *charity care spending* (in the multivariate analysis) included religious affiliation (β = .44), log total revenue (β = 1.09), community benefit state laws (β = .40), CHNA state laws (β = .26) and hospital system membership (β = .22). Significant predictors of greater *research spending* included log total revenue (β = 1.54), and Medicaid expansion (β = .95). Significant predictors of greater *Community-Oriented spending* (in the multivariate analysis) were log total revenue (β = 1.09) and profit margin (β = 2.26). And lastly, significant predictors of greater *unreimbursed Medicaid spending* (in the multivariate analysis) were religious affiliation (β = .35) log total revenue (β = 1.03) percent of people living in poverty (β = .03) Medicaid expansion status (β = .49) and community benefit state laws (β = .31).

Paper 2

Based on findings from Paper 1, Paper 2 sought to examine the creation of Schedule H. Paper 1 brought to light the various ways in which nonprofit hospitals spend on the seven community benefit categories which begged the questions: *How were the seven categories of community benefit decided upon?* And *Why wasn't a minimum benchmark of spending incorporated in the form?* To answer these questions, Paper 2 draws on qualitative historical methods and therefore analyzes primary historical documents and historians' interpretations of these documents (Thies, 2002). Specifically, Congressional hearing transcripts, letters, testimonies, and reports from 2005-2009 are examined.

This analysis revealed that the seven categories of community benefit were primarily derived from the CHA's *Social Accountability Budget* categories and I argue that the decision to base Schedule H off of the CHA's preexisting categories was partially due to their usage of these categories with member hospitals prior to federal policy existing, as well as their positive relationship with Sen. Charles Grassley and other lawmakers. Additionally, when analyzing documents pertaining to decisions about setting a benchmark spending amount, I argue that the majority of stakeholders testify against the inclusion of a benchmark spending amount based on their belief that nonprofit hospitals are financially burdened and need "flexibility" in their provision of community benefits.

Paper 3

To follow up on findings from Paper 1 indicating that spending on *Community-Oriented Categories* is low and appears to be primarily driven by profit margin and revenue rather than state or federal laws, Paper 3 explores the relationship between CHNAs and Community Benefit Spending. Specifically, through multiple case study methodology, Paper 3 analyzes in-depth, semi-structured interviews with 14 CHNA staff and other key stakeholders in the CHNA and/or Schedule H reporting processes. By understanding the processes of conducting and reporting on CHNAs and Schedule H, insight into why we do not see greater investment in Community-Oriented Categories is gained.

The three major findings derived from these interviews include: low levels of involvement from CHNA staff on Schedule H reporting, differing priorities between CHNA staff and community benefit expenditure decision makers (especially with regard to the prioritization of the social determinants of health), and confusion regarding the Schedule H categories and reporting process. Taken together, Paper 3 argues for greater connection between CHNA

departments and decision makers as well as revising Schedule H to delineate a category that explicitly links CHNA findings and community benefit spending.

PAPER 1: NONPROFIT HOSPITAL COMMUNITY BENEFITS: THREE POTENTIAL DRIVERS OF SPENDING VARIATION

Introduction

Nonprofit hospitals in the United States exist in a duality. They are both financially powerful businesses and tax-exempt charitable entities. This paradox has led many to question whether nonprofit hospital tax-exempt status is justified and has contributed to significant policy changes during the past two decades aimed at ensuring they meet their charitable missions. In particular, since 2009 to maintain their tax-exempt status, nonprofit hospitals have been required to report their spending on seven categories collectively known as "community benefits" to the Internal Revenue Service (IRS) (Internal Revenue Service, 2018). Despite this additional regulatory oversight, several studies have noted significant variation across nonprofit hospitals in community benefit spending (Singh et al., 2015; Young et al., 2013). Why might this variation exist?

This study examines three potential drivers of community benefit spending variation: organizational characteristics (such as profit margin or religious or academic hospital affiliation), state-level Community Health Needs Assessment (CHNA) policies, and Medicaid expansion. The research questions addressed in this study are: (1) How (if at all) are organizational factors such as profit margin, religious affiliation or academic affiliation associated with Total Community Benefit spending and spending on specific categories of community benefits? (2) What is the impact of state-level CHNA policies on Total Community Benefit spending and spending on Community-Oriented Categories? (3) How (if at all) is Medicaid expansion status associated with Total Community Benefit spending, spending on the category *unreimbursed costs for means-tested government programs* and spending on the category *charity care*? To

address these research questions, this study uses publicly available data from 2016, retrieved from the website, Community Benefit Insight, to examine the association between the potential drivers of spending mentioned above and five spending outcome variables.

The aforementioned potential spending drivers were selected for several reasons. First, nonprofit hospitals in the United States are heterogeneous organizations. Some nonprofit hospitals are large, financially powerful entities that pay their executives millions of dollars and build gleaming state-of-the-art facilities while others are on the brink of closure and lack equipment and staff. It would be unwise to assume that all hospitals would spend similarly on community benefits given the expansive differences across organizations. Next, this study examines two policies as potential drivers: state-level CHNA policies and Medicaid expansion status. These policies are examined as both were designed with the intention of changing various categories community benefit spending.

By examining three potential drivers of nonprofit hospital community benefit spending through an organizational theory lens, this study informs hospital administrators, policy makers, and community members on the current landscape of spending and proposes policy revision. In a time when many have questioned whether nonprofit hospitals truly deserve their tax benefits, this information serves as an indication of how hospitals are doing and where improvement is needed.

The Nonprofit Status of Hospitals

The early 20th century set the stage for our current system where nonprofit hospitals are most often private and financially powerful yet also perceived as charitable and benevolent. Since 1969, many have argued that nonprofit and for-profit hospitals have grown increasingly similar. Indeed, IRS Commissioner Everson noted in 2005 that nonprofit hospitals resembled

for-profit hospitals because they are both "…complex joint ventures with profit-making companies, [providing] excessive executive compensation, operating for the benefit of private interest rather than the public good…" (Hellinger, 2009). This assessment demonstrates the early-2000's burgeoning belief that nonprofit hospitals were in need of greater oversight and accountability.

The difficulty differentiating nonprofit hospitals from for-profit hospitals sparked concern at federal and state levels. At the federal level, the Senate Finance Committee held hearings regarding justification for nonprofit hospital federal tax exemption in 2004 and 2006 (Folkemer et al., 2011). At the state level, several state supreme courts, including Utah, Pennsylvania, and Vermont questioned the IRS interpretation of hospitals as "charitable" (Burns, 2003); and, with each state ruling, the definition of charitable was further refined, creating additional questions about which hospitals are indeed charitable and how to measure level of charity. Despite concerns surrounding the tax-exempt status of nonprofit hospitals, their presence in the United States health care system remains significant.

The majority of hospitals in the United States are nonprofit (American Hospital Association, 2019) and it is important, therefore, to understand why hospitals would choose to operate as such. There are, of course, nonprofit hospitals whose administrators are motivated by the belief that health care is a public good and that hospitals should be nonprofit to ensure quality, affordable health care for all. However, there are other potential motives for pursuing nonprofit status as well. One motivating factor is the financial benefit nonprofit hospitals are afforded. Currently, nonprofit hospitals receive a federal income tax exemption, many receive state and local tax exemptions, and they "…also have access to charitable donations that are tax deductible to the donor and tax-exempt bond financing" (Government Accountability Office,

2008). The federal tax exemption is significant and was valued at $24.6 billion in 2011 including $10.5 billion in charitable donations (Rosenbaum et al., 2015). These figures shed light on possible financial incentives behind hospitals' nonprofit statuses.

In addition to financial motives, hospitals may be driven to pursue nonprofit status based on their desire to be perceived as legitimate in their field. Some research has suggested that the public may view nonprofit hospitals as "more trustworthy" (Byrd & Landry, 2012) than for-profit hospitals because they may be less motivated by profits. The ubiquity of the private nonprofit hospital in the United States may suggest that such a model is appealing for producers and consumers of healthcare alike. If nonprofit hospitals are indeed seen as "more trustworthy," hospital administrators may wish to keep their tax-exempt status for reasons beyond financial efficiency, they may keep their status for purposes of organizational legitimacy which in turn may aid in organizational success.

Types of Community Benefit Spending

Charity care was first regulated under the 1946 Hill-Burton Act when hospitals were required to provide free or discounted care to low-income patients in exchange for federal grants (Folkemer et al., 2011). Later, in 1956, charity care became a nonprofit hospital requirement for federal tax exemption (Folkemer et al., 2011). However, due to the passage of Medicare and Medicaid in 1965 and the subsequent reduction in uninsured/non-paying hospital patients (Folkemer et al., 2011), the requirement for tax-exempt status changed from the provision of charity care to the provision of "benefits to the community" (Burns, 2003). In 2007, the IRS instituted a new tax reporting structure to capture the amount and type of community benefits provided by nonprofit hospitals. This new reporting structure, Form 990/Schedule H, was first filed in 2009 and delineated seven specific categories of community benefit to be reported on

annually (see **Table 1**) (Folkemer et al., 2011). In addition to the seven major categories of spending, there are three categories deemed important enough to track but are not automatically counted as community benefits: *community building activities, bad debt, and unreimbursed Medicare*.

Table 1. *Description of Community Benefit Categories*

Community Benefit Category	Description
Charity care/Financial Assistance	*Free or discounted health services provided to persons who meet the hospital's criteria for financial assistance and are unable to pay for all or a some of the services provided.*
Unreimbursed costs for means-tested government programs	*The amount incurred by the hospital on the difference between what care costs and what is paid by Medicaid.*
Subsidized health services	*Clinical services that meet identified community needs provided despite a financial loss.*
Community Health Improvement	*Activities or programs subsidized by the tax-exempt hospital, carried out or supported for the purpose of improving health.*
Contributions to community groups	*Cash or in-kind donations to community organizations who provide any of the categories of community benefits.*
Research	*Any study or investigation designed to increase general knowledge, and which is made available to the public. Cannot include research funded by a for-profit entity and starting in 2013, hospitals could no longer report restricted grants.*
Health professions education	*Educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional as required by state law.*
Supplemental Categories	
Community Building Activities	*An array of activities that have may improve community health-physical improvements in housing, economic development, community support, environmental improvements etc.*
Unreimbursed Medicare	*The difference between the cost of care and what is covered by Medicare.*
Bad Debt Expenses	*Amount uncollected from patients who did not qualify for charity care*

The seven categories of community benefit do not all directly benefit the community to the same degree, and scholars have previously collapsed the seven categories into three: "patient care" (*charity care, unreimbursed costs for means-tested programs,* and *subsidized health services*), "community health" (*direct spending on community health* and *contributions to community groups*), and "other" (all remaining categories) illustrating the belief that some categories are more closely related to community health (Young et al., 2018). This study will

contribute to, and expand upon, the current body of literature by focusing on "Community-Oriented Categories" of spending. For purposes of this study, the categories deemed "Community-Oriented" are: *community health improvement, contributions to community groups* and *community building activities*. By highlighting spending on Community-Oriented Categories, this study stresses the importance of the allocation of resources directly to community organizations and initiatives.

By focusing on the "Community-Oriented Categories" this study also seeks to interrogate the rationale for the seven categories included on Form 990/Schedule H. Specifically, this study questions whether *unreimbursed Medicaid* should be counted as a community benefit alongside a category such as *contributions to community groups.* While both are important activities, *unreimbursed Medicaid* is based on the hospital calculating their own charges compared to Medicaid reimbursement and then subsidizing Medicaid reimbursement tax-free. *Unreimbursed Medicaid* may help some struggling nonprofit hospitals stay afloat but spending in this category and its calculation is entirely different from categories such as *contributions to community groups* which is discretionary and based on the budgets of hospital community health departments.

Organizational Factors and Community Benefit Spending

Organizational factors may be driving type and amount of community benefit spending and one important organizational factor is possessing a significant surplus or profit margin each year. While nonprofit hospitals are not allowed to distribute their surplus/net earnings to private shareholders or individuals as a for-profit entity might (Internal Revenue Service, 2018), they are able to use their surplus in other ways. For purposes of this study, "surplus" is codified as "profit margin." Past studies have demonstrated that nonprofit hospitals with higher operating expenses

may spend differently on community benefits (Leider et al., 2017) and therefore this study hypothesizes that nonprofit hospitals with high profit margins spend differently than low profit-margin hospitals. In addition to spending more, this study hypothesizes that high profit margin hospitals may behave like for-profit hospitals and may need to signal their legitimacy through different spending patterns. For these reasons, this study examines the impact of profit margin on both Total Community Benefit Spending as well as spending on Community-Oriented Categories.

In addition to profit margin, organizational factors such as religious affiliation may play a role in community benefit spending. In 2016, 18.5% of all US hospitals were religiously affiliated with 9.4% being Catholic-affiliated (Guiahi et al., 2019). These religiously affiliated hospitals have been found to spend less on community health initiatives (Singh et al., 2018) indicating that something about religious affiliation could cause hospitals to spend differently. Religious hospitals have long focused their mission statements on serving the poor through charitable actions. Indeed, in the mission statement of The Catholic Health Association they state the goal of bringing, "…compassionate care and healing to people of all ages, races, religious beliefs and backgrounds *with special attention to persons who are poor and vulnerable"* (Catholic Health Association, n.d.). Because of the emphasis on attending to the poor and providing charity in religiously affiliated hospital mission statements, this study will examine the hypothesis that there is a positive association between religious affiliation and spending on the community benefit category of *charity care*.

Academically affiliated hospitals in the United States have also been found to spend on certain types of community benefit spending such as greater total spending and spending on categories associated with "patient care" (Singh et al., 2018). For purposes of this study,

academically affiliated hospitals are those that are a member of the Council of Teaching Hospitals and Health Systems through the Association of American Medical Colleges. According to the American Hospitals Association, there are over 1,000 academically affiliated hospitals in the United States and their mission includes, "…educating and training future medical professionals; [and] *conducting state-of-the-art research*…" (American Hospital Association, 2017). This study examines the association between academic affiliation and spending on the community benefit category of *research* due to the mission of academically affiliated hospitals, coupled with their history of different community benefit spending patterns.

By examining three potential organizational factors that impact spending: profit margin, religious affiliation and teaching hospital status, this study emphasizes the role of these factors in driving community benefit spending. Through an understanding of the constraints and pressures placed on certain types of organizations, policymakers could tailor incentives based on these organizational factors.

Community Health Needs Assessments

Community Health Needs Assessment (CHNA) policy is explicitly tied to addressing the needs of communities and is therefore likely to influence community benefit spending. Since 2012, nonprofit hospitals have been required by the federal government to conduct CHNAs and report on their findings (Cramer et al., 2017). Additionally, many *states* had already been requiring CHNAs and by 2016, 11 states had issued their own CHNA requirements (The Hilltop Insitute, 2016). A key goal of conducting and reporting on CHNAs, is to encourage nonprofit hospitals to "…look beyond providing medical services to patients…" (Crossley, 2015) while increasing focus on social determinants of health and "upstream factors." Should hospitals fail to

complete their CHNA within three taxable years, there is a financial penalty imposed of up to $50,000 (Community Benefit Insight, 2018).

Studies have raised questions regarding the impact of the CHNA and the extent to which hospitals actually use this information to determine the allocation of community benefit spending across the seven categories (Singh et al., 2015). There is also evidence suggesting that the state-level requirement to conduct a CHNA increases Total Community Benefit spending (Singh et al., 2018). In a 2009-2011 study by Singh and colleagues examining state-level regulations on community benefits, State-Mandated CHNAs was the only variable associated with greater total community benefit spending (Singh et al., 2018). This study expands on findings from Singh et al. by examining the impact of state-level CHNA policy following the enactment of *federal* CHNA policy. Additionally, this study hypothesizes that hospitals in states with their own CHNA requirements may spend more on both Total Community Benefit Spending and/or spending on Community-Oriented Categories due to the CHNA emphasis on community health.

Medicaid Expansion

The 2010 Affordable Care Act allowed states to expand Medicaid coverage to nonelderly adults with income up to 138% of the Federal Poverty Line (Mazurenko et al., 2018). By 2017, 32 states had expanded Medicaid and in July 2020, 38 states had adopted Medicaid expansion (Kaiser Family Foundation, 2019). The impact of Medicaid expansion has had profound effects on nonprofit hospitals in a number of ways. Safety net hospitals in states that did not expand Medicaid have experienced financial difficulty and closures due to uncompensated care and cuts to disproportionate-share hospital (DSH) payments (Khullar et al., 2018). Medicaid expansion has also had profound effects on community benefit spending.

As noted earlier, one of the categories of community benefit spending is *charity care* which is generally provided to those who are uninsured. Due to Medicaid expansion, it is estimated that 20 million people gained coverage following passage of the ACA and Medicaid expansion (Sommers et al., 2017). Because more people have gained insurance coverage, *charity care* is hypothesized to be less necessary. A recent study published in the Journal of the American Medical Association found that between 2011 and 2017, "Medicaid expansion was associated with a .68 percentage point decline in spending on charity care…" (Kanter et al., 2020). The authors of this study noted that while Medicaid expansion releases hospitals from the "burden of providing uncompensated care [charity care]… this financial relief was not redirected toward spending on other community benefits" (Kanter et al., 2020). The authors also found, that there was an increase in the reported amount spent on *unreimbursed costs for means-tested government programs* which is the category that subsidizes Medicaid payments (Kanter et al., 2020). It is perhaps not surprising that nonprofit hospitals would simply shift funds from *charity care* to Medicaid subsidies as these categories make financial sense for hospitals. These findings do raise the question of how lawmakers can effectively incentivize spending on direct community health categories (if this is indeed the goal).

This study builds on past research by examining whether nonprofit hospitals in Medicaid expansion states indeed spend less on *charity care* and more on *unreimbursed costs for means-tested government programs* than hospitals in non-expansion states. This study adds to the conversation by examining differences in spending on Total Community Benefit Spending as well as Community-Oriented Categories of spending between expansion and non-expansion states and hypothesizes that expansion states may see greater spending on Community-Oriented Categories.

New Institutional Theory and the Organizational Field of Hospitals

This study primarily draws upon New Institutional Theory (NIT) to understand hospital decision making. NIT explains organizational behavior as resulting from social pressures and constraints from the environment (Byrd & Landry, 2012) and it further states that these environmental pressures lead organizations in the same field to begin to resemble one another, a phenomenon known as isomorphism (DiMaggio & Powell, 1983). Isomorphism can take three forms: coercive, mimetic, or normative (DiMaggio & Powell, 1983). New Institutional Theory also posits that decision making is not driven solely by efficiency, but rather by a quest to gain legitimacy which, in turn, leads to greater resources and likelihood of organizational survival (Barley & Tolbert, 1997). This framework lends itself toward understanding nonprofit hospitals with regard to community benefit decisions because nonprofit hospitals face significant isomorphic pressures as they strive for legitimacy in their field. Insights from NIT can be seen in each of the three analyses.

First, NIT's emphasis on organizational fields helps us understand how different hospitals may signal legitimacy in different ways. For example, this would explain why an academic medical center might be expected to spend more on *research* than other categories, while a religiously affiliated hospital might be expected to spend more on *charity care*. This study will help explain the associations between organizational factors and community benefit spending.

Second, hospitals are considered highly institutionalized organizations partly because they are so highly regulated. Regulatory pressures can be thought of as what DiMaggio and Powell (1983) refer to as "coercive isomorphism" which results from "…formal and informal pressures exerted on organizations by other organizations upon which they are dependent…" (1983). In this case, the organization providing pressure is the government and the pressures

result in changing organizational behavior in the form of community benefit and CHNA reporting. Regulations are intended to coercively affect hospital decision making when it comes to community benefit spending and are imposed at the federal level via IRS requirements and the ACA, as well as at the state-level through state attorney general mandates/state community benefit regulations. Nonprofit hospitals' legitimacy relies strongly on the regulatory environment so they face great pressure to comply (Byrd & Landry, 2012). Should nonprofit hospitals fail to comply with regulations, they risk fines and more importantly, the potential loss of their nonprofit status.

Research has demonstrated that coercive pressures (such state specific reporting requirements) have had a significant impact on nonprofit hospital community benefits reporting as those states with requirements "reported significantly more community health orientation activities" than states without (prior to the 2009 IRS requirements) (Ginn & Moseley, 2006). By requiring nonprofit hospitals to report their community benefit expenditures to the IRS and to conduct CHNAs, the government is acting coercively to cause all nonprofit hospitals to change (at least in reporting habits). Federal pressures affect all hospitals equally, but state-level regulations vary providing an opportunity to explore how the degree of coercive isomorphic pressures may be associated with Total Community Benefit Spending and spending on Community-Oriented Categories.

Third, the desire to be seen as a charitable entity is demonstrated by the mission of the American Hospital Association (AHA), "To advance the health of individuals and communities. The AHA leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement" (American Hospital Association, 2018). The emphasis placed on the health of communities is particularly

striking in the AHA mission as hospitals spend only an average of 7.5-8.5% of total expenditures on community benefits and far less than that on direct spending on community health or contributions to community groups (Young et al., 2018). The dissonance between hospital missions and action/spending can be described as "decoupling" (Meyer & Rowan, 1977). Decoupling helps us understand why hospitals may appear charitable in the formal sense despite their activities (Meyer & Rowan, 1977), in this case spending, varying based on other organizational considerations. To better understand what these "other considerations" might be, this study exposes factors associated with spending on Community-Oriented Categories which may help hospitals appear legitimate in their mission statements but has historically been a low spending priority (Young et al., 2018).

Methods

The primary data source for this study is the website, Community Benefit Insight, which was designed by The George Washington University School of Public Health and RTI International to inform researchers and the public on nonprofit hospital community benefits by gathering data from nonprofit tax returns (IRS Form 990/Schedule H), the American Hospital Association, and the Centers for Medicare and Medicaid Services (Community Benefit Insight, n.d.). This website is an innovative and relatively new tool designed to show nonprofit hospital spending through use of graphics and search tools. To the best of this author's knowledge, this is only the second study to use a large sample of data from Community Benefit Insight (Chen et al., 2020). Community Benefit Insight data was merged with additional data from the American Hospital Association Annual Survey and Herfindahl-Hirschman Index data in order to control for hospital system affiliation and market concentration (see Appendix 1A **Table 2**).

The study sample is relatively similar to the population of nonprofit hospitals with slightly fewer teaching hospitals, religious hospitals, and system affiliated hospitals being present. Additionally, there are no sole provider hospitals in this data set which is a limitation when attempting to generalize these findings especially to rural areas. These differences are partially due to the decision to drop all hospitals from the sample that filed a consolidated tax return with their hospital network. Past researchers have made the decision to drop nonprofit hospitals that filed consolidated returns (Singh et al., 2015; Young et al., 2018) because these returns obscure the amount spent on community benefits by individual hospitals (Young et al., 2013) and it is therefore difficult to accurately compare consolidated tax return data with individual hospital data.

The research questions addressed in this paper are: (1) How (if at all) are organizational factors such as religious and academic affiliation and total revenue associated with Total Community Benefit Spending and spending on specific categories of community benefits? (2) What is the impact of state-level CHNA policies on Total Community Benefit Spending and spending on Community-Oriented Categories? (3) How (if at all) is Medicaid expansion status associated with Total Community Benefit Spending, spending on *unreimbursed costs for means-tested government programs* and spending on *charity care*?

This study first examined five multiple regression analyses using Huber-White robust standard errors to assess the aforementioned research questions (see Appendix 1B, **Table 3**). Each regression examined a different dependent variable while the independent variables remained identical. The goal of these regressions was to see whether certain key organizational and policy variables were associated with community benefit spending. By examining different categories of spending, this study sheds light on spending priorities for different types of

hospitals. To assess these research questions, the following Ordinary Least Squares (OLS) regression model was used:

$$\text{CommunityBenefitSpending}_i = \alpha + \beta_1 * \text{OrgVariables}_i + \beta_2 * \text{PolicyVariables}_i + \varepsilon_i$$

In this model, $\text{CommunityBenefitSpending}_i$ represents the five outcomes of interest: Total Community Benefit Spending, *charity care* spending, *research* spending, Community-Oriented Categories of spending and spending on *unreimbursed Medicaid* for hospitals_i. OrgVariables_i represent a vector of organizational-level independent variables for hospitals_i including religious affiliation, teaching hospital status, bedsize, total revenue, urban location, profit margin, hospital system affiliation, and the percent of people living in poverty. The key organizational variables of interest were religious affiliation, academic affiliation, and profit margin. $\textit{PolicyVariables}_i$ represents a vector of policy-level independent variables for hospitals_i including Medicaid expansion status, community benefit state laws, CHNA state laws, multiple hospital CHNA, Medicaid fee bump, and the Herfindahl-Hirschman Index. The key policy variables of interest were state CHNA laws and Medicaid expansion status.

Because all five multiple regression analyses examined nonprofit hospital spending, and because this author hypothesized that spending in one category may influence spending on another category, the Seemingly Unrelated Regression Equations (SURE) test was conducted to assess for biased coefficients. This author found evidence of biased coefficients and therefore Multivariate Multiple Regression Analysis was used which examines all dependent variables simultaneously. Total Community Benefit Spending was excluded as a dependent variable in the Multivariate Regression Analysis as it is a sum of all other spending categories **(**see Appendix 1C **Table 4).** Additionally, Log Research Spending was excluded from the Multivariate Multiple Regression Analysis due to censoring at zero. Because the independent variable "profit margin"

is scaled to revenue-expenditure, it is endogenous to hospital decisions regarding charity care and Medicaid. To account for this concern, a sensitivity analysis was run which removed "profit margin" and significant results remained identical. Univariate Multiple Regression Analyses was used to examine Log Research Spending and Log Total Community Benefit Spending (see Appendix 1D **Table 5** and Appendix 1E **Table 6)**.

Dependent Variables

The five dependent variables were chosen based on this study's hypotheses and research questions. By examining Log Total Community Benefits, this study illuminates the landscape of community benefit spending based on organizational and policy variables. Through an examination of Log *charity care* spending and Log *research* spending, this study assesses the hypotheses that religious affiliation may be associated with Log *charity care* spending and that academic affiliation may be associated with Log *research* spending. By examining Log Community-Oriented Categories of Spending, this study sheds light on the effect of policy and organizational level variables that may be associated with spending on direct community needs. Finally, Log *unreimbursed Medicaid* spending is examined to test the hypothesis that hospitals in Medicaid expansion states may spend less on *charity care* and more on *unreimbursed Medicaid*.

Independent Variables

To better understand the aforementioned independent variables (both independent variables of interest as well as control variables), descriptions are provided below.

1. Religious Affiliation: Defined as nonprofit hospitals that are owned or operated by a religious organization.
2. Academic Affiliation: Defined as being a Member of the Council of Teaching Hospitals.
3. Hospital Bedsize: Defined as the number of beds in the hospital.

4. Hospital Total Revenue: Total Revenue corresponds to what was reported by the nonprofit hospital on IRS Form 990. For purposes of this study, the log version of Total Revenue was analyzed.
5. Urban Location: Urban location is determined through use of the Urban-Rural Continuum data available from the Area Health Resources file. Continuum values of 01, 02 and 03 were flagged as "urban" by Community Benefit Insight.
6. Profit Margin: Profit Margin was calculated by taking total revenue minus total expenses, divided by total revenue.
7. Percent of People Living in Poverty: This data originally came from the Area Health Resource File which gathers "…county level hospital information for hospital county" and was merged with Community Benefit Insight Data.
8. Medicaid Expansion Status: This information was retrieved from the Kaiser Family Foundation.
9. CHNA State Laws: CHNA State Law information was gathered from the Hilltop Institute which tracks individual state regulations on CHNAs on a yearly basis.
10. Multiple Hospital CHNA: This data is collected via Form 990 Schedule H and was compiled by Community Benefit Insight. Nonprofit Hospitals are required to answer the question, "Was the hospital facility's CHNA conducted with one or more other hospital facilities?"
11. Hospital System Membership: Hospital System Membership was determined by the American Hospital Association Annual Survey, information that was generously shared with this author by Dr. Simone Singh at the University of Michigan.

12. Primary Care Fee Bump: The Primary Care Fee Bump refers to the Affordable Care Act policy that raised Medicaid reimbursement rates to the same level as Medicare. To determine which states continued to use the fee bump in 2016, this author used information reported by the Urban Institute (Zuckerman et al. 2017).
13. Herfindahl-Hirschman Index: The Herfindahl-Hirschman Index (HHI) was used as a measure of market concentration. The range of the Index is 0-1 where "1" indicates the hospital has a total monopoly (Young et al., 2013). This author gratefully acknowledges that the HHI data was shared with me by Stuart Craig, PhD student at the University of Pennsylvania.

Results

Total Community Benefit Spending

The first univariate multiple regression analysis examined the outcome variable, Log Total Community Benefit Spending. The variables that were significantly associated with *greater* total spending on community benefits were academic affiliation (β =.13), log total hospital revenue (β = 1.05), community benefit state laws (β = .23), CHNA state laws (β = .13), and multi-hospital CHNAs (β = .09).

Charity Care Spending

Because I hypothesized that hospital religious affiliation may be related to *charity care* spending and hospital academic affiliation may be related to *research* spending, the next two univariate regressions examine the outcome variables Log *charity care* spending and Log *research* spending. When examining *charity care* as the dependent variable, religious affiliation (β = .38), log total revenue (β = 1.07), percent of people living in poverty (β = .01), community benefit state laws (β = .39), CHNA state laws (β = .27) and hospital system membership (β =

.26) were significantly associated with greater *charity care* spending whereas Medicaid expansion (β = -.93) was significantly associated with lower *charity care* spending.

Research Spending

When examining *research* as the dependent variable**,** bedsize (β = -.70) was significantly *negatively* associated with spending on research, while log total revenue (β = 1.54), and Medicaid expansion (β = .95) were significantly *positively* associated with greater spending on research. It is notable however, that this regression has a significantly lower number of observations due to the censoring at zero of this variable.

Community-Oriented Categories of Spending

In the OLS model for the next the dependent variable, Log Community-Oriented Categories of spending, religious affiliation (β = .28), log total revenue (β = 1.12) and profit margin (β = 2.44) were also significantly and positively associated with spending. However, percent of people living in poverty was significantly and negatively associated with Community-Oriented Categories of Spending (β = -.02)

Unreimbursed Medicaid

The final univariate multiple regression analysis examined *unreimbursed Medicaid* as the outcome variable of interest. Findings included religious affiliation (β = .33) log total revenue (β = 1.04), percent of people living in poverty (β = .03) Medicaid expansion status (β = .45) and community benefit state laws (β = .38) being significantly and positively associated with Log *unreimbursed Medicaid* spending. Variables that were associated with significantly less spending in the *unreimbursed Medicaid* category included academic affiliation (β = -.21) and Herfindahl-Hirschman Index (β = -.46).

Interaction Effects

This study also posited that nonprofit hospitals with higher profit margins may look different from other hospitals in their field. To test this theory, interaction terms including teaching hospital status * profit margin and religious affiliation * profit margin were examined. Teaching hospitals with higher profit margins were found to be significantly associated with Total Community Benefit spending (β = .034) but were not statistically significantly related to other spending categories in the multivariate multiple regression analysis. Religiously affiliated hospitals with higher profit margins were found to be significantly and negatively associated with spending on Community-Oriented Categories of spending (β = -5.0) in the multivariate multiple regression but not significantly associated with other categories of spending.

Multivariate Multiple Regression

In the Multivariate Multiple Regression Model, this study found that for log *charity care* spending, the following variables were significantly and positively related to spending: religious affiliation (β = .44) log total revenue (β = 1.09) community benefit state laws (β = .40) CHNA state laws (β = .26) and hospital system membership (β = .22). Additionally, the following variables were found to be negatively associated with log *charity care* spending: Medicaid expansion (β = -.99) and multiple hospital CHNA (β = -.16).

When examining Log Community-Oriented Spending in the Multivariate Multiple Regression Model, this study found the following variables to be positively associated with spending: log total revenue (β = 1.09) and profit margin (β = 2.26).

Lastly when examining Log *unreimbursed Medicaid*, in the Multivariate Regression Model, this study found the following variables to be positively associated with spending: religious affiliation (β = .35), log total revenue (β = 1.03), percent of people living in poverty (β

= .03), Medicaid expansion (β = .49), and community benefit state laws (β = .31). Whereas the following variables were negatively associated with Log *unreimbursed Medicaid* Spending: academic affiliation (β = -.25), profit margin (β = -.97), and the Herfindahl-Hirschman Index (β = -.40).

Discussion

This study examined the effects of three potential drivers of nonprofit hospital community benefit spending variation: organization-level characteristics, state CHNA policies, and Medicaid expansion status. Findings illustrate that the primary organizational characteristic associated with community benefit spending is total revenue while religious affiliation is associated with *charity care* and *unreimbursed Medicaid* spending. Additionally, while state CHNA policies are associated with overall spending, they do not appear to influence Community-Oriented Categories of spending. Finally, while Medicaid expansion status did indeed appear to lower spending on *charity care*, it did not increase spending on Community-Oriented Categories of spending, rather, those funds appear to be reallocated toward the category of *unreimbursed Medicaid*. These findings point toward nonprofit hospitals prioritizing spending that benefits their financial bottom line. While hospitals do indeed exist in a highly regulated environment and are driven by a quest for legitimacy, it appears that they do not yet need to spend significantly on Community-Oriented Categories to maintain this legitimacy or keep up with their field.

The finding that greater total spending on community benefits is associated with the existence of CHNA state laws and CHNAs being conducted with multiple hospital facilities suggests that state laws and coordinated efforts on the part of hospitals may lead to greater spending. However, the subsequent finding that these same variables (state laws and multiple

hospital CHNA efforts) are not associated with spending on Community-Oriented Categories complicates this picture. This is consistent with a previous finding that even after the Affordable Care Act, spending in "Community Health Benefits" did not increase (Young et al., 2018a). The previous study by Young et al. noted that spending may not have increased due to the short period of time that had elapsed between the passage of the ACA and the study. However, this study suggests that perhaps it was not the short length of time but something else that is preventing hospitals from investing to a greater extent in Community-Oriented Categories.

Previous studies have shown that the primary spending category for nonprofit hospitals is *unreimbursed costs for means-tested government programs* or spending that subsidizes the lower reimbursement rates from Medicaid and the Children's Health Insurance Program (CHIP) (Young et al., 2013, 2018). It is possible that as long as hospitals maintain discretion in their community benefit spending, *unreimbursed costs for means-tested government programs* will always receive more funds as it contributes to hospitals' bottom line whereas Community-Oriented Categories will only be spent on in years of great surplus. However, this study expands on past research by also noting that hospital profit margin is significantly and positively associated with spending on Community-Oriented Categories. This finding suggests that financially well-off hospitals have the funding surplus to spend on these categories that do not increase the bottom line. Taken together, it appears that nonprofit hospitals require greater incentives to spend on Community-Oriented Categories and that profit margin plays a role in ability and/or likelihood to spend on these categories.

With regard to Medicaid expansion status, in line with past literature (Kanter et al., 2020) nonprofit hospitals in expansion states spent less on *charity care* and more on *unreimbursed Medicaid.* However, somewhat surprising is that hospitals in expansion states were *not* more

likely to spend significantly more on Community-Oriented Categories even though aligning spending with community need was a goal of the ACA (Folkemer et al., 2011). This finding again illustrates the importance of providing the right incentives/mandates. By lessening the need to spend on *charity care*, the ACA helped hospitals free up dollars for other categories. However, given the option of spending on community groups or subsidizing Medicaid reimbursement payments, it appears that hospitals will continue to choose (or feel forced) to spend on *unreimbursed costs for means-tested government programs* as this most directly benefits the hospitals themselves. While some nonprofit hospitals may be in dire need of these funds, other reports have argued that many nonprofit hospital systems continue to make large profits and spend highly on executive compensation (Bai & Anderson, 2016; Diamond, 2017; Paavola, 2019) suggesting that they do have the option to spend differently.

Limitations

When examining the above regression analyses it is important to note several limitations of this study. Because there is a lag between tax reporting and aggregation of data on the website Community Benefit Insight, 2016 was the most recent year available. Additionally, the sample of hospitals examined in these analyses is not representative of the population of all U.S. nonprofit hospitals especially because those hospital systems that filed consolidated returns were dropped from the data set and the sample therefore underrepresents hospital systems. Despite running a sensitivity analysis which removed the independent variable "profit margin," it is possible that concerns regarding endogeneity remain. Finally, in discussions with key informants involved in the CHNA and tax preparation/reporting processes for nonprofit hospitals, this author has learned that taking community benefit expenditure numbers at face value can be somewhat misleading. For example, some academic medical centers are partnerships between medical

schools and hospital systems and therefore, the medical school may report *research* spending rather than the hospital system thereby making the hospital appear to spend very little on research when in fact the expenditures were reported by the medical school. Nuanced issues such as these complicate cross-hospital spending comparisons.

Conclusion

While recent regulatory changes have led to some changes with regard to community benefit spending, expenditures allocated toward Community-Oriented Categories still appear neglected. Despite freeing up funds from other categories (*charity care*) and placing emphasis on the social needs of communities through CHNAs, the majority of community benefit funds remain focused on *unreimbursed costs for means-tested government programs*. To move the needle toward spending on Community-Oriented Categories, several steps would need to be taken.

First, there is currently no policy indicating that nonprofit hospitals must spend on certain categories or that they must spend a certain amount on community benefits. While the lack of regulation surrounding spending type and amount prevents an undue burden being placed on less financially stable hospitals, it has also led to significant variability among hospital spending. To truly address the health and social needs of communities, policies should be enforced that require hospitals to spend a percentage of their profit margin on the Community-Oriented Categories. Because we have seen nonprofit hospital compliance with other coercive pressures (such as state expansion of Medicaid and CHNA requirements), it is likely that hospitals would also comply with a federal regulation mandating a certain level of spending. It is important that spending is tied to profit margin so that hospitals in areas where the majority of patients have private health

insurance are required to do more than hospitals that may struggle financially due to a lower share of privately insured patients.

Secondly, Community-Oriented Categorical spending should be explicitly tied to CHNAs. Because the current policy arguably emphasizes *conducting* the CHNA rather than financially implementing the CHNA, greater focus may be placed on the actual reporting than on the response to the community identified needs. To prevent nonprofit hospitals from decoupling their mission statements from their actual spending on community benefits, the federal government should require a connection from the CHNA to actual community benefit spending and penalize those hospitals that do not spend accordingly.

This study examined current community benefit spending patterns with particular focus on three potential drivers of spending: organizational factors, state CHNA policies, and Medicaid expansion. By understanding current spending and the variables related to spending on certain categories of benefits, this study found the need for additional incentives for nonprofit hospitals to spend on Community-Oriented Categories that most directly benefit the communities in which nonprofit hospitals reside. By regulating that a percentage of profit margin be allocated toward meeting the needs of the community, nonprofit hospitals would address critical health needs in their surrounding communities and be held accountable for their tax exemptions.

APPENDIX 1A

Table 2. *Description of Sample Nonprofit Hospitals (N=1,552)*

Variable	n	%
Religious Affiliation	155	9.99
Academic Affiliation	431	27.77
Bedsize		
<100	802	51.68
100-299	462	29.77
>299	288	18.56
Urban Location	845	54.45
Subject to Community Benefit State Laws	1,094	70.49
Member of Hospital System	626	56.24
Medicaid Fee Bump Hospital	361	23.26
Hospital in Medicaid Expansion State	994	64.05
Subject to CHNA State Laws	468	30.15
Participated in Multi-Hospital CHNA	683	44.76
Total Revenue (/1,000,000)		
Mean	226.10	
SD	432.04	
Min	0	
Max	6,710.82	
Profit Margin		
Mean	0.03	
SD	0.14	
Min	-3.69	
Max	0.09	

APPENDIX 1B

Table 3. *Five Multiple Regression Analyses-Community Benefit Spending by Category Fiscal Year 2016*

	Dependent Variables				
Independent Variables	Log Total Community Benefit Spending	Log Charity Care Spending	Log Research Spending	Log Community Category Spending	Log Unreimbursed Medicaid Spending
Religious Affiliation	-0.06	0.38***	-0.39	0.28**	0.33***
	-0.08	-0.10	-0.41	-0.13	-0.10
Academic Affiliation	0.13**	-0.01	0.37	0.05	-0.21**
	-0.054	-0.09	-0.39	-0.12	-0.10
Bedsize	-0.01	-0.08	-0.70*	0.02	-0.037
	-0.06	-0.08	-0.38	-0.12	-0.09
Log Total Revenue	1.05***	1.07***	1.54***	1.12***	1.04***
	-0.04	-0.05	-0.27	-0.08	-0.06
Urban	-0.06	0.05	1.05	-0.05	-0.04
	-0.06	-0.10	-0.67	-0.13	-0.10
Profit Margin	-0.758	-0.12	-5.06	2.44***	-1.17
	-0.59	-0.59	-3.30	-0.91	-0.78
Percent of People Living in Poverty	0	0.01*	0.05	-0.02*	0.03***
	-0.01	-0.01	-0.04	-0.01	-0.01
Medicaid Expansion	-0.05	-0.93***	0.95**	0.07	0.45***
	-0.05	-0.07	-0.40	-0.11	-0.09
Community Benefit State Laws	0.23***	0.39***	0.69	0.00	0.38***
	-0.07	-0.09	-0.49	-0.12	-0.10
CHNA State Laws	0.13**	0.27***	0.21	0.04	0.05
	-0.05	-0.08	-0.46	-0.14	-0.09
Multiple Hospital CHNA	0.09**	-0.09	0.19	-0.146	0.08
	-0.05	-0.07	-0.38	-0.11	-0.08
Fee Bump	-0.09	0.10	0.14	0.11	-0.02
	-0.06	-0.09	-0.53	-0.12	-0.10
Herfindahl-Hirschman Index	-0.11	-0.18	0.75	0.10	-0.46***
	-0.11	-0.15	-0.95	-0.24	-0.17
Hospital System Member	-0.05	0.26***	-0.43	-0.121	-0.05
	-0.049	-0.08	-0.38	-0.11	-0.08
Constant	-3.674***	-6.061***	-20.214***	-7.879***	-4.74***
	-0.72	-0.89	-4.83	-1.31	-1.04
Observations	930	900	139	850	788
R-squared	0.815	0.7	0.544	0.535	0.672

Note: Model is significant at ***p<.001, **p<.05, *p<.1.

*Huber-White Standard Errors were used to address heteroskedasticity

APPENDIX 1C

Table 4. *Multivariate Multiple Regression Analysis-Community Benefit Spending by Category for Fiscal Year 2016*

	Dependent Variables		
Independent Variables	Log Charity Care Spending	Log Community-Oriented Spending	Log Unreimbursed Medicaid Spending
Religious Affiliation	0.44***	0.28	0.35***
	-0.13	-0.18	-0.13
Academic Affiliation	0.01	0.07	-0.25**
	-0.10	-0.14	-0.10
Bedsize	-0.10	0.07	-0.02
	-0.09	-0.13	-0.09
Log Total Revenue	1.09***	1.09***	1.03***
	-0.05	-0.08	-0.05
Urban	0.01	-0.18	-0.06
	-0.10	-0.15	-0.10
Profit Margin	-0.31	2.26***	-0.97*
	-0.56	-0.80	-0.56
Percent of People Living in Poverty	0.01	-0.02	0.03***
	-0.01	-0.01	-0.01
Medicaid Expansion	-0.99***	0.02	0.49***
	-0.09	-0.13	-0.09
Community Benefit State Laws	0.40***	-0.03	0.31***
	-0.10	-0.14	-0.10
CHNA State Laws	0.26***	-0.05	0.06
	-0.10	-0.141	-0.10
Multiple Hospital CHNA	-0.16**	-0.11	0.07
	-0.08	-0.11	-0.08
Fee Bump	0.14	0.08	-0.06
	-0.10	-0.14	-0.10
Herfindahl-Hirschman Index	-0.32*	-0.00	-0.40**
	-0.17	-0.24	-0.17
Hospital System Member	0.22***	-0.18	-0.06
	-0.08	-0.12	-0.08
Constant	-6.13***	-7.34***	-4.78***
	-0.94	-1.34	-0.95
Observations	691	691	691
R-squared	0.685	0.506	0.66

Note: Model is significant at ***p<.001, **p<.05, *p<.1.

APPENDIX 1D

Table 5. *Univariate Multiple Regression Analysis-Log Total Community Benefit Spending for Fiscal Year 2016*

	Dependent Variable
Independent Variables	Log Total Community Benefits
Religious Affiliation	-0.06
	-0.08
Academic Affiliation	0.13**
	-0.05
Bedsize	-0.01
	-0.06
Log Total Revenue	1.05***
	-0.04
Urban	-0.06
	-0.06
Profit Margin	-0.76
	-0.59
Percent of People Living in Poverty	0
	-0.01
Medicaid Expansion	-0.05
	-0.05
Community Benefit State Laws	0.23***
	-0.07
CHNA State Laws	0.13**
	-0.05
Multiple Hospital CHNA	0.09**
	-0.05
Fee Bump	-0.09
	-0.06
Herfindahl-Hirschman Index	-0.11
	-0.11
Hospital System Member	-0.05
	-0.049
Constant	-3.67***
	-0.72
Observations	930
R-squared	0.82

Note: Model is significant at ***p<.001, **p<.05, *p<.1.

*Huber-White Standard Errors were used to address heteroskedasticity

APPENDIX 1E

Table 6. *Univariate Multiple Regression Analysis-Log Total Research Spending for Fiscal Year 2016*

	Dependent Variable
Independent Variables	Log Research Spending
Religious Affiliation	-0.39
	-0.41
Academic Affiliation	0.37
	-0.39
Bedsize	-0.70*
	-0.38
Log Total Revenue	1.54***
	-0.27
Urban	1.05
	-0.67
Profit Margin	-5.06
	-3.30
Percent of People Living in Poverty	0.05
	-0.04
Medicaid Expansion	0.95**
	-0.40
Community Benefit State Laws	0.69
	-0.49
CHNA State Laws	0.21
	-0.46
Multiple Hospital CHNA	0.19
	-0.38
Fee Bump	0.14
	-0.53
Herfindahl-Hirschman Index	0.75
	-0.95
Hospital System Member	-0.43
	-0.38
Constant	-20.21***
	-4.83
Observations	139
R-squared	0.54

Note: Model is significant at ***p<.001, **p<.05, *p<.1.

*Huber-White Standard Errors were used to address heteroskedasticity

PAPER 2: THE DEVELOPMENT OF SCHEDULE H: A HISTORICAL ANALYSIS

Introduction

Nonprofit hospitals in the United States have been required to provide "community benefits" to maintain their tax-exempt status since 1969. However, these community benefits were not reported on or tracked at the federal level until 2009. In 2009, nonprofit hospitals were first required to report community benefit activities to the Internal Revenue Services (IRS) via Form 990 Schedule H (hereafter "Schedule H"). The creation of Schedule H had a significant impact on community benefit policy as it delineated seven categories defined as community benefits and notably did not require hospitals to spend a "benchmark" or minimum amount on these benefits.

The creation of Schedule H took place at a time when many questioned whether nonprofit hospital tax exemption was justified (Grassley, 2008). Since its creation, scholars have noted that Schedule H affords nonprofit hospitals "broad latitude" in determining the type and amount of community benefit they provide (Grassley, 2008; Rosenbaum et al., 2013) leading to extreme variability in the provision of community benefits (Government Accountability Office, 2008; Young et al., 2013). Additionally, since the Schedule H filing requirement began, concerns about whether nonprofit hospitals provide sufficient community benefits given the tax benefits they receive have continued from scholars and reporters alike (Bai et al., 2021; Diamond, 2017) especially with regard to collections practices and the provision of charity care. Given the opportunity to hold hospitals accountable to a greater extent, questions remain about why Schedule H was designed as it was.

This article fills in the historical record by documenting 1) *how the seven categories of community benefit were decided upon,* and *2) why a minimum benchmark of spending was not*

incorporated in the form. It does this by exploring hearings, letters, public commentary, and reports primarily from 2005-2009 pertaining to Schedule H creation. Based on this analysis, we see that the seven categories of community benefit largely stemmed from the Catholic Health Association's preexisting categories of community benefit and the decision not to establish a minimum spending benchmark was due to opposition from the Catholic Health Association, the American Hospital Association and other key stakeholders. Central to these decisions were baseline assumptions that the provision of community benefits is financially burdensome to hospitals and that they should therefore be afforded "flexibility" in the type and amounts of community benefit they provide. This paper demonstrates that a confluence of factors in the 1980's-2000's gave way to a legislative appetite for increased nonprofit hospital accountability; and that despite this opportunity, certain key accountability features such as establishing a benchmark spending amount and requiring spending on charity care were ultimately abandoned.

Early History of Nonprofit Hospitals in the United States

Hospitals in the United States have historically been viewed as "charitable" partially due to their origins as "almshouses" for the poor (Stevens, 1999). In the late 19th century, medical care for those who could pay was primarily offered within the home and only those who were extremely low-income would make use of hospitals, which offered respite rather than medical care (Stevens, 1999). Due to their provision of free care, hospitals were included as an "institution[s] dedicated to the pursuit of charitable purposes" and were therefore tax-exempt under the 1894 Wilson-Gorham Tariff Act (Folkemer et al., 2011). Despite the early view that nonprofit hospitals were charitable, by the early 1900's critics were already questioning whether hospitals had become "…self-serving, entrepreneurial private agencies" (Stevens, 1984). Indeed, by 1910 complaints arose that there was no fixed rule ensuring that state appropriations to

nonprofit hospitals guaranteed benefits for "needy patients" (Stevens, 1984) illustrating early concern about nonprofit hospital accountability. The first time "charitable care" was officially regulated, however, did not come until the Hill-Burton Act of 1946 when hospitals were required to provide "free or discounted care for those who could not pay" in exchange for grants (Folkemer et al., 2011). The provision of free or discounted care, otherwise known as "charity care," was not federally tracked or monitored and therefore issues of accountability arose again.

In 1956 the provision of charity care became a standard not only for Hill-Burton grants, but also for federal tax exemption (Folkemer et al., 2011). At this point, hospitals were to provide "as much charity care as they could afford," and this was another metric which faced issues of accountability and transparency (Folkemer et al., 2011). Partially in response to the passage of The Social Security Act and Medicare and Medicaid in 1965, the requirements for hospital tax exemption shifted again in 1969 based on the belief that more people would be insured and there would be less need for charity care (Folkemer et al., 2011). Under Revenue Ruling 69-545, hospitals were required to provide "community benefits" rather than just charity care (Folkemer et al., 2011). This new ruling, known as the "Community Benefit Standard" continued to allow hospitals significant discretion in interpreting what may be counted as a community benefit and how much they wished to spend.

Implicit in each regulatory change was the belief that nonprofit hospitals are "charitable," and it is therefore important to interrogate what this means. There are two major reasons tax exemption was rationalized for charitable organizations in the United States according to Folkemer et al. (2011). The first is that charitable organizations "relieve the government of financial burdens that otherwise would be a public responsibility to be discharged at public cost" (Folkemer et al., 2011). The second is that "the public benefits from the promotion of general

welfare" taken on by institutions such as hospitals (Folkemer et al., 2011). Based on this rationale, the general public, as well as legislators, must believe that nonprofit hospitals truly promote general welfare and relieve government burdens, and these beliefs appear to have waned in the late 20th century.

Since 1969, there has been considerable critique of nonprofit hospitals and their provision of community benefits by Congressional leaders and the public alike. Critics have noted an inability to distinguish nonprofit and for profit hospitals with regard to issues such as executive compensation, willingness to exploit market power, and quality and cost of services (Burns, 2003). For example, regarding the exploitation of market power, studies found that following an increase in market concentration in 1986, *all* hospitals (nonprofit and for-profit) raised prices due to increased demand (Burns, 2003). By raising prices, nonprofit hospitals demonstrated their willingness to operate like any other business. Also in 1986, to prevent nonprofit hospitals from "patient dumping" or turning away primarily uninsured patients from receiving emergency medical care, The Emergency Medical Treatment and Labor Act (EMTALA) was enacted (Rosenbaum et al., 2012), further signaling the need for regulation to ensure nonprofit hospitals behaved as charitable entities. This is the historical context that led us to events that transpired in the late 20th century and early 21st century and which ultimately led to the development of Schedule H.

Schedule H

Tax-exempt organizations in the United States are required to file Form 990 to the IRS. The Internal Revenue Services (IRS) is a bureau of the United States Department of Treasury and they are charged with enforcing the laws enacted by Congress (Internal Revenue Service, 2021b). Scholars have questioned whether the IRS truly just "enforces" Congressional laws or if

they have been forced to create policy outside the scope of their official duties (Fox & Schaffer, 1991). Schedule H also raises this question as the categories and requirements involved with Schedule H significantly shaped nonprofit hospital community benefits and were decided upon by the IRS. Form 990 is "…the IRS' primary tool for gathering information about tax-exempt organizations, educating organizations about tax law requirements and promoting compliance" (Internal Revenue Service, 2021a). In 2008, the IRS revised form 990 for the first time since 1979 (Folkemer et al., 2011) and added new Schedules, including Schedule H. The goal of Schedule H, according to the IRS, is to "…promote transparency and to facilitate the comparison of the community benefits provided by hospitals" (Hellinger, 2009). Schedule H requires nonprofit hospitals to annually report their community benefit activities however, how much these hospitals spend, and what they spend on, remains at hospital discretion.

The seven categories defined as community benefits by the IRS which are reported on in Part I of Schedule H include: *charity care, unreimbursed costs for means-tested government programs, community health improvement services, health professions education, subsidized health services, research* and *cash and in-kind contributions to community groups*. Additionally, in Part II of Schedule H, the IRS identified three categories that are tracked but not automatically included as community benefits: *community building activities, unreimbursed costs for Medicare,* and *bad debt* (Internal Revenue Service, 2019a). Considerable debate took place with regard to these three categories as will be examined in the analysis of historical documents later in this paper. *community building activities* is a unique category in that it *may* be included as a community benefit if hospitals demonstrate that these activities "…promote the health of the community it [the hospital] serves" (Rosenbaum et al., 2014). The decision to place *community building activities* in Section II of Schedule H has prevented investment in this category

(MacDougall, Paper 3) further demonstrating the impact of Schedule H on community benefit spending. Schedule H clarified what was meant by "community benefits" and standardized the reporting process.

Methods

The methodological approach used to examine the formation of Schedule H is Qualitative Historical Analysis which employs "…the use of primary historical documents or historians' interpretations thereof in service of theory development and testing" (Thies, 2002). Additionally, Critical Discourse Analysis is used to "…investigate critically social inequality as it is expressed, constituted, legitimized and so on, by language use (or in discourse)" (Wodak & Meyer, 2009). These methods allow for an in-depth examination of the discourse between lawmakers, lobbyists, and academics that led to the creation of Schedule H and uses quotes, primarily from Congressional hearings, to highlight this discourse. Key to examinations of historical discourse is the question: *what is missing?* (Maza, 2017). While examining who was present at Congressional hearings and what they said is important, equally important is who was not present and what went unsaid. This critical lens helps us understand the role of power (Wodak & Meyer, 2009) in the creation of policy.

Primary source materials, in this case transcripts from Congressional hearings, letters, and reports were selected based on their relevance to Schedule H formation. Additionally, interviews were conducted to aid in the understanding of Schedule H development and guided the interpretation of the discourse surrounding Schedule H. Quotes from interviews are not included in this paper for confidentiality purposes however interviews did play an important role in interpreting and triangulating data. This study also triangulated primary sources by looking at follow up letters, responses to reports, and multiple perspectives on hearings to ensure credibility

and to increase understanding of individual events. By examining documents put forth by Congress, the IRS, the CHA, the AHA as well as verbatim transcripts of Senate Finance Committee testimonies, this study sought to minimize selection bias of source material to offer a fuller picture of Schedule H formation.

Historical methods were chosen as the goal of this paper is to "construct a narrative of events selected for their significance with respect to one hypothetical explanation of 'what happened.'" (Alford, 1998). Taken together, this paper will help explain why Schedule H was created in its current form and allow for a deeper interrogation of the following specific research questions:1) *How were the seven categories of community benefit decided upon?* 2) *Why wasn't a minimum benchmark of spending incorporated in the form?*

Differentiating Between Nonprofit and For-Profit Hospitals

In the 1980's-90's local governments received fewer federal funds and the 1990-91 economic recession led to strained budgets at the state and local levels (Burns, 2003). Because of this, many states increasingly relied on revenue raised through real estate taxes, a reality that drew attention to nonprofit hospital exemption from these taxes (Burns, 2003). Simultaneously, the United States saw an increase in the number of people without health insurance which raised questions about the role of nonprofit hospitals in caring for those unable to pay (Lewin et al., 1988). Critics in the 1980's-90's also began questioning whether nonprofits were truly different from for profit hospitals leading to State Supreme Courts in Utah, Pennsylvania and Vermont hearing cases that questioned the validity of nonprofit hospital state tax exemption (Burns, 2003).

Scholars were also scrutinizing the validity on nonprofit hospital tax exemption in the 1980's and in 1987, a Harvard Business Review study entitled *Who Profits from Nonprofits,*

argued that nonprofits receive more "social subsidies" but are not "more accessible to the uninsured and medically indigent, nor do they price less aggressively" (Herzlinger & Krasker, 1987). Additionally, the study argued that "For-profit hospitals, in contrast, produce better results for society and require virtually no societal investment to keep them afloat" (Herzlinger & Krasker, 1987). This indictment was rebutted in a New England Journal of Medicine article entitled, *Setting the Record Straight,* written by Larry Lewin, who claimed that past studies did not accurately take into account the amount of uncompensated care provided by nonprofit hospitals and that when uncompensated care is considered, "real differences" are evident between nonprofit and for profit hospitals (Lewin et al., 1988). The debate taking place in these prominent academic journals partially led to the decision by the Catholic Health Association to reconsider their charitable responsibilities.

The Catholic Health Association (CHA) is often cited as a major player in the creation of Schedule H and their decisions in the late 1980's contributed to this station (Folkemer et al., 2011; Hellinger, 2009). Concern regarding the similarities between nonprofit and for-profit hospitals, along with for-profit hospital chains propositioning Catholic Hospitals to sell their facilities to them, led the nuns at the CHA to question whether their member hospitals were still truly charitable (Trocchio, 2017). After reading his article in the New England Journal of Medicine, the board of the CHA decided to invite Larry Lewin, founder of the Lewin Group to "…develop his ideas of how nonprofit hospitals benefit their communities and address social needs" (Lewin et al., 1988; Trocchio, 2017). As a defender of nonprofit hospitals, Lewin contributed significantly to the discussion of what a nonprofit hospital should do to remain "charitable" as well as the CHA text, *The Social Accountability Budget* (Trocchio, 2017). Published in 1989, *The Social Accountability Budget* "…itemized and categorized…" hospital

community benefits and led to CHA member hospitals reporting on their community benefits in a standardized way (Trocchio, 2017).

Some key points from the *Social Accountability Budget* included the delineation of six categories of community benefit: (1) Charity Care (2) Unpaid Costs of Public Programs-such as Medicaid (3) Education and Research (4) Cash and in-kind contributions (5) Low or Negative-Margin Services and (6) Non-billed Services such as Free Clinics and Health Screenings (Trocchio, 2017). Additionally, the *Social Accountability Budget* included the recommendation that a budget be set aside for community benefits (rather than relying on the yearly surplus), it recommended hospitals have a designated infrastructure for community service (staff, policies and reporting mechanisms), and it led to the creation of the software program, the *Community Benefit Inventory for Social Accountability* (CBISA) which continues to be used by many nonprofit hospitals today (Trocchio, 2017). By the early 1990's, the CHA had cemented itself as a leader in standardized nonprofit hospital community benefit reporting and this position would lead it to possess enormous sway by the time the IRS was attempting to standardize community benefit reporting themselves. While the CHA was establishing new community benefit standards, nonprofit hospitals in the United States as a whole were facing scrutiny for uncharitable practices.

Beginning in March 2003, the Wall Street Journal ran a series of articles exposing the aggressive debt collections practices of nonprofit hospitals (Cohen, 2006). These articles detailed debt collections tactics used by nonprofit hospitals such as "body attachment" where police arrested patients who failed to appear in court for outstanding hospital bills (Lagnado, 2003). This extreme action was defended by some nonprofit hospital executives who claimed they deserved payment for their services, and decried by others who stated it was essentially the

recreation of debtors prisons and "Les Miserables" (Lagnado, 2003). These newspaper articles, along with critical reports published by organizations such as the Commonwealth Fund, and a rise in class action lawsuits from indebted patients against nonprofit hospitals, brought national attention to the behavior of nonprofit hospitals and further called into question their charitability (Cohen, 2006).

In 2004, the Committee on Energy and Commerce's Subcommittee on Oversight and Investigations responded to these issues by examining nonprofit hospital behavior, especially with regard to billing and collections practices (*A Review of Hospital Billing and Collections Practices*, 2004). A key feature of this hearing was to address the significant issue that the only people in the United States paying full and undiscounted rates for hospital care were the uninsured-the group least likely to be able to afford these payments (*A Review of Hospital Billing and Collections Practices*, 2004). This hearing catalyzed discussions about nonprofit hospital behavior overall.

Following the 2004 Committee on Energy and Commerce hearing, The House Committee on Ways and Means, then chaired by Republican Congressperson Bill Thomas, held a series of hearings addressing nonprofit hospital behavior. The first hearing was held on April 20, 2005 and its goal was "…to examine the history of the tax-exempt sector, the legal rationale for tax-exemption, and its economic impact" (*The Tax Exempt Hospital Sector*, 2005). The second hearing in the series took place on May 26, 2005 and its goal was to examine the standards for nonprofit hospital tax exemption, to determine what criteria are used to assess whether a hospital meets requirements for tax exemption and to determine whether tax exempt hospitals were essentially "businesses selling their services in a competitive market" (*The Tax Exempt Hospital Sector*, 2005). The first witness to speak at this hearing was then IRS

commissioner Mark Everson. Everson noted his concern that nonprofit and for-profit hospitals were becoming "increasingly similar" and made the case for the IRS receiving more money if it was expected to adequately audit nonprofit hospitals (*The Tax Exempt Hospital Sector*, 2005). In his opening remarks, Everson stated the following:

> *What we have seen since 1969 has been a convergence of practices between the for-profit and nonprofit hospital sectors, rendering it increasingly difficult to differentiate for-profit from not-for-profit health care providers… Let me state clearly that, as with other parts of the tax-exempt sector and enforcement generally, we have not been able to do enough with respect to tax-exempt hospitals. Our audit rates are too low. We welcome your support as we strive to do more.* (*The Tax Exempt Hospital Sector*, 2005)

As perhaps the most prominent witness to give testimony, Everson's remarks made a significant impact on Congress. On the other side of the argument was Sister Carol Keehan, then Chairperson of the Catholic Health Association and a strong proponent of the belief that nonprofit hospitals are intrinsically different from for-profit hospitals in their motives and activities.

Throughout her testimony, Sister Keehan described the motivation of Catholic hospitals to provide community benefit services as beyond the desire to be tax-exempt. In her testimony Sister Keehan stated:

> *"I would like to emphasize that Catholic hospitals do not provide these services to justify continued tax exemption. We provide them because serving our communities in this way is integral to our history, our identity, and our mission-it is what we always have done."* (*The Tax Exempt Hospital Sector*, 2005)

Sister Keehan goes on to state that the "essential purpose" and mission of nonprofit health care is different from the for-profit sector (*The Tax Exempt Hospital Sector*, 2005). Sister Keehan uses

the argument that nonprofit hospitals are motivated by purpose rather than profits throughout her testimony to justify fewer regulations for nonprofit hospitals.

Coming to Consensus on Standardization

In the end of her testimony to the House Ways and Means Committee in 2005, Sister Keehan suggested federal regulation should mirror the CHA/VHA Articles: "Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability" which delineates accounting procedures and categories of spending (*The Tax Exempt Hospital Sector*, 2005). The CHA argued that they had standardized community benefit reporting which created the ability to compare benefits across hospitals and break down the nebulous term "community benefit" (*The Tax Exempt Hospital Sector*, 2005). While significant debate continued on the particulars, historical events demonstrate the willingness of various lobbyist groups to concede that it would be useful to standardize what is meant by "community benefits" and the already established CHA categories provided the template for this standardization. Notable in standardization discussions is the belief that the provision of charity care should not be separated from other community benefits, a decision with enormous ramifications for uninsured and low-income patients as they would not be guaranteed financial assistance.

At the same time that the House of Representatives was conducting the Ways and Means Committee Hearing, the Senate Finance Committee was preparing for its own investigation led by Republican Senator Charles Grassley. Sen. Grassley had long questioned the validity of nonprofit tax exemption broadly, and nonprofit hospital tax exemption specifically, and on September 13, 2006, Sen. Grassley (then Chairman of the Senate Finance Committee) began a

hearing entitled “Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals.” In Grassley’s opening remarks he stated that more must be done to ensure all nonprofit hospitals meet the community benefit requirements and he praised Sister Keehan and the CHA for their efforts, signaling the positive relationship between Grassley and the CHA (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals,* 2006). It appears that one reason the CHA was influential in the formation of Schedule H was because they had already established a standardized form that was used and accepted by their member hospitals. The CHA proved that standardization was possible and that they had done the work to establish a possible blueprint. Senator Grassley stated:

> *“Hundreds of hospitals have already agreed to comply CHA’s standards. Should we get everyone else on board?”*(*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals,* 2006*)*.

The following witnesses were present at the Senate Finance Committee Hearing: Phill Kline, Attorney General for the state of Kansas; Sister Carol Keehan, President and CEO of the Catholic Health Association; Kevin E. Lofton, Chairman-Elect of the American Hospital Association; Scott A. Duke, Glendive Medical Center; Dr. Nancy Kane, Harvard School of Public Health; and Ray Hartz, Executive Director of the Legal Aid Society of Eastern Virginia (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals,* 2006). It is notable that while some of these witnesses presented stories of affected individuals in the community, no community members affected by nonprofit hospital community benefit policy were included as witnesses. By not including these voices directly in policy discussion, the most power resides with those that may feel the effects of policy the least.

Of these witnesses, Phil Kline, Dr. Kane, and Ray Hartz were critical of current nonprofit hospital behavior and argued for increased regulation. Phil Kline (Attorney General from Kansas) testified that concerns regarding aggressive collections actions and medical debt led him to establish a task force in Kansas to examine the charity care and collections practices of nonprofit hospitals in his state (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Dr. Kane also argued for greater accountability for nonprofit hospitals stating, "*The terms and conditions under which charity care is provided are entirely up to the discretion of the hospital board in most states, and boards often delegate the development of charity care policy to management"* (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Finally, Ray Hartz, Executive Director of the Legal Aid Society of Eastern Virginia Inc. gave testimony describing the harm caused by nonprofit hospitals who aggressively target patients who cannot pay their bills (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006).

It is notable that despite the concerns raised regarding nonprofit hospital provision of charity care and the ramifications for low-income patients, charity care remained at the discretion of nonprofit hospitals. The recommendations provided by Dr. Kane would become the basis of Section 501(r) of the tax code which was passed as a part of the Affordable Care Act in 2010 and while the provision of charity care remains at hospital discretion, nonprofit hospitals are now required to have a "widely publicized" financial assistance policy and are directed to make "reasonable efforts" to determine charity care eligibility before pursuing collections actions (Internal Revenue Service, 2019b).

Positioned somewhere between strong arguments for greater accountability and arguments against any regulation was Sister Keehan of the CHA. This positioning was perhaps

strategic as Sister Keehan and the CHA appeared savvy at striking a balance between admitting that some requirements, such as additional tracking of community benefits was warranted but more prescriptive requirements, such as benchmark spending amounts, were unnecessary (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). By positioning themselves in this way, the CHA/Sister Keehan, maintained their position as influential over community benefit policy. Additionally, Sister Keehan stated that the CHA had created a task force to remedy issues of accountability. These remedies included creating a new process that standardized how member hospitals reported eight categories of community benefits and ensuring charity care policies were posted publicly (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006).

Witnesses who explicitly rejected the need for greater oversight or regulation were Kevin E. Lofton Chairman-Elect of the American Hospital Association (AHA) and Scott Duke, CEO Glendive Medical Center in rural Montana. Both Lofton and Duke testified that no changes should be made to the Community Benefit Standard (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Lofton stated that the AHA was in support of nonprofit hospitals using a standardized report of community benefits to be attached to Form 990 but otherwise argued that nonprofit hospitals provide "immense value" and therefore should not be subject to increased regulation (such as benchmarks) (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Duke argued against further regulation stating that rural nonprofit hospitals may be unable to afford the new requirements being proposed (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Duke and Lofton's arguments that nonprofit hospitals are invaluable to their communities

and that they cannot afford new requirements are used frequently as a justification for not increasing regulations on hospitals.

Senator Grassley ended the hearing by stating that he believed the Finance Committee needed to strengthen community benefit policy and should incorporate ideas from the CHA and Dr. Kane in particular (*The Tax Exempt Hospital Sector*, 2005). Sen. Grassley's summation of the hearing demonstrates that he was not wholly persuaded by arguments for no regulation on nonprofit hospitals. Additionally, Sen. Grassley appeared particularly persuaded by arguments to standardize the categories of community benefit and study options for greater transparency in charity care and collections practices.

Following the Senate Finance Committee hearing described above, the CHA and Sister Keehan received follow up questions from several senators including Sen. Rick Santorum. Two question from Santorum are particularly important in understanding the formation of Schedule H. First, when Santorum questioned how hospitals "make ends meet" given the requirement to provide community benefits, Sister Keehan used the opportunity to again argue for the eight categories delineated by the CHA (Keehan, 2006). By allowing hospitals to spend in any of these categories rather than prioritizing benchmark spending on Charity Care spending, Keehan argued that nonprofit hospitals could stretch community benefit dollars on low-cost community health programs (Keehan, 2006). Second, when asked whether Medicare shortfalls should be counted as a community benefit, Sister Keehan argued against their inclusion noting that,

> "…*Medicare was originally designed to fairly reimburse efficient providers. Participation in Medicare does not distinguish not-for-profit hospitals, and when a loss is experienced it may be viewed more as the cost of doing business than community benefit"* (Keehan, 2006).

This response is important as the IRS ultimately did not include "Medicare shortfalls" as a community benefit category despite other groups, such as the AHA, arguing for its inclusion (American Hospital Association, 2008).

By May 2007, Sen. Grassley along with Sen. Max Baucus (D-MT) penned a letter to Henry Paulson, then Secretary for the Department of Treasury, requesting increased "transparency and openness" from charities through an update of IRS Form 990 (Grassley & Baucus, 2007). The senators notably encouraged Sec. Paulson to review the CHA's standard for community benefit. They closed their letter by stating, "It is important you send the signal to Treasury and IRS officials that a new and improved Form 990 and supplemental information should be a top priority to be completed and implemented" (Grassley & Baucus, 2007). This letter was effective as by December of the same year, Form 990 and its accompanying schedules were revised and Schedule H was created and applied specifically to nonprofit hospitals (Litten & Link, 2010). It is notable that while Grassley and Baucus argued for greater regulation, it is in the name of "transparency" rather than "accountability." While the senators asked for nonprofit hospitals to provide more information, they stopped short of demanding greater investment in communities.

On July 19, 2007, The IRS released an Interim Report, which included responses from "almost 500 tax-exempt hospitals" to a May 2006 questionnaire relating to community benefit activities (Internal Revenue Service, 2007). Then director of the IRS's Exempt Organizations Division, Lois Lerner, stated the interim report was an "important first step" in an "ongoing review" of tax exempt hospitals (Internal Revenue Service, 2007). The report found significant differences existed in how community benefits were reported (Internal Revenue Service, 2007). Based on this report, Lerner stated that, "The lack of consistency or uniformity in classifying and

reporting uncompensated care and various types of community benefit often makes it difficult to assess whether a hospital is in compliance with current law" (Internal Revenue Service, 2007). The IRS "hospital project team" went on to recommend developing what is now Schedule H to address "the lack of uniformity in definitions and reporting" (Internal Revenue Service, 2007). Agreement appeared to be reached that Schedule H should provide standardization to community benefit reporting and that greater regulation and oversight was needed to ensure financial assistance policies were more uniform and available to patients. Questions regarding "benchmark" or minimum amounts were still being considered and discussion continued about whether additional legislation was needed.

Benchmark and Schedule H Pushback

In the 2005 House of Representatives Ways and Means Committee Hearing mentioned earlier, Sister Keehan of the CHA noted that she supported a standardization of reporting on community benefit, but she did not support adding a "benchmark" amount that should be spent on community benefits (*The Tax Exempt Hospital Sector*, 2005). The belief that there should be no "benchmark" amount permeates Sister Keehan's testimony and contributes to her statement, *"Often some of the most efficient programs cost little but can make a huge difference for persons in our communities"* (*The Tax Exempt Hospital Sector*, 2005). Sister Keehan argued throughout her testimonies to Congress that benchmark amounts are especially unnecessary because community benefits can be very low-cost. This statement begs the question, *what is the goal of community benefit policy?* Is the goal to create the most effective low-cost programs possible or is it to use tax savings to invest financially in the surrounding community?

Another argument made by Sister Keehan is that the need for certain community benefits differ hospital to hospital (*The Tax Exempt Hospital Sector*, 2005). This point is made to again

rebut the argument that nonprofit hospitals should spend a benchmark amount on specific categories such as charity care. Moreover, this commentary contributes to legislation that does not prioritize certain categories of community benefit over others. This decision is often defended as the need to keep community benefit policy needs to be "flexible" and "adaptable." Missing from this discussion is whether community members and community-based organizations are also calling for nonprofit hospitals to have this flexibility and questions of whether nonprofit hospitals truly tailor their spending to the unique needs of the community remain. Additionally, because hospitals can decide whether to spend on *charity care* or *unreimbursed Medicaid* or *community health promotion*, federal policy leaves the financial well-being of low income and/or uninsured Americans at the discretion of the hospital.

In the 2006 Senate Finance Committee Hearing mentioned earlier, Scott Duke of Glendive Medical Center also expressed concern regarding benchmark spending amounts. Duke argued that a "one size fits all" approach to community benefit was not only unnecessary, it was not feasible for struggling health systems because they could not afford it (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Duke argued that the hospitals in the Glendive Medical System spent significantly on community benefits however it is notable that he included *bad debt* and *Medicare shortfall* in his numbers (*Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). *Bad debt* and *Medicare shortfall categories* were ultimately excluded from the list of reportable community benefits, as many believe neither are "charitable" in nature. The belief that nonprofit hospitals could not afford a benchmark amount of community benefit spending takes for granted that this amount would be fixed rather than a percentage of nonprofit hospital surplus.

In the 2006 letter from Senator Rick Santorum to Sister Keehan following up on the Senate Finance Committee Hearing mentioned earlier, additional remarks on benchmark spending are made. Senator Santorum first asks Sister Keehan, *"How do hospitals make ends meet when they have to provide community benefits?"* (Keehan, 2006). This question in and of itself could reveal Sen. Santorum's belief that the provision of community benefits was financially difficult for nonprofit hospitals and/or his desire to provide an opportunity for Sister Keehan to discuss the burdensome nature of increased regulation. Sister Keehan responded that nonprofit hospitals must be innovative in providing low-cost community benefits (Keehan, 2006). Again, the question of how hospitals "make ends meet" when faced with the responsibility of providing community benefits, as well as Sister Keehan's response that hospitals provide benefits in the most cost-effective ways, demonstrates the belief that the primary goal of the Community Benefit Standard is not necessarily to reinvest tax savings into the community through substantial financial investment. This belief is important as it devalues the importance of a "benchmark amount of spending" on the part of nonprofit hospitals.

Senator Grassley held a "roundtable discussion" that was open to the press and public to weigh in on community benefit proposals in the end of October 2007. Grassley noted, "I haven't made any decisions about whether legislation is necessary to address the issues we've seen regarding non-profit hospitals, but this is an important discussion to help me decide whether to pursue legislation" (US Senate Committee on Finance, 2007). Grassley went on the state that he had "…*very real questions…about whether the revised form alone is enough to ensure that all non-profit hospitals are committed to public service in exchange for their generous tax breaks"* (US Senate Committee on Finance, 2007). This statement demonstrates Grassley's hesitancy to

support Schedule H without "benchmark" amounts as well as his concern about the delineation of categories.

In response to Grassley's "roundtable discussion," he received statements from many stakeholders, including the CHA. In October of 2007, Michael Rodgers, then CHA Senior Vice President for Advocacy and Public Policy responded that the with regard to setting a benchmark spending amount, "*we [the CHA] strongly disagree that federal legislation is needed in order to achieve this goal."* (2007). Rodgers' gives several reasons for why a minimum federal benchmark spending amount is "misdirected" (Rodgers, 2007). He argues that "…*flexibility is needed to respond to unique community needs and a fixed percentage is not in the best interest of the communities we serve…"* (Rodgers, 2007). Absent from Rodgers argument are statements from the community indicating whether they also disagree with minimum benchmark amounts. Rodgers also disagrees with separating *charity care* from other spending categories and states, "*We disagree with the proposal for a two-tiered system that separates charity care and community benefit"* (Rodgers, 2007). Moreover, Rodgers argues that Schedule H will increase transparency and no further legislation is therefore necessary.

The argument against benchmark spending amounts is often phrased as a matter of "flexibility" to ensure that hospitals can meet the unique needs of their communities. Rodgers further makes this argument through the following statement:

> *"We believe that an arbitrary 'one size fits all' minimal requirement would interfere with the flexibility and creativity needed by hospital community benefit programs and would discourage innovative low-cost solutions to community programs"* (Rodgers, 2007).

In addition to arguing that minimal/benchmark amounts would limit flexibility, it is notable that Rodgers argues that setting benchmark amounts would stimy innovation. While creating low-

cost programs may be useful to nonprofit hospitals attempting to provide community benefit, the argument that a requirement to spend money limits innovation appears primarily motivated by the goal to spend less.

Another statement stemming from the discussion draft and roundtable discussion was by written by David W Benfer, then President and CEO of Saint Raphael Healthcare System New Haven CT, who also argued against more federal legislation and stated that the current Community Benefit Standard was working (Benfer, 2007). Benfer noted that prioritizing charity care over other types of community benefit would be misguided.

> *"First, prioritizing charity care over other community benefit and granting 501 c 3 status for the former but not that latter, is wrong. Our outreach, prevention, education, and research programs are, in my view, even more important than charity care. They are preventive, provide early detection and improve community health status."* (Benfer, 2007).

Additionally, Benfer argued that giving "credit" only for nonprofit hospital community benefits that can be "counted" in expenditures does not encapsulate the scope of what nonprofit hospitals provide (Benfer, 2007). Opponents of benchmark spending amount and a requirement to spend on charity care cite the need to give "credit" for innovative, low-cost programs however they do not address the possibility that nonprofit hospitals could in fact do both: invest a percentage of profit on charity care and/or certain spending categories *and* continue providing other valuable services uniquely tailored to their community needs.

The significant pushback from various actors in the nonprofit hospital realm seems to have worked as no benchmark amount was ever added to Schedule H. Additionally, the argument that establishing a benchmark amount of spending would limit flexibility in community benefits seemed to have been accepted by the IRS and some legislators alike.

Significant questions remained however, about whether a benchmark was needed for hospitals to truly be held accountable and recently, states such as Oregon and Connecticut have established their own benchmark requirements in lieu of federal regulation (Clary & Higgins, 2019) and many states have set their own Minimum Charity Care Provision (Rothbart & Yoon, 2021). Additionally, absent research indicating that benchmark spending amounts limit innovation or harm the community through less "tailored" programming, these arguments appear motivated by the desire of nonprofit hospitals to save money.

Ongoing Concern

In September 2008, at the request of Sen. Grassley, the Government Accountability Office (GAO) conducted a study to examine nonprofit hospital community benefits with regard to IRS requirements, how hospitals define community benefit activities, and the ways nonprofit hospitals measure the costs of providing community benefit activities (Government Accountability Office, 2008). The report found extreme variability in what counts as a community benefit and how to measure it, and the belief that federal and state policymakers should continue addressing issues of definition and measurement with regard to community benefits (Government Accountability Office, 2008). Responding to the report, Sen. Grassley stated that while Schedule H will help increase transparency of community benefit activity, legislative action may still be necessary. Grassley stated:

> *As long as there's such uncertainty and inconsistency in the definition of community benefit, it'll be impossible to gauge whether the public is getting a fair return for the billions of tax dollars that tax-exempt hospitals don't pay. While the new IRS Form 990 will help, Congress may need to fill in the blanks since hospitals still get to choose how they calculate their cost."* (Grassley, 2008).

Sen. Grassley expressed his continued openness to possible legislation regulating community benefits that goes beyond Schedule H.

In February 2009, the IRS gave a final report on the results from their 500-hospital questionnaire study mentioned previously. Notably, they found that the average amount spent on community benefits was 9% of total revenue, and the average amount spent on *uncompensated care* was 7% (Internal Revenue Service, 2009). These numbers demonstrate that, on average, the priority for nonprofit hospitals is subsidizing Medicaid payments to themselves rather than investing in other community initiatives or *charity care*. With regard to overall findings on The Community Benefit Standard and Schedule H, the IRS report provided the following statement:

> *The data suggests that any attempt to refine the standard will seriously impact the existing tax-exempt hospital sector because of the hospitals' varying practices and financial capabilities. Put another way, any revised standard would affect the different types and sizes of hospitals depending upon the types of activities required to be taken into account as community benefit, the quantitative measure (if any) included in such a standard, and the extent the rule provides for exceptions or special rules…"* (2009).

It appears that the heterogenous nature of hospitals was a significant factor in the IRS not setting a "quantitative measure" or benchmark spending amount on Schedule H. This finding coupled with pressure from significant players in the nonprofit hospital world such as the CHA and the AHA appears to have caused the IRS to focus solely on standardizing community benefit categories rather than establishing a benchmark spending amount. While the diversity of nonprofit hospital financial ability is clear, it remains unclear why the IRS could not regulate benchmark spending amounts as a percentage of nonprofit hospital surplus.

Since 2009, concern regarding nonprofit hospital behavior has continued especially with regard to collections practices (Bruhn et al., 2019; Diamond, 2017; Thomas, 2019) and the

provision of charity care (Bai et al., 2021). Sen. Grassley has also recently restarted his probe into nonprofit hospital behavior and has recommitted to legislation designed to prevent aggressive collections practices by nonprofit hospitals (Grassley, 2020). While concerns remain, it is unclear whether Congress or the IRS plan to revise Schedule H.

Discussion

Through an examination of historical discourse and events that led to the creation of Schedule H, a greater understanding of the form is gained. By reviewing hearings and testimony of key players, we learn that powerful lobbyists (such as the CHA and the AHA) largely opposed prescriptive regulations such as benchmark spending requirements overall or on certain categories such as *charity care*. While reading and interpreting these conversations it is important to remember which voices were not represented in these conversations and which perspectives were therefore left out. Should community members or indebted patients have been represented to a greater extent, we may have heard more regarding the impact of low investment in community-based organizations and/or a call for benchmark spending on charity care, for example. Additionally, almost totally absent from these conversations is that there is significant racial segregation across hospitals in the United States (Vaughan Sarrazin et al., 2009) as well as the disproportionate effect medical debt has on Black patients and their families (Wiltshire et al., 2016).

Several arguments are made against separating charity care from the other community benefit categories and/or creating a benchmark spending amount. First, several stakeholders argue that separating charity care from other community benefit categories limits flexibility and the ability of nonprofit hospitals to tailor their benefits to their unique communities (Benfer, 2007; *The Tax Exempt Hospital Sector*, 2005; Rodgers, 2007). This argument assumes that

nonprofit hospitals cannot do both: tailor benefits to the community *and* ensure they significantly invest in charity care. It is possible that in higher income communities, there are fewer uninsured patients and less need for charity care. However, even in high income communities, medical debt remains problematic (Seifert, 2004) and should hospitals truly be unable to find patients in need of financial assistance, they could partner with hospitals in lower income communities with higher rates of low-income patients.

Perhaps these arguments stem from the belief that requiring nonprofit hospitals to spend a benchmark amount on *charity care*, Total Community Benefits, or other categories of spending is too financially burdensome. Indeed, we saw this perspective expressed by Senator Santorum and numerous other stakeholders (Keehan, 2006; *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals*, 2006). Additionally, the IRS noted that nonprofit hospitals are heterogenous and some may be unable to meet a benchmark community benefit spending requirement (Internal Revenue Service, 2009). All of these arguments appeared to infer that benchmark spending amounts would be fixed and would not take into account the financial wellbeing of the hospital. One easy way to remedy this concern would be to set benchmark spending amounts as a percentage of nonprofit hospital yearly financial surplus. This solution would take into account the financial realities of various hospitals. While some may argue that *no* nonprofit hospitals could afford a benchmark spending amount, a recent Forbes report indicated that 13 nonprofit hospitals pay their executives between $5 and $21 million and 61 nonprofit hospitals paying over $1 million, (Andrzejewski, 2019). This study demonstrates that mandates such as capped executive compensation could aid nonprofit hospitals in finding additional funds for the communities that subsidize them.

Another argument against benchmark spending was that it would stimy innovation and that many community benefit activities are low-cost which should be encouraged (Benfer, 2007; *The Tax Exempt Hospital Sector*, 2005). While many valuable programs are indeed low-cost, the question of whether the *goal* of nonprofit hospital community benefits should be low-cost programming is a different matter. Even with a benchmark spending amount in place, nonprofit hospitals would be welcome to both develop low-cost, innovative programs *and* invest significantly in community-based organizations and/or develop very generous financial assistance policies. Should the concern be that benchmark spending amounts would stimy innovation because hospitals would only spend up to the benchmark amount (and not above), then the primary concern would be how the benchmark is calculated and incentivized rather than whether it should exist.

While Schedule H did little to address aggressive collections actions, the Affordable Care Act of 2010 did further refine the tax code to put in place additional requirements for nonprofit hospitals (Internal Revenue Service, 2019b). These new requirements mandated that hospitals publicize their financial assistance policies and make "reasonable efforts" to contact patients prior to sending bills to collections (Internal Revenue Service, 2019b). While these requirements are a step in the direction of accountability, issues of aggressive collections actions persist (Bruhn et al., 2019) and nonprofit hospitals were recently found to spend less than their for-profit counterparts on charity care (Bai et al., 2021).

Conclusion

Through an examination of major events and discussions that occurred during the time Schedule H was developed and implemented, an understanding of its design is gained. The political, economic, and legal events of the 1980's-early 2000's led to Congressional interest in

examining nonprofit hospital behavior and their tax-exempt status. Congressional hearings and persuasive testimony from lobbyist groups, academics, and hospital executives shaped what would become Schedule H.

Because the CHA had created an easy-to-replicate template that had been used by hundreds of hospitals and due to their positive relationship with key legislators such as Sen. Grassley, they became a leading voice in nonprofit hospital community benefit policy. The nebulous concept of "community benefits" was in need of standardization and the CHA offered a solution. While not all of the CHAs categories of community benefit were replicated in Part I of Schedule H, the majority were, and the sway of the CHA was seen clearly. Additionally, despite some discussion of *charity care* being a prioritized category of spending, arguments that this prioritization would limit nonprofit hospital "flexibility" were sufficiently persuasive.

While the majority of powerful lobbyists were in agreement that a form standardizing community benefit reporting was acceptable, almost no lobbyists were in support of establishing a benchmark spending amount. Arguments against a benchmark amount ranged from concern that it would limit flexibility, decrease innovation in creating low-cost programs, and be a financial burden. These concerns get to the heart of the issue: is the provision of community benefits about nonprofit hospitals spending the smallest amount possible on community health initiatives? Or is it about nonprofit hospitals investing in their community through use of their significant tax savings? We see a focus on the former throughout these historical events and the repercussions are evident today as the community benefit categories of *cash and in-kind contributions to community groups* and *community building activities* are consistently the lowest categories of spending (MacDougall, Paper 1). This historical narrative reveals the events and discussions that led to the formation of Schedule H, a document that allows nonprofit hospitals

broad discretion in their type and amount of community benefit spending and subsequently causes the well-being of low-income patients and communities to be at the mercy of their local hospital's idiosyncratic decision making.

PAPER 3: THE RELATIONSHIP BETWEEN COMMUNITY HEALTH NEEDS ASSESSMENTS AND COMMUNITY BENEFIT EXPENDITURES

Introduction

Nonprofit hospitals in the United States have the potential to promote community health and address the social determinants of health. Federal policy promotes these goals as nonprofit hospitals are exempt from federal taxes in exchange for providing "benefits to the community." In 2009, nonprofit hospitals were required for the first time to report their community benefit spending to the Internal Revenue Service (IRS) via Form 990 Schedule H (Young et al., 2013). This requirement arose out of concern that nonprofit and for profit hospitals were becoming increasingly similar (Burns, 2003; *The Tax Exempt Hospital Sector*, 2005), which called into question whether nonprofit hospitals deserved their tax benefits. Shortly thereafter, in 2010, the Affordable Care Act (ACA) mandated that nonprofit hospitals conduct Community Health Needs Assessments (CHNA) once every three years to maintain their tax-exempt status (Rosenbaum & Margulies, 2011). The CHNA requirement aimed to address both the medical needs of the community as well as the "structural social and economic conditions that influence health" (Carroll-Scott et al., 2017). However, current policy notably does not require nonprofit hospitals to address the health needs they find in the CHNA, and therefore arguably places more importance on the creation of the CHNA report rather than the actions that follow.

Taken together, CHNA and community benefit reporting policies had the potential to promote nonprofit hospital spending on factors known as the "social determinants of health" which are defined by the World Health Organization as, "The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (World Health Organization, 2021). This is important because there is growing

acknowledgement among policy makers and researchers that addressing the social determinants of health plays a larger role than medical care in determining health outcomes (Horwitz et al., 2020). Despite the potential of these policies to promote the social determinants of health, scholars have noted minimal change with regard to community health benefits (Young et al., 2018). There is also concern that community benefit spending does not align with actual community health needs (Singh et al., 2015). *Why, despite these policies, do community benefit expenditures continue to demonstrate a lack of investment in Community-Oriented Spending?*

One reason we may see a lack of Community-Oriented Spending is that the actual activities of nonprofit hospitals do not match their formal policy, a concept known as "decoupling" (Meyer & Rowan, 1977). While hospitals may symbolically comply with new policies regulating community benefit spending and CHNAs, their spending decisions demonstrate a lack of financial investment in the community. By decoupling official policy from actual activity, nonprofit hospitals maintain their legitimacy as a charitable institution in the community while in fact under-investing in community health needs. Current policy allows for this decoupling as nonprofit hospitals are not required to address the health needs found in the CHNA and have discretion in the type and amount of spending they pursue.

Through 14 in-depth, semi-structured interviews primarily with professionals working in the realm of community benefits at nonprofit hospitals and consulting agencies in the midwestern United States, this study illuminates the process of conducting and reporting on CHNAs and Form 990/Schedule H. By employing the theoretical lens of "decoupling" this study reveals why expenditures may not reflect CHNA findings. This study also explores current nonprofit hospital practices and makes recommendations to further promote alignment between CHNA findings and spending on community benefits.

Community Benefits

To maintain their tax-exempt status, nonprofit hospitals in the United States have been required to provide "benefits to the community" since 1969 (Folkemer et al., 2011). However, these benefits were not federally tracked until 2009 when nonprofit hospitals were first required to report on their community benefits to the IRS via Form 990 Schedule H (hereafter "Schedule H"). This new requirement was the result of increased concern from lawmakers, researchers, and community stakeholders that nonprofit and for profit hospitals were becoming too alike thereby calling into question whether nonprofit hospitals deserved their tax exempt status (Hellinger, 2009; *The Tax Exempt Hospital Sector*, 2005). The concern that nonprofit hospitals were not truly providing benefits to the community was heightened given their significant tax benefits which, in 2011, were estimated at 24.6 billion dollars (Rosenbaum et al., 2015). Schedule H was developed to ensure nonprofit hospital community benefit reporting was standardized.

Schedule H separates "community benefits" into seven categories: *charity care, unreimbursed costs for means-tested government programs, subsidized health services, community health improvement services, research, health professions education,* and *financial/in-kind contributions to community groups* (Young et al., 2013). The IRS also tracks a category of community benefit called *community building activities,* which is not automatically counted as a community benefit but may be included if proven to benefit the health of the community (Rosenbaum et al., 2014). The *community building activities* category is thought of as the "social determinants of health category", as it encompasses activities such as housing, economic development, and environmental improvements. The seven categories of community benefit were derived directly from the Catholic Health Associations' (CHA) existing reporting

standards and the CHA has continued to be influential in community benefit policy (Folkemer et al., 2011; Trocchio, 2017).

While each category of community benefit arguably serves an important purpose for nonprofit hospitals, some scholars have collapsed the seven categories into two: "direct patient care" (*charity care, unreimbursed costs for means-tested government programs,* and *subsidized health services*) and "community services" (*community health improvement, contributions to community groups, research,* and *health professions education*) (Young et al., 2013). This delineation demonstrates the belief that some categories are viewed as more closely related to community needs. The three categories of focus in this study are *community health improvement, contributions to community groups, and community building activities* and will be referred to collectively as the "Community-Oriented Categories." This study notably differs from past researchers' "community services" grouping by adding the category *community building activities* and by removing the *research* and *health professions education* categories. The rationale for examining these three categories in particular, is that they represent the most direct community spending and are the categories where spending on social determinants of health activities would be reported. Additionally, despite the important role these categories could play in promoting community health, there has traditionally been a lack of investment in the Community-Oriented Categories (MacDougall, Paper 1; Young et al., 2013). To better understand this lack of investment, this study examines the relationship between CHNAs and Community-Oriented Categories.

Community Health Needs Assessments

The 2010 Affordable Care Act (ACA) established the federal requirement that nonprofit hospitals complete a CHNA and Implementation Plan once every three years. This requirement

is enforced by the IRS, codified in Section 501(r), and states that nonprofit hospitals must make the assessment and plan "widely available to the public" (Internal Revenue Service, 2020). This requirement was largely seen as a way to address population health and non-medical "upstream factors" however scholars have contended that too much discretion was left to nonprofit hospitals (Rosenbaum & Margulies, 2011).

The Implementation Plan is a document that demonstrates how the nonprofit hospital is addressing the health needs found in the CHNA. However, it is notable that Section 501(r) states that if a nonprofit hospital chooses not to address a need found in the CHNA, they must simply document their reasoning (Internal Revenue Service, 2020). Section 501(r) further states that possible reasons for not addressing a health need could include, "resource constraints, other facilities or organizations in the community are addressing the need, relative lack of expertise or competencies to effectively address the need…" (Internal Revenue Service, 2020). Requiring nonprofit hospitals to conduct a CHNA and Implementation Plan could be an important step toward addressing "upstream" factors addressing health however several studies have noted a disconnect between CHNA findings and community benefit spending and current policy places greater importance on conducting the CHNA than on addressing community health needs.

The Disconnect Between Community Benefit Spending and Community Health Needs

Past studies have raised concern about the disconnect between community benefit spending and the actual health needs of communities (Rosenbaum et al., 2016; Singh et al., 2015). Several quantitative studies have proven that neither the ACA nor community health concerns have led to greater community health spending (Singh et al., 2015; Young et al., 2018). Young et al. found virtually no change in spending on "community health benefits" following passage of the ACA/CHNA requirement (Young et al., 2018). Additionally, in their seminal

study, Singh et al. found that nonprofit hospitals in areas of greater health needs (as measured by County Health Rankings data) spent more on patient care (where "patient care" included *financial assistance, subsidized health services,* and *unreimbursed costs for means-tested government programs categories*) than community health (2015). Indeed, Singh et al. found that "community health improvement" spending (inclusive of *community health improvement* and *contributions to community groups categories*) was unrelated to community health needs (2015). This study was one of the first to demonstrate a disconnect in actual community need and nonprofit hospital spending patterns. These quantitative studies are valuable as they demonstrate the disconnect between community health needs and community benefit spending, however they are unable to tell us *why* this disconnect exists.

Quantitative reports have found that nonprofit hospitals are heterogenous in their levels of Community-Oriented Spending and ability to address CHNA findings. Indeed, higher profit margin and higher total revenue are associated with greater spending on Community-Oriented Categories (MacDougall, Chapter 1). Additionally, one study found that communities with a greater percentage of uninsured people showed "less progress toward CHNA implementation" and nonprofit hospitals that showed the greatest progress toward CHNA implementation also spent the most on the *community health improvement* category of spending (Cramer et al., 2017). Taken together, these findings demonstrate that lower profit margin hospitals in areas of higher need may be the least likely or able to spend on Community-Oriented Categories. The heterogenous nature of nonprofit hospital CHNA implementation and community benefit spending demonstrates the importance of examining a variety of nonprofit hospital processes to better understand the disconnect between community benefit spending and community health needs.

Other studies have focused on ideas for policy revision to strengthen the connection between community health needs and community benefit spending. Rosenbaum et al., in their report on improving community health through community benefit spending, described a "policy opportunity" that included creating a new category of community benefit that is linked to CHNA activities, where hospitals could report the percent of their community benefit spending allocated toward CHNA findings (2016). This new category would improve transparency with regard to CHNA/community benefit spending alignment. In addition to the idea of adding a new category to Schedule H, Rosenbaum et al. made the argument that the community benefit category, *community building activities*, should be moved to Section I of Schedule H (Rosenbaum et al., 2016). The *community building activities* category is unique in that it *can* be counted as a community benefit but only if nonprofit hospitals justify each expenditure in this category (S. Rosenbaum et al., 2014). The burdensome nature of this category has likely led to lower investment as nonprofit hospitals do not have to justify spending in the categories listed in Section I of Schedule H (Rosenbaum et al., 2014; Rosenbaum et al., 2016).

In addition to considering monetary inputs to a greater extent, scholars have argued that there should be a greater focus on health outcomes. Authors Rubin et al. argue that current policy places an "undue emphasis" on input-based reporting such as expenditures, and that population health outcomes are the outcomes of importance (Rubin et al., 2013). Because current policy does not require CHNAs and implementation strategies be tied to expenditures or outcomes, there may be more energy spent on the report than on the actual community health activities. Some have argued that the IRS should refine regulations for CHNAs (Crossley, 2016; Rubin et al., 2013) to further promote "…transparency, accountability, community engagement, and collaboration…" (Crossley, 2016). While suggestions to enhance the connection between

community health needs and community benefit spending are valuable, a richer understanding of current nonprofit hospital processes enhances the precision of these ideas.

Decoupling as a response to CHNA mandates

It is important to consider the ways that nonprofit hospitals have responded to these new mandates and the impact of this response on spending. When exploring this study's primary research question, *Why, despite these policies, do community benefit expenditures continue to demonstrate a lack of investment in Community-Oriented Spending?* it is helpful to see this as an *organizational* problem through the lens of decoupling.

Decoupling, as mentioned previously, is when an organization's actual activities or practices do not match their formal rules and policies (Meyer & Rowan, 1977). Heese et al. draw on Meyer and Rowen to identify two pressures that lead to organizational decoupling: "external pressures for conformity that conflict with internal pressures for economic efficiency, and conflicts within external pressures regarding appropriate organizational goals" (Heese et al., 2016; Meyer & Rowan, 1977). Both of these pressures can be seen in the example of nonprofit hospitals. Federal and state policies requiring CHNAs and community benefit spending are in conflict with nonprofit hospital economic efficiency *and* external regulatory bodies such as Congress and the IRS are in conflict regarding the role of nonprofit hospitals in addressing community health needs.

In this paper I argue that nonprofit hospitals decouple their formal policies on community health promotion from actual community benefit spending because it is not organizationally efficient from a financial standpoint and because nonprofit hospitals do not actually need to spend in this way to maintain legitimacy in their field and comply with regulations. Spending on community health initiatives identified by CHNAs is not in the financial interest of the hospital

and can therefore be thought of as "organizationally inefficient." Additionally, the staff that conducts the CHNA likely does not have significant decision power with regard to overall community benefit spending which offers another opportunity for decoupling. Moreover, nonprofit hospitals have broad discretion and are not truly held accountable for addressing community need and can therefore maintain legitimacy without substantially investing in community health. While CHNAs are often rich and detailed reports completed by staff dedicated to community health, I argue that nonprofit hospitals treat CHNAs symbolically.

Nonprofit hospitals are required to provide community benefits and espouse to be committed to community health promotion but the majority of expenditures are designated toward *unreimbursed costs of means-tested government programs* (subsidies for Medicaid reimbursement) (Young et al., 2013, 2018). This category allows hospitals to "…treat as community benefits the difference between the cost of caring for beneficiaries and the actual Medicaid payments received in connection with such care" (Rosenbaum et al., 2016). Essentially, nonprofit hospitals can subsidize Medicaid reimbursement payments tax-free. While it can be argued that subsidizing Medicaid payments benefits the community because nonprofit hospitals are able to survive financially and are more likely to accept Medicaid-eligible patients, it is also clear that the primary beneficiary of these funds are the hospitals themselves. Therefore, this category can be thought of as organizationally efficient. Additionally, a recent study found that nonprofit hospitals spend less on *charity care* than for-profit hospitals and government-owned hospitals (Bai et al., 2021), further demonstrating the lack of commitment by nonprofit hospitals to spend on categories deemed "organizationally inefficient." Nonprofit hospitals decouple their actual activities from stated priorities by prioritizing community benefit spending

categories that help the hospital financially over categories that help the community or low-income patients directly.

Some studies have shown that what is initially decoupled can become more tightly coupled in an organization over time (Haack et al., 2012; Sauder & Espeland, 2009). One example of this "recoupling" can be seen in companies adopting "corporate responsibility" standards (Haack et al., 2012). Haack et al. state that when companies symbolically adopt corporate responsibility standards such as environmental preservation, they remain subject to societal evaluation (Haack et al., 2012). Should companies espousing environmental commitments begin clear-cutting forests, public scrutiny may give way to the recoupling process where companies must truly carry out the corporate responsibility practices they had symbolically touted (Haack et al., 2012). In this way, the public has power to hold organizations accountable for coupling their actual activities with formal policy. Thus, coupling the CHNA requirement with community benefit expenditures may be possible for nonprofit hospitals if stakeholders, lawmakers, and other interested parties call for this alignment.

Methods

The primary research question for this study is: *Why, despite nonprofit hospitals conducting Community Health Needs Assessments, do community benefit expenditures continue to demonstrate a lack of investment in Community-Oriented spending?* To answer it, I conducted interviews with 14 CHNA staff members and stakeholders familiar with and/or involved in the CHNA/Schedule H processes. Multiple case study methodology was used for collecting and analyzing data. The "cases" in this study were nonprofit hospital CHNA departments. Multiple case study methodology was chosen as it is an advantageous method when asking "how" or "why" questions about "…a contemporary set of events over which a researcher has little or no

control" (Yin, 2018) and when the research question is about "developing an in-depth understanding about how different cases provide insight into an issue or unique case" (Creswell et al., 2007).

Interview Protocol Development

Prior to developing the interview guides, key informant interviews were conducted with two experts familiar with the CHNA and Schedule H processes. The content of the interview protocols was guided by these conversations and the primary research question to understand the process of conducting CHNAs and their connection to Schedule H. Interview Guide 1 was used when interviewing CHNA hospital staff (see Appendix 2B) and Interview Guide 2 was used when interviewing non-CHNA staff (see Appendix 2C).

Sample Selection and Participant Recruitment

Prior to recruiting participants, a quota table was developed to ensure that respondents represented a variety of nonprofit hospitals (See Appendix 2A). This process is consistent with multiple case study methodology where the researcher "purposefully selects multiple cases to show different perspectives on the issue" (Creswell et al., 2007). It is also consistent with research indicating that hospitals are heterogenous in their spending on community benefits (Young et al., 2013; MacDougall, Paper 1). Types of nonprofit hospitals represented include religious and non-religious hospitals, academic and non-academic hospitals, hospitals in Medicaid expansion states and non-expansion states, and rural and urban hospitals. By interviewing respondents from a diverse array of hospitals, I ensured that the insight I gained on the process of conducting CHNAs and reporting on community benefits via Schedule H was not limited to one type of hospital only.

Fourteen professionals were interviewed from five hospitals and four non-hospital organizations including governmental departments, universities, and health care consulting agencies with the majority of respondents being hospital employees (n=10). Respondents were first recruited by viewing publicly available CHNAs on nonprofit hospital websites and contacting listed professionals via email. Each respondent was asked if "there was anyone else I should contact to better understand this process," thereby employing snowball sampling to recruit additional respondents. Interviews were stopped after thematic saturation was reached. All respondents received consent forms and interview questions ahead of time and provided verbal consent over the phone. All fourteen interviews took place over the phone and averaged 43 minutes with a range of 21-61 minutes. CHNA reports and Schedule H forms were reviewed to triangulate data. Study procedures were approved by the University of Chicago Institutional Review Board.

Data Analysis

During each of the fourteen interviews, I wrote analytic memos as a way to begin thinking about codes and themes as data was being collected (Saldana, 2016). These memos helped guide future interviews and allowed me to take note of emerging themes. Each interview was audio taped and then transcribed by a professional transcription company. Following transcription, I uploaded all transcripts into Dedoose qualitative coding software for analysis. Dedoose was used for data storage, coding, and thematic development.

Steps in the analysis included 1) An initial exploration of the conversations/data, 2) Coding segments of the data, 3) Using these codes to develop overall themes, 4) Constructing a case study narrative composed of themes. During the initial exploration of data phase, I reviewed all initial memos and wrote additional analytic memos to further reflect on "…emergent patterns,

categories and subcategories, themes and concepts…" (Saldana, 2016) in the data. This phase and review of my research and interview questions led to the development of my codebook. A code is a "…word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldana, 2016, p. 4). These words/short phrases were assigned to portions of the 14 interviews in the first round of coding. I then edited and adjusted the codebook and recoded the interviews to further draw out salient features of the data with the goal of identifying major themes (Saldana, 2016, p. 9). Once major themes were identified, the case study narrative incorporating identified themes was developed. The analytic technique used was that of "explanation building" where the goal is to "analyze your case study data by building an explanation about the case" (Yin, 2018, p. 179). This technique is primarily used for exploratory case studies and its goal is to generate hypotheses as well as identifying ideas for future research (Yin, 2018).

Findings

The analysis of interviews led to three major themes/findings. The first major finding is that the majority of CHNA staff reported low levels of involvement with, and/or knowledge of, the Schedule H process. This finding demonstrates that there is likely organizational separation between staff doing the CHNA and the finance/accounting staff (responsible for Schedule H). This could contribute to a disconnect between the community health needs discovered in the CHNA process and hospital spending on community benefits. The second finding is that all CHNA staff expressed a commitment to addressing the social determinants of health. This commitment furthers the argument that CHNA staff are disconnected from community benefit spending decisions. Should CHNA staff have greater involvement in spending decisions, they likely would prioritize those categories that closely align with the social determinants of health.

The third finding is that respondents were confused about Schedule H categories, which activities are "counted," and/or how to accurately report on Schedule H. This confusion helps explain the disconnect between CHNA findings and community benefit spending because it could mean that Schedule H data does not accurately reflect hospital spending. This confusion may also lead to less spending if hospitals are unclear on what "counts" as a community benefit. I discuss each of these in more detail below.

Role Delineation Among CHNA Staff

Each respondent from CHNA departments were asked about their role in reporting and submitting Schedule H based on the belief that if CHNA staff were significantly involved in the Schedule H process, they may have greater influence over spending decisions. Respondents represented a spectrum of involvement with reporting on Schedule H with the majority of respondents stating they had low to no involvement. Low to no involvement respondents had official roles such as: providing community health programming (exercise classes etc.), only writing a narrative statement for Schedule H, or most commonly, reporting community health information to the finance/accounting department who then completed Schedule H. Having low to no involvement with Schedule H was most common for respondents in rural hospitals and/or hospitals with very small community health departments.

Not all respondents were removed from the Schedule H process, however. Two respondents noted a much stronger role and were well-versed in the Schedule H categories. The first of these respondents noted that their primary role was "IRS recording" where they are sent data on community benefits from hospital staff and complete certain sections of Schedule H. The most involved respondent worked very closely with the finance/accounting department and was extremely well versed in Schedule H.

> ***Respondent 1****: We create all the tax reports for the form 990. We create all of those and feed those to the tax department to actually put on the 990's…I have an actual 990 here plus all the worksheets. The line item that we submit all that data from is under part one, section seven E: community health improvement services and community benefit operation. Everything we report is on that line item. However, we work closely with all of the people, and in fact I lead what we call the community benefit work group, that all of the leaders who have input in all the other sections, part of my role and the role of my team is to do the external facing communications about community benefits."*

The finance professional at the same hospital as Respondent 1 corroborated this close working relationship and stated that having a cross-organization work group has led to a smoother reporting process.

The finding that the majority of CHNA staff have low to no involvement in Schedule H demonstrates both the variability among hospitals as well as the possibility that the separation between CHNA staff and the tax reporting process allows hospitals to spend less on Community-Oriented Categories. While respondents noted that it is typically departmental business executives and not the finance/accounting departments who make decisions with regard to community benefit spending, greater CHNA staff involvement in the Schedule H reporting process could still aid CHNA staff in advocating for higher spending on the health needs they have identified in the community. This would allow CHNA staff to "recouple" formal CHNA policy with the actual spending practices of the hospital.

Addressing the Social Determinants of Health

All respondents who were CHNA hospital staff and most financial/tax staff verbalized a commitment to addressing health needs in their communities with particular enthusiasm for the burgeoning focus on the social determinants of health. This commitment highlights the disconnect between CHNA processes and actual community benefit spending as spending on

social determinants of health-related categories is very low. The majority of respondents noted that their annual budget was set by business leaders for the associated departments. For example, an annual research budget may be set by the head of the research business unit. Spending on categories such as *unreimbursed costs for means-tested government programs,* however, was noted to be based on yearly projections and patient need. CHNA staff reported having access only to the business leaders for the categories they primarily spend within (*community health improvement* and *contributions to community groups).* Schedule H spending is therefore decided by multiple business executives within the nonprofit hospital who may or may not be communicating with one another. Despite the fragmented nature of spending decisions, the majority of CHNA employees noted their departments had made positive changes toward truly addressing community needs.

One respondent, who had previously worked at a for-profit hospital, noted the welcome change toward "true public health work" after moving to a nonprofit hospital. Another respondent also remarked on the shift from viewing community benefits as a marketing ploy to an actual way to address the social determinants of health and noted that their department used to be housed under the Public Affairs Department which had been heavily influenced by marketing goals. The belief among the majority of CHNA department respondents was that their departments were truly invested in addressing identified broad community health needs. This belief was seen by respondents noting that their departments shifted away from marketing and had begun to address "upstream factors" associated with community health.

While CHNA employees were pleased with departmental changes, they recognized that there was a lack of categorical spending aimed at social determinants of health and hypothesized reasons for this low spending. The first hypothesis for why nonprofit hospitals were not

financially investing in social determinants of health to a greater extent was that there was a lack of financial incentive. This hypothesis was noted in the following statement by a CHNA employee who said the primary focus was on "downstream" spending:

> ***Respondent 11:*** *And it [charity care] is important, but there's lot of other ways, it's honestly, without value-based payment models, what incentive is there to not be thinking downstream? That's the only thing that gets hospitals upstream really.*

The second hypothesis given for why there was not more investment in social determinants of health categories was that until recently many nonprofit hospitals did not believe it was their role to address social determinants of health partially because these issues were outside the scope of the hospital and board members were reticent to get involved.

> ***Respondent 10:*** *...I think there were board members that would say, "The schools aren't our responsibility." But if we've got a lot of obese kids or kids who are living in violence, we're not going to have a healthy community. I think more and more, boards have accepted that the health of a community is part of their responsibility.*

The third hypothesis given was that nonprofit hospitals did not connect CHNA findings to community benefit expenditures because Schedule H placed the "social determinants of health category" (*community-building activities*) in Section II of the form.

> ***Respondent 6****: I would say what we put on the return [Schedule H] is not focused as much on community building. That's not an emphasis in our organization, as a result of that [it being in Part 2 of Schedule H]. I would say as we evolve and as the social determinants of health and those type of things become more of things that our executive leadership focuses on, especially in the last couple of years have become more important….Now as we expand on that, I think we have not done as good of a job reporting that information [Community Building Activities] because as an organization and from those groups within both the state of XX and nationally that review our tax*

return…they don't really focus on the second part [of Schedule H], they primarily focus on the first part [of Schedule H].

While all of the CHNA professionals and most of the professionals from stakeholder organizations discussed the need for greater focus on social determinants of health both through CHNAs as well as through expenditures, one respondent from a health care organization with expertise in CHNAs and Schedule H believed the social determinants of health were getting too much attention and other categories, such as health professions education, should receive more focus than they do. The argument that CHNAs should focus concerns such as provider supply demonstrates the breadth of the policy and its interpretations. While flexibility in determining what constitutes a "community health need" allows for hospitals to tailor their implementation to their communities, it also leaves room for hospitals to address needs that may not be community priority.

When asked what suggestions the respondents had to revise policy to encourage spending on social determinants of health, responses varied. Multiple respondents stated that CHNAs should be required to also report on "actual impact" which could include financial investment in addressing identified health needs. This idea was noted by many respondents who believed the focus of CHNA policy was on conducting the report rather than addressing the findings in the report. This belief is demonstrated in the following statement:

Respondent 8*: And then of course the community health needs assessment rules where again the hospital doesn't have to succeed. There's no standard in the law for how well we have to meet the community health needs.*

The majority of respondents in this sample demonstrated a philosophical commitment to "true public health work" and addressing the social determinants of health while simultaneously

recognizing that federal policy does not force nonprofit hospitals to spend in this area. Nonprofit hospital business leaders/budget decision makers do not appear to share a commitment to spending on the "social determinants of health" community benefit categories.

Confusion in Schedule H Reporting

The last major finding was that significant confusion exists in reporting on community benefits. The majority of respondents noted that the categories of community benefit were vague, and they therefore relied heavily on consulting agencies such as the Catholic Health Association (CHA) or other health care agencies for advice. Additionally, respondents stated that it would be difficult to compare community benefit expenditures across hospitals because reporting was so different hospital to hospital (especially for *research* and *community building activities* categories).

Several respondents noted confusion in reporting on Schedule H and discussed strategies to ensure compliance with the law. Many respondents noted that they relied on trainings and support from the CHA to ensure accurate reporting. This reliance was true for religious and non-religious hospitals alike and demonstrated the significant role played by the CHA in community benefit reporting.

> ***Respondent 4:*** *All of the questions I ever have about the process of anything community health assessment related, that's where I go is Catholic Health Association. They're kind of the go to for any questions.*

Another respondent noted that many hospitals seek help from outside consulting agencies, if they can afford it, and argued that larger and "more sophisticated hospitals" prepare Schedule H "in house" and rely on consulting agencies to ensure compliance.

> ***Respondent 6****: Yeah, I would say the larger the hospital the more sophisticated hospitals are more similar to us in that they prepare their own return but they get guidance from*

some type of outside consulting organization to ensure that they are aligned with what—they're kind of presenting themselves in the best case possible in alignment with the intent of the law.

The common need to seek out consultation with either the CHA or other organizations demonstrates the complicated nature of Schedule H. One respondent noted that while some large hospitals may be better equipped to correctly file these forms, other hospitals may be in greater need of outside help.

Whether or not hospitals sought help from outside agencies, the belief that the categories as they stand are "grey or vague" was echoed by many respondents who also noted that the variety of reporting decisions likely make it difficult to compare expenditures from one hospital to another.

Respondent 6*: I think it's very grey, I think that different organizations put things on different lines and therefore I think the most important thing however is to make sure you accurately and completely represent what you're doing, and I don't have any problem going to the IRS and saying "I put this number on Line A versus on Line B. I have no problem with that as long as I'm sure that the expenses that we paid that we put online one are accurate and complete.*

Two common categories that respondents reported significant confusion on were *research* and *community building activities*. One consistent area of confusion or disagreement is with regard to *community building activities* which is currently located in Section II of Schedule H. One respondent stated that they believed nothing should be reported in Section II of Schedule H:

Respondent 10: *They've (The IRS) made it really clear that if an activity meets the definition of community benefit and that means it's addressing a community health need and its purpose is to improve community health or one of those other objectives that [another respondent's name] probably mentioned, you can report it as community health*

> *improvement. We tell our people, "there shouldn't be anything left in community building." That's a damned if you do damned if you don't because some researchers say hospitals aren't doing anything in the social determinants of health because they don't report anything in part 2 (of Schedule H). That's because if it meets the definition…record it as community health improvement.*

This respondents' belief that nothing should be reported under *community building activities* begs the question of why this category still exists under Part II and how can Schedule H be revised to clarify where social determinants of health investments should be reported.

The other major category of confusion is *research*. Several respondents noted that scholars often try to compare hospitals based on Schedule H data and that this is a mistake as it is difficult to compare this data because hospitals often report differently based on organizational structure. One respondent stated:

> ***Respondent 9****: I mean here's another issue that when you don't have the research dollars in the revenue side, you can have two hospitals one of which just by virtue of where things get accounted for, Teaching Hospital A happens to have a couple hundred million dollars of research on its books…Hospital B is affiliated with a medical school that's doing the same amount of research collectively but it's all on the books of the medical school. And one of these hospitals would look much like it's doing so much more community benefit than the other when in fact they're basically doing about the same.*

The third reason it is difficult to compare one hospital to another is due to the ability for hospitals to file "group returns." Multiple respondents noted that when hospital systems file group returns, they "reduce transparency" about individual hospital spending and make comparisons between independent hospitals and hospital systems difficult. One respondent who works in accounting/finance noted that CHNAs were designed to have a greater "level of detail" than community benefit spending as illustrated through group return policy.

All of these comments demonstrate areas of confusion with regard to reporting, understanding, and comparing Schedule H's. Respondents noted that due to "grey" and "vague" categories and differing reporting decisions, cross-hospital comparison on community benefit expenditures may be difficult. The confusion in this area could be a factor in the low expenditures for Community-Oriented Categories.

Discussion

There is currently a disconnect between the importance placed on CHNAs and subsequent community benefit spending. The three categories of nonprofit hospital community benefit that I argue contribute most directly to communities (*community health promotion, contributions to community groups,* and *community-building activities*), the "Community-Oriented Categories," have consistently been the lowest categories of spending. To better understand why there is low investment in these categories despite CHNA findings that indicate their importance, this study employed qualitative case study methodology and found three major themes that may contribute to this decoupling.

First, respondents indicated that CHNA staff are often either not involved or minimally involved in filing Schedule H. The disconnected nature of tax filing by financial departments and conducting CHNAs may play a role in low Community-Oriented Spending. While CHNA staff are knowledgeable of the categories their work most closely relates to (primarily *community health promotion*), they are less knowledgeable about spending across all seven categories of community benefit. CHNA staff tend to be professionals invested in public health and community health promotion and their greater involvement in the entirety of the Schedule H process may lead to advocacy for greater spending on those categories that most directly contribute to community health. Additionally, by not requiring nonprofit hospitals to address the

health needs they find in the CHNA, current policy arguably places more importance on the creation of the CHNA report rather than the actions that follow. Should policy require a connection between CHNAs and spending, the important work being done by CHNA departments would be truly prioritized and reflected in spending decisions.

Second, the majority of respondents expressed an investment in addressing the social determinants of health as demonstrated by CHNA findings. This response demonstrates the lack of connection between Schedule H spending and CHNA findings, as the categories of spending most closely related to the social determinants of health are low spending categories. The differing priorities between CHNA departmental professionals and nonprofit hospital business executives who make spending/budgetary decisions is not surprising and demonstrates the importance of policy that truly requires spending on the social determinants of health/CHNA findings. Many respondents also noted their desire for *community building activities* to be moved to Part I of Schedule H as they believed this would lead to greater spending in this category and therefore greater investment in the social determinants of health.

Lastly, respondents noted confusion with regard to filing and understanding Schedule H. A majority of the CHNA staff respondents noted that the Schedule H categories were difficult to understand and they often looked to outside consulting agencies and/or the Catholic Health Association website for advice. Additionally, many respondents noted that it would be difficult to compare hospitals' Schedule H's for multiple reasons. For example, categories such as *research* and *community building activities* appear to be handled very differently by different hospital thereby making cross-hospital comparison difficult. Moreover, respondents noted that filing group returns reduces spending transparency and further differentiates community benefit

spending from CHNA reporting (as CHNA reports must be completed at the individual hospital level).

These major findings explore some reasons that Schedule H spending does not always reflect CHNA findings. While the CHNA staff that were interviewed were very invested in social determinants of health and worked hard to report spending correctly, many hospitals continue to prioritize spending that benefits the hospital financially and therefore spend significantly less on Community-Oriented Categories. To remedy this disconnect, policy should mandate a stronger relationship between CHNA and Schedule H reporting and the creation of a category of spending that relates directly to CHNA findings. Additionally, this study echoes past research that calls for moving the category *community building activities* to Section I of Schedule H (Rosenbaum et al., 2016). This study also demonstrates the importance of qualitative research in this field based on responses indicating discrepancies in reporting making cross-hospital comparison less accurate.

Limitations

The majority of respondents were CHNA staff and there may be additional perspectives, such as board members, public health department officials, and community-based organization leaders that would illuminate other important parts of the CHNA/Schedule H processes. Additionally, research centers such as The Hilltop Institute, have examined state-level differences with regard to community benefit regulations (The Hilltop Institute, 2016) and therefore future studies that look nationally or at different regions of the country could contribute valuable insight that this study's midwestern context may be missing.

Conclusion

Nonprofit hospitals could be powerful actors in addressing the social determinants of health. Despite these hospitals espousing a commitment to addressing social determinants of health and direct community investment, we have seen a decoupling of these formal policies and actual practices (in the form of community benefit spending). Current policy does not incentivize a true link between CHNA findings and spending on community benefit categories that most directly invest in the community and this leaves the social determinants under-resourced. By interviewing individuals most closely involved in conducting and reporting CHNAs and Schedule H forms, this study highlights themes that lead to disconnection and makes the case for policy revision. By revising policy, nonprofit hospitals could fully live up to their community benefit requirement and communities could receive the direct investment they deserve.

APPENDIX 2A

Table 7. *Sample Quota Table*

Type of Hospital	**Number of Respondents**
Religious	4
Non-Religious	6
Academic	8
Non-Academic	2
Located in a Medicaid Expansion State	6
Located in a Non-Medicaid Expansion State	4
Rural	4
Urban	6
Non-Hospital Respondents	
Consulting/Academic/ Financial Organizations	4

APPENDIX 2B

Interview Guide 1: Chart for Critical Review of Question Development

Research Question: *Why, despite nonprofit hospitals conducting Community Health Needs Assessments, do community benefit expenditures continue to demonstrate a lack of investment in community-oriented spending?*

Figure 1. CHNA Staff Interview Guide

QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
Please tell me about your role at _____. ***Probes:*** *Title, Education, Licensure*	To begin the conversation, get an initial sense of the department.	I hope to get the conversation started and begin to understand the department/roles.	High: Establishing rapport and starting the conversation is key to later understanding how the department is structured is key.	
How long have you been in this position?	Another question that helps me understand how long the department has existed/any major changes.	Helps me understand the persons role and their expertise.	Medium: Another good question to further the conversation and gain information that aids in future questions.	
How (if at all) has this position changed over time? ***Probe:*** *Impact of the ACA/Schedule H Reporting Requirements*	To begin talking about changing policies and their impact on this person's role changes if any.	Helps me understand the impact of major policies and whether these policies at all affected this person's department and reporting process.	High: The effect of these policies is key to understanding the connectedness of CHNAs and Schedule H.	

Fig. 1 continued				
QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
How has your organization defined "community" for purposes of the health needs assessments?	To understand how the department is thinking about their role and who they are serving.	To get a sense of the process of conducting the CHNA and the scope of the document.	High: This is a major point of variability and understanding how it is operationalized helps to better understand the CHNA process.	
What do you see as the strengths and weaknesses of your process of conducting the community health needs assessment?	To get an overall view of the process and allow issues to come up that I would not know to ask about.	This helps me to understand current frustrations and/or positive parts of the process.	High: This will likely reveal items I did not know about and their impact on the process.	
How do you believe your organization views the Community Health Needs Assessment process?	To understand the support or lack thereof from the institution.	If institutions are not supportive it may be more likely that benefit spending is not connected to CHNAs.	Medium: Another direct specific question about the organization and its views on CHNAs.	
Who (if anyone) are your partners in the community? ***Probes:*** *Local health departments? Community stakeholders? Other hospitals?*	To understand collaborations and whether this has an impact on either CHNAs or Schedule H or both.	Helps me to know how decisions are being made and who is involved.	Medium: A direct question about a major component of CHNA policy.	
Walk me through the process of reporting results from the health needs assessment to hospital administrators/	To allow space for the person to share previously unmentioned components of the process.	Helps me to know what else to ask and have a high-level view of the process.	High: This question will hopefully reveal the connectedness of the departments and the system in place.	

Fig. 1 continued				
QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
financial departments—				
What (if any) is your role in the process of filing Form 990/Schedule H?	Straightforward question to know how the process works at this hospital and get a sense of how hospitals may decide on roles differently.	Helps me to know whether there is separation between CHNAs and Schedule H processes.	High: This is important to know because if the person has no role in the Schedule H process, they likely know less about it and the departments are likely very separated.	
Have you seen any changes in the Form 990 reporting over time?	To understand whether ACA policy shifted spending toward community-oriented categories.	Helps me to know whether categorical spending changes based on community need/policy.	Medium: Important to understand these changes, may have already come up in the discussion by now.	
What category/categories of community benefit expenditure are your implemented programs placed under?	To understand whether there is knowledge of the relationship between CHNAs and Schedule H as well as whether hospitals report differently on Schedule H.	Helps me to understand how hospitals are actually reporting on CHNA related activities and/or whether CHNA departments are aware of this reporting.	High: This gets at connectedness of CHNA processes and Schedule H processes directly.	
If you could improve upon the community health needs assessment process, what would you change?	To allow space for additional comments/concerns.	To help me understand how the CHNA process is viewed.	Medium: Opens the door for additional comments but these may have already come up.	
Is there anything else you think I should know to	To allow more space for general thoughts/ideas/concerns.	To help me understand challenges or positive parts	Medium: Open-ended question for additional comments.	

Fig. 1 continued				
QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
understand the CHNA process?		about the process in an open-ended way.		
Is there anyone else you think I need to talk with to understand the CHNA process?	To recruit more participants in the study.	To recruit participants from a variety of departments/hospitals.	High: Snowball sampling necessity.	

APPENDIX 2C

Chart for Critical Review of Question Development

Research Question: *Why, despite nonprofit hospitals conducting Community Health Needs Assessments, do community benefit expenditures continue to demonstrate a lack of investment in community-oriented spending?*

Figure 2. Non-CHNA Staff Interview Guide

QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
Please tell me about your role at _____. ***Probes:*** *Title, Education, Licensure*	To begin the conversation, get an initial sense of the department.	I hope to get the conversation started and begin to understand the department/roles.	High: Beginning the conversation is key for later understanding how the department is structured is key.	
How long have you been in this position?	Another question that helps me understand how long the department has existed/any major changes.	Helps me understand the persons role and their expertise.	Medium: Another good question to further the conversation and gain information that aids in future questions.	
How (if at all) has this position changed over time? ***Probe:*** *Impact of the ACA/Schedule H Reporting Requirements*	To begin talking about changing policies and their impact on this person's role changes if any.	Helps me understand the impact of major policies and whether these policies at all affected this person's department and reporting process.	High: The effect of these policies is key to understanding the connectedness of CHNAs and Schedule H.	

Fig. 2 continued

QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
The ACA requires hospitals to conduct CHNAs to encourage them to better understand and address the needs of communities. Have you seen evidence of this on Schedule H's?	To prompt discussion on changes based on ACA requirements/focus on community health.	To help me see whether the ACA/CHNAs actually play a role in Schedule H reporting.	High: This is a major concept I would like to gain an understanding of.	
Please walk me through the process of reporting on community benefit expenditures. **Prompts:** guidelines, categories	To get an overall view of the process and allow issues to come up that I would not know to ask about.	This helps me to understand current processes.	High: This will likely reveal items I did not know about and their impact on the process.	
What are your thoughts on the seven categories? Meaningful? Arbitrary?	To better understand the categories from the point of view of people reporting on Schedule H's.	Helps me know whether my hunches about the categories seeming duplicative or confusing are shared by staff.	Medium: This gives me a sense of how Schedule H is perceived.	
Have you seen changes in reporting community benefit expenditures over time? **PROMPT**: Medicaid Expansion	To learn whether policy changes led to visible changes on Schedule H.	Helps me understand whether policy changes actually "moved the needle" on expenditures from a reporter's point of view.	Medium: An important point to understand with regard to effectiveness of policy.	
Do you think it's important to report community benefit expenditures to the IRS?	To gain a general understanding on how Schedule H is perceived.	Helps me to get a sense of overall perception of the form/policy.	Medium: Important to know how Schedule H is received and could bring up new thoughts/ideas.	

Fig. 2 continued				
QUEX	PURPOSE	OBJECTIVE	PRIORITY (H, M, L)	MISC. Notes
If you could improve upon the community health needs assessment/Schedule H process, what would you change?	Open ended question to see if there are ideas/concerns that I do not know to ask about.	Helps me to hear what the areas of improvement are from the point of view of someone working in the field.	Medium: Could bring up great suggestions/ideas.	
Is there anything else you think I should know to understand the process of reporting community benefit expenditures?	Open ended question that allows respondent to bring up ideas I may not know to ask about.	Helps me to further understand the process from the respondent's point of view.	Medium: Could bring up new ideas/concerns.	
Is there anyone else you think I need to talk with to understand the community benefit expenditure reporting process?	To recruit more respondents for the study.	Helps me identify people who work in the field and have a connection.	High: This is how I conduct snowball sampling.	

DISSERTATION CONCLUSION

Current community benefit policy does not do enough to hold nonprofit hospitals accountable to the communities they serve. Past criticism of nonprofit hospitals has argued for greater transparency and greater accountability (Diamond, 2017; Grassley, 2005; Trocchio, 2017) and I argue that only certain types of transparency has been achieved. Through the creation of Schedule H and the CHNA requirement, we gained insight into how hospitals spend community benefit dollars and what the needs of their communities are. However, as this study reveals, nonprofit hospitals continue to invest minimally in Community-Oriented Categories of spending unless they have high profit margins (MacDougall, Paper 1) which could be due to the decision not to require a benchmark spending amount (MacDougall, Paper 2) or the lack of other requirements mandating that organizations more closely link CHNA findings to community benefit spending (MacDougall, Paper 3). At a time when the social determinants of health are being viewed with increased interest from the Department of Health and Human Services, state Medicaid programs, and health systems (Horwitz et al., 2020), this study demonstrates opportunities to revise current community benefit policy to ensure nonprofit hospitals are truly held accountable for addressing these "upstream" issues to improve the health of communities.

This study also critically questions the validity of the seven categories of community benefit as they stand. While each of the seven categories may play an important role in the financial survival and practices of nonprofit hospitals, this study argues that the grouping of all seven categories together under the umbrella term "community benefits" may obscure actual hospital activities. Specifically, the category *unreimbursed Medicaid,* is budgeted for and calculated significantly differently than other categories. Moreover, the *unreimbursed Medicaid* category of spending primarily benefits the nonprofit hospital itself which is able to subsidize

Medicaid reimbursement tax free. The complicated nature of funding Medicaid through taxes and then subsequently subsidizing nonprofit hospitals through tax free Medicaid subsidies created a complex shell game and differentiates this category from others. By creating a new reporting structure for *unreimbursed Medicaid*, I argue that actual hospital activities would be transparent to a greater extent and the public could clearly evaluate the level of spending by nonprofit hospitals on categories such as *community health promotion, cash and in-kind contributions to community groups,* and *community building activities.* By questioning the nature of "Community Benefits" writ large, this study expands on past philosophical discussions of the role of nonprofit hospitals.

Implications for social work research, practice and policy

This study's findings offer opportunities for social work research, practice, and policy to leverage community benefit policy to address the social determinants of health. Findings from Paper 1 demonstrate neither current state-level CHNA policy nor the expansion of Medicaid has led to greater spending on Community-Oriented Categories of spending including *community health promotion, contributions to community groups* and *community building activities*. Indeed, only the variables *total revenue* and *profit margin* were associated with greater spending on these three important categories in the multivariate analysis. Additionally, findings showed that a greater percentage of people living in poverty was *negatively* associated with Community-Oriented Spending. This finding could indicate that communities needing the most investment are getting the least. One hypothesis for why this is happening, is that nonprofit hospitals in these high-poverty communities see a higher percentage of Medicaid recipients and therefore spend more community benefit dollars on the *unreimbursed Medicaid* category. Additional social work scholarship is therefore required to understand what causes less Community-Oriented Spending

in communities experiencing greater poverty and to understand overall barriers to spending on Community-Oriented Categories to further target policy revision that promotes this vital spending. By increasing social work research in these areas, lawmakers will have the necessary information to promote nonprofit hospital community benefit policy that truly addresses the social determinants of health.

Paper 2 demonstrated the power of advocacy by stakeholders such as the Catholic Health Association (CHA) in shaping Schedule H, a document that greatly affects nonprofit hospital community benefit spending. By creating a blueprint for standardization that had been accepted by hundreds of hospitals, the CHA played a significant role in the delineation of the seven categories of community benefit spending. Moreover, the CHA demonstrated the importance of forging strong relationships with legislators to influence policy. Social work researchers and practitioners can use these lessons to establish relationships and advocate for community benefit policy revision that ensures the categories present on Schedule H hold hospitals accountable to a greater extent and link community needs to community benefit spending.

Additionally, Paper 2 showed the power of stakeholders, especially the CHA and AHA, in advocating against benchmark spending amounts. This lesson again demonstrates the importance of social workers developing relationships with lawmakers and advocating for greater accountability through benchmark spending. Social workers can demonstrate their understanding of the issue by linking benchmark amounts to profit margin thereby ensuring nonprofit hospitals with greater financial surplus are required to spend more than those struggling financially. Additionally, social workers can advocate for studies on nonprofit hospital executive compensation to encourage transparency and accountability regarding these surplus

amounts. Finally, by focusing on the three categories of Community-Oriented Spending in our advocacy, we can ensure that direct community investment is prioritized.

Paper 3 begins to reveal the "black box" of the process of linking CHNA findings to community benefit spending and Schedule H reporting. Significant research is needed to better understand nonprofit hospital processes on a national level and the perspectives of additional stakeholders such as nonprofit hospital boards and public health collaborators in the community. Social work practitioners working at nonprofit hospitals can collaborate with their employers to ensure social workers are involved in the CHNA process as well as the community benefit spending decision process. Social workers are uniquely qualified to provide guidance on the identified non-medical needs of patients, to advocate for community-based organizations to receive the needed financial resources, and to work within their organizational system to affect change with regard to level of investment in Community-Oriented Categories.

As a profession, social work has long recognized the impact "social issues" have on health (Richmond, 2017). As other professions and systems begin to prioritize these issues, social work has the opportunity to be leaders in this field and advocating for nonprofit hospital community benefit policy revision is one way to achieve this goal. As anchor institutions with considerable financial power, nonprofit hospitals are well positioned to address the social determinants of health. Moreover, nonprofit hospitals are federally mandated to provide "benefits to the community" in exchange for the significant tax benefits they are afforded and should therefore already be doing this work. Current community benefit policy begins to expose nonprofit hospital decisions but does not go far enough in ensuring accountability. This study sheds light on the reasons nonprofit hospitals are not currently addressing social determinants of

health and argues for stronger policy mandates. It is time for "community benefits" to truly benefit communities.

While there are significant policy opportunities to promote further investment in Community Oriented Categories, the larger questions raised by this study are whether nonprofit hospitals should be tax-exempt and whether they should be providing benefits to the community. It is often argued that nonprofit hospitals should not be required to address the social determinants of health as this is not their role. It is possible that these arguments are correct and that the better option would be to require nonprofit hospitals to pay taxes to the state and federal government and these entities can then use those funds to invest in education, housing, and social services that broadly benefit society. Another possibility is that these funds should be directed to public health departments who may then be able to provide free health care and needed social and health services based on community need. The historical belief that nonprofit hospitals are charitable and benevolent actors in American society seems to have led to the belief that these organizations will be good stewards of tax savings and will invest these funds wisely in their communities. However, as nonprofit hospitals have argued in the past, addressing social determinants of health in their communities may be outside of their scope and other organizations or departments may be able to do this work. Historical events tell us that it is more likely that Congress and the IRS will continue to refine and revise Form 990/Schedule H and other nonprofit hospital requirements rather than overhauling the entire tax-exempt system. Given this reality, this study contributes to our understanding of how current policy was created and what its implication are, while also providing policy recommendations.

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