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Establishing a Baseline: Community Benefit Spending by Not-for-Profit Hospitals Prior to Implementation of the Affordable Care Act

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ABSTRACT

Context: Community Benefit spending by not-for-profit hospitals has served as a critical, formalized part of the nation's safety net for almost 50 years. This has occurred mostly through charity care. This article examines how not-for-profit hospitals spent Community Benefit dollars prior to full implementation of the Affordable Care Act (ACA).

Methods: Using data from 2009 to 2012 hospital tax and other governmental filings, we constructed national, hospital-referral-region, and facility-level estimates of Community Benefit spending. Data were collected in 2015 and analyzed in 2015 and 2016. Data were matched at the facility level for a non-profit hospital's IRS tax filings (Form 990, Schedule H) and CMS Hospital Cost Report Information System and Provider of Service data sets.

Results: During 2009, hospitals spent about 8% of total operating expenses on Community Benefit. This increased to between 8.3% and 8.5% in 2012. The majority of spending (>80%) went toward charity care, unreimbursed Medicaid, and subsidized health services, with approximately 6% going toward both community health improvement and health professionals' education. By 2012, national spending on Community Benefit likely exceeded $60 billion. The largest hospital systems spent the vast majority of the nation's Community Benefit; the top 25% of systems spent more than 80 cents of every Community Benefit dollar.

Discussion: Community Benefit spending has remained relatively steady as a proportion of total operating expenses and so has increased over time—although charity care remains the major focus of Community Benefit spending overall.

Implications: More than $60 billion was spent on Community Benefit prior to implementation of the ACA. New reporting and spending requirements from the IRS, alongside changes by the ACA, are changing incentives for hospitals in how they spend Community Benefit dollars. In the short term, and especially the long term, hospital systems would do well to partner with public health, other social services, and even competing hospitals to invest in population-based activities. The mandated community health needs assessment process is a logical home for these sorts of collaborations. Relatively modest investments can improve the baseline level of health in their communities and make it easier to improve population health. Aside from a population health justification for a partnership model, a business case is necessary for widespread adoption of this approach. Because of their authorities, responsibilities, and centuries of expertise in community health, public health agencies are in a position to help hospitals form concrete, sustainable collaborations for the improvement of population health.

Conclusion: The ACA will likely change the delivery of uncompensated and charity care in the United States in the years to come. How hospitals choose to spend those dollars may be influenced greatly by the financial and political environments, as well as the strength of community partnerships.

KEY WORDS: ACA, Affordable Care Act, Community Benefit, health care finances, hospital spending

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This year marks just over a quarter century of Congressional interest in not-for-profit hospitals' Community Benefit expenditures and almost 50 years since promulgation of the IRS ruling requiring hospitals provide charity care to qualify for tax exemption.[1-3] Not-for-profit organizations serving "charitable" purposes, including "relief of the poor, the distressed, or the underprivileged,"[4] have historically been allowed exemptions from certain state and federal taxes in exchange for providing services of general benefit to the US population.

In 1969, after the creation of Medicare and Medicaid, the IRS issued a regulation specific to nonprofit hospitals, stating that hospitals must provide a "Community Benefit" to justify their tax exemption. This signaled a broader definition of tax-exemption requirements to include more than charity care provision.[5] However, the IRS offered no guidance on the types of activities included in the Community Benefit requirement, nor did it provide clarification on calculating costs related to these Community Benefits.

Over the next 40 years, many states developed more specific requirements for Community Benefit provision. This yielded a great deal of variation in the state-level legislative requirements, as well as the degree of detail, and the definition of Community Benefit.[6-10] A number of studies have examined the provision of charity care and Community Benefit more broadly during the late 1900s. They generally found inconsistency in charity care provision, including large differentials in the types of services provided, and hospital goals and policies that discouraged elective treatment provision to the uninsured. In some cases, a hospital's tax liability exceeded the provision of uncompensated care and other Community Benefits.[1,7-9,11-12]

Traditionally, financial assistance and other charity care have been the main source of hospitals' Community Benefit spending and the focus of state requirements.[10] However, this began to change in 2009 around the same time as the Patient Protection and Affordable Care Act (ACA) was being debated in Congress (and later signed into law in 2010). The ACA included many provisions recognizing the importance of community and population-oriented health and aimed to expand health insurance coverage, potentially dramatically decreasing the demand for charity care.[13-18] Not-for-profit hospitals were now expected to focus less on direct patient financial assistance and more on public and population health efforts. In 2009, the IRS issued a new Schedule H addendum to the Form 990 (the standard form all tax-exempt organizations must complete), which collected data on hospitals' Community Benefit costs and allocations.[19] These new data allow policy makers and researchers alike to finally paint a more accurate picture of hospital Community Benefit spending.

There is growing recognition that not-for-profit hospital Community Benefit activities are an important area with tremendous potential to advance the integration of health care and public health systems infrastructure. Others have begun to publish work that examines hospital Community Benefit activities.[10,17,20-23] This work represents critical steps in surveying the landscape of Community Benefit spending. However, previous use of IRS Schedule H filings has also been impacted by data quality and other limitations of the Form 990 and Schedule H data that have resulted in underestimates of nonprofit hospital Community Benefit spending. In this article, we address those data quality and issues and examine Community Benefit spending data from 2009 (the first year of Schedule H data) through 2012 (the most recent year of available data at the time of writing).

Methods

This article characterizes changes in total and types of Community Benefit spending between 2009 and 2012 in the United States. We utilize 2 major sources of data: hospitals' financial information reported to the IRS and information reported in the CMS Hospital Cost Report Information System (HCRIS) and Provider of Service data sets. Information on hospital system membership was acquired from Guidestar, a third party that digitizes publicly available IRS Schedule 990 filings of not-for-profit organizations.

Tax information from not-for-profit hospital systems

As part of the IRS' rules and regulations, all private not-for-profit hospitals and systems in the United States began filing addenda to their 990 tax forms called the Schedule H after passage of the ACA. The primary data used in our analyses are derived from these tax data submitted to the IRS and digitized by a third party, Guidestar. These data were acquired from Guidestar. Exploratory data analysis and cleaning found numerous missing records and data errors. Because of extensions in IRS filing deadlines and Guidestar's digitization schedule, as of calendar year 2015, only full data sets from 2009 to 2010 were available, a subset of about 75% of records were available for 2011, and about 47% of records were available for 2012. As such, several types of estimates are ill-advised for 2011 and 2012 at the time of publication, including both total spending and per capita spending estimates, especially for 2012; such estimates would represent vast undercounts of actual Community Benefit spending.

Validation of the original data identified problems with about 2000 of 8500 submissions across all years. We worked with Guidestar to address the erroneous values. Overall, our final data set contains all 2642 US hospital systems that reported data from 2009 and 2602, 2041, and 1235 hospital systems* reported data in 2010, 2011, and 2012, respectively. We report the results of analyses of different cohorts of hospital systems, including those that reported in each year 2009-2011 ($n \approx 1950$ hospital systems), as well as those that reported each year 2009-2012 ($n \approx 1060$ hospital systems).

Defining Community Benefit spending

The IRS' Schedule H classifies 7 major types of Community Benefit activities—financial assistance at cost (charity care), Medicaid, costs of other means-tested government programs, community health improvement (CHI) services and Community Benefit operations, health professions education, subsidized health services, research, and cash and in-kind contributions for Community Benefit.[24] Estimates of Community Benefit "spending" relate to the net expenditures by a hospital system in a given area like at-cost financial assistance (charity care), Medicaid, or health professions' education—that is, "total Community Benefit expense" minus "direct offsetting revenue."[24] In some cases, this will relate to actual expenses associated with, for example, CHI services minus offsetting revenue. In other cases, total expenses will relate to the cost-to-charge ratio of a hospital system—namely, for charity care or Medicaid. As such Community Benefit "spending" relates to net (often unreimbursed) expense by a system, and not *all* costs or charges related to, for example, serving patients with Medicaid.

Transforming national estimates to state and regional estimates

The IRS requires hospital systems (not individual facilities) to file 1 tax return. As such, creating accurate state and local area estimates necessitates allocation of the various types of Community Benefit spending to each facility. We used the HCRIS data, which hospital facilities must complete as part of participation in Medicare, to cross-validate certain charity care and financial assistance spending. Data for 2009-2012 for each facility were merged with IRS data, and Community Benefit expenditures were allocated proportionate to operating expenditures (E. K. Johnson, G. Tung, J. P. Leider, and R. Lindrooth, unpublished data, 2015). For estimates available in both the HCRIS and IRS data, this allocation process yielded a correlation above 0.72 after allocation to each hospital facility (see Supplement Digital Content Appendix, available at http://links.lww.com/JPHMP/A257, and Supplement Digital Content Figure, available at http://links.lww.com/JPHMP/A258).

Estimates by state and hospital referral region (HRR) were generated using ArcGIS (ESRI, Redlands, California) in combination with our analytic data set. HRR shapefiles were created by the Dartmouth Atlas, and we used TIGER census tract data from the US Census Bureau to generate demographic and per capita estimates. We report the 2010 level of per capita expenditures and the changes in Community Benefit expenditures between 2009 and 2011 among a cohort of 1950 hospital systems reporting in 2009, 2010, and 2011. The 2010 level is reported because it was the last complete year of data available due to IRS filing and digitization timelines. Overall, 2895 individual facilities were included in our final data set derived from 2009 filings, 2950 in 2010, 2241 in 2011, and 1356 in 2012.

Analytic approach

Descriptive analyses of the 2009-2012 cohort of hospital systems were performed to summarize level and change in expenditure over the sample period. We also analyzed the slightly larger 2009-2011 cohort and report those results for comparison. Overall, the share of spending and observed trends were not significantly different, although the aggregate level of spending is significantly different, reflecting the different sample sizes. Sensitivity analyses suggest the largest hospital systems are relatively less likely to have filed their 2011 and 2012 tax information than are smaller systems. As such, estimates of total spending derived from the cohorts are significantly underestimated in the cohort analysis. Trends over time are based on the same systems, but they are not representative of all large systems. We also computed the 2010 level and the 2009-2011 change in expenditures in each HRR using the facility-level data set. Finally, we computed annual estimated spending on Community Benefits, in aggregate. Missing data were interpolated using average annualized growth by HRR as well as state and achieved similar results to the IRS' recent estimates.[24]

Results

Community Benefit spending as measured by absolute dollars and percentage of operating expenses in

*We use the term "hospital system" to refer to hospital ownership as defined by the organizations tax ID. This encompasses large multihospital systems as well as independent hospitals operating in a single site.

the United States increased as the economy emerged from the Great Recession. In 2009, hospital systems spent slightly less than 8% of their total operating expenses on Community Benefits, on average (Table 1). This increased to 8.3% to 8.5% in 2012. Among the larger cohort of hospitals reporting tax information in 2009-2011, total Community Benefit spending in absolute dollars grew about 20%. Among those reporting in 2009-2012, total Community Benefit in absolute dollars spending grew about 22%. However, total operating expenditures for hospitals grew concomitantly, so the relative proportion of funds directed toward Community Benefit was similar to previous years. During this time period, charity care provision remained relatively stable overall, at 68% of total Community Benefit spending, on average, each year among hospitals reporting tax information in 2009-2012. Hospital systems spent about 14.7% of Community Benefit on subsidized health care services (separate from charity care) in 2009 and 16.1% of Community Benefit expenditures in 2012. Systems spent between 6% and 7% of Community Benefit dollars on health care professional education and training in 2009-2012. Hospitals spent 6.4% of Community Benefit dollars on CHI activities in 2009 and 5.4% in 2012—representing a proportional and absolute decrease in spending among hospitals reporting financials for each year.

Significant variation exists across hospital systems in terms of how much they allocated toward Community Benefit spending and on what activities it was spent (Tables 2 and 3). A small percentage of hospital systems (25%) spent more than 80% of all Community Benefit dollars nationally. These systems were the largest—with more than $250 million in operating expenses. The largest 5% of hospitals—that is, those with more than $800 million in operating expenses—alone spent 47% of all Community Benefit spending in 2009 and 51% in 2012. Systems in the top quartile of operating expenses spent an additional 3.4 percentage points of their operating expenses on Community Benefit overall compared with those in the lowest quartile ($P \leq .001$) and 2 percentage points higher than the second and third quartiles ($P = .016$ and $P = .008$, respectively). Those in the third quartile spent approximately the same as the second quartile. Overall, nonprofit hospitals spent a relatively small proportion of Community Benefit dollars in the category of CHI, which is hospital-subsidized activities and programs to support CHI (including community health needs assessments [CHNAs], community planning, etc) compared with other reporting categories. About 0.44% of operating expenses (6.4% of total Community Benefit spending) went toward CHI in 2009-2012. "Community-building activities"[24,25] is another category of community support recorded on the Schedule H separate from Community Benefit. Items include physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, CHI advocacy, workforce development, and other. Across all 9 subcategories tracked by the Schedule H, hospitals spent 0.11% of operating expenses on community-building activities. In 2010, this amounted to $480 million compared with $57.4 billion in Community Benefits and $624.7 billion in total operating expenses across 2600 hospital systems. This amount likely increased to approximately $600 million by 2012 after extrapolating to those systems that had not yet filed returns for 2012.

Table 3 highlights some key differences between the largest and smallest systems in the country. The largest spent more on health professional education

TABLE 1
Community Benefit Spending in the United States by Private, Not-for-Profit Hospital Systems, 2009-2012

	All Reported Records (as of December 2014)			Cohort Reporting 2009-2012 (n = 1051 Hospital Systems)		Cohort Reporting 2009-2011 (n = 1928 Hospital Systems)	
Year	Total Community Benefit Spending	Percent[a]	Number of Hospital Systems	Total Community Benefit Spending	Percent[a]	Total Community Benefit Spending	Percent[a]
2009	$52.2 billion	7.6	2608	$22.4 billion	8.0	$38.6 billion	7.8
2010	$57.4 billion	7.8	2560	$23.8 billion	7.9	$42.9 billion	8.0
2011	$47.4 billion	8.4	2016	$26.4 billion	8.5	$46.5 billion	8.3
2012	$29.3 billion	8.3	1215	$27.6 billion	8.5		

[a] *The "Percent" column represents the average proportion of operating expenses not-for-profit hospitals reported that they spent on Community Benefit. This table shows the changes in Community Benefit spending over 2009-2012. Because of IRS tax-reporting requirements, a number of systems with late submissions for their final 2011 and 2012 tax information had not yet been reported to Guidestar as of December 2014. As such, trend analyses utilize cohorts of systems reporting in 2009-2012 (center columns) or 2009-2011 (right columns).*

TABLE 2
Proportion of Total Community Benefit Spending, Community Health Improvement, and Community-Building Activities by Size of Hospital System Operating Expenses, 2009-2012[a]

Operating Expenses	Percentile of Operating Expenses	2009	2010	2011	2012
Proportion of national Community Benefit spending by size of hospital system operating expenses					
<$20 million	0-25	1%	1%	1%	1%
$20.1 million-$80 million	25-50	4%	4%	4%	4%
$80.1 million-$250 million	50-75	14%	13%	13%	12%
$250.1 million-$800 million	75-95	33%	32%	32%	32%
>$800 million	95-100	47%	50%	50%	51%
Proportion of national community health improvement spending by size of hospital system operating expenses					
<$20 million	0-25	1%	1%	1%	1%
$20.1 million-$80 million	25-50	5%	4%	4%	4%
$80.1 million-$250 million	50-75	15%	17%	15%	16%
$250.1 million-$800 million	75-95	23%	32%	29%	29%
>$800 million	95-100	56%	45%	51%	51%
Proportion of national community-building spending by size of hospital system operating expenses					
<$20 million	0-25	1%	1%	1%	1%
$20.1 million-$80 million	25-50	16%	6%	5%	5%
$80.1 million-$250 million	50-75	26%	30%	31%	25%
$250.1 million-$800 million	75-95	28%	27%	27%	30%
>$800 million	95-100	29%	36%	36%	39%

[a] *Estimates are drawn from a cohort of 1060 hospital systems reporting tax information for each year, 2009-2012.*

($P < .001$) and research ($P < .001$) than smaller systems. Similarly, smaller systems spent relatively more of their operating expenditures on subsidized services ($P < .001$).

Separate from cross-tabulations by size of the system's operating expenses, we analyzed differences in the composition of expenditures based on the total amount of the hospital's total Community Benefit

TABLE 3
Community Benefit Spending 2009-2012, by Size of Hospital System's Operating Expenses[a]

	$0 million-$25 million	$20 million-$80 million	$80 million-$250 million	$250 million-$800 million	$800 million+	Total
Financial assistance	1.7	2.4	2.4	2.7	2.8	2.3
Medicaid	2.6	3.2	3.4	3.5	3.8	3.2
Other gov	0.4	0.4	0.2	0.1	0.2	0.3
Community health improvement	0.3	0.4	0.4	0.4	0.6	0.4
Health professional education	0.1	0.2	0.4	1.3	2	0.6
Subsidized services	1.5	1.5	1.1	1.1	1.1	1.3
Research	0.1	0	0	0.2	1.2	0.2
Cash	0.2	0.2	0.2	0.2	0.2	0.2
Total	6.9	8.3	8.1	9.5	11.9	8.5

[a] *The values given are the percentage of net expenses not-for-profit hospital systems expended toward charity care in 2009-2012 (pooled). Data are from 1060 hospital systems that reported in each year of 2009-2012. "Financial assistance" represents net spending for direct patient care covered by financial assistance policies. "Medicaid" represents unreimbursed expenses for Medicaid charges. "Other gov" represents unreimbursed expenses for charges under other government means-tested programs. "Community health improvement" represents hospital-subsidized activities and programs to support community health improvement (including community health needs assessments, community planning, etc). "Health professional education" represents medical education and certification programs made available to professionals not directly employed by the hospital. "Subsidized health services" represents services that are needed by the community but not financially beneficial to the hospital (eg, neonatal intensive care units). "Research" represents both internally funded research conducted by the hospital and costs related to research funded by another entity. "Cash" represents cash and in-kind contributions for the hospital's other Community Benefit activities.*

spending. Those in the top quartile of Community Benefit spending account for the vast majority of spending. In 2012, the lowest quartile of hospital systems, in terms of absolute dollars spent on Community Benefit (<$1 million), averaged about 3% of operating expenses on Community Benefit spending and accounted for less than 1% of the national total. The second quartile ($1 million to $5 million of Community Benefit spending) averaged approximately 3% of operating expenses on Community Benefit and accounted for 3% of the total. Those in the third quartile ($5 million to $20 million) spent 9% of operating expenses on Community Benefit on average, accounting for 12% of the national total. Systems in the top 75th to 95th percentiles ($20 million to $85 million) spent 13% of operating expenses on Community Benefit on average, accounting for 31% of the national total. Those in the top 5% of total Community Benefit spending ($85 million+) spent more than 15% of their operating expenses on Community Benefit, accounting for 54% of national spending.

Regional variation

In 2010—the most recent year all hospitals reported data—an estimated $182 per capita was spent across the United States on Community Benefit activities. Examination of spending estimates by HRR shows considerable variation geographically (Figure 1). The average across the HRRs was $164 per capita (median $151). The largest amount spent was $867 per capita in the Bismark (North Dakota) HRR and $708 in the Cleveland (Ohio) HRR in 2010. Other HRRs with the highest expenditures include the Boston (Massachusetts) HRR ($699 per capita), the San Mateo (California) HRR ($532 per capita), and the Manhattan (New York) HRR ($518 per capita).

In a larger cohort of systems responding from 2009 to 2011, we were able to categorize both the regional averages in expenditures on Community Benefit allocation and the drivers of changes over time as the country emerged from the Great Recession. As Figure 2 illustrates, most HRRs saw an increase in the proportion of operating expenses not-for-profit hospitals spent on Community Benefits. Across the majority of HRRs, total Community Benefit spending increased between 2009 and 2011. Most of the increase was driven by increased charity care expenses, especially uncompensated care (as opposed to losses due to Medicaid or other government means-tested programs).

In states that had expanded Medicaid or eventually expanded under the ACA, average net uncompensated care costs as a proportion of overall expenses

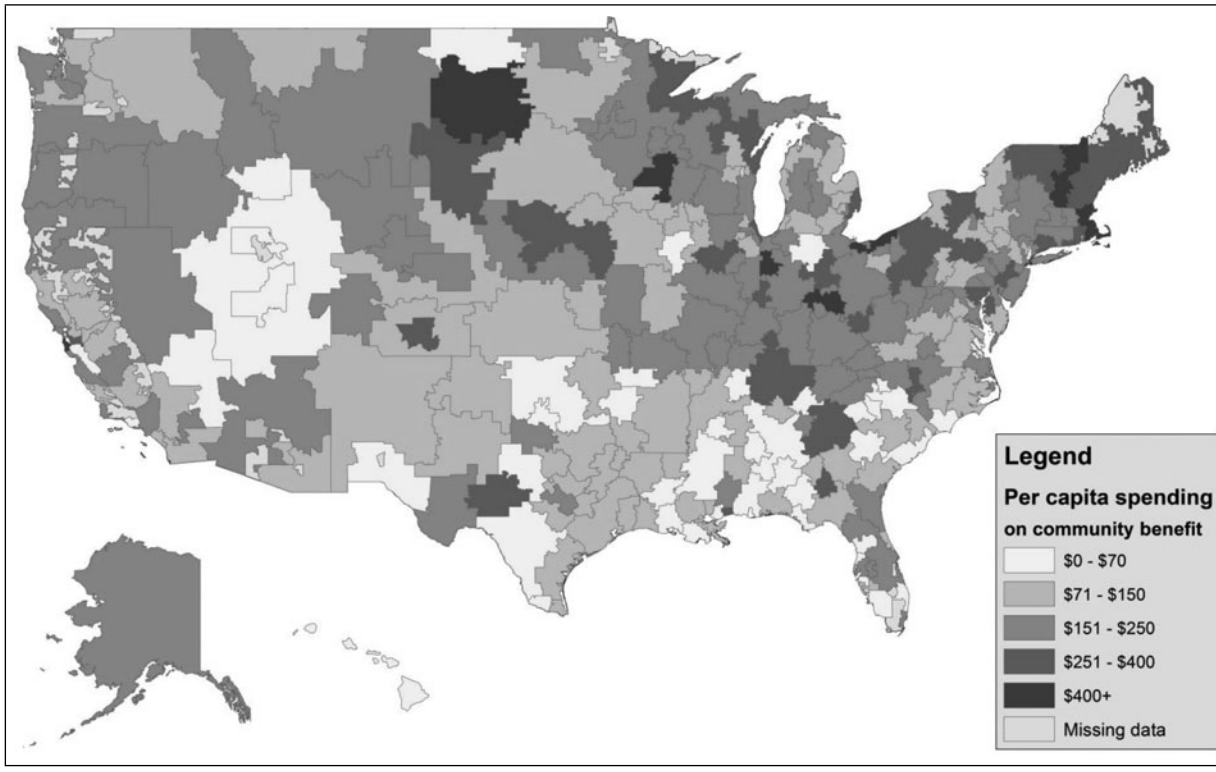

FIGURE 1 Community Benefit per Capita Spending by Hospital Referral Region, 2010

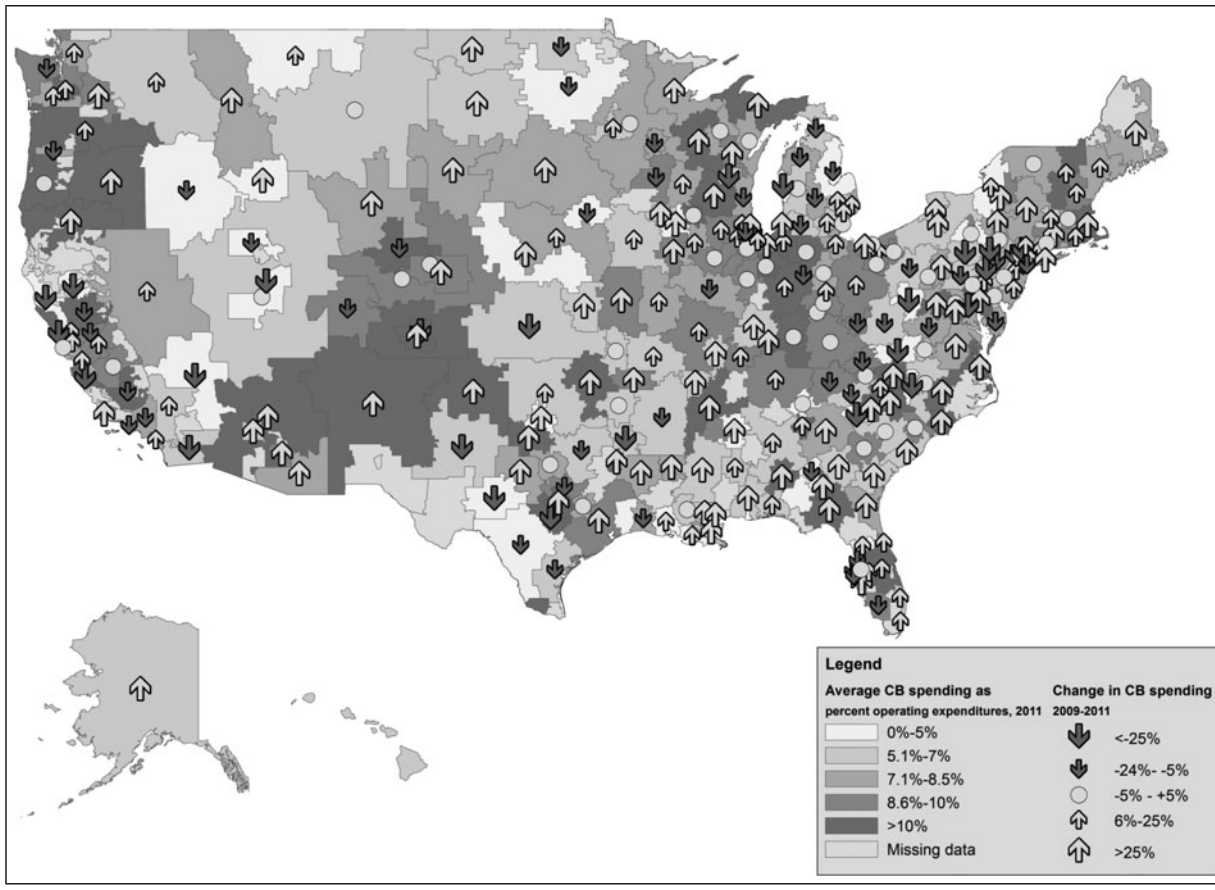

FIGURE 2 Changes in Community Benefit Spending by Hospital Referral Region, 2009-2011

was 1.9% compared with 2.6% in states that were not expanding Medicaid prior to full implementation of the ACA. This difference was most significant in the largest 5% of facilities. Hospitals in expansion states had spent about 1.8% of operating expenses on at-cost charity care and 3.2% on losses due to Medicaid in 2009; in 2012, this had changed to 2.2% on at-cost charity care and 3.6% on Medicaid losses. Hospitals in nonexpansion states spent 2.4% on at-cost charity care in 2009 and 2.2% on Medicaid losses; in 2012, this had grown to 2.8% on at-cost charity care and 2.5% on Medicaid losses. Overall, hospitals in expansion states spent 7.9% on total Community Benefit compared with 7.3% for hospitals in nonexpansion states in 2009. In 2012, this gap had closed slightly, with hospitals in expansion states spending 8.4% whereas hospitals in nonexpansion states spent 8.1% on total Community Benefit.

Discussion

The ACA holds the potential to shift the incentives associated with Community Benefit provision in the United States. Greater public and private insurance coverage may change how hospital systems choose to provide new services and write off others. Our estimates of Community Benefit spending prior to full implementation of the ACA suggest that Community Benefit spending exceeded $50 billion in 2009 and likely $55 billion to $60 billion by 2012. Other examinations of this topic suggest similar results,[26] although some estimate markedly less, and some are due to the exclusion of large, multistate hospital systems from estimates.[17,22,27,28] Approximately 70% of Community Benefit spending consistently went toward at-cost financial assistance, unreimbursed Medicaid expenses, and other means-tested government programs during that time. In smaller systems, subsidized health services accounted for 15% to 20% of total Community Benefit spending. Multiple studies have shown that billions of these dollars may be in play, as various payers and providers adjust to a post-ACA landscape.[10,14-17,20-22,29-32] On the one hand, continued financial pressures on not-for-profit hospitals, including cuts to federal disproportionate share payments, may incentivize some systems to protect or reinvest any net revenue realized from lower expenditures on uncompensated care. On the other hand,

many systems—constituting billions of dollars previously spent on charity—may be looking at other, more effective ways to improve community health with their Community Benefit monies.[10,27] As hospitals are now required to do CHNAs and invest in some accordance with a CHI plan, CHI spending holds significant potential for the improvement of population health, but the current lack of specific requirements around CHI creates uncertainty. The specific guidance or requirements that should be provided to hospitals need to be carefully researched and considered for hospital Community Benefit activities to realize their full potential as an important avenue to connect hospitals to community and integrate health care and public health infrastructure.

It is likely that some systems will experience a "surplus" generated from declines in uncompensated care costs due to the combination of more privately and Medicaid-insured individuals. Some may be substantial,[33] but most may be a bit more modest. Such declines may be offset by an expected reduction in disproportionate share payments, but gains will likely still be substantial, especially in states that expanded Medicaid. Beyond guidance for a better definition of Community Benefit and its constituent parts, not-for-profit hospital executives and boards would benefit from alternative models for use of these dollars. Currently, for those wanting to continue investing in Community Benefit, there are questions on how to do so effectively. Many different potential models have been discussed over the last 30 years.† The most recent, and perhaps most compelling, expands on the often-discussed system under which hospitals within a community or geographic area would pool resources toward commonly identified community needs.[23,27] Corrigan et al[27] and Singh et al[23] have highlighted the need for the involvement in several sectors, including public health and other social services. This model shows promise, but more evidence on the effectiveness of the approach and how it impacts hospitals is needed to construct a business case that would motivate hospital systems to adopt a pooling approach. The CHNA process more broadly is also noteworthy, as community partnerships may arise around it across the public and private sectors.

Implications for Policy & Practice

- Community Benefit spending by private not-for-profit hospitals has the potential to be a catalyst for meaningful improvements in population health.
- It has been the subject of much interest, discussion, and debate over the last quarter century.
- Data show that a fairly small percentage of hospitals are spending the lion's share of Community Benefit dollars in the United States.
- These complex, multifacility hospital systems spend relatively more on health professional education, research, and population-based CHI activities than their smaller counterparts.
- However—large or small—all hospitals experiencing a shift downward in uncompensated care costs will have to decide where to spend those dollars, especially whether those dollars will go toward other types of Community Benefit or go back toward the hospital system's bottom line.
- Additional research examining Community Benefit spending and activities post-ACA is critical to understanding the changes in Community Benefit and informing policy moving forward.
- In the short term, and especially the long term, hospital systems would do well to partner with public health, other social services, and even competing hospitals to invest in population-based activities.
- The mandated CHNA process is a logical home for these sorts of collaborations. Relatively modest investments can improve the baseline level of health in their communities and make it easier to improve population health.
- Aside from a population health justification for a partnership model, a business case is necessary for widespread adoption of this approach.
- Because of their authorities, responsibilities, and centuries of expertise in community health, public health agencies are in a position to help hospitals form concrete, sustainable collaborations for the improvement of population health.

Limitations

This article is among the first to use nationwide not-for-profit tax filings to chart changes in Community Benefit spending over multiple years (E. K. Johnson, G. Tung, J. P. Leider, and R. Lindrooth, unpublished data, 2015). The primary limitation of this approach is the lack of availability of data for 2011 and 2012, especially at the time of publication due to IRS filing rules. For this reason, total and per capita estimates are not appropriate for 2011 and 2012. This limits our ability to extrapolate to the present, especially after implementation of the various ACA rules and regulations. As such, our analyses should be viewed as they are described—as a baseline for Community Benefit spending prior to full implementation of the ACA. While we use cohorts of responding systems to

†References 3, 10, 11, 17, 21, 23, 27, 29, 34–37.

look at changes over time, a limitation of this approach may be that impact of the largest systems may be underestimated, as they are somewhat less likely than smaller systems to have reported in the 2011 and 2012 data. Another limitation comes from our approach in the allocation of Community Benefit dollars from multihospital systems to individual facilities. Although correlation is high between the IRS 990 filings and HCRIS reports under this approach, the most significant limitation relates to extrapolation of population-based activities. Although recent studies using single hospital systems show a similar apportionment of CHI and community-building activities as our approach does for comparable facilities, our extrapolation of spending on population-based activities is allocated on the basis of operating expenditures and does not take into account local variation in demand for different types of Community Benefit services, especially population-oriented measures of need.

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