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## STRENGTHENING COMMUNITY BENEFIT:

# Restoring the Social Contract Between Nonprofit Hospitals and Taxpayers

*A 50-State Evaluation and Reform Blueprint*

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**Chris Jones, Tanner H. Jones, Ryan Quandt, Joshua Reynolds**

## I. Introduction

Nonprofit hospitals receive billions in tax exemptions each year in exchange for "community benefit" provision. In theory, these tax breaks constitute one end of a social contract: hospitals enjoy tax relief, and communities enjoy community health programs and health education, preventative care initiatives, medical research, and reduced medical costs, including charity care. It is unclear, however, whether nonprofit hospitals meet their community benefit obligations, yet their communities lose an otherwise lucrative source of tax revenue. Absent clear reporting requirements and accountability measures, tax-exempt hospitals may spend only a token amount on charity care as they pour funds into other ventures unrelated to patient needs.

While nonprofit hospitals and health systems avoid taxes, they also consistently lobby both the federal and state governments for programs to address the rising cost of providing care to the uninsured, underinsured, and their bad debt obligations. Over the years, policy has attempted to address the providers' concerns. These include facility-based payments, 340b, disproportionate share hospital payments, sole community hospital payments, and, most recently, state-directed payments — all payments to address the unpaid costs these providers incur. However, there is little to no transparency on these payments, so it is unclear the extent to which (and how well) nonprofit hospital and health system spending is being used to lessen their cost burden while addressing community needs.

We call for comprehensive policy changes to hold tax-exempt nonprofit hospitals accountable to the public will and interest. First, we diagnose the problem: most states have *lackluster requirements* (or none at all) for nonprofit hospitals' community benefit spending and transparency. Second, we introduce a new 10-point state ranking system to evaluate all 50 states on three pillars — Transparency, Accountability, and Enforcement — highlighting best practices and worst offenders. Finally, we propose a solution: policy standards to ensure hospitals earn their tax exemptions through real, transparent community investment. Our goal is persuasive but practical: arm policymakers and the public with a clear roadmap to demand more from tax-exempt hospitals and reclaim the original promise of the nonprofit healthcare provision.

## II. The Problem: Lackluster Requirements Among States

In many states, hospitals enjoy property tax exemptions, state corporate tax breaks, and other subsidies with few strings attached. Despite the federal mandate that nonprofit hospitals must provide community benefits to justify their 501(c)(3) status (Section 501(r) of the Internal Revenue Code), nonprofit hospitals face varying requirements so that their benefit to the community matches the benefits from their exempt status. State-level standards vary in the transparency they require, whether and how much community benefit is required from nonprofit hospitals, and whether there is enforcement for noncompliance. Following these differences, this section outlines the methodology for our 10-point state ranking system and presents a 50-state standing, exposing how the vast majority of states impose limited requirements on nonprofit hospitals.

### a. Methodology: The 10-Point Ranking System

To objectively compare states, we developed a 10-point ranking system based on three critical factors:

- **Transparency (4 points):** Measures how openly and in detail hospitals must report their community benefit activities and finances. High-transparency states require *itemized, publicly accessible reports* with state oversight, whereas low-scoring states might only mandate a basic IRS Form 990 filing with no state-level detail.
- **Accountability (4 points):** Assesses whether states tie hospitals' tax-exempt status to concrete community benefit obligations. This ranges from merely expecting hospitals to conduct a Community Health Needs Assessment (CHNA) (low score) to requiring minimum spending floors on community benefits linked to the hospital's revenue or tax savings (high score).
- **Enforcement (2 points):** Evaluates if there are penalties for noncompliance. Top marks go to states with strong enforcement mechanisms (like fines or revocation of tax-exempt status for failing to meet requirements), while most states score low or zero for having no meaningful penalties.

**Scoring Criteria in Detail:**

- **Transparency (0–4 points):**
    - **1 point:** Only basic financial disclosure is required (e.g., filing IRS Form 990, no detailed public reporting at the state level).
    - **2 points:** Some state-level reporting is required, but reports lack detail or are not easily accessible to the public.
    - **3 points:** Publicly available reports detailing charity care spending, community programs, and financial assistance provided. (For example, New York requires hospitals to publicly report charity care costs and how they meet community health needs.)

    - **4 points:** Mandatory detailed, itemized reporting with spending categories (charity care, community health improvement, etc.), easily accessible to the public, *and* subject to state oversight/review. (Maryland, for instance, requires each nonprofit hospital to submit an annual community benefit report itemizing each initiative's cost and objectives; the state compiles these into a public report (Community Benefit State Law Profiles Comparison - The Hilltop Institute).)

- **Accountability (0–4 points):**
    - **1 point:** Only a general expectation to provide community benefits, no formal obligation or planning requirement. (Most states historically fell into this category, assuming tax-exempt hospitals would "do good" voluntarily.)
    - **2 points:** Hospitals must take *some* action, such as conducting a CHNA or developing a community benefit plan, but with no required spending level. Compliance is procedural, not financial.
    - **3 points:** A minimum spending requirement exists, usually defined as a percentage of revenue or a requirement to spend equivalent to some tax measure, *but* it may be loosely defined or not directly tied to the value of tax exemptions. Alternatively, a state may impose charity care requirements for licensure or require Medicaid participation – a step beyond voluntary plans but not a full alignment of tax benefits with spending.
    - **4 points:** The state sets mandatory spending floors linked to the hospital's tax benefits or community needs and/or explicitly ties required community benefit spending to state/local health priorities. This is the gold standard where a nonprofit hospital's tax-exempt status hinges on giving back. (Texas, for example,

offers multiple ways to qualify but explicitly requires a minimum level of charity care and community benefit spending, such as at least 5% of net patient revenue, with charity care at least 4%. Illinois links tax exemption to providing charity care equal to what the hospital would otherwise owe in taxes.)

- **Enforcement (0–2 points):**
    - **0 points:** *No enforcement mechanism.* Hospitals face no penalty if they ignore state community benefit guidelines (common in states where requirements are merely aspirational).
    - **1 point:** Basic penalties in place, such as fines for failing to file required reports or complete a CHNA, but no serious threat to a hospital's financial privileges. (For example, a nominal fine for late reporting would earn 1 point.)
    - **2 points:** Strong enforcement — the state can impose significant consequences like substantial fines, withholding of licenses, or revocation of state tax-exempt status for noncompliance. In these states, a hospital that fails to meet community benefit obligations could lose the very tax breaks that justified its obligations. (Texas effectively falls here: a nonprofit hospital that doesn't meet one of the minimum community benefit standards risks losing its state tax exemption.)

Each state can earn a maximum of 10 points (4 Transparency + 4 Accountability + 2 Enforcement). A score of 0 indicates a state that has *no* meaningful community benefit laws (other than the federal baseline), whereas a perfect 10 indicates a state with rigorous reporting, robust spending requirements, and strong enforcement.

**b. 50-State Rankings**

| Rank | State | Transparency (4 pts) | Accountability (4 pts) | Enforcement (2 pts) | Total |
|---|---|---|---|---|---|
| **1** | **Illinois** | 4 | 4 | 2 | 10 |
| **2** | **Nevada** | 3 | 4 | 2 | 9 |
| **2** | **Oregon** | 4 | 4 | 1 | 9 |
| **2** | **Rhode Island** | 3 | 4 | 2 | 9 |
| **2** | **Texas** | 3 | 4 | 2 | 9 |
| **2** | **Utah** | 3 | 4 | 2 | 9 |
| **7** | **Connecticut** | 4 | 2 | 1 | 7 |
| **7** | **New Hampshire** | 4 | 2 | 1 | 7 |
| **7** | **Pennsylvania** | 1 | 4 | 2 | 7 |
| **10** | **Colorado** | 3 | 2 | 1 | 6 |
| **10** | **Georgia** | 2 | 3 | 1 | 6 |
| **10** | **Indiana** | 3 | 2 | 1 | 6 |
| **10** | **Maine** | 2 | 3 | 1 | 6 |
| **10** | **Maryland** | 4 | 1 | 1 | 6 |
| **10** | **Minnesota** | 4 | 1 | 1 | 6 |
| **10** | **Mississippi** | 2 | 2 | 2 | 6 |

| | | | | | |
|---|---|---|---|---|---|
| **10** | **New Mexico** | 2 | 2 | 2 | 6 |
| **10** | **New York** | 3 | 2 | 1 | 6 |
| **10** | **Washington** | 2 | 3 | 1 | 6 |
| **19** | **California** | 3 | 2 | 0 | 5 |
| **19** | **Missouri** | 3 | 1 | 1 | 5 |
| **19** | **Montana** | 2 | 2 | 1 | 5 |
| **22** | **Idaho** | 2 | 1 | 1 | 4 |
| **22** | **Massachusetts** | 1 | 2 | 1 | 4 |
| **25** | **Alabama** | 1 | 1 | 0 | 2 |
| **25** | **Alaska** | 1 | 1 | 0 | 2 |
| **25** | **Arizona** | 1 | 1 | 0 | 2 |
| **25** | **Arkansas** | 1 | 1 | 0 | 2 |
| **25** | **Delaware** | 1 | 1 | 0 | 2 |
| **25** | **Florida** | 1 | 1 | 0 | 2 |
| **25** | **Hawaii** | 1 | 1 | 0 | 2 |
| **25** | **Iowa** | 1 | 1 | 0 | 2 |
| **25** | **Kansas** | 1 | 1 | 0 | 2 |
| **25** | **Kentucky** | 1 | 1 | 0 | 2 |
| **25** | **Louisiana** | 1 | 1 | 0 | 2 |
| **25** | **Michigan** | 1 | 1 | 0 | 2 |

| | | | | | |
|---|---|---|---|---|---|
| **25** | **Nebraska** | 1 | 1 | 0 | 2 |
| **25** | **New Jersey** | 1 | 1 | 0 | 2 |
| **25** | **North Carolina** | 1 | 1 | 0 | 2 |
| **25** | **North Dakota** | 1 | 1 | 0 | 2 |
| **25** | **Ohio** | 1 | 1 | 0 | 2 |
| **25** | **Oklahoma** | 1 | 1 | 0 | 2 |
| **25** | **South Carolina** | 1 | 1 | 0 | 2 |
| **25** | **South Dakota** | 1 | 1 | 0 | 2 |
| **25** | **Tennessee** | 1 | 1 | 0 | 2 |
| **25** | **Virginia** | 1 | 1 | 0 | 2 |
| **25** | **Vermont** | 1 | 1 | 0 | 2 |
| **25** | **Wisconsin** | 1 | 1 | 0 | 2 |
| **25** | **West Virginia** | 1 | 1 | 0 | 2 |
| **25** | **Wyoming** | 1 | 1 | 0 | 2 |

**The results of our 50-state nonprofit hospital community benefit ranking reveal an alarming truth:**

- The majority of states scored below 4 points out of 10, indicating minimal transparency and virtually no spending obligations on nonprofit hospitals.

- Only 6 states scored 9 or higher, meaning they have relatively strong community benefit laws with a combination of transparency, accountability, and enforcement.
- 18 states scored between 4 and 8 points, representing partial measures but with significant gaps in enforcement or accountability.
- 26 states scored 3 or lower, meaning they have weak or nonexistent community benefit requirements, leaving hospitals with no obligations beyond federal standards.

This section outlines the top-tier, mid-tier, and low-tier states, highlighting leading policies and identifying areas for reform.

**Top-Tier States (9–10 points): Leading in Transparency and Accountability**

Illinois (10/10): The Gold Standard for Community Benefit Laws

Illinois stands alone at the top of our ranking with a perfect 10/10 score, achieving the strongest combination of transparency, accountability, and enforcement by directly tying tax exemptions to mandatory community benefit spending.

- Transparency (4/4): Hospitals must file detailed community benefit reports with the Attorney General, breaking down charity care, financial assistance, and other community investments.
- Accountability (4/4): Nonprofit hospitals must spend at least the equivalent of their property and sales tax exemptions on charity care and community programs.
- Enforcement (2/2): The state actively enforces compliance, with hospitals facing revocation of tax exemptions if they fail to meet spending thresholds.

Illinois provides a model framework for other states looking to ensure nonprofit hospitals justify their tax benefits.

Nevada, Oregon, Rhode Island, Texas, and Utah (9/10): Strong Protections with Some Gaps

These five states earned a 9/10, ranking among the strongest in the nation for community benefit laws.

- Nevada: Requires hospitals to provide 0.6% of net revenue as charity care and imposes substantial penalties if hospitals fall short.
- Oregon: Established state-mandated spending floors, ensuring hospitals reinvest in communities based on health priorities. However, enforcement is weaker, relying heavily on public scrutiny.
- Rhode Island: Ties hospital licensure to meeting charity care and community benefit standards. Strong reporting but lacks strict financial penalties.
- Texas: Hospitals must meet strict spending requirements, such as 5% of net revenue on charity care and community benefits, with strong enforcement mechanisms.
- Utah: Nonprofit hospitals must contribute at least as much in community benefits as they would owe in property taxes, ensuring substantial reinvestment in the community.

**Mid-Tier States (4–8 points): Partial Measures, Significant Gaps**

18 states fall into this category. These states have some community benefit laws but lack spending requirements, strong enforcement, or full public transparency.

Connecticut (7/10): Strong Transparency, Weak Enforcement

- Transparency (4/4): Hospitals must publicly report detailed charity care and financial assistance data to the state.
- Accountability (2/4): Hospitals must submit community benefit plans, but no required spending floor exists.
- Enforcement (1/2): The state can fine hospitals for failing to report but does not revoke tax exemptions for noncompliance.

Colorado, Georgia, Indiana, Maine, Maryland, Minnesota, Mississippi, New Mexico, New York, Pennsylvania, and Washington (6–7/10): Moderate Protections but Weak Enforcement

- Colorado: Requires community health needs assessments but does not mandate specific spending levels.
- Georgia: Hospitals must report charity care spending but face no penalties for failing to provide sufficient care.
- Indiana: Hospitals must develop and submit a community benefit plan, but no mandated spending exists.
- Maine: Hospitals must provide free care to residents up to 150% FPL, but there is no enforcement beyond licensing oversight.
- Maryland: Publicly discloses hospital community benefit spending but lacks strict enforcement tools.
- Minnesota: Hospitals must report charity care spending by income level, but no required minimum spending threshold exists.
- Mississippi: Nonprofit hospitals must operate charity care wards, with penalties for failing to meet obligations.
- New Mexico: Licensure is tied to serving indigent patients to ensure access, but there are no strict financial penalties for failing to meet obligations.
- New York: Mandatory public reporting but no required spending floors, reducing accountability.
- Pennsylvania: Strong tax exemption requirements for charity hospitals but lacks a universal spending mandate.
- Washington: Charity care is required, but there is no set minimum spending floor.

**Low-Tier States (0–3 points): No Real Obligations for Nonprofit Hospitals**

26 states scored 3/10 or lower, meaning they impose no meaningful obligations on nonprofit hospitals beyond federal IRS requirements.

Florida (3/10): One of the Weakest Large States

- Transparency (2/4): Hospitals must file some financial data but not itemized public reports.
- Accountability (1/4): Hospitals are expected to provide charity care but have no legal obligation to do so.
- Enforcement (0/2): No penalties exist for hospitals failing to provide community benefits.

Missouri, Montana, Idaho, Alabama, and Oklahoma (1–2/10): Minimal to No Requirements

These states impose no obligations beyond the federal IRS guidelines:

- Missouri: Requires basic reporting but no spending mandates or enforcement.
- Montana: Hospitals must adopt charity care policies, but there is no required spending level.
- Idaho: Limited reporting for large hospitals only, with no accountability or penalties.
- Alabama & Oklahoma: No transparency, no spending mandates, no enforcement.

Worst Performing States (0-2/10): No Protections for Community Benefit

- Alaska, Arizona, Arkansas, Delaware, Florida, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Michigan, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia, Vermont, Wisconsin, West Virginia, Wyoming

These states impose no community benefit spending requirements, no enforcement mechanisms, and limited or no transparency.

Key Takeaways & Reform Priorities

- Only six states (Illinois, Nevada, Oregon, Rhode Island, Texas, Utah) have strong nonprofit hospital regulations.
- 26 states impose no serious obligations on nonprofit hospitals beyond federal tax-exempt requirements.
- Enforcement is a major weakness – only 11 states have laws that revoke tax-exempt status or impose strict penalties for noncompliance.
- Transparency is critical. Publicly available, detailed reports must be mandatory to hold hospitals accountable.
- Spending requirements are essential. Nonprofit hospitals must reinvest in communities at levels tied to tax exemptions.

Without reform, nonprofit hospitals will continue to accumulate billions in tax-free revenue while failing to provide adequate charity care. States must follow the lead of Illinois, Texas, and Oregon by implementing clear spending floors, public reporting, and meaningful enforcement mechanisms.

The following section outlines the policy recommendations needed to fix this broken system.

## III. The Solution: Clear Transparency and Accountability Standards

State policymakers have an exciting opportunity to recalibrate the social contract with nonprofit hospitals. The solution is to establish clear, consistent standards for transparency and accountability backed by meaningful enforcement. By drawing on best practices from leading

states (and closing the loopholes exploited in lagging states), we can ensure that every nonprofit hospital truly earns its tax exemption by improving community health.

We propose model policy language that states can adopt, built around the three pillars of our ranking system. Below, we outline each pillar of reform and provide examples from existing laws that exemplify strong provisions.

**1. Transparency: Mandatory Public Reporting of Community Benefits**

**Policy Goal:** The public should easily access robust information on what each nonprofit hospital is doing for the community and how it spends the money it would have paid in taxes. Transparency is the foundation for accountability; without detailed reporting, neither the state nor citizens can assess whether a hospital provides sufficient community benefits.

**Key Elements of Transparency Reform:**

- **Annual Community Benefit Reports:** Every nonprofit hospital must file an annual report with a state agency (e.g., the Department of Health or Attorney General) detailing its community benefit activities and expenditures for the past year. This is more than just attaching an IRS Form 990 Schedule H – it means a narrative and financial breakdown of charity care, unreimbursed Medicaid, community health programs, etc.
- **Standardized, Itemized Categories:** Reports should use standardized definitions (so the data is comparable across hospitals) and itemize spending by category: charity care (free or discounted care for those unable to pay), community health improvement services, health professions education, research, financial contributions to community groups, etc. For example, charity care should be reported at cost (not inflated charges), and any

"community building" investments (like housing or economic development projects) should be listed separately.

- **Public Accessibility:** These reports must be made publicly available, ideally on a state-managed website where anyone can search for their local hospital and review its community benefit report. Transparency isn't just for regulators – it's for the community's knowledge. States like Maryland and Oregon already post hospital community benefit reports online.
- **State Oversight of Reports:** A designated state body should review the reports for completeness and accuracy and compile a statewide summary each year. This allows legislators and the public to see the big picture (e.g., total community benefit spending as a percentage of hospital revenue in the state, trends over time, etc.) and identify outliers or bad actors.

**Model Language Example:** Many states have good language to emulate. Consider Maryland's statute that spells out what hospitals must include in their annual community benefit report:

> "Each nonprofit hospital shall annually submit a community benefit report including: (1) the hospital's mission statement; (2) a list of the community benefit initiatives undertaken by the hospital; (3) the cost of each initiative and the objectives for the community; and (4) a description of efforts to evaluate the initiative's effectiveness. The report shall also describe gaps in the availability of medical specialists for uninsured persons and the hospital's efforts to track and reduce health disparities in the community." (Community Benefit State Law Profiles Comparison - The Hilltop Institute) (Md. Code Ann., Health–Gen. §19-303(c))

This kind of detailed, itemized reporting requirement (which Maryland uses) earns a full 4 points on our transparency scale. Any state reform should include similar language to ensure hospitals provide *specifics*, not generalities, about their community contributions.

Another model comes from New York, where hospitals must involve the community and be transparent about their finances:

> "At least every three years the governing body of a nonprofit hospital shall make available to the public a summary of the hospital's financial resources and allocations, including provision of free and discounted care. Annually, the hospital shall publish an implementation report detailing its efforts to meet community health needs, provide charity care, and improve access for the underserved."

By mandating public disclosure of financial resources and charity care, New York pushes hospitals toward transparency and keeps communities informed. We recommend combining these approaches: an annual report and a comprehensive community benefit plan update every few years, all made public.

**2. Accountability: Tying Tax Exemptions to Real Community Investment**

**Policy Goal:** If a hospital is not meaningfully benefiting its community, it should not continue to enjoy tax-exempt status. States must draw a clear line: *tax exemption is conditioned on giving back.* Accountability standards make the community benefit expectation concrete – usually by setting a minimum amount or level of services that hospitals must provide.

**Key Elements of Accountability Reform:**

- **Minimum Spending Requirement:** The simplest and most direct standard is to require each nonprofit hospital to spend *at least a certain amount on community benefits* annually. This can be defined in a few ways:
    - As a percentage of revenues (e.g., X% of net patient revenue must go to charity care and community benefit).
    - As a multiple of the hospital's tax savings (e.g., spend at least the equivalent of your property tax exemption value on community benefits each year).
    - As a dollar amount tied to community size or needs (less common, but for smaller hospitals a fixed floor might be set).
- Texas gives hospitals options, one of which is 5% of net patient revenue with at least 4% in charity care. Illinois uses the tax value method, essentially requiring charity care equal to what property taxes would have been. Oregon's new law directs the state health authority to set individualized spending floors for each hospital every two years (Oregon and Connecticut Hold Hospitals Accountable for Meaningful Community Benefit Investment - NASHP), based on community needs and the hospital's financial capacity – an innovative approach to tailor obligations.
- **Alignment with Community Health Needs and State Priorities:** What matters is not only how much hospitals spend *but what they spend this money on*. Accountability standards should encourage or require that community benefit spending addresses identified needs from the CHNA and fits into state or local health improvement plans. New York explicitly links hospital community service plans to the state's Prevention Agenda priorities, and Connecticut (through its CON process) has required hospitals to invest in social determinants of health like housing or food security identified by the

community. Our model policy would require that a hospital's community benefit plan (updated every 3 years with community input) include initiatives targeting top community health issues (e.g., mental health, chronic disease prevention, maternal health) rather than tangential projects.

- **Charity Care Policy Requirements:** As part of accountability, states should mandate robust financial assistance policies. This means hospitals must offer free or discounted care on a sliding scale, at least for low-income patients (for example, free care up to 200% of the federal poverty level, discounted up to 400% FPL – which is what Oregon now requires). Many states already set charity care minimums for patients; for instance, Washington guarantees free hospital care for those under 100% FPL and sliding scale discounts up to 200% FPL. Ensuring a baseline of charity care for individuals is a direct way to fulfill the nonprofit mission and should be a universal standard.
- **Community Benefit Plan Requirement:** Every hospital should not only report past activities but also maintain an updated Community Benefit Plan or Implementation Strategy that is shared with the state and the public. This plan (often tied to the CHNA cycle) lays out what community benefit activities the hospital will undertake in the coming years, how those address identified needs, and what resources will be committed. States like New York and Maryland already require such plans. Having a forward-looking plan that the community can see and comment on greatly improves accountability.

**Model Language Example:** The clearest language tying tax exemption to spending comes from Texas law. Texas provides multiple standards, but here's a powerful excerpt:

> "A nonprofit hospital shall provide charity care and community benefits in an amount that is at least equal to 5% of the hospital's net patient revenue, provided that charity care and government-sponsored indigent health care are at least 4% of net patient revenue."

Another part of Texas law states a qualitative standard:

> "The level of charity care must be reasonable in relation to community needs, as determined through the community needs assessment, the hospital's available resources, and the tax-exempt benefits received by the hospital."

Together, these provisions ensure a hospital's obligation is "linked to tax benefits" (as our 4-point Accountability definition requires) and responsive to the community's needs. A state reform could adopt the 5%/4% rule or a variant; the exact percentage could vary, but it must be ambitious enough to justify tax breaks. Policymakers might, for instance, average the hospital's last 3 years of tax exemptions (property, sales, etc.) and set that as a required spending floor going forward.

From Illinois, we have model language tying charity care to tax liability:

> "Nonprofit hospitals seeking property tax exemption must provide charity care and other services at levels at least equivalent to the property tax liability they would otherwise owe."

This effectively means a hospital breaks even with the community: it "pays" its taxes in the form of free care and community services. Illinois also extends this to sales tax exemptions. Adopting such a dollar-for-dollar requirement is a compelling way to ensure taxpayers aren't getting a bad deal.

Finally, with respect to aligning priorities, New York's Public Health Law §2803-l (as summarized by the Hilltop Institute) explicitly ties hospital community benefit plans to state health goals:

> "Each tax-exempt hospital's community service plan must include at least two priorities from the state's health improvement plan, selected in conjunction with the local health department, and describe strategies to address them in a three-year action plan."

This kind of provision guarantees that hospital activities aren't happening in a vacuum but are part of a broader strategy to improve public health.

**3. Enforcement: Penalties and Oversight to Ensure Compliance**

**Policy Goal:** Even the best transparency and accountability rules mean little if hospitals can ignore them without consequence. Enforcement provisions give the law teeth, ensuring hospitals take their obligations seriously. This pillar includes both deterrence (penalties for non-compliance) and a mechanism for ongoing oversight.

**Key Elements of Enforcement Reform:**

- **Financial Penalties:** There should be fines or fees for failing to comply with reporting requirements or spending floors. For example, if a hospital doesn't file its community benefit report on time or at all, a fine (daily or per incident) should apply. If a hospital falls short of the minimum spending requirement without a valid reason, the state could impose a penalty equal to the shortfall or some percentage of it.
- **Threat of Tax-Exempt Status Revocation:** The ultimate enforcement tool is revoking the state-level tax exemption (property, sales, etc.) for hospitals that egregiously or

repeatedly fail to meet community benefit requirements. In practice, this is a nuclear option and would likely be used rarely, but having it on the books underscores the seriousness of the mandate. The process could involve giving the hospital notice and an opportunity to correct course or increase spending, but if after a certain period they remain non-compliant, they lose their tax-exempt status for the next tax year. (This is analogous to what the IRS *could* do at the federal level for 501(c)(3) status, but federal enforcement has been lax. States can take initiative here.)

- **Oversight Body and Public Accountability:** Enforcement isn't just about punishment; it's also about *monitoring*. States should designate either an existing agency or a new commission to oversee hospital community benefits. For example, Maryland's HSCRC plays this role by reviewing and publishing reports. An oversight body can issue an annual "hospital community benefit scorecard" or ranking (similar to what we've done) to publicly call out which hospitals are exemplary and which are lagging. Public reputation can be a motivator alongside legal penalties.
- **Community Involvement in Enforcement:** A further idea is to allow community representatives or local governments to challenge a hospital's tax exemption if it's not providing sufficient community benefits. For instance, a city or county could be empowered to hold a hearing or object to a hospital's property tax exemption renewal by presenting evidence that the hospital isn't meeting state standards. This would activate a review by the state and possible revocation. It gives local stakeholders a direct voice in enforcement.

**Model Language Example:** States have been cautious on enforcement, but there are examples. Texas again stands out — its law implies that if a hospital fails to meet any of the community

benefit standards, it would no longer qualify as a "charitable organization" for tax purposes. While Texas doesn't spell out a step-by-step penalty process in the excerpt we cited, the condition itself is an enforcement mechanism (no compliance, no tax exemption).

On the reporting side, California's community benefit law (Health & Safety Code §127285 et seq.) sets a small fine (on the order of a few hundred dollars) for failure to file the required report. That's relatively weak. We suggest scaling penalties to hospital size or tax benefit — for example, "a hospital that fails to submit its annual report shall be subject to a fine of $1,000 per week of delay, up to $50,000." The penalty must outweigh any benefit the hospital might see in hiding information.

Colorado offers another approach. A 2014 Colorado bill (SB 14-050) established monitoring of hospital community benefit activities and potential penalties for "knowing or willful noncompliance" (Community Benefit State Law Profiles Comparison). While details are scant in that summary, the phrase suggests that egregious offenders can be penalized. Model language might be:

> "The Department of Health shall review each hospital's report and compliance with spending requirements. If a hospital is found to be in knowing or willful noncompliance, the Department may impose an appropriate penalty, including monetary fines or suspension of the hospital's state tax-exempt status for a period of time."

Additionally, to involve local authorities:

> "Any taxing authority or constituent resident may petition the state to review a nonprofit hospital's tax-exempt status if evidence suggests the hospital has not provided required community benefits. Upon such petition, a hearing shall be held to

determine compliance. A finding of non-compliance may result in revocation of tax-exempt status for the applicable tax year."

Enforcement doesn't seek to punish hospitals *unfairly*. The aim is to ensure compliance. So, the law can also include a grace period or corrective action plan option: if a hospital falls short one year, it can avoid penalties by submitting a plan to make up the deficit in the next year (or within a certain timeframe). The focus is on getting hospitals to invest in the community, not on collecting fines. But without the stick in the closet, the carrot of tax exemption won't be effective.

**Model Policy Summary**

Here is a composite model statute snippet that brings together transparency, accountability, and enforcement:

**MODEL STATE COMMUNITY BENEFIT STATUTE:**

(a) Annual Reporting: Each tax-exempt hospital shall annually submit a Community Benefit Report to the Department of Health, which shall be made public. The report shall itemize the hospital's community benefit expenditures by category (charity care, community health improvement services, subsidized health services, research, etc.) and provide narrative descriptions of major initiatives, populations served, and outcomes.

(b) Minimum Community Benefit Requirement: Each hospital shall devote no less than 5% of its net patient revenue to community benefit expenditures each fiscal year. In any year that a hospital's community benefit spending is less than the value of its state and local tax exemptions, the Department shall require an explanation and may require additional spending to equal the value of tax exemptions. Charity

care (free or discounted care) shall comprise at least 4% of net patient revenue within the overall requirement, ensuring direct relief for low-income patients.

(c) Financial Assistance Policy: Hospitals must provide, at a minimum, free care to individuals earning up to 200% FPL and discounted care on a sliding scale up to 400% FPL. The policy shall be widely publicized, and no eligible patient shall be sent to collections for medical debt.

(d) Community Health Needs & Plan: Every three years, each hospital shall conduct a Community Health Needs Assessment (CHNA) with meaningful input from community members and public health officials. Based on the CHNA, the hospital shall adopt a Community Benefit Implementation Plan, identifying priority health needs and detailing the hospital's strategies and resource commitments to address those needs over the next three years. The plan must include at least two priorities from the State Health Improvement Plan and align with local health department goals. Annual reports under (a) shall document progress on this plan.

(e) Enforcement: The Department of Health is authorized to enforce these requirements. A hospital that fails to file a report under (a) or conduct a CHNA under (d) shall be subject to a civil fine up to $50,000. If a hospital fails to meet the minimum spending requirement in (b) without an approved waiver or corrective plan, the Department may revoke the hospital's property and sales tax exemptions for the following year, in addition to levying a fine equal to the shortfall. The Department shall publish an annual summary of hospital compliance, and any hospital in non-compliance for two consecutive years shall be referred to the state

Attorney General for investigation of whether it continues to qualify as a charitable institution.

The above model integrates language and concepts from multiple states' laws and the best practices identified in our research. Notably, it ties tax exemption to spending, requires itemized transparency, and gives enforcement power to revoke tax benefits – a true reflection of "no community benefit, no tax break."

## IV. Conclusion

Nonprofit hospitals hold a privileged position in our healthcare system. In exchange for billions of dollars in tax breaks, society expects them to provide charity care and invest in community health. Too often, this bargain has been broken. Patients are pursued by collections for medical bills even as their local "charity" hospital spends funds on naming rights for sports arenas or accumulates massive surpluses. Add to this the additional payments from facility-based payments, 340b, disproportionate share hospital payments, sole community hospital payments, and state-directed payments–none of which are easily viewable. Tax exemptions are not freebies; they are *investments* by taxpayers, and taxpayers deserve a healthy return through accessible care and healthier communities.

Our 50-state analysis makes it clear that the status quo is unacceptable: most states don't ask for that return on investment. But it doesn't have to stay that way. A handful of reform-minded states like Texas, Illinois, Oregon, and Maryland have pioneered stronger requirements — proving that it is both possible and reasonable to expect hospitals to do more. These states show that clearer rules *can* move the needle on community benefits. For example, after Illinois tied tax exemption to charity care, major hospital systems boosted their charity care spending to

meet the threshold, directly benefiting low-income patients. Oregon's new spending floors are pushing hospitals to collaborate with the state to address unmet needs. These are steps in the right direction, but we need a nationwide course correction.

In sum, a stronger community benefit framework is a win-win: communities get more charity care and health programs, and hospitals get to demonstrate their charitable mission in concrete terms. By implementing mandatory reporting, spending requirements linked to tax breaks, and real penalties for noncompliance, we can transform the nonprofit hospital model into one that truly puts the community first. Nonprofit hospitals were created to serve the public; let's hold them to that promise.

**V. State-by-State Rankings**

**State: Illinois**

**Rank: #1**

**Score: 10/10**

**Transparency (4/4):** Illinois law requires nonprofit hospitals to file annual community benefit plans with the Attorney General, detailing the amount and types of community benefits provided, including charity care.

**Accountability (4/4):** Illinois mandates that to retain property and sales tax exemptions, a hospital's charity care and other services for low-income individuals must at least equal the value of the taxes foregone. This establishes a minimum spending floor tied to tax benefits.

**Enforcement (2/2):** Strong enforcement – a hospital that fails to meet the minimum charity care threshold can lose its tax-exempt status.

**State: Nevada**

**Rank: #2**

**Score: 9/10**

**Transparency (3/4):** Nevada requires large hospitals (100+ beds, in counties with 2+ hospitals) to file an annual community benefits report with the state, detailing expenses for community benefits and in-kind services.

**Accountability (4/4):** State law mandates these hospitals provide indigent inpatient care equal to at least 0.6% of net revenue each year. This is a numeric minimum community benefit requirement.

**Enforcement (2/2):** Strong enforcement – if a hospital falls short of the 0.6% charity care floor, the shortfall is deducted from any county payments owed to the hospital (effectively a financial penalty).

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**State: Oregon**

**Rank: #2**

**Score: 9/10**

**Transparency (4/4):** Oregon's 2019 law (HB 3076) greatly expanded reporting – hospitals must report annual community benefit spending to the Oregon Health Authority (OHA), which sets spending targets and publishes each hospital's required minimum and performance.

**Accountability (4/4):** Oregon established a mandatory spending floor for community benefits tailored to each hospital, set every two years by OHA. Hospitals also must expand free/discounted care (e.g., free care up to 200% FPL) by statute.

**Enforcement (1/2):** Moderate enforcement – the spending floors are publicly posted and noncompliance is subject to public scrutiny, but penalties rely largely on transparency rather than automatic tax revocation.

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**State: Rhode Island**

**Rank: #2**

**Score: 9/10**

**Transparency (3/4):** Rhode Island requires each hospital to have a Board-approved community benefit plan and meet state "community benefits" standards as a condition of licensure.

**Accountability (4/4):** State regulations set mandatory charity care standards – hospitals must provide free essential care to patients up to 200% FPL (and sliding-scale discounts up to 300% FPL).

**Enforcement (2/2):** Strong enforcement – these requirements are tied to hospital licensure. The Health Department can take action (including license sanctions) if a hospital fails to meet charity care obligations or comply with its community benefit plan.

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**State: Texas**

**Rank: #2**

**Score: 9/10**

**Transparency (3/4):** Texas law requires each nonprofit hospital to submit an annual community benefit report ("community benefit plan") to the state health department, including the hospital's mission, community needs considered, the amount and categories of community benefit provided, and an evaluation of outcomes.

**Accountability (4/4):** Texas ties state tax-exempt status to meeting one of several minimum community benefit standards. For example, a nonprofit hospital must spend at least 5% of net patient revenue on charity care and community benefit (with at least 4% on charity care) or charity care at least equal to 100% of its tax-exempt benefits. A community health needs assessment and implementation plan are also required by state law.

**Enforcement (2/2):** Strong enforcement – failure to meet the required spending floor can result in loss of state tax exemptions. Texas law also mandates nonprofit hospitals maintain financial assistance policies and publicize their charity care programs, with compliance enforced through state oversight of tax status.

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**State: Utah**

**Rank: #2**

**Score: 9/10**

**Transparency (3/4):** Utah conditions nonprofit hospitals' property tax exemption on annual reporting of community benefits ("gifts to the community"). Hospitals must quantify the charity care and other community benefit contributions they make, which are categorized by state guidelines.

**Accountability (4/4):** Utah law requires nonprofit hospitals to provide community benefits exceeding the value of their property tax liability each year. In effect, hospitals must spend at least as much on charity care and other community programs as they would owe in property tax – a clear spending floor linked to tax benefits. They also must adopt an "open access" financial assistance policy to treat indigent patients without charge or at reduced cost.

**Enforcement (2/2):** Strong enforcement – noncompliance means loss of property tax exemption. Utah's tax authorities can deny or revoke a hospital's tax-exempt status if it fails to meet the

community contribution requirement. The state also requires proof of efforts to inform the public of free care availability.

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**State: Connecticut**

**Rank: #7**

**Score: 7/10**

**Transparency (4/4):** Connecticut mandates extensive reporting. All hospitals (nonprofit and for-profit) must annually file their charity care and financial assistance policies, debt collection policies, and detailed data on uncompensated care with the state Office of the Healthcare Advocate. Hospitals must also biennially report whether they have a community benefit program and, if they do, provide a detailed community benefit report.

**Accountability (2/4):** Connecticut law stops short of requiring hospitals to spend a set amount on community benefit – having a community benefit program is essentially voluntary. However, hospitals must at least have charity care policies on file and report on any community programs they undertake.

**Enforcement (1/2):** Moderate enforcement – the filing requirements are legal obligations, so failure to report could trigger regulatory action. While there is no specific penalty outlined in the statute beyond potential fines for non-reporting, state oversight provides some accountability.

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**State: Pennsylvania**

**Rank: #7**

**Score: 7/10**

**Transparency (1/4):** Pennsylvania does not impose state-level community benefit reporting beyond federal IRS filings. Nonprofit hospitals are generally only required to file IRS Form 990 (Schedule H) for public disclosure.

**Accountability (4/4):** Pennsylvania's Act 55 (1997) sets rigorous standards for charitable institutions to qualify for tax exemption. Hospitals must "donate or render gratuitously a substantial portion of their services" to be deemed a "purely public charity." While the law doesn't specify a single fixed percentage, it provides tests that, in practice, require significant charity care or community service.

**Enforcement (2/2):** Strong enforcement – tax authorities and courts can and have revoked property tax exemptions if a hospital fails to meet Act 55's criteria. A nonprofit hospital that doesn't provide sufficient charity/community benefit risks losing its property and sales tax exemptions.

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**State: New York**

**Rank: #10**

**Score: 6/10**

**Transparency (3/4):** Hospitals must develop a Community Service Plan (CSP) and report it to the state, including CHNA findings and health priorities.

**Accountability (2/4):** New York law mandates community health planning but does not require hospitals to meet a minimum spending threshold.

**Enforcement (1/2):** Moderate enforcement – compliance is monitored, but penalties mainly involve eligibility for state charity care funding.

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**State: Washington**

**Rank: #10**

**Score: 6/10**

**Transparency (2/4):** Washington requires hospitals to report charity care statistics, but reports focus on free/discounted care rather than a full breakdown of community benefits.

**Accountability (3/4):** Hospitals must provide free medically necessary care for patients up to 100% FPL and sliding scale discounts for those up to 200% FPL.

**Enforcement (1/2):** Moderate enforcement – noncompliance with charity care requirements can lead to state investigations, fines, and corrective actions.

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**State: California**

**Rank: #19**

**Score: 5/10**

**Transparency (3/4):** California law (SB 697) requires each tax-exempt hospital to prepare an annual community benefit plan report. Hospitals must include the economic value of the community benefits provided, broken down by category. These reports are filed with the state and made public. While detailed, the reports largely reflect hospital-defined metrics rather than standardized measures.

**Accountability (2/4):** Hospitals must conduct a community health needs assessment every three years and create a benefit plan. However, there is no required spending minimum, and hospitals set their own priorities.

**Enforcement (0/2):** Weak enforcement – there are no penalties for failing to file the community benefit plan or for low spending. Compliance is driven by public oversight rather than legal consequences.

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**State: Missouri**

**Rank: #19**

**Score: 5/10**

**Transparency (3/4):** Missouri requires all hospitals to report charity care annually, including financial data on bad debt and patient charges.

**Accountability (1/4):** There are no specific obligations beyond federal requirements. Nonprofit hospitals must simply meet general charitable operation standards to remain tax-exempt.

**Enforcement (1/2):** Moderate enforcement – failure to report charity care data can lead to regulatory sanctions, though there is no penalty for low charity care provision.

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**State: Montana**

**Rank: #19**

**Score: 5/10**

**Transparency (2/4):** Hospitals must file annual financial reports detailing charity care and government program expenditures. However, full community benefit details are not required.

**Accountability (2/4):** Hospitals must adopt charity care policies and treat patients regardless of ability to pay, but there is no mandated spending threshold.

**Enforcement (1/2):** Moderate enforcement – hospitals must comply with charity care policy requirements, and violations can result in licensing penalties.

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**State: Idaho**

**Rank: #22**

**Score: 4/10**

**Transparency (2/4):** Large nonprofit hospitals (>150 beds) must report community benefit activities, but there is no centralized publication of detailed breakdowns.

**Accountability (1/4):** No minimum spending requirement or CHNA mandate exists.

**Enforcement (1/2):** Moderate enforcement – failure to file required reports can result in fines, but there are no penalties for the content of those reports.

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**State: Massachusetts**

**Rank: #22**

**Score: 4/10**

**Transparency (1/4):** Community benefit reporting is voluntary under Attorney General guidelines, though many hospitals comply.

**Accountability (2/4):** New acute care hospitals must provide charity care at levels matching historical baselines as a condition of licensure. Beyond this, community benefit participation is voluntary.

**Enforcement (1/2):** Limited enforcement – compliance relies on informal Attorney General oversight rather than legal mandates or penalties.

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**State: Alabama**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** No state requirement for community benefit reporting. Hospitals follow only federal IRS reporting standards.

**Accountability (1/4):** No obligation to provide a minimum amount of charity care or community benefits.

**Enforcement (0/2):** No enforcement – hospitals are not subject to penalties or reporting obligations beyond federal tax laws.

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**State: Alaska**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Alaska does not require hospitals to report community benefits at the state level.

**Accountability (1/4):** No mandated charity care or community benefit obligations.

**Enforcement (0/2):** No enforcement – no state laws impose penalties for failing to provide community benefits.

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**State: Arizona**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** No state-mandated community benefit reporting exists.

**Accountability (1/4):** Arizona law does not require hospitals to provide a specific amount of charity care.

**Enforcement (0/2):** No enforcement – hospitals receive tax exemptions without additional state conditions.

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**State: Arkansas**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** No state requirement for charity care or community benefit reporting.

**Accountability (1/4):** No state-imposed obligations for hospitals beyond federal regulations.

**Enforcement (0/2):** No enforcement – no mechanisms exist to ensure nonprofit hospitals provide community benefits.

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**State: Delaware**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** No mandatory community benefit reporting requirements.

**Accountability (1/4):** No state law requires hospitals to provide charity care or other community benefits.

**Enforcement (0/2):** No enforcement – no penalties exist for hospitals failing to provide community benefits.

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**State: Florida**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Florida does not require nonprofit hospitals to file community benefit reports with the state.

**Accountability (1/4):** Florida imposes no state community benefit or charity care obligations on hospitals.

**Enforcement (0/2):** No enforcement – no state-level hospital community benefit rules exist to enforce.

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**State: Hawaii**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Hawaii has no hospital community benefit reporting requirement.

**Accountability (1/4):** Hawaii law does not require hospitals to provide community benefits or charity care beyond federal law.

**Enforcement (0/2):** No enforcement – there are no state requirements and consequently no enforcement provisions.

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**State: Iowa**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Iowa does not mandate any community benefit or charity care reporting by hospitals.

**Accountability (1/4):** Iowa has no state community benefit requirements for hospitals.

**Enforcement (0/2):** No enforcement – no state standards to enforce.

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**State: Kansas**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Kansas requires no community benefit reporting from hospitals.

**Accountability (1/4):** Kansas law does not require hospitals to perform CHNAs, community benefit plans, or charity care beyond federal obligations.

**Enforcement (0/2):** No enforcement – no state community benefit rules.

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**State: Kentucky**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Kentucky does not require hospitals to report community benefit data.

**Accountability (1/4):** Kentucky has no hospital community benefit or charity care mandate.

**Enforcement (0/2):** No enforcement – no state-imposed requirements.

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**State: Louisiana**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Louisiana imposes no community benefit reporting on hospitals.

**Accountability (1/4):** No state requirements for providing charity care or community benefits in Louisiana.

**Enforcement (0/2):** No enforcement.

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**State: Michigan**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Michigan does not require any state-level community benefit or charity care reporting by hospitals, relying solely on federal disclosure.

**Accountability (1/4):** Michigan law does not mandate hospitals to provide a specific amount of charity care or community services. Community benefit is voluntary apart from federal tax-exempt expectations.

**Enforcement (0/2):** No enforcement – no state standards to enforce for community benefit.

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**State: Nebraska**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Nebraska has no requirement for hospitals to report on charity care or community benefits to the state.

**Accountability (1/4):** Nebraska does not impose community benefit obligations on hospitals by statute.

**Enforcement (0/2):** No enforcement – no state community benefit mandates. Nebraska hospitals follow federal 501(c)(3) requirements only.

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**State: New Jersey**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** New Jersey law does not require nonprofit hospitals to submit community benefit reports to the state. Hospitals report financial data for charity care reimbursement purposes, but no public community benefit report.

**Accountability (1/4):** New Jersey has no additional community benefit requirements; its hospitals receive charity care subsidies from the state but are not compelled to spend a set amount – it's need-based funding, not a mandate.

**Enforcement (0/2):** No enforcement specific to community benefit. Tax-exempt status in NJ is governed by general charitable purpose tests, without a set spending threshold.

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**State: North Carolina**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** North Carolina does not require hospitals to publicly report community benefit or charity care spending to the state.

**Accountability (1/4):** No state community benefit or minimum charity care law exists in North Carolina. Hospitals must comply with federal CHNA requirements, but the state has not added to those.

**Enforcement (0/2):** No enforcement – community benefit is not regulated at the state level in NC.

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**State: North Dakota**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** North Dakota has no statutory hospital community benefit reporting requirement.

**Accountability (1/4):** North Dakota does not mandate the provision of charity care or other community benefits by hospitals (outside of federal law).

**Enforcement (0/2):** No enforcement.

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**State: Ohio**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Ohio does not require state-level community benefit reporting by hospitals.

**Accountability (1/4):** Ohio has no specific community benefit or charity care mandate in law. Instead, it relies on federal standards and general charitable obligations for tax exemption.

**Enforcement (0/2):** No enforcement.

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**State: Oklahoma**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Oklahoma does not mandate community benefit or charity care reports from hospitals.

**Accountability (1/4):** Oklahoma imposes no community benefit spending or planning requirements on hospitals by statute.

**Enforcement (0/2):** No enforcement.

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**State: South Carolina**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** South Carolina has no hospital community benefit reporting law.

**Accountability (1/4):** South Carolina does not require hospitals to conduct CHNAs or provide minimum charity care beyond federal requirements.

**Enforcement (0/2):** No enforcement.

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**State: South Dakota**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** South Dakota does not require any state-level community benefit reporting.

**Accountability (1/4):** South Dakota has no state hospital community benefit requirements.

**Enforcement (0/2):** No enforcement.

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**State: Tennessee**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Tennessee has no community benefit reporting requirement for hospitals.

**Accountability (1/4):** Tennessee law does not mandate hospitals to provide charity care or other community benefits beyond federal law.

**Enforcement (0/2):** No enforcement.

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**State: Virginia**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Virginia does not require hospitals to file community benefit reports with the state.

**Accountability (1/4):** Virginia has no statutory requirement for hospitals to provide a set amount of community benefit or charity care. However, charity care conditions may be individually attached to COPN (Certificate of Public Need) approvals, but no uniform rule exists.

**Enforcement (0/2):** No enforcement at the state level for community benefit.

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**State: Vermont**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Vermont has no specific hospital community benefit reporting mandate. Hospitals do submit budget info to the Green Mountain Care Board, but not a designated community benefit report.

**Accountability (1/4):** Vermont does not impose additional community benefit or charity care requirements by law.

**Enforcement (0/2):** No enforcement specific to community benefits.

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**State: Wisconsin**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Wisconsin law does not require hospitals to publicly report community benefit spending apart from IRS requirements.

**Accountability (1/4):** Wisconsin has no state community benefit mandate for hospitals.

**Enforcement (0/2):** No enforcement.

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**State: West Virginia**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** West Virginia does not mandate community benefit reports from hospitals.

**Accountability (1/4):** West Virginia law does not set specific community benefit or charity care requirements for hospitals. In practice, the state had an uncompensated care fund but no direct hospital mandate.

**Enforcement (0/2):** No enforcement.

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**State: Wyoming**

**Rank: #25**

**Score: 2/10**

**Transparency (1/4):** Wyoming imposes no hospital community benefit reporting requirements.

**Accountability (1/4):** Wyoming does not require hospitals to provide any minimum level of community benefit or free care by law.

**Enforcement (0/2):** No enforcement.


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