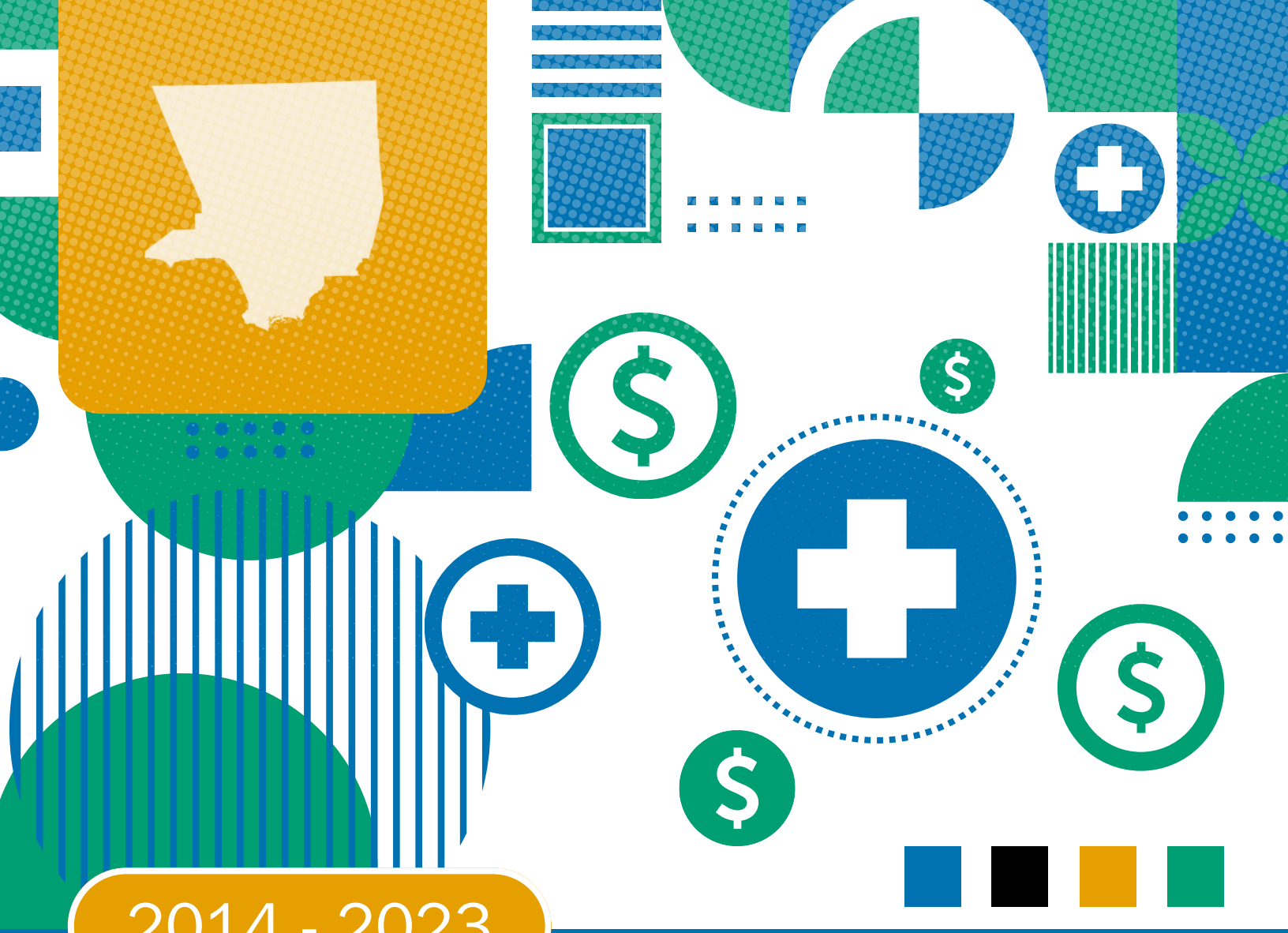

2014 - 2023

Landscape of Hospital Financial Assistance in Los Angeles County

County of Los Angeles Public Health

Executive Summary

Financial assistance programs represent the original charitable mission of hospitals and remain a key component of community and workforce trust. They are an important, legally required mechanism for preventing medical debt, which now burdens 1 in 9 adult residents in Los Angeles County. To better understand how hospitals in LA County have supported patients through these programs, federal and California state data was used to analyze financial assistance awarded by 69 hospitals from 2014 through 2023. To make fair comparisons between hospitals of different size, financial assistance was normalized as a percentage of gross patient revenue (the total income from patients). Hospital financial health metrics were averaged over 4 years to account for year-to-year variations.

In 2023, the 69 hospitals reported awarding $426.5 million of financial assistance in total. Nonprofit hospitals (n=40) awarded 48.0% of the total, County-owned (n=4) awarded 38.4%, for-profit (n=22) awarded 9.6%, and other government-owned hospitals (n=3) awarded 4.0%. There was a disproportionate burden of financial assistance on the 4 County-owned hospitals, which serve only 16% of Medi-Cal members in the County but awarded more than a third of the total financial assistance. This suggests that additional focus may be needed on utilization of financial assistance programs in other facilities which are serving the remainder of the safety net population.

Overall, 1.2% of the gross patient revenue earned by the LA County hospitals was spent on financial assistance. County-owned hospitals spent 3.6% of their gross patient revenue on financial assistance, while nonprofit and for-profit hospitals spent 0.9% and 1.1%, respectively. The amount of financial assistance awarded did not vary significantly by nonprofit versus for-profit ownership type despite the differences in institutional missions.

No significant trends were identified in LA County between hospital financial health or Medi-Cal patient utilization and reported financial assistance. This suggests that neither low margins nor a high Medi-Cal share of payor mix preclude the ability to award more financial assistance and other factors, such as operational choices and prioritization, can influence the financial assistance performance of an organization.

Nationally, hospitals in Medicaid-expansion states reported spending 1.7% of overall gross patient revenue on financial assistance, with government-owned hospitals spending 2.7%, and nonprofit and for-profit hospitals both spending 1.5%. If LA County nonprofit and for-profit hospitals gave similar levels of financial assistance, then at least $134.1 million more could have been given as financial assistance. Various factors such as the prevalence of out-of-pocket cost insurance products, overall health insurance coverage, and public policy regarding financial assistance such as minimum spending floors could explain this difference.

With wide variation in financial assistance practices, ongoing, collaborative efforts by the LA County Medical Debt Coalition are critical to understanding where improvements can be made to reduce financial harms to those seeking medical care.

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Background

Hospitals are more than just centers for medical treatment— they are cornerstones of communities. They provide critical care during times of crisis, drive medical innovations, educate current and future healthcare providers, and play a vital role in advancing public health. However, despite their essential role in improving community health, the high cost of hospital care coupled with limitations in coverage can leave patients with lasting debt, creating financial burdens that undermine their ability to maintain their health and well-being. Medical debt is of course a system wide issue across the United States involving the entire healthcare sector and not limited to hospital charges alone. 1 in 9 adult residents in Los Angeles (LA) County have burdensome medical debt according to an analysis by the LA County Department of Public Health.[1] Despite attempts over the past 10 years to expand insurance coverage and improve access to healthcare, the proportion of LA County residents struggling with medical debt has not improved.

Medical debt can compound with other burdens.

1 in 9 adults in LA have medical debt.

> "I don't make a lot of money, but I try to pay all my debts as soon as I can. **[My medical bill] was such a burden on my conscience.**"
>
> LA County resident

Burden of medical debt

Medical debt negatively impacts both patients and health systems. For patients, medical debt disproportionately affects low-income individuals, who are not able to pay off their bills and are already at higher risk for poor health outcomes.[1] For these individuals especially, medical debt can compound with other financial, mental, and physical burdens.[2,3] For health systems, unpaid medical debt is equated to "bad debt", or uncompensated financial losses. As an iatrogenic harm, medical debt also contributes to the 'moral injury' of healthcare workers that is driving burnout and turnover.[4] Identifying the sources of medical debt and mechanisms to eliminate or reduce it can improve the financial status and experience for both patients and hospitals.

The role of financial assistance

Financial assistance (FA) can directly prevent medical debt by mitigating out-of-pocket costs associated with receiving healthcare services. The concept of hospital charity care originated from institutions founded to care for the indigent for religious or philanthropic reasons.[5] There were no financial or operational incentives for providing free care to the indigent, rather, these almshouses were founded to ensure everyone had access to care regardless of ability to pay. Through these noble intentions, hospitals have been established as pillars of community trust and are granted special privileges to better provide care services. Today, FA is still available as part of the healthcare safety net that exists to protect the most vulnerable communities.

In the state of California, all hospitals are legally required to award FA, and there are stringent process requirements. Under Assembly Bill (AB) 1020, hospitals are required to provide patients with written information about their FA policies and eligibility requirements and to include contact

Financial assistance can be inaccessible.
The responsibility is often on the patient to apply for assistance.

> "No one ever told me there was financial assistance for my medications, and **signing up wasn't easy**."
>
> LA County resident

information for both the hospital's FA representative and third-party resources that can help patients understand billing. In addition, hospitals are required to post notices about their FA policies in conspicuous public-facing locations in their facilities.[6] While minimum eligibility floors exist, there are no requirements on outcomes including the amount of assistance that is awarded to each patient. Each hospital has a unique FA policy, application process, and threshold for eligibility. Generally, the onus is on the patient to understand FA policies, apply for FA, and appeal if their application is wrongfully denied.[7] Nationally, the Affordable Care Act requires nonprofit hospitals to promote and make accessible FA programs to patients[8], but there are no such national requirements for for-profit hospitals.

Patients with incomes at or below 400% of the federal poverty level and/or catastrophic medical debt are eligible for FA in California.[6] Without FA, they would not be able to settle their medical bill and would generate bad debt for the hospital.[9] A recent national analysis found that $14 billion of medical debt belonged to patients who should have qualified for FA.[10] High rates of preventable medical debt are caused in part by lower FA activity, which could be for many reasons including lack of awareness or follow through by the patient or access and operational barriers on the side of the hospital. Hospitals with poor financial health may not prioritize FA over concerns about financial sustainability. However, while awarding FA means hospitals cover the cost of care, this is equivalent to incurring that cost as bad debt. Hospitals report FA and bad debt similarly on their financial statements, both as reductions in income. Through awarding FA, hospitals may paradoxically save resources and reduce costs associated with continued debt collection activities which typically generate low yields among these affected populations. An analysis of Medicare-certified hospitals in the United States found that hospital profitability and margins have no correlation with local medical debt rates.[11] Illustrating the landscape of hospital financial trends provides important context for identifying realistic solutions that account for hospital financial health and capacity.

Medi-Cal in Los Angeles County

California has a population of over 39 million people, including nearly 10 million people living in LA County. LA County has a higher percentage of residents who are eligible for Medi-Cal (about 43%), compared to the entire state of California (about 37%).[12] Medi-Cal is California's Medicaid program, which is designed to minimize financial liability for consumers receiving care. California also has expanded coverage for immigrants who are undocumented, which comes from state funding.[13]

A high Medi-Cal enrollment rate should, in theory, reduce medical debt by eliminating or reducing out-of-pocket payments. However, Medi-Cal enrollees can still incur medical debt through multiple mechanisms, including out-of-network facility charges or insurance claims denials. Furthermore, LA County has a unique and complicated managed Medi-Cal environment; there are three parent Medi-Cal managed care plans (MCPs): LA Care Health Plan, Health Net, and Kaiser Permanente. LA Care

Health Plan and Health Net both delegate consumers to additional health plans, which may further delegate consumers to downstream entities that accept risk for those consumers. Consumers who qualify for Medi-Cal are typically eligible for FA if their claim is denied[14], but this complex MCP environment can be challenging for patients to navigate and reinforces fragmentation of the health care system, leading to patients that slip through the cracks and incur medical debt.

Medi-Cal should minimize financial liability for healthcare. However, medical debt persists despite increased Medi-Cal enrollment in LA County.

High Medicaid enrollment rates can place financial strain on hospitals due to the lower reimbursement rates from Medicaid compared to private insurance plans. The Medi-Cal reimbursement rate has not increased in California since 2000, and Medi-Cal also ranks 47th in Medicaid reimbursement rates in the country.[15] Seeing Medicaid patients can be financial challenging for hospitals, which can lead to restrictions in care access for consumers enrolled in Medicaid. To support healthcare providers, the state has multiple mechanisms for drawing down federal Medicaid matching funds to provide supplemental payments, including the Hospital Quality Assurance Fee[16], which is for private hospitals, and intergovernmental transfers, which are for public hospitals[17]. Providers in California are also incentivized to accept Medi-Cal patients through improved provider reimbursement rates, funded through Proposition 35, which provides a framework on how to use revenue generated from the California Managed Care Organization provider tax.[18] The Medi-Cal enrollment rate plays a crucial role in both hospital financial health and patient panels access to care; analysis of Medi-Cal utilization is critical for examining the intersection of care access, hospital capacity, and FA practice sustainability.

Overview of hospital ownership types

Hospitals are subsidized by tax payors to award FA, but the level and type of subsidy varies based on ownership status, that is, whether the hospital is nonprofit, for-profit, or government-owned. The landscape of hospital ownership in LA County is unique, with a larger proportion of for-profit hospitals (41.7%) compared to the national average (30.0%) and the state of California (32.8%).

California law requires all hospitals, regardless of ownership type, to have a written FA policy. However, the incentives for awarding FA differ across ownership types. For-profit hospitals may receive limited tax exemptions, such as sales tax on medical devices in California, and can deduct FA amounts from their taxable income. Nonprofit hospitals are granted broader tax exemptions, including federal and state income taxes, property taxes, and bond interest to help them provide community benefits, like FA.[19] Government-owned hospitals, funded through public mandates, are required to serve those who are uninsured and under-insured. Understanding the differences in FA expenditures among hospital ownership types is important for identifying areas of improvement in FA practices, as each type has unique obligations and financial structures.

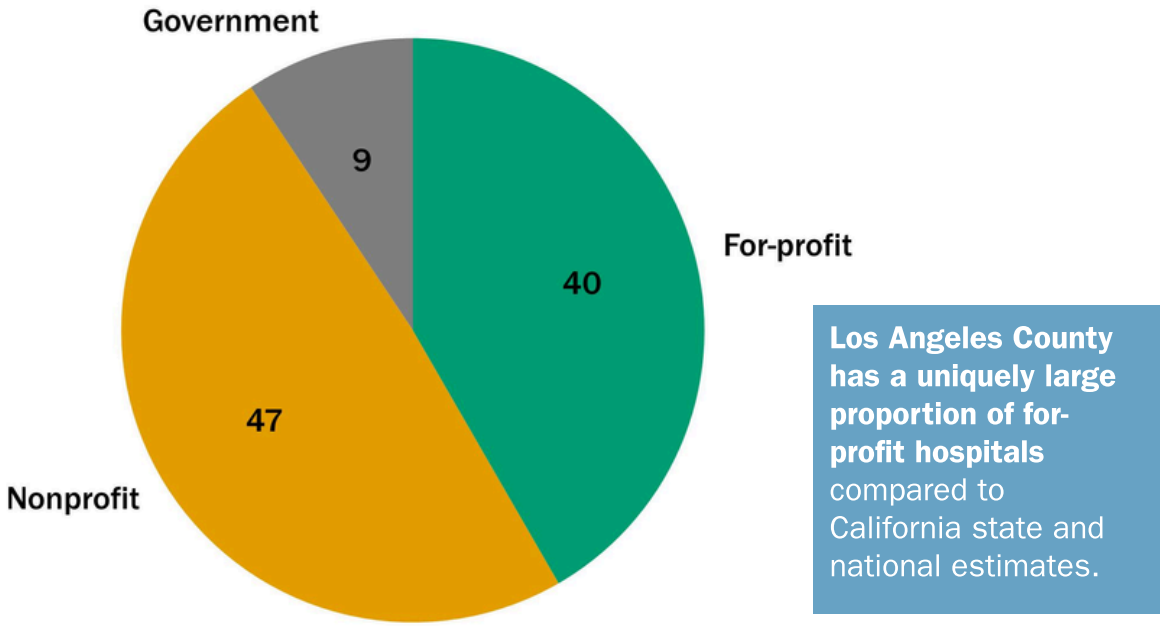
This report describes the current landscape of FA in LA County hospitals and provides insights for improving these programs to reduce the burden of medical debt among the residents of the County.

Results

For detailed descriptions of variables and calculation methods, please refer to the **Methods** section.

In 2023, 96 hospitals submitted cost reports to Centers for Medicare and Medicaid Services (CMS) out of 101 eligible hospitals in LA County. Forty-seven (49.0%) were nonprofit hospitals, 40 (41.7%) were for-profit, and 9 (9.4%) were government-owned (**Figure 1**). Of the 9 government-owned hospitals, 4 were County-owned, 3 were University of California (UC)-owned, 1 was a health district facility, and 1 was a state hospital.

Figure 1: Hospitals in LA County by Ownership Type (2023)

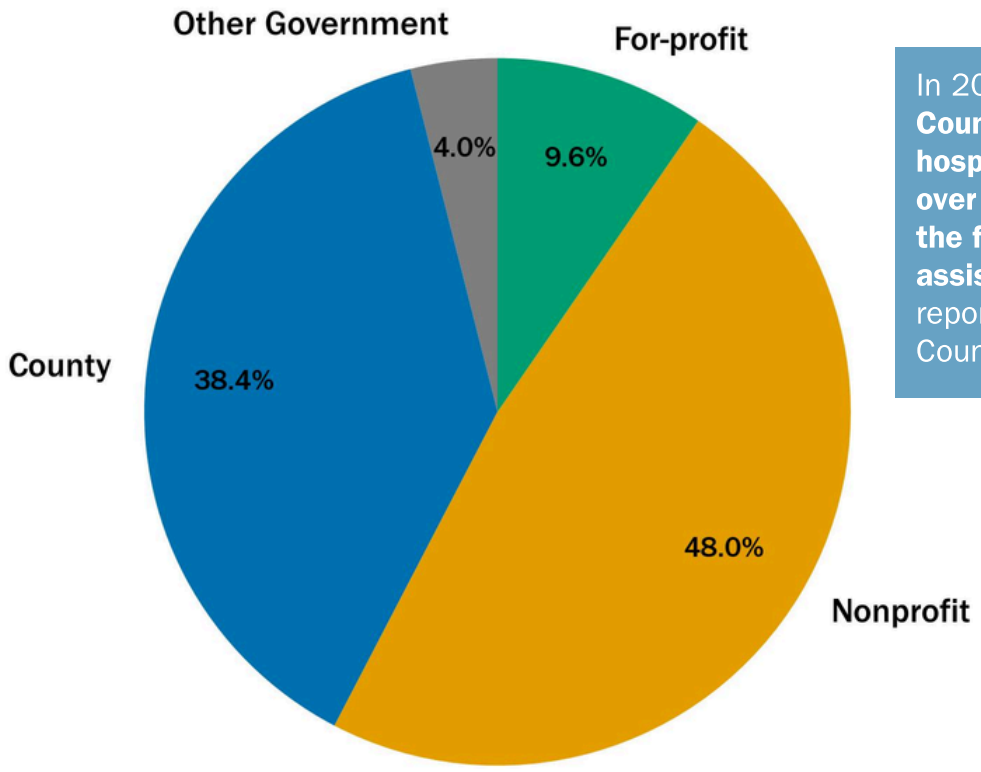


Total Financial Assistance

In 2023, only 69 hospitals in LA County reported charity care amounts to CMS. Only general acute care hospitals are required to submit Form S10 with their cost report. Among hospitals that reported charity care amounts, 40 (58.0%) were nonprofit, 22 (31.9%) were for-profit, 4 (5.8%) were County, and 3 (4.3%) were other government-owned hospitals.

The total amount of FA reported was $426.5 million. The 4 County hospitals awarded 38.4% of the reported FA dollars awarded in 2023. Nonprofit hospitals aggregately awarded 48.0%, for-profit hospitals awarded 9.6%, and other government-owned facilities awarded the remaining 4.0% (**Figure 2**).

Figure 2: Total Financial Assistance Awarded by Ownership Type (2023)



In 2023, **the 4 County-owned hospitals awarded over a third of all the financial assistance** reported in LA County.

Financial Assistance Normalized to Gross Patient Revenue

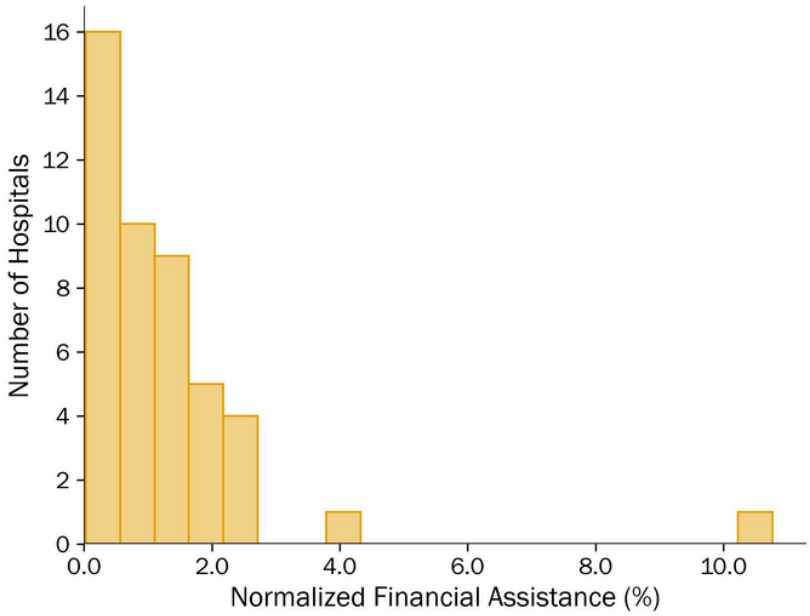
In 2023, hospitals in LA County reported aggregately awarding 1.2% of their gross patient revenue as FA on cost reports. County-owned hospitals reported awarding 3.6% of their gross patient revenue as FA, nonprofit hospitals reported 0.9%, and for-profit hospitals reported 1.1%.

$$\text{Normalized Financial Assistance} = \frac{\text{Financial Assistance}}{\text{Gross Patient Revenue}} \times 100\%$$

Nonprofit hospitals

In 2023, the range of normalized FA reported by nonprofit hospitals on cost reports and audited financial statements spanned from 0.03% to 10.8%, with a median of 0.8%. Martin Luther King Community Hospital was an outlier at 10.8%. The interquartile range (IQR) was 0.2% to 1.5% (**Figure 3**).

Figure 3. Distribution of Financial Assistance Normalized to Gross Patient Revenue for Nonprofit Hospitals (2023)

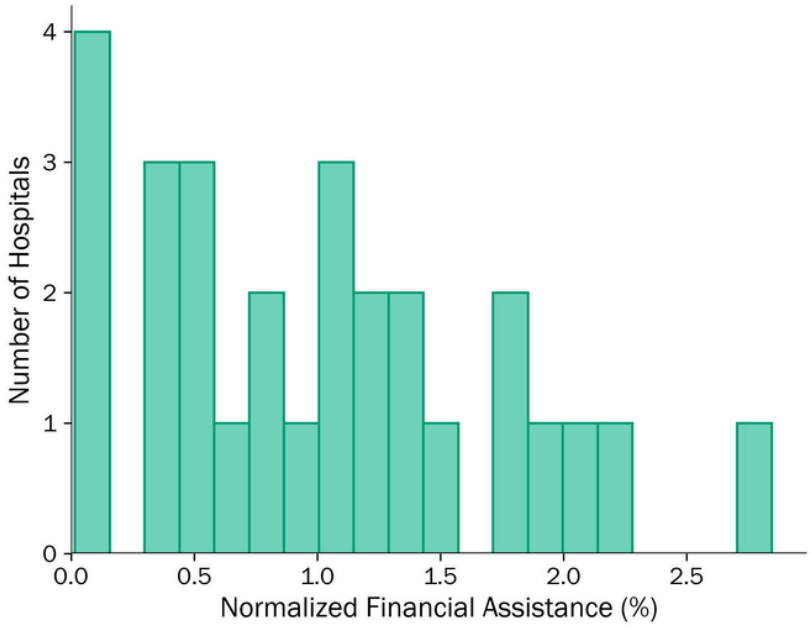


Nonprofit hospitals had greater variation in financial assistance practices compared to for-profit hospitals.

For-profit hospitals

In 2023, the range of normalized FA reported by for-profit hospitals on cost reports and audited financial statements spanned from 0.01% to 2.8%, with a median of 1.0%. The IQR was 0.4% to 1.4% (**Figure 4**).

Figure 3. Distribution of Financial Assistance Normalized to Gross Patient Revenue for For-profit Hospitals (2023)

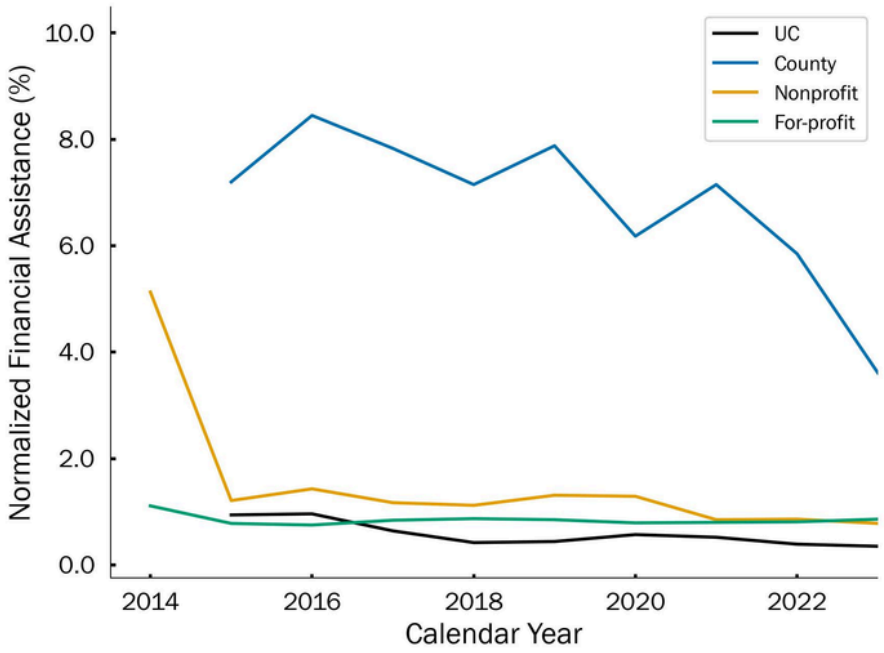


Differences between for-profit and nonprofit practices could be due to **payor mix, mission statement, or supplemental funding access.**

All hospitals

There was no significant trend for reported FA normalized to gross patient revenue from 2014 to 2023 besides a slight decrease in recent years for nonprofit and UC-owned hospitals. Anomalies around 2020 are attributable to the COVID-19 pandemic. The aggregate proportion of FA awarded by for-profit hospitals has been consistent from 2014 to 2023 (**Figure 5**).

Figure 5: Aggregate Financial Assistance Normalized to Gross Patient Revenue Over Time by Ownership



From 2015 - 2023, **there was no significant time trend for financial assistance practices** for nonprofit, for-profit, and UC-owned hospitals.

Comparison with California and other states

- In 2023, hospitals in California reported aggregately awarding 1.2% of their gross patient revenue as FA. Government-owned hospitals awarded 2.1%, nonprofit hospitals awarded 0.9%, and for-profit hospitals awarded 1.3%.
- Hospitals in Medicaid-expansion states reported aggregately awarding 1.7% of their gross patient revenue as FA. Government-owned hospitals awarded 2.7%, nonprofit hospitals awarded 1.4%, and for-profit hospitals awarded 1.5%.
- Hospitals in non-Medicaid-expansion states reported aggregately awarding 4.6% of their gross patient revenue as FA. Government-owned hospitals awarded 4.0%, nonprofit hospitals awarded 3.8%, and for-profit awarded 4.4%.

Overall, the aggregate reported FA normalized to gross patient revenue in LA County was 1.1% higher than that of the state of California and 25.5% lower than that of Medicaid expansion states. The aggregate reported FA normalized to gross patient revenue for nonprofit hospitals in LA County was 4.8% higher than that of the state of California and 36.6% lower than that of Medicaid expansion states. Similar performance by LA County nonprofits to Medicaid expansion states would yield an additional $116.3 million of FA awarded. The aggregate reported FA normalized to gross patient

revenue for for-profit hospitals in LA County was 18.3% lower than that of the state of California and 30.3% lower than that of Medicaid expansion states. Similar performance by LA County for-profits to Medicaid expansion states would yield an additional $17.8 million of FA awarded. The reported normalized FA for County-owned hospitals in LA County was 41.6% higher than that of government-owned hospitals in California and 24.3% higher than that of Medicaid-expansion government-owned hospitals (**Table 1**).

$134.1 million more could have been awarded as financial assistance in the County if nonprofit and for-profit hospitals awarded assistance at the same levels as other Medicaid-expansion states

Table 1. Financial Assistance as a Percentage of Gross Patient Revenue (2023)

Ownership Type		Los Angeles County (n=69)	California (n=298)	National		
				All States (n=4,231)	Expansion (n=2,995)	Non-Expansion (n=1,236)
Nonprofit		0.92%	0.88%	1.88%	1.45%	3.81%
For-profit		1.05%	1.29%	3.04%	1.51%	4.42%
Government	County*	3.61%	-	-	-	-
	District*	0.76%	-	-	-	-
	UC	0.36%	0.92%	-	0.92%	-
	Total	2.09%	2.11%	3.99%	2.73%	6.72%
All		1.23%	1.21%	2.36%	1.65%	4.58%

*County and district hospitals were not analyzed separately from all government hospitals for the state of California and national-level calculations, so those table entries are marked with a dash.

Sensitivity analyses for financial assistance normalized to gross patient revenue

A sensitivity analysis was conducted to assess the impact of excluding Kaiser Permanente hospitals, which do not award as much FA due to their integrated care delivery model. Excluding Kaiser increased the normalized FA of LA County nonprofit hospitals from 0.92% to 1.14%, representing an increase of 23.9%. Excluding Kaiser narrowed the gap in normalized FA between nonprofit hospitals in LA County and other Medicaid-expansion states by 0.18 percentage points. Excluding Kaiser also

changes the difference in normalized FA between nonprofit and for-profit hospitals in LA County by 0.15 percentage points.

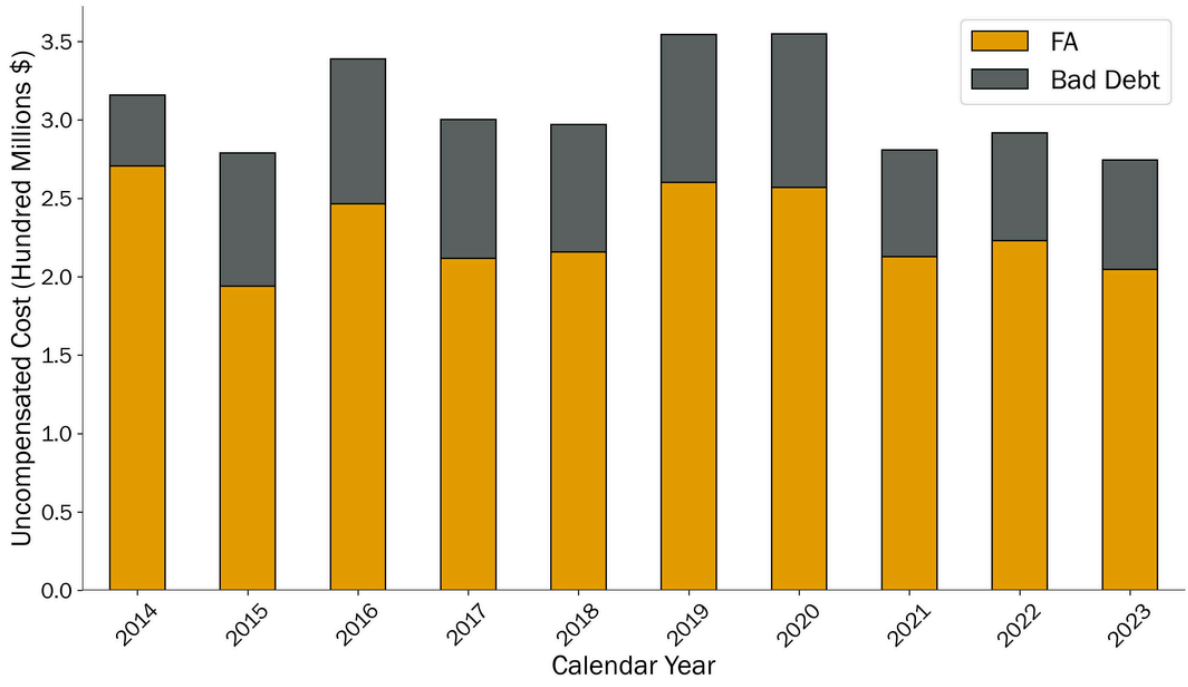
Another sensitivity analysis was conducted to assess the impact of including the subset of hospitals who only reported FA activity to HCAI and not CMS. The inclusion of the HCAI-only subset led to increases in aggregate normalized FA values of 0.05 to 0.15 percentage points across nonprofit, for-profit, and UC-owned hospitals. The changes in normalized FA were all directionally consistent, indicating that inclusion of the HCAI-only subset would not significantly impact conclusions.

Financial Assistance & Total Uncompensated Care

Nonprofit hospitals

In 2023, 74.6% of total uncompensated costs that would otherwise be assigned to patients receiving care at nonprofit hospitals were attributable to FA. Overall uncompensated costs increased in 2019 and 2020 and then decreased in 2021-2023. The proportion of uncompensated costs attributed to FA has stayed relatively consistent over time (**Figure 6**).

Figure 6: Total Uncompensated Costs Attributed to Financial Assistance or Bad Debt for Nonprofit Hospitals by Year

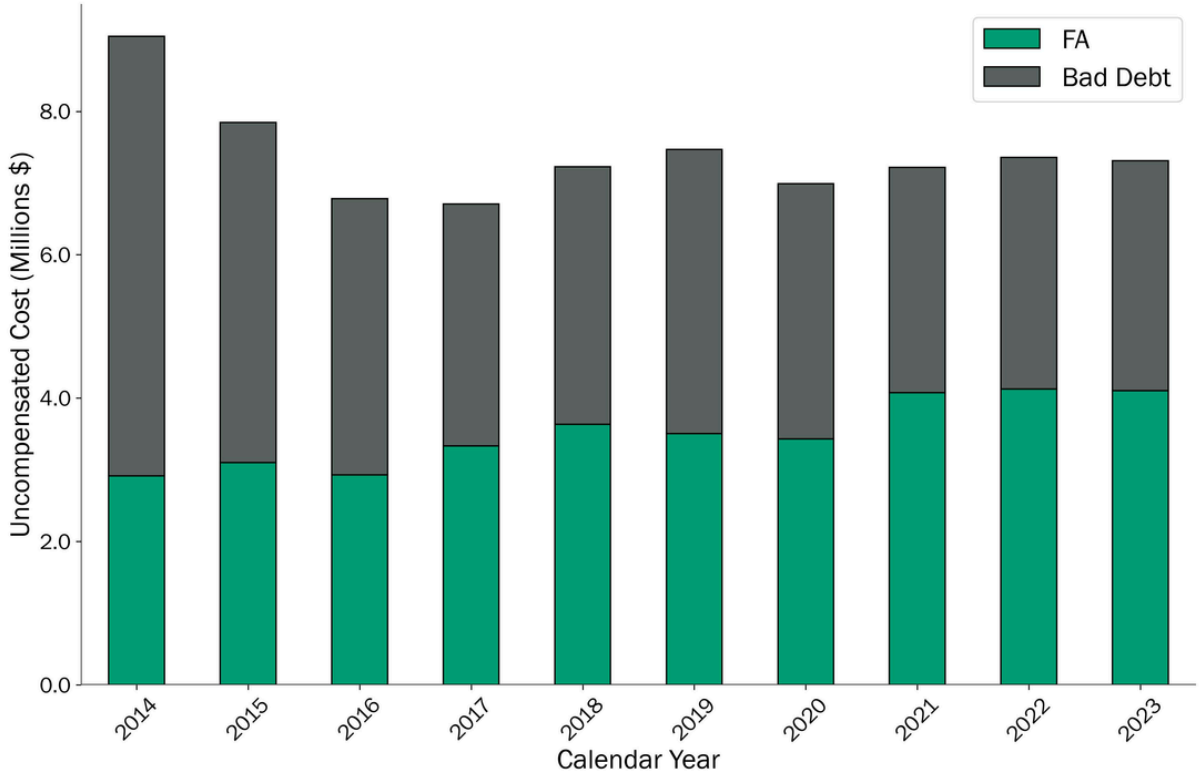


For-profit hospitals

In 2023, 56.1% of uncompensated costs that would otherwise be assigned to patients receiving care at for-profit hospitals was attributable to reported FA. Overall uncompensated costs decreased from 2014-2017, increased slightly in 2018, and have stayed relatively consistent since then. The

proportion of uncompensated costs that is attributable to FA slightly increased from 2014-2021 but has stayed relatively constant since then. In 2021-2023, an average of 56.2% of uncompensated for-profit hospital costs were attributable to FA (**Figure 7**).

Figure 7: Total Uncompensated Costs Attributed to Financial Assistance or Bad Debt for For-profit Hospitals by Year



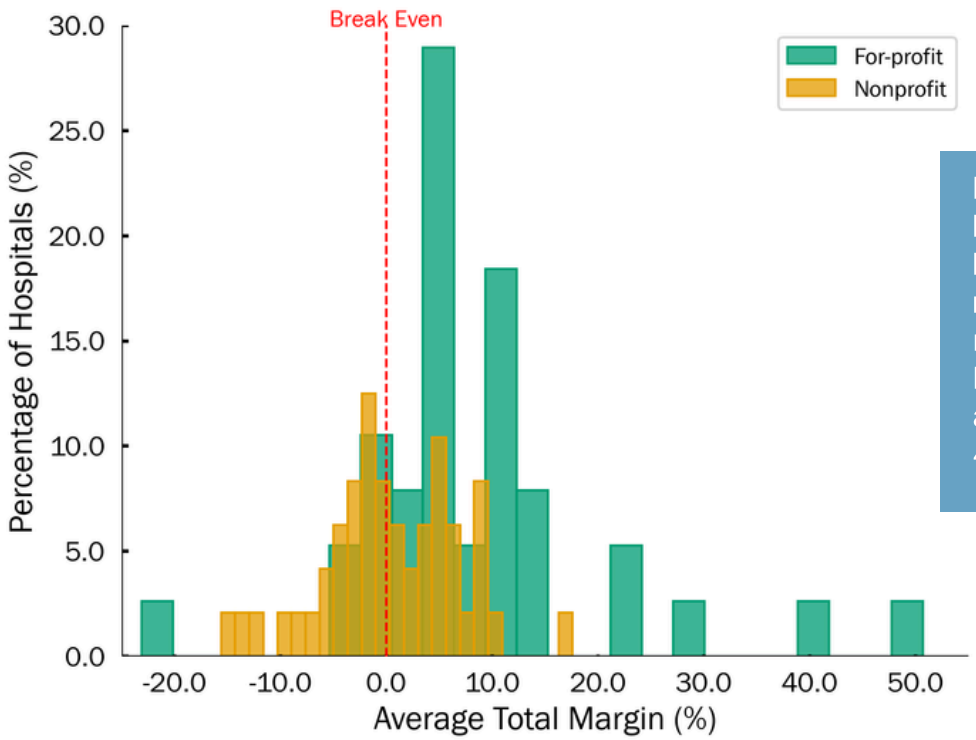
When looking at uncompensated costs that patients would be responsible for, **bad debt makes up a greater proportion of uncompensated costs for for-profit hospitals than nonprofit hospitals.**

Overall Financial Health

The reported total margin averaged over 4 FYs ranged from -15.6% to 17.6% for nonprofit hospitals and the median was 4.5%. Twenty-four out of 48 (50.0%) nonprofit hospitals had a total margin greater than 0. The reported range for for-profit hospitals was -23.1% to 50.7% and the median was 5.4%. Thirty-two out of 38 (84.2%) for-profit hospitals had a total margin greater than 0 (**Figure 8**).

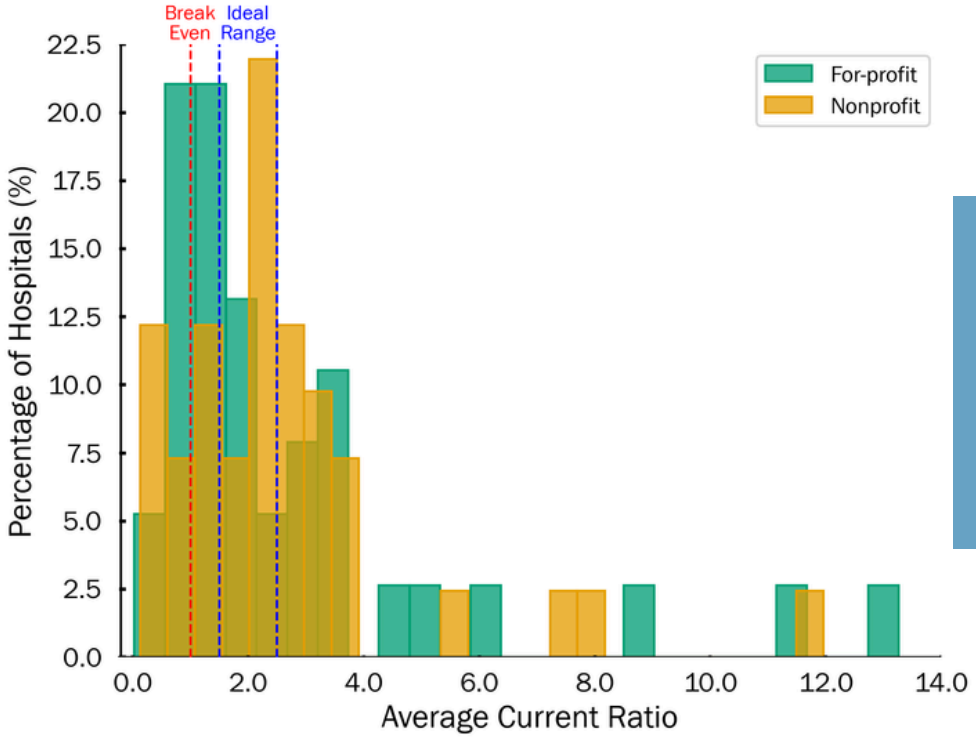
The reported current ratio averaged over 4 FYs ranged from 0.1 to 12.0 for nonprofits and the median was 2.3. Thirteen hospitals out of 41 (31.7%) nonprofit hospitals had a current ratio in the financially healthy range. The reported range was 0.03 to 13.3 for for-profits and the median was 1.9. Seven hospitals out of 38 (18.4%) had a current ratio in the financially healthy range (**Figure 9**).

Figure 8. Distribution of Total Margin by Ownership Type (FYs 2017-2019, 2022)



For-profit hospitals had higher total margins than nonprofit hospitals when averaged over 4 fiscal years.

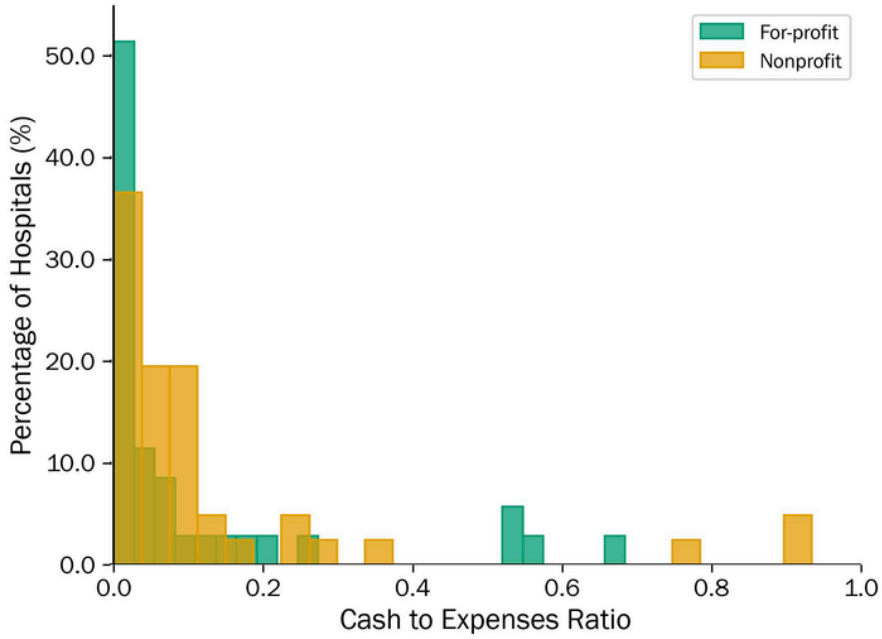
Figure 9. Distribution of Current Ratio by Ownership Type (FYs 2017-2019, 2022)



Nonprofit hospitals had healthier current ratios than for-profit hospitals when averaged over 4 fiscal years.

The reported ratios of total cash to total operating expenses averaged over 4 FYs ranged from 0.00008 to 0.9 for nonprofits and the median was 0.06. The reported ratios ranged from 0.000002 to 0.7 for for-profits and the median was 0.03 (**Figure 10**).

Figure 10: Distribution of Cash to Total Operating Expenses Ratio (FYs 2017-2019, 2022)



Nonprofit hospitals had more cash assets available to cover expenses than for-profit hospitals when averaged over 4 fiscal years.

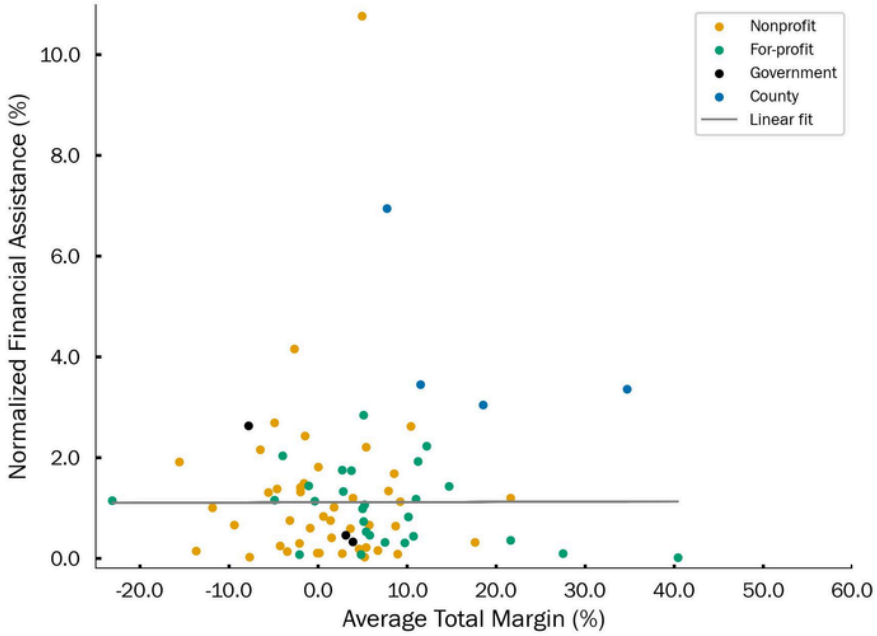
There was no significant trend between reported total margin and the proportion of gross patient revenue that was reported as FA. The coefficient of determination (R^2) for a linear fit after excluding outliers for normalized FA was 0.01 for nonprofits and 0.11 for for-profits. For all reporting hospitals, the R^2 was 0.00 and this linear fit is presented in the figure. This merged dataset using RAND and HCAI has a population of 47 nonprofit hospitals, 28 for-profit hospitals, 4 County hospitals, and 3 other government-owned hospitals (**Figure 12**).

Sensitivity analysis for operating margin versus total margin

Using operating margin instead of total margin still resulted in no trend between FA practices and hospital financial health. The R^2 after excluding outliers for normalized FA was 0.00 for nonprofits and 0.12 for for-profits. For all hospitals, the R^2 was 0.04.

The change in margin for nonprofit hospitals saw great variation on an individual level. The range of change in individual margin was -14.4% to 5.0%, which are percentage changes of -533.3% to 185.2%. The median margin changed from 0.05% to -0.4%, which is a difference of -0.45% or a 900% decrease. The change in margin for for-profit hospitals was more consistent. The range of change was -5.1% to 0.1%, which are percentage changes of -127.5% to 25.0%. The median changed from 5.4% to 5.6%, which is a difference of 0.3% or a 4.6% increase.

Figure 11. Total Margin vs Normalized Financial Assistance by Ownership

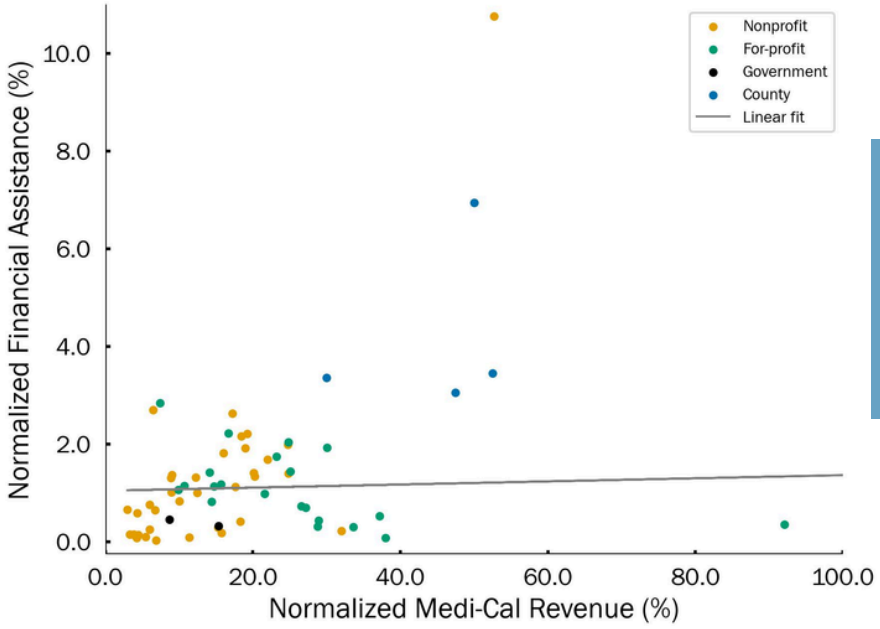


There was no association between hospital financial health and the amount of financial assistance awarded.

Financial Assistance & Medi-Cal

There is no significant trend between Medi-Cal utilization and FA awarded by either nonprofit or for-profit hospitals. County-owned hospitals both award more FA and see more Medi-Cal patients. The R^2 after removing outliers for normalized FA was 0.20 for nonprofit hospitals and 0.23 for for-profit hospitals. For all reporting hospitals excluding outliers, the R^2 was 0.01 (**Figure 12**).

Figure 12: Medi-Cal Revenue Normalized to Net Patient Revenue vs Financial Assistance Normalized to Gross Patient Revenue



There was no association between Medi-Cal utilization and the amount of financial assistance awarded.

Discussion

In 2023, hospitals in LA County reported awarding a total of $426.5 million as FA. The 4 County-owned hospitals reported awarding over $163.7 million (38.4%), 40 nonprofit hospitals reported awarding over $204.7 million (48.0%), 22 for-profit hospitals reported awarding over $41.0 million (9.6%), and 3 other government-owned hospitals reported awarding about $17.1 million (4.0%).

Overall Financial Assistance

There was a large decrease in FA around 2015, reflecting the increase in insurance coverage as a result of the Affordable Care Act. Since then, the percentage of gross patient revenue awarded as FA has remained relatively unchanged. In 2023, nonprofit hospitals in LA County reported 0.92% of their aggregate gross patient revenue as FA, for-profit hospitals reported 1.05%, and County-owned hospitals reported 3.61%. Overall, LA County hospitals aggregately reported a similar percentage of gross patient revenue as FA compared to the state of California but less than the reported percentage of the Medicaid-expansion subset of states. Nonprofit and for-profit hospitals in LA County are spending similar amounts of their aggregate gross patient revenue as FA compared to California and less than national and Medicaid-expansion states. However, the County-owned hospitals are reporting far more of their gross patient revenue as FA compared to government-owned hospitals in the rest of California and Medicaid-expansion states. If nonprofit and for-profit hospitals matched the percent of gross patient revenue awarded as FA in 2023 by Medicaid-expansion states, an additional $134.1 million in FA could have been awarded, representing a 54.6% increase from the actual $245.8 million awarded.

There was no significance difference in financial assistance awarded between nonprofit and for-profit hospitals despite differences in institutional mission.

Ownership Status

Nonprofit and for-profit hospitals award similar percentages of their gross patient revenue as FA despite having different incentive models for awarding FA. Nonprofit hospitals reported slightly less of their gross patient revenue as FA than for-profit hospitals. In 2023, the normalized FA for for-profit hospitals was 13.9% higher than that of nonprofit hospitals in LA County. For California, the normalized FA for for-profit hospitals was substantially higher (46.4%) than that of nonprofit hospitals. In Medicaid-expansion states, the normalized FA for for-profit hospitals was 4.1% higher than that of nonprofit hospitals.

Nonprofit hospitals demonstrated greater variation in their FA practices, and the distribution of normalized FA was skewed towards the lower end of FA awarded. For-profit hospitals demonstrated a tighter range of normalized FA. Variations in individual hospital FA practices could be due to reporting practices, payor mix, patient panel acuity, hospital financial health, mission statement, or supplemental funding access. Some of these differences may also be attributable to variations in reporting practices. For-profit hospitals may report bad debt, such as uncollected copays and outstanding patient account amounts, as charity care, as evidenced in Mark Hall's analysis on HCA

Healthcare's acquisition of Mission Health.[20] The trend of FA as a proportion of total uncompensated care among for-profit hospitals in LA County over time was stable suggesting this may not be of great concern locally.

The normalized FA awarded aggregately by County-owned hospitals in LA County, which actively identify and reach out to connect self-pay or uninsured patients with Medi-Cal enrollment and FA information, is much higher than the normalized FA for both California and Medicaid-Expansion states. Although there are only 4 County hospitals in LA County out of 69 total hospitals that reported charity care activity, they reported awarding over a third of the aggregate FA dollars awarded in 2023. The disproportionately large amount of FA awarded by the County hospitals compared to other hospitals in LA County is suggestive of a broader unmet need for FA in LA County, also reflected in the persistence of medical debt for LA County residents.

The other government-owned hospitals in LA County, which were the UC-owned and health district hospitals, reported much lower amounts of FA than their County-owned counterparts. UC-owned hospitals operate as academic medical centers in UC systems that receive substantial funding from multiple revenue streams, including public funding, research grants, student tuition and fees, and auxiliary enterprises. UC-owned hospitals operate similarly to nonprofit hospitals in the sense that they are largely financially self-sufficient from clinical and grant revenue. Health district hospitals were established under the California Health and Safety Code to serve specific geographic areas. They are typically not financially self-sustaining from patient revenue and rely on local taxes and supplemental public funding similar to County operated facilities.

County Hospitals
- Gave highest overall levels of FA
- Public mandate to provide FA

Other Government Hospitals
- Gave less FA than County hospitals

Nonprofit Hospitals
- Gave similar FA to for-profits
- Tax exemption to provide FA

For-profit Hospitals
- Gave similar FA to nonprofits
- Can deduct FA from taxable income

Hospitals not included in aggregate analyses

Twenty-seven hospitals did not report FA activity on their cost reports, including 18 for-profit hospitals, 7 nonprofit hospitals, 1 UC-owned hospital, and 1 health district hospital. Fourteen hospitals that did not report FA activity on cost reports were licensed as general acute care hospitals, 12 were acute psychiatric hospitals, and 1 was a psychiatric health facility. Capacity ranged from 17 to 1,106 beds. Two acute psychiatric hospitals were associated with a larger health system, which may have reported consolidated FA activities. One for-profit hospital system, Kindred, did not report FA activity for all 5 of its general acute care hospitals in LA County. Three acute psychiatric hospitals submitted incomplete reports for all financial variables consistently across all years. The remaining 25 hospitals all reported non-zero dollar amounts for other financial variables but reported 0 for charity care and net Medi-Cal revenue. Specialty hospitals in LA County often do not report FA activity to cost reports due to having low Medicare volumes in payor mixes, which excludes them from Medicare Disproportionate Share Hospital payments. Furthermore, freestanding children's hospitals and cancer centers are not

paid under the Inpatient Prospective Payment System, which uses cost report data. Thirteen of the hospitals that did not report FA activity on their cost reports did report FA activity on their audited financial statements (see **Appendix**), including 6 for-profit hospitals, 6 nonprofit hospitals, and 1 UC-owned hospital. Following a sensitivity analysis, these hospitals were ultimately excluded from aggregate analyses due to misaligned FY reporting periods between datasets. All changes were directionally consistent and did not materially affect the report's conclusions.

Outlier Analysis

Martin Luther King Jr. Community Hospital (MLKCH) was a nonprofit outlier for normalized FA, reporting 10.76% of its gross patient revenue as FA. This is 35.4% higher than the next highest reported normalized FA, which was a County-owned hospital, LAC Olive View. However, MLKCH is not financially self-sufficient due to its payor mix. It is a mission-driven hospital in South LA, which is historically underserved, and has inpatient and outpatient payor mixes of mainly Medi-Cal patients.[21] In January 2024, the LA County Board of Supervisors moved to invest $20 million in MLKCH to supplement operating revenue, with funds to be distributed through FY 2026-27.[22]

Martin Luther King Jr. Community Hospital was an outlier for nonprofit hospitals. It had significantly higher normalized FA than its peers but is financially unsustainable.

Uncompensated Costs for Hospitals

Bad debt and charity care are both uncompensated costs that patients would otherwise directly be responsible for. Hospital financial trends indicate that uncompensated costs otherwise attributable to patients, such as FA and bad debt, are decreasing overall. This reflects the expansion of coverage in the United States as a result of the Affordable Care Act and Medi-Cal expansion. While hospitals do write off outstanding patient accounts as bad debt, another common downstream mechanism is the sale or assignment of debt to a third-party debt collector.[23] Debt collectors employ persistent and sometimes invasive tactics to collect payment, which can lead to mental and financial strain on the patient. Charity care, on the other hand, leaves the patient with either a balanced account and no downstream responsibility to provide payment for services received or a more manageable financial liability or payment plan. Bad debt leads to financial harm to the consumer while charity care mitigates potential downstream financial harm. As mentioned earlier, for-profit hospitals may report bad debt as FA. Understanding what proportion of reported uncompensated costs is attributable to bad debt provisions presents more insight on FA practices from for-profit hospital systems, which encompass a significant source of care for LA County residents. For nonprofit hospitals, FA has consistently made up about two-thirds of their total uncompensated costs. For for-profit hospitals, the proportion of total uncompensated costs attributed to FA is increasing, but still substantially lower than that of nonprofit hospitals.

SOURCES OF HOSPITAL UNCOMPENSATED COSTS

Financial Assistance
- No payment collection pursued
- Protects patients from financial harm

Bad Debt
- Unpaid patient bills written off by hospitals
- Can result in financial harm for patients

Financial Assistance & Hospital Financials

While hospital financial health might be expected to influence how much FA a hospital awards, there was no relationship in our findings. Overall, many financially healthy hospitals awarded low FA and many financially strained hospitals awarded high amounts of FA. This suggests that FA operations are influenced by other factors and their improvement should not be limited by potential concerns about their financial implications. This may be because the cost of share from patients awarded FA contributes negligibly to revenue to begin with. The distribution of total margin indicates that the majority of nonprofit hospitals are operating at a net loss. However, the majority of nonprofit hospitals have enough assets to cover their short-term liabilities and are in or above the "financially healthy" range of 1.5 to 2.5. Having a current ratio above 2.5 isn't the best indicator of financial health because it indicates a surplus of uninvested assets, but it still indicates having plentiful assets. This combination can be caused by multiple reasons: nonprofit hospitals may have cash reserves built up from years of establishment or may earn revenue from non-operating assets, such as investments, to offset operational losses. For-profit hospitals demonstrate the opposite trend, with most hospitals operating at a profit but having a lower current ratio. This combination could be due to high operational efficiency, recent heavy investments, or the storage of cash in non-liquid assets, such as long-term investments or endowments. These financial trends are also reflected in the distribution of cash-to-expenses ratios by ownership. Non-profits tend to have higher cash reserves and can rely more on cash for operating expenses, while for-profits do not keep much cash on hand and instead likely invest that cash in non-liquid assets. Having a lower current ratio is not always a sign of poor financial health, especially when combined with other positive financial indicators.

Financial Assistance & Medi-Cal

Another key aspect of the landscape is the high rate of Medi-Cal coverage in LA County. Medi-Cal reimburses at a lower rate, so hospitals that serve a large Medi-Cal population may also have thinner financial margins despite supplemental Medi-Cal payments from state funding, impacting their ability to provide FA. Furthermore, if hospitals see more Medi-Cal patients, less FA may be necessary due to higher rates of coverage. However, a high Medi-Cal revenue proportion can also indicate a poorer, sicker neighborhood or patient panel, which are populations that often need FA the most and should qualify for most FA policies. Despite these expectations, there was no identified trend between Medi-Cal utilization and the proportion of FA awarded. FA practices from nonprofit and for-profit hospitals were relatively similar regardless of the volume of Medi-Cal patients. There were both for-profit and nonprofit hospitals that received a substantial amount of their net patient revenue from Medi-Cal but awarded higher amounts of FA. Greater El Monte Community Hospital and San Gabriel Valley Medical Center are two examples of for-profit hospitals that awarded high amounts of FA with high proportions of net patient revenue

A high Medi-Cal revenue proportion can indicate:

- thinner hospital margins
- lower need for financial assistance due to increased coverage
- higher proportion of patient population that is eligible for financial assistance

attributed to net Medi-Cal revenue. Greater El Monte Community Hospital awarded 1.93% of its gross patient revenue as FA with 30.0% of its net patient revenue attributed to net Medi-Cal revenue and San Gabriel Valley Medical Center awarded 2.04% as FA with 24.8% attributed to Medi-Cal revenue. Two of Emanate Health's hospitals are examples of nonprofit hospitals besides MLKCH that awarded high amounts of FA with high Medi-Cal utilization. Emanate Health Medical Center awarded 1.99% with 24.7% of its net patient revenue attributed to Medi-Cal revenue and Emanate Health Foothill Presbyterian Hospital awarded 2.21% with 19.3% attributed to Medi-Cal revenue. The challenges of a high Medi-Cal payor mix are likely not limiting FA awards as the cost of share from these patients represent negligible patient revenue.

Despite no overall association between Medi-Cal utilization and financial assistance practices, **there are examples of both for-profit and nonprofit hospitals that had high Medi-Cal utilization and awarded high amounts of financial assistance.**

Limitations

Limitations for this report include the nature of the Cost Report Information System (HCRIS) dataset, which is generated through continual individual reports from hospitals. Hospitals are not required to report to CMS unless they are Medicare-certified institutional providers and are not required to report on specific fiscal schedules, so there are hospitals that may not be represented in this dataset. Reporting methods are not standardized across hospitals, which may result in varied representations of hospital financial indicators. Furthermore, hospitals are not required to report in completion to CMS.

Hospitals are not required to submit audited financial statements with their cost reports, which is why the HCAI audited financial statements dataset was used to calculate financial health. However, the most recent complete dataset was from FY 2022-2023, when some hospital financials may still be affected by the COVID-19 pandemic. The information available through HCAI is not always facility-level information, so the full HCAI dataset is only used to provide a general landscape of hospital financials by ownership.

Our Medi-Cal utilization proxy (revenue from Medi-Cal as a proportion of net patient revenue) may inflate Medi-Cal utilization rates at facilities performing procedures with higher reimbursement rates. Analyses on additional payor mix and patient utilization data could add further insight to our findings on FA.

Conclusions & Next Steps

While hospital financial assistance is not the sole solution for decreasing the medical debt burden in Los Angeles County, it is crucially important for preventing it. The landscape analysis suggests that improvements are needed and possible.

Efforts to improve financial assistance in Los Angeles County are already underway involving local government, hospitals, the hospital association, and legal aid and other community groups. These include developing collaborative recommendations for improving and synchronizing financial assistance processes reflected in a model financial assistance policy and application. An additional effort includes support from LA Care Health Plan and the Hospital Association of Southern California to develop methods to expand the use of electronic presumptive eligibility tools to hospitals to automatically qualify patients for financial assistance. Finally, a new ordinance for financial assistance and debt collection data sharing will help provide operational metrics to help improve financial assistance as well as overall transparency and accountability.

Ongoing assessments of safety net programs, including financial assistance, are necessary to ensure that best practices are utilized to promote health and minimize harm to healthcare consumers.

Methods

Study Sample

The study sample for aggregate analyses included all licensed acute care hospitals (which we will refer to simply as "hospitals" moving forward) in LA County that reported non-zero FA activity on the CMS HCRIS Form CMS 2552-10 in FYs 2014-2023, which was the most recent completed dataset. Non-zero FA activity was defined as reporting a number greater than zero on Form S10, Line 23, which is uncompensated charity care. If hospitals did not consistently report non-zero FA activity every FY, then they were excluded from aggregate calculations for any FYs for which they reported zero dollars of FA. County hospitals have less discretion over FA practices, which are written into County code, and receive public funding to supplement operational revenue, so they are represented separately in FA analyses from UC hospitals, which are financially self-sustaining. County hospitals in LA were classified as "County" rather than "government-owned" but were included in calculations for all government hospitals. Similarly, UC-owned hospitals were classified as "UC" but were included in overall calculations. The national and state of California aggregate analyses used populations with the same parameters – all hospitals that reported non-zero FA activity to CMS. County hospitals not in LA County were classified as "government-owned."

The study sample for the distribution of individual hospital FA activity included hospitals that reported non-zero FA activity to CMS as well as hospitals that reported zero FA activity to CMS but had non-zero FA activity reported on their financial statements from the Hospital Annual Financial dataset from HCAI in FY 2023. This dataset is not complete so some of the financial statements were not audited. The HCAI FA data were retrieved by individually reviewing submitted annual financial statements for hospitals that reported zero FA activity to CMS. These hospitals were excluded from aggregate analyses due to misalignment between the FY reporting periods of the HCAI FA field and the CMS patient revenue field. A sensitivity analysis confirmed that excluding this subset did not materially impact the overall findings.

The study sample for the financial distribution analyses included all hospitals in LA County that reported non-zero dollar amounts for variables needed to calculate financial metrics (see **Appendix**) on their audited financial statements for FYs 2017-2019 and 2022. Hospital financials were averaged over 4 FYs, 2017, 2018, 2019, and 2022, which was the most recent completed dataset. FYs 2020 and 2021 were excluded to account for anomalies resulting from the COVID-19 pandemic. If hospitals did not report non-zero dollar amounts for the variables every FY, then any FYs with zero reported dollars were excluded from average calculations. Government-owned hospitals were excluded from financial health figures because they receive public funding to supplement revenue from patient operations, so their financial health data are not generalizable to other ownership types.

The study sample used to plot reported normalized FA against total margin is the overlap between hospitals that reported non-zero FA activity to cost reports or HCAI and non-zero dollar amounts for variables needed to calculate financial metrics.

The study sample for the Medi-Cal utilization proxy included all hospitals in LA County that reported non-zero Medi-Cal revenue that was lower than total patient revenue. Medi-Cal revenue that exceeds total patient revenue indicates reporting error.

Data Sources

Hospital reported FA data were from the CMS HCRIS Form CMS 2552-10 that is then processed by RAND. The RAND dataset is continuously updated. The dataset used in this report was retrieved in March 2025. For the purposes of this report, charity care and FA are referenced interchangeably. Hospital financial data were collected from the Hospital Annual Financial dataset from HCAI. Hospital financial health was calculated using information from the most recent consolidated audited financial statements.

Data Definitions

Table 2 presents the definitions and calculations for key variables used to generate this report. To normalize FA dollars awarded, FA was presented as a percent of gross patient revenue. The RAND reported gross patient revenue variable often represents the amount billed for services rather than dollars earned. This is not representative of actual patient revenue earned, especially for hospitals that see many patients but are reimbursed at a lower rate. To calculate gross patient revenue, FA and bad debt provisions were added to net patient revenue, which is the revenue earned from patient operations after contractual allowances and deductions. Gross patient revenue was selected for adjustment because it represents unrestricted resources that are earned from operations and FA is reported as a reduction of revenue on hospital financial statements.

Table 2 presents the definitions and calculations for the variables used to generate this report. The specific variables used from each dataset are available in the Appendix.

Table 2. Definitions of Variables

Variable	Definition
Financial assistance	Uncompensated charity care for both insured and uninsured patients, including (after 2017)[24] uncollected coinsurance and deductibles from patients that qualify for a hospital's FA policy.
Bad debt	Uncompensated cost attributed to non-Medicare-reimbursable patient accounts that were not balanced by either payment or charity care.
Gross patient revenue*	Revenue earned from patient operations after contractual allowances, calculated by adding FA and bad debt to net patient revenue.
Normalized financial assistance	Uncompensated charity care as a percentage of gross patient revenue, calculated by dividing charity care amount by gross patient revenue.

*Different from the RAND gross patient revenue variable, which is only used in calculations for tables and figures in the **Appendix**.

Table 2. Definitions of Variables (cont.)

Variable	Definition
Total uncompensated costs	Total uncompensated costs to a hospital that patients are responsible for, calculated by adding bad debt and financial assistance.
Total margin	The amount of profit (or net income) per dollar of total revenue, calculated by dividing net income after adjustment for nonoperating revenue by total operating revenue from the income statement. Zero represents the breakeven point; a negative total margin means that the hospital is operating at a net loss overall.
Operating margin	The amount of profit from operations (or net operating income) per dollar of total revenue, calculated by dividing net income from operations by total operating revenue from the income statement. Zero represents the breakeven point; a negative operating margin means that the hospital is operating at a net loss from its core business operations.
Current ratio	The ability of a hospital to pay off its short-term liabilities, calculated by dividing total current assets by total current liabilities from the income statement. A current ratio around 1.5 to 2.5 is considered financially healthy for hospitals.
Cash-to-expenses ratio	The period (in years) of expenses a hospital can cover with cash on hand, calculated by dividing total cash from the balance sheet by total operating expenses from the income statement.
Medi-Cal utilization proxy	The percentage of net patient revenue that is attributed to revenue from Medi-Cal reimbursement, calculated by dividing net Medicaid revenue by net patient revenue.

Data Analysis

Data were analyzed using Python with the pandas and NumPy libraries. All calculated numbers are based on unrounded numbers. We conducted descriptive summaries of FA as a percentage of gross patient revenue, total margin, current ratio, and cash-to-expenses ratio. We stratified on ownership type.

Aggregate calculations were used when considering FA practices by the overall market for each type of hospital ownership. To acknowledge the heterogeneity of hospitals within each ownership type,

distributions of normalized FA at the individual hospital level were included. The median was used in descriptive summaries due to wide variations in hospital FA practices. FA practice outliers were identified and characterized.

The mean was used to generate hospital financial metrics over 4 FYs to account for year-to-year variations and provide a stable estimate of financial health and sustainability.
Linear regression lines were applied and coefficients of determination were calculated for a scatter plot of individual hospital total margin versus normalized FA to assess the presence and strength of a correlation between hospital financial health and FA practices by ownership type.

A sensitivity analysis was conducted to assess the impact of excluding Kaiser Permanente facilities, which provide care to a significant proportion of the California population but award less financial assistance due to their integrated care delivery model. To evaluate this, two different analyses were conducted. The first analysis examined how the difference in aggregate normalized FA between LA County hospitals and hospitals in Medicaid expansion states changed when Kaiser Permanente facilities were included versus excluded. The second analysis examined how the difference in aggregate normalized FA between nonprofit and for-profit hospitals in LA County changed when Kaiser Permanente facilities were included versus excluded.

A sensitivity analysis was conducted to assess whether including the subset of hospitals that reported FA activity to HCAI but not to CMS would significantly affect the study's conclusions. To evaluate this, aggregate normalized FA values were compared with and without the inclusion of the HCAI-only subset.

A sensitivity analysis was conducted to assess whether using operating margin versus total margin would make a significant difference when assessing hospital financial health and FA practices. To evaluate this, individual hospital operating margins were calculated and plotted against individual hospital normalized FA. Linear regression lines were applied and coefficients of determination were calculated for this plot and were compared to the values calculated for total margin versus normalized FA.

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH

Barbara Ferrer, PhD, MPH, MEd
Director

Muntu Davis, MD, MPH
Health Officer

Anish Mahajan, MD, MS, MPH
Chief Deputy Director

Nichole Quick, MD, MPH
Interim Chief Science Officer

ACKNOWLEDGEMENTS

The authors thank Kristof Stremikis, Nancy Kane, Hossein Zare, Erin Duffy, Keith Hearle, and the Hospital Association of Southern California for their valuable comments and insights on earlier drafts of this report. Their feedback improved the clarity and rigor of the work. The authors also thank Alice Cai for her significant contributions to the graphic design and formatting of the report. The views expressed herein, as well as any errors or omissions, are the sole responsibility of the authors.

DIVISION OF MEDICAL AND DENTAL AFFAIRS

Naman Shah, MD, PhD
Division Director

Ali Stirland, MBChB, MSc
Medical Affairs Program Director

Melina Boudov, MA
Healthcare Consumer Protection Manager

Jennifer Zhang, MPH
Health Program Analyst

Vardan Shamamyan
Health Program Analyst

Ashley Hopkins, MPH
Health Program Analyst

Andrew Friedman, BA
Health Program Analyst

Corresponding author: Jennifer Zhang, MPH
Email: hccp@ph.lacounty.gov

Suggested Citation: Los Angeles County Department of Public Health. *Landscape of Hospital Financial Assistance in Los Angeles County, 2014-2023.* September 2025.

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Appendix

Abbreviations

AB - Assembly bill
CMS - Centers for Medicare and Medicaid Services
FA - Financial assistance
FY - Fiscal year
HCAI - California Department of Health Care Access and Information
HCRIS - Healthcare Cost Report Information System
IQR - Interquartile range
LA - Los Angeles
MCP - Managed care plan
MLKCH - Martin Luther King Jr. Community Hospital
UC - University of California

Table A1: Variables from the RAND Dataset

Name	Form	Line, Column	Variable Name
Financial Assistance	S10	23, 3	uncomp_charity_patients_only10
Hospital Ownership	S2I	2, 0	ownership_hcris_only10
RAND Gross Patient Revenue	G2	28, 3	gross_patient_rev
Bad Debt	S10	29, 3	nonmdcr_baddebt_costs_only10
Net Patient Revenue	G3	3	net_patient_rev
Medicaid Net Revenue	S10	2, 4	mdcd_net_revenue_only10
Total Operating Expenses	G3	4	operating_expenses

Table A2: Variables from the HCAI Dataset

Name	Form	Variable Name
Current Assets	Balance Sheet	balance_sheet_current_assets_total_current_assets

Table A2: Variables from the HCAI Dataset (cont.)

Name	Form	Variable Name
Current Liabilities	Balance Sheet	balance_sheet_current_liabilities_total_current_liabilities
Net Income	Income Statement	income_statement_net_income
Net Operating Income	Income Statement	income_statement_net_from_operations
Operating Revenue	Income Statement	income_statement_total_operating_revenue
Cash	Balance Sheet	balance_sheet_current_assets_cash
Operating Expenses	Income Statement	income_statement_total_operating_expenses
Charity Care	Income Statement	income_statement_deductions_from_revenue_charity_discounts_-_other
Type of Care	Hospital Description	type_of_care_...

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
ADVENTIST HEALTH GLENDALE	Nonprofit	General	Yes	1.41	24.79	-2.00	2.26	0.08
ADVENTIST HEALTH WHITE MEMORIAL	Nonprofit	General	Yes	1.34	20.24	7.90	8.07	0.93
ALHAMBRA HOSPITAL	For-profit	General	Yes	0.73	26.58	5.10	1.29	0.52
ANTELOPE VALLEY HOSPITAL**	Government	General	Yes	0.76	-	3.80	1.14	1.43
AURORA CHARTER OAK BHS	For-profit	Psych	No	0.47*	-	5.80	1.65	0.06

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
AURORA LAS ENCINAS BHS	For-profit	Psych	No	1.74*	-	3.70	1.40	0.02
BARLOW RESPIRATORY HOSPITAL	Nonprofit	Specialty	No	4.16*	-	-2.70	2.44	0.01
BEVERLY HOSPITAL	Nonprofit	General	Yes	-	-	-6.20	1.55	0.14
BHC ALHAMBRA HOSPITAL	For-profit	Psych	No	0.01*	-	40.40	2.76	-
CALIFORNIA HOSPITAL MEDICAL CENTER**	Nonprofit	General	Yes	2.63	17.21	10.40	2.70	0.24
CALIFORNIA REHABILITATION INSTITUTE	For-profit	Specialty	No	-	-	11.10	2.22	-
CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE	Nonprofit	General	No	0.03	6.86	-7.70	0.60	0.76
CATALINA ISLAND MEDICAL CENTER	Nonprofit	Long-term General	Yes	0.10	11.36	2.70	2.22	0.04
CEDARS-SINAI MARINA DEL REY HOSPITAL	Nonprofit	General	Yes	2.70	6.47	-4.90	0.63	0.11
CEDARS-SINAI MEDICAL CENTER**	Nonprofit	General	Yes	0.65	6.73	8.70	3.16	0.15
CENTINELA HOSPITAL MEDICAL CENTER	For-profit	General	Yes	0.32	28.78	7.50	3.51	0.02
CHILDRENS HOSPITAL LOS ANGELES **	Nonprofit	Children's	Yes	0.03*	-	5.20	2.75	0.08
CITY OF HOPE NATIONAL MEDICAL CENTER	Nonprofit	Specialty	No	0.61*	-	-0.90	3.26	0.06
COAST PLAZA HOSPITAL	For-profit	General	Yes	1.15	10.71	-23.10	0.20	0.01

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
COLLEGE HOSPITAL INC	For-profit	Psych	No	0.08*	-	4.80	0.79	0.03
COLLEGE MEDICAL CENTER	For-profit	General	Yes	1.44	25.06	-1.10	1.93	0.12
COMMUNITY HOSPITAL OF HUNTINGTON PARK	For-profit	General	No	1.14	14.75	-0.40	0.58	0.01
DEL AMO HOSPITAL	For-profit	Psych	No	0.10*	-	27.50	2.10	-
DOCS SURGICAL HOSPITAL	For-profit	Specialty	No	-	-	50.70	4.32	0.07
DOWNEY REGIONAL MEDICAL CENTER	Nonprofit	General	Yes	-	-	-1.60	1.40	-
EAST LOS ANGELES DOCTORS HOSPITAL	For-profit	General	Yes	1.07	9.91	5.20	2.73	0.06
EMANATE HEALTH FOOTHILL PRESB. HOSPITAL	Nonprofit	General	Yes	2.21	19.26	5.40	2.59	0.04
EMANATE HEALTH MEDICAL CENTER	Nonprofit	General	Yes	1.99	24.74	-	-	-
EMANATE HEALTH QUEEN OF THE VALLEY HOSPITAL	Nonprofit	General	Yes	-	-	6.40	2.17	0.02
ENCINO HOSPITAL	Nonprofit	General	Yes	0.42	18.32	1.50	1.76	0.09
GARFIELD MEDICAL CENTER	For-profit	General	Yes	1.75	23.18	2.70	1.02	0.57
GATEWAY HOSPITAL	For-profit	Psych	No	-	-	4.00	4.86	0.19
GLENDALE MEMORIAL HOSPITAL & HLTH CT	Nonprofit	General	Yes	1.92	18.94	-15.60	1.26	0.01
GLENDORA HOSPITAL	For-profit	Psych	No	-	-	-21.70	0.26	0.03

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
GREATER EL MONTE COMMUNITY HOSPITAL	For-profit	General	Yes	1.93	30.04	11.20	1.89	0.53
HARBOR-UCLA MEDICAL CENTER**	County	General	Yes	3.05	47.48	18.50	1.56	0.04
HENRY MAYO NEWHALL MEMORIAL HOSPITAL**	Nonprofit	General	Yes	0.76	5.97	1.40	2.34	0.24
HOLLYWOOD PRESBYTERIAN MEDICAL CNTR	For-profit	General	Yes	0.53	37.21	5.40	1.50	0.03
HUNTINGTON HOSPITAL**	Nonprofit	General	Yes	1.38	9.00	-4.60	2.63	0.03
JOYCE EISENBERG KEEFER MEDICAL CENTER	Nonprofit	Long-term Psych	No	-	-	-2.70	7.67	0.00
KAISER BALDWIN PARK	Nonprofit	General	Yes	0.16	3.87	6.70	-	-
KAISER DOWNEY	Nonprofit	General	Yes	0.11	5.43	-0.10	-	-
KAISER LOS ANGELES	Nonprofit	General	Yes	0.09	4.27	8.90	-	-
KAISER PANORAMA CITY	Nonprofit	General	Yes	0.14	4.48	-3.50	-	-
KAISER SOUTH BAY	Nonprofit	General	Yes	0.11	4.10	0.10	-	-

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
KAISER WEST LOS ANGELES	Nonprofit	General	Yes	0.25	5.99	-4.30	-	-
KAISER WOODLAND HILLS	Nonprofit	General	Yes	0.15	3.28	-13.70	-	-
KECK HOSPITAL OF USC	Nonprofit	General	No	0.30	15.29	-2.10	0.97	0.91
KEDREN COMMUNITY MENTAL HEALTH	For-profit	Pysch	No	-	-	0.50	1.19	0.04
KINDRED HOSPITAL BALDWIN PARK	For-profit	Long-term General	No	-	-	14.70	1.46	0.00
KINDRED HOSPITAL LA MIRADA	For-profit	General	No	-	-	7.10	8.72	0.00
KINDRED HOSPITAL LOS ANGELES	For-profit	Long-term General	No	-	-	13.40	11.4	0.00
KINDRED HOSPITAL PARAMOUNT	For-profit	Long-term General	No	-	-			
KINDRED HOSPITAL SOUTH BAY	For-profit	Long-term General	No	-	-			
L A DOWNTOWN MEDICAL CENTER	For-profit	General	No	1.16*	-	-4.90	0.70	0.01
LAC OLIVE VIEW/UCLA MEDICAL CENTER	County	General	Yes	6.95	50.01	7.70	1.81	0.06

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
LAKEWOOD REGIONAL MED. CTR.	For-profit	General	Yes	0.83	14.43	10.10	6.24	0.00
LOS ANGELES COMMUNITY HOSPITAL	For-profit	General	No	0.36	92.12	21.60	-	-
LOS ANGELES GENERAL MEDICAL CENTER**	County	General	Yes	3.46	52.5	11.50	1.70	0.04
MARTIN LUTHER KING COMMUNITY HOSPITAL	Nonprofit	General	Yes	10.76	52.69	4.90	3.41	0.06
MEMORIAL HOSPITAL OF GARDENA	For-profit	General	Yes	1.18	15.71	11.00	3.68	0.14
MEMORIALCARE LONG BEACH MED CTR**	Nonprofit	General	Yes	1.69	21.99	8.50	11.96	0.00
MEMORIALCARE MILLER CHILDREN'S AND WOMEN'S HOSPITAL LONG BEACH	Nonprofit	Children's	No	2.44*	-	-1.50	0.13	0.00
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	Nonprofit	General	Yes	-	-	-3.20	3.69	0.10
METROPOLITAN STATE HOSPITAL	Government	Psych	No	-	-	-	-	-
MISSION COMMUNITY HOSPITAL	For-profit	General	Yes	1.33	-	2.80	1.06	0.03

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
MONROVIA MEMORIAL HOSPITAL	For-profit	General	No	-	-	21.50	2.18	0.25
MONTEREY PARK HOSPITAL	For-profit	General	Yes	1.43	14.14	14.70	2.76	0.68
NORTHRIDGE MEDICAL CENTER - ROSCOE**	Nonprofit	General	Yes	1.81	16.00	0.00	3.45	0.35
OCEAN VIEW PSYCHIATRIC FACILITY	For-profit	Psych	No	-	-	-	-	-
PACIFICA HOSPITAL OF THE VALLEY	For-profit	General	Yes	0.31	33.64	9.70	1.13	0.09
PALMDALE REGIONAL MEDICAL CENTER	For-profit	General	Yes	0.99	21.58	5.00	1.09	-
PIH HEALTH GOOD SAMARITAN HOSPITAL	Nonprofit	General	Yes	1.32	12.25	-2.00	2.29	0.05
PIH HEALTH HOSPITAL - DOWNEY	Nonprofit	General	Yes	1.49	-	-1.60	1.40	0.00
PIH HEALTH WHITTIER HOSPITAL	Nonprofit	General	Yes	0.67	-	5.70	3.56	0.02
POMONA VALLEY HOSPITAL MED CTR**	Nonprofit	General	Yes	0.19	15.73	4.60	2.37	0.07
PROVIDENCE CEDARS-SINAI TARZANA MEDICAL CENTER	Nonprofit	General	Yes	1.01	12.44	-11.90	0.40	0.08

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
PROVIDENCE HOLY CROSS MED. CENTER**	Nonprofit	General	Yes	1.13	17.65	9.20	3.17	0.03
PROVIDENCE LITTLE COMPANY OF MARY MC SAN PEDRO	Nonprofit	General	Yes	1.42	20.11	-2.00	2.33	0.01
PROVIDENCE LITTLE COMPANY OF MARY MC TORRANCE	Nonprofit	General	Yes	0.84	10.00	0.60	2.37	0.02
PROVIDENCE ST JOHNS HEALTH CENTER	Nonprofit	General	Yes	0.67	2.95	-9.40	0.60	0.01
PROVIDENCE ST JOSEPH MEDICAL CENTER	Nonprofit	General	Yes	1.02	8.93	1.80	1.81	0.03
RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER	County	General	No	3.36	29.98	34.70	1.28	0.15
RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA	UC	Psych	No	2.63*	-	-7.80	0.13	0.18
RONALD REAGAN UCLA**	UC	General	Yes	0.33	15.37	3.90	0.76	0.54
SAN DIMAS COMMUNITY HOSPITAL	For-profit	General	Yes	0.08	37.96	-2.10	1.92	0.02
SAN GABRIEL VALLEY MEDICAL CENTER	For-profit	General	Yes	2.04	24.82	-4.00	1.10	0.01

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
SANTA MONICA UCLA MEDICAL CENTER	UC	General	Yes	0.46	8.71	3.10	0.66	0.03
SHERMAN OAKS HOSPITAL-HLTH	Nonprofit	General	Yes	0.22	32.04	5.40	5.43	0.07
SOUTHERN CALIF HOSPITAL AT HOLLYWOOD	For-profit	General	No	0.71	27.14	-	-	-
ST FRANCIS MEDICAL CENTER**	For-profit	General	Yes	0.44	28.89	10.70	3.63	0.04
ST. MARY MEDICAL CENTER**	Nonprofit	General	Yes	2.17	18.43	-6.50	1.66	0.01
TARZANA TREATMENT CENTERS	Nonprofit	Psych	No	0.04*	-	-	-	-
TORRANCE MEMORIAL MEDICAL CENTER	Nonprofit	General	Yes	0.59	4.33	3.60	0.60	0.04
USC ARCADIA HOSPITAL	Nonprofit	General	Yes	0.75	-	-	-	-
USC NORRIS CANCER HOSPITAL	Nonprofit	Specialty	No	0.32*	-	17.60	1.43	0.28
VALLEY PRESBYTERIAN HOSPITAL	Nonprofit	General	Yes	1.20	-	3.90	1.04	0.09

Table A3. Hospital Normalized FA, Medi-Cal Utilization, and Financial Metrics (2023) (cont.)

Hospital Name	Ownership	Type of Facility	Emergency Services	FA %	Medi-Cal %	Avg Total Margin	Avg Current Ratio	Avg Cash: Expenses
VALLEY PRESBYTERIAN HOSPITAL	For-profit	General	No	-	-	21.60	13.26	0.00
VERDUGO HILLS HOSPITAL	Nonprofit	General	Yes	1.32	8.90	-5.60	2.53	0.09
WEST COVINA MEDICAL CENTER	For-profit	General	No	-	-	5.40	0.93	0.02
WEST HILLS HOSPITAL	For-profit	General	Yes	2.85	7.42	5.10	0.03	0.00
WHITTIER HOSPITAL MEDICAL CENTER	For-profit	General	Yes	2.23	16.67	12.20	3.39	0.20

*Normalized FA was calculated using HCAI dataset.
**Indicates trauma center.

Figure A1. National Hospital Ownership Type (2023)

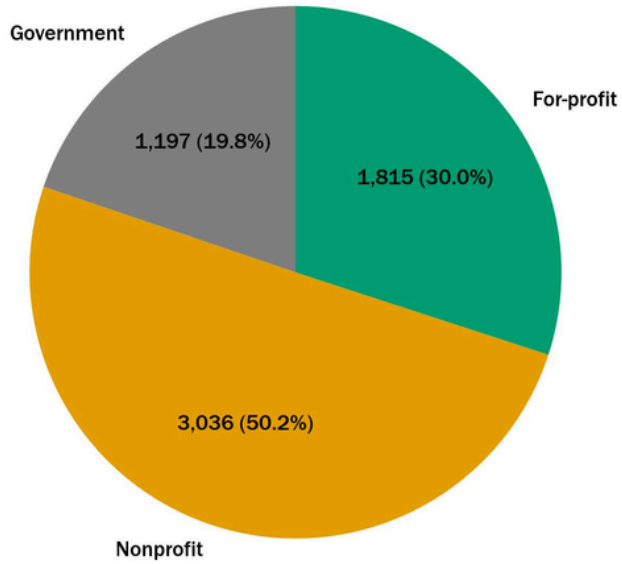

Figure A2. California State Hospital Ownership Type (2023)

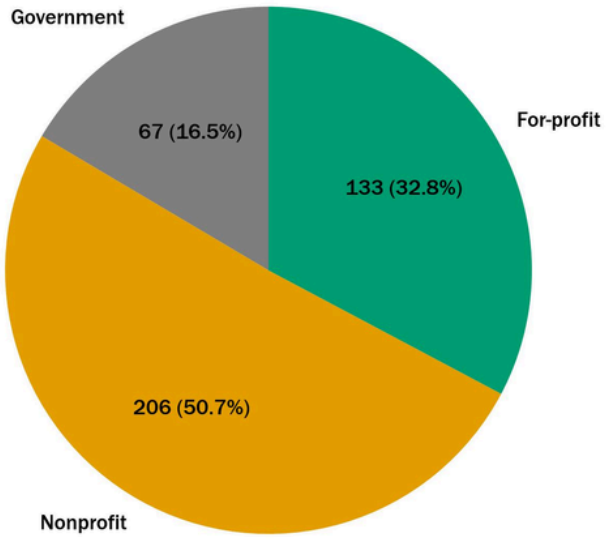

Table A4. Financial Assistance as Percentage of HCRIS Gross Patient Revenue (2023)

Ownership Type		Los Angeles County (n=69)	California (n=298)	National		
				All (n=4,231)	Expansion (n=2,995)	Non-Expansion (n=1,236)
Nonprofit		0.18%	0.19%	0.49%	0.39%	0.91%
For-profit		0.18%	0.17%	0.42%	0.23%	0.55%
Government	County*	2.14%	-	-	-	-
	District*	0.64%	-	-	-	-
	UC	0.13%	0.27%	0.27%	0.27%	-
	Total	0.92%	1.04%	1.17%	0.87%	1.70%
All		0.27%	0.26%	0.57%	0.43%	0.91%

*County and district hospitals were not analyzed separately from all government hospitals for the state of California and national-level calculations, so those table entries are marked with a dash.

Table A5. Financial Assistance as a Percentage of Total Operating Expenses (2023)

Ownership Type		Los Angeles County (n=69)	California (n=298)	National		
				All (n=4,231)	Expansion (n=2,995)	Non-Expansion (n=1,236)
Nonprofit		0.88%	0.86%	1.85%	1.85%	3.96%
For-profit		0.94%	1.29%	3.63%	1.63%	5.85%
Government	County*	3.81%	-	-	-	-
	District*	0.76%	-	-	-	-
	UC	0.36%	0.90%	0.90%	0.90%	-
	Total	2.13%	1.76%	3.71%	2.56%	6.19%
All		1.18%	1.14%	2.35%	1.60%	4.87%

*County and district hospitals were not analyzed separately from all government hospitals for the state of California and national-level calculations, so those table entries are marked with a dash.

Table A6. Uncompensated Costs for Hospitals by Ownership over Time (2014-2023)

Year	Ownership	FA (%)	Total FA ($)	Total Bad Debt ($)	Total Uncompensated Costs ($)
2014	For-profit	32.3	29,178,080	61,288,118	90,466,198
	Government	33.4	2,031,700	4,045,548	6,077,248
	Nonprofit	85.7	270,643,022	45,200,132	315,843,154
2015	For-profit	39.5	31,001,269	47,449,045	78,450,315
	Government	87.4	203,424,562	29,407,700	232,832,261
	Nonprofit	69.6	194,090,967	84,873,620	278,964,586
2016	For-profit	43.2	29,314,161	38,492,111	67,806,271
	Government	90.3	216,358,641	23,220,081	239,578,722
	Nonprofit	72.8	246,603,906	92,338,142	338,942,049
2017	For-profit	49.7	33,348,810	33,732,536	67,081,346
	Government	83.5	231,795,908	45,849,410	277,645,317
	Nonprofit	70.5	211,682,563	88,636,959	300,319,521
2018	For-profit	50.3	36,332,177	35,962,309	72,294,486
	Government	77.5	239,527,085	69,572,496	309,099,580
	Nonprofit	72.7	215,870,479	81,203,690	297,074,170
2019	For-profit	46.9	35,056,104	39,618,887	74,674,991
	Government	79.1	279,240,950	73,678,665	352,919,615
	Nonprofit	73.4	260,197,150	94,266,017	354,463,166

Table A6. Uncompensated Costs for Hospitals by Ownership over Time (2014-2023) (cont.)

Year	Ownership	FA (%)	Total FA ($)	Total Bad Debt ($)	Total Uncompensated Costs ($)
2020	For-profit	49.1	34,310,785	35,587,808	69,898,593
	Government	81.1	234,525,475	54,631,585	289,157,060
	Nonprofit	72.4	256,969,830	98,009,338	354,979,167
2021	For-profit	56.5	40,781,537	31,384,912	72,166,449
	Government	85	246,724,867	43,697,362	290,422,229
	Nonprofit	75.8	212,885,868	67,921,852	280,807,720
2022	For-profit	56	41,249,291	32,347,866	73,597,157
	Government	87.4	271,108,748	39,222,736	310,331,483
	Nonprofit	76.4	223,016,663	68,736,411	291,753,074
2023	For-profit	56.1	41,036,256	32,071,018	73,107,273
	Government	83.4	180,688,984	35,843,421	216,532,405
	Nonprofit	74.6	204,794,170	69,609,763	274,403,933