Reforming the Community Benefit Standard for Nonprofit Hospital Tax Exemption

by

Daniel B. Rubin

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Doctoral Committee:

**Assistant Professor Nicholas Bagley, Co-Chair
Assistant Professor Simone Rauscher Singh, Co-Chair
Professor John R. Chamberlin
Associate Professor Scott E. L. Greer
Professor Gary J. Young, Northeastern University**

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TABLE OF CONTENTS

Chapter 1 Introduction..1

Chapter 2 Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice..4

Chapter 3 Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption....................................29

Chapter 4 An Outcome-Based Approach to Nonprofit Hospital Tax Exemption............43

Chapter 5 Conclusion 108

CHAPTER 1

Introduction

The community benefit standard for nonprofit hospital tax exemption is the touchstone for nonprofit form of organization of healthcare providers. For hospitals and health systems, is the sine qua non of nonprofit status. Under IRS regulations not for profit healthcare providers must satisfy this standard to maintain their exemption. Despite its importance, the standard as it currently exists is highly problematic. It was established with limited public discussion or policy deliberation and in a time when the healthcare industry was very differently constituted than it is today. Due to the drastic changes which have accrued in the decades since the community benefit standard was established, as well as the more recent dramatic changes brought about by the affordable care act, a reexamination of the community benefit standard for nonprofit hospital tax exemption is timely.

This dissertation will consist of three papers. The first of these is a review article. It is entitled "Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice" and co-authored with Simone Rauscher Singh and Gary Young. This piece was an invited article for the Annual Review of Public Health. Currently, a draft of the paper, revised on the basis of peer review comments, has been resubmitted to the journal. This article first lays out the historical and legal development of the community benefit standard for nonprofit hospital tax exemption in the United States. It then introduces the various controversies that exist

surrounding the adequacy of tax-exempt hospitals' current provision of community benefits to the populations they are supposed to serve. This is followed by a discussion of recent legal and policy developments surrounding tax-exemption of nonprofit hospitals, including how expanded reporting, new exemption requirements and a recent increase in litigation over community benefit at the state and local level have reshaped the environment for the nonprofit sector. Finally, the paper lays out future policy directions for community benefit and tax exempt hospitals.

The second paper of the dissertation is entitled "Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption." It was co-authored with Simone Rauscher Singh and Peter D. Jacobson. It was published in the American Journal of Public Health in April of 2013. The article argues that expanding the current input-based reporting requirement to include not only monetary inputs but also population health outcomes would achieve greater benefit for society. The article first provides an introduction to the role that nonprofit hospitals play in our society and then explains the history and development of the community benefit standard. It then suggests that the community benefit standard, as it is currently constituted, encourages hospitals to have an undue focus on monetary inputs. It argues that we instead adopt a modified approach based on both input and outcome measures would require hospitals to design community-benefit programs that make a measurable difference in the health of their respective communities. It then proceeds to identify possible challenges which could be faced by an outcome based approach to community benefit.

The final chapter of this dissertation is a law review article. It is provisionally entitled "An Outcome Based Approach to Nonprofit Hospital Tax Exemption." It argues that an

outcome-oriented approach to community benefit could provide a better regulatory model for nonprofit hospital tax exemption. The first part of this chapter is devoted to the current legal standard for tax-exemption of nonprofit hospitals. It relates in detail the historical development of the community benefit standard and how that development was mired by path dependences and lack of thoroughgoing policy analysis. It then examines the various theories that have been put forward to justify the nonprofit form. This is followed by an exploration of the case law that has been generated by litigation over hospitals community benefit obligations. Finally, the first section concludes with a review of the empirical literature. The second section of the article puts forward a new, outcome-oriented approach to community benefit and then explores its application to this area of law. It does so by first examining competing alternative models for community benefit reform, then exploring the strengths and weakness of an outcome-oriented approach. Next is an exploration of the policy ramifications of a such an approach. Finally, the new approach is applied to a number of illustrative cases to show how they could have been better resolved with an outcome-oriented model.

CHAPTER 2

Tax-Exempt Hospitals and Community Benefit: New Directions in Policy and Practice

Abstract

The current community benefit standard for nonprofit hospital tax exemption has been the subject of mounting criticism. Many different constituencies have advanced the view that in its present form it fails to ensure that nonprofit hospitals provide adequate benefits to their communities in exchange for their tax exemption. In contrast, hospitals have often expressed the concern that the community benefit standard in its current form is vague and therefore difficult to comply with. A variety of suggestions have been made regarding how the existing community benefit standard could be improved or even replaced. In this article, we first discuss the historical and legal developments of the community benefit standard. We then present the key controversies that have emerged in recent years and the policy responses attempted thus far. Finally, we evaluate possible future policy directions which efforts at reform could follow.

Introduction

Nonprofit hospitals represent an important group of organizations in the United States. Nearly 60 percent of the approximately 5,000 acute care hospitals in the US are private, nonprofit entities (1). They are vital to the health and welfare of millions of Americans (64), and constitute a major portion of the US economy. Significantly, almost all nonprofit hospitals in the

US are exempt from paying federal, state, and local taxes. The Joint Committee on Taxation estimated that tax exemptions for all nonprofit hospitals totaled $12.6 billion in 2002, and the value of these exemptions have only grown since (23). About half of this amount is constituted of exemptions from federal income taxes. The rest is from state and local tax exemptions, which include income, property and sales taxes (64).

In exchange for these tax exemptions, there exists a general expectation that nonprofit hospitals will provide community benefits. However, the amount and type of these benefits are a source of ongoing controversy involving policy makers, community groups, and tax-exempt hospitals (25, 46). Current tax exemption standards for nonprofit hospitals, both federal and local, are beset by certain inherent ambiguities. They also are out of step with the current health needs of communities and the market conditions faced by hospitals as most were designed for the healthcare environment as it existed several generations ago (56). Because of these limitations, current exemption standards pose compliance challenges for hospitals and, we argue, fail to ensure that hospitals provide adequate benefits to the communities they serve. A revision or replacement of the current tax-exemption standards for nonprofit hospitals is thus timely.

In this article, we first discuss the historical and legal development of the community benefit standard. We then present some of the controversies that have emerged over the existing community benefit standard as well as recent policy and legal developments which have arisen because of these controversies. Finally, we discuss and evaluate possible future policy directions which efforts at reform could follow.

Historical and Legal Development of the Community Benefit Standard

Nonprofit hospitals in the US qualify for tax exemption as charitable organizations. At the federal level, the United States Code title 26, Section 501, subsection (c), specifies charitable organizations as one of several types of entities that qualify for tax exemption (63). Nonprofit hospitals also qualify for tax exemption at the state and local level based on their charitable status (27, 36). Both federal and local standards for charitable organizations are largely grounded in the common law doctrine of charity (20). The common law meaning of charity is that it is for the benefit of an indefinite number of people (30). Public benefit thus is the essential feature justifying the special status of the charitable enterprise.

Federal and local standards for determining whether a nonprofit hospital qualifies as a charitable organization have evolved over time. For many years, the Internal Revenue Service (IRS), the federal agency that determines whether organizations qualify for federal tax exemption, required that nonprofit hospitals be "operated to the extent of [their] financial ability for those not able to pay for services rendered (31)." Thus, hospitals demonstrated their charitable nature by giving health care to people who were unable to pay (68). This was, in fact, the primary function of hospitals through the late 19th and early 20th centuries. Most hospitals at the time were religious, explicitly charitable organizations dedicated strictly to helping those without alternative sources of medical care. The wealthy, by contrast, received medical attention in their homes (59). However, even as medical technology expanded the clinical capabilities of hospitals so that they became an important source of care for non-indigent patients, hospitals' tax exemption continued to be justified by their commitment to providing care to all individuals regardless of financial means (6).

The creation of the country's two largest public health insurance programs, Medicare and Medicaid, in the mid-1960s led to a change in the federal tax-exemption standard for nonprofit hospitals. At the time, many policy makers and health care analysts were of the opinion that these new federal programs would provide adequate insurance coverage to most of the country's poor and thus significantly reduce the need for hospital-based charity care (12). This possibility raised questions as to what nonprofit hospitals would do in the future to qualify as charitable organizations for purposes of tax exemption. In 1969, the IRS introduced a new tax-exemption standard, the community benefit standard, for determining whether hospitals qualify as charitable organizations for purposes of I.R.C. Section 501(c)(3) (13, 32).[1] This standard, still in use as of this writing, puts forth an expanded view of hospitals' potential contributions to the communities they serve based on the concept that such institutions promote health. The standard includes the provision of charity care as only one of several exemption-related criteria:

- Operate a 24 hour emergency room;
- Provide charity care to the extent of the hospital's financial ability;
- Extend medical staff privileges to all qualified physicians in the area, consistent with the size and nature of the facility;
- Accept payment from Medicare and Medicaid programs on a non-discriminatory basis; and
- Maintain a community-controlled board (i.e., a governing board with membership, by appointment, primarily from the local community).

The standard does not require that each criterion be satisfied in all circumstances. Moreover, in 1983 the IRS issued a ruling holding that hospitals without emergency rooms could still be eligible for exemption under certain circumstances (33). By the early 1980s as well, predictions that the Medicare and Medicaid programs would largely eliminate the need for

[1] To qualify for tax-exempt status under I.R.C. 501(c) (3) entities must meet organizational and operational tests, the latter requiring that the entity be operated primarily to accomplish one of its exempt purposes. For hospitals, the community benefit standard is an element of the operational test. The operational test also prohibits private inurement and benefit, and also includes limitations on political activity by exempt organizations (32).

hospital-based charity care proved to be incorrect as a large population of uninsured individuals continued to exist in the US (40). As such, the provision of charity care continued to be seen by many policy makers, community leaders, and members of the general public as an important, if not the most important, community benefit activity of tax-exempt hospitals (6).

While the IRS' community benefit standard serves as the federal requirement for the tax exemption of nonprofit hospitals, states are free to set their own requirements for exemption from state and local taxes. There is some variety among state and local standards, but certain larger trends are discernable. Many states have chosen to emulate the federal standard. Indeed, some states automatically grant tax-exempt status to any hospital that has been deemed by the IRS to be in compliance with the federal standard (11).

Among the states that have departed from the federal standard, two trends have emerged. A handful of states, such as Nevada, Texas, and Virginia, have established minimum standards that all nonprofit hospitals must meet if they are to retain their tax- exempt status (41, 61, 67). Texas is widely regarded to have the most aggressive and detailed requirements. Texas law requires, inter alia, that charity care and shortfalls from government sponsored indigent-care programs equal at least four percent of hospitals' net patient revenue or, alternatively, one hundred percent of the value of the hospital's state tax exemption (62). The other broad trend at the state level is the increasing prevalence of mandated disclosures by hospitals of their community benefit activities to government agencies, and also, often the public at large. More than half of all states require that hospitals make some sort of disclosure of their community benefit activities.

Controversy over Tax-Exempt Hospitals' Provision of Community Benefits

For at least the last 30 years, there has been much controversy regarding whether tax-exempt hospitals meet their community benefit obligations as set out by federal and local standards (46). Policy makers and community leaders have often accused tax-exempt hospitals of providing inadequate community benefits, such as charity care (11). In addition, there have been related criticisms leveled at tax-exempt hospitals pertaining to their investments in for-profit business ventures, aggressive billing and debt collection practices, and compensation arrangements for senior administrators (24). The resulting controversy has sparked both governmental hearings and media scrutiny (19).

A key consideration underlying this controversy is the fact that federal and most state and local exemption standards lack explicit criteria regarding what is expected of tax-exempt hospitals in terms of their management practices and community benefit activities. Moreover, no consensus exists on the primary rationale for why, as a society, we extend tax exemption to nonprofit hospitals. Some commentators contend that tax exemption should be seen as a quid pro quo between hospitals and communities thereby requiring hospitals to provide a certain amount of community benefit in exchange for tax exemption (70, 71). However, others believe nonprofit hospitals are deserving of tax exemption for embodying a fundamental charitable character that cannot be measured in financial terms or otherwise quantified (13, 50-52).

The controversy over whether tax-exempt hospitals meet their community obligations has generated numerous empirical studies. Much of this research has provided only a partial picture of tax-exempt hospitals' community benefits, mainly because of disagreement regarding what should count as a community benefit and the lack of adequate data (8, 48). A recent study, national in scope and based on 2009 IRS tax filings, found that tax-exempt hospitals devoted an

average of 7.5 percent of their expenditures to community benefits as defined by the IRS (69). Of these expenditures, more than 85 percent went toward charity care, government payer payment shortfalls, and subsidized health services. The remaining 15 percent went toward community health improvement activities, health professions education, and medical research. The level and composition of community benefits provided, however, varied widely both across hospitals and states (2, 3, 69). A related line of studies also compared the provision of community benefits between tax-exempt hospitals and investor-owned hospitals. On average, tax-exempt hospitals do appear to spend more on charity care as a percentage of their operating budgets than their investor-owned counterparts but the difference tends to be small. Additionally, the difference between tax-exempt and investor-owned hospitals appears to be even smaller when the comparison includes bad debt as well as charity care. Both tax-exempt and investor-owned hospitals incur bad debt that is attributable to treating patients who lack adequate health insurance but do not meet the hospital's charity care guidelines. If such patients do not ultimately pay all or some portion of the bill for their care, the unpaid charges are written off as bad debt. However, because most hospitals have discretion to set their own charity care guidelines as they see fit, the distinction between charity care guidelines and bad debt is not well defined. As such, in comparison to tax-exempt hospitals, investor-owned hospitals may have more stringent criteria for patients seeking charity care and so have relatively lower charity care expenditures but ultimately face comparable costs for treating indigent patients due to relatively higher levels of bad debt (5, 14, 16, 18, 22, 28, 49, 53, 58, 60).

Studies have also been conducted to assess the adequacy of tax-exempt hospitals' community benefits compared to the value of the tax exemptions they receive. These studies have produced mixed results (17, 26, 39, 42, 55). While a few studies have found that greater tax

benefits are associated with more charitable spending, most studies have concluded that tax-exempt hospitals' community benefits fall short when compared to the absolute value of their exemptions. The conclusions that these studies have drawn regarding the adequacy of tax-exempt hospitals' community benefits, however, depend on how broadly community benefit was defined and how the value of a hospital's tax exemption was estimated.

Recent Policy and Legal Developments Regarding Tax-Exemption for Nonprofit Hospitals

Expanded Reporting

Federal and state policy makers have generally responded to the previously noted controversy through regulatory actions and lawsuits aimed at increasing the accountability and oversight of tax-exempt hospitals with respect to their community benefit activities. At the federal level, one recent initiative is the expansion of reporting requirements contained in IRS Form 990. Form 990 is a tax form that all exempt organizations must submit (34). In 2007, the IRS created a related schedule for Form 990, Schedule H, to improve the transparency of the community benefits that tax-exempt hospitals provide (35). The IRS created Schedule H at least in part as a response to calls from numerous policy makers for greater transparency regarding the community benefit activities of tax-exempt hospitals (74). Among those calling for greater transparency was Senator Charles Grassley, who, at the time, served as chairman of the Senate Finance Committee which held hearings in 2006 regarding community benefits provided by tax-exempt hospitals (75).

IRS Form 990-H requires that hospitals disclose their expenditures for two broad categories of community benefits (35). The first comes under the rubric of "Financial Assistance and Means-Tested Government Programs" and the second comes under the broad category of

"Other Benefits." Under the first category, tax-exempt hospitals are asked to report on financial assistance at cost, the unpaid costs of providing care to Medicaid, and the costs of other means-tested government programs. Under the "Other Benefits" category tax-exempt hospitals are asked to report the unreimbursed costs of community health improvement services and community benefit operations, health professions education, subsidized health service, research, as well as any cash and in-kind contributions for community benefit.

While, as noted, many states have community benefit reporting requirements for hospitals that cover many of these same categories, IRS Form 990 Schedule H establishes uniform reporting requirements for all tax-exempt hospitals in the US and thus constitutes an important new source of data for monitoring tax-exempt hospitals' provision of community benefits. As of yet, the IRS has not made clear how it will use the Schedule H data, but it is possible that simply having to report such information may have an effect on tax-exempt hospitals' behavior.

New Exemption Requirements

Congress has established new requirements that nonprofit hospitals must follow to maintain their federal tax exemption. These requirements, now codified as I.R.C. Section 501(r), were included in the Patient Protection and Affordable Care Act (hereafter referred to as the ACA), the comprehensive health reform law that was enacted in 2010. This law conditions hospitals' eligibility for tax-exempt status on their ability to meet four basic requirements: (1) complete a community health needs assessment (CHNA) every three years and develop an implementation strategy to address identified needs; (2) establish and publicize a written financial assistance policy (FAP) and emergency medical care policy that meet certain statutory

requirements; (3) limit amounts charged for emergency and other medically necessary care provided to individuals eligible for assistance under the hospital's financial assistance policy to no more than amounts generally billed to insured individuals; and (4) make reasonable efforts to determine whether an individual is eligible for the hospital's financial assistance policy before engaging in extraordinary collection actions (46, 57).

Among these new requirements, the requirement for hospitals to conduct a community health needs assessment is particularly relevant to the issue of whether and how tax-exempt hospitals are meeting their community benefit obligations. However, as of this writing, the IRS is still largely in the process of implementing 501(r) requirements through final regulations. It remains to be seen whether, and if so, how the IRS or state and local tax authorities will decide to use hospitals' community health needs assessments in making determinations of their tax-exempt status. However, this has not stopped community stakeholders from taking action. One recent example is the case of The National Health Law Program, which along with Florida Legal Services has filed an administrative complaint with the IRS against Jackson Health Systems of Miami-Dade County, Florida. The complaint alleges that the health system is not meeting its charity care obligations under the ACA. Jackson Health System is further accused of subjecting poor Miami-Dade residents to aggressive collection practices, despite the fact that they should have qualified for its financial assistance program (72). The emergence of administrative complains such as this one, brought pursuant to the ACA, may force hospitals to more critically examine the adequacy of the community benefits they provide.

Litigation

In addition to new exemption and reporting requirements at the federal level, state and local governments also have responded to controversies regarding tax exemption for nonprofit hospitals. Many states have established reporting requirements for tax-exempt hospitals that cover at least some of the information hospitals are now required to report in Form 990 Schedule H (45). Additionally, there have been several high profile lawsuits by municipalities that have challenged the property tax exemption of nonprofit hospitals on the ground of inadequate community benefit. While such litigation has not been widespread, certain prominent cases have emerged in recent years. These cases may be indicative of the kinds of issues that exist at the local level as hospitals and the communities they serve find themselves in the position where they have differing interpretations or understandings of what sort of community benefit should be provided by the hospitals. These divergent understandings of community benefit have emerged at a time when municipalities have been facing increasing costs for local services and funding of public employees' pensions and retiree health benefits. Thus, cash-strapped municipalities now have additional incentives for viewing nonprofit hospitals, with their very valuable real estate holdings, as potential sources of revenue.

Three examples of community benefit litigation are particularly noteworthy. Two of these were litigated to completion several years ago. These include *Utah County v. Intermountain Health Care, Inc.* and *Provena Covenant Medical Center v The Department of Revenue*. A third and more recent case stems from the dispute between the University of Pittsburgh Medical Center and the City of Pittsburgh.

Utah County v. Intermountain Health Care, Inc. presents significant issues regarding the justification for property tax exemption. Intermountain Health Care (IHC) is a nonprofit

corporation, which operates twenty-two hospitals in Utah and one in Idaho (66). When IHC applied for tax-exempt status, the Utah County Board of Equalization found that two of IHC's hospitals were not eligible. The matter proceeded through several rounds of appeals, eventually reaching the state Supreme Court. The dispositive issue in IHC was a constitutional one, namely whether the Utah statutes governing tax exemption impermissibly expanded the constitutionally defined meaning of "charitable purposes" when it made the sweeping generalization that all hospitals acted for charitable purposes (65). The Utah Supreme Court held that charity requires the existence of a gift to the community, not just community benefit (66). In its ruling, the Court highlighted the fact that, though IHC had a policy of treating everyone regardless of ability to pay, due to the overall paucity of charity care, along with efforts to keep charity care levels as low as possible IHC's provision of charity care was inadequate.(66) The Court explicitly excluded discounted care as charity care, quoting an earlier case: "Where material reciprocity between alleged recipients and their alleged donor exists--then charity does not."(66) The court found that IHC was not in any substantive way different from an investor-owned hospital.(66) The court also struck down the statute at issue as an unconstitutional expansion of the narrow exemption in the Utah Constitution.(66)

Provena Covenant Medical Center v The Department of Revenue (2010) has been a watershed case for community benefit law (44). In *Provena,* litigation ensued between a nonprofit healthcare provider and the State of Illinois, following a determination by the Champaign County Board of Review that the health system's provision of community benefits was insufficient. The Illinois Supreme Court held that there is indeed a minimum threshold for benefit to the community, though it did not go so far as to state what that minimum is. In its ruling the court castigated Provena for the inadequacy of its charitable activity. The Provena case

has reshaped the legal landscape for tax-exempt health-care providers in Illinois. It has spurred greater regulatory scrutiny of healthcare providers, and given hospitals reason to scrutinize carefully the adequacy of their own community benefit practices.

One recent case involved a dispute between the City of Pittsburgh and the University of Pittsburgh Medical Center (UPMC) (4). In recent state litigation, the City of Pittsburgh demanded both the withdrawal of the medical center's tax exempt status and the payment of back taxes. The litigation focused on the meager nature of UPMC's community benefit provisions as well as the disproportionate compensation of its executives. The latter, it is alleged, is an indication that the institution is not being run as a charity. UPMC responded by filing its own law suit in federal court alleging violation of its civil rights by the City of Pittsburgh. Following the counter-suit, both parties entered into negotiations and eventually both cases were dropped. (76) This example is nonetheless indicative of the kinds of controversies which may emerge as cash-strapped municipalities turn increasingly to large nonprofit hospitals as potential sources of revenue.

Future Policy Directions for Community Benefit and Tax-Exempt Hospitals

Since 1969, when the IRS adopted the community benefit standard, much has changed in the US healthcare system generally and for nonprofit hospitals specifically. No longer almshouses for the poor, nonprofit hospitals today are typically large corporate entities with complex business operations and financial structures. As such, they compete with a substantial investor-owned health care sector that includes hospitals, freestanding ambulatory surgical centers, and diagnostic imaging centers (29). Moreover, nonprofit hospitals are facing growing pressures from public and private payers to redefine their role in the US healthcare system.

Among these pressures is the expectation that hospitals take broader responsibility for the health of the populations they serve (54). Hospitals are encouraged, for instance, to form or join accountable care organizations (ACOs), which offer participating providers financial incentives to meet spending and quality targets by managing the health status of a defined population (43).

Together, these developments have raised new issues and concerns regarding the adequacy of the community benefits that nonprofit hospitals provide in return for tax exemption. Indeed, while controversy over the community benefits of tax-exempt hospitals is long standing, it appears to have reached new heights in recent years. This is evinced by the governmental hearings and media attention devoted to the topic and the percolation of litigation at the local level over the property tax exemption of nonprofit hospitals (24). As such, this may be an opportune time to reevaluate current tax-exemption standards and seriously discuss new policies for tax-exemption as applied to nonprofit hospitals. In the remainder of this article, we outline three areas for reform that would help ensure that the community benefits provided by tax-exempt hospitals meet the needs of their communities: (1) increasing transparency regarding nonprofit hospitals' provision of community benefits via wider public availability of data, (2) fostering accountability by establishing standards for what community benefits may justify healthcare providers' tax-exempt status, and (3) improving population health by encouraging hospitals to attend to the broader health needs of the communities they serve.

The first potential area for reform concerns increasing transparency. As a result of advances in information technology, detailed data on the state of health and health care in the US is increasingly becoming publicly available. Greater availability of information, however, does not always translate into improved transparency. In the case of tax-exempt hospitals' community benefit reporting on Form 990 Schedule H, for instance, detailed information on hospital

expenditures is available, yet the information itself is not readily accessible to individuals and groups that may have an interest in the activities of tax-exempt hospitals. As noted, the IRS has not articulated a plan for how it will utilize data from Form 990 Schedule H. Nor has it taken steps to make the information readily available to communities. At present, the public can only access Schedule H information by obtaining the reports directly from hospitals or through data vendors, such as GuideStar, both of which can be time consuming and costly. Similarly, among states that require tax-exempt hospitals to report on their community benefit activities, there is variation as to the public accessibility of the reported information. Some states, such as California and Maryland, foster transparency by making all data publicly available online (9, 38).

Given the availability of information regarding hospitals' community benefit activities, federal and state agencies should consider taking steps to compile these data and make the information available to the public in an easily accessible online database, ideally free of charge. Such a database would greatly increase transparency and as a result inform civic dialogue regarding the role that nonprofit hospitals do and should play in their communities. Increased transparency also would ensure continued scrutiny of the adequacy of tax-exempt hospitals' community benefit activities. As an example, one can look to the significant advances that have been made in the transparency of performance data for health care providers, particularly quality of care. Today, community groups and individual consumers can access websites that offer a wide range of information pertaining to the quality of care furnished by hospitals, physicians, and types of healthcare providers (21). While providers frequently have concerns about the validity of the performance measures posted on such websites, increased transparency has itself spurred more effort in developing better performance measures (73).

A second potential area for reform concerns increasing accountability through the development of clear expectations for tax exemption for nonprofit hospitals. The federal and most local tax exemption standards generally lack explicit criteria regarding what is expected of tax-exempt hospitals in terms of their organizational structure and activities. In the absence of clear expectations, communities will continue to question whether the community benefits that tax-exempt hospitals provide are adequate when compared to the value of their federal, state, and local tax exemptions. At the same time, tax-exempt hospitals will continue to be vulnerable to government inquiries, lawsuits, and media scrutiny regarding their community benefit activities.

Increasing accountability may involve developing clear, well-defined expectations for tax-exempt hospitals. One approach might be for the IRS to adopt quantitative standards for the amount and composition of hospitals' community benefit expenditures required in exchange for tax exemption. The benefit of such an approach is that federal-level quantitative standards would be fairly unambiguous and thus relatively easy to apply to determine tax exemption. Several states, including Pennsylvania, Utah, and Texas, have adopted explicit quantitative standards that nonprofit hospitals must meet or exceed to remain tax-exempt at the local level (11, 27). However, explicit quantitative standards represent a "one size fits all" approach that may not result in the optimal level and types of benefit for an individual community. Health needs differ across communities and some variation in the composition of community benefits provided by nonprofit hospitals is thus desirable. Federal standards bear the risk that hospitals may focus their efforts on the activities that "count" for the purpose of tax exemption rather than the ones that are most needed. Moreover, explicit quantitative standards can result in a "race to the bottom" when hospitals that have historically provided high levels of community benefits reduce their efforts to the level required for tax exemption. In Texas, for instance, where there are explicit standards for

how much community benefit is required of nonprofit hospitals to remain tax-exempt at the local level, hospitals with spending levels above the threshold level have been found to lower their community benefit spending (37).

Alternatively, an approach to increase accountability might be to avoid establishing explicit quantitative criteria at the federal level and instead encourage states or even communities to define the expectations for tax-exempt hospitals. This would avoid the problems of a "one size fits all" approach discussed above. State or local level policymakers could define standards based on the unique health needs of their populations. The community health needs assessments that tax-exempt hospitals are required to conduct every three years for the purpose of federal tax exemption might provide useful information to policymakers on the most pressing health needs of a community. Specific needs identified in hospitals' CHNAs might be helpful to develop and continuously update state or local-level standards to ensure that the community benefits hospitals provide meet the most pressing needs of their communities.

Of course, state or local-level standards may still result in a "race to the bottom." To avoid this situation, it might be possible to define standards not in terms of financial resources spent by a hospital on community benefits but in terms of the outcomes achieved as a result of a hospital's community benefit activities (47). This would entail evaluating the consequences and the health benefits ensuing from hospitals' community benefit activities to determine their adequacy rather than focusing merely on their dollar amounts spent. Moving away from an input-oriented approach toward a more outcome-oriented evaluation of hospitals' community benefits, however, represents a major paradigm shift. Improved availability and accessibility of data at the community level, for instance, in the form of the County Health Rankings (15), may

enable such a shift, yet at this point no state or local entity has made tax exemption partially or fully conditional on the achievement of predefined health outcomes.

Focusing on outcomes rather than inputs also would be a first step toward achieving our third area of reform, ensuring that the community benefits that tax-exempt hospitals provide contribute to meaningful improvements in population health. This area of reform is closely linked to broader changes in how health care in the US is organized and financed. There is growing recognition that the prevailing medical model of focusing on treatment and cure at the expense of prevention and health promotion is ineffective and unsustainable. Broad efforts to reform the US health system thus include calls for increased attention to population health (7). While hospitals have historically focused on providing inpatient care to acutely ill patients, they are now facing growing pressures to move beyond caring for individual patients to take broader responsibility for the health of the population they serve (54). This paradigm shift has become evident in new reimbursement initiatives launched by both public and private payers. The Medicare Shared Savings Program, for instance, offers providers involved in an accountable care organization (ACO) financial incentives to manage the health of a defined population of Medicare beneficiaries in- and outside of the hospital (10). Medicaid and private payers have established similar reimbursement arrangements whereby participating providers are paid – at least in part – for keeping patients healthy and out of the hospital.

Hospitals' community benefit activities have the potential to play an important role in the country's efforts to improve population health. First, in their CHNAs, all tax-exempt hospitals should now be regularly identifying the most pressing health needs of their communities. This is an important starting point. In addition, as part of their CHNAs, hospitals are required to develop an implementation strategy to meet the community health needs identified through the CHNA.

These strategies will ideally contribute to meaningful improvements in the health of the communities served. Second, as the ACA takes effect and the number of uninsured Americans declines the demand for hospital-based charity care should also decline. While the magnitude of these changes is not yet foreseeable, hospitals may be able to use any savings achieved to invest in community activities that benefit the health of their communities more broadly. Third and lastly, targeting community benefit activities to address the most critical needs of the community will not only help a hospital fulfill federal, state, and local expectations for tax exemption but also support their efforts to keep patients healthy. While in the past, keeping patients healthy and out of the hospital has been bad for business, in this new era, improving population health directly supports hospitals' related efforts undertaken as part of ACO or similar reimbursement arrangements.

Conclusion

We appear to be entering a new era regarding the nexus between tax-exemption for nonprofit hospitals and community benefits. As noted, the last major change to the federal tax-exemption standard occurred in 1969. Since then, a great deal has changed in terms of the delivery of healthcare and its funding, as well as the expectations which society has regarding how health is to be maintained and improved. Likewise, a significant expansion has occurred in the information that is now available to policymakers and the public for reviewing the community benefit activities of tax-exempt hospitals. Yet, the long-standing controversy over whether tax-exempt hospitals meet their community benefit obligations has only become more intense in recent years. This controversy will likely continue as long as federal and most local exemption standards lack clearly defined expectations for nonprofit hospitals. Therefore, an examination of

current tax-exemption standards for nonprofit hospitals relative to the promotion of community benefits is timely.

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CHAPTER 3

Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption

Abstract

Nonprofit hospitals are exempt from federal income taxation if they pass organizational and operational tests, including satisfying the community-benefit standard. Policymakers, however, have questioned the adequacy of the community benefits that nonprofit hospitals provide in exchange for these exemptions.

The Internal Revenue Service recently responded to these concerns by redesigning its tax forms for nonprofit hospitals. The new Form 990 Schedule H requires nonprofit hospitals to provide additional information about their community-benefit activities. This new reporting requirement, however, places an undue focus on input-based community-benefit indicators, in particular expenditures.

We argue that expanding the current input-based reporting requirement to include not only monetary inputs but also population health outcomes would achieve greater benefit for society.

Introduction

Nonprofit hospitals are vital to the health and welfare of millions of Americans (1) and constitute a major portion of our economy (2). The tax exemption that these institutions received was worth $12.6 billion in 2002 and has subsequently grown (3). To remain tax-exempt,

nonprofit hospitals have to meet the Internal Revenue Service's (IRS's) community-benefit standard, which grants health care organizations tax exemptions in exchange for engaging in activities that promote health for the benefit of the community (4).

Policymakers have recently started to question the adequacy of the community-benefit activities that nonprofit hospitals provide in exchange for their substantial tax exemptions. The IRS responded to these concerns by redesigning its federal tax return for nonprofit hospitals, Form 990, and adding Schedule H (5). However, this new reporting requirement only partially achieves its policy objective because it is hampered by an undue focus on input-based indicators of community benefit, in particular how much nonprofit hospitals spend on community-benefit activities. The current standard does not assess the health outcomes that these community-benefit activities do or do not help to achieve. The community-benefit standard would provide a more meaningful evaluation of hospitals' community-benefit activities if it complemented input-based measures of community benefit with information on population health outcomes, thereby better effectuating the standard's original policy goals and achieving greater benefit for society (6).

A standard that includes input as well as outcome measures would offer significant incentives for nonprofit hospitals to increase public benefit. A new community-benefit standard should thus take a more balanced approach, evaluating both input and outcome-related measures, which show how benefit accrues to the public. A more robust conception of community benefit, with tighter criteria for inclusion and exclusion of potential population benefits, would help facilitate this transition.

Provisions in the Patient Protection and Affordable Care Act (ACA) have modified the community-benefit standard to include measures of both input and outcomes. As of this year, nonprofit hospitals are required to conduct regular community-health needs assessments and

implement improvement plans, which may provide some of the information necessary for a meaningful evaluation of the outcomes of a hospital's community-benefit initiatives (7).

Policymakers at both the federal and state level have many tools at their disposal to help make the community-benefit standard more outcome-focused. The IRS, for instance, could require nonprofit hospitals to complement their community-benefit expenditures disclosed in Form 990 Schedule H with a detailed report on the population health outcomes of their community-benefit activities. Federal and state governments could then use this information when deciding whether to grant nonprofit hospitals tax exemptions.

Overview of Nonprofit Hospital Tax Exemption

Federal policy supports charitable organizations through tax exemptions as a way of furthering policy goals. These tax exemptions are codified in Section 501(c)(3) of the Internal Revenue Code (8). Historically, the goal of this policy has been to give nonprofit hospitals incentives to provide additional benefits to their communities beyond providing health care service in exchange for reimbursement.

Originally, for an entity to be tax-exempt, it either had to fit into one of the enumerated categories contained in Section 501(c)(3) (educational, religious, etc.) or else be charitable (9). Charitable had 2 meanings: either broad-based public benefit or alleviation of poverty (9). When hospitals were in the business of providing free care to the poor, they fit neatly into the alleviation of poverty category. In 1956, the IRS codified this qualification in the financial-ability standard, which required hospitals (to the extent financially possible) to provide health care to those who would otherwise be unable to afford it (10).

Because of changes in both the practice of medicine and the financing of health care,

hospitals evolved out of the parameters of the exemption they had once received. In its 1969 Revenue Ruling, the IRS introduced a new standard for tax exemption, the community-benefit standard, which grants health care organizations tax exemptions in exchange for engaging in activities that promote health for the benefit of the community (4). To be granted tax exemptions, nonprofit hospitals generally have to meet all of the following criteria:

1. operate an emergency department that cares for anyone, regardless of ability to pay;
2. provide nonemergency department care for anyone who can pay;
3. participate in Medicare and Medicaid;
4. create a governing board that represents the community;
5. allow any qualified professional who applies to receive medical-staff privileges; and
6. reinvest surplus funds, rather than disseminate them as dividends (11).

In 1983, the IRS determined that hospitals without emergency departments could be considered tax-exempt if all other factors were satisfied (12). Moreover, not all of the factors have to be satisfied in every circumstance because the IRS can make determinations on a case-by-case basis (12). Despite the broad scope of the community-benefit standard, many nonprofit hospital leaders still consider community benefit to be largely synonymous with charity care despite the fact that they are no longer required to provide such care to qualify for tax exemptions (13).

In addition to federal income tax exemptions, states and localities frequently grant nonprofit hospitals exemptions from state income and local property taxes. Although in principle federal and state tax systems are separate, a number of states and localities automatically grant tax exemptions to hospitals that have been awarded 501(c)(3) tax-exempt status by the IRS (14).

Policymakers at the federal, state, and local levels are concerned that the current standards used to determine whether nonprofit hospitals receive tax-exempt status do not achieve their full policy objective of promoting health for the benefit of the community. As any tax exemption shifts the tax burden from the tax-exempt entity to the rest of the tax-paying

community (15), there must be a compelling justification for any tax exemption (16). Sen Charles Grassley (R, Iowa) stressed this point during a hearing in 2006 on nonprofit tax exemptions (16). Moreover, once the ACA takes full effect, a substantial number of currently uninsured people are expected to gain health insurance coverage (17), which will reduce the need for charity care in many communities. Nonprofit hospitals in these communities will thus be required to seek alternative avenues for providing community benefit if they wish to remain tax-exempt.

Undue Focus on Monetary Inputs

In 2008, the IRS revised its Form 990 and added Schedule H, which henceforth requires hospitals to disclose their community-benefit activities in detail (18). This new reporting requirement is intended to enable the IRS to better assess hospitals' compliance with the community-benefit standard (12).

In Schedule H, nonprofit hospitals are required to report on the care provided to charity patients and patients covered under means-tested government programs such as Medicaid and the Children's Health Insurance Program. In addition, hospitals are asked to report on select other community-benefit activities, including subsidized health services, community health improvement services, medical research, and health professions education (18). At a minimum, nonprofit hospitals are required to disclose their net community-benefit expenditures, which is their total expenditures minus any direct offsetting revenues (19). Furthermore, hospitals may choose to provide additional information such as the number of activities they engaged in during the reporting period and the number of people served through their community-benefit programs (19). The fact that the IRS now asks for an account of a broad range of community-benefit

activities signifies some recognition of the notion that the term community benefit not only includes charity care but also encompasses other services aimed at improving the health and well-being of the community at large.

Form 990 Schedule H, as it exists currently, focuses on inputs to assess the adequacy of a hospital's community-benefit activities. Inputs, both monetary and nonmonetary, play a crucial role in improving community health. In addition, from the perspective of the IRS, inputs are easy to measure and, more importantly, do not require risk adjustment and are thus less susceptible to gaming (19). However, committing additional resources to community-benefit activities does not always result in better population-health outcomes. We therefore argue that the community-benefit standard should be expanded to include not only input-based but also outcome-related measures. A combination of input and outcome metrics would allow policymakers to better evaluate whether a hospital's community-benefit activities are actually generating benefits for the community. For example, a nonprofit hospital may report that it spent $50 000 on workforce development. This number and the accompanying financial data, however, indicate nothing about whether the program created any real benefit. Based on the expenditure information reported in Schedule H alone, there is no way to accurately identify how many individuals were trained, what they were trained in, and whether they were successfully placed in jobs.

Rather than evaluating community benefit solely in terms of dollars spent, a modified approach based on both input and outcome measures would require hospitals to design community-benefit programs that make a measurable difference in the health of their respective communities. Such an approach would assess hospitals' achievements by measuring both dollars spent on the set of community-benefit activities defined in Form 990 Schedule H and improvements in a number of health-outcome indicators tied to the specific community-benefit

activity. Reforms of this type are already under way at the state level. Maryland, for instance, passed legislation in 2012 that requires hospitals to describe their efforts to track and reduce health disparities within their communities as part of their community-benefit reports (20).

Challenges of an Outcome-Based Approach

Complementing the current input-based approach to nonprofit-hospital tax exemption by also assessing hospitals' performance on a number of health outcomes brings with it certain challenges, among them the problems of 1. How population-health outcomes can be measured, and 2. How these outcomes can be attributed to individual hospitals and their community-benefit initiatives.

With respect to the first challenge, measuring health outcomes is the routine work of epidemiologists. Scholars have already provided compelling examples of ways to mount community-based interventions (21) and have shown measurable differences in health outcomes between different health systems (22). Moreover, many hospitals across the country have engaged in targeted interventions to fulfill particular health needs in their communities with very positive results (23). In addition, efforts are under way at the national level to develop population-health measures that will allow hospitals to assess their contributions to the community. The National Quality Forum, for instance, has endorsed a set of standardized, scientifically evaluated indicators that hospitals can use to assess population-health performance (24). Likewise, the Agency for Healthcare Research and Quality has developed a number of indicators, such as the measures of preventable admissions included in its Prevention Quality Indicators, which could be utilized to evaluate the efforts of hospitals at improving population health (25).

Attributing population-health outcomes to individual hospitals and their community-benefit initiatives remains a more difficult challenge. Given that many factors influence population health and do so in complex ways, no single entity can be held accountable for health outcomes. In particular, in large urban settings with multiple nonprofit hospitals, members of the communities surrounding any 1 hospital may not necessarily seek services at that particular hospital, so the correlation between the health status of the surrounding communities and a hospital's community-benefit programs may be weak or even nonexistent. Hospital managers are thus understandably apprehensive about any discussion that suggests using health-outcome measures to complement the current input-based approach for the purpose of maintaining tax-exempt status.

Despite the inherent difficulties, attributing outcomes to specific community-benefit interventions is possible in well-defined circumstances (26). For instance, a study conducted via a series of large-scale trials in Elmira, New York; Memphis, Tennessee; and Denver, Colorado, found that when nurses educated new parents from disadvantaged populations about proper infant care, the health of both mother and child improved on several dimensions, including better perinatal health, lower rates of abuse and neglect, and reduced reliance on public-assistance programs (27). A second example comes from the 1990s, when the New York State Department of Health and Mt. Sinai Hospital worked together to combat tuberculosis. Together, the hospital and the department created "TB directly observed treatment" to help those afflicted with tuberculosis to properly care for themselves. Many of those afflicted were homeless or HIV positive, and presented special treatment difficulties. All those who began the program either completed it or were finishing at the time of the study. The study found that the program greatly improved the health of the indigent population of New York (28).

Besides having programs that focus on improving health outcomes of certain subgroups of patients, nonprofit hospitals have also begun to engage in activities calibrated to improve the health of the population at large. For instance, St. Joseph Mercy Hospital in Ypsilanti, Michigan, has established a weekly farmer's market in the hospital lobby to provide fresh fruits and vegetables to a population of patients whose access to fresh produce may be limited (29, 30). In addition to local initiatives, nonprofit hospitals are also participating in broader efforts to improve health outcomes. For example, Vermont has been working steadily to reform its health care system by turning it into a "pay-for-population health system" (31). Vermont's efforts rely on the convergence of several different factors, which include implementing and strengthening Patient Centered Medical Homes and Accountable Care Organizations. The successful development of both of these concepts depends in large part on the participation of hospitals. Another example is Community Care of North Carolina (CCNC), which is a program that has been spearheaded by primary care physicians who aim to improve quality, utilization, and cost objectives among North Carolina's Medicaid population (32). The CCNC works to link all of its patients to medical homes and has forged partnerships with hospitals that help the CCNC connect to communities and provide essential resources.

Alternatively, if the community-benefit activities a hospital engages in are evidence-based and contribute to measurable improvements in health behavior or community environments, then it may be unnecessary to require proof of a causal connection between a specific community-benefit initiative and improved population-health outcomes. In such cases, documentation of the specific community-benefit activities as well as evidence of their effectiveness should be considered sufficient for the purpose of tax exemption. However, given that each hospital's community-benefit program is unique, the IRS should—as it has always

done—use discretion in assessing the adequacy of a hospital's community-benefit activities given the complexities of existing programs.

First Step toward an Outcome-Based Approach

In addition to recent amendments to federal nonprofit hospital reporting standards, the ACA established a number of new requirements that nonprofit hospitals must comply with in order to remain tax-exempt (33). Most importantly, the ACA's "Additional Requirements for Charitable Hospitals" mandate (§9007 ACA) requires that, starting in 2012, nonprofit hospitals conduct a community-health needs assessment (CHNA) at least once every 3 years. A CHNA is a written document that describes the community served by the hospital and identifies the health needs of the community. As part of their CHNA, hospitals are asked to develop and implement an improvement strategy to address unmet needs identified through the CHNA. In their implementation plans, hospitals are asked both to identify specific activities to be conducted to improve community health and to develop a set of valid and actionable performance measures to ensure accountability.

The requirement that nonprofit hospitals conduct regular CHNAs and implement community-health improvement plans will compel such institutions to evaluate community-health needs and the impact of their community-benefit activities on the health of the communities they serve. Evaluating changes in population health outcomes from one community-health needs assessment to the next could provide some of the information needed for an outcome-based assessment of hospitals' community-benefit activities and thus be a first step toward a modified approach to nonprofit hospital tax exemption. In this way, the new requirement may represent a first step toward an outcome-based approach to nonprofit hospital

tax exemption.

To implement this new approach, the Federal Government, via the IRS, could integrate population-health outcome measures into its current process for determining nonprofit hospital tax exemptions under section 501(c)(3) of the tax code. Specifically, the IRS could assess hospitals' contribution to the health of their communities by noting the improvements in the population-health performance measures that hospitals specified in their implementation plans. Similarly, depending on their particular legal framework, state governments could integrate outcome-based measurements into their tax exemption determinations either administratively via a state revenue agency or legislatively through either new state or local laws. State tax assessors could thereby promulgate new standards for exemptions from state income and local property taxes.

Developing effective community-benefit programs that are responsive to the health needs of the community and aimed at improving community-health outcomes will become increasingly important for hospitals in the future. Beyond the additional community-benefit requirements mandated by the ACA, the new health reform law mandates significant changes to the way health care will be delivered and paid for. In particular, the move toward bundled or even population-based provider-reimbursement systems, as exemplified in the rules and regulations governing Patient Centered Medical Homes and Accountable Care Organizations (34), will provide additional incentives for hospitals to establish community-benefit programs that promote health in the community and reduce the need for and use of expensive hospital services, for which hospitals may no longer be reimbursed separately. Adopting an outcome-based population-health approach to community-benefit planning will thus serve hospitals well in the long run, and not only for the purpose of maintaining their tax exemptions.

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CHAPTER 4

An Outcome-Based Approach to Nonprofit Hospital Tax Exemption

Introduction

In 2000, the Wexford Medical Group, a small clinic in Cadillac, MI, provided charity care to only two patients. In 2001, that number had increased to eleven, bringing the combined charity care amount for both years to only $2,400. This was despite an annual patient volume of 40,000 to 44,000 and a yearly budget of $10 million (1). Despite the fact that the provision of charity care in this case was nearly non-existent, the Michigan Supreme Court found that Wexford had passed the test for sufficient community benefit (2). The Court failed to articulate a compelling principle for how to measure whether the non-profit did enough to benefit the community and thus could be considered deserving of a tax exemption. This case is indicative of a broader phenomenon. It illustrates how the jurisprudence on the community benefit standard has betrayed the policy objectives behind the exemptions of non-profit health systems. The confusion of legal standards, combined with an ossified focus on institutional structure, has obscured the original purpose of this tax exemption, which was to foster activities that benefit the public by promoting health.

Nonprofit healthcare systems are both vital to the health and welfare of millions of Americans (3) and constitute a major portion of our economy (4). The tax exemption that these institutions enjoy was worth $12.6 billion in 2002, and has grown since (5). The community benefit standard is the test for federal tax exemption for nonprofit hospitals in the United States

(6). In 1969, the IRS established that for a nonprofit healthcare provider to be charitable it need not give out charity care (7), rather "[t]he ruling defined the charity provided by nonprofit hospitals to be the provision of benefits to the community as a whole..." (8). The reasoning expressed in the revenue rulings was as follows: To qualify for a federal exemption a nonprofit hospital must be "organized and operated exclusively for some purpose considered 'charitable'…the promotion of health is considered to be a charitable purpose [therefore] a nonprofit organization whose purpose and activity are providing hospital care is promoting health and may, therefore, qualify as organized and operated in furtherance of a charitable purpose." This portion of the test has since been superseded. Notably, the IRS now also considers research and educational activities in its community benefit determinations. While, formally, community benefit could encompass a broad scope of factors, in practice uncompensated care constitutes the *sine qua non* of the current community benefit test (9).

There is mounting evidence that, as currently applied, this federal standard and the state and local standards modeled on it are problematic and do not achieve their express policy goal of providing an appropriate contribution from nonprofit entities to the public good. One reason this policy fails to achieve its goal is because of an undue focus on input-based indicia of community benefit and insufficient attention paid to the health outcomes that these institutions' community-benefit activities achieve.

There are a variety of ways in which the tax exempt status on nonprofit hospitals could be justified. Yet the model the IRS has settled on, community benefit, is undermined by both conceptual weaknesses and practical constraints. It has, nonetheless, proved to be politically and institutionally durable. Therefore, the most compelling avenue for reform is to provide more rigorous and meaningful metrics for measuring the sufficiency of the community benefits that

nonprofit hospitals must provide. This manuscript thus argues that greater attention to individual and population health outcomes will provide a more meaningful evaluation, better effectuating the policy goals of this standard, achieving greater benefit for society, and instituting a standard more consistent with the theoretical justification for tax exemption.

This manuscript puts forward the thesis that courts and tax administrators should enforce the community benefit standard in a way that focuses on outcome-related measures that show that benefit inures to the public. A population health approach to community benefit would provide such an outcome-oriented approach. As articulated in Rubin, et al. such a standard could provide a more rational basis for evaluating community benefit:

> Rather than evaluating community benefit solely in terms of dollars spent, a modified approach based on both input and outcome measures would require hospitals to design community-benefit programs that make a measurable difference in the health of their respective communities. Such an approach would assess hospitals' achievements by measuring both dollars spent on the set of community-benefit activities defined in Form 990 Schedule H and improvements in a number of health-outcome indicators tied to the specific community-benefit activity (10).

A more robust conception of benefit, with tighter criteria for inclusion and exclusion of potential population benefits, will help facilitate this transition. Moreover, there is mounting evidence that both changes brought about by the Affordable Car Act, as well as broader trends in the healthcare industry will lead to population health being the dominant force in healthcare delivery over the coming decades.

Part I of this manuscript explains the justification for the nonprofit exemption policy and the ways in which the current standards fail to realize the goals of that policy. Part II puts forward a new way of formulating that standard, considers several alternatives, and then explains the advantages of an outcome-based standard, particularly with respect to creating a more unified legal standard.

Part I: The Current Legal Standards For Tax-Exemption of Nonprofit Hospitals

Part I of this manuscript argues that the current standards for nonprofit hospital tax-exemption are faulty. The current standards in use for tax exemption for nonprofit hospitals have led to divergent rulings in recent litigation, do not accord with the best normative justification for such a policy, and do not produce optimal outcomes. Part I.A uses illustrative cases to demonstrate that trends in current case law lead to two increasingly divergent approaches. Part I.B explores the justifications for nonprofit tax exemption, and argues that the "subsidy" justification is the only one applicable to nonprofit hospitals. Part I.C describes the history and development of the federal community benefit standard. Part I.D summarizes the empirical evidence of the effects of the current standard, and shows that the current incentives are, to some degree, perverse.

Section I.A Historical Analysis: Development of the Community Benefit Standard

Current standards for tax exemption of nonprofit hospitals are grounded in the common law doctrine of charity (11). The concept of public benefit is integral to this doctrine of charity (12). The inurement of benefit to the public is the essential feature justifying the special status of the charitable enterprise. In the case of nonprofit health care providers, the lack of forethought in administrative determinations, path dependence, and rapid change in the provision of health care have created perverse incentives for health providers. These incentives explain the dissatisfaction that many have expressed with the current community benefit standard.

Federal policy supports charitable organizations through tax exemptions as a way of furthering community goals. The Internal Revenue Service has codified this support in United States Code title 26, Section 501, subsection (c), which defines what manner of charitable

organizations qualifies for tax-exemption (13). The Joint Committee on Taxation estimated that these tax exemptions for nonprofit hospitals totaled $12.6 billion in 2002 (14).

The current legal regime governing tax-exempt medical providers is the result of a century of ad hoc changes and path-dependence (15). Originally, for an entity to be tax exempt it either had to fit into one of the enumerated categories (educational, religious, etc.) or else be charitable, which had two meanings (16). One was broad-based public benefit, and the other was the alleviation of poverty (17). When hospitals were in the business of giving care to the poor for free, they fit rather neatly into the alleviation of poverty category. In 1956, the IRS codified this qualification with the financial-ability standard, which required hospitals to provide (to the extent financially possible) health care to those unable to afford it otherwise (18).

Because of changes in the practice of medicine and changes in the public and private finance of medical care, hospitals evolved out of the exemption they had once enjoyed. Contemporary observers thought that the creation of Medicare and Medicaid in 1965 would obviate the financial-ability standard (19). In 1969, the IRS introduced a new tax standard, the community benefit standard (20), and with it a new *raison d'être* for nonprofit health providers. This ruling, in some ways, was insightful, as it recognized that the improvement of the health of the public could constitute charitable activity. The problem is that the standard that the IRS instituted had a maladroit test that was not a good metric for whether an institution provided benefit to the public, because it looks at institutional form rather than achievement of community benefit. This test, still in use as of this writing, requires hospitals to do the following: Formally, the test for exemption is as follows:

1) Operate an emergency room that cares for anyone, regardless of ability to pay;
2) Provide non-emergency room care for anyone who can pay;
3) Participate in Medicare and Medicaid;
4) Create a governing board that represents the community;

5) Allow any professional who is qualified and applies to have medical-staff privileges;
6) Re-invest surplus funds, rather than disseminate them as dividends (21).

Notably, in 1983 the IRS modified this standard. It determined that hospitals without emergency rooms could still be eligible for exemption. It also determined that not all of the above-mentioned factors must be satisfied in all circumstances (22). While there have been some minor formal changes since the 1969 ruling, in practice the standard has narrowed considerably with uncompensated care constituting in the minds of many, if not the dispositive criterion for exemption, then at least the he *sine qua non* of the current community benefit test. While education and research are also of considerable importance, charity care is now regarded by many as the central defining feature for nonprofit status.

As currently constituted, the community benefit standard does not take into account the consequences of these requirements or any of the benefits they may or may not yield to the community. The first three criteria focus on allowing individuals access to health care, particularly emergency room care. The focuses of the fifth and sixth criteria on medical staff and on revenues, respectively, do not require that any benefit be created for the public at-large. Many have argued that the fifth and sixth criteria help the hospital better aid the community, but they do not, in and of themselves, constitute such a benefit. A similar critique can be mounted against the fourth criterion, which does not require that care and benefits flow to the community the board is drawn from (23).

As the community benefit standard was designed to be a counterpoint to the original "financial need standard," and the PPACA specifically mentions assessing what the "community needs," it is apparent that it must be more than merely helping discrete individuals in need (24). To meaningfully constitute a community benefit, there must be a measurable increase in the social welfare of the community. If not, then merely redirecting other funding sources to assist

those unable to afford healthcare (the old "financial ability" standard) would still be sufficient. Instead, nonprofits are being asked to provide some service that "lessens the burden of government" in exchange for the subsidies they receive (25).

In 2010, Congress passed the Patient Protection and Affordable Care Act, which has added additional requirements for nonprofit status. Consistent with the traditional idea of a hospital as a place to help those who cannot afford medical care, the new rules mandate that tax-exempt hospitals cannot charge those who qualify for charity care more than the lowest amount charged for the same procedure to those with health insurance (26). Nonprofit hospitals now must have an explicit financial assistance policy that is publicized throughout the community (27). Moreover, the hospital may not send a patient to collections before it has ascertained whether that patient was eligible for financial assistance (28). Under the new law, nonprofit hospitals must conduct a "community health assessment" every three years to determine what needs the community has unfilled.

The Patient Protection and Affordable Care Act also modified Form 990, the IRS tax form exempt organizations use (29). In 2007, the IRS created a new portion of the form, Schedule H, to measure compliance broadly in nonprofit health systems (30). The new form was created in an effort to demand greater financial transparency from nonprofit health systems and to make regulatory standards less ambiguous (31). Form 990-H requires the nonprofit health systems to document various expenses incurred, such as "health professions education" and charity care, to show exactly how much each nonprofit was spending on community benefit (32). The PPACA has added more to the form, requiring that hospitals now conduct studies on community health needs, and submit a description of how they will go about fulfilling these health needs, with an explanation of why they are not meeting any needs left unaddressed (33).

Section I.B Theoretical Analysis: The Policy Justification for Nonprofit Tax Exempt Status

Policy makers are concerned that the current tax exemption for nonprofit hospitals is outmoded and provides perverse incentives (34). It encourages nonprofits to focus on expenditures rather than whether such expenditures yield any tangible results. Moreover, they encourage a race to the bottom. As any tax exemption shifts the tax burden to the rest of the tax-paying community (35), there must be some justification for any tax exemption. Historically, hospitals justified their tax exempt status by providing charity care. With the number of uninsured in the US expected to decrease by 32 million people (36), charity care will recede further as a compelling justification, and some other justification is necessary if the exemption is to be maintained. The current "community benefit standard," which was intended to replace charity care after the creation of Medicare and Medicaid (37), was not developed *in toto*, but instead accrued incrementally from IRS rulings, court orders, and subsequent legislative modifications (38), and therefore inconsistencies and *ad hoc* irregularities mar the standard (39). This *ad hoc* process created a standard that does not comport with the objectives of the policy it is intended to serve.

As both the IRS and Congress have in the past put restrictions on what qualifies for this exemption, it follows that these entities need not be considered "sovereign" in the present day. Others have argued that the exemption is justified on the basis that what charities do falls outside of the appropriate tax base. For instance, some argue that without profit, there is nothing to tax (40). Nonprofit hospitals, like most businesses, do create profits that could be taxable. Similarly, others argue that donations to charities must be tax-exempt because they are not "income" for the person making the donation (41). This does nothing to support the tax-exempt status of

institutions that rely more heavily on user fees than donations, such as most modern health care providers.

The most robust justification for continuing the tax-exempt status of nonprofits is that nonprofits provide some form of benefit that the taxing body finds worth subsidizing in this way. This is most commonly called either the "quid pro quo" or the subsidy justification (42). This theory is also consistent with our understanding that some organizations, while completely nonprofit, do not merit government subsidies, as the "goods" they produce are actually contrary to public policy (43). The question of what goods are to be subsidized then ensues. The traditional (though problematic (44)) answer is that public goods, public services, and those private goods with large positive externalities should be subsidized by tax exemptions (45). As any tax exemption imposes a burden on the rest of the tax base, it is the rest of the tax base that should receive the benefits of the public goods the exemption provides (46). This means that the policy justification for subsidy via tax exemption at the local level is distinct from the justification at the federal or even the state level, and thus the standards put forth in the different tax codes should also be distinct (47).

Section I.C Case Law Analysis: Illustrative Cases

The tax exemption for nonprofit organizations is justified in many ways, but they do not all apply equally to nonprofit hospitals. The earliest justification for such tax exemptions is found in the "sovereignty" theory, which holds that charities and religious organizations are not subject to taxation by their nature. This theory of tax exemption claims that it is not ethically permissible for states to tax charities, because the business of charities is outside the tax base. While, in the past, churches were considered outside the king's realm, and thus immune from

taxation, in modern times this justification takes a more secular tone. For example, some claim nonprofits are not businesses, and thus not subject to the same tax regulation (48).

A recent increase in litigation over nonprofit property tax exemption demonstrates that community benefit determinations on the local level can become contentious. In addition, on the state level, differences of opinion over which legal test to apply to determine tax-exemption are increasing. Two standards are emerging, with some states' courts opting for institutional structure and nonprofit form as the dispositive criteria, whereas other states look to community benefit expenditure as an indication of an institution's charitable activities.

This analysis will be restricted to an examination of disputes over property tax for several reasons. One is that in recent years issues of the justification for tax exemption have played out vividly in state courts. Another reason this analysis is restricted to property tax exemption is that local property tax exemption disputes subject institutions to more exacting scrutiny because there is an immediate relationship between the institution and the people in the community in which it operates. There is also the closest tie between the performance of an individual institution and the well-being of a distinct population at the local level, making it easier for courts to analyze the effects of noncompliance (49). For that reason, an evaluation of community benefit on the local level is more amenable to rigorous accounting standards.

Dialysis Clinic, Inc. v. Levin (50), a recent opinion of the Supreme Court of Ohio, is illustrative of the disputes that can emerge over whether a nonprofit health provider merits a property tax exemption. Dialysis Clinic Incorporated (DCI) is a nonprofit health provider incorporated under the laws of Tennessee. It operates a facility in Butler County, Ohio, which is the focus of this litigation. On December 22, 2003, DCI applied for a property tax exemption for the Butler County facility, and the tax commissioner denied it (51). DCI appealed to the Board of

Tax Appeals (52), which upheld the tax commissioner's ruling. DCI appealed again to the Supreme Court of Ohio.

The dispositive issue on appeal in *DCI v. Levin* was whether the activities of its Butler facility were charitable, and thus whether the facility was entitled to an exemption under Ohio law (53). This particular facility lost $250,000 per year, but DCI as a whole had excess earnings of $6,306,492 in 2003 and $32,167,517 in 2004. While DCI had never turned an indigent patient away from the Butler County facility, it also had a policy that explicitly stated that indigent care was not a "charity or gift to patients," and that DCI retained the rights to refuse to admit and treat a patient who cannot pay (54). Although DCI conceded that it provided no free or charitable care at that property, it contended that its 501(c)(3) status "militates heavily in favor of finding it to be a 'charitable institution'" (55). DCI was unable to provide a monetary figure for the charity care that it gave (56), but it did report that the Medicare "bad-debt" write-off for all of its locations was $6.7 million, or 1.27% of all charges. The BTA did not accept this as charity care, but also stated that even if it were acceptable as charity care, it would be "insufficient to meet the charitable service standards required for exemption" (57). The BTA also rejected DCI's contributions to kidney research because charitable status cannot be achieved vicariously (58).

The Ohio Supreme Court held that the fact that DCI's policy allowed it to refuse care to the indigent rendered its activities non-charitable (59). In the course of its opinion, the Court expressed disagreement with DCI's contention that federal 501(c)(3) status "militates heavily" for state charitable status. The Court stated that such an interpretation is inconsistent with the Ohio statute's legislative intent: "This expansive construction of R.C. 5709.121 is inconsistent with the legislative purpose behind its enactment and with ordinary principles of statutory construction..." (60). The court found that "DCI's argument would conflate Ohio's property-tax

exemption requirements with standards under federal law for tax-exempt charities" (61). With this finding, the court expressly delinked local property tax exemption in Ohio from federal 501(c)(3) status. Referring to a previous opinion, the court stated, "Congress does not define the scope of charitable use under Ohio law" (62). The commissioner found, and the BTA affirmed, that some threshold of unreimbursed care was necessary to qualify for charitable status under Ohio law. The Supreme Court of Ohio reversed, holding that "case law does not require a threshold amount of unreimbursed care" (63).

Similar issues were at play in *Wexford Medical Group v City of Cadillac,* which the Michigan Supreme Court decided in 2006. In 2000 and 2001, the City of Cadillac assessed property taxes on the Wexford Medical Group, a 501(c)(3) entity providing health care in Wexford County, Michigan. Wexford is a "federally designated health professional shortage area" (64). The Wexford Group appealed its tax assessment to the Tax Tribunal, which upheld the assessment, finding that "serving 13 patients under the [charity-care] program in a two-year time period is not sufficient" to justify property tax exemption (65). The Wexford Group then appealed this decision to the Court of Appeals. The appellate court affirmed the Tribunal's decision, finding that the Wexford Group "failed to present evidence that its 'provision of charitable medical care constituted anything more than an incidental part of its operation'" (66). The Court of Appeals also held that mere underpayment by Medicare and Medicaid does not make a service charitable, nor does simply providing service in an underserved area (67).

In its decision on *Wexford Medical Group v City of Cadillac,* the Michigan Supreme Court modified an existing test (68). The new test, which they applied, had the following parts:

1) The real estate must be owned and occupied by the exemption claimant
2) The exemption claimant must be a nonprofit charitable institution

3) The exemption exists only when the buildings and other property thereon are occupied by the claimant solely for the purposes for which it was incorporated (69).

The Wexford group clearly met factors 1 and 3. It was only number 2, the charitable institution prong, that was in doubt. The Michigan Supreme Court held that the Wexford Group was a charitable institution (70), despite the *de minimis* expenditure on charity care for the relevant period (71). Most notably, the Court held that "if the overall nature of the institution is charitable, it is a 'charitable institution' regardless of how much money it devotes to charitable activities in a particular year" (72). As the Ohio Court found in *DCI v. Levin*, the Michigan court held that there can be no threshold of charity care for the purposes of non-profit tax exemption. Rather, it is the nature of the institution that is dispositive.

In *Provena Covenant Medical Center v The Department of Revenue* (2010), the Illinois Supreme Court, facing similar issues, reached a conclusion that differs from the preceding cases. Provena Hospitals is a subsidiary of Provena Health, which was created when three Catholic health-care operations merged. Provena Hospitals is a nonprofit organized under the laws of Illinois, and is exempt from federal income tax (73). As a nonprofit, Provena Hospitals applied for a property tax exemption for the 2002 tax year for 43 parcels in and around Urbana, Illinois (74). The parcels were all registered under one hospital run by Provena Hospitals, the Provena Covenant Medical Center. The Director of Revenue found Provena to be ineligible for the tax exemption (75), despite an Administrative Law Judge's recommendation to the contrary (76). Provena appealed to the circuit court, which reversed the Director of Revenue, and granted the tax exemption on both charitable and religious grounds (77). The Director then appealed, and the Illinois Court of Appeals found that Provena was not entitled to either a religious or a charitable exemption (78). Provena then appealed to the Supreme Court of Illinois (79).

The Supreme Court of Illinois dispensed with the religious exemption issue, stating that to qualify for a religious exemption "the property in question must be used exclusively for religious purposes" (80). To hold that Provena deserved a religious exemption merely because a church created Provena would be to exempt all church-owned businesses, no matter what services were provided (81). In particular, "medical care, while potentially miraculous, is not intrinsically, necessarily, or even normally religious in nature" (82).

The charitable question was more complex. The court used a five-part test (83), describing the characteristics of a charity thusly:

> 1) It has no capital, capital stock, or shareholders;
> 2) It earns no profits or dividends but rather derives its funds mainly from private and public charity and holds them in trust for the purposes expressed in the charter;
> 3) It dispenses charity to all who need it and apply for it;
> 4) It does not provide gain or profit in a private sense to any person connected with it; and
> 5) It does not appear to place any obstacles in the way of those who need and would avail themselves of the charitable benefits it dispenses (84).

No one of these factors was regarded as dispositive, but instead they were evaluated jointly. The court found that Provena easily met the first and fourth factors, as there was no sign of private inurement and it did not have shareholders (85). The court held that Provena failed on the other three factors. Provena's income was almost wholly derived from patient fees, not donations. Moreover, the lack of charitable care made it impossible to hold that Provena dispensed charity to all who applied for it or that Provena did not put obstacles in the way of those who sought it (86).

The court also held that Provena did not meet the actual charitable use standard. The Illinois court had held previously that charity is "a gift…for the benefit of an indefinite number of persons…lessening the burdens of government" (87). Moreover, "[c]onditioning charitable

status on whether an activity helps relieve the burdens on government is appropriate," (88) and "services extended for value received do not relieve the [s]tate of its burden'" (89). Charitable care at Provena was *de minimis,* and Provena did nothing to help patients learn about charity care options (90).

Provena is exceptional among recent court cases in that the plurality of the Court expressed the view that there is indeed a minimum threshold for benefit to the community, though it did not go so far as to state what that minimum is. There was only a plurality because two justices dissented in part. Therefore, the case does not provide a binding precedent (91). Those who dissented in part agreed that Provena failed the test for charitable status, but objected to the notion of a threshold (92). While no precedent emerged from this case, it nonetheless lends support to those who believe that there is a minimum amount of benefit or charity that is required for a non-profit to enjoy a tax exemption.

Utah County v. Intermountain Health Care, Inc. presents similar issues over the justification for property tax exemption. Intermountain Health Care was a nonprofit corporation under Utah law that operated 21 hospitals. It also owned other subsidiaries, including at least one for-profit corporation. When IHC applied for tax-exempt status, the Utah County Board of Equalization found that two of IHC's hospitals, the Utah Valley Hospital and the American Fork Hospital, were not eligible. The Utah Tax Commission then overruled the Board (93). In this case, it was apparent that IHC met the statutory requirements for a charitable hospital, but Utah County argued that the statutes under which IHC qualified violated the Utah state constitution and that under the constitutional requirements, IHC would not qualify as a charity (94). The first statute in question maintained that as long as a nonprofit does not engage in any private inurement, and is used for a charitable purpose, it qualified for a tax exemption (95). The second

statute expressly stated that “[p]roperty used exclusively for religious, hospital, educational, employee representation, or welfare purposes which use complies with the requirements of section 59-2-30, shall be deemed to be used for charitable purposes” (96). The Utah Constitution merely states that “[t]he property of the state, cities, counties, towns, school districts, municipal corporations and public libraries, lots with the buildings thereon used exclusively for either religious worship or charitable purposes … shall be exempt from taxation” (97).

The dispositive issue in *IHC* was a constitutional one, namely whether the Utah statutes impermissibly expanded the constitutionally defined meaning of “charitable purposes” when it made the sweeping generalization that all hospitals acted for charitable purposes (98). As the Illinois Supreme Court later held in Provena, the Utah Supreme Court held that charity requires the existence of a gift to the community, not just community benefit (99). The court used a six-part test (100) to determine whether IHC was indeed using its property “exclusively for … charitable purposes” (101). The factors were:

1) Whether the stated purpose of the entity is to provide a significant service to others without immediate expectation of material reward;
2) Whether the entity is supported, and to what extent, by donations and gifts;
3) Whether the recipients of the "charity" are required to pay for the assistance received, in whole or in part;
4) Whether the income received from all sources (gifts, donations, and payment from recipients) produces a "profit" to the entity in the sense that the income exceeds operating and long-term maintenance expenses;
5) Whether the beneficiaries of the "charity" are restricted or unrestricted and, if restricted, whether the restriction bears a reasonable relationship to the entity's charitable objectives; and
6) Whether dividends or some other form of financial benefit, or assets upon dissolution, are available to private interests, and whether the entity is organized and operated so that any commercial activities are subordinate or incidental to charitable ones.

The court emphasized that of these criteria, none was dispositive, nor were they necessarily of equal importance (102). It held that IHC met the first, fifth, and sixth criteria (103). The court

also held that IHC did not meet the second, third, and fourth (104). In particular, though IHC had a policy of treating everyone, regardless of ability to pay, due to the overall paucity of charity care (105) along with efforts to keep charity care levels as low as possible (106), the majority found that IHC was not in any substantive way different from a for-profit hospital (107). In doing so, the court also struck down the statutes as an unconstitutional expansion of the narrow exemption in the Utah Constitution (108).

Two distinct patterns emerge from recent state-level property-tax litigation over community benefit. One is the view that institutional form is dispositive. States that take that view, including Michigan, Vermont (109), Tennessee (110), and Ohio, hold that, so long as the formalistic requirements are met, there can be no threshold for monetary expenditure on community benefit nor is there a need for any accounting of the population health outcomes achieved through such expenditures. Not only are these courts not interested in outcomes, they are not even interested in expenditures as predictive indicators of outcome. Other states have reached a nearly opposite conclusion. In the Illinois and Utah cases, the Courts showed some interest in outcomes, and in keeping with current practice were willing to accept input related measures (such as charity care expenditure and proportion of charity care) as indicia of community benefit. Even those indirect measures were deemed inadequate in both of these cases.

Section I.D Analysis of the Empirical Literature: The Community Benefit Standard's Perverse Incentives

Nonprofit healthcare providers try to maintain their tax-exempt status by touting many benefits. For-profit hospitals provide many of those same benefits (111). There is also a lack of consensus on whether nonprofits serve poverty-stricken areas that need additional care better than for-profit hospitals. While studies in the 1990s found that for-profits tended to operate in

areas with higher percentages of insured people (112), more recent research has shown that for-profit hospitals are concentrated in the poorest sections of the country, specifically the South and West. As government hospitals are also far more common in the South and West, the market share of nonprofit hospitals is the lowest in these areas.

Moreover, many nonprofits fail to provide sufficient community benefits. For example, nonprofit hospitals do not provide significantly more uncompensated care than do for-profits, and provide significantly less than government-run hospitals (113). Nonprofits actually provide less help for Medicaid patients than for-profits, and these patients often cost a hospital more than Medicaid reimburses (114). Some research-oriented hospitals have come under fire for inadequate emergency-room services, including the Cleveland Clinic (115).

The argument that many nonprofits offer to rebut the aforementioned criticisms does not withstand scrutiny. They claim that they provide other benefits, including research and jobs. Research may partially justify federal and state income tax exemptions; these benefits do little for the local communities that provide property tax exemptions to the nonprofits within their jurisdictions. For instance, while research is vital for medical progress on a national and global level, it does not provide a health benefit to the communities subsidizing research-oriented nonprofit hospitals with tax exemptions. Clinical trials needed for research provide some benefit to local communities, but such benefits are only incidental to the research endeavor and cannot constitute a *quid pro quo* for local tax exemption. At the same time, the argument that nonprofits provide essential jobs is fatuous, as any comparable nonsubsidized, for-profit corporation would provide similar levels of employment (116).

One recurring claim regarding the benefits of nonprofit hospitals, that they provide distinct services that for-profit hospitals under-provide, is not sufficient. In particular, some

maintain that nonprofits provide a disproportionate share of vital services that are necessary for all, particularly poor and uninsured patients (117). That for-profits are not providing enough of these services is a market failure, and a correction of a market failure is a legitimate reason, on its own, for providing such as subsidy (118). Where for-profit hospitals control the greatest share of the market, and thus the market failure is likely to be the most severe, nonprofits actually decrease the amount of unprofitable services they provide (119). This prevents them from correcting the market failure. There is also mounting evidence that some nonprofits fail to live up to this ideal, and impose even more costs on their communities than they ameliorate (120). Subsidizing all nonprofits because they can or may lessen a market failure invites abuse of the nonprofit form.

As tax exemption currently relies on providing an unspecified amount of charity care and a non-quantified amount of community benefit, nonprofit hospitals have an incentive to provide as little community benefit as they can get away with. Because there is no threshold for input, and they are not held to account for outcome, they have an incentive to provide the minimum amount of input they believe to be defensible. The new IRS Form 990, schedule H may put some pressure on hospitals to provide benefits because of the scrutiny they may receive. Nonetheless, notwithstanding the moral pressure which might be brought to bear by outside scrutiny, as long as hospitals provide something above *de miminis*, they continue to receive the subsidy. The only thing that keeps this incentive from being zero is the indeterminacy of the threshold (121). The current standard imposes incentives that are orthogonal to the ostensible policy goals that animate the revenue ruling that brought it into existence.

Part II: An Outcome-based Approach to Community Benefit

Given the flaws in the current standard for tax exemption of nonprofit health systems, it is worth exploring alternatives. Part II.A describes alternative approaches and examines their feasibility and efficacy. This examination shows that some options would be counter-productive, while others could be effective but are exceedingly difficult to put into place, ranging from impracticable to all but impossible. While the proposal put forward in this manuscript may face difficulties, it is manifestly better than the other plausible alternatives. Part II.B argues that the tax incentives for nonprofit hospitals should promote social welfare directly, rather than promoting spending or a particular institutional form, and that this can be done by focusing explicitly on outcomes. Part II.C shows how this standard would provide a more meaningful and rational metric by which to evaluate such cases.

Section II.A Possible Alternatives

Practicability and efficacy constrain most alternatives to the current system. Furthermore, there is likely to be a great deal of resistance to any change, as nonprofit hospitals are entrenched actors and are likely to lobby against any such changes. This is a problem that is not amenable to an ideal solution. While the proposal put forward in this manuscript may face difficulties, it is manifestly better than the other conceivable alternatives.

One option is appealing in its simplicity: Repeal the community benefit standard entirely and tax nonprofits. This could be imposed absolutely, eliminating the tax exemption entirely, or it could allow for incremental exemption based on some amount of community benefit. Alternatively, legislators could impose an excise tax on certain health services and use the funds to subsidize public health services. There would be considerable political opposition to enacting

this plan, and it is unlikely that there would ever be enough political will to overcome that resistance. Such a move would, in most meaningful respects, convert all nonprofits into for-profits, and this might change the behavior of nonprofits in ways that could be counterproductive. There are some apparent benefits to nonprofits, in that they give a different profile of services than for-profits (122). For the reasons discussed above, this is an unattractive option.

Professor Jessica Berg has proposed that population health interventions by nonprofit health systems would satisfy the community benefit test, and justify the continuation of the tax exemption (123). This would keep the current standard but encourage (via a variety of mechanisms) nonprofit hospitals to engage in population-based health measures, justifying their exemption. She suggests that communities institute "community health boards." Such regulatory boards would cover the geographic area that would benefit from the property taxes of the hospitals within it. The board would prioritize the services that nonprofits must provide to maintain tax-exempt status, though it would not have the power to make tax-exemption decisions (124). The structure Berg proposes specifies that the board be made up of a "variety of local community members," as well as members of the boards of the hospitals and representatives from social service agencies, including the local health board (125). The local community members would include consumers, community leaders, and representatives from the nonprofit community (126). Berg's suggestion is compelling because it fits the traditional rationale for nonprofit tax exemption. It is also responsive to the normative justification for tax exemption.

While Prof. Berg's proposal is compelling, it must overcome several problems to be practicable. One problem with her proposal is that it could result in boards requiring hospitals to provide services outside of their core competence. Hospitals, both for-profit and nonprofit,

provide interventional medical care and diagnostics; they are not public health agencies. Another problem with Berg's proposal is that the recommended "community health boards" could be subject to regulatory capture, which would render them largely useless. Regulatory capture is the phenomenon in which industries and interests control the state bodies charged with regulating them (127). Regulatory capture has been defined as "...the phenomenon whereby regulated entities wield their superior organizational capacities to secure favorable agency outcomes at the expense of the diffuse public" (128). It is at its nadir when "regulation is acquired by the industry and is designed and operated primarily for its benefit" (129). This problem arises because the benefits to the population are diffuse, while the benefits available to the industries are concentrated, thus causing those within the industry to pay more attention to the regulating board than the population at large (130).

Indeed, if community health boards were created, and then members friendly to nonprofit hospitals dominated the boards, it could lead to even less accountability of nonprofit health systems and a further reduction in public benefit. Hospitals are likely to dominate the community health board, unless the board is strongly insulated from industry influence (131). Policy makers will find it difficult to fully insulate a local board from capture, particularly in a jurisdiction where the hospital is a major industry. If the board is democratically elected, then the nonprofit industry can motivate its employees and supporters to vote for and support those regulators who will be friendly to the hospital. Meanwhile, the general population is likely to be largely apathetic. It is well established that very few local elections are able to engage the entire electorate, due to resource constraints (132). This difference in motivation between the entity and the wider population will influence the outcomes of elections in favor those who support institutional interests (133). Even if the board is not elected, the hospital will have leverage over

those elected officials who appoint the board members (134). Moreover, industries have many more methods available to influence regulators, including gifts, offers of jobs, and relationships with board members (135). Many nonprofits operate in a number of different markets, and thus would be subject to a patchwork of regulations. The geographic power of these boards will have to be delineated carefully, as well as the activities of the nonprofits. Otherwise, one nonprofit might be required to conform to contradictory imperatives, if it falls into multiple community jurisdictions.

While Regulatory Capture is a serious problem for various areas of regulation, it is not an intractable problem. Various theories have been advanced by scholars from a number of fields, including law, economics and political science, to address this issue by devising means of reducing or eliminating the effects of capture on agency decision-making (136). For instance, Rachel Barkow has posited that four factors that go "…beyond the conventional mechanisms to address additional design features that have largely gone under the radar of administrative law scholarship[]" (137) could be particularly effocatious in addressing capture. The design features she identifies are "an agency's funding source; qualifications for appointment and post-employment restrictions for agency officials; the agency's relationship with other federal agencies; the agency's relationship with state-level actors; and various political tools, including the agency's ability to generate politically powerful information, its ability to recruit political benefactors, and the potential for public advocates to become part of the agency structure" (138). Both Barkow's suggestions regarding agency structure and the engagement with public advocates could be of particular relevance if new institutional structures are developed to make community benefit determinations.

An additional problem with Berg's proposal is that the continuing consolidation of the nonprofit health sector may exacerbate problems of capture. Larger, more centralized nonprofits are more capable of capturing regulatory bodies than smaller ones and will, through better organization, be better able to engage in rent-seeking behavior by steering policymaking towards creating monopolistic privileges (139). Captured community benefit boards might set the community benefit bar at a level that only a large institution could fulfill, thus removing competition. The likelihood of regulatory capture with a lack of an outcome-based accountability could be fatal for Berg's scheme. Indeed, it might lead to outcomes that are considerably worse than the consequences of the current regime.

Section II.B Forging an Outcome-Based Approach

A basic understanding of the way that law can shape economic incentives leads to the conclusion that there should be a different legal regime, which could be implemented through regulatory action on the federal and state level, but might also require state-level legislation comparable to what has already been passed in several states. This new regime would create appropriate incentives while also being consistent with a more robust theoretical justification for tax exemption (140). Even in the absence of a clear policy agenda, systems of taxation inevitably change individual and institutional behavior because of the incentives they create (141). As was shown in Part I, the existing standard of tax-exemption creates perverse incentives.

An outcome-based approach would focus on measurable benefits to the health of populations. In contrast, the current community benefit approach focuses on expenditures, without any evidence of their efficacy or adequacy. Such an outcome-based approach has the advantage that it can be consistently applied at the federal, state, and local levels, and yet still be

sensitive to context. For instance, the data yielded by form 990 schedule H disclosures could be compared to epidemiological data corresponding to the catchment areas of hospitals, no matter how narrow or broad they might be. Thus, it can reach different determinations at the various levels, depending on the nature of the benefits that the institution provides and where they are directed. An outcome-based standard requires that the local community receive the necessary, tangible and measurable benefits of the exemption (142). Appropriate metrics may vary depending on the health needs of the community. In time, longer-term measures of morbidity and mortality could be used. These would be even better ways of accounting for health outcomes, though they would have to be measured over a longer time scale. While medical education and research would continue to provide a partial justification for the federal, and perhaps state, exemptions, the outcome-based community benefit standard would provide the essential touchstone for establishing the charitable nature of nonprofit healthcare providers. On the local level, it could serve as the *sine qua non* for tax exemption.

Shaping incentives for nonprofit health systems encourages them to maximize social welfare. While regulatory bodies, particularly at the local level, may be able to identify the community's needed health services, these bodies are unlikely to know the best method for nonprofits to provide these services and even whether the nonprofits can do so efficiently. This constraint can be removed, and social welfare maximized, by providing a subsidy that is conditional on the achievement of certain outcomes. Such a subsidy system would allow institutions to choose whether to receive it, which would encourage them to make the most efficient choice (143).

The *sine qua non* of tax exemption for nonprofits should be positive evidence of demonstrable public inurement (144). To qualify as public inurement an activity must take the

form of a material effort to promote the health and welfare of the community; such an effort must also be amenable to empirical verification of its efficacy. An outcome-based standard should not merely be an accounting of the dollar value of an activity that might benefit the public, but rather demonstrable evidence of a benefit that has accrued to the public. Such efforts must have reasonable prospects of efficacy and be amenable to empirical measures of success. This is consistent with the old common law notion of charity (145), and in that way is an appeal to precedent. An outcome-based standard is also desirable because it provides appropriate incentives to perform, not merely to spend.

Principles of population health can provide both a framework for devising appropriate interventions for hospitals to engage in, as well as a lens through which the outcomes of such interventions can be viewed and evaluated. The term population health has taken on a variety of meanings throughout the public health and health policy literature. One cogent definition of population health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (146). Recent innovations in the study of population health and the convergence of public health and health services provides a means by which nonprofit hospitals could provide broad-based community benefits and readily document the health outcomes brought about by such activities. The attraction of a population-health oriented outcome-based standard are manifold. By focusing on whole populations rather than on individual charity care, hospitals can provide truly public goods (147). A revamping of the community benefit standard could also yield compliance-related benefits for hospitals by replacing the current murky community benefit standard with something more amenable to verification. If the value of community benefit activities can be measured via their outcomes, and positive outcomes are the touchstone for compliance, then under an outcome-oriented approach

hospitals will be able to know clearly whether or not they are in compliance with the requirements they bear as a result of their nonprofit status.

A critic could mount three challenges to this standard: 1) the accounting standards would be unduly burdensome for non-profit hospitals and 2) measuring outcome is impractical and 3) even when outcomes can be measured, it will be difficult to attribute outcomes to specific hospitals. The first criticism does not withstand scrutiny, because under the new accounting standards mandated by the PPACA, hospitals already must conduct community needs assessments (148).

The second does not withstand scrutiny either. Scholars have already provided compelling examples of ways to mount community-based interventions (149), and have shown the measurable differences in health outcomes among different systems (150). There are many ways to approach population health, most all of which can be usefully employed (151). Nonprofit hospitals can reduce negative externalities and increase positive externalities relative to the current system (152). The easiest way to do this is to increase the amount of preventive care provided to the population. The present failure to engage in prevention is a market failure because the current market incentives make it more profitable for healthcare providers to perform costly operations and surgeries after the fact, rather than provide relatively inexpensive care to prevent problems. Prevention activities are easy to target to specific populations. For example, the Denver school district, in conjunction with local health care providers and funding groups, is focusing preventive health care on adolescents (153). They have created school-based health centers (SBHCs) (154). Researchers recently studied these SBHCs and found that they were very successful in reducing the number of student emergency-room visits (155). In other locations, SBHCs have immunized students, protecting the overall population from

communicable diseases (156). The New York State Department of Public Health, with the assistance of several other agencies, created Breast Health Partnerships (BHPs) to screen low-income uninsured and underinsured women for breast and cervical cancer (157). The BHPs also provide diagnostic testing and treatment support for those who test positive (158). A majority (51%) of the 40,000 women screened had never had a mammogram (159). The University of Illinois at Chicago Department of Public Health, Cook County Hospital, and the Chicago Department of Public Health created similar interventions directed at African American communities (160). They focused on teaching women how to do self-examinations and promoted free cancer screenings (161). Both interventions were successful in increasing the number of breast health screenings each population received.

Health care providers can also assist in preventing outbreaks of communicable disease (162). They are well equipped to help public health departments contain epidemics and treat those who are affected. Hospitals are well placed to treat the earliest infected and to keep statistics on those exposed (163). In turn, the local health department can help immunize the community and limit overall exposure. In the 1990s, the New York State Department of Health and the Mt. Sinai Hospital worked together in this way to combat tuberculosis (164). Together, the hospital and the department created "TB directly observed treatment" to help those afflicted with TB properly care for themselves. Many of those afflicted were homeless or HIV+, and thus presented special difficulties in treatment. All those who began the program either completed it or were finishing at the time of the study (165). The study found that the program greatly improved the health of the indigent population of New York.

Regarding the third critique, the Mt. Sinai example, discussed *supra*, serves as a demonstration of how a coordinated program can succeed in reaching individuals in need.

However, it also highlights the obstacles one can face when attempting to attribute changes in population health to the efforts of a single program or health system. Without a coordinated approach from the health department and hospital, this program would not have been as successful as it was. When the a goal is to measure the individual effects of a hospital on a community to determine non-profit tax status, one must take care to develop an approach which ensures that outcomes are appropriately linked to the institution providing services.

The third critique is in many ways the most problematic as inferring causation from population health data can be challenging. It is, nonetheless, overcomeable. Econometric analysis of a program's population health outcomes is a methodologically difficult task. Measuring successes in population health takes time. Even large longitudinal studies with statistically significant findings can be subject to confounding outside factors. An example that illustrates several of these assessment challenges is the Class of 1989 study performed by the Minnesota Heart Health Program (MHHP), which followed students exposed to an educational initiative over a thirteen year period, assessing weekly smoking rates of participants as compared to a reference population. The intervention was performed over a five year period. While a significant decrease in weekly smoking rates among intervention participants was observed, researchers did note possible confounding of outcomes: "[a]t issue is whether the lower onset rate in the intervention community was due to some cause other than the intervention, and whether the increase in smoking in the reference community was as high as it was due to some cause other than the usual high school secular trend" (166). Even the best designed observational studies are subject to confounding by outside inputs such as economic factors, social pressure, and additional programs that could have an effect on the measured outcome (167). Even the geographic area may have an effect on the desired outcome, creating another

possible source of bias or confounding. These "neighborhood effects" on population health prompted one investigator to opine that "Ideally, [population health studies] should include sufficient numbers of neighborhoods and sufficient numbers of individuals per neighborhood to allow examination of within- and between neighborhood variability in the outcomes and in the factors associated with them" (168). Defining exactly what a neighborhood is and what healthcare services reach a population is challenging. In the modern healthcare system, to meaningfully evaluate the effects of a public health-oriented program one must disentangle the effects of a single institution's efforts in the context of overlying institutional catchments and populations consisting of individuals who seek treatment from multiple health systems (169). Ongoing population health surveys, such as the as the National Health and Nutrition Examination Survey (NHANES), one of the largest studies of population health in the United States, which has been active from the 1960's to the present, are only designed to measure the overall changes in population health trends, not to attribute them to one institution or another (170). Several large studies that rely on NHANES data on diabetes and coronary heart disease do make note that even significant statistical inferences on the data could be influenced by complex population factors, not by simple causation (171, 172).

It is true that it will be challenging, at least at first, to reliably link hospital performance to population-health outcomes. At present we do not have a good set of population-based outcome measures. The lag between policy initiative and the development of appropriate metrics is an oft-encountered issue in health policy. Similar challenges were faced when the first major pushes for quality improvement were initiated (173). In time, however appropriate metrics were developed. A similar pattern will likely follow in this area as the measurement of population health is already an active area of research. In the area of nonprofit tax exemption, one way to

deal with the problem of measurement and attribution is to begin by focusing on things that we can readily measure at present, in particular intra-institutional factors within the four walls of hospitals and then gradually shift to outcome-related measures as such metrics become more accessible and reliable. Thus, a population-health approach could be implemented in the near term by adapting tools from the Pay For Performance (sometimes abbreviated as P4P) movement. In the longer term, as population-based measures improve, the focus could shift increasingly to true measures of the population-level contributions of hospitals to the public's health.

Pay for performance systems for hospital quality improvement can provide a structure that could be applicable to the evaluation of nonprofit hospital tax exempt status as a measure of population health improvement. Pay for performance programs in healthcare have ranged from small HMO-based provider programs, to national quality improvement programs that endeavor to influence all hospitals that received reimbursement from government sources and have been in use in healthcare for more than 20 years (174). The structure of pay for performance systems varies, but the goal is frequently the same: fiscally reward providers for measurable quality improvement beyond a specified threshold (175).

While pay for performance systems are now common in modern healthcare, they have taken different forms, each with its own challenges. There are numerous examples of both private sector and government-based pay for performance programs that have yielded improvements in quality process measures. Studies on one of the largest federal programs, the Center for Medicare and Medicaid services (CMS) Premier Hospital Quality Incentive Demonstration, showed improvement in evidence-based quality measures relating to Acute Myocardial Infarction (AMI), pneumonia management, and total hip and knee replacement

surgery. Of the approximately 450 hospitals in this program, those institutions which showed improvement in these measures received reimbursement bonuses of up to 2% (176).

Statewide pay for participation and performance quality programs are another area where improvements in quality have been demonstrated. These programs are particularly important as they can be the incubators for best practices and quality improvement in discrete regions which then, if successful, can be implemented on a larger scale. The Hawaii Medical Service Association's (HMSA) collaborative on Coronary Heart Disease is an example of a regional collaborate that used a pay for performance model to make rapid improvements in process measures (177). Facilities eligible to participate in this program had to have 30 admissions annually for acute coronary heart disease. Thirteen hospitals were enrolled and tasked with implementing quality process guidelines dictated by the American Heart Association. The majority of the hospitals complied with the process improvement initiatives after one year of implementation and four of the facilities displayed 85% compliance with these best practice measures, which lead to additional reimbursement (178).

Such evaluations could be done in the context of data-sharing partnerships, such as the recently developed successful enterprises known as Multistakeholder Regional Collaboratives. These sorts of partnerships have already been shown to be an effective way of improving quality, as a recent investigation found that "collaborative[s'] reporting activities to be positively associated with improvement on a number of reported quality measures" (179). To conduct such evaluations to determining tax exemption status, one could utilized validated measures endorsed by organizations such as the National Quality Forum (180) and the National Committee on Quality Assurance (181). In particular, the Healthcare Effectiveness and Data Information Set (HEDIS) (182) has proved to be a valuable tool for conducting institutional evaluations (183).

Another notable regional collaborative that has demonstrated quality improvements using a pay for performance model is the Blue Cross Blue Shield of Michigan (BCBS) Collaborative Quality Initiative (CQI). This program includes 14 programs that all hospitals participating within the Blue Care Network and provide certain services are invited to participate in (184). Currently, over 80 hospitals are participating in at least one of these collaborative, the first of which was launched in 1997 (185). Each of these programs has an individually-tailored model that evolves over time. Hospitals are first invited and paid for participation in the program, then the focus is shifted to pay for performance process initiatives, and ultimately patient outcomes. Throughout every stage of the collaborative, the focus is on sharing data, best practices, and collective teamwork that drives a regional focus to achieve each of the collaborative's goals. While many of these programs are new (some only within the first five years of their inception), they have already yielded promising evidence of quality improvement. For example, hospitals participating in a vascular intervention collaborative demonstrated improvement in AMI process measures, such as proper medication dosing after an event, measures that have shown to have a significant effect on patient outcomes and to effect marked reduction in costs (186). Collaboratives that focus on general and vascular surgery improvements have demonstrated a significant decrease in risk adjusted morbidities from 2005-2009 compared to other hospitals in Michigan (187). As more of these Michigan collaboratives shift into pay for performance measures, there will be additional evidence with which to rate the effectiveness of such programs, though the initial evidence already looks promising.

While there is some evidence supporting the effectiveness of pay for performance programs, it also has some notable drawbacks. Physician based pay for performance programs have been criticized for only compensating already high performing practitioners, rather than

rewarding performance improvement (188). There is only limited evidence of the efficacy of pay for performance programs that attempt to tie quality improvement measures with tangible patient outcomes or overall improvement in patient disparities (189). There is also evidence indicating that pay for performance initiatives may not even be able to demonstrate accurate improvements in process measures because of other inputs into the quality improvement system such as public reporting of quality metrics, though a review of the CMS Premier program did find that there were more significant improvements in quality process measures in the pay-for-performance CMS Premier group then other facilities that were only publically reporting their data (190, 191).

Hospital Value Based Purchasing (VBP) is one of the most ambitious pay for performance programs in the United States mounted to date. It began in 2012 in the early stages of the implementation of the Affordable Care Act (ACA). This program, with its notable successes, may serve as a model for how the kinds population health improvement metrics needed for an outcome-based approach to community benefit can be derived. The initial goals of hospital Value Based Purchasing (VBP) as outlined in the ACA and implemented by CMS are simple: provide incentives for quality patient care as opposed to the standard model of higher reimbursement for higher throughput (192). Over 3,000 hospitals with inpatient services nation-wide are eligible for CMS hospital VBP in all 50 states and the District of Columbia. VBP through CMS is a budget-neutral program, achieving payments for its results by taking a portion of reimbursement off of the top of hospital diagnosis-related group (DRG) payment (starting at 1% in FY 2013 and moving to 2% in FY 2017 and beyond) and redistributing this amount so that top performers are rewarded, while others are not reimbursed for their full costs (193). This small percent is not trivial. With an estimated $1.4 billion dollars slated for redistribution in FY

2015, inpatient facilities must demonstrate improvement in the stated measures quickly, or be forced to give up critical reimbursement dollars. Hospital VBP incentives are not only derived from a combination of meeting threshold quality measures, but continuous improvement from baseline period to performance period on a rolling basis. The VBP target is fluid from year to year, not only in terms of what performance targets need to be reached, but also via shifting overall from a process-based to an outcome-based system, with certain measures phasing in and out each year (194). For example, the "Clinical Process of Care" measure domain of VBP in FY 2013 was 70% of the total VBP weight and was constituted by quality processes, such as antibiotic prophylaxis prior to surgery and distribution of discharge instructions. By fiscal year of 2017, the "Clinical Process" domain will be worth only 5%, with the majority of the VBP reimbursement directed towards measures of patient outcome such as post-operative infection or mortality.

CMS's hospital VBP system, despite its many strengths, is vulnerable to some of the same critiques mounted against other pay for performance programs. First, the measures chosen for VBP have allready been in use in payer and HMO based pay for performance programs for some time (195). These CMS-directed National Hospital Inpatient Quality Measures all militate toward support of evidence based practice such as the process measures outlined by the Joint Commission's Surgical Care Improvement Project (SCIP), a project that has looked for measured quality improvement in surgical process in Joint Commission certified hospitals since 2004 (196). Second, the measures on which VBP is gauged are, in most instances, publically reported and have been so for years (197). This can correct for some of the competitive effect seen from provider based pay for performance programs. These measures have helped to rank hospitals in public forums, such as in the Hospital Compare system, a consumer website

regulated by CMS that allows the user to compare facilities based on quality measures (198). Third, the budget-neutral aspect of VBP allows for only minimal additional cost to provide incentives for the participants in the program. Fourth, the two tiered payment structure of VBP also helps to correct for inequity of payment to institutions for higher quality and gaming of the quality measure system. Hospitals will need to show continuous improvement to gain back full payment from the VBP system. For example, if a top performing hospital, which has always met a threshold for a quality measure, does not show distinct improvement in the measure each year in the VBP cycle, it will not be fully compensated for the measure. This system also rewards underperforming hospitals that are demonstrating improvement, even if they are not meeting thresholds for these measures. This rolling system of measure for VBP performance also helps to eliminate gaming of the quality system. For example, a hospital can display artificial performance improvements in a quality measure if documentation errors are addressed surrounding that measure (199). A hospital will have to make actual quality improvement changes based on best practices to demonstrate continuous, sustainable improvement in this measure to achieve its full VBP earning potential. While there are incomplete data documenting the effectiveness of this new CMS hospital VBP program, the system could be used as a guide and incubator for quality improvement metrics to drive population health improvements. Regional collaboratives such as the Hawaii or Michigan models or a small federal pilot program, such as CMS Premier, are examples of ways to test a sample system before moving to a large program that would encompass all non-profit hospitals. The incentive for these population based improvements and performance on outcome measures could be connected to non-profit status, rather than reimbursement.

An alternative, though related, framework for community benefit evaluation could be to model determinations of tax exemption on the hospital licensure process (200). Both to avoid issues of capture and to mitigate the measurement problems associated with an econometric approach to measuring outcomes and attributing them to particular institutions, one could draw upon the field of program evaluation to conduct detailed, qualitative and quantitative evaluations of hospital's population health activities. It is worth considering whetehr attribution should not be based on statistical inferences of causality but, rather, on a deeper qualitative effort by trained personnel who look at the total efforts of a hospital and its accomplishment much the way accreditation works. This could be an adjunct or, at least in the short-term, alternative to actual outcome-measurement. In such a context, attribution would not be nearly as problematic as via econometric means because the focus is largely on services the hospital is providing within its four walls.

An outcome-oriented standard could be implemented administratively, legislatively, or both, and is therefore practicable. On the federal level, a new revenue ruling could implement this administratively, accompanied by modification of Form 990-H to accommodate accounting standards that would provide information about the effects of the community benefit activities. To reduce the burden on institutions, this could be evaluated on a longer-term interval (e.g. every 3 to 5 years) to allow time for interventions to show effect. On the state level, depending on the restrictions imposed by states' statutes and constitutions, this could be done either administratively by a state revenue agency, or legislatively through state (or, in some cases, local) legislation. This would accommodate the current fragmentation of authority over community benefit.

Section II.C: Implementation

The community benefit standard for nonprofit hospital tax exemption should be both expanded in scope and revised in substance. It should be focused more on actual health outcomes rather than structural criteria, particularly those that relate to population health in accordance with national priorities as reflected in the ACA. In previous chapters, I have made the argument that the community benefit standard as it currently exists is out of step with the contemporary health needs of communities. Presently, the standard is very focused on structural matters (such as whether a hospital has a community-oriented board and an emergency department). It needs to shift to outcome-related criteria, or, at least, include outcome-related parameters along with structural criteria.

Because of the challenges inherent in measuring community-based health outcomes, and the even greater challenges posed by the task of attributing such outcomes to the efforts of particular hospitals, identifying a limited set of quantitatively-measureable health outcomes for assessing the population-level benefits of hospitals is not feasible. There are, however, other ways of assessing the potential population health contributions of hospitals that are both feasible, and, likely to yield meaningful data which could be used to shape hospitals' activities so they better serve the public interest. The model I propose is one based on current methods for the accreditation and licensure of health care organizations. It would be part of a regular evaluation cycle for community benefit compliance that would both use the current disclosures made via Community Health Needs Assessments (abbreviated as CHNAs) and Form 990 data, as well as "on the ground," detailed evaluations of qualitative and quantitative data gathered via site visits by specialized contractors. The key features of this model are: (1) a revised exemption standard focused on indicia of community-based health outcomes, (2) the conduct of site visits to assess

hospital's contributions to community based health outcomes relative to IRS criteria and based on both quantitative and qualitative data, and (3) the IRS will retain sole authority to make determination of exempt status based on the site visit findings and other relevant data. The site visits will be done to gather a variety of qualitative and quantitative data from hospitals to assess what they have done over a defined period of time to contribute to their respective communities' health status, as well as what those contributions have achieved in terms of improved health outcomes.

In principle, the IRS could conduct site visits itself. However, doing so would require it to build a large staff of professionals with detailed knowledge of program evaluation. A potentially more tractable way to implement a population health-based framework for purposes of hospital tax exemption determinations would be for the IRS to contract with specially-equipped organizations, which could perform site visits and institutional evaluations to gauge the adequacy of the community benefit activities of nonprofit hospitals. Under such a model, the IRS would be the customer of the contractor, not the healthcare entities which are to be examined. This should help to assure independence and objectivity in the evaluation process.

The aforementioned model would require a revision of the current IRS community benefit standard, and, thus, the likely issuance of a new revenue ruling. As noted above, such independent evaluators could draw on the data now being collected via Form 990 Schedule H and the Community Health Needs Assessments. Similar to an accreditation or licensing model, these organizations could perform regularly-scheduled site visits (perhaps on a biannual or triannual schedule). They also could engage in ongoing or annualized review of institutional data, such as those forms of information disclosed in the CHNAs. The IRS could engage in notice and comment rule-making processes to provide a framework for how these tasks will be

contracted out, what sorts of qualifications and resources the contractors will need to have, and most importantly, how the results provided by the contractors will be evaluated by the IRS's own personnel, and what process a hospital would have available for appealing an adverse decision. The outside organizations would gather and summarize data, conduct analysis and generate reports, and, possibly, issue recommendations regarding a hospital's nonprofit status. Under this model, the IRS will review the results provided by the contractor as it gauges whether nonprofit status should be conferred or maintained. Nonetheless, final determinations regarding an institution's federal tax exempt status will, as now, be under the sole jurisdiction of the IRS. The role of the non-governmental entity will be purely assistive and advisory.

The object of such a relationship between the IRS and outside contractors would be to facilitate on the federal level a move toward an accreditation-type process of community benefit evaluation. Under such a model, to maintain nonprofit status, an institution would need to do more than merely document its activities on paper. Rather, both their submissions and their activities should be subject to a rigorous mechanism of evaluation. There is already considerable pressure from states and localities for greater disclosure of data regarding hospitals' activities and expenditures. The model being advanced here is in keeping with this trend and may well benefit from the momentum that has already been generated.

One key consideration is what kind of criteria the contractors will look for during their site visits. Criteria could be drawn from previously validated population health-related parameters which have been established by independent organizations. For instance, the National Quality Forum (NQF) has endorsed a set of standardized, scientifically evaluated indicators that hospitals can use to assess population-health performance (201). The NQF indictors have been systematized and made publically available through a searchable database

(202). Similarly, the Agency for Healthcare Research and Quality has developed an array of probative indicators, such as measures of preventable admissions, which could be utilized to evaluate the efforts of hospitals at improving population health (203). These include: the long-term and short-term complications admissions rates for diabetes, asthma, chronic obstructive pulmonary disease (COPD), as well as the admission rates for low birth weight, dehydration, hypertension, heart failure and uncontrolled diabetes.

In addition, the site visit teams could qualitatively examine the health promotion activities of hospitals to ensure that they comport with established best practices. The measures need not be fully standardized across hospitals. They could be, at least in part, customized to fit the hospital's community activities. Careful examination of the CHNA will be key to this process. The first step will be to profile the community's health needs based on the information gathered by the hospital in the CHNA, as well as other publically available data. The next step will be to ask certain key questions pertaining to the hospital's community benefit activities and whether, and how, they address the unmet needs. Some key questions could be:

- What were the identified needs?
- What has the hospital done to address these needs?
- What has been the plan to address needs?
- What measurable results can the hospital put forth?
- How has the hospital engaged with the local public health infrastructure to monitor health status?
- Has the hospital has developed a community health surveillance infrastructure that allows the hospital to monitor health status of its community?
- What kind of community initiatives has the hospital done?
- How has the hospital engaged the community or undertaken in outreach?
- How much has spent on these activities?

No one criterion will be dispositive. Rather, the goal is to provide a holistic picture of the hospital's activities which will provide transparency for the community, as well as a rich data set for qualitative analysis. At the very least, such an inquiry will make it very easy to identify if

hospitals are not doing anything to meaningfully address their community benefit responsibilities, or not taking this requirement seriously.

Section II.C.1: Relevant Institutional Players

As discussed above, one potentially attractive option for implementing a revised community benefit framework is the establishment of new relationships with private sector or nonprofit contractors. Under such an arrangement, the IRS would, as now, remain the central institutional player in nonprofit hospital tax exemption. The IRS would develop specific criteria for what it expects from hospitals relative to a revised community benefit standard, such as a requirement that hospitals must demonstrate how they are contributing to the actual improvement of the most critical health issues in their community as identified in their own CHNA. The IRS will also be responsible for developing an evaluative process, as well as making final determinations based on the site visit findings. It will promulgate specific criteria that will be the basis for such evaluations. For instance, it might require that hospitals demonstrate how they are contributing to the actual improvement of the three most critical health issues in their community based on their own CHNAs.

While the IRS would specify the evaluative process, and ultimately evaluate compliance, the process of conducting the site visits could be accomplished via a relationship with contractors with relevant skills and expertise. The contractors might be existing non-governmental organizations, or, perhaps, new non-governmental organizations constituted expressly for the purpose of implementing this initiative. The third-party NGO entities could be existing contractors with specialized expertise in the healthcare industry, such as the RAND corporation, the Altarum Institute, or similar bodies. They would undertake both the qualitative and quantitative aspects of the evaluation of hospitals' community benefit activities. This would

include reviews of the CHNAs and form 990-H reports generated by hospitals in addition to periodic site visits to assess qualitatively the nature and efficacy of the hospital's community benefit activities. The evaluations made by this body will be ongoing, on a cyclical basis, rather than a one time event. The contracted nongovernmental organization will make recommendations regarding exemption status based on a review of the site visit and the data disclosed by the hospital. However, authority over final determination of nonprofit status will remain with the IRS.

As a matter of federalism, state and local taxation authorities have great latitude to set their own standards for tax exemption. As such, this proposal for reform of the federal standard for nonprofit hospital tax exemption, if implemented, would not affect state and local tax exemption directly. It might, however, have a significant indirect effect on state and local tax exemption. Currently, many states "piggyback" on the federal standard; if an institution is deemed to be in compliance with the federal standard by the IRS, the state tax authorities automatically deem them to be in compliance with their requirements as well. Under a reformed community benefit standard, states could be free to continue to rely on federal determinations as they do now. However, they also could choose to enact more exacting standards and use the data generated by the federal evolution process to gauge compliance with requirements calibrated to met with their own needs and expectations.

The IRS, could, and should, freely share the results of the site visit evaluations it commissions with state and local authorities as well as the public at large. The information could therefore be used by state authorities to not only monitor the current community benefit activities of hospitals under their jurisdiction, but also to gain insight into the health needs of their communities and whether they are unmet. Such information might prove influential if the

state or locality should choose to set standards for exemption that more closely suit their communities' health needs and policy priorities.

Section II.C.2: Comparison with Previous Proposals

The above-mentioned proposal for implementation of community benefit reform would have a number of advantages over Berg's proposal for locally-constituted boards. Not least among these advantages is that it would be less prone to capture. Hospitals have tremendous political power in their local communities as they are large employers with significant economic effects on their local communities. While hospitals as an industry have a lobby nationally, it cannot compare but it does not compare to what happens locally. As such, locally-constituted boards could be particularly prone to capture.

Under the model I'm proposing, the contactors will be hired by and accountable to the IRS, not the hospitals they examine. Costs associated with site visits will be imposed on to hospitals via a special assessment, but the nonprofit institutions will not have any latitude in selecting the contractor or defining the parameters by which they are examined. Having the government as the customer should reduce the tendency for the contractors to be captured by the nonprofit industry.

A central problem with Berg's approach is that by involving local boards it will create a hodge-podge of expectations with no uniformity or guarantee of fundamental fairness. Moreover, her approach effectively pushes the IRS to the sidelines of the exemption process, though it has been an integral part of the tax exemption process for decades. Also, her approach does not address at all how such evaluation will be done. She also does not address whether her approach is for income or property tax exemption. The only nod she makes to these issue is by

positing that the community benefit boards will send a report to the IRS. Her approach will cause a lack of uniformity nationally, and raise issues of fundamental fairness.

Berg suggest that the locally-constituted boards would be able to make determinations regarding local property tax exemption eligibility. Nonetheless, she does not provide procedures for ensuring that the boards do so is a systematic manner. She also fails to explain how an adverse determination by a board could be appealed or contested. This combination of sweeping power and lack of accountability could lead one to be concerned that she has designed a kind of "star chamber" courts for the heath care industry.

The foremost advantage of reforming community benefit via a revised IRS standard is that it will maintain the current level of national uniformity. As this process of reform progresses, it will be important to institute protections to avoid institutional capture by the healthcare industry. To that end, the IRS should seek input from a diverse array of relevant stakeholders from the public health and consumer advocacy communities, in addition to the healthcare industry as it formulates its new policy. At a minimum, it should create an advisory board to provide input on the new regulations that has strong representation from consumer groups, academics and health care experts who are independent of the hospital industry.

<u>Section II.C.3: Criticisms that Critics Could Mount and Responses to These Potential Concerns</u>

A number of potential criticisms could be mounted against the aforementioned approach to the implementation of community benefit reform. One potential concern is whether such a proposal could be politically viable, particularly in this present time of highly charged partisan gridlock, which could make the passage of new federal legislation a potentially difficult undertaking. However, on the federal level, much of the necessary reform could likely be done

under existing legislation through administrative action via notice and comment rule-making or other like means. It is worth noting that the adequacy of community benefit provision by nonprofit hospitals has attracted attention from both the political left and right. Thus, even if new federal legislation is required, it might prove more politically viable than it might at first seem.

Another challenge for the kind of model being advanced is that it will admittedly be costly, particularly in the initial stages as assessment criteria are established and verification mechanisms are refined. The costs will most likely need to be borne by the nonprofit hospitals via a special assessment. This will have to become another element of a nonprofit hospital's operating expenses. While this will be an imposition, it also comes with significant financial benefits in the form of tax exemptions; most all of the studies to date on community benefit expenditures have found that the financial benefits that nonprofit hospitals receive via tax exemption far outstrip the costs they incur as a result of their community benefit activities and compliance requirements.

The level of costs imposed on hospitals will depend on how frequently they will have to engage in this process and how intensive the site visit and information disclosure process will be. But not all that much additional work may be required beyond hospitals' current data maintenance and disclosure activities. Much of this data already has to be compiled. Nonprofit hospitals may not get quite as good a deal as they are getting now, but it still will likely still be a very favorable bargain. Such a venture could prove to be expensive, both in terms of the expenditures required to start up such an initiative, and in terms of the compliance costs for nonprofit hospitals. However, such expenses may be offset by the increased public benefit achieved by such an approach.

A final concern might be whether such an imitative will prove to be effective in its efforts to improve the provision of community benefits by nonprofit hospitals. In terms of efficacy, such an arrangement will likely have some significant benefits over the community-committee model advanced by Berg. Specialized contractors will have much greater resources in terms of human capital. They will be able to recruit and train a highly skilled staff. It would prove difficult for a diffuse collection of multiple local boards to develop the expertise and the infrastructure necessary to make informed decisions regarding population health needs. This would prove to be much less of a challenge for an ongoing national-level initiative.

Section II.D: Application of An Outcome-Based Approach To Illustrative Cases

An application of an outcome-based approach to the cases described above, makes the significance of the change in standards becomes clear. For example, in *Wexford v. City of Cadillac,* given the *de minimis* provision of charity care (204), and the complete lack of evidence of demonstrable change in population health outcome and reduction in government health-related expenditures (205), under an outcome-based approach the Wexford Medical Group clearly would have lost its property tax exemption. The fact that the clinic was in a federally designated "health professional shortage" area (206) need not alter that conclusion. Losing the tax exemption would not necessarily cause the Wexford Group to move out of the area, and even if it did, the void might draw in a new clinic that could comply with the standard, and thus enjoy the tax exemption.

The case *Dialysis Clinic, Incorporated v. Levin*, hinged on the question of DCI's institutional form and policy. The dispositive question was whether having a policy that allowed DCI to turn away indigent persons, though it had never done so, disqualified it from exemption (207). Under an outcome-based approach, a court might have come to the same conclusion

though via different reasoning and on a stronger conceptual footing. The case shows some evidence of charity care, but it is poorly documented (208). DCI did not do much to reduce the burden of government, as private or public insurance compensated DCI for most its care (209). An outcome-based approach would have led to a more meaningful and rigorous analysis of this case. The inquiry would have been focused on what DCI achieves for the public, not an abstruse question of whether it had the appropriate institutional structure in its charter.

In *Provena*, the Illinois Court came to the right conclusion, but for the wrong reasons. *Provena* lays out a test much stricter than that in use by the federal government or most other states, but it still does not offer the right incentives. It looks only at institutional form and a minimum threshold of charity care expenses (210), rather than any indicators of health improvement in the community that provides the subsidy. There is no evidence of health promotion or other benefits to the community, and thus the court was right to strip Provena of its tax-exempt status (211).

In *Intermountain Health Care*, the statute regarding charitable tax exemption only addressed institutional form and purpose (212), whereas the Utah Constitution only mentions "charitable purpose" (213). This suggests, if not outcome, at least charitable function is the essential consideration. The Utah Supreme Court held that Intermountain Health Care did not have a charitable function, because the hospital provided no more community benefits than a similar for-profit (214). This reasoning militates towards an outcome-based approach, but the outcome is problematic. Much like the IRS in 1969, the Utah Supreme Court made policy without considering what incentives it was putting into place for nonprofit health systems (215), and whether those incentives would lead to socially beneficial outcomes.

Conclusion

Given the problems evident with the standard for tax exemption of nonprofit hospitals on the federal, state, and local levels, a reevaluation of these standards is timely. An outcome-based standard would provide greater analytic clarity and conceptual cogency to determinations of tax-exemption. It would more closely adhere to the policy rationale for nonprofit tax exemption, and likely also increase social utility by providing better calibrated incentives for the provision of public benefit. Recent changes in federal reporting requirements make it feasible to institute an outcome-based approach on the federal level through administrative means, and on the state and local level administratively or legislatively. In this way, an outcome-based approach is also practicable, which adds to its appeal. This new standard is consistent with precedent in that it harkens back to the traditional common law notion of charity. Therefore, an outcome-based approach merits further consideration by state and federal legislators and officials as an alternative to the current standard for tax exemption of nonprofit healthcare providers.

References and Notes

1. *Wexford Med. Group* v. City of Cadillac, 474 Mich. 192 (2006).

2. *Wexford Med. Group*, 474 Mich. at 212.

3. Nonprofit hospitals are roughly 62% of all nonfederal, general hospitals in the United States. U.S. Gov't Accountability Office, GAO-05-743T, Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Benefits 4 (2005).

4. Expenditures on hospital care in the United States came to $718 billion dollars in 2008. Am. Hosp. Ass'n, Trendwatch Chartbook 2010: Trends Affecting Hospitals and Health Systems, Chart 1.5 http://www.aha.org/research/reports/tw/chartbook/2010/chapter1.pdf (last visited Feb. 22, 2013).

5. Cong. Budget Office, Non Profit Hospitals and the Provisions of Community Benefits 3 (2006).

6. Rev. Rul. 69-545, 1969-2 C.B. 117.

7. *Id*., at 2.

8. Daniel M. Fox & Daniel C. Schaffer, Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*,* 16 *J. Health Pol., Pol'y and L*. 251 (1991).

9. Rev. Rul. 69-545, 1969-2 C.B. 117, 2.

10. Daniel B. Rubin, Simone Rauscher Singh, and Peter D. Jacobson. "Evaluating Hospitals' Provision of Community Benefit: An Argument for an Outcome-Based Approach to Nonprofit Hospital Tax Exemption." *American Journal of Public Health*: April 2013, Vol. 103, No. 4, pp. 612-616.

11. FOX & SCHAFFER, *supra* note 9 at 257.

12. The common law meaning of charity is "for the benefit of an indefinite number of people". I. T. 1800, II-2 Cum. Bull. 152 (1923).

13. Specifically, organizations created for religious, charitable, scientific, safety, literary, educational, or amateur athletic purposes are exempt from taxation. Moreover, they must accept certain limitation on political activity, including limits on lobbying and political campaigning. 26 U.S.C. § 501(c)(3) (2006).

14. About half of this amount is from the federal taxation. The rest is the value of the local and state tax exemptions. See Cong. Budget Office, *supra* note 5 at 3.

15. FOX & SCHAFFER, *supra* note 9 at 251.

16. FOX & SCHAFFER, *supra* note 9 at 256.

17. *Id*. at 257.

18. Prior to 1969, many of the rulings put forward by the IRS with regards to the meaning of charitable stated clearly that the relief of poverty was the primary consideration for regarding a nonprofit as fitting the narrow category of "charitable." This was due to the long list of other possibilities allowed in the legislation. This ruling (Rev. Rul. 56-185, 1956-1 C.B. 202) conforms to that interpretation. FOX & SCHAFFER, *supra* note 9 at 257.

19. FOX & SCHAFFER, *supra* note 9 at 262. Because Medicare and Medicaid made service to indigent and elderly populations compensable by establishing the government as the payer of health care coverage for certain at-risk populations, it created new revenue streams for hospitals. On the other hand, it threatened their core mission and their justification for nonprofit status, since for-profit hospitals could also serve those same populations. In fact, the nonprofit industry at the time argued that there would soon be no charity cases left to help. This was not a

completely specious argument at the time, as it was expected that there would be even greater expansion of health coverage around the corner.

20. Rev. Rul. 69-545, 1969-2 C.B. 117. It should also be noted that the meaning of "charitable" had changed in new regulations, put forward in 1959, to a much more inclusive definition that meant "for the benefit of an indefinite number of people." FOX & SCHAFFER, *supra* note 8 at 256.

21. Rev. Rul. 69-545, 1969-2 C.B. 117, as summarized by Jessica Berg, *Population Health and Tax-Exempt Hospitals: Putting the Community Back into the Community Benefit Standard*, 44 Ga. L. R. 1, 5 (2009).

22. Colombo J, Griffith G, King J. Overview of federal tax exemption for nonprofit hospitals and other health care providers. In: *Charity Care for Nonprofit Hospitals: A Legal and Administrative Guide*. New York, NY: Aspen Publishers; 2011.

23. In theory, a failure to fulfill any of the aforementioned criteria is grounds for the revocation of an institution's nonprofit tax status, but in practice the loss of nonprofit status is considered so draconian that it is rarely invoked. Doing so would not only force the hospital to pay taxes on its income, but also make it ineligible for various grants and remove tax benefits for donors. Revocation of the tax-exempt status would cripple most nonprofits. Berg, *supra* note 101 at 5. For this reason, Congress has allowed an intermediate sanction only if the sixth criterion of 26 U.S.C. § 4958 is violated or the community needs assessment is not completed. Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119, Tit. IX, § 9007, Tit. X, Subtit. H, § 10903 (Mar. 23, 2010), amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) at § 9007 (a)(r)(3). Even these intermediate sanctions have been applied very infrequently. In 2007, the IRS levied intermediate sanctions on only 25 tax-exempt organizations. Lawrence E. Singer, *Leveraging Tax-Exempt Status of Hospitals*, 29 J. Legal Med. 71 (2008). With the community aspect left as vague as it is, it is exceedingly difficult for a regulator to judiciously impose any penalties at all.

24. Berg, *supra* note 101 at 12, makes this same point. She argues that charity care is an important safety net, for now, but that a change away from relying on hospitals as the payer of last resort for medical care is needed, and that the emphasis in "community benefit" should be the community.

25. Indeed, this exact idea has been recognized by many courts at the state level. *Wexford Med. Group v Cty. of Cadillac*, 474 Mich. 19 (2006) and *Downtown Hosp. Ass'n. v Tenn. State Bd. of Equalization* 760 S.W.2d 95 (Tenn. App. 1988*)* both use this idea of "lessening the burden of government."

26. This is to prevent inflation of the charity care numbers, a common practice at many nonprofit hospitals. At the same time, hospitals still set their own requirements for financial assistance, and may do so unilaterally. Therefore, they can exert some control over the total amount of financial assistance provided. They must also report this exact policy on IRS Form 990-H. Patient Protection and Affordable Care Act at § 9007(a)(r)(5).

27. Patient Protection and Affordable Care Act at § 9007(f),§10903. This part of the act is to discourage further cases like *Provena Covenant Med. Ctr. v Dep't of Revenue, No. 107328, 2 (Ill. Mar. 23, 2010)*, in which many customers were not aware of the charity care program offered and to ensure access for all who need it.

28. *Id.* at § 9007(a)(1)(6). This is to prevent hospitals from ruining the credit of those who are unable to pay and do not know to take advantage of the charity care options.

29. *Id*. at § 9007 (a)(r)(3).

30. Letter from Renee Markus Hodin, Project Director, and Jessica L. Curtis, Staff Attorney, Community Catalyst, to the IRS (May 30, 2008).

31. *Id*.

32. Internal Revenue Service, Tax-Exempt & Government Entities Division, Office of Exempt Organizations, Draft Form 990 Redesign Project-Schedule H 2-4 (June 14, 2007).

33. Patient Protection and Affordable Care Act at § 9007 (a)(r)(3). The penalty for failing to file this community needs assessment is $50,000. Patient Protection and Affordable Care Act at §4959 (d). While Form 990-H has, until now, focused almost exclusively on costs borne by the nonprofit health systems, this new community needs report is almost tailored for an outcome-based assessment, as each nonprofit must now state what the community needs and how it is being addressed. Judging outcomes from one assessment to the other could easily provide the information needed for an outcome-based assessment.

34. Senator Charles Grassley made this point during a hearing on the nonprofit exemption. He was noting that a different commission on simplifying the tax code took this exact same approach. *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing Before the S. Comm. on Finance*, 109th Cong. 1-3 (2006) (statement of Sen. Chuck Grassley, Chairman, Comm. on Finance).

35. "These exemptions confer an indirect subsidy and are usually justified as the quid pro quo for charitable entities undertaking functions and services that the state would otherwise." Utah Cnty. v. Intermountain Health Care, 709 P.2d 265, 266 (Utah, 1985).

36. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker of the House of Representatives (Mar. 18, 2010).

37. *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways & Means,* 109th Cong. 87 (2005) (testimony of John Colombo, Law Professor, Univ. Ill. Urbana-Champaign).

38. I.R.C. § 4958(a) (describing penalties on excess benefit transactions).

39. This ruling was made without giving though to the effect it would have on overall health policy, and thus was made without consulting with many of the other actors in health policy.

Since then, other actors have accepted it and modified it, but without ever accepting or debating the normative or policy justifications for it. Fox & Schaffer, *supra* note 9 at 252.

40. This argument relies explicitly on the idea that "income" must be profit-seeking income. Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Tax,* 85 Yale L. Rev. 299, 307-314 (1976). The argument also includes property taxes, as those taxes (in some normative theories) complement income taxes and fall on the beneficiaries of the charity in question, most of whom are too poor to pay income taxes.

41. These theorists define income as accumulation plus consumption, with consumption being defined as only the private consumption of divisible goods. Moreover, as charities do not use these donations to accumulate wealth, but instead to create public goods, the nonprofit could not report it as income either. William D. Andrews, *Personal Deductions in an Ideal Income Tax,* 86 Harv. L. Rev. 309, 313 (1972).

42. The point of exempting charitable institutions from taxation is to "encourage the development of private institutions that serve a useful public purpose." Bob Jones Univ. v. United States. 461 U.S. 574, 586 (1983). There is disagreement on why a tax exemption is better than direct government spending on these public goods. Many explanations have been put forward with regards to the exemptions on charitable giving. Colombo and Hall argue, for example, that the very existence of a large amount of donations to a given cause suggests that it is providing an underserved need and thus should receive some form of tax exemption. John D. Colombo & Mark A. Hall, The Charitable Tax Exemption (1995). These explanations do not apply to institutions that rely more heavily on user fees than donations. This is also true of the "pluralism" argument, which holds that one of the goods that comes from nonprofits is that public goods that the majority under-values but that a substantial minority values will be better served through allowing the public to put their tax dollars to work directly, rather than relying on the government. For example, one explanation is that it would be more equitable to allow taxpayers who wish to fund some projects and to do so through their own donations rather than through government grants. Mark P. Gergen, *The Case for Charitable Contributions Deductions*, 74 Va. L. Rev. 1393, 1401 (1988). If an institution is not relying on donations, this justification does not hold for granting them tax-exemption.

43. One of the clearest examples of this is the case of Bob Jones University, which had its tax exemption revoked due to its racial discrimination policies. The fact that it provided educational benefits did not outweigh the policy damage done by the discrimination. *Bob Jones Univ*.

44. Just stating that charities should "do good" (or, less bluntly, "provide public goods") fails to explain what goods should be provided by these charities. Miranda Perry Fleischer, *Theorizing Charitable Tax Subsidies: The Role of Distributive Justice,* 87 Wash. U. L. Rev. 505, 525 (2010).

45. This definition was developed in order to avoid using moral judgments to determine which activities and organizations deserve support through tax subsidies. Some still argue that choosing which externalities to support, or even determining that something is an externality, requires some degree of moral judgment. Mark P. Gergen, *The Case for Charitable Contributions*

Deductions, 74 Va. L. Rev. 1393, 1396 (1988). Due to the fact that all of these goods give more benefit to the public than to the creator, they are consistently underprovided by the private sector.

46. The Illinois Supreme Court expressly stated this same idea. Provena Covenant Med. Ctr. v. Dep't of Revenue, 236 Ill. 2d 368, 405 (2010). When a locality gives a subsidy to a nonprofit, it is with the intention to provide greater social utility for those within that locality. It is inappropriate for a town or state to provide this subsidy, and bear the additional burden, and receive no public goods in return.

47. Communities are now acting to realize benefits directly, with many states revising their own standards. Many communities are also using litigation to increase the benefits provided by nonprofits. There is little common ground among the states on what should be required for local and state exemptions. Alice A. Noble et. al., Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives, 26 *J. L. Med. & Ethics*. 116, 119 (1998).

48. Evelyn Brody, Legal Theories of Tax Exemption: A Sovereignty Perspective, in *Property Tax Exemptions for Charities: Mapping the Battlefield* 145, 146 (Evelyn Brody, ed., 2002).

49. *Provena Covenant Med. Ctr. v. Dep't of Revenue* spells this out explicitly, listing all of the tax districts that lose revenue due to an exemption for *Provena*, and notes that the "record is devoid of findings regarding any of these taxing bodies." No. 107328, 21 (Ill. Mar. 23, 2010).

50. 127 Ohio St. 3d 215 (2010).

51. *Id.* at 216.

52. Dialysis Clinic, Inc. v. Levin, No. 2006-V-2389, 12 (BTA Nov. 24, 2009).

53. R.C. 5709.12(B) and R.C.5709.121

54. *Dialysis Clinic, Inc.* at 218.

55. *Id*. at 220.

56. *Id*. at 218.

57. Dialysis Clinic, Inc. v. Levin, No. 2006-V-2389, 12 (BTA Nov. 24, 2009).

58. *Id*.

59. Dialysis Clinic, Inc. v. Levin 127 Ohio St. 3d 215, 223-24 (2010). In contrast, the dissent argued that the fact that the evidence showed that DCI has not, to date, refused care to the indigent suffices to make it charitable.

60. *Id*. at 221.

61. *Id*.

62. *Id*. (quoting *NBC-USA Hous., Inc.-Five v. Levin*, 125 Ohio St.3d 394 (2010)).

63. *Id.* at 225.

64. Wexford Med. Group v. City of Cadillac*,* 474 Mich. 192, 196 (2006).

65. *Id.* at 200.

66. *Id*.

67. *Id*.

68. *Id*. at 202-03. This test comes from *Engineering Society of Detroit v. Detroit*, 308 Mich. 539, 550 (1944).

69. *Wexford Med. Group* at 203.

70. This was based on several factors, no one of which is dispositive. A “charitable institution” must be nonprofit, must be organized chiefly for charity, does not discriminate among the population that it serves, and has one of several functions including that it “relieves people’s bodies from disease, suffering, or constraint.” Notably, a charitable institution may charge and need not meet any monetary threshold of charity. This definition of a charity is based on one from *Retirement Homes of the Detroit Annual Conference of the United Methodist Church, Inc., v. Sylvan Twp*, 416 Mich. 340, 348-9 (1982).

71. For the two-year period, only $2,400 was spent on charity care: $129 in 2000 and $2,229 in 2001. Wexford Med. Group v. City of Cadillac*,* 474 Mich. 192, 204 (2006).

72. *Id*. at 210.

73. Provena Covenant Med. Ctr. v Dep’t of Revenue, No. 107328, 2 (Ill. Mar. 23, 2010).

74. *Id.* at 9.

75. *Id*. at 10.

76. *Id*. at 11.

77. *Id*.

78. *Id*.

79. *Id*.

80. *Id*. at 30.

81. *Id*. at 32 (citing *Faith Builders Church, Inc. v. Dept. of Rev.*, 378 Ill. App. 3d 1037, 1046 (2008)).

82. *Id*.

83. *Id.* at 16. This test was adapted from an earlier case, *Methodist Old Peoples Home v. Korzen* 39 Ill. 2d 149, 157 (1968).

84. *Provena* at 16.

85. *Id*.

86. *Id*. at 18-19

87. Crerar v. Williams,145 Ill. 625 (1893) at 643 (quoting *Jackson v. Phillips*, 96 Mass. 539, 556 (1867)).

88. *Provena*, at 20.

89. *Id*. at 21 (quoting *Willows v. Munson*, 43 Ill. 2d 203, 208 (1969)).

90. *Provena* at 21. The Court also held that “discounted” care did not qualify as charity care, as charity must be a gift, and if there is a fee, it cannot be a gift. Martin v. Martin, 202 Ill. 382, 388 (1903).

91. Two others abstained entirely, leaving the seven-member court split 3-2. *Provena* at 37. According to the dissent, this prevents the plurality decision from being “binding under the concept of state decisis.” *Id.* at 37.

92. “By imposing a quantum of care requirement and monetary threshold, the plurality is injecting itself into matters best left to the legislature.” *Id*. at 33.

93. Utah Cnty. v. Intermountain Health Care, 709 P.2d 265, 266 (Utah, 1985).

94. *Id*. at 267

95. UTAH CODE ANN. §§ 59-2-30 (West 1974).

96. UTAH CODE ANN. §§ 59-2-31 (West 1974).

97. Utah CONST., art. XIII, § 2.

98. UTAH CODE ANN. §§ 59-2-31 (West 1974).

99. *Intermountain Health Care* at 269.

100. *Id.* at 269-270. This test was adapted from a test in a Minnesota case, *North Star Research Institute v. Cnty. of Hennepin*, 306 Minn. 1, 6 (1975).

101. Utah CONST., art. XIII, § 2.

102. *Intermountain Health Care* at 269-270.

103. *Id*. at 269-276.

104. *Id*. at 269-276.

105. The Court explicitly excluded discounted care as charity care, quoting an earlier case: "Where material reciprocity between alleged recipients and their alleged donor exists--then charity does not." United Presbyterian Ass'n v. Bd. of Cnty. Commiss'rs, 167 Colo. 485, 503 (1968).

106. *Intermountain Health Care* at 274.

107. *Id*. at 275.

108. *Id*. at 278.

109. Downtown Hosp. Ass'n v. Tennessee State Bd. of Equalization, 760 S.W.2d (Tenn. 1988).

110. Noble et. al., *supra* note 87 at 130. In particular, Noble shows that many "benefits" touted by nonprofits are no different than those touted by *any* for-profit business, including employment and "cost containment."

111. Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care For the Uninsured*, 25 RAND J. of Econ., 171, 184 (1994). More exactly, nonprofits tend to concentrate in those parts of a county that are poorer and have less health insurance.

112. Cong. Budget Office, *supra* note 6. This does not exactly contradict the previous study, as that study focused on the distribution within a single county, whereas the CBO focused on distribution around the country as a whole.

113. U.S. Gov't Accountability Office. *supra* note 4. This study used five dissimilar states to model the whole country. In Florida and Georgia, there was nearly the same percentage of operating costs going to charity care for both nonprofits and for-profits. In Texas, where there are strict regulations requiring nonprofits to provide enough charity care to compensate the state for its exemption, nonprofits provided nearly 50% more charity care, as a proportion of costs, than for-profits. In Indiana, it was double. Most interestingly, in California, for-profits actually provided more charity care than nonprofits. In all states, nonprofits and for-profits were both dwarfed by the charity care provided by the public hospitals.

114. Cong. Budget Office, *supra* note 6. The actual difference between nonprofit and for-profit hospitals on this measure is very small (15.6% of all days as Medicaid covered days compared to 17.2% at for-profits), but once again both are dwarfed by public hospitals (27%).

115. Christine Jindra. *Clinic and UH Pressured to Treat More ER Patients* Cleveland.com Blog (Oct. 24, 2007 7:15 pm), http://blog.cleveland.com/metro/2007/10/pressure_is_mounting_to_get_cl.html. The requirement that a nonprofit have an emergency room open to all is the one that provides the most direct community benefit.

116. Hospitals often tout jobs when defending their tax exemption, especially to the public. Joan Mazzolini, *Clinic and UH Worth a Lot, But Taxed a Little*, The Plain Dealer, April 9, 2006.

117. Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-For-Profit Hospitals,* 50 UCLA L. Rev. 1345, 1405-8 (2003). In particular, nonprofits seem more willing to provide unprofitable or low-profit services and are more willing to serve underserved populations, particularly the poor and uninsured.

118. A market failure is when the market fails to provide a welfare maximizing level of a good. In this case, if subsidizing nonprofit health providers causes an increase in underprovided goods, it may be worth subsidizing the nonprofit health providers. N. Gregory Mankiw, Principles of Economics 11 (5th ed. 2000). For further discussion of market failures and nonprofit health providers, see *id.* at 1405. It is likely more efficient to correct this market failure through tax exemption rather than regulation or contracting, as the health care market is too complex to be centrally administered, and a more direct hand will skew it more. In fact, Medicare and other government programs may be responsible for some market failures, by setting price levels incorrectly relative to the true market price. It is a common tenet of economics that shortages result when prices are forced at a lower level than the market clearing price. This problem is avoided by the use of a blanket subsidy, rather than by purchasing specific healthcare products. *See id*.

119. This is likely due to the effect that for-profit competition has on nonprofits, and the need for nonprofits suffering from this competition to bolster their own revenue sources. In order to bolster these revenues, many nonprofits increase the amount of profitable services, in effect acting like nearby for-profit hospitals. For more discussion, see Jill R. Horwitz & Austin Nichols, *Hospital Ownership and Medical Services: Market Mix, Spillover Effects, and Nonprofit Objectives*, 28 J. Health Econ. 924, 934 (2009).

120. The mounting number of cases against nonprofits, including *Provena Covenant Med. Ctr. v Dep't of Revenue,* No. 107328, 2 (Ill. Mar. 23, 2010) and the Cleveland Clinic, shows this to be a real concern. See Mazzolini, *supra* note 119, and the description of recent litigation, below.

121. In particular, as shown in section I.C, state courts have been sharply divided on whether any actual benefit must be given for a nonprofit to maintain its status. Even those courts that have

required benefit, such as Illinois and Utah, have never stated what the exact threshold is. Provena Covenant Med. Ctr. v Dep't of Revenue, No. 107328, 2 (Ill. Mar. 23, 2010).

122. Horwitz, *supra* note 120.

123. As a new field of study, the idea of what constitutes population health is still being codified, but the most cogent definition of population health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." David Kindig & Greg Stoddart, *What Is Population Health?* 93 Am. J. Pub. Health 380, 380-83 (2003).

124. Berg, *supra* note 101 at 24

125. *Id*.

126. *Id*. at 25

127. Regulatory capture is when "regulation is acquired by the industry and is designed and operated primarily for its benefit." George Stigler, *The Economic Theory of Regulation* 11 Bell J. Econ. 3, 3 (1971). This problem arises because the benefits to the population are diffuse, while the benefits available to the industries are concentrated, thus causing those within the industry to pay more attention to the regulating board than the population at large.

128. Nicholas Bagley *Agency Hygiene* 89 Tex. L. Rev. See Also 1 2010, p.2

129. George Stigler, *The Economic Theory of Regulation* 11 Bell J. Econ. 3, 3 (1971).

130. For further discussion see: Jean Jacques Laffont & Jean Tirole, The Politics of Government Decision-Making: A Theory of Regulatory Capture, 106 Q. J. Econ. 1089, 1089-1127 (1991). ; Michael E. Levine & Jennifer L. Forrence, Regulatory Capture, Public Interest, and the Public Agenda: Toward A Synthesis, 6 J. L. Econ. Org. 167, 170 (1990).

131. George Stigler, *The Economic Theory of Regulation* 11 Bell J. Econ. 3, 3 (1971).

132. David Schleicher, *Why Is there No Partisan Competition in City Council Elections?*, 23 J. L. & Pol. 419, 419 (2007).

133. David Schleicher, *Why Is there No Partisan Competition in City Council Elections?*, 23 J. L. & Pol. 419, 419 (2007). Very few local elections are able to engage the entire electorate, due to resource constraints.

134. Jean Jacques Laffont & Jean Tirole, *The Politics of Government Decision-Making: A Theory of Regulatory Capture*, 106 Q. J. Econ. 1089, 1089-1127 (1991).

135. *Id*. at 1091

136. *Preventing Regulatory Capture: Special Interest Influence and How to Limit It*. Daniel Carpenter and David Moss [Eds]. Cambridge University Press, 2013.

137. Rachel E**.** Barkow, *Insulating Agencies: Avoiding Capture through Institutional Design, 89* Texas L. Rev. 15 (2010). P. 3.

138. *Id.*

139. Michael E. Levine & Jennifer L. Forrence, *Regulatory Capture, Public Interest,and the Public Agenda: Toward A Synthesis*, 6 J. L. Econ. Org. 167, 170 (1990).

140. Shavell, *supra* note 129.

141. The fundamental axiom of economics is that individuals and institutions are influenced by incentives. Mankiw *supra* note 121 at 7

142. This idea, tying benefit to the taxing body, is put forward most directly by the Illinois Supreme Court in Provena Covenant Med. Ctr. v Dep't of Revenue, No. 107328, 2 (Ill. Mar. 23, 2010).

143. Shavell, *supra* note 129 at 96. Even without perfect knowledge by the producer, this should theoretically lead to the most efficient outcome.

144. Obviously, a lack of private inurement should be an additional *sine qua non.*

145. FOX & SCHAFFER, *supra* note 9, at 257.

146. As a new field of study, the idea of what constitutes population health is still being codified. However, this definition, proposed by David Kindig & Greg Stoddart, *supra* note 133 at 380-83, is the most cogent and clear one to be proposed so far. They also admirably go through many of the competing definitions.

147. Many of the justifications for tax exemption require that the benefits being provided be public goods or other goods with public benefit, in a way that individual charity care simply is not. See Mark P Gergen, *supra* note 100 at 1401.

148. Patient Protection and Affordable Care Act at § 9007 (a)(r)(3).

149. Mark Schlesinger and Brad Gray have already compiled many different ways in which hospitals already create community benefit that inure more broadly than just charity care. Mark Schlesinger & Brad Gray, *A Broader Vision for Managed Care, Part 1: Measuring the Benefit to Communities*, 17 Health Aff. 152, 152-168 (1998); Mark Schlesinger et al., *A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits*, 17Health Aff. 26, 26-49 (1998); Mark Schlesinger et. al., *A Broader Vision for Managed Care, Part 3: The Scope and Determinants of Community Benefits*, 23 Health Aff. 210, 210-21 (2004).

150. Gusmano et al., *supra* note 126 at 518.

151. Schlesinger & Gray

152. *Id.*

153. David W. Kaplan et al., *Managed Care and School Based Health Centers*, 152 Archives Pediatric Adolescent Med. 25, 25-33 (1998).

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156. Matthew F. Daley et al., *Adolescent Immunization Delivery in School-Based Health Centers: a National Survey*, 45 J. Adolescent Health 445, 445-52 (2009).

157. Susan J. True. *Community-Based Breast Health Partnerships*, 1 J. Pub. Health Mgmt. Prac. 67 (1995).

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160. Loretta Lacey et al., *Referral Adherence in an Inner City Breast and Cervical Cancer Screening Program*, 72 Cancer 950, 950-55 (1993).

161. Loretta Lacey et. al., *An Urban Community Based Cancer Prevention Screening and Health Education Intervention in Chicago*, 104 Pub. Health Rep. 536, 536-41 (1989).

162. Schlesinger et al. *supra* note 155.

163. *Id*.

164. Meg Smirnoff et. al., *Public Health Campaign Funds Provide a "Safety Net" for Indigent Tuberculosis Patients at the Mount Sinai Hospital*, 1 J. Pub. Health Mgmt. Prac. 28-34 (1995).

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204. Only 13 patients were treated under the charity care program in two years. Wexford Med. Group v. City of Cadillac, 474 Mich. 192, 197 (2006).

205. No evidence of efficacy was ever presented in the Wexford case. *Id*.

206. *Id*. at 195.

207. Dialysis Clinic, Inc. v. Levin, No. 2006-V-2389, para. 34-36 (BTA Nov. 24, 2009).

208. *Id*. at para 39.

209. *Id*. at para 14.

210. Provena Covenant Med. Ctr. v Dep't of Revenue, No. 107328, 16 (Ill. Mar. 23, 2010).

211. It should be noted that, due to the Court's inability to reach a majority ruling, *Provena* does not establish precedent in Illinois, though it is a useful touchstone for further analysis. *Provena*, at 37.

212. U.C.A., 1953, §§ 59-2-30 (1974) and 59-2-31 (1974). The regulation specifically stated that operating a hospital was a "charitable purpose," and that as long as there was no private inurement, the property was tax-exempt.

213. UTAH CONST., art. XIII, § 2

214. Utah Cnty. v. Intermountain Health Care 709 P.2d 265, 271 (Utah, 1985).

215. Specifically, the Court declared this case a "record case," and that the ability of other hospitals to meet this requirement was not at issue. *Id*. at 279.

CHAPTER 5

Conclusion

Together, the three papers of my dissertation constitute a cohesive whole. The first provides a comprehensive review of the problem of community benefit and the empirical, theoretical and policy literature generated by this problem. The second chapter posts a possible policy solution to the problem and examines the challenges and promises such an approach could bring. The final chapter examines the legal changes which would be necessary to bring about such a policy changes and explores how such legal reform could be brought about. It then presents the regulatory and legal ramifications of such a change.

One future direction which I would like to explore to build upon the research conducted for this dissertation, is to examine empirically the relationship between the features of state-level community benefits laws and the provision of community benefits by nonprofit hospitals. Despite policymakers' efforts to ensure that nonprofit hospitals provide adequate benefits for the tax exemptions received, little is known currently about the relationship between state-level community benefit reporting requirements and nonprofit hospitals' provision of community benefits. As a result, it is unknown whether nonprofit hospitals act in a manner consistent with the normative justification for tax exemption. The few existing empirical studies in this area provide evidence from a number of states that the implementation of a community benefit reporting requirement increases hospitals' provision of uncompensated care but fail to establish a relationship between reporting requirements and nonprofit hospitals' community orientation and

other community benefit initiatives. I would like to conduct research to provide empirical evidence of the effect of state-level community benefit reporting requirements on nonprofit hospitals' provision of community benefits for a nationally representative sample of U.S. hospitals.

I am interested in answering a variety of research questions related to the community benefit standard for a nonprofit hospital tax exemption. Using the Form 990 data and American Hospital Association survey data, combined with my own coding of state level community benefit laws and their disclosure provisions, I hope to answer the question of whether these laws have an effect upon the provision of community benefits by nonprofit hospitals, what effects those are, and how they are mediated. From the initial descriptive statistics that have been done thus far, it seems that state level community benefit laws do indeed have an effect on the provision of both clinical and nonclinical community benefit services by nonprofit hospitals.

One important research question that I hope to answer is whether the mechanism for this increase in provision is the prospect of public disclosure and scrutiny of the hospital's activities or whether it is the hospital's own awareness of the needs of its community. To use an interpersonal analogy, the question is whether the changes in community benefit provision are mediated by "shame" or by "guilt." That is, is it the prospect of negative attention in popular press or other public venues, governmental scrutiny, or other kinds out outside pressure that encourages hospitals to provide more community benefits? Or is it that the process of being forced to evaluate the health needs of their communities and the expenditures that they devote to community benefit provides hospitals with insight into the needs of their populations, and thereby changes their patterns of spending on community benefit activities?

Further aspects that I would like to elucidate include whether the process of engaging in a Community Health Needs Assessment, often abbreviated as CHNA, is associated with increase level of community benefit expenditures. Community Health Needs Assessments are mandated under the Affordable Care Act for nonprofit hospitals. However, there is not yet a solid evidentiary foundation for the efficacy of this mandate as a policy intervention. Examining whether this policy made a difference before the introduction of the Affordable Care Art could therefore be illuminating. Even before the mandate of Community Health Needs Assessments in the Affordable Care Act, they were mandated by state laws in a variety of different states. Comparing provision levels in those states that had Community Health Needs Assessment requirements and those that did not could provide a natural experiment to examine their efficacy.

This project would expand the work of prior studies by: (1) broadening the notion of state-level community benefit reporting requirements to include both legislation and litigation; (2) employing a broader definition of community benefits that focuses not only on charity care but also includes measures of other community benefit activities; and (3) examining a nationally representative sample of U.S. hospitals.