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# The Converging Public Health Responsibilities of Nonprofit Hospitals and Government Hospitals, Government and Public Health

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## Abstract

**Background:** Given the Affordable Care Act (ACA) implementation and the rapid transformation underway in the U.S. hospital system, it is important to take stock of the context in which governmental entities and nonprofit hospitals are meeting their shared responsibility for the public's health. This article discusses key requirements for hospital tax exemption at the federal and state levels, and specifically discusses the responsibilities of nonprofit hospitals with regard to community benefit and to lessening the burdens of government. The emerging convergence of responsibilities presents a unique opportunity for government, hospital and community collaboration to improve public health in the U.S.

**Purposes:** The purpose is to suggest the foundation and incentives for nonprofit hospitals and government to work more closely in addressing the public health needs of the populations they serve.

**Methodology/Approach:** Our analysis focused on case law, statutory language and journal articles.

**Findings:** As part of the ACA, an important policy objective of the Community Health Needs Assessment (CHNA) requirement for nonprofit hospitals is to encourage greater responsibility for public health into the nonprofit hospital sector. The CHNA requires input from the community and public health experts. Providing community benefit and lessening the burden of government are tax-exempt requirements in many states. The closer that nonprofit hospitals and local governments work together during the CHNA process, the greater the opportunities to tangibly improve public health, and at the same time reduce hospital risk of taxation at the local level.

**Practice implications:** The sum of state and local tax exemption laws and regulations and the new CHNA federal requirements under the Affordable Care Act set the stage for a convergence of hospital government public health responsibilities. Therefore, for those states and communities interested in promoting and improving public health, the CHNA requirement of the ACA provides a unique opportunity for governmental entities to partner with their community hospitals to improve the public's health.

**Keywords:** Tax exemption; Hospitals; Nonprofit; Patient protection and affordable care act; Community health needs assessment; Community benefit; Government burden

## Introduction

Law and public opinion recognize an important role of government is to protect the public's health [1]. Carrying out this responsibility in many cases requires collaboration among federal, state and local public health agencies, private-sector entities, nonprofit foundations and associations and community organizations. The collaborative U.S. public health model and broad responsibilities of "fulfilling society's interest in assuring conditions in which people can be healthy" [2] is articulated in the U.S. Health and Human Services (HHS) Three Core Functions and Ten Essential Services of Public Health [3]. It is a fair assumption from these enumerated and expansive public health functions and services that government lacks the total resources to provide all of these essential services, and therefore should consider collaborating with the hospital sector to help fulfill *society's interest*. It is also not unexpected for government to look to the tax code to incentivize private organizations to provide publicly useful benefits.

From the experience of the authors, many hospital bylaws include clear missions to improve the health of the individuals and communities they serve. The American Hospital Association, the preeminent association representing hospitals in the U.S., states that its mission is to represent "hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement" [4]. Of the 4999 registered community hospitals in the U.S., 2894 are nonprofit and 1037 are state and local government hospitals. Taken together, government and nonprofit hospitals comprise 79 percent of our hospital system [5]. It appears that the public health responsibilities of at least nonprofit hospitals can be better understood through the evolving and complex tapestry of hospital laws, regulations and community benefit activities.

There has been a modicum of discussion about the Patient Protection and Affordable Care Act (ACA) requirement that all nonprofit hospitals conduct a community health needs assessment (CHNA) and submit an implementation strategy every three years to the IRS of how they plan to address those needs identified in the CHNA [6]. Given that hospitals have now conducted the first set of CHNAs and complied with IRS reporting requirements, and the

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concurrent rapid transformation and consolidation underway in the U.S. hospital sector, it is important that we take stock of the context in which governmental entities and nonprofit hospitals are meeting their shared responsibility for the public's health. This article will update the literature on the requirements for hospital tax exemption, specifically discuss the possibilities for nonprofit hospitals to lessen the burdens of government and finally suggest that the stage is set for a convergence of roles that presents a unique opportunity for government, hospital and community collaboration to improve public health in the U.S.

## Theory/Conceptual Framework

The requirements for federal tax exemption for nonprofit hospitals in the United States have changed over the years to keep pace with national healthcare policy. The requirement for rendering "free care" of the past has been supplanted to great extent by a requirement for "community benefit," which is intended to incentivize tax-exempt hospitals to address the broader health needs of the communities they serve, including public health needs, but not without additional costs to hospitals.

In support of a national policy for the increasing access to care and for improving public health, the ACA was signed into law on March 23, 2010, by President Obama (Pub.L.111-148) in §9007(a) and the corollary §501(r) of the Internal Revenue Code. 111 P.L. 148; 26 USCS § 501(r). The ACA includes provisions that require nonprofit hospitals to conduct and implement CHNAs every three years in order to prevent facing financial penalty and potential loss of federal tax-exempt status. 26 USCS § 501(r)(3)(A)(i)(B). A CHNA must take into account input from persons who represent the broad interests of the community served by each hospital facility, including those with special knowledge or expertise in public health. § 501(r)(3)(B)(i). The reasons for this section of the ACA were for Congress with the help of the Internal Revenue Service to add a more substantive component to the community benefit requirement for nonprofit hospitals to justify their federal tax exemption [7] and at the same time promote public health initiatives [8]. A CHNA identifies and prioritizes community health needs, and it describes how these needs are to be addressed. CHNA activities must also be reported on Worksheet 4 of Schedule H of the IRS Form 990. This Worksheet also identifies what should be reported.

"To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following.

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective; including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following.

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to health care services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Strengthen community health resilience by improving the ability of a community to withstand and recover from public health emergencies.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public."

Of special note are references to community need collaboration with public health agencies and government, enhancing public health, relief of government burden, and general knowledge through education and research. These also relate to the functions and services of public health referenced above, and not solely to the provision of health care services.

## At The State Level

As illustrated below, most states also have requirements that nonprofit hospitals must satisfy in order to be tax exempt from various taxes including income, property and sales; and, in some instances, approved for licensure and certificate of need. With respect to community benefit, the Hilltop Institute of the University of Maryland Baltimore County (UMBC) in its May 2014 issue brief, compares state-level regulation of hospital community benefits with the major categories of federal community benefit requirements [9]. Although there are 23 states that have some form of community benefit requirement, only 10 require hospitals to develop implementation strategies. Some examples of states that have created programs or passed legislation to address hospital community benefit obligations follow.

Indiana requires nonprofit hospitals to develop a community benefit mission statement and plan. Burns Ind. Code Ann. § 16-21-9-4. Illinois has an almost identical statute but allows only for fines of up to $100 per day for hospital non-compliance. 210 Ill. Comp. Stat. Ann. 76/25. New York has similar statutory requirements, without the fines, and requires a mission statement as well as a CHNA to be reevaluated every three years. NY CLS Pub Health § 2803-l. Nevada has a basic statute setting forth filing requirements for hospitals that have over 100 beds, which includes a section referring to community benefit reporting to the state health department. Nev. Rev. Stat. Ann. § 449.490. None of these states provide comprehensive guidelines.

New Hampshire provides clarity in its community benefit statute, requiring needs assessments every five years and potential fines of up to $1,000 per day plus attorney's fees for violation of the statutory provisions. N.H. Rev. Stat. Ann. Tit. I, § 7:32(f)(g). New Hampshire, however, exempts hospitals whose health care charitable trusts are below $100,000 and where compliance would be a financial or administrative burden. § 7:32(j). Connecticut's statute, although more detailed, applies only if a hospital elects a "voluntary" community benefit program. Conn. Gen. Stat. § 19(a)(1). Although the Connecticut

Department of Health does not have any oversight authority, it prepares a multiyear state health plan, which provides an assessment of the health of Connecticut's population and the availability of health facilities. § 19(a)-7(a).

Massachusetts has a comprehensive "Community Benefits Program," established through the statutory oversight authority for charitable organizations by the Office of the State Attorney General and was originally effective in 1994 [10]. The voluntary program encourages hospitals to address health and social needs in the communities they serve. The *Guidelines* seek to continue to encourage charitable activities on the part of hospitals as well as the spirit of cooperation and partnership between hospitals and their communities that promote meaningful and effective community benefit programs (1).

Under the Massachusetts program, each hospital issues a formal public Community Benefits Mission Statement setting forth its commitment to provide resources to and support the implementation of its annual Community Benefits Plan (7). It identifies the relevant community and assesses its needs and priorities with an emphasis on significant community involvement (7-9). The statement includes a plan with both short and long-term goals and identifies measurable outcomes (21). In many respects the ACA CHNA process is similar to the Massachusetts approach.

Texas has developed a program that is directly linked to tax-exempt status, and it focuses primarily on developing minimum charity care standards and creates a floor beneath which hospitals are not supposed to fall. Tex. Health and Safety Code § 311.041. Its community benefit statute requires community benefit planning and is one of the few states that links these requirements to its state code. § 311.043-045. The statute also provides three quantifiable standards against which hospitals' community benefit efforts may be measured: (a) charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital or hospital system, and the tax-exempt benefits received by the hospital or hospital system; (b) charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or (c) charity care and community benefits are provided in a combined amount equal to at least 5 percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue. § 311.045(b)(1)(A)-(C). The statute defines a "community benefit" as the "unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services. Community benefits do not include the cost to the hospital of paying any taxes or other governmental assessments." § 311.042(2).

California also has a detailed statute codifying the community benefit requirements for hospitals that has the added benefit of being legislatively promulgated. Cal Health and Saf Code § 127340. The legislature found that the "public recognition of their unique status has led to favorable tax treatment by the government. In exchange, nonprofit hospitals assume a social obligation to provide community benefits in the public interest." § 127340(a). The statute states that in the community benefit plans, the hospitals should include measurable objectives and benefits categorized into: medical care services, other benefits for vulnerable populations, other benefits for the broader community, health research, education, and training programs and non-quantifiable benefits. § 127355(b)-(c).

Maryland has also codified comprehensive community benefit requirements. Md. HEALTH-GENERAL Code Ann. § 19-303. The statute requires that hospitals submit a "Nonprofit Hospital Community Health Benefit Report" to the House Health and Government Operations Committee and the Senate Finance Committee. § 19-303(d)(4). The Maryland General Assembly passed House Bill 15 during the 2001 Legislative Session, which created a new responsibility under the Health Services Cost Review Commission. *See Id.* The Health Services Cost Review Commission published guidelines that provide specific examples of aspects of programs that qualify as "community benefit" [11]. As Maryland law defines a community benefit as an activity that is "intended to address community needs and priorities primarily through disease prevention and improvement of health status," hospitals are able to utilize these guidelines as an invaluable resource in determining appropriate community benefit activities. § 19-303(3).

As demonstrated above, state requirements vary significantly. The lack of a standard community benefit definition and implementation requirements across the states had led to a patchwork of hospital community benefit programs, most of which are reported without clearly defined outcomes [12]. Based on the complementary intent of the federal ACA and Section 501(r) of the Internal Revenue Code CHNA requirements, we believe that satisfying the federal CHNA requirement should be helpful to nonprofit hospitals in also satisfying many state community benefit requirements; and, even though the community benefit requirements differ among states, the basic concept of improving the public's health is a consistent factor in its most general form and with respect to responsibilities of government at all levels for public health.

However, satisfying the community benefit requirement at the state level is not the sole requirement for hospital tax exemption in many states. Twenty-seven states have no community benefit requirement; some of those that do have the additional requirements of supporting public health programs or serving "Medicaid Patients"; some focus on reporting requirements; some encourage hospitals to think broadly about the range of possible community benefit activities that hospitals might pursue [13]; and several have an additional government burden test, including four that also have some form of the community benefit requirement.

## Methods

At the federal level, the term "charitable" for tax exemption purposes includes among other tests, a Government Burden Test (GBT) which requires an organization desiring tax exemption prove that its charitable activities lessen the burdens of government (CFR 1.501(c)(3)-1(d)(2)). As guidance and not involving a hospital, the GBT is characterized in a revenue ruling as a "facts and circumstances test" involving two central components. Rev. Rul. 85-1 (I.R.S. 1985). First, it is necessary to determine whether the government unit considers the activities to be its burden. *Id.* at 3. Second, the activities must actually lessen such burden of the government. *Id.* At the state level, the requirement to satisfy the GBT varies in interpretation among those states that have such a requirement. Examples in relevant case law follow.

The central issue in the case of *Provena Covenant Medical Center, et al., Appellants v. The Department of Revenue, et al., Appellees*; Supreme Court of the State of Illinois, March 18, 2010, (the "*Provena*" case)

was whether Provena established that it was entitled to a charitable exemption for the 2002 tax year for various parcels of real estate it owned in Urbana, Illinois. 236 Ill. 2d 368 (Ill. 2010). After many years of administrative and judicial proceedings, the Illinois Supreme Court ultimately concluded that the charitable and religious property tax exemptions requested by Provena were properly denied by the Department of Revenue. *Id.*

In rendering its decision, the Illinois Supreme Court noted that there is nothing in the record to show that the Provena properties in question were used to lessen any of the burdens of the government entities taxing the properties. *Id.* Otherwise, tax exemption might have been granted.

In the *Provena* case, the Illinois Supreme Court diverged from a previous decision it had made in *Canon v. Southern Illinois Hospital Corp.*, where the hospital was granted tax exemption based on satisfaction of the government burden test. 404 Ill. 66 (Ill. 1949). In this case, the hospital charged the county deeply discounted rates to treat indigent residents relieving the government from having to transport and pay for the treatment of those patients elsewhere since the hospital was the only one in the area. *Id.*

In *Camp Hachshara Moshava v. Wayne County Bd. for the Assessment and Revision of Taxes*, the Pennsylvania Commonwealth Court discusses that a camp conducted summer camps for children and consisted of seven synagogues, bunk houses, a dining hall, family and living areas, two libraries, walking trails, and a camp-out area. 47 A.3d 1271 (Pa. Commw. Ct. 2012). The trial court determined that the camp did not relieve the government of some of its burden and was not an institution of purely public charity within the meaning of Pa. Const. art. VIII, §2(a)(v). *Id.* at 1273. The trial court reasoned that the camp did not relieve the government of some of its burden because the local firefighting and ambulance service was entirely voluntary, without government involvement or obligation, and the camp's charitable donations were not sufficient to constitute a service to the public. *Id.* at 1274. The Pennsylvania Commonwealth Court held that the trial court properly found that the camp did not relieve the local government of some of its burden. *Id.* at 1280.

Recently, the Pennsylvania Supreme Court rendered a similar holding in *Mesivtah Eitz Chaim of Bobov, Inc. v. Pike County Board of Assessment of Appeals*. 615 Pa. 463. In this case, the Court ignored the legislature's definition of the government burden test, which if applied would have enabled the exemption being sought for religious reasons. *Id.*

Previously, the Pennsylvania Supreme Court in *St. Margaret Seneca Place v. Bd. of Property Assessment*, stated that the "Hospital Utilization Project *(HUP)* test of whether an institution has relieved the government of some of its burden does not require a finding that the institution has fully funded the care of some people who would otherwise be fully funded by the government. The test is whether the institution bears a substantial burden that would otherwise fall to the government. The nursing home pays a substantial portion of the cost for Medicaid patients, who comprise about half of its residents; this fulfills the requirement that the home relieve the government of some of its burden." 536 Pa. 478, 488.

Pennsylvania tax exempt law in this area is unique. It has shifted from Pennsylvania Supreme Court broadly based case law standards to more specifically defined legislative statutory standards and now back to the original broadly based Pennsylvania Supreme Court case standards. The Pennsylvania Legislature has currently moved to amend the Pennsylvania Constitution giving it the authority to define what is meant by "purely public charity".

More broadly, the Michigan Supreme Court has declared: "Relieving patients from disease or suffering *is* lessening the burden of government. In other words, the purportedly charitable entity does not have to prove that its actions lessen the burden of government. Rather, it has to prove that it relieves its patients from disease, suffering or constraint, which is, by its nature, a lessening of the burden of government. In any event, even though the entity helps to enroll patients in Medicare and Medicaid, it still subsidizes the cost of care in light of the government's underpayment, thus lessening the government's burden of covering the full cost of a person's care." *Wexford Med. Group v. City of Cadillac*, 474 Mich. 192. The New Jersey Superior Court similarly found "the plaintiff nursing home performs a charitable function that benefits the public-at-large inasmuch as the burden of taxation is lessened by obviating the necessity on the part of government to construct facilities to accommodate the poor who are unacceptable to or who cannot afford the rates charged by nursing homes operating for profit." *Catholic Charities of Diocese v. Pleasantville*, 109 N.J. Super. 475 (App.Div.1970).

In *St. Joseph's Living Ctr., Inc. v. Town of Windham*, the court reasons that the Center clearly undertakes a "financial burden" by virtue of the fact—which the trial court expressly recognized—that reimbursement under the Medicaid program "does not fully compensate the Center for actual patient care costs." 290 Conn. 695. This funding gap relieves the state of having to shoulder the entire financial burden of caring for the indigent elderly.

Two *Temple Law Review* articles are also instructive as to the government burden test. The 2000 Temple Law Review article by Loren D. Prescott, "Pennsylvania Charities, Tax Exemption, and The Institutions of Purely Public Charity Act" discusses the implementation variations among states of the government burden test including the quid pro quo test [14]. This test assesses whether the value assumed by the tax-exempt entity is equal to or surpasses the value of the tax exemption. The 1994 article, "Do Hospitals in Pennsylvania Relieve the Government of Some of Its Burden?" is by Kellen McClendon whose analysis concludes that hospitals in Pennsylvania do not relieve government of some its burdens by merely providing treatment services [15].

## Findings

Although compliance with the CHNA requirements of the ACA may enable tax exemption for nonprofit hospitals at the federal level and may also help to satisfy community benefit requirements for tax exemption at the state and local levels, there is no guarantee that the government burden test will also be satisfied. The question then becomes to what extent do nonprofit hospitals, through the CHNA process at the community level, address those components of public health for which government is responsible, thus relieving it of some of its burdens?

In order to answer that question, we need to consider the components of public health and discuss how they relate to the concept of community benefit. As many organizations provide community benefits but do not focus on public health, the concept of community benefit is thus more encompassing than simply "public health." As we have seen with the array of statutory language on the subject, community benefit is broad enough to include a large variety of activities. Jessica Berg, in her article "Putting the Community Back into the 'Community

Benefit' Standard," discusses the validity of the breadth of "community benefit" [16]. She delves into the idea that if the activities included in the realm of community benefit is so vast, critics of hospitals' tax-exempt status may be correct in asserting that there is little difference between the community benefits offered by nonprofit and for-profit health care institutions, and nonprofit hospitals should be required to provide population-type health benefits to the communities in which they operate (392).

As Worksheet 4 of Schedule H of Form 990 quoted above suggests, the focus should be on hospitals using the community benefit requirements to complement what public health departments and government are held responsible for. Berg states "… some activities may be more appropriate as hospital services than others. Ideally, some of the responsibilities of public health departments, however, could shift to hospital community services, enabling the health departments to focus on other areas" (395).

There does not appear to be specific case law that clearly defines what "public health" is. In the literature, however, "Public health law is the study of the legal powers and duties of the state to assure the conditions of people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection or promotion of community health" [17]. According to a report from the Institute of Medicine, "public health is what we, as a society, do collectively to assure the conditions for people to be healthy," a definition seeming to include everything but individuals' actions to promote their own health (13). Professor Gostin distinguishes individual health from public health, stating "health care is devoted to personal medical diagnosis, clinical prevention, and treatment, while public health is devoted to strategies to identify health risks and improve behavioral, environmental, social, and economic conditions that affect the health of wider populations" (17-18). Clinical services provided by hospitals and by government have also been considered part of the public health continuum.

We can look to work done by our predecessors and Worksheet 4 of Schedule H of Form 990 to establish a useful basis for thinking about the types of activities in which a hospital could engage to meet its community benefit requirement [18]. Thus, population health might include "efforts to improve access to health care as well as more general measures to prevent injury and illness and reduce morbidity and mortality, such as advice to use sunscreen and eat healthy foods…" (73). Rothstein rejects the use of the concept of population health as a definition for public health for a number of reasons, including: the overlap between public and private roles, the blurring of individual and public health, and the lack of justification for coercive measures (73-74). As population health focuses on health of a group in a global sense, this still does not preclude its use for community benefit.

## Practice Implications

An obvious question is whether the ACA requirement for nonprofit hospitals to conduct CHNAs and implement strategies to improve public health satisfies the GBT and community benefit requirements at the local or state level for tax-exempt purposes. From a facts-and-circumstances perspective, the most likely answer is "perhaps, but it depends."

It depends upon whether there are local and state government entities responsible for preventing chronic disease and for improving public health, and, if so, to what extent. It also depends upon how these terms are interpreted and to what extent relevant government entities knowingly enable hospitals to perform them.

Most public health programs have been conducted at the local level, under state regulations, with broad, generalized directions or incentives being provided by the federal government. Usually, local government through authority delegated from the states, have undertaken communicable disease surveillance and control, maternal and child health services, environmental surveillance and control, and other traditional public health activities [19].

It could be argued that the purpose and requirements of the ACA are evidence of the federal government's responsibility for public health. The CHNA requirement for nonprofit hospitals is a way in which the ACA and, therefore, the federal government, is attempting to infuse greater responsibility for public health into the communities served by nonprofit hospitals. The CHNA process requires input from the community and public health experts. Reporting under Schedule H of Form 990 appears to be public health and government collaborative oriented. Worksheet 4 is also a good starting point for government at all levels to evaluate whether a hospital has done an effective job of establishing a collaborative relationship with the community and has shifted its community benefits budget to be more responsible to the needs that stakeholders care most about. By doing so, hospitals might address the components of public health for which government is responsible. By not doing so, hospitals may be at further jeopardy of losing tax exempt status.

It may then be a fair assumption that nonprofit hospitals through a regulatory compliant CHNA process are at a minimum generally relieving government at both the federal and state levels of some burden. However, the degree of specificity of that relief will depend upon the priority state and local government politically place on public health versus generating tax revenues for non-health related projects. It may be that the closer nonprofit hospitals and local governments work together during the CHNA process, the greater the opportunities to improve public health and at the same time reduce the risks of outright taxation.

Within its overall policy goal of improving access to care and the health of the U.S. population, the ACA employs nonprofit hospital tax exemption as a way to incentivize hospitals to play a greater role in the health, including public health, of the communities they serve. Many states have requirements at the local level parallel to those of the ACA with respect to the CHNA requirement for hospitals. However, as discussed there are significant variations among states as well as complicating factors, including competing fiscal and political agendas.

Given the long U.S. history of inefficient and often overlapping federal, state and local regulation of nonprofit hospitals, it is unlikely that a set of nationally agreed-upon standards of hospital public health or community benefit responsibilities will emerge anytime soon. However, the sum of these state and local regulations and new CHNA requirements under the Affordable Care Act are setting the stage for a convergence of responsibilities and community benefit activities. Therefore, for those states and communities interested in promoting and improving public health, the CHNA requirement of the ACA provides a unique opportunity for governmental entities to partner with their community hospitals to improve the public's health, and for nonprofit hospitals to better protect their tax exempt status.

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