

Charitable Expectations Of Nonprofit Hospitals: Lessons From Maryland

Maryland's program points the way for other states as a new federal law goes into effect in 2010.

by **Bradford H. Gray and Mark Schlesinger**

ABSTRACT: Little is known about nonprofit hospitals' community benefit spending other than for charity care. Better accountability is desirable, but critics have focused too narrowly on charity care. Using data from reporting requirements in Maryland similar to federal rules that take effect in 2010, we describe the broad range of community benefit spending in nonprofit hospitals there, which amounted to 7.4 percent of expenses in 2007. Charity care for hospital services accounted for one-third of this amount (payments to physicians for charity patients are reported separately). Hospitals' community benefit spending varies with local needs, resources, and resource allocation decisions. [*Health Affairs* 28, no. 5 (2009): w809-w821 (published online 23 July 2009; 10.1377/hlthaff.28.5.w809)]

HOW SHOULD NONPROFIT HEALTH CARE PROVIDERS be expected to benefit the communities that they serve? This question has increasingly drawn attention from policymakers at the state and federal levels, most often in debates regarding community hospitals' tax-exempt status. Proposed answers are often expressed in quantitative terms. In 2007, for example, the minority staff of the Senate Finance Committee proposed that nonprofit hospitals, as a condition of their federal tax exemption, be required to devote at least 5 percent of their expenditures to charity care, narrowly defined to exclude other types of charitable activities, as well as bad debt.¹ Although it has attracted little support, this proposal came after several years of critical scrutiny of nonprofit hospitals' charitability by that committee, as well as by other congressional committees and the Government Accountability Office (GAO), and multiple expressions of frustration about hospitals' charitable performance by then Finance Committee chair Charles Grassley (R-IA).

Establishing charitable-threshold requirements for nonprofit hospitals is not a new idea. In 2006 the attorney general of Illinois, Lisa Madigan, called for requir-

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ing nonprofit hospitals in that state to devote at least 8 percent of their total operating costs to uncompensated care (broadly defined).² The proposal attracted more criticism than support, and no legislation was enacted. Several states already have requirements along these lines. As a condition of tax exemption, Texas requires nonprofit hospitals (with some exceptions) to devote at least 4 percent of their expenses to charity care (broadly defined) and an overall 5 percent of their expenses to charitable activities. Utah's nonprofit hospitals and nursing homes must annually provide a "gift" to the community that exceeds the property tax liability from which they are exempt. Pennsylvania hospitals can meet their obligation as tax-exempt organizations by providing uncompensated goods or services equal to at least 5 percent of their costs. Outside of health care, foundations are required to spend at least 5 percent of their assets annually for their charitable purpose, and in 2008 Senator Grassley proposed a similar spending threshold on university endowments greater than \$500 million.

In evaluating the idea of charitable thresholds for nonprofit hospitals, it would be useful to know about their current charitable spending and how it is financed. Previous research has provided a partial picture.³ However, information about the full range of nonprofits' charitable activities has not been published. Such information has not been collected by the federal government, and state reporting requirements have generally been limited in scope or have lacked standardization.

Maryland's reporting requirements cover a broad range of charitable activities and standardize definitions of what counts. In this paper we describe the amount, forms, and funding sources of community benefit activities reported by nonprofit hospitals in Maryland, and we consider implications for contemporary policy making. The picture provided by Maryland's hospitals foreshadows the information that will become available in 2010 in hospitals' reports in the Internal Revenue Service's (IRS's) revised Form 990, with its Schedule H for reporting hospitals' community benefit spending. The activities to be included there are similar to those in Maryland's community benefit reports.

Maryland's Reporting Requirements

In 2001 Maryland adopted requirements for hospitals to report annually to the Health Services Cost Review Commission (HSCRC), a regulatory agency, on community benefit expenditures. The reports are public information. The HSCRC's reporting form uses categories (and definitions) similar to those developed by the Catholic Health Association in its "social accountability" process.⁴ They include community health services, health professional education, mission-driven health services, research, financial contributions made by the hospital, community-building activities, and charity care.⁵ Activities aimed at increasing market share or that are part of the cost of doing business are not to be included, even if they could be fit into one of these categories; the instructions warn against including, for example, marketing activities in the guise of community health education or

staff development activities as health professional education.

Also included in the reports are operating costs of the hospitals' community benefit program as well as community benefit activities (not reported elsewhere) funded by hospitals' foundations. Except for charity care, hospitals must report expenditures for each category, using indirect cost rates approved by the HSCRC. Charity care is based on charges, which differ little (in Maryland) from costs and which include indirect costs.⁶ Offsetting revenues from fee-for-service payments or grant support are shown in the report and deducted in calculations of net community benefit expenditures.

Maryland's community benefit reporting occurs in the context of a unique decades-old hospital rate-setting system.⁷ The HSCRC sets rates for all payers, including Medicaid and Medicare, and uncompensated care expenses (charity and bad debt) are factored into each hospital's rates. As a result, Maryland hospitals, which are required to have and apply a written charity care policy, do not have disincentives to provide charity care faced by hospitals elsewhere that must subsidize such care from charges to insured patients. Maryland has slightly fewer uninsured people than average (13.8 percent compared with 15.8 percent nationally).⁸ Nonprofits provide virtually all of the charity hospital care in the state, since there are no public hospitals and only one small for-profit hospital.

Study Data And Methods

This paper is based primarily on Maryland hospitals' community benefit reports for 2005–07 and secondarily on interviews at twenty of the forty-five acute care hospitals covered by the reporting requirement.⁹ The hospitals were selected to ensure diversity in size, region of the state, mission (teaching versus nonteaching), system membership, and type of community served. Five hospitals were selected from the ten with the highest level of community benefit spending, and five from the ten with the lowest; five others had shown large changes in community benefit spending, and five had stable levels.

Between February and May 2008, interviews were conducted at each hospital with a senior executive (chief executive officer, chief financial officer, or chief operating officer) and a person responsible for the community benefit report. Topics covered included the components and sources of funding of community benefit activities.

Community Benefit Expenditures In Maryland

Community benefit spending grew from almost \$646 million in 2005 to just over \$800 million in 2007. Exhibit 1 shows the types of community benefit spending as a percentage of hospitals' total expenses, net revenues (total revenues less expenses), and total community benefit expenditures. Aggregate community benefit expenditures reported by Maryland's hospitals over three years accounted for 7.2 percent of operating expenses and are much larger (163 percent) than their net

EXHIBIT 1
Type Of Community Benefit Expenditures (Net) As Percentage Of Operating Expenses, Net Revenues, And Total Community Benefit Expenditures, In Maryland Hospitals, Fiscal Years 2005–2007

Type of expenditure	As percent of operating expenses			As percent of total net revenues			As percent of total community benefit expenditures		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Charity care	2.10	2.32	2.38	52.79	53.96	47.48	29.98	32.53	32.32
Community health services	0.48	0.49	0.54	12.11	11.49	10.70	6.88	6.93	7.28
Health professions education	2.72	2.49	2.45	68.31	58.01	48.87	38.80	34.97	33.27
Mission-driven health services	1.28	1.39	1.52	32.04	32.35	30.33	18.20	19.50	20.64
Research	0.07	0.06	0.13	1.76	1.30	2.51	1.00	0.78	1.71
Financial contributions	0.14	0.14	0.10	3.57	3.35	2.08	2.03	2.02	1.42
Community building	0.12	0.12	0.14	3.02	2.91	2.86	1.72	1.75	1.95
Foundation-funded benefits	0.06	0.05	0.06	0.93	1.36	1.12	0.88	0.69	0.77
Community benefit operations	0.04	0.06	0.05	1.55	1.15	0.95	0.53	0.82	0.65
Total	7.02	7.12	7.37	176.08	165.87	146.90	100.00	100.00	100.00

SOURCE: Maryland Health Services Cost Review Commission, Community Benefit Reports for fiscal years 2005–2007.

NOTE: Includes data for forty-five acute care hospitals.

revenues.

Charity care and health professions education each account for about a third of the total community benefit spending. The reported charity care spending involves the costs of hospital services for patients who qualify under hospitals' charity care policies (not bad debt). Health professions education spending is primarily associated with graduate medical education, although many hospitals have expenditures for students from nursing and other health professions.¹⁰

Mission-driven health care services accounted for about 20 percent of community benefit expenditures. By definition, this category includes services that (1) lose money, (2) are offered as a direct result of the hospital's mission, and (3) would not be available to the community if not provided by the hospital. Such services may generate some revenue but lose money because they are offered for nominal charges or are provided to patients with limited ability to pay and are not covered by payments for hospital services, because they occur outside the hospital or involve physician services. (As does Medicare, Maryland distinguishes between hospital services, which are covered by the payment rates set by the state, and physician services, which are not.) Mission-driven services listed on some hospitals' reports include cardiac rehabilitation; hospice; home care services; outpatient mental health treatment programs; and various other programs targeted to seniors, immigrants, women, adolescents, substance abusers, and the homeless.

The mission-driven category also includes costs of some hospitals' payments to

physicians for their services to charity patients. Increasingly common in Maryland (and elsewhere), this involves many arrangements.¹¹ In some instances, hospitals must guarantee specialty physicians an income greater than local payer mix enables them to generate. For example, without such a guarantee, even a busy obstetrician in a locale with a largely Medicaid population would not have an economically viable practice because of Medicaid's low physician fees in Maryland. Care for the hospital's uninsured patients may be provided by salaried physicians or by physician groups that are paid under a contract to provide specialty services (such as anesthesiology). Some hospitals must pay physicians fees for surgery or other services for charity patients. Hospitals serving many uninsured people in the emergency department (ED) may have to pay physicians to take call or provide services, making that department a "mission-driven" expense in some hospitals' community benefit reports. The types of mission-driven services vary a great deal among hospitals because hospitals in some locales encounter few charity patients or don't have to pay their physicians to take call or care for charity patients.

To make an implicit point explicit, many services in the "mission-driven" category are forms of charity care that do not get counted as charity care, which includes only hospital services provided to charity patients. Hospitals' expenses for providing other services, including their payments to physicians, are not counted as charity care.

About 7 percent of community benefit spending was for community health services, including community health education (health fairs, lectures), community-based clinical services (screenings, free clinics, mobile units), and health care support services (enrollment assistance in public programs, nurse consultation lines, transportation for patients). Some of these activities sit near a fuzzy line with marketing, but the overall amount is but a small share of reported community benefit expenditures.

Community-building activities (almost 2 percent of the total) include expenditures for physical improvements (neighborhood improvement and housing rehabilitation projects), economic development (small business assistance), support-system enhancements ("adopt a school" efforts, disaster preparedness), environmental improvements focused on various types of hazards and pollution, leadership development for community members, coalition building and advocacy related to health, and workforce enhancement (recruitment of health professionals for medically underserved areas, partnerships with colleges to address workforce shortages, health career programs in the schools). The instructions say that for such activities to be counted as a community benefit, a connection must be made with addressing community needs through disease prevention and improvement of health status. Specialists in population health readily see relationships between housing or economic conditions and the health of a community's residents, but this is not always recognized by regulators. Thus, in its new reporting requirements, the IRS does not treat community-building expenditures as a community

benefit, although Schedule H asks hospitals to report such expenditures and explain how they pertain to health.

The other community benefit categories are small and self-explanatory. They include unfunded costs of research, financial (and in-kind) contributions by the hospital, and activities funded by the hospital's foundation and not counted elsewhere.¹² The final category is the cost of the community benefit operations themselves, which, as reported by Maryland hospitals in 2006, was less than 1 percent of community benefit costs.¹³

Changes In Community Benefit Spending

Reported community benefit spending in Maryland has increased since the program was initiated (Exhibit 1). Notably, the largest increases occurred among the hospitals with the lowest initial levels. For example, direct community benefit spending more than doubled (from 1 percent to 2.4 percent of spending) for the ten hospitals with the lowest community benefit expenditures in 2004, while the ten with the highest expenditures increased only slightly (from 6.6 percent to 6.9 percent, on average; data not shown).

Interviews suggest that increases in reported community benefit expenditures resulted from both improvements in hospitals' ability to capture the pertinent information and changes in policies and practices regarding community benefit. At all twenty hospitals where interviews were done, respondents described ways in which the hospital had increased its ability to obtain relevant information from throughout the organization. In most cases, this resulted in the capture of more information, although officials at one hospital said that they had reduced reported mission-related expenditures after deciding that they had been including activities that did not fit the definition.

Four dynamics produced changes in reported community benefit expenditures. First, hospitals acted to make the data-collection process routine, which some respondents described as initially painful because it required capture of information that did not exist anywhere and for which no reporting channels existed. Some institutions began using software tailored to the task. Second, some institutions reported that assembling the data had increased awareness of the whole topic, making them more mindful about it thereafter. Third, new executives who had had experience elsewhere with community benefit activities increased attention to the topic at some hospitals. Finally, some executives reported being embarrassed when making comparisons with peer institutions and had thereafter given the topic more emphasis.

Sources Of Funding For Community Benefit Activities

Support for hospitals' community benefit activities comes from several sources. Hospitals can seek external funding, via charitable contributions, grants, and contracts. Some activities are partially supported by fee-for-service charges or volun-

tary contributions by participants. Funds may be available from nonoperating revenues (investments, unrelated business activities). Institutionalized subsidies exist for some activities, as with indirect medical education payments from Medicare. Finally, activities may be financed out of operating revenues.

For reporting purposes, these sources of support are handled in different ways in Maryland. Support from grants, contracts, and fees are treated as offsets and excluded when “net” community benefit expenditures are calculated. Such offsetting revenues are substantial, amounting to about 30 percent of direct community benefit expenses in 2006 (data not shown).¹⁴ They are largely concentrated in mission-driven services.

Although most nonprofit hospitals in Maryland have separately incorporated foundations, few community benefit reports show foundation expenditures. Some foundation-supported activities get reported in other categories (for example, community health services) where funding sources are invisible. But most foundations were described in interviews as supporting the hospital itself (equipment, renovations), not community benefit activities.

The main and often only source of funding for community benefits in Maryland is hospitals’ operating revenues. Subsidies for health professional education expenses are built into hospital payments, and charity care costs are factored into the payments hospitals receive for their services. Supporting charity care out of the revenue stream generated by paying patients is an oft-described phenomenon in health care.¹⁵ This generally implicit source of support is made explicit in Maryland in the all-payer rates set for each hospital.¹⁶

Over the long term, hospitals’ ability to finance many community benefit activities will depend on the relationship between their expenses and the amount they are paid for their services. This varies from hospital to hospital and place to place.

Variation In Community Benefit Spending

Although some executives contend that virtually all expenditures by hospitals (for example, as providers of important services or as employers) provide benefit to communities, “community benefit” is a term of art that originated with the IRS in 1969 in distinction to private benefit and is defined operationally in Maryland in the categories described in this paper. Although aggregate community benefit spending reported by Maryland hospitals exceeds 7 percent of their total expenditures, the amount and forms of community benefit activities vary widely among hospitals. In 2006, for example, community benefit spending ranged from 1.2 percent of operating expenses at Upper Chesapeake Hospital, a small community hospital in Bel Air, to 14.1 percent at the University of Maryland Hospital in Baltimore.

Exhibit 2 demonstrates how community benefit expenditures vary within this small state, both in the aggregate and on the various dimensions of community benefit activity. Does this mean that some hospitals don’t do enough? This ques-

EXHIBIT 2
Variations In Patterns Of Community Benefit Activity Among Maryland Hospitals (As Percentage Of Operating Expenses), Fiscal Year 2006

Category	Median	Range		Interquartile range	
		Minimum	Maximum	25th percentile	75th percentile
Total community benefit	5.31%	1.17%	14.10%	3.34%	7.13%
Charity care	1.88	0.05	6.33	1.08	2.51
Community health services	0.41	0.00	1.70	0.20	0.74
Health professions education	0.39	0.00	8.01	0.09	2.45
Mission-driven health services	0.75	0.00	9.31	0.17	1.59
Research	0.00	0.00	0.61	0.00	0.05
Financial contributions	0.09	0.00	0.90	0.03	0.17
Community building	0.06	0.00	1.08	0.02	0.24
Foundation-funded benefits	0.00	0.00	0.42	0.00	0.00
Community benefit operations	0.01	0.00	1.57	0.00	0.06

SOURCE: Authors' analysis of data from the Maryland Health Services Cost Review Commission, Community Benefit Reports for fiscal year 2006.

tion is difficult to answer because the amount and forms of any given hospital's spending reflects not only resource allocation decisions but also community needs and hospitals' resources.

Regarding need, hospitals that provide high levels of community benefit tend to be located in low-income areas. With that comes a high amount of charity care and an increased likelihood of involvement in health professional education. In Maryland, the share of families that fall below the federal poverty level ranges from almost 20 percent in Baltimore city and Somerset County to 4.8 percent in Howard County. This helps explain why charity care ranged from 6.5 percent of hospital expenses at Bon Secours, a Catholic hospital in impoverished southeast Baltimore, to 0.5 percent at Howard County Hospital. As a crude indicator of hospitals' responsiveness to the need for charity care, a reasonably strong correlation ($r = 0.62$) exists between poverty and charity care (narrowly measured) at the county level.

Hospitals' capacity for community benefit spending depends on their financial health and ability to draw funding from operating revenues, including whatever subsidies are built into those revenues (as with graduate medical education payments and, in Maryland, charity care), as well as their ability to raise funds for charitable purposes. A hospital's financial health may itself be affected by its commitment to certain community benefit activities, particularly in providing "mission-related" services that in Maryland are not covered by hospital payments.

The levels and forms of hospitals' community benefit spending are also undoubtedly influenced by resource allocation decisions made by the hospital's leadership. This involves choices not only among current alternatives but also be-

tween present demands and the need for reserves for future capital spending. Also, our interviews suggest that the amount of community benefit spending is influenced by the extent to which hospitals plan and budget for such activities rather than simply counting up the spending that took place during the reporting period.

If hospitals' community benefit spending is partially the product of internal resource allocation and fund-raising decisions, some could perhaps do more. A community benefit reporting process that uses credible categories and instructions about what should and should not be counted can start important conversations, both internally within hospitals and in the larger health and tax policy communities, about charitable expectations.

Questions about whether hospitals are making good decisions about community benefit spending will likely become more prominent as more information about such spending becomes available. In Maryland, some county health officers have begun seeking a voice in hospitals' community benefit planning. However, there is no consensus in Maryland (or nationally) about how the adequacy of charitable performance should be assessed, and low-spending hospitals are not asked for explanations. This could change, particularly if the national numbers show as much variability as Maryland's do.

The Idea Of Threshold Requirements

We began with the question of charitable expectations. Maryland hospitals report that more than 7 percent of their spending goes to community benefit activities. Charity care accounts for a third of that amount (2.1 percent, on average). This does not begin to approach the 5 percent requirement proposed by the Senate Finance Committee's minority staff as a condition for federal tax exemption. (As noted earlier, the Maryland figure includes only charity care for hospital services, not their expenditures for physicians' services to charity patients.) Only two hospitals have had charity care levels that exceeded 5 percent. Fewer than half devoted at least 5 percent of their revenues to all forms of community benefit activity.

The extent to which hospitals meets any charitable threshold depends, of course, upon what is counted as charitable. Exhibit 3 shows the number of Maryland hospitals that would have met different thresholds using different measures of community benefit. Were consequences (for example, tax-exempt status) to be attached to meeting thresholds, increases would likely occur in reported community benefit spending, in part because hospitals would work harder to capture pertinent data.

The idea of expenditure requirements has very different implications for different types of nonprofit organizations. It is one thing to apply a 5 percent spending rule to the endowments of foundations or universities, but quite another to apply such a rule to the expenditures of organizations that generate most revenues from

EXHIBIT 3
Number Of Maryland Hospitals (N = 45) That Would Have Exceeded Different
Thresholds Using Different Measures Of Charitability, 2006

Community benefit measure	Threshold level		
	3 percent	5 percent	7 percent
Charity care only	8	2	0
Charity care + mission-related services	21	10	3
Charity care + mission-related services + health professions education	28	20	9
All community benefit expenditures	36	24	14

SOURCE: Maryland Health Services Cost Review Commission, Community Benefit Reports for fiscal year 2006.

the sale of services in competitive environments. Such organizations support their charitable activities from operating revenues (either implicitly or, as in Maryland, at least partly explicitly), as well as nonoperating revenues (such as investment income), fund raising (grants or philanthropic campaigns), or reserves. Each of these revenue sources presents complexities, particularly in competitive markets.

Supporting charitable activities from operating revenues amounts to a hidden tax on payers, as Mark Pauly has observed, noting that charitable threshold requirements shift resource allocation decisions from activities valued by nonprofits' boards to those valued by the policy process.¹⁷ The variations seen in Maryland hospitals' spending (Exhibit 2) raise doubt about whether spending requirements would be flexible enough to meet community needs, but boards themselves may be insufficiently attentive to such needs. Hence the need for better accountability.

Increased public reporting of community benefit activities may improve hospitals' responsiveness to community needs. When hospitals begin reporting on the IRS's new Schedule H in 2010, the revealed variability is likely to create pressure for improved performance on the measured categories. Resource allocation decisions within hospitals may change, and more efforts may be undertaken to raise funds to support community benefit activities. In this regard, the fact that the IRS will allow hospitals to count community benefit expenditures that are supported by charitable contributions or grants may have a strong positive effect on fund-raising efforts.

Limitations Of This Study

Data reported by Maryland hospitals illustrate the amount of and variation in community benefit expenditures as hospitals are currently regulated. However, findings from any single state cannot be generalized to other states because of the many ways that states differ from each other—in rates of poverty, lack of insurance (ranging from less than 5 percent to more than 25 percent), and many health-related programs and regulations. Although Maryland is only slightly below aver-

age in its rate of uninsurance, its unique all-payer rate-setting system makes subsidies from other payer sources explicit, largely eliminates differences between hospitals' costs and charges, restrains hospitals' margins, and greatly minimizes disincentives to provide charity care. The latter factor lends interest to the amount of charity care provided by Maryland hospitals, but it reduces generalizability to states with higher uninsurance rates or where hospitals must generate resources for charity care on their own.

Second, except for the variation it reveals, Maryland's community benefit reporting experience might not predict what will be shown when the IRS's national reporting requirements take effect in 2010. The IRS will count shortfalls that do not exist in Maryland in means-tested programs (such as Medicaid and the Children's Health Insurance Program, or CHIP) and will not deduct grant support from community benefit expenditures. Even though the IRS will not count community-building expenditures as a community benefit (although it will ask hospitals to report such expenditures), the net effect of these differences will increase community benefit expenditures reported to the IRS over what has been reported in Maryland.

Finally, the data we have examined are self-reported by hospitals, subject to audit. This will also be true of the data to be reported to the IRS in 2010. Hospitals may fail to report some expenditures, particularly those that cannot be pulled from their accounting systems, and there may be inconsistencies in hospitals' inclusion of expenditures that fall near the line between business and community benefit purposes, as with some community health education and mission-driven services described in this paper. An important lesson from Maryland, however, is that the public reporting about these expenditures will likely start new conversations, both within hospitals and in the broader community, about what should and should not be counted.

Policy Implications

The Maryland experience shows that under current policies and practices, substantial numbers of nonprofit hospitals would not meet proposed threshold tests. The number that would fail depends upon what is counted and where the threshold is set, but as charity care is now counted in its reporting system, 95 percent of Maryland's hospitals would not meet the standard proposed by the minority staff of the Senate Finance Committee. This raises serious doubt about whether a 5 percent threshold is sensible, particularly because Maryland's hospitals face no deterrent to providing care other than the effort needed to determine eligibility.

Second, if consequences are to be attached to the amount of charity care that is provided, better measures are needed. As counted in Maryland and on IRS Schedule H, charity care is limited to services for which hospitals typically bill (that is, Medicare Part A). Other forms of charity such as sustaining needed but money-losing services or paying physicians for treating the hospital's charity care patients

are not counted as “charity care.” The fact that some bad debt comes from by patients who lack means to pay is a further complication.

Third, although community benefit reporting using standardized categories and definitions is a major improvement in accountability, expenditures are an imperfect measure of community benefit. One need only consider programs that reduce morbidity (and such programs exist) to realize that dollars spent is an inadequate measure of benefit. Expenditure data should be supplemented with information about how hospitals assess community needs, set priorities for addressing them, and evaluate the results of their efforts. Such information may also help reveal whether substantial differences in hospitals’ community benefit activities reflect differences among served communities and hospitals’ resources.

The Catholic Health Association, on whose work the Maryland and IRS reporting requirements are based, has long encouraged members to plan and manage community benefit activities; also, some states require hospitals to provide information about community needs and how they are being addressed. Until such information is reported in standardized ways, expenditure data will be interpreted as the totality of community benefit performance. That is understandable, but we should be aware of the limitations.

Similarly, if we want hospitals to address community needs through disease prevention and improvement of health status, to use the words of the Maryland statute, we should think of how to define, encourage, and measure performance on such dimensions, not just count expenditures.

A new era of accountability begins when nonprofit hospitals start reporting on Schedule H in 2010. It would be wise now to defer further policy changes regarding tax exemption of nonprofit hospitals until the effects of Schedule H are seen. Given also the possibility of larger policy changes to address the problems of cost and the uninsured, we should hesitate to impose new charitable expectations.

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NOTES

1. Senate Committee on Finance—Minority, “Tax-Exempt Hospitals: Discussion Draft,” <http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf> (accessed 7 July 2009).
2. Broad definitions include bad debt and payment shortfalls from governmental programs.
3. U.S. Government Accountability Office, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption*, Pub. no. GAO/HRD-90-84 (Washington: GAO, 1990); M. Morrissey, G.J. Wedig, and M. Hassan. “Do Nonprofit Hospitals Pay Their Way?” *Health Affairs* 15, no. 4 (1996): 132–144; N.M. Kane and W.H. Wubbenhorst, “Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption,” *Milbank Quarterly* 78, no. 2 (2000): 185–212; and S. Nicholson et al., “Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals,” *Health Affairs* 19, no. 6 (2000): 168–177.
4. Catholic Health Association, *Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory for Social Accountability* (St Louis: Catholic Health Association of the United States, VHA

- Inc., and Lyon Software, 2004).
5. "Mission-driven health services" are similar to the CHA/VHA and IRS category called Subsidized Health Services.
 6. Because hospitals' charges may be two or three times costs, community benefit calculations based on charges are generally viewed as misleading. However, because Maryland's hospital rates (charges) are based on audited costs, the difference between costs and charges there is negligible.
 7. For an explanation, see Maryland Hospital Association, "Maryland Hospital Rate Regulation," August 2006, http://www.mdhospitals.org/mha/News_Publications/HSCRC.Md.Rate.Setting.Facts.pdf (accessed 7 July 2009).
 8. U.S. Census Bureau, Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2006, in *Current Population Survey, 2007 Annual Social and Economic Supplement* (Washington: U.S. Government Printing Office, 2007).
 9. An article based primarily on those interviews is to appear in the Summer 2009 issue of *Inquiry*.
 10. Medical education spending is greatly offset by Medicare's graduate medical education expenditure payments to hospitals. Even so, this is treated as community benefit spending in Maryland (and in the new IRS requirements), presumably because education is explicitly mentioned in Section 501(c)(3) as a charitable purpose.
 11. P.J. Cunningham and J.H. May, "A Growing Hole in the Safety Net: Physician Charity Care Declines Again," Tracking Report no. 13 (Washington: Center for Studying Health System Change, March 2006).
 12. The decline in financial contributions in 2007 was largely due to a regulatory change that gave hospitals discretion not to include indirect costs; many then decided not to add indirect costs to their charitable donations.
 13. Some hospitals allocate such administrative costs to other community benefit categories.
 14. Calculated from hospitals' community benefit reports, available on the Web site of the Health Services Cost Review Commission, <http://www.hscrc.state.md.us>.
 15. A. Dobson, J. DaVanzo, and N. Sen, "The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications," *Health Affairs* 25, no. 1 (2006): 22–33.
 16. Bad-debt expense is also built into the rates set for hospitals in Maryland but is not counted as a community benefit expenditure, even though research (elsewhere) has shown that a substantial portion of hospital bad debt is incurred by patients who might be eligible for charity care. See J.S. Weissman, P. Dryfoos, and K. London, "Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals," *Health Affairs* 18, no. 4 (1999): 156–166.
 17. M.V. Pauly, "Health Systems Ownership: Can Regulation Preserve Community Benefits?" *Frontiers in Health Services Management* 12, no. 3 (1996): 3–34.