
Hospital Community Benefits and Health Care Reform in Maryland: A Strategy for Improving Population Health

Submitted to the Abell Foundation

By Anna L. Davis, JD, MPH



Introduction

The United States has long relied on private charitable institutions to fill critical social welfare gaps in services to the poor. According to the American Hospital Association, there are approximately 2,900 nonprofit hospitals in the U.S.¹ Hospitals and nonprofit health care organizations, which are by far the largest element within the universe of tax-exempt entities, receive billions of dollars in government subsidies due to their status as charitable organizations.² To qualify for federal tax-exempt status, a hospital must demonstrate, among other things, that it is organized and operated for a charitable purpose, and that it provides sufficient health benefits to the community at large. These “community benefits” comprise a broad range of health services, including uncompensated (charity) care, health services to vulnerable and underserved populations, and investments in public health programs and initiatives.

In Maryland, hospitals have been required to report their community benefit expenditures to an independent state agency on an annual basis since 2001. In 2008, the IRS revised its rules to require specific reporting requirements regarding hospital charitable activities. These reporting requirements were an attempt by lawmakers and others to increase transparency,

and to make publicly available information about how hospitals were earning their status as charitable entities and what community benefits hospitals were providing. Greater accountability has not quieted all concerns about the adequacy of tax-exempt hospitals’ charitable activities; these reports have also not provided full insight into whether hospitals’ community benefit expenditures are properly aligned with the needs of the community.

President Barack Obama’s health care law,³ The Patient Protection and Affordable Care Act (ACA), brought about health care reforms that established new accountability measures for hospitals that have the potential to affect the nature and scope of hospital community benefit investment. In addition, Maryland’s unique hospital payment system was transformed in 2014 from a fee-for-service model to a global budget cap on hospital expenditures. These changes will require hospitals to find new and innovative ways of controlling costs and reducing utilization of services, while improving the overall quality of care. To meet these performance measures, hospitals will have to increase health care outreach and services at the community level, and promote a comprehensive public health approach to health care delivery. It is, therefore, important to understand the impact

The community benefit standard eliminated the requirement that hospitals provide free or reduced-cost care to indigent patients. Under this new standard, tax-exempt status was determined based upon whether a hospital could demonstrate that it engaged in health promotion activities for a broad class of individuals in the community.¹⁰

of this new health care financing framework on both population health and community benefit spending.

This report looks at the evolution of hospital reporting and accountability requirements under both federal and state law, examines the shift in priority toward population health improvement now required by the ACA, and discusses the importance of these provisions for the success and sustainability of Maryland's new global budget revenue system. The report also analyzes the direction that health care reform in Maryland must move in order to meet the demands imposed by the state's new hospital payment system and concludes with recommendations for further study of this important subject. This report is by no means a comprehensive evaluation of community benefits, a topic that has been explored in detail elsewhere.⁴ Instead, it is intended to inform a broad audience about a complex topic that has great potential for improving public health, in Baltimore and throughout the country.

A Brief History of Community Benefits

Origins of the Charity Care Requirement for Hospitals

The IRS has long recognized a tax-exempt status for hospitals and health care organizations.⁵ Section 501(c)(3) of the Internal Revenue Code (IRC) identifies as

tax-exempt, organizations established and operated solely for, among other things, "religious, charitable, scientific, educational, or other nonprofit purposes...."⁶ Prior to the 1950s, hospitals were deemed "charitable" because the primary mission of most of these institutions in the first half of the 20th century was to serve the poor and marginalized members of society. In 1956, the IRS adopted a "financial ability" standard that required a charitable hospital be "operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay."⁷ Under this standard, the IRS required a hospital operating as a charitable institution to provide some amount of free or reduced-rate medical care to its patient population in order to qualify for tax exemption under 501(c)(3). Although the required amount of "free or reduced-rate medical care" was not quantified, the charity care requirement reflected a policy sentiment that hospitals were only exempt as "charitable" if they served the dual purpose of both providing relief to the poor and promoting health.⁸

From Charity Care to Community Benefits

Despite criticism from the U.S. Congress and others that the "financial ability" test was imprecise and lacked specific requirements as to the level of charity care necessary to qualify for tax-exempt status, it nevertheless remained the standard for more than a

decade. By the mid-1960s, however, the health care industry had been transformed by the widespread availability of employer-provided health insurance coupled with the creation of public insurance programs in the form of Medicare and Medicaid.⁹ The expansion of health insurance coverage meant increased access to care, but it also signaled a shift in traditional notions of “charity care.” In response, the IRS modified the financial ability requirement in 1969 and established an alternative community benefit standard for hospitals seeking tax-exempt status. The community benefit standard eliminated the requirement that hospitals provide free or reduced-cost care to indigent patients. Under this new standard, tax-exempt status was determined based upon whether a hospital could demonstrate that it engaged in health promotion activities for a broad class of individuals in the community.¹⁰ In formal guidance issued at the time, the IRS noted that the “promotion of health, like the relief of poverty...is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, provided that the class is not so small that its relief is not of benefit to the community.”¹¹

The community benefits ruling signaled an important public policy shift that remains the legal standard today. Although changing technology and modernization of social safety net structures have caused hospitals to move beyond their original and purely charitable purposes, they maintain a singular role in serving the needs of the most vulnerable and disenfranchised members of the community. Charity care remains a necessary element of the tax-exemption test, but the community benefit standard gives hospitals wide latitude to establish how much charity care they provide, and to determine — from a broad range of educational, research, and public health programs and initiatives — what they report as community benefit expenditures.¹²

Transparency and Accountability for Hospitals’ Tax-Exempt Status

IRS Form 990, Schedule H

From the start, the community benefit standard has generated significant controversy over the treatment of hospitals under the tax code. In particular, some have questioned whether the benefits hospitals provide to the community are sufficient to justify or compensate for lost tax revenues. In 2008, a series of contentious Congressional hearings were held to scrutinize the history, legal rationale, and economic impact of the tax-exempt hospital sector.¹³ The IRS released a report summarizing responses from nearly 500 tax-exempt hospitals about how they provide and report benefits to the community.¹⁴ As a result, the IRS announced new federal reporting requirements for hospitals regarding their charitable activities.

The centerpiece of the IRS’s revised approach was a new reporting form — known as Schedule H — within a redesigned Form 990, the annual return required for all federally tax-exempt organizations. The new schedule was created specifically to address concerns generated by the lack of transparency surrounding the community health improvement activities of hospitals and attempted to “quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals.”¹⁵ Schedule H, which all hospitals are now required to complete beginning with tax year 2009, purported to usher in a “new era of accountability” for tax-exempt hospitals in the United States.¹⁶ The form requires detailed information about each hospital’s community benefit spending in relation to other costs incurred, billing and collection practices, community building activities, costs due to Medicare shortfalls, and bad debts owed to the hospital.¹⁷

The list of prioritization criteria drafted by the IRS as a guide is intentionally nonexhaustive, allowing hospitals the prerogative to choose how best to prioritize the significant health needs of their particular community.

The ACA and Community Health Needs Assessments (CHNAs)

The adoption of the ACA in March 2010 expanded access to health care coverage and brought sweeping reforms to the health care delivery system in the United States.¹⁸ It also created new community benefit obligations that have the potential to affect the investments and health improvement activities of hospitals and their communities. Amendments to the ACA also include specific reporting obligations for hospitals in order to maintain a tax-exempt status. Section 9007(a) of the ACA amends the tax code by adding subsection 501(r), which requires, among other things, that hospital organizations recognized — or seeking to be recognized — as tax-exempt must conduct a community health needs assessment (CHNA) at least once every three years.¹⁹

The CHNA is an important, two-step process that includes *both* an assessment and an implementation plan to meet the identified community health needs.²⁰ The ACA requires that the assessment phase be systematic, inclusive, and transparent.²¹ A hospital facility must “identify the significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as organizations, facilities, and programs in the community, including those of the hospital facility) potentially available to address those health needs.”²² “Health needs” should be interpreted broadly to include not only financial and other barriers to care, but

also resources focused on preventive care; food security and nutrition; and other social, behavioral, and environmental factors that influence public health.²³

Hospitals are given broad autonomy to prioritize the significant health needs that are identified through the CHNA process. Hospitals may use any criteria, including, but not limited to, the burden, scope, severity, or urgency of the health need identified; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.²⁴ The list of prioritization criteria drafted by the IRS as a guide is intentionally nonexhaustive, allowing hospitals the prerogative to choose how best to prioritize the significant health needs of their particular community. The only caveat within the final regulations in this respect is that, in order to ensure transparency, a hospital’s CHNA report must describe the process and criteria used to prioritize the significant health needs it identified.²⁵

The ACA also requires a hospital facility to solicit and take into account input from community partners in identifying the resources potentially available to address public health needs. Hospitals should seek out agencies or organizations that represent the broad interests of the community, including local health departments; members of medically underserved, low-income, and minority populations in the community; health

care consumers and advocates; academic experts; and others.²⁶ This requirement seeks to promote collaboration between nonprofit hospitals, public health agencies, nonprofit community organizations, and other stakeholders. It also encourages community partners to leverage their investments in the community to better address health needs.

Once the community's needs and resources have been identified, hospitals then must adopt an implementation plan to meet those needs.²⁷ The implementation plan is a written strategy that addresses each of the community health needs identified through the CHNA.²⁸ The plan must describe how the hospital intends to meet the health need or, alternatively, identify the need as one the hospital does not intend to meet and articulate the reasons why the need will not be met.²⁹ The implementation plan must also identify the specific programs and resources that the hospital will use to meet the health need and the anticipated impact of those programs and resources.³⁰ Finally, the implementation plan should note whether the hospital intends to collaborate with any governmental, nonprofit, or other health care organizations or related organizations in order to meet the identified need.

The comprehensive assessment and reporting requirements imposed by the ACA reflect an unsettling truth. Historically, the correlation between a hospital's operating income and total community benefit expenditures has not been robust.³¹ Although the IRS reporting requirements have made hospitals' tax-exempt status more transparent and generated significant data about the community benefits they provide, hospitals have often fallen short in achieving a balance between the financial demands of the institution and population health improvement goals and metrics. The ACA, with its emphasis on population health improvement, has raised the bar for hospitals to demonstrate a deeper commitment to the overall health of the communities they serve.³² The intent of the CHNA framework was to incentivize hospitals to look for opportunity outside the four walls of their own institutions

and to become drivers for measurable change within their communities. With only one triennial cycle of CHNAs complete, it is, perhaps, still too early to see the full impact of the CHNA process on community benefit expenditures. As more data are collected, hospitals will be under increasing pressure to apply community benefit expenditures to address the social and economic determinants of health. Hospitals in Maryland face even greater scrutiny as the state emerges as a national leader in redesigning and reforming its entire health care financing system.

Community Benefit Spending in the Context of Maryland's All-Payer Global Budget Model

Maryland's Long-Standing Community Benefits Reporting Requirements

Maryland has required extensive documentation of hospital community benefit expenditures since 2001, long before the enactment of federal community benefit reporting requirements. In addition to the federal reporting requirements discussed above, hospitals in Maryland are required to submit an annual community benefits report to the state's independent health care rate-setting agency, known as the Health Services Cost Review Commission (HSCRC).³³ Each year, the HSCRC collects and compiles the relevant data into a publicly available statewide Community Benefit Report (CBR). Hospitals must submit to the HSCRC their mission statement and a list of the hospital's community benefit initiatives, along with the objectives and costs of each initiative. Hospitals must also describe efforts they have taken to evaluate the initiatives' effectiveness, the gaps in the availability of specialist providers, and the hospital's efforts to track and reduce health disparities in the community it serves. Designed to standardize the definitions used and data collected, the CBR process provides an opportunity for each hospital in Maryland to critically review and report the activities

it generates to benefit the community. It also complements the federally mandated reporting and reinforces the importance of aligning community benefit spending with community health needs.

Maryland's All-Payer Hospital Payment System

Wholly apart from the community benefit requirements in state law, Maryland has for decades operated a unique, statewide all-payer hospital rate regulation system as a means of constraining hospital costs, improving access to care, and ensuring financial stability and predictability for both hospitals and payers.³⁴ The HSCRC, established by the Maryland General Assembly in 1971 as the state's independent rate-setting agency, was granted broad authority to review and approve reimbursement rates for all hospital acute-care inpatient, emergency, and outpatient services.³⁵ Since 1977, HSCRC has set payment rates of all third-party purchasers of hospital services in Maryland.³⁶ Payment rates for each hospital were tied to historical cost data, the health status of the patient population served, and the level of uncompensated care provided to that population.³⁷

Maryland's all-payer approach successfully contained per-admission costs for more than 30 years. Under the terms of the original waiver agreement, the state was required to limit the growth in Medicare payments per inpatient hospital admission to below the growth of Medicare payments nationally.³⁸ Over time, however, the incentives inherent in a fee-for-service model, coupled with changes in the health care delivery system itself, caused the state's health care costs to grow at an unsustainable rate.³⁹ Radical change was needed to achieve the "Triple Aim" goal of improving the quality of patient care, improving health outcomes at the population level, and reducing health care costs in Maryland.⁴⁰

The New Global Budget Revenue Model in Maryland

On January 1, 2014, the HSCRC implemented the state's new all-payer Global Budget Revenue (GBR) model. Developed in partnership with the Centers for Medicare and Medicaid Services (CMS), the five-year statewide initiative represents a fundamental transformation of the health care system in Maryland. GBR is a revenue constraint and quality improvement system that provides a fixed annual budget to hospitals based on the number of patients served, rather than the number of procedures or services provided to patients.⁴¹ Global budgets shift hospital revenues from a volume-based fee-for-service model to a population health-based model that embraces the goals of the Triple Aim. Hospitals retain savings realized by reduced utilization of services and the effective management of resources, which then may be reinvested or redirected in the form of community benefits to fund population health initiatives. Under the new system, hospitals benefit financially if they can reduce the number of avoidable hospital services. This creates a powerful incentive for hospitals to invest in and partner with programs and services that will improve the health of individuals in their communities, thereby reducing unnecessary reliance on hospital services. The GBR model uniquely positions Maryland hospitals to invest in community benefit activities while at the same time improving their own bottom lines.

The results of the first two years of performance under the new waiver show considerable promise. Maryland committed to limiting its annual all-payer per capita hospital cost growth to 3.58 percent for the first three years.⁴² In the first year of the new waiver system, per capita hospital costs for all payers grew at just 1.47 percent.⁴³ The state pledged to generate \$330 million in Medicare savings over the five years of the agreement, measured by comparing Maryland's Medicare per capita total hospital cost growth to the

In 2014, Medicare per capita hospital costs decreased in Maryland by 1.08 percent, which translates into savings for Medicare of \$116 million.⁴⁵

national trend.⁴⁴ In 2014, Medicare per capita hospital costs decreased in Maryland by 1.08 percent, which translates into savings for Medicare of \$116 million.⁴⁵ Maryland also agreed to shift virtually all hospital revenue over the five-year period into a population-based global payment model.⁴⁶ As of April 2015, 95 percent of Maryland hospital revenues had moved into global budget structures.⁴⁷

As the third year of the waiver experiment comes to a close, hospitals are beginning to engage in care coordination activities with payers, providers, community-based organizations, health departments, and other groups that aim to integrate primary care, prevention, and interventions that address patients' nonmedical needs, such as housing, transportation, and economic and social relationships. HSCRC has facilitated these efforts with funding to encourage collaboration between hospitals and community-based partners. In June 2016, the HSCRC awarded more than \$30 million in "Healthcare Transformation Grants" to nine hospital-community collaborations throughout Maryland, supporting a variety of innovative efforts to transform the healthcare delivery system by shifting services out of the hospitals and into the community, with an overarching goal of reducing costs while improving health outcomes. Given the variety of approaches supported by the Healthcare Transformation Grants, these partnerships offer an opportunity to learn about which models are most effective in delivering on the promise of the Triple Aim. At the same time, they could provide a road map for hospitals that want to use their community benefit dollars to support community partnerships that produce real, measurable improvements in population health needs.

Despite its early success, the current all-payer model faces challenges in the final two years of the waiver. An important loophole in the existing framework that must be addressed is that the GBR payment model at present applies only to hospital services. Physician expenditures and other nonhospital providers are not subject to a cap under the current global budget model.⁴⁸ HSCRC is working to address the issue with new policies adopted in 2016.⁴⁹ But until the present system is expanded to include nonhospital providers, the disconnect that exists between the global budget revenue payment model and the fee-for-service payment model for physicians and other providers will impede efforts to improve population health.

Conclusion and Recommendations

Hospital community benefit expenditures are a critical component of health care reform to strengthen population health improvement efforts at both the federal and state levels. Accountability measures under the ACA in the form of CHNAs provide a framework to ensure that the billions of dollars hospitals receive in tax subsidies are reinvested to meet the significant social and economic needs of communities. The global budget revenue model has transformed the health care delivery system in Maryland by modernizing hospital reimbursement incentive structures to align with population health improvement initiatives. As the global budget model continues to evolve, hospitals should look to leverage community benefit expenditures as a source of funding for ongoing public health engagement. Projects funded through the

The current climate offers a good opportunity for policymakers and stakeholders in the health care community to reaffirm a leadership role in reducing health disparities and improving population health.

HSCRC's Healthcare Transformation Grants, and other innovative hospital-community partnerships, provide an opportunity to learn about which partnerships are — and which are not — successful in delivering promised health improvements. It will be important to study the outcomes of these projects as they move forward.

This process will be especially important as a new administration takes charge of the federal healthcare system. It is difficult to predict the full extent of the policy implications of the 2016 election, but the likely repeal and replacement of the ACA will hit hospitals and safety net providers hard. Indeed, hospital associations recently warned members of Congress that the financial impact on hospitals of repealing the law could trigger an "unprecedented public health crisis."⁵⁰ Repeal of the ACA would cause nearly 350,000 people in Maryland to lose their health care coverage and would significantly increase health care premiums for everyone. Without a replacement plan to evaluate, it is difficult to know how a rollback of the law would impact Maryland's global budget system. In the midst of an uncertain future, perhaps Maryland will serve as a model for other states that want to engage their hospitals in effectively addressing local public health priorities.

The current climate offers a good opportunity for policymakers and stakeholders in the health care community to reaffirm a leadership role in reducing health disparities and improving population health. Hospitals should engage in an iterative process to

evaluate performance and accountability in their community benefit spending. Increased transparency and uniform reporting by hospitals statewide will ensure that resources are properly invested and aligned with the needs of the community, and may lead to reduced fragmentation and duplication of efforts by hospitals with overlapping service areas. And finally, research should be focused on understanding the impact that the global budget model and/or the CHNA requirements under the ACA have had on the nature and scope of hospital community benefit activities in Maryland. As evidence-based practices emerge through evaluation of the HSCRC-funded transformation grants and other hospital-community partnerships, hospitals can make strategic investments in those programs and initiatives that address the social, economic, and environmental factors that will most profoundly influence the public's health.

About the Author

Anna L. Davis, JD, MPH, is the health policy director for Advocates for Children and Youth, a nonprofit that works to improve the lives of children in Maryland through policy change and program improvement. She is also a visiting scholar at the Johns Hopkins Bloomberg School of Public Health in the department of health policy and management, and serves as program manager for the Clinic for Public Health Law and Policy. The author wishes to thank Rhya Ghose, a 2017 MSPH candidate at the Johns Hopkins Bloomberg School of Public Health, for her valuable contributions and research assistance on earlier drafts of this report.

Endnotes

1 American Hospital Association, "AHA Hospital Statistics, 2013 Edition."

2 Lunder, E. K., Liu, E. C., 501(c)(3) Hospitals and the Community Benefit Standard (CRS Report No. RL34605). Washington, DC. Congressional Research Service, 2009, citing, Congressional Budget Office, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, Dec. 2006, at 5 (federal, state, and local tax exemptions provided to nonprofit hospitals in 2011 was estimated to be \$24.6 billion). "Nonprofit status is a state law concept. Nonprofit status may make an organization eligible for certain benefits, such as state sales, property and income tax exemptions. Although most federal tax-exempt organizations are nonprofit organizations, organizing as a nonprofit organization at the state level does not automatically grant the organization exemption from federal income tax. To qualify as exempt from federal income tax, an organization must meet requirements set forth in the Internal Revenue Code." See <https://www.irs.gov/charities-non-profits/frequently-asked-questions-about-applying-for-tax-exemption>. In addition to benefits derived from state and federal income tax exemptions, nonprofit organizations may benefit from tax-exempt bond financing and receive charitable contributions, which are tax deductible to the individual or corporate donor.

3 The Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, 124 Stat. 1028 (2010), collectively referred to herein as the Affordable Care Act (ACA).

4 The Hilltop Institute, a nonpartisan health research organization located at the University of Maryland at Baltimore County, has released a number of publications on community benefit reporting, community benefit accountability, community benefit effectiveness, community health needs assessment, among other topics.

5 House Ways and Means Committee Report, 12. It should be noted that neither the IRC nor the underlying regulations explicitly provide an exemption from federal income tax for nonprofit hospitals. *Ibid.*

6 26 U.S.C. §501(c)(3).

7 Rev. Rul. 56-185, 1956-1 C.B. 202. The ruling also required that a hospital not restrict the use of its facilities to particular groups of physicians or surgeons to the exclusion of other qualified physicians and that a hospital's net earnings must not inure directly or indirectly to the benefit of any private shareholder or individual.

8 See *Geisinger Health Plan v. Commissioner*, 985 F.2d 1210, 1216 (3rd Cir. 1993).

9 See, e.g., Mark A. Hall and John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 Wash. L. Rev. 307, 320 (April 1991). The community benefit standard was promulgated, at least in part, in response to concerns that Medicare and Medicaid had reduced the demand for charity care to such an extent that the previous standard for exemption had been rendered an anachronism.

10 Rev. Rul. 69-545, 1969-2 C.B. 117. The IRS did not define the term "community benefit" nor did the agency require at the time a detailed method for collecting information about the nature and scope of a hospital's community benefit activities. Thus, whether a hospital's expenditures rose to the level of providing a tangible benefit to the community to justify exemption from taxation turned on the facts and circumstances of each individual case. Rosenbaum, S., Byrnes, M., Hurt, N., *Community Benefit and the ACA: A Brief History and Update*, George Washington University, Milken Institute School of Public Health. http://www.nchh.org/Portals/0/Contents/HCF_CBACA%20overview.pdf Accessed January 6, 2016.

11 *Ibid.* Additional factors set forth in the ruling to be considered in the determination of tax-exempt status are whether the hospital: (1) is run by an independent board of trustees composed of representatives of the community; (2) operates with an open medical staff policy with privileges available to all qualified physicians; (3) provides care for all those persons in the community able to pay the cost thereof either directly or through third-party reimbursement; and (4) utilizes surplus funds to improve the quality of patient care; expand its facilities; and advance medical training, education, and research.

12 Rosenbaum, S., Byrnes, M., Hurt, N., *Community Benefit and the ACA: A Brief History and Update*, George Washington University, Milken Institute School of Public Health. http://www.nchh.org/Portals/0/Contents/HCF_CBACA%20overview.pdf. Accessed January 6, 2016.

13 *The Tax-Exempt Hospital Sector: Hearing Before the H. Comm. on Ways & Means, 109th Cong. 87 (2005)*. See also, *Benefits Questioned in Tax Breaks for Nonprofit Hospitals*, New York Times, Elizabeth Rosenthal, Dec. 16, 2013. <http://www.nytimes.com/2013/12/17/us/benefits-questioned-in-tax-breaks-for-nonprofit-hospitals.html>.

14 See, e.g., IRS News Release, *IRS Releases Interim Report on Tax-Exempt Hospitals and Community Benefit Project*, IR-2007-132 (IRS), 2007 WL 2052000. According to the report, nearly all hospitals reported that they provided some form of community

benefit identified by the questionnaire. "Although 97 percent of responding hospitals said they have a written uncompensated care policy, no uniform definition of what constitutes 'uncompensated care' emerged from the responses. Further, there appear to be significant differences in the way other components of community benefit are reported." The lack of consistency or uniformity in classifying and reporting uncompensated care and various types of community benefit alerted the IRS to the difficulty in assessing whether a hospital was in compliance with the law.

15 IRS, Draft Form 990 Redesign Project – Schedule H, June 14, 2007. Available at https://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf.

16 Gray, B.H., Schlesinger, M., The Accountability of Nonprofit Hospitals: Lessons Learned from Maryland's Community Benefit Reporting Requirements, *Inquiry* 46: 122-139 (Summer 2009).

17 See generally, IRS, Schedule H: Instructions.

18 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1028 (2010), collectively referred to herein as the Affordable Care Act (ACA). The Reconciliation Act amended the Affordable Care Act and related laws.

19 I.R.C. § 501(r)(3)(A). See also, Somerville, M.H., Seeff, L., Hale, D., O'Brien, D.J., Hospitals, Collaboration, and Community Health Improvement, *J. Law, Med. & Ethics*, Spring 2015.

20 IRS/Treasury Notice 2011-52. Available from <https://www.irs.gov/pub/irs-drop/n-11-52.pdf>.

21 26 C.F.R. § 1.501(r) – 3. Available from https://www.irs.gov/irb/2015-5_IRB/ar08.html.

22 26 C.F.R. § 1.501(r)-3(4).

23 Ibid. See also, Internal Revenue Bulletin 2015-5 TD 9708. Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return. Retrieved from: https://www.irs.gov/irb/2015-5_IRB/ar08.html.

24 Ibid.

25 Ibid.

26 26 C.F.R. § 1.501(r)-3(b)(5).

27 Somerville, M.H., Nelson, G.D., Mueller, C.H., Boddie-Willis, Hospital Community Benefits after the ACA: Present Posture, Future Challenges, (Hilltop Institute, UMBC, October 2013).

28 Notice 2011-52, supra n. 31, at 19.

29 Ibid, 20.

30 Ibid.

31 See, e.g., Principe, K., et al., The Impact of the Individual Mandate and Internal Revenue Service Form 990 Schedule H on Community Benefits from Nonprofit Hospitals, *Am J Public Health*, 2012; 102: 229-237 (a study was conducted showing that, in 2008, 60 percent of hospitals in Maryland spent less than 5 percent of their annual operating income on community benefit expenditures). See also, Nikpay, S., Ayanian, J., Hospital Charity Care – Effects of New Community Benefit Requirements, *N Engl J Med* 2015; 373(18): 1687.

32 Young, G.J., et al., Provision of Community Benefits by Tax-Exempt U.S. Hospitals, *N Engl J Med* 2013; 368: 1519-27.

33 Maryland law defines a "community benefit" as "an activity intended to address community needs and priorities primarily through disease prevention and improvement of health status." Such activities include: (i) health services provided to vulnerable and underserved populations; (ii) financial or in-kind support of public health programs; (iii) donations of funds, property, or other resources that contribute to a community priority; (iv) health care cost containment activities; and (v) health education, screening, and prevention services. Md. Code Ann., Health-Gen. Art. §19-303(a)(3)(West).

34 Cohen, H.A., Maryland's All-Payer Hospital System. HSCRC; 1995. Available from http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsReports/GeneralInformation/MarylandAll-PayerHospitalSystem.pdf.

35 After a phase-in period of three years, the HSCRC began reviewing and approving rates in 1974.

36 Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, The Advisory Board Company, May 16, 2016. Available from <https://www.advisory.com/health-policy/resources/2016/maryland-all-payer-model-and-implications-for-providers>. Accessed Nov. 21, 2016.

37 Ibid.

38 Section 1814(b)(3) of the Social Security Act, codified at 42 U.S.C. §1395f.

39 Rajkumar, R., et al., Maryland's All-Payer Approach to Delivery-System Reform, *N Engl J Med* 2014; 370(6):493.

40 Ibid.

41 Maryland All-Payer Model to Deliver Better Care and Lower Costs, 2014 CMS Fact Sheet. Available from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10.html>.

42 Monitoring of Maryland's New All-Payer Model Biannual Report, HSCRC, October 2015, 20. Available from <http://www.hscrc.state.md.us/documents/Legal-Legislative/Reports/HSCRC-Biannual-Report-All-Payer-Model-2015-10-22.pdf>.

43 Patel, A., et al., Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model, *N Engl J Med* 2015;373(20):1899.

44 CMS Fact Sheet, supra n. 60.

45 Patel, supra n. 62.

46 Maryland All-Payer Model. Available from <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>.

47 Monitoring of Maryland's New All-Payer Model Biannual Report, HSCRC, October 2015. Available from <http://www.hscrc.state.md.us/documents/Legal-Legislative/Reports/HSCRC-Biannual-Report-All-Payer-Model-2015-10-22.pdf>.

48 Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, The Advisory Board Company, May 16, 2016. Available from <https://www.advisory.com/health-policy/resources/2016/maryland-all-payer-model-and-implications-for-providers>. Accessed Nov. 21, 2016.

49 Health Services Cost Review Commission – Report to the Governor Fiscal Year 2016, October 2016. Available from <http://www.hscrc.state.md.us/documents/pdr/ar/Gov-Report-FY2016-102516.pdf>.

50 Goodnough, A., "Safety Net Hospitals Fear Cuts as Health Law's Repeal Looms," *New York Times*, December 28, 2016, A1.

.....
A B E L L
.....
F O U N D A T I O N
.....

111 South Calvert Street, Suite 2300
Baltimore, Maryland 21202-6174

.....
The
Abell Report
.....

Published by the Abell Foundation
Volume 30, Number 1

**Hospital Community Benefits and Health
Care Reform in Maryland:**
A Strategy for Improving Population Health

By Anna L. Davis, JD, MPH
January 2017

About the Abell Foundation

The Abell Foundation is dedicated to the enhancement of the quality of life in Maryland, with a particular focus on Baltimore. The Foundation places a strong emphasis on opening the doors of opportunity to the disenfranchised, believing that no community can thrive if those who live on the margins of it are not included.

Inherent in the working philosophy of the Abell Foundation is the strong belief that a community faced with complicated, seemingly intractable challenges is well-served by thought-provoking, research-based information. To that end, the Foundation publishes background studies of selected issues on the public agenda for the benefit of government officials; leaders in business, industry and academia; and the general public.

For a complete collection of Abell publications, please visit our website at www.abell.org/publications