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The Calamity of Community Benefit: Redefining the Scope and Increasing the Accountability of Minnesota's Nonprofit Hospitals

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**THE CALAMITY OF COMMUNITY BENEFIT: REDEFINING
THE SCOPE AND INCREASING THE ACCOUNTABILITY OF
MINNESOTA'S NONPROFIT HOSPITALS**

*Theodore J Patton**

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I. INTRODUCTION

Every year the cries grow louder for nonprofit hospitals to justify their tax exemptions. One overarching reason for the growing frustration is that healthcare costs continue to skyrocket¹—reaching a projected \$2.8 trillion in 2013, with healthcare's share of the gross domestic product (GDP)

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¹ Jill Horwitz, *Nonprofit Ownership, Private Property, and Public Accountability*, 25 HEALTH AFFAIRS w308, w309 (2006).

surpassing 18%.² Another reason is the number of non-elderly, uninsured Americans rose above 49 million in 2010, which increases demand for entities that provide charity care.³ Thus, the question remains: do nonprofit hospitals “provide community benefits commensurate with the value of their tax exemptions[?]”⁴ If the analysis used to answer this question takes into account only charity care, then the answer is a majority of nonprofit hospitals do not provide enough charity care to offset the value of their tax exemptions.⁵ As a result of this imbalance, a broader definition of community benefit has come into fashion within government agencies and hospital associations, which includes a variety of activities in addition to charity care.⁶ The purpose of this article is twofold: (1) to redefine the “community benefit” standard in Minnesota; and (2) to hold Minnesota’s nonprofit hospitals accountable by empowering the communities they serve.

II. BACKGROUND

There are three different classifications for American hospitals: nonprofit, for-profit, and governmental.⁷ This article only discusses nonprofit hospitals and does not address their for-profit counterparts, other related institutions, or health plans. A majority of all hospitals in the United States are classified as nonprofit.⁸ As of 2010, nonprofit hospitals comprised 58% of all American hospitals.⁹ In 2012, the Alliance for Advancing Nonprofit Health Care found that 72% of Minnesota’s hospitals are classified as

² Compare Mortimer B. Zuckerman, *The High Cost of Staying Well: The U.S. Gets Poor Bang for its Medical Buck*, U.S. NEWS (Oct. 22, 2013), www.usnews.com/opinion/mzuckerman/articles/2013/10/22/why-health-care-costs-so-much-and-how-to-fix-it (indicating that the United States is projected to spend \$2.8 trillion on healthcare in 2013, which is an increase of \$300 billion from 2010) with U.S. DEP’T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURE PROJECTIONS 2009–2019, Table 1 (2010) (projecting that the United States will spend \$2.5 trillion on healthcare in 2010).

³ KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 8 (2012), <http://www.kff.org/uninsured/upload/7451-06.pdf>.

⁴ *Taking the Pulse of Charitable Care and Community Benefit at Nonprofit Hospitals: Before the Senate Committee on Finance*, 109th Cong. 14 (2006) [hereinafter Kane Statement] (statement of Nancy M. Kane, Professor of Management, Harvard School of Public Health).

⁵ *Id.*

⁶ *Id.*

⁷ CONG. BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 1 n.1 (2006).

⁸ *Id.* at 3.

⁹ ALLIANCE FOR ADVANCING NONPROFIT HEALTHCARE, BASIC FACTS AND FIGURES: NONPROFIT COMMUNITY HOSPITALS 1, 3 (2012), *available at* <http://www.nonprofithealthcare.com/resources/BasicFacts-NonprofitHospitals.pdf>; *see also* Steven T. Miller, Remarks at the Office of the Attorney General of Texas for Charitable Hospitals: Modern Trends, Obligations, and Challenges 2 (Jan. 12, 2009) (indicating that more than 2,900 out of more than 5,700 hospitals in the United States are nonprofit).

nonprofit.¹⁰ For-profit hospitals represent a far smaller percentage. In fact, only 6% of all hospitals in the Midwest are classified as for-profit.¹¹

Hospital form determines a great deal about hospital ownership, governance, and tax treatment.¹² For-profit hospitals are operated by a board to benefit owners or shareholders.¹³ Stated more simply, for-profit hospitals are run as businesses with the intent of generating a profit. If a for-profit hospital generates a profit, it is distributed amongst the owners or shareholders.¹⁴ In contrast, nonprofit hospitals have boards that govern in accordance with a non-distribution restraint.¹⁵ This restraint requires that nonprofit hospitals reinvest profits back into hospital operations.¹⁶ Finally, and possibly most importantly, nonprofit hospitals receive favorable tax treatment.¹⁷ The reasoning behind such favorable tax treatment is often based on the “public benefit” theory.¹⁸

A. Tax Exemption for Nonprofit Hospitals

Favorable tax treatment for nonprofit organizations is a concept deeply rooted in American public policy because of the public benefits such organizations provide.¹⁹ Congress, as a matter of course, determined that it was ill-advised to tax organizations operated solely for the purpose of advancing the general welfare.²⁰ In fact, as early as 1894, nonprofit hospitals were exempt from federal income tax because, at the time, they provided care almost exclusively to the indigent.²¹ While caring for the poor was the impetus for their creation, several factors have contributed to the evolution and expanding missions of nonprofit hospitals: (1) more widely used hospital technology in the 1920s; (2) customers’ increased purchase and use of

¹⁰ ALLIANCE FOR ADVANCING NONPROFIT HEALTHCARE, *supra* note 9, at 3.

¹¹ CONG. BUDGET OFFICE, *supra* note 7, at 3.

¹² *Id.* at 3–4.

¹³ *Id.* at 4.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ CONG. BUDGET OFFICE, *supra* note 7, at 4.

¹⁷ See JAMES J. FISHMAN & STEPHEN SCHWARZ, NONPROFIT ORGANIZATIONS: CASES AND MATERIALS 327 (3d ed. 2006) (discussing nonprofit tax benefits); see also MINN. CONST. art. X, § 1 (exempting “institutions of purely public charity” from taxation); MINN. STAT. § 290.05, subd. 2 (2013) (exempting federally tax-exempt organizations from state income tax); MINN. STAT. § 272.02, subd. 7 (2013) (exempting “institutions of public charity” from state property tax); MINN. STAT. § 297A.70, subd. 7(a) (2013) (exempting nonprofit hospitals from state sales tax).

¹⁸ See FISHMAN & SCHWARZ, *supra* note 17, at 328 (stating that nonprofit tax exemptions are “justif[ied] on the basis of the benefits conferred by the organization—benefits which relieve the burdens of government by providing goods or services that society or government is unable or unwilling to provide.”).

¹⁹ M. Gregg Bloche, *Tax Preferences for Nonprofits: From Per Se Exemption to Pay-for-Performance*, 25 HEALTH AFFAIRS w304 (2006).

²⁰ FISHMAN & SCHWARZ, *supra* note 17, at 328.

²¹ Bloche, *supra* note 19, at w304.

insurance in the 1930s; (3) hospitals' increasing dependence on customers with insurance following World War II; and (4) the advent of Medicaid and Medicare in 1965.²² This evolution has helped nonprofit hospitals grow into one of the most significant players in the American healthcare system.

This evolution and expansion has placed nonprofit hospitals under increased scrutiny and pressure to justify their tax exemptions. Nonprofit hospitals are granted tax exemption under § 501(c)(3) of the Internal Revenue Code.²³ In 2002, the Joint Committee on Taxation estimated that the total value to nonprofit hospitals from federal, state, and local tax exemption was \$12.6 billion, with exemption from state and local taxation worth approximately \$6.3 billion of that amount.²⁴ This equates to \$16.2 billion worth of tax exemptions in 2012 dollars.²⁵ Additionally, nonprofit hospitals now comprise a large portion of all 501(c)(3) assets and revenue. As of 2006, nonprofit hospitals owned 40% of all 501(c)(3) assets and generated 57% of the revenue.²⁶ Being designated as a 501(c)(3) organization provides several advantages, including, but not limited to the following: exemption from federal, state, and local taxation; exemption from several regulatory regimes; and tax-deductible contributions.²⁷ In exchange for such generous treatment, nonprofit hospitals are required to provide "community benefits."

B. Community Benefit Requirement

Providing community benefits is the quid pro quo for a nonprofit hospital's designation as a tax-exempt 501(c)(3) organization. In the late nineteenth and early twentieth century, it was widely recognized that the role of nonprofit hospitals was to care for the impoverished.²⁸ At that time, patients with sufficient means received private, in-home care, and those with insufficient means received care at nonprofit hospitals, which provided such care in exchange for generous tax exemptions.²⁹ This structure was central to

²² *Id.*

²³ 26 U.S.C. § 501(c)(3) (2012); FISHMAN & SCHWARZ, *supra* note 17, at 328.

²⁴ CONG. BUDGET OFFICE, *supra* note 7, at 3.

²⁵ TRUST FOR AM.'S HEALTH, PARTNER WITH NONPROFIT HOSPITALS TO MAXIMIZE COMMUNITY BENEFIT PROGRAMS' IMPACT ON PREVENTION 1 (2013), *available at* <http://healthyamericans.org/assets/files/Partner%20With%20Nonprofit%20Hospitals04.pdf>.

²⁶ FISHMAN & SCHWARZ, *supra* note 17, at 357.

²⁷ *See id.* at 327 (detailing the advantages of being designated as a § 501(c)(3) under the Internal Revenue Code); *see also* Sara Rosenbaum & Ross Margulies, *Tax-Exempt Hospitals and the Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REP. 283, 283 (2011), *available at* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056045/pdf/phr126000283a.pdf> (estimating that the value of charitable contributions to nonprofit hospitals was \$5.3 billion in 2010).

²⁸ Bloche, *supra* note 19, at w304.

²⁹ *See infra* Part III.A (describing the evolution of nonprofit hospitals from their origin of caring exclusively for the destitute to drawing most of their revenue from paying clients).

the Hill-Burton Act of 1946, and the notion of charity care formed the crux of the first IRS standard for hospital tax exemption in 1956.³⁰

Starting with the advent of Medicare and Medicaid in 1965, however, two distinct definitions regarding the charity required of nonprofit hospitals have evolved: (1) the ordinary and (2) the legal.³¹ The ordinary definition of charitable purpose, in the context of nonprofit hospitals, follows a restrictive interpretation that remains focused on relief for the poor.³² The legal definition, through agency and court interpretations, has become more expansive and focuses on a myriad of “community benefits” that nonprofit hospitals can provide.³³ As a result, community benefits are now practically defined as “those programs and services that are generally thought to be provided at low or negative margin and are intended to improve access for disadvantaged groups or to address important health care matters for a defined population.”³⁴ The disconnect between the ordinary definition of charitable purpose and the practical application of community benefits has fueled public confusion and discontent.

C. A Problematic Standard

Nonprofit hospitals have significantly altered the notion of charitable purpose as a result of the evolving definition of community benefits and other external forces. First, the practical definition of community benefit makes it difficult to quantify the amount of community benefit provided by any one nonprofit hospital.³⁵ Even when an amount *can* be calculated, the amount of charity care is often overshadowed by other community benefits provided by the hospital.³⁶ For example, of the 500 nonprofit hospitals surveyed by the IRS in 2007, 43% spent three percent or less of their revenue on charity care.³⁷ Viewed another way, Minnesota’s nonprofit hospitals

³⁰ MINN. DEPT. OF HEALTH, BUILDING COMMUNITY CAPACITY FOR PREVENTION: A PLAN TO IMPLEMENT STATEWIDE STRATEGIES THROUGH HOSPITALS AND HEALTH PLANS COMMUNITY BENEFIT INVESTMENTS 6 (2012); Rev. Rul. 56-185, 1956-1 C.B. 202.

³¹ FISHMAN & SCHWARZ, *supra* note 17, at 354.

³² *Id.* at 356.

³³ Bloche, *supra* note 19, at w305.

³⁴ CONG. BUDGET OFFICE, *supra* note 7, at 15 (quoting Joel Weissman, *Uncompensated Hospital Care: Will It Be There If We Need It?*, 276 JAMA 823–28 (1996)).

³⁵ Mark Schlesinger & Bradford H. Gray, *How Nonprofits Matter in American Medicine, and What to do About It*, 25 HEALTH AFFAIRS w296 (2006) [hereinafter *How Nonprofits Matter*].

³⁶ Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1521–22 (2013) (noting that community benefit activities include, in addition to charity care, unreimbursed costs for government programs, clinical services provided at a loss, “community health improvement services,” such as immunization efforts, research, medical education, and “financial and in-kind contributions to community groups”).

³⁷ INTERNAL REVENUE SERV., IRS NONPROFIT HOSPITAL PROJECT 9 (2009). It should also be noted that the community benefits provided are not evenly distributed with

received \$482 million in tax exemptions and provided only \$80 million in charity care in 2005.³⁸ Moreover, the amount of charity care provided is, at best, ineffectively monitored by government agencies.³⁹

Second, external forces, such as growth, have also impacted the provision of charity care by nonprofit hospitals. The hospital sector “has grown from \$28 billion in 1970 to \$571 billion in 2004.”⁴⁰ Despite the sector’s exponential growth during this period, the total number of hospitals has actually declined by approximately 20% as hospitals have consolidated.⁴¹ Consolidation has resulted in large health systems competing for patients. This competition amongst health systems has compelled hospitals to reduce resources for unprofitable clients—polite terminology for minimizing services to the poor—and seek new revenue sources, such as through specialty services or expansion (the “medical arms race”).⁴² These problems underscore the urgency of redefining the community benefit standard in Minnesota.

III. ANALYSIS

There has been a wide-range of solutions proposed to address the definition and provision of community benefits. Some have simply advocated for the revocation of nonprofit hospitals’ tax exemptions.⁴³ This

19% of nonprofit hospitals—generally large hospitals located in urban settings—reporting 78% of aggregate community benefit expenditures. *Id.* at 8.

³⁸ See MINN. DEPT. OF HEALTH, MINNESOTA HOSPITALS: UNCOMPENSATED CARE, COMMUNITY BENEFITS, AND THE VALUE OF TAX EXEMPTIONS iv (2007) (explaining how an expansive definition of community benefits affects the value provided by nonprofit hospitals). When bad debt was included in the analysis, the amount of “uncompensated care” rose to \$191 million. *Id.* at 6. When all “community benefit activities” were included, the value provided by nonprofit hospitals was estimated at \$535 million. *Id.* at 24 tbl.6; see also MINN. HOSP. ASS’N, 2012 COMMUNITY BENEFIT REPORT 5 (2012) (noting that the charity care provided by Minnesota’s hospitals totaled \$228 million in 2011).

³⁹ See Kane Statement, *supra* note 4, at 3–4 (detailing how the IRS examination rate of the Form 990 is less than 1%).

⁴⁰ *Id.* at 2.

⁴¹ *Id.*

⁴² *How Nonprofits Matter*, *supra* note 35, at w297; see also Jack Gordon, *The Medical Arms Race: How Much High-Tech Medical Equipment Does Minnesota Really Need? And How Much Can We Afford Before the System Collapses Under the Expense?*, MINN. MEDICINE, Feb. 2007, at 26–27 (describing the medical arms race as “the proliferation of high-priced technology [in] driving up health care costs to crippling levels with . . . no regard at all for cost-effectiveness.”). Former U.S. Senator David Durenberger, a Republican from Minnesota, explains that, in health care, “the checks and balances inherent in ordinary market systems do not operate ‘to temper our enthusiasm for novelty and innovation’” for two reasons: (1) patients rely on physicians to diagnose them and inform them as to what medical treatment is necessary and appropriate; and (2) patients do not directly pay for the treatment(s) they receive. *Id.* at 30 (quoting David Durenberger). “So ‘someone else decides what we need, and someone else pays for it That’s true for our personal health, and it’s true of [health care] decisions made for us as a community.” *Id.* (quoting David Durenberger).

⁴³ Kane Statement, *supra* note 4, at 4.

punitive approach is unnecessary and would hurt the organizations that have responsibly pursued their charitable mission.⁴⁴ Another approach is the standardization of criteria to more effectively quantify the amount of community benefits provided by any one nonprofit hospital.⁴⁵ This approach has been attacked as “excessively inflexible” because it supplants decisions best made by individual communities with those of the state or federal government.⁴⁶ The proper solution lies between these two positions and focuses on accountability. Greater accountability can be accomplished by redefining the community benefit standard to more effectively prioritize specific charitable activities and by empowering the communities served by nonprofit hospitals to shape the services and care available. My position is best understood in the context of how we got here.

A. Internal Revenue Service Rulings and Confounding Ambiguity

Two IRS revenue rulings established different standards and have helped fuel this debate for the last half century. As indicated *supra*, the first standard, given in 1956, was based on the traditional concept of nonprofit hospitals providing care for the indigent and focusing on relief of the poor.⁴⁷ Under the 1956 revenue ruling, nonprofit hospitals were required, to the extent possible, to pay for services provided to those unable to pay.⁴⁸ Additionally, nonprofit hospitals had to maintain an open staff,⁴⁹ furnish services at reduced rates, and utilize earnings for capital improvements.⁵⁰ In 1969, the IRS modified and broadened what nonprofit hospitals can do to be eligible for tax exemption under 501(c)(3).⁵¹ Hospitals effectively lobbied for this reform, arguing that the passage of Medicaid and Medicare would eliminate or greatly reduce the need for charity care.⁵²

⁴⁴ *Id.*

⁴⁵ See generally Bradford H. Gray & Mark Schlesinger, *The Accountability of Nonprofit Hospitals: Lessons from Maryland's Community Benefit Reporting Requirements*, 46 INQUIRY J. 122–139 (2009), available at http://www.inquiryjournalonline.org/doi/pdf/10.5034/inquiryjrnl_46.02.122 (examining Maryland's approach to reporting and evaluating community benefit through pricing standardization and more comprehensive reporting requirements).

⁴⁶ *How Nonprofits Matter*, *supra* note 35, at w298.

⁴⁷ Rev. Rul. 56-185, 1956-1 C.B. 202.

⁴⁸ See *id.* (explaining the “financial ability” standard, which required that nonprofit hospitals provide charity care to the extent of their financial abilities).

⁴⁹ An open staff refers to the permission granted by hospitals to “physicians, who are not employees of the hospital, to practice at the hospital. A policy of having an open medical staff demonstrates that a hospital furthers the interests of the community rather than the private interests of a select group of physicians.” JANET E. GITTERMAN & MARVIN FRIEDLANDER, HEALTH CARE PROVIDER REFERENCE GUIDE 12 (2004), available at <http://www.irs.gov/pub/irs-tege/eotopic04.pdf>.

⁵⁰ Rev. Rul. 56-185, 1956-1 C.B. 202.

⁵¹ FISHMAN & SCHWARTZ, *supra* note 17, at 358.

⁵² See Bloche, *supra* note 19, at w304–w305 (discussing the argument made by nonprofit hospitals “that the need for free care had ‘largely disappeared’”).

The 1969 standard is fact-sensitive and requires a case-by-case analysis.⁵³ The factors that demonstrate community benefit under the 1969 ruling are as follows: (1) an emergency room open to all; (2) a board of directors drawn from the community; (3) an open staff; (4) treatment of those who utilize public programs to pay medical bills; and (5) use of surplus funds to improve facilities, patient care, medical training, education, or research.⁵⁴ The 1969 revenue ruling has been criticized by some as being “no standard at all”⁵⁵ and applauded by others as being “appropriately flexible.”⁵⁶ There are two distinct problems with the 1969 standard. First, several of the determining factors are now shared by both nonprofit and for-profit hospitals (e.g., open medical staffs, participation in Medicaid and Medicare, and open emergency rooms). Second, the standard lacks precision and accountability.⁵⁷ The lack of precision provided by the 1969 revenue ruling is readily apparent from the varying application of its community benefits standard.

B. Hospital Application and Exploding Profits

Nonprofit hospitals have become big business; in many circumstances, the charity care they were intended to provide appears to be an afterthought. Nonprofit hospitals in the inner cities that care for large numbers of uninsured patients have become an anomaly.⁵⁸ Between 2001 and 2006, the net income of the fifty largest nonprofit hospitals jumped dramatically to \$4.27 billion.⁵⁹ While only 61% of for-profit hospitals were profitable in 2008, 77% of nonprofit hospitals were in the black.⁶⁰ Their profitability is not an accident and comes from strategies honed to increase revenue. These strategies include “demanding upfront payments from patients; hiking list prices for procedures and services to several times their actual cost; selling patients’ debts to collection companies; [and] focusing on expensive procedures.”⁶¹ When these income strategies are placed side-by-side with \$12.6 billion in tax exemptions, it leaves many questioning the community benefit standard as it relates to nonprofit hospitals.⁶² United States Senator Charles Grassley, a Republican from Iowa, has opined that the priorities of nonprofit hospitals are “out of whack.”⁶³

⁵³ FISHMAN & SCHWARZ, *supra* note 17, at 358.

⁵⁴ Rev. Rul. 69-645, 1969-2 C.B. 117.

⁵⁵ Miller, *supra* note 9, at 6.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ John Carreyrou & Barbara Martinez, *Nonprofit Hospitals, Once for the Poor, Strike it Rich*, WALL. ST. J., Apr. 4, 2008, at A1, available at <http://online.wsj.com/news/articles/SB120726201815287955>.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² See *supra* Part II.A (explaining the Joint Committee on Taxation’s estimate of the value received by nonprofit hospitals from tax exemption).

⁶³ Carreyrou & Martinez, *supra* note 58, at A1.

While the practical community benefit standard requires a fact-sensitive, case-by-case analysis, it does not set forth quantitative expectations, which leaves individual hospitals determining, often on an *ad hoc* basis, their own charitable resource allocation.⁶⁴ The IRS standard also does not require (1) that the value of community benefits provided be equal to the tax benefits received or (2) that nonprofit hospitals provide *any* charity care.⁶⁵ The community benefit analysis—with its expansive interpretation and excessive flexibility—has become overly complex, and differing standards have developed as a result.⁶⁶ These differing standards define a multitude of activities as community benefits, including charity care, the unreimbursed costs of Medicaid and Medicare, cash and in-kind contributions, education, medical research, subsidized health services, bad debt, and community-building activities.⁶⁷ In aggregate, these activities stray widely from the original rationale for exempting nonprofit hospitals from taxation. For this reason and due to heightened public scrutiny, a growing minority of states have defined community benefit more specifically within their respective states.

C. State Survey and Minnesota Framework

States have recently pursued community benefits legislation that further defines the community benefit standard for the purpose of evaluating state and local tax exemptions. Legislation in this area has become increasingly varied. As of 2008, eighteen states had enacted community benefits legislation.⁶⁸ Nine of the eighteen states require some charity care; the other nine states recognize a wider range of community benefit

⁶⁴ ST. LOUIS UNIV. & MO. FOUND. FOR HEALTH, COMMUNITY BENEFIT: MOVING FORWARD WITH EVIDENCE-BASED POLICY AND PRACTICE 6–7 (2009), *available at* <http://www.mffh.org/mm/files/communitybenefitreport.pdf>.

⁶⁵ EILEEN SALINSKY, NAT'L HEALTH POLICY FORUM, WHAT HAVE YOU DONE FOR ME LATELY? ASSESSING HOSPITAL COMMUNITY BENEFIT 4, 7 (2007) [hereinafter WHAT HAVE YOU DONE FOR ME LATELY?], *available at* http://www.nhpf.org/library/issue-briefs/IB821_HospitalCommBenefit_04-19-07.pdf (explaining that the “broader definition of charitable purpose [does] not solely depend on (or even require) the provision of charity care” and “[t]he IRS has never revoked [the] tax exemption [of] a not-for-profit hospital based solely on a failure to demonstrate community benefit”).

⁶⁶ See HEATHER DEVLIN, GA. HEALTH POLICY CTR., NON-PROFIT HOSPITALS, TAX-EXEMPTION AND COMMUNITY BENEFITS 2 (2009), *available at* [http://fiscalresearch.gsu.edu/taxcouncil/downloads/HCA provided GSU Report.pdf](http://fiscalresearch.gsu.edu/taxcouncil/downloads/HCA%20provided%20GSU%20Report.pdf) (including the IRS, American Hospital Association, Catholic Health Association, and the Veterans Health Administration).

⁶⁷ *Id.*; *Cf.* ST. LOUIS UNIV & MO. FOUND. FOR HEALTH., *supra* note 64, at 9 (explaining the types of community benefit activities found by a 2009 study, which are: “Community Leadership and Engagement; Community Needs and Health Status; Economics; Finance; Charity Care and Bad Debt; Ethics; Evaluation and Program Effectiveness; Governance; Quality and Performance Measurement; Role of Health Professions Education; State and Federal Policy; and Structure and Staffing”); DEVLIN, *supra* note 66, at 2.

⁶⁸ *Id.*

activities.⁶⁹ Five states have developed minimum quantitative standards for the amount of community benefits provided.⁷⁰ Four states have adopted penalties for noncompliance with state-specific community benefit legislation.⁷¹ Additionally, twenty-two states have some form of community benefit reporting.⁷² Reporting community benefit is mandatory in twelve states and voluntary in ten.⁷³ In mandatory reporting states, a state agency collects the information; and in voluntary reporting states, the hospital association often collects the information.⁷⁴ Finally, twelve states have enacted laws mandating community health needs assessments (CHNA).⁷⁵ This survey represents a snapshot of the states' attempts to address the problematic community benefit standard for nonprofit hospitals and serves as a useful guide for analyzing the issue in Minnesota.

The Minnesota framework for addressing the problems associated with the community benefits standard more closely resembles using a band aid to treat a broken arm. Not only has Minnesota inadequately defined community benefits, but it has also failed to empower the communities served by nonprofit hospitals.⁷⁶ In fact, the Minnesota standard does not explicitly require *any* charity care and, in place of charity care, will count a *smorgasbord* of other activities.⁷⁷ These activities include, but are not limited to, community care, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, education costs, and the cost of operating subsidized services.⁷⁸ Minnesota law requires nonprofit hospitals to annually report the following: (1) services provided at no cost or for a reduced fee; (2) teaching and research activities; and (3) other community or charitable activities.⁷⁹ Minnesota law does not, however, specify a minimum level of community benefits necessary to retain tax exemption or require a community health needs assessment. There are also no statutory penalties for reporting noncompliance.⁸⁰ The Minnesota Commissioner of Health oversees the reporting of community benefits and

⁶⁹ *Id.*

⁷⁰ *See id.* (Alabama, Mississippi, Pennsylvania, Texas, and West Virginia).

⁷¹ *See id.* (Illinois, Indiana, Maryland, and Texas).

⁷² MINN. DEPT. OF HEALTH, *supra* note 38, at 21.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *See* DONNA C. FOLKEMER ET AL., THE HILLTOP INST., HOSPITAL COMMUNITY BENEFITS AFTER THE ACA: THE EMERGING FEDERAL FRAMEWORK 7 (2011) (California, Connecticut, Idaho, Illinois, Indiana, Massachusetts, Maryland, New Hampshire, New York, Rhode Island, Texas, and Utah).

⁷⁶ *See* COMMUNITY CATALYST, HEALTH CARE COMMUNITY BENEFITS: A COMPENDIUM OF STATE LAWS 27 (2007) (quoting MINN. R. 4650.0102 (1992)).

⁷⁷ MINN. STAT. §§ 144.698–99 (2013).

⁷⁸ *See* COMMUNITY CATALYST, *supra* note 76, at 27 (detailing the activities recognized for providing a community benefit in Minnesota and noting that bad debt and the underpayment for Medicare services do not count in Minnesota).

⁷⁹ MINN. STAT. § 144.698, subd. 1(5).

⁸⁰ *Id.*

has a statutory obligation to compile an annual report detailing each hospital's community benefit activities, and the Minnesota Attorney General can enforce any failures to report.⁸¹

In 2006, the Minnesota Legislature requested that the Minnesota Department of Health perform a study of these issues in Minnesota.⁸² Completed in January 2007, the Department of Health recommended that hospitals be required to have a written charity care policy, that debt collection practices be standardized, and that community benefit reporting be public and standardized.⁸³ In 2007, State Senator Linda Berglin, a Democrat from Minneapolis, introduced a bill based on these recommendations.⁸⁴ Senator Berglin also advocated for redefining the community benefit definition to separate charitable activities—such as charity care—from benefits that more closely represent business promotional activities.⁸⁵ Unfortunately, the Democrat-controlled Minnesota Legislature could not agree to terms with Governor Tim Pawlenty, a Republican from Eagan, and the bill was not enacted.⁸⁶

While the Minnesota Legislature failed to enact appropriate reform, it should be noted that the Minnesota Attorney General executed voluntary agreements with Minnesota's nonprofit hospitals in 2012 (the "2012 Agreement").⁸⁷ The 2012 Agreement requires nonprofit hospitals to adopt a charity care policy "which takes into consideration the financial ability" of patients to pay for medical care.⁸⁸ It also requires that each nonprofit hospital annually review its charity care practices and debt collection practices.⁸⁹ Each nonprofit hospital agreed to "cooperate with, respond to inquiries of, and provide information to the Attorney General in a timely manner"⁹⁰ Unfortunately, the 2012 Agreement was unsuccessful in redefining community benefit and in establishing a minimal threshold. However, the

⁸¹ COMMUNITY CATALYST, *supra* note 76, at 28; MINN. STAT. § 144.699, subd. 5 (2013); *see also* Robert Pear, *Nonprofit Hospitals Face Scrutiny Over Practices*, N.Y. TIMES, Mar. 19, 2006, at A1 (describing the enforcement efforts made by former Minnesota Attorney General Mike Hatch and his request for stronger regulation).

⁸² MINN. DEPT. OF HEALTH, *supra* note 38, at iii.

⁸³ *Id.* at 29.

⁸⁴ Anna Wolke, *Community Benefit and Tax Exemption Come Under the Microscope*, STATE HEALTH NOTES (Nat'l Conf. of State Legislatures, F. for St. Health Pol'y Leadership, D.C.), Jan. 7, 2008, at 2, *available at* <http://www.ncsl.org/print/health/shn/shn506.pdf>.

⁸⁵ Telephone Interview with Senator Linda Berglin, Minnesota Senate, in St. Paul, Minn. (Apr. 12, 2011).

⁸⁶ *Id.*

⁸⁷ *In the Matter of _____ Hospital*, No. C6-05-6078 (Minn. Dist. Ct. July 19, 2012) [hereinafter 2012 Agreement], *available at* <http://www.hilltopinstitute.org/MinnAG-HospAgreement.pdf>.

⁸⁸ *Id.* ¶ 36(e).

⁸⁹ *Id.* ¶¶ 14–26, 37.

⁹⁰ *Id.* ¶ 41.

struggle over community benefits in Minnesota, and in states across the country, became a catalyst for federal reform.

D. New Federal Requirements from the Internal Revenue Service and the Affordable Care Act

Following widespread public scrutiny, state variation and frustration, and Congressional investigation, the IRS adopted enhanced filing requirements for nonprofit hospitals.⁹¹ Phased in during 2009 (the 2008 tax year), nonprofit hospitals are now required to report facility information in connection with IRS Form 990, Schedule H.⁹² Thus, the entire Schedule H was first required to be completed in 2010 (for the 2009 tax year).⁹³ Prior to 2008, IRS Form 990 did not require the reporting of community benefit activities.⁹⁴ Schedule H includes six parts and aggregates information from individual hospitals and hospital systems.⁹⁵ This enhanced reporting requirement is intended to allow for a better evaluation of the types and amounts of community benefits provided by nonprofit hospitals.⁹⁶ While Schedule H may reduce large discrepancies in the valuation of community benefit, nonprofit hospitals are still afforded a great deal of flexibility in estimating the amount of community benefits provided.⁹⁷ These enhanced filing requirements will provide greater transparency for policymakers in evaluating community benefit practices, but do little to clarify the ambiguity of the community benefit standard.⁹⁸

Nonprofit hospitals, and their community benefit practices, were also on the hot seat during the drafting of the Patient Protection and Affordable Care Act (ACA).⁹⁹ Section 9007 of the ACA requires that nonprofit hospitals (1) work with the community to determine community health needs and then

⁹¹ See GOV'T ACCOUNTABILITY OFFICE, NONPROFIT HOSPITALS: VARIATION IN STANDARDS AND GUIDANCE LIMITS COMPARISON OF HOW HOSPITALS MEET COMMUNITY BENEFIT REQUIREMENTS 12 (2008); See also I.R.C. § 501(r) (2010) [hereinafter Schedule H], available at <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>, as enacted by the Patient Protection and Affordable Care Act.

⁹² I.R.S., EXEMPT ORGANIZATIONS HOSPITAL COMPLIANCE PROJECT 147 (2009) [hereinafter HOSPITAL COMPLIANCE PROJECT].

⁹³ *Id.* at 149.

⁹⁴ *Id.* at 147.

⁹⁵ See Schedule H, *supra* note 91 (listing the six parts as: Part I, Charity Care and Certain Other Benefits at Cost; Part II, Community Building Activities; Part III, Bad Debt, Medicare, & Collection Practices; Part IV, Management Companies and Joint Ventures; Part V, Facility Information; and Part VI, Supplemental Information); see also HOSPITAL COMPLIANCE PROJECT, *supra* note 92, at 148 (expanding on the reporting requirements for each of Schedule H's six parts).

⁹⁶ HOSPITAL COMPLIANCE PROJECT, *supra* note 92, at 149.

⁹⁷ EILEEN SALINSKY, NAT'L HEALTH POLICY FORUM, SCHEDULE H: NEW COMMUNITY BENEFIT REPORTING REQUIREMENTS FOR HOSPITALS 22 (2009).

⁹⁸ *Id.* at 24.

⁹⁹ Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.)

work to meet those needs; and (2) implement consumer protection regarding billing, collection, and financial assistance.¹⁰⁰ The ACA requires that nonprofit hospitals complete a CHNA at least once every three years.¹⁰¹ The ACA also requires nonprofit hospitals to (1) collect input from a broad cross-section of the community served; (2) make each assessment public; and (3) adopt implementation strategies for each assessment.¹⁰² Unfortunately, the ACA does not define the process for conducting a CHNA, nor does it state to what degree the public must be involved in the assessment.¹⁰³ Forthcoming regulations may provide some guidance, but now the question becomes: how will state and local governments incorporate the new federal framework into their exemption evaluations?

IV. RECOMMENDATION

The goals of this article are simple: to protect and empower the Minnesota communities served by nonprofit hospitals. Unfortunately, reaching consensus on the appropriate reform(s) is complicated, especially considering the increasing difficulty in simply delineating the “defining characteristics of not-for-profit hospitals. Comparative assessments are premised on the assumption that for-profit hospitals provide some level of community benefit in the form of broad community access . . . as well as uncompensated care for the poor,” despite minimal legal requirements to do so.¹⁰⁴ These comparative assessments between nonprofit and for-profit hospitals are inconclusive as to whether nonprofits operate significantly differently than for-profits.¹⁰⁵ The answer appears to largely depend on the sample of hospitals chosen for comparison.¹⁰⁶ Given this uncertainty, and even if Schlesinger and Gray’s conclusions are accepted, Minnesota must redefine its community benefit standard so that Minnesotans can effectively discern nonprofit hospitals from for-profit institutions.¹⁰⁷

¹⁰⁰ *Id.* § 9007, 124 Stat. at 855 (codified as amended in scattered sections of 26 U.S.C.).

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ FOLKEMER ET AL., *supra* note 75, at 5.

¹⁰⁴ WHAT HAVE YOU DONE FOR ME LATELY, *supra* note 65, at 11.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *See id.* at 12 (explaining Schlesinger and Gray’s findings that: (1) a majority of studies found that nonprofit hospitals are less expensive than for-profits, but a third of available studies found no difference in cost; (2) there is no significant difference in the quality of care between nonprofit and for-profit hospitals; and (3) access to care is greater at nonprofit hospitals); *see generally How Nonprofits Matter*, *supra* note 35, at w287–w303 (explaining their methodology for the studies and results discussed by Salinsky).

A. Redefining the Minnesota Community Benefit Standard

Redefining the community benefit standard in Minnesota is long past due. A new “Minnesota standard” would be used to evaluate the state and local tax exemptions of Minnesota’s nonprofit hospitals. The 1969 IRS revenue ruling, which established the standard that Minnesota closely parallels, identified specific factors to be considered in determining federal tax exemption for nonprofit hospitals.¹⁰⁸ Unfortunately, several of those factors are far less meaningful four decades later and provide little in terms of “distinguish[ing] one type of hospital from another.”¹⁰⁹ Commissioner Steven Miller correctly points out, however, that the non-distribution restraint and community board factors remain relevant distinguishing characteristics between nonprofit and for-profit hospitals.¹¹⁰ Charity care will also continue to be a relevant factor.¹¹¹ Considering the profitability, growth, and influence of nonprofit hospitals, the community benefit standard is in desperate need of a makeover here in Minnesota.¹¹²

The 1969 revenue ruling has resulted in a mixed bag. Critics cast it as not providing any tangible community benefit standard while supporters praise its flexibility.¹¹³ Minnesota should work to increase accountability by modifying and simplifying the standard. This will ensure that the Minnesota standard both establishes clear expectations for nonprofit hospitals and allows for ample flexibility. The author believes that the new standard should be redefined as a two-part analysis: (1) required characteristics; and (2) other non-required factors included in the community benefit valuation. This two-part analysis will in effect help nonprofit hospitals prioritize community benefit activities and remove the excessive flexibility of the current standard while maintaining an appropriate level of self-determination.

The first step in the proposed two-part analysis is determining which characteristics should be required for state and local tax exemption. In the decades following the 1969 revenue ruling, certain characteristics have become commonplace at both nonprofit and for-profit institutions, including (1) an open staff; (2) an open emergency room; and (3) participation in Medicare and Medicaid.¹¹⁴ These characteristics should be *required* under

¹⁰⁸ See *supra* Part III.A (explaining the community benefit standard).

¹⁰⁹ Miller, *supra* note 9, at 6 (describing how an open medical staff, Medicare and Medicaid participation, and an open emergency room are “characteristics now shared by tax-exempt and for-profit hospitals); see also discussion *supra* Parts II.C and III.A (discussing the problematic nature of the current community benefit standard).

¹¹⁰ Miller, *supra* note 9, at 6.

¹¹¹ See *id.*

¹¹² See *supra* Part III.B (detailing the impressive growth and revenues of nonprofit hospitals).

¹¹³ See *supra* Part III.A (discussing common critiques of the current standard).

¹¹⁴ Miller, *supra* note 9, at 6; see generally *How Nonprofits Matter*, *supra* note 35, at w288–w295.

this proposed standard. “Community care,”¹¹⁵ which is more inclusive than charity care, but does not include bad debt, should also be *required* and performed at the level at which each organization is able. In determining whether nonprofit hospitals are providing sufficient community care, a basic “reasonableness” test should be employed.¹¹⁶ Under the proposed reasonableness test, the cost of community care provided by any nonprofit hospital should equate to *at least* half the value of its tax exemptions.

Each of the characteristics in existence prior to Medicare and Medicaid—community care, open staffs, and open emergency rooms—are the types of activities that nonprofit hospitals have been exempted from taxation to provide.¹¹⁷ Thus, these activities should once again be made a priority. In addition, new factors—namely the protections provided by the ACA for billing and collection practices and community needs assessments—should be added to the standard and *required* for state and local tax exemption.¹¹⁸ While the Minnesota Attorney General has taken the lead on fair collection practices, the Minnesota Legislature should make the requirements statutory, as the 2012 Agreement was only agreed to for a period of five years.¹¹⁹ Maintaining a community board should also be *required*. Community boards comprised of local board members with diverse skill sets will ensure that nonprofit hospitals remain accountable to the communities they serve. Under this proposal, in order for nonprofit hospitals to receive state and local tax exemption in Minnesota, they would be required to do the following: (1) provide an open staff; (2) provide an open emergency room; (3) participate in Medicare and Medicaid; (4) provide community care at a level at which each organization is able; (5) implement fair billing and collection practices; and (6) implement community health needs assessments.

For many reasons—including location, patient income, and organization size—nonprofit hospitals, by adhering to the proposed requirements, may be unable to provide community care at a level that equates to *more than* half the value of their tax exemptions. Therefore, additional community benefit activities should be considered in part two of the proposed analysis. Minnesota’s current community benefit standard

¹¹⁵ See MINN. STAT. §§ 144.699, subd. 5(c) (2013) (defining community care as the cost of charity care or the costs associated with a patient billed for services who subsequently demonstrates an inability to pay).

¹¹⁶ See Kane Statement, *supra* note 4, at 5 (arguing for a reasonableness test where the cost of charity care provided equates to the *entire* value of a nonprofit hospital’s tax exemptions). Kane’s proposal provides too little flexibility.

¹¹⁷ See *supra* Part II.A (explaining the rationale for exemption nonprofit hospitals from taxation).

¹¹⁸ See *supra* Part III.C (detailing the efforts of the Minnesota attorney general with respect to collection practices); see also Miller, *supra* note 9, at 2 (explaining the difficulties with the current community benefit standard and why the current standard cannot encompass everything for everyone).

¹¹⁹ 2012 Agreement, *supra* note 87, ¶ 41.

includes the following activities: “underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, education costs, and the cost of operating subsidized services.”¹²⁰ These activities should be considered and reported, but not required. This proposal would expressly limit additional consideration of these activities and thereby simplify the community benefit analysis. It would also operate to clarify an ambiguous standard and prioritize the community benefits provided by Minnesota’s nonprofit hospitals.

B. Structuring Community Boards and Community Health Needs Assessments

Community boards and community needs assessments share a common purpose: to hold nonprofit organizations accountable to the communities they serve.¹²¹ The composition of a nonprofit hospital’s board of directors should reflect the community it serves.¹²² Unfortunately, American boards trail well behind the diversity of the U.S. population; 35% of Americans belong to an ethnic minority and only 12% of boards are non-white.¹²³ This problem is further compounded in the context of hospitals because a larger percentage of minorities are hospitalized yet hospital boards are 90% white.¹²⁴ Diverse hospital boards more closely relate to the communities their nonprofit hospitals serve and improve the hospitals’ chances of meeting the needs of their patients.¹²⁵ In Minnesota, for example, Allina Hospitals & Clinics is a hospital system comprised of eleven hospital facilities. Its board is comprised of seventeen directors; thirteen directors are white and thirteen directors hold one of the following titles: CEO, president, executive director, or senior vice-president.¹²⁶ Minnesota needs to do a better job in pursuing diversity on nonprofit hospital boards with the intention of providing “culturally competent care.”¹²⁷ Under the proposed Minnesota

¹²⁰ MINN. STAT. § 144.699 (2013).

¹²¹ See generally Nancy R. Axelrod, *Board Leadership and Development*, in THE JOSSEY-BASS HANDBOOK OF NONPROFIT LEADERSHIP AND MANAGEMENT 131, 134 (Robert D. Herman & Assocs. eds., 2d ed. 2005).

¹²² See MINN. COUNCIL OF NONPROFITS, PRINCIPLES & PRACTICES FOR NONPROFIT EXCELLENCE 7 (2005), available at http://www.minnesotanonprofits.org/Principles_Practices.pdf.

¹²³ Jan Greene, *Why Board Diversity Matters*, HHN MAGAZINE, January 2011, at 21.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Allina Health Board of Directors*, ALLINA HEALTH, http://www.allina.com/ahs/aboutallina.nsf/page/board_of_directors (last visited Oct 11, 2013).

¹²⁷ See Greene, *supra* note 123, at 22 (quoting Frederick Hobby, president of the Institute for Diversity in Health Management).

community benefit standard,¹²⁸ a community board should be defined as a board that “mirror[s] the community it serves” and should not be comprised of almost entirely white business leaders.¹²⁹ Oversight of this nonprofit requirement falls within the auspices of the Minnesota Attorney General who should periodically review progress and, if necessary, step up enforcement.¹³⁰

In addition to the requirement of maintaining a community board, a second method for increasing the accountability of Minnesota’s nonprofit hospitals is implementing community health needs assessments. Community health needs assessments are of relatively young vintage.¹³¹ For community health needs assessments to be effective, three characteristics must be present: (1) the community needs to play an active role in producing the assessments; (2) the assessments need to be reported publicly; and (3) implementation strategies must be adopted to address the needs. Schedule H only requires public reporting and implementation strategies.¹³² Under the proposed standard,¹³³ Minnesota should carry the Schedule H requirements one step further and mandate direct community involvement in producing the assessments.¹³⁴ However, one of the primary challenges of direct community involvement is geographically defining “the community.” While hospitals seek participation within boundaries established by self-identified service areas, a broader definition of community would promote a more equitable sharing of responsibility. Direct community involvement from an appropriately-defined community would ensure that Minnesota’s nonprofit hospitals remain accountable to the communities they serve.

V. CONCLUSION

Minnesota’s current community benefit standard is ambiguous and excessively flexible. It is critical that Minnesota redefine the community benefit standard to more effectively evaluate the state and local tax exemption of Minnesota’s nonprofit hospitals. This article has proposed a two-part analysis that requires certain characteristics, yet is flexible enough to consider other factors. Also, direct community involvement on nonprofit

¹²⁸ See *supra* Part IV.A (discussing the continued importance of nonprofit hospitals maintaining a community board).

¹²⁹ Greene, *supra* note 123, at 21.

¹³⁰ See MINN. STAT. § 144.699 (2013).

¹³¹ See *supra* Part III.D (explaining the new requirements under the ACA); see also *How Nonprofits Matter*, *supra* note 35, at w298 (discussing the effectiveness of the California and Massachusetts models).

¹³² See *supra* Part III.D (describing the new requirements of Schedule H).

¹³³ See *supra* Part IV.A (proposing a two-part community benefit analysis in Minnesota that requires a CHNA).

¹³⁴ Telephone Interview with Representative Thomas Huntley, Minnesota House of Representatives, in St. Paul, Minn. (Apr. 11, 2011) (advocating for a balance between community demands and the recommendations of medical professionals).

hospital boards and in producing the new community health needs assessments is essential to holding nonprofit hospitals accountable to the communities they serve. Modifying the current community benefit standard represents a middle-of-the-road approach to protecting the viability of nonprofit hospitals in today's healthcare system. Increasing the involvement of the communities served by nonprofit hospitals ensures accountability to their constituencies and might, in time, help repair the public's perception of nonprofit hospitals.