Issue Overview

Hospital Charity Care in the United States

Summer 2005

Prepared for:
The Missouri Foundation for Health
Health Policy Committee

Prepared by:
MFH Health Policy Staff

Issue Overview:
Hospital Charity Care in the United States

Introduction

The *St. Louis Post Dispatch* ran a series of editorials and letters to the editor on the issue of charity care from December 2004 through January 2005. These editorials generated considerable interest both in the community and on the MFH Community Advisory Committee (CAC). During the Missouri Foundation for Health Board of Directors' (BoD) meeting in January, the CAC voiced its concern regarding the issue of charity care. The BoD then charged the Health Policy Committee (HPC) with considering this issue. In February, the HPC asked the health policy staff to provide background information on the subject. This issue overview presents a broad look at how Missouri and other states have defined and worked on issues relating to charity care.

Traditionally, charity care has been most closely associated with hospitals. Therefore, this issue overview focuses solely on hospital charity care. Within these parameters, this paper examines the historical context in which charity care emerged and evolved, as well as important concepts that have stemmed from the topic of charity care. Likewise, it provides a broad sketch of the national landscape of charity care, paying special attention to the state of Missouri. Finally, it discusses policy and legal implications of charity care.

The paper contains the following sections:

- **I. History of Charity Care**
- **II. Important Definitions and Concepts**
- **III. Charity Care Legislation and Charity Care Models**
- **IV. The Case of Missouri**
- **V. Policy Implications**
- **VI. Conclusion**

I. History of Charity Care

The concept of charity care has been closely linked to the development of hospitals. As these institutions have evolved, so has the relatively vague definition of charity care.
Today's hospitals differ considerably from their predecessors. Founded in Europe during the middle ages, and centuries later in America, hospitals served as the last resort for the infirm, the mentally and physically disabled, and the homeless.[1] Hospitals performed multiple functions,

but primarily provided shelter for the poor. Those who were better off usually received care in their own homes from private physicians.[1] The growing number of epidemics and the need to isolate those affected led to establishment of city and voluntary hospitals during the 19th century. However, it was not until the advent of anesthesia and antiseptics that modern hospitals began to develop.[1]

In the United States at the beginning of the 20th century, the prevailing hospital systems in major cities consisted of municipal and private secular hospitals, most of which were charitable in character and affiliated with medical schools. They relied upon government appropriations rather than fees to sustain their operations. Religious and ethnic hospitals, less prominent at the time, relied entirely on fees and donations to finance their operations.[1] Until the 1970s, some hospitals managed to provide care for the poor by marking up the standard charges of the medical services they provided to the general population, a practice known also as cost-shifting.[2] Insurance plans emerged in the 1930s, as the non-poor began to demand hospital care.

The Hill-Burton Act of 1946, which sought to promote hospital modernization, provided government grants to non-profit hospitals. In exchange for these grants, Hill-Burton required non-profit hospitals to provide charity care or discounted care for those who could not afford care at regular costs.[3] Financing of the hospital industry shifted again with the creation of Medicare and Medicaid in the 1960s. By the end of that decade, about 90 percent of hospital revenue came either from government programs or private insurance.[3]

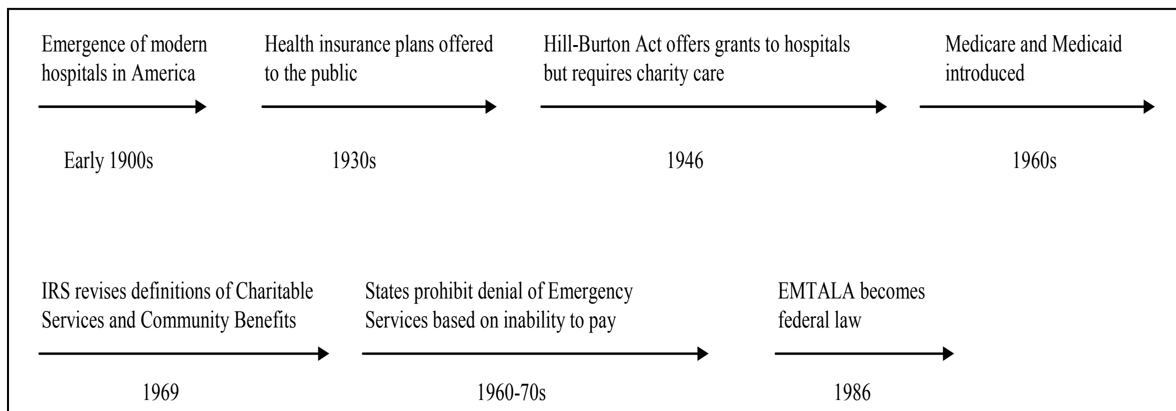
Significantly, political pressure in the 1960s and early 1970s resulted in new state laws prohibiting hospitals with emergency care facilities to deny treatment to those in critical condition. Texas and New Jersey were among the first to pass such laws.[4] However, it was not until the enactment of the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 that a federal law required hospitals participating in the Medicare and Medicaid programs to provide a minimum of care to all patients coming to an emergency room regardless of their ability to pay.[5]

The Internal Revenue Service (IRS) revised the definition of “charitable services” for non-profit hospitals in 1969, eliminating the clause requiring free or below-cost care except for hospitals that had emergency rooms. Moreover, the IRS also provided guidelines for tax exempt

hospitals for assessing "community benefits" and as a result the promotion of health and the advancement of medical education were added to the mix of benefits allowed. In 1983, the IRS redefined charity care once again by allowing hospitals without an emergency room to have a tax-exempt status under special circumstances.[3]

As a result of these changes, what constitutes charity care and community benefits has historically had no clear, universal definition. Lack of federal standards, and creative accounting practices on the part of hospitals, have only added to the confusion. Nevertheless, it is important to understand the language implications surrounding many of the concepts related to charity care.

Table 1. **Historical Factors that Influenced Charity Care in America**



II. Important Definitions and Concepts

Establishing a full understanding of the term charity care requires a discussion of a patchwork of related definitions and concepts. Five definitions and two significant concepts appear frequently in legal and academic discussions of the issue. Different stakeholders define them with slight variations. Non-profits have had the discretion to adopt and use this terminology as they see fit.

Definitions Related to Charity Care

1) Charity care

In its "pure" form charity care includes all the costs and write-offs associated with services rendered to individuals determined prior to service delivery to be unable to pay.[6] A hospital may write-off all or part of the cost of providing

In its "pure" form charity care includes all the costs and write-offs associated with services rendered to individuals determined prior to service delivery to be unable to pay[6]

service to such a patient. A write-off results from removing items from the accounting books. The Catholic Health Association (CHA), which has taken an active role in determining how community benefits should be accounted for, considers charity care to be:

> "free or discounted health and health-related services to persons who cannot afford to pay; care to uninsured, low-income patients who are not expected to pay all or part of a bill, or who are able to pay only a portion using an income-related fee schedule; the unreimbursed cost to the health system for providing free or discounted care to persons who cannot afford to pay and are not eligible for public programs. Charity care does not include bad debt."[7]

Furthermore, Community Catalyst, a national advocacy organization that engages the public in health care issues, notes that charity care can be also referred to as "free care."[8]

2) Uncompensated care

Hospital vernacular usually defines uncompensated care as the combined cost of charity care and the cost of bad debt. Many hospitals use this equation in their accounting practices. In this case, bad debt relates to charges that the hospitals have not collected from patients who otherwise are able to pay.[6; 9; 10]

3) Unreimbursed care

Health care literature defines unreimbursed care as the sum of pure charity care and the shortfalls and contractual allowances resulting from Medicare and Medicaid. These shortfalls and allowances represent the difference between the costs to hospitals for providing a service and the reimbursement rate to the hospitals for that service.[6] The inclusion of Medicare and Medicaid shortfalls as a community benefit remains controversial. Some non-profit groups recommend following strict guidelines as to when to consider these items a community benefit.[7]

4) Total charity care

Ultimately, the sum of all of the above, pure charity care, bad debt, and the shortfalls and contractual allowances generated by Medicare and Medicaid add up to what hospitals consider total charity care.[6]

5) Indigent care

Indigent care constitutes services provided to uninsured or underinsured individuals who are not expected to pay for those services. Prospective patients in this category must meet specific eligibility requirements.[7] Interestingly, some institutions and state laws make no apparent distinction between the terms "charity care," "free care" and "indigent care."

Concepts Related to Charity Care

1) Community benefits

In 1969 the Internal Revenue Service (IRS) established the community benefit standard, which requires that non-profit health organizations must deliver health care services in a way that benefits their community in exchange for federal tax exemption.[11] Several revisions to this standard have occurred since 1969. However, except for a few vague suggestions, the IRS has not provided a detailed description of the specific community benefits expected from non-profit hospitals, significantly reducing the impact of this standard.[11]

Community Catalyst recommends that community benefits be defined as the "unreimbursed goods, services and resources provided by health care institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved."[8] This definition limits community benefit activities to the following:

a) health promotion
b) charity care
c) disease prevention, and
d) access to health care.

However, variations to this definition abound as institutions have freely interpreted the IRS stipulation. The Catholic Health Association in their efforts to standardize terminology defines community benefits as:

> "…a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs. It implies collaboration with a community to benefit its residents—particularly the poor, minorities, and other underserved groups—by improving health status and quality of life."[7]

In addition to the community benefits outlined by other definitions, CHA includes the education of health professionals, research, donations and gifts, and community

development activities. Some organizations dispute the validity of these items as community benefits. Many demand that tax-exempt, non-profit hospitals justify how these activities directly benefit their community. For example, some assert that research should not count as a community benefit unless it directly improves the health of the community in which the hospital operates.

2) Disproportionate Share Hospital (DSH) payments

Hospitals treating a large share of low-income and Medicaid patients incur higher operating costs. Disproportionate Share (DSH) payments offset these additional costs. Medicaid federal and state DSH programs require hospitals to provide charity care to individuals who meet certain criteria. DSH payments offset the cost of caring for these individuals. Hospitals access DSH funds through state programs in accordance with each state's matching rate.[12] The state of Missouri makes DSH payments to certain hospitals above what it reimburses other providers for Medicaid services. Overall, these additional payments go to hospitals that provide healthcare for a relatively high number of Medicaid patients, provide some charitable care, and have significant levels of bad debt. Interestingly, while DSH payments were originally designed primarily to cover the contractual allowances resulting from Medicaid and bad debt losses, hospitals have ultimately used these funds to cover charity care.[13]

III. Charity Care Legislation and Charity Care Models

According to a compendium of free care laws compiled by Community Catalyst, most states have some form of legislation that addresses the issue of free or charity care.[14] Unfortunately, lack of clarity and consistency across states, and the general character of the laws, only add to the difficulty of understanding the laws and their application. Some states use the term "charity care," others "free care," while some use "indigent care" and "community benefits" in the same sense. Clear definitions seldom appear in the narratives of these laws. Moreover, some laws seem to apply to public hospitals, some to non-profit hospitals, and others to all hospitals.

For practical reasons this paper does not provide a state-by-state summary of charity care laws. The following table provides an overview of states' approaches and treatment of charity care.

Table 2. **Charity Care Across Various States**

	AL	AZ	CA	CT	FL	GA	IL	MA	ME	MN	MO	NJ	NV	NY	OH	OR	PA	TX	UT	VA	WA	WI
Community Benefit Defined		✓	✓					*		✓								✓	*			
Charity Care Defined							✓		✓	✓				✓			✓	✓		✓	✓	✓
Uncompensated Care Defined				✓				✓									✓					
Use of Other Terminology	✓	✓	✓			✓		✓	✓				✓		✓			✓				
Legislation Exists	✓	✓	✓		✓	✓		✓	✓	✓		✓		✓	✓		✓	✓	✓		✓	✓
Charity Care Models																						
a) Minimum amount required													✓		✓		✓	✓	✓			
b) Uncompensated care pools						✓		✓				✓		✓	✓					✓		
c) Volunteer-based									✓										✓			
d) Other	✓	✓			✓													✓				
Income Guidelines/Eligibility	✓		✓	✓	✓	✓		✓	✓		✓	✓	✓		✓		✓	✓	✓	✓	✓	✓
Reporting Requirements		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓		✓

* Limited definition Source[14; 15]

1) Existing State Laws and Regulations Regarding Charity Care and Community Benefits

Some themes recur in the legislation and policies regarding charity care. In terms of specificity, they run the gamut from the very detailed, containing well articulated standards and definitions, to the complete lack of any formal requirements or common terms. The following section highlights the approach some states have taken to charity care.

Comprehensive Charity Care Legislation

Comprehensive legislation encompasses carefully structured and integrated laws and regulations. Often a designated state agency oversees compliance with the regulations. Such legislation includes clear definitions of what constitutes charity care and community benefits and clearly outlines very specific eligibility requirements for the patient, as well as reporting responsibilities for the hospitals. These laws often prescribe penalties for noncompliance.

A good example of comprehensive charity care legislation is that of the state of **Washington**. The Department of Health in Washington requires hospitals to provide full charity care to indigent individuals, namely those with an income

equal to or below 100 percent of the FPL. This legislation also considers families with incomes ranging from 100 to 200 percent of the FPL to be indigent qualifying them for charity care. This state defines charity care as "appropriate hospital-based medical services provided to indigent persons."[14] To qualify as medically indigent a person must be ineligible for public insurance programs. Further, Washington's legislation compels hospitals to publicly display clear descriptions of their charity care policies, making special provisions for non-English-speaking patients wherever necessary.[14]

In the past, **California** fell into the flexible legislation category. Community Catalyst reports that California hospitals used to set their own free care requirements.[14] Until 1994, California had vague definitions and eligibility requirements. However, in 1994 the governor of the state approved Senate Bill 697 which required non-profit hospitals to revise their missions and adopt policies reflecting their commitment to the public. Non-profit hospitals in California now must prepare needs assessments in collaboration with community stakeholders every three years. Moreover, SB 697 provided a broad but detailed definition of community and community benefits.[15] As a result, this state fits in the comprehensive charity care legislation category, perhaps indicating a developmental spectrum for states' investment in charity care.

Flexible Charity Care Legislation

This category includes laws and regulations that lack the specificity of the comprehensive approaches above. Although they may include the right terminology, they often lack full definitions. These laws often give hospitals the discretion to set their own charity care standards. For example, **Alabama** through the Health Care Responsibility Act stipulates that hospitals in each county of the state are free to choose whether they want to participate in the Hospital Service Program for Indigents. It limits eligibility to those who have resided in the state for at least one year, are severely ill or injured, and unable to pay for hospital services. Admission Committees in each county determine whether an individual meets the criteria for indigence.[14]

No Charity Care Legislation

Some states have no specific charity care laws. This does not mean that hospitals do not provide charity care; hospitals in such states simply set their own charity care policies. For example, Community Catalyst reports that no formal statutes and regulations exist in the state of **Oregon**. Note, however, that hospitals in states that do not legally sanction charity care must still comply with federal laws such as EMTALA regarding the treatment of individuals in critical condition.[14]

2) Charity Care Financing & Other Innovative Models of Charity Care

Heightened scrutiny of non-profit, tax-exempt hospitals around the country has drawn the attention of politicians and advocates alike. This interest does not always reflect concern for the poor and politically powerless, as some hospital associations point out. In some instances, states running large budget deficits set their sights on the substantial tax revenues that non-profit hospitals could generate if they were taxed. Nevertheless, whatever the motives, hospitals, sometimes in collaboration with state authorities, have begun taking proactive steps not only to protect their tax-exempt status but also to address the growing numbers of uninsured and underinsured persons.

The following section provides a brief summary of the remedies and strategies that states and hospitals are implementing to address charity care. While some of the methodologies are not new, they fit in this section because of their visibility; we feature others for their innovation.

Minimum Charity Care Requirement

In recent years, states across the country have been considering the different alternatives to promote and ensure that hospitals provide their fair share of charity care. Some states have enacted laws that required hospitals to provide charity care as a percentage of their total revenues. In 1993, the state of **Texas** passed a law that required non-profit hospitals to revise their mission, and specifically outline benefits provided to the community, emphasizing charity care. The law made Texas the first state to require private, non-profit hospitals to spend four percent of their net patient revenue on charity care.[15; 16] Due to aggressive lobbying by the Texas Hospital Association, some revisions to this

law were made, and the use of creative accounting practices has enabled some hospitals to include bad debt in their original charity care equation. This new method enabled hospitals not hitting the four percent mark to do so, while others at the mark exceed it.[16]

Similarly, **Utah** poses an interesting case because the state's charity care draws support from various financing schemes. In 1990 the Utah State Tax Commission issued a six point test to determine whether non-profit hospitals qualified for property tax exemption. Hospitals were required to:

a) operate for charitable purposes
b) demonstrate that neither earnings nor donations should benefit any private shareholder or individual
c) maintain an open access policy
d) have policies aimed to benefit the public
e) provide benefits to the community in excess of its annual property tax liability; and
f) prove that hospital facilities reflect and support their mission.[15]

The commission also required Hospitals to have an explicit charity plan. Benefits to the community include unreimbursed indigent care, discounted medical services, donations of time and money, and volunteer and community service activities.[15]

Volunteer-Based Charity Care

Volunteer-based charity care while less common than other models of charity care has a long history among medical professionals. Volunteer-based charity care relies on the good will of medical professionals and medical equipment companies to make donations of time or in kind goods and services to help those who do not have health insurance.

Utah's Health Access Project (HAP), a community-driven effort established in 2001, seeks to build a more effective health delivery system for low-income, uninsured residents of Salt Lake County, usually those falling below 150 percent of the FPL. The program focuses on prevention and primary health care for the uninsured. With support of local medical associations HAP has developed a network of 400 volunteer medical professionals who pledge to treat twelve patients a year at no cost as part of their regular patient load. Donated

laboratory and diagnostic services, and equipment donations support the contributions of these physicians. Patients eligible for this program can also obtain free or discounted medicines.[17]

Maine currently experiments with a similar approach through its Carepartners program. Carepartners improves access to health care for low-income, uninsured residents of three Maine counties. To qualify for this program individuals must demonstrate proof of residence in the service area, pass income tests, and prove ineligibility for other forms of insurance. With the support of a grant from Communities in Charge, Carepartners works by developing networks of providers willing to contribute physician services for free or at a deep discount. The program also provides free or subsidized medications to patients in the program. Carepartners currently has enlisted the support of 750 physicians, in addition to other medical professionals. The program plans to add mental health providers as well as medical equipment donors to its network.[18]

Uncompensated Care Pools

An Uncompensated Care Pool makes payments to hospitals and community health centers for services provided to low-income uninsured and underinsured people. Financing for Uncompensated Care Pools comes from a mix of sources, including hospital contributions, government programs, and taxes. Hospitals receive payments in proportion to the amount of charity care they provide.

In **New Jersey** the Uncompensated Care Trust Fund law became effective in 1987. Under this law, the New Jersey state government used a special commission to create an uncompensated care pool based on a state-wide "add-on" to hospital rates. In effect, this pool results in hospitals with uncompensated care costs less than the revenue generated from the add-on paying into the fund, while hospitals with higher charity care costs draw from the trust fund.[9] New Jersey revised its law in 1993, developing a new funding scheme to pay for hospital charity care, the so-called "Health Care Subsidy Fund" (HCSF). A portion of unemployment taxes, and the state general revenue fund also support the HCSF.[4]

In similar fashion, the **Massachusetts** Uncompensated Care Pool, established in 1985, reimburses hospitals and community health centers for providing free or discounted health care to the uninsured and the indigent. A mixture of sources including contributions from hospitals and insurance companies, government funds, DSH funds, and monies from tobacco settlements finance this uncompensated care pool.[19; 20]

IV. The Case of Missouri

It remains unclear what kind of impact charity care has had in alleviating the needs of Missouri's indigent and uninsured. Estimates of the number of uninsured in Missouri vary according to the reporting source. However, the common standard used, the Current Population Survey (CPS), reports the number of uninsured in 2004 at 646,000, or approximately 11.5 percent of the population. The data from a ten year study by the St. Louis Area Business Health Coalition (BHC), which calculates charity care rates as a percentage of revenue, reveals that charity care provided by St. Louis area hospitals has declined approximately 46 percent from 1992 to 2001.[13] Using the BHC information as representative for the state, it would appear that in Missouri the levels of charity care have shown a downward trend.

Charity care provided by St. Louis area hospitals has declined approximately 46 percent from 1992 to 2001.[13]

Mark D. Smith president of MHA posits that the decline in charity care merely reflects hospital supported eligibility expansions to Medicaid. He adds that Missouri's hospitals pay over $600 million annually in provider taxes to cover uncompensated care.[21] In reality, these provider taxes are proportionally refunded to the hospitals to compensate for Medicaid shortfalls. Clearly, consensus remains elusive on the issue, some legislators and advocates for the poor and uninsured see reduced levels of hospitals charity care as a gaping hole in Missouri's safety net, while hospitals and the Hospital Association see it as a sign of victories on other fronts. According to the 2003 Community Catalyst report, *Free Care: A Compendium of State Laws,* Missouri does not have a legal mandate on charity care.[14] With a few exceptions, Missouri's hospitals set their own charity care policies. The Missouri Department of Health and Senior Services (DHSS) requires all hospitals to submit a yearly financial report that must include, among other items, charity care rates. The DHSS data represents the only publicly available information about Missouri's charity care rates. Nonetheless, because each hospital and

hospital system in Missouri defines charity care differently, this data provides an unclear picture of Missouri's charity care landscape.

One noteworthy exception to the loose requirements on Missouri's hospitals lies in the sale of the non-profit Saint Louis University Hospital to the for-profit Tenet Health Systems Inc. Negotiators for the university developed an agreement to ensure, among other things, that the hospital would continue to provide, in perpetuity, the same level of charity care and pastoral care it had under the university. At the time of the agreement, Tenet pledged at least $10 million annually towards charity care.[22]

Community Catalyst notes that in Massachusetts, which is considered to have some of the most sound charity care regulations, the Attorney General chose to impose target goals instead of absolute minimums.[8] In the general debate over this issue, others argue that setting standards of any kind limits rather than expands charity care provision.

V. Policy Implications

Charity care encompasses broad and complicated issues ranging from financing, accounting and social responsibility on the part of non-profit providers, to federal and state legislation. Although all hospitals must provide some amount of charity care, the principal burden falls on non-profit hospitals. The sheer variety of types of hospitals, non-profit-tax exempt, non-profit-taxable, and for profit facilities, all of which may be contained in large hospital systems adds to the complexity of establishing an equitable approach to charity care.[23]

In general, the literature recommends two broad approaches: setting standards and creating effective legislation.

1) Setting Standards

Some argue that at the core of the charity care debate lies a generalized lack of consistency, which reveals itself in a lack of universal definitions, flexible accounting practices, and ambiguous eligibility requirements. Some policy experts propose the following:

- *Definitions.* Currently there is no universal definition of what constitutes charity care or community benefit. The Catholic Health Association of the

United States and Community Catalyst have taken steps in this direction. Despite the work of these organizations in defining charity care, their proposed definitions still diverge on important points.[10] A simple, commonly held definition is vital to unraveling the issues surrounding charity care.

- *Accounting Practices.* Non-profit hospitals exempt from paying taxes have no standardized way to record the charity care they provide. While some hospitals report their charity care at cost of service, others report charity care based on hospital charges.[4] Hospitals reporting charity care based on charges posted appear to provide a higher level of charity care than those reporting the actual cost of care. This reporting inequity needs to be resolved.
- *Debt-Collection Practices.* While hospitals must make every effort to collect outstanding debts, many argue that current collection practices target poor and uninsured individuals who might otherwise qualify for charity care. Moreover, bad debt should include only those cases where patients were expected and able to pay but did not. Conversely, bad debt should not be considered charity care.
- *Charity Care Policies.* As is the case in Pennsylvania, hospitals should be compelled to clearly state their charity care policies to the public, especially to individuals who may benefit from them. Further, policies should be expressed in a manner consistent with the cultural context of the community.[24]

2) Legislation

In general, policy approaches aimed at changing legislation at the state or federal level constitutes a difficult, though not impossible, strategy. Some analysts propose the following policy options:

- *Tax exemption based on amount of charity care.* This policy alternative suggests providing tax exemption in proportion to level of charity care provided. In other words, hospitals that provide large amounts of charity care would benefit from larger tax exemptions.[6]
- *Conditional tax exemption.* Another proposed policy approach would require the government to establish a set of criteria that hospitals must meet to qualify for tax exemption. Failure to meet the set criteria would result in

revocation of tax-exempt status.[6] While some states already have opted for this kind of alternative, enforcement and compliance remain a challenge.

- *Revocation of hospital tax exemptions.* Finally, some researchers suggest that the difference between charity care provided by non-profit and for-profit hospitals does not justify allowing tax advantages to one over the other.[6] Arguably, revoking hospital tax exemption could increase state tax revenue, which states could use to care for the indigent. This alternative, however, poses serious political challenges.

VI. Conclusion

This review of charity care in the United States reveals a highly complex subject. Charity care and community benefits have historically not had a clear, universal definition to guide and measure the implementation and practice of these concepts. The lack of a single authoritative view about the most effective way to mandate charity care perpetuates the on-going variation in approaches to this issue. The best strategy to facilitating consistency in charity care may rest in the development of clear definitions and legislation on the individual state level.

Bibliography

Works Cited:

"About the Health Access Project". 2003. (March 21, 2005). <http://www.healthaccessproject.org/>.

Bellandi, Deanna. "Taking Account; Change in Rules Helps Texas Not-for-Profit Hospitals Meet Charity-Care Requirements." Modern Healthcare 30 (2000): 18.

Bovbjerg, Randall R., et al. Health Policy for Low-Income People in New Jersey. Washington, D.C.: The Urban Institute, 1998.

"Carepartners of Portland Maine". Portland, 2004. Communities in Charge. March 21 2005. <http://www.communitiesincharge.org/Documents/>.

"Charity Care and the Bottom Line: The Quantity of Mercy." The St. Louis Post Dispatch December 12, 2004, sec. Editorial.

"CMS Advisory Group on Emergency Medical Treatment and Labor Act Responsibilities to Hold First Meeting". Washington DC, 2005. Press release. Center for Medicare & Medicaid Services. April 11, 2005. <http://www.cms.hhs.gov/media/press/release.asp?Counter=1381>.

Cohn, Jonathan. "Uncharitable." The New York Times December 19, 2004.

"Commentary to the Health Care Institution Responsibility Model Act". Boston, 1999. Report. Community Catalyst. March 8 2005. <http://communitycatalyst.org/>.

Community Benefit Reporting. St. Louis: The catholic health association of the United States, 2005.

Compliance Review Charity Care and Collection Practices. St. Paul: Minnesota Attorney General's Office, 2005.

Cunningham, Peter J., and Ha T. Tu. "A Changing Picture Uncompensated Care." Health Affairs 16.4 (1997): 167-75.

"Fair Share for Health Care: San Francisco Hospitals' Care for the Poor and the Public Health Crisis". San Francisco, 2000. Report. Health Care Workers Union, Local 250, SEIU. March 8, 2005. <http://www.seiu250.org/>.

Gardner, James. "Tenet Agreement on Charity Care Clears Way for St. Louis University to Sell Hospital". Jefferson City, 1998. News Releases. Missouri Attorney General's Office. March 23, 2005. <http://www.ago.mo.gov/newsreleases/1998/022398.htm>.

Gaskin, Darrell J. "Altruism or Moral Hazard: The Impact of Hospital Uncompensated Care Pools." Journal of Health Economics 16 (1997): 397-416.

"Guidelines Cover Five Rules for Charity Care, Collections." Healthcare Risk Management 26.9 (2004): 102.

Kane, Nancy M., and William H. Wubbenhorst. "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption." The Milbank Quarterly 78.2 (2000): 185-212.

Karlin, Bradley E., and T.J. Sullivan. Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations. Washington D.C.: Coalition for Nonprofit Health Care, 1999.

Kentucky General Assembly 2005. Louisville: Kentucky Hospital Association, 2004.

Maiuro, Lisa Simonson, Helen Schneider, and Nicole Bellows. "Endangered Species? Not-for-Profit Hospitals Face Tax-Exemption Challenge: How Can You Maintain Your Organization's Tax-Exempt Status? One Way Is to Participate in the Debate over How to Measure Charity Care and Community Benefits." Healthcare Financial Management 58.9 (2004): 74-78.

"Massachusetts: Uncompensated Care Pool". New York, 2004. Tools & Innovation. The Commonwealth Fund. March 18, 2005. <http://www.cmwf.org/tools/tools_show.htm?doc_id=235092>.

"Oregon Health Action Campaign Activity Report 2003-2004". Salem, 2004. Oregon Health Action Campaign. March 21, 2005. <http://www.ohac.org/>.

An Overview of Charity Care in New Jersey - Past, Present and Future. Trenton, NJ: The Forums Institute for Public Policy, 2004.

"The Quantum Foundation; Advancing Health and Education in Palm Beach County". West Palm Beach, 2002. The Quantum Foundation. March 21, 2005. <http://www.quantumfnd.org/>.

Reilly, Patrick. "Making Good Acts Mandatory; Legislation Would Require Certain Level of Charity Care." Modern Healthcare 33.25 (2003): 32.

Richardson, Pearl. "Health Care Trends and the Tax Treatment of Health Care Institutions." Congressional Budget Office, 1994.

Saint Joseph Hospital Foundation Annual Report. Denver: Saint Joseph Hospital Foundation, 2002.

Sanders, Susan M. "Measuring Charitable Contributions: Implications for Hospital's Tax-Exempt Status." Hospital & Health Services Administration 38.3 (1993): 401-18.

Silow-Carroll, Sharon, and Tanya Alteras. Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds. New York: The Commonwealth Fund, 2004.

Smith, Mark D. "Charity Care: Newspaper Series Doesn't Reflect Hospitals' True Commitment." The St. Louis Post Dispatch December 19 2004, sec. Letters to the Editor.

St. Louis Area Hospitals Industry Financial and Statistical Overview. St. Louis: St. Louis Area Business Health Coalition, 2004.

Stoll, Betsy. Free Care: A Compendium of State Laws. Boston: Community Catalyst, 2003.

Sutton, Janet P., and Jeffrey Stensland. "Promoting Accountability: Hospital Charity Care in California, Washington State, and Texas." Journal of Health Care for the Poor and Underserved 15 (2004): 237-50.

"Tax Exemption the Key to Charitable Service". Harrisburg, 1993. Statements by the Catholic Bishops of Pennsylvania. Pennsylvania Catholic Conference. <http://www.pacatholic.org/bishops%27%20statements/taxex.htm>.

"Washington Square to the Rescue". Chicago, 2002. Highlighted Grants. Washington Square Health Foundation. March 21, 2005. <http://www.wshf.org/highlighted-grants.html#2002-uninsured>.

"What Are Disproportionate Share Hospital (DSH) Payments?" Washington, D.C., 2004. NAPH Issue Briefs. National Association of Public Hospitals and Health Systems. April 13, 2005. <http://www.naph.org/>..

"What Is Communities in Charge". Cleveland, 2002. Communities in Charge. March 21, 2005. <http://www.communitiesincharge.org/>.

Wright, Elizabeth L. "Are You Getting Your Money's Worth from Nonprofit Hospitals". Washington DC, 1998. Through the looking glass. Citizens Against Government Waste. March 9, 2005. <http://www.cagw.org/upload/CommunityBenefits.pdf>.

Personal Communication:

Bell, Berna. Policy Analyst. Ohio Hospital Association, 2005. Telephone interview. March 18, 2005.

Stoll, Betsy. Development & Policy Director: Community Catalyst, 2005. Telephone interview March 8, 2005.

Endnotes

1. Richardson, Pearl. "Health Care Trends and the Tax Treatment of Health Care Institutions." Congressional Budget Office, 1994.

2. Cohn, Jonathan. "Uncharitable." The New York Times December 19, 2004.

3. Wright, Elizabeth L. "Are You Getting Your Money's Worth from Nonprofit Hospitals". Washington DC, 1998. Through the looking glass. Citizens Against Government Waste. March 9, 2005. <http://www.cagw.org/upload/CommunityBenefits.pdf>.

4. An Overview of Charity Care in New Jersey - Past, Present and Future. Trenton, NJ: The Forums Institute for Public Policy, 2004.

5. "CMS Advisory Group on Emergency Medical Treatment and Labor Act Responsibilities to Hold First Meeting". Washington DC, 2005. Press release. Center for Medicare & Medicaid Services. April 11, 2005. <http://www.cms.hhs.gov/media/press/release.asp?Counter=1381>.

6. Sanders, Susan M. "Measuring Charitable Contributions: Implications for Hospital's Tax-Exempt Status." Hospital & Health Services Administration 38.3 (1993): 401-18.

7. Community Benefit Reporting. St. Louis: The catholic health association of the United States, 2005.

8. Commentary to the Health Care Institution Responsibility Model Act. Community Catalyst, 1999.

9. Gaskin, Darrell J. "Altruism or Moral Hazard: The Impact of Hospital Uncompensated Care Pools." Journal of Health Economics 16 (1997): 397-416.

10. Sutton, Janet P., and Jeffrey Stensland. "Promoting Accountability: Hospital Charity Care in California, Washington State, and Texas." Journal of Health Care for the Poor and Underserved 15 (2004): 237-50.

11. Maiuro, Lisa Simonson, Helen Schneider, and Nicole Bellows. "Endangered Species? Not-for-Profit Hospitals Face Tax-Exemption Challenge: How Can You Maintain Your Organization's Tax-Exempt Status? One Way Is to Participate in the Debate over How to Measure Charity Care and Community Benefits." Healthcare Financial Management 58.9 (2004): 74-78.

12. Kentucky General Assembly 2005. Louisville: Kentucky Hospital Association, 2004.

13. St. Louis Area Hospitals Industry Financial and Statistical Overview. St. Louis: St. Louis Area Business Health Coalition, 2004.

14. Free Care: A Compendium of State Laws. Boston: Community Catalyst, 2003.

15. Karlin, Bradley E., and T.J. Sullivan. Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations. Washington D.C.: Coalition for Nonprofit Health Care, 1999.

16. Bellandi, Deanna. "Taking Account; Change in Rules Helps Texas Not-for-Profit Hospitals Meet Charity-Care Requirements." Modern Healthcare 30 (2000): 18.

17. "About the Health Access Project". 2003. (March 21, 2005). <http://healthaccessproject.org>.

18. "Carepartners of Portland Maine". Portland, 2004. Communities in Charge. March 21 2005. <http://www.communitiesincharge.org/Documents/>.

19. Silow-Carroll, Sharon, and Tanya Alteras. Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds. New York: The Commonwealth Fund, 2004.

20. "Massachusetts: Uncompensated Care Pool". New York, 2004. Tools & Innovation. The Commonwealth Fund. March 18, 2005. <http://www.cmwf.org/tools/tools_show.htm?doc_id=235092>.

21. Smith, Mark D. "Charity Care: Newspaper Series Doesn't Reflect Hospitals' True Commitment." The St. Louis Post Dispatch December 19 2004, sec. Letters to the Editor.

22. Gardner, James. "Tenet Agreement on Charity Care Clears Way for St. Louis University to Sell Hospital". Jefferson City, 1998. News Releases. Missouri Attorney General's Office. March 23, 2005. <http://www.ago.mo.gov/newsreleases/1998/022398.htm>.

23. Compliance Review Charity Care and Collection Practices. St. Paul: Minnesota Attorney General's Office, 2005.

24. "Guidelines Cover Five Rules for Charity Care, Collections." Healthcare Risk Management 26.9 (2004): 102.