

**LOCAL TAX EXEMPTIONS AND THE  
COMMUNITY SERVICE RESPONSIBILITIES  
OF NON-PROFIT HEALTH CARE PROVIDERS**

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This project will assist the design of local initiatives to promote the delivery of health care to low-income households. The project, titled *Local Tax Exemptions and the Community Service Responsibilities of Non-Profit Health Care Providers*, will be undertaken by Roger Colton (law and economics) of the firm Fisher, Sheehan & Colton, Public Finance and General Economics (FSC).

#### **PURPOSE AND ORIENTATION OF THE STUDY**

**Purpose:** This proposal presents four propositions. First, traditional "community service" obligations imposed on non-profit health care providers, developed during an era of free-standing, fee-for-service facilities with independent physicians, are breaking down in this era of consolidation, managed care, and joint ventures. Second, the federal tax exempt status of joint ventures is in considerable flux. The process of sorting out the federal tax consequences of new organizational structures (*e.g.*, staff HMO vs. non-staff HMO, provider-of-care vs. arranger-of-care) continues. Third, the conceptual underpinnings of the "community benefit" *federal* tax standard, based in the theory of charitable trusts, may no longer be sufficient to govern *local* tax decisions. Finally, the considerable work that has been undertaken respecting the community service obligations of health care providers can provide both a practical and a conceptual basis upon which to ground local tax exemption decisions.

**Context and Objectives:** This research will consider a theory of "community service obligations" within a three-pronged context: (1) the theory can be made applicable to managed care entities as well as to hospitals; (2) it is conceptually grounded in existing law; and (3) it has foreseeable, even if not completely defined, applicability to both for-profit and not-for-profit institutions. This specific project will not seek to define and articulate the applicability to managed care; nor will it seek to apply the theory to for-profit entities. Instead, the overall approach will be *developed* within the non-profit context with sufficient analysis pursued to identify the reasonably

foreseeable expanded applicability possible through additional research. More particularly, this project has four specific objectives: (1) to define and consider a new mechanism to promote universal health care service for indigent households; (2) to identify, analyze and explain the legal, economic and regulatory foundations for that mechanism; (3) to create that mechanism without resort to federal intervention; and (4) to empower local persons to engage in local efforts to identify and address local community health care needs.

### ***Problems Being Addressed***

The first and primary problem to be addressed by this project is the failure to attain universal health care. The litany is familiar. Health disparities between poor people and those with higher incomes exist for all aspects of health. Low-income status is a special risk factor for virtually all chronic diseases. The poor disproportionately suffer from traumatic injuries and death. Higher infant mortality rates and poor pregnancy outcomes are associated with poverty. The second problem is that competition will never attain, and will likely impede, achieving universal health care. This is true primarily because a competitive market can be expected to *exclude* rather than to *include* those most in need of health care services. A market can be expected to raise prices for service, not only as the value of that service increases, but as the demand for the service increases as well. Moreover, a cost-averse competitive service provider will seek to avoid users who are either risky or high cost. From a universal service perspective, therefore, since poverty is often associated with poorer health, those who need the service most will be least likely to obtain and afford access.

The final problem is that federal initiatives to promote universal service have failed. The Hill-Burton Act often lacked enforcement and, in any event, has largely passed by its contractual commitment period. Medicaid leaves millions of American's uninsured. The duty to render emergency care under COBRA is hard to enforce and easy to avoid. Finally, IRS Revenue Rulings have narrowed

the community service requirement for non-profit federal tax exemption into unenforceable mush. Restrictions on standing to sue have further limited the usefulness of federal tax exemptions in promoting universal service.

### ***Rationale for the Proposed Study***

Local governments offer a promising vehicle to use in pursuing the goal of universal health care. Non-profit exemptions from state and local taxes and fees are not bound by the limited IRS community service requirements. State and local governments not only can, but have, insisted that non-profit health care providers meet community service obligations as the *quid pro quo* for local tax and fee exemptions (*See e.g., Utah County v. Intermountain Health Care*, 709 P.2d 265 (Utah 1985)). A tax-exempt status at the state and local levels has been "exchanged" for a two-fold commitment: (1) to provide medical care to the indigent up to some minimum level of health care resources; and (2) to provide emergency care irrespective of ability to pay. Given the fact that in 1996, nonprofit hospitals accounted for between 85 and 90 percent of all hospitals that existed, to extend universal service obligations that could be enforced at the local government level would represent a substantial advance in the pursuit of universal access to health care.

### ***The Conceptual Framework for the Proposed Research***

The conceptual question posed by this project is whether a local "community service obligation" can be imposed for non-profit health care providers in exchange for the grant of non-profit tax and fee exemptions, similar to the local duty-to-serve imposed on public utilities in exchange for the public perquisites provided to that industry. For utilities, the fundamental "rule" requires a utility to serve on reasonable terms all those who desire the service it renders.<sup>11</sup> This duty-to-serve was

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<sup>11</sup> The real meat of this fundamental rule, however, arises in the application of the rule to decide specific issues. For a comprehensive discussion of the specific requirements/implications flowing from the common law duty to serve, *see generally*, Roger Colton (1993). *The Regulation of Rural Electric Cooperatives*, National Consumer Law Center: Boston (Chapter 4, pp. 39 - 67, "The Common Law Duty to

imposed on the utility industry as the *quid pro quo* for the grant of certain public perquisites in support of the industry, including the right to exercise eminent domain, the right to use city streets and public ways, and the right to be exempt from local zoning restrictions.

## **RESEARCH DESIGN**

### ***Research Questions***

The conceptual framework identified above resolves itself into three research questions: (1) is the "duty to serve" of a public utility sufficiently similar to the "community service obligations" of non-profit health care providers so that the lessons from the former can inform and help form the basis for actions relative to the latter? (2) is the exchange of consideration which forms the basis of the public utility's obligation to serve sufficiently similar to the exchange of local tax-exemptions for nonprofit health care providers so that the lessons from the former can inform and help form the basis for actions relative to the latter? and (3) are there specific actions taken by, and decisions made by, health care providers which a broadly-stated "community service obligation" can influence, and through which a broadly-stated "community service obligation" can be meaningfully implemented and operationalized?

This project hypothesizes that the answer to all three questions is "yes." First, the utility's obligation to provide reasonably adequate service to all who apply on reasonable and non-discriminatory terms has its counterpart in the health care industry in the doctrine of community service obligations. Second, a tax-exemption-based exchange between local governments and non-profit health care providers is very similar to the eminent-domain-based exchange underlying the obligation to serve that has occurred for public utilities. Finally, transactions *have* occurred in the health care industry, where public support or perquisites have been exchanged for specific "community service obligation" commitments. Like the utility industry's "duty to serve," none of these health care commitments has  
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Serve").

been to guarantee universal service generally. However, also like the utility industry, the commitment to universal service has formed the basis for specific decisions and narrower actions *in support of* universal service. These health care exchanges to date, however, have been *ad hoc*, arising in individual situations involving merger approvals, non-profit health care conversions, group health insurance purchasing decisions (both private and public), and the like. This project posits that it is possible to tie the three strands arising out of the research questions together and, in so doing, to develop an *institutionalized* mechanism through which local governments, as a matter of course, may seek to impose and enforce a community service obligation.

### ***Research Methodology***

The ultimate end-in-view of this project involves developing a community service obligation model to serve as the basis for local non-profit tax exemption decisions. Reaching this end will, in turn, involve five tasks: (1) engaging in a detailed review of the "obligation-to-serve" doctrine for public utilities; (2) engaging in a detailed review of the range of community service obligations imposed on health care providers today, whether in exchange for federal, state or local tax exemptions; in exchange for merger approvals; as part of statutory enactments or regulatory promulgations; or otherwise; (3) synthesizing existing utility and health care doctrine into a coherent theory and set of specific recommendations for practical application by local officials to non-profit tax exemption decisions regarding health care institutions; (4) identifying the policy changes necessary to effectuate and implement the synthesized model within the context of recent state health care reform debates; and (5) identifying the potential future expansion and application of the synthesized model to various forms of managed care entities, as well as to for-profit health care providers (outside the tax exemption process). The research in furtherance of the objectives outlined above involves a law and economics analysis.

**TASK #1: Review basis for utility obligation-to-serve:** Task #1 involves reviewing the legal basis for the obligation to serve in the utility industry. The first inquiry at this point will be historical. This inquiry will trace statutory and case law back through the initiation of the obligation to serve for "common carriers" (such as railroads and ferries) in the mid-19th century. A second inquiry will be more contemporary. This legal research will further trace the case law and statutory law through the present day for electric, natural gas, cable television, and other similar "public utilities." The six questions that will be addressed include: (1) what obligation was imposed, (2) on whom was it imposed, (3) when was it imposed, (4) through which mechanism was it imposed, (5) why was it imposed, and (6) how was it enforced. A utility's obligation to serve is a function of state common law and, as a result, this research will involve case law research.

***Deliverable #7: Chapter specifying an operational community service proposal**  
for local tax decisions (see Task #3(b)).*

**TASK #2: Review health care community service obligations:** Health care "community service obligations" have been imposed in various forms depending upon the context in which they have arisen. Seven specific sources of community service obligations will be reviewed in this research, each of which will be a specific sub-task:

**Sub-Task #2(a): Federal statutory duties:** Sub-Task #2(a) will examine the various *federal statutory duties* that could be construed as imposing community service obligations in the health care industry today. This research will involve statutory and case law research akin to the public utility case law. The "statutory" research in this instance will involve not only an examination of specific statutory language, but also a detailed look at legislative history, including committee hearings, statutory amendments, committee reports, and related legislative documents. Legal, economic and industry

analysis and commentary will also be examined, whether in published journals, books and reports; academic thesis/dissertations; or other published literature.<sup>121</sup> The legal duties that will be subject to this inquiry begin with the community service obligations imposed by the Hill-Burton Act. More recent legislative enactments adopted as "anti-dumping" statutes will be examined as well. These will include statutes such as the amendments to COBRA --the Consolidated Omnibus Budget Reconciliation Act of 1986-- where Congress created affirmative treatment obligations for emergency rooms and imposed penalties for inappropriate patient transfers.

**Deliverable #1:** *Chapter on community service obligations flowing from federal statutes.*

**Task(s):** #2(a) \*\*\* **Date:** End of Month 6

**Sub-Task #2(b): State statutory duties:** Sub-Task #2(b) will examine existing *state statutes* (including state constitutions) that could be construed as imposing community service obligations on the health care industry. Public hospitals are generally required to serve the poor at a discount or at no charge. Where administration of the public hospital is contracted out to a private firm (as increasingly occurs for cost containment reasons) or where the entire hospital is sold to private interests, the private administrators or new owners may be obligated by contract to provide some level of indigent care. North Carolina has gone even further, enacting a provision requiring both purchasers and lessees of public hospitals to continue indigent care. It has been argued that two states' constitutions require those states to provide for the poor, while three others require counties and hospital districts to do so. State statutory mandates on lesser jurisdictions can also be binding. Some state courts have interpreted even ostensibly permissive statutes to mandate local governments to fund care for the indigent. The Arizona

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<sup>121</sup> It is impossible to describe the full range of legal research techniques and sources. Suffice it to say that the Principal Investigator for this proposal has, during his 20 years as an attorney, published nearly 60 articles and three law books and is familiar with the full range of legal research techniques.

Supreme Court, for example, read two statutes authorizing counties to care for the sick as imposing a duty to provide medical care for the indigent sick. The obligation to provide some variety of indigent medical care may even appear in a city charter. In some thirty-seven states, counties or towns are to some degree responsible for indigent care (often shared among levels of government); in four other states, counties are responsible for care only if they operate county hospitals. State statutory duties will be researched using standard legal research methods (*see*, note **Error! Bookmark not defined.**).

**Sub-Task #2(c): State common law obligations:** Sub-Task #2(c) will examine the *common law obligations* currently imposed on health care providers. For example, there is a common law duty to provide "continuing attention." Under such a rule, treatment obligations terminate only if the physician can do nothing more for the patient or if the care for the patient has been transferred to another physician. In some jurisdictions, there is a duty of "necessary rescue." Under this rule, an obligation is imposed in situations where a person would be left helpless if the professional refuses to help. In at least one jurisdiction, an obligation to care has been imposed beyond the "emergency" situation: where there is a critical need for treatment and the unavailability or lack of time to secure a replacement. While perhaps not universal, these obligations are certainly ubiquitous. Since common law obligations are, by definition, judicially created by case law decisions, this common law inquiry will be limited to state case law (and federal case decisions applying state law doctrine). It is generally accepted that there is no federal "common law."

**Sub-Task #2(d): Essential community provider programs:** Sub-Task #2(d) will consider the lessons learned from contemporary proposals regarding "*essential community provider*" (*ECP*) *programs*. Essential provider laws require managed care plans to contract with certain providers that serve poor and underserved communities. For example, Minnesota state law requires managed care plans to contract with local community health clinics as primary care providers, although it does not

require that the plans send clients to the clinics. This ECP research involves state statutory research akin to that in Sub-Task 2(b). Because of the specific focus of these "essential community provider" proposals, however, they will be examined separately from other state statutory schemes.

***Deliverable #2: Chapter on community service obligations based on state statutes and common law.***

***Task(s): #2(b), #2(c), #2(d) \*\*\* Date: End of Month 12***

**Sub-Task #2(e): Administrative obligations:** Sub-Task #2(e) will examine the *administrative community service obligations* imposed on health care providers. Research into administratively-imposed community service obligations for health care will be limited to two sets of circumstances: where community service obligations are imposed as a precondition: (1) to approval of horizontal hospital mergers; and (2) to approval of non-profit health care conversions (to for-profit). Mergers and non-profit conversions in the past five years will be identified through the health care industry, general business and popular press. State regulatory agencies will also be contacted directly seeking lists of mergers and conversions that they have considered in the past five years. Final agency decisions will be reviewed to determine which, if any, imposed community service obligations. Final agency decisions "imposing" such obligations are defined to include all settlements, stipulations, or other binding non-litigated agreements. Final decisions will be obtained through published legal reporters as well as through direct contact with the appropriate state agency.<sup>131</sup> Massachusetts, for example, dropped its objections to the merger of the second and third largest HMOs in that state upon reaching an agreement to freeze group rates for one year, double enrollment in Medicare risk program, and spend \$4 million on social services such as health care for the homeless, violence prevention and

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<sup>131</sup> A recent report on the application of federal OSHA standards to "volunteers," prepared for the U.S. Occupational Safety and Health Administration (OSHA) by the Principal Investigator, was based on this same type of data collection protocol.

AIDS prevention. Similarly, Pennsylvania dropped its objection to a hospital merger upon reaching an agreement that the merged entity would provide \$31.5 million in free or low-cost indigent health care out of the \$40 million in net savings claimed to be generated by the merger.

***Deliverable #3: Chapter on community service obligations flowing from administrative decisions.***

***Task(s): #2(e) \*\*\* Date: End of Month 14***

**Sub-Task #2(f): Market-based obligations:** Sub-Task #2(f) will examine the *purchaser-based community service obligations* imposed on health care providers as pre-conditions to the award of purchasing contracts. Three types of purchasing arrangements will be considered in particular: (1) the purchase of services within the context of managed Medicaid programs; (2) the purchase of services by public health purchasing cooperatives (*e.g.*, California's HIPC, Minnesota's MEIP); and (3) the purchase of services by private health purchasing cooperatives (*e.g.*, Pacific Business Group on Health (California), Group Health Association (Washington D.C.)). PBGH has, for example, pushed managed care organizations to provide preventative care. PBGH has required plans to target specific preventative services (such as smoking cessation rates) and provide data on how many members have received those services. Managed care plans can lose up to two percent of their premiums from all group members if their performance falls short of yearly goals.

Public health purchasing cooperatives will be identified on a state-by-state basis. Indeed, the Principal Investigator, through other work, has identified these entities. Private health purchasing alliances will be identified through published periodicals (*e.g.*, academic journals, trade press, business press), through public and private published commentary and analysis (books, reports), and research and policy analysis institutions (note, for example, that the 1998 conference of the National Academy for State Health Policy has a session on exercising purchasing power in the Fall of 1998). In each

instance, the purchasing group will be contacted, annual reports and other program evaluations will be obtained/purchased, and written materials (to supplement correspondence and interviews) will be solicited. Again, note that this project is not designed to collect data on program performance or results. The scope of this project is limited to identifying potential community service obligations bargained for by the purchasing group.

**Deliverable #4: Chapter on market-based "community service obligations."**

**Task(s): 2(f) \*\*\* Date: End of Month 16**

**Sub-Task #2(g): Industry and academic community service proposals:** Sub-Task #2(g) will examine a variety of formal and informal *industry and academic proposals* setting forth community service obligations on the part of health care providers. One inquiry will involve efforts already underway by charitable hospital industry groups to encourage voluntary self-policing. The American Hospital Association and Catholic Health Association, for example, have developed self-assessment guides for nonprofit hospitals. In addition, New York University's Wagner School of Public Service has developed a voluntary accreditation program, known as the "Hospital Community Benefit Standards Program," for hospitals serving their local communities. Similarly, the Alpha Center's 1996 *State Legislative Impact Model (SLIM)* will be used as will the Alpha Center's proposed *Essential Access Community Hospital Program*.

**Deliverable #5: Chapter on industry & academic "community service obligation" proposals.**

**Task(s): 2(g) \*\*\* Date: End of Month 18**

**TASK #3: Synthesize the utility obligation-to-serve with existing community service obligations into a set of local recommendations:** Task #3 involves synthesizing the existing utility

and health care doctrines into a coherent theory and set of recommendations for practical application by local officials to non-profit tax exemption decisions regarding health care institutions. Task #3 will consist of two discrete sub-tasks: (1) developing a "logic model" which best "fits" the community service obligations identified in the seven components of Task #2; and (2) generalizing and applying that logic model to local decisions regarding community service obligations within the context of the grant of non-profit exemption from local taxes and fees, in order to specify individual components that should be included in a tax-exemption-based community service obligation.

**Sub-Task #3(a): Developing a logic model to "fit" the previously identified community service obligations:** This task will develop a "logic model" for the community service obligations identified in Task #2. A logic model begins by identifying the underlying assumptions about the obligations. These include primarily assumptions about the needs of the population served by each community service obligation, the services available to those populations, and how those services fail to meet the needs of the population. These assumptions will be identified through an examination of written records underlying the obligations (*e.g.*, testimony in merger proceedings; hearings and other legislative history for statutes), interviews with the involved persons, and contemporaneous policy analysis (*e.g.*, program evaluations, academic reviews). The second step of developing a logic model is to identify the immediate changes resulting from the imposition of the community service obligations. For example, more preventative care will be delivered; more indigent emergency care will be delivered; and the like. The third step is to identify the intermediate and ultimate outcomes and to relate those intermediate and final outcomes to the interventions. The importance of the intermediate and ultimate outcomes is that they might well arise from a combination of related interventions and immediate changes. Improved pregnancy outcomes, for example, might well be the intended ultimate result of the combination of increased access to neonatal care and increased community nutrition

programs.

The job of Sub-Task #3(a) is *not* to measure actual outcomes. The point of Sub-Task #3(a) is to identify the *intent* behind the imposition of the various community service obligations developed through Task #2 and to create the logic model illustrating the chain of causation between the identification of need, the community service obligations that serve as the interventions which were adopted, and the intended health care results. The logic model will result in a document that presents (1) what has been done; (2) why; and (3) with what hoped-for results. The research involves identifying and following the "paper trail," as is the case with other legal research into legislative intent.

**Deliverable #6: Chapter presenting logic model and applying to local tax decisions.**

**Task(s): 3(a) \*\*\* Date: End of Month 22**

**Sub-Task #3(b): Specifying an operational community service proposal:** Using the logic model from Sub-Task #3(a), Sub-Task #3(b) synthesizes the conceptual, policy and administrative underpinnings from the above inquiries, with the specific operationalization of the community service concept, into a proposed tax-exemption-based community service obligation imposed and enforced at the local level. If left too broad, a tax-exemption-based community service obligation will create practical difficulties. These difficulties would relate to the inability or unwillingness of courts and judges to require establishing a particular program or extending an existing financing or delivery program in any significant way. Past mistakes must be considered and avoided. For example, after two decades of attempting to enforce the much-publicized "right to treatment" for mental patients recognized in *Wyatt v. Aderholdt* (503 F.2d 1305 (5th Cir. 1974)), the federal courts officially terminated efforts to do so, openly admitting their inability to enforce such an obligation absent legislative cooperation.

This synthesis step is one of the most important steps in the research process. This step will be designed to move the discussion down out of the stratosphere of concept and doctrine into the specifics of implementation. The parallel to the public utility duty to serve is particularly helpful in understanding this synthesis. While the utility's obligation is stated broadly in support of utilities providing universal service, the implementation of that obligation occurs within the context of narrowly circumscribed factual situations. For example, decisions prohibiting a utility from terminating service for nonpayment of debts by a third party are based on the obligation to serve. Decisions restricting a utility's demand for a security deposit to an amount reasonably related to the utility's expected loss are based on the obligation to serve. The list, while not limitless, is long. While no-one would suggest that the utility industry has generically addressed low-income affordability problems, neither would anyone suggest that the obligation to serve has failed to generate meaningful results in promoting universal service. The synthesis step in this project would be to begin, using the community service obligations identified in Task #2, the process of identifying similar narrowly defined intervention points affecting universal service in the health care industry capable of being reached through local tax exemption decisions.

***Deliverable #7: Chapter specifying an operational community service proposal for local tax decisions.***

***Task(s): 3(b) \*\*\* Date: End of Month 24***

**TASK #4: Identify the policy changes necessary to effectuate and implement the synthesized model within the context of recent state health care reform debates:** Task #4 involves reviewing the major state health care reform initiatives statutorily enacted in the past five years. This review will examine: (1) the extent to which, if at all, a local government role was identified for universal service health care reform efforts; and (2) the extent to which, if at all, state and

local non-profit exemptions from taxes and fees were considered as a component of universal service health care reform efforts. In addition, the recommendations developed in Task #3 will be compared to the existing law, at the time of the enactment of the health care reform initiatives, to determine whether a local tax-exemption-based community service obligation would have been possible without affirmative legislative action. If existing law would permit such local actions, the basis for that conclusion will be presented. If not, the additions or modifications to the state health care reform initiative that would have been necessary in order to enable and authorize such local government actions will be identified. This research will involve: (1) legal research into existing statutory schemes; and (2) legal research into the specific state health care reform initiatives enacted.

*Deliverable #8: Chapter comparing Deliverable #7 with existing law and state health care reform proposals.*

*Task(s): #4 \*\*\* Date: End of Month 26*

**TASK #5: Identify the potential future expansion and application of the synthesized model to various forms of managed care entities, as well as for-profit health care providers (outside the tax exemption process):** Every good research project has as one of its outputs recommendations for future research. Task #5 not only makes explicit the intent to develop those recommendations for future research, but focuses the development of those research needs on pre-determined directions. The intent of this Task, in other words, is to ensure that a successful model developed within a non-profit health care context will not be pigeon-holed and limited *exclusively* to that context. It is difficult, if not impossible, to articulate in advance what methodology will be used for developing these recommendations. Instead, the focus of Task #5 will flow out of the results of Tasks #1 through #4.

**Deliverable #9: Chapter recommending expanded future applicability.**

**Task(s): #5 \*\*\* Date: End of Month 26**

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