

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-26

Subject: Nonprofit Status

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee G

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1 Resolution 221, “Nonprofit Status,” was introduced by the New York delegation at the 2025  
2 Interim Meeting and was referred. It asks the following:

3  
4 RESOLVED, that our American Medical Association advocate that the granting and  
5 maintenance of health care entities not-for-profit status be reassessed by both the state  
6 legislature and the U.S. Congress.

7  
8 Resolution 221-I-25 was referred largely due to concerns about vague language and the potential  
9 for unintended consequences. The Reference Committee report noted that technical questions  
10 regarding federal and state tax law should be considered to ensure that the American Medical  
11 Association (AMA) does not advocate for an outcome with harmful consequences. This report  
12 provides a review of the topic and recommendation to modify current AMA policy.

## 13 14 BACKGROUND

15  
16 Nonprofit hospitals account for 58 percent of community hospitals in the United States and most of  
17 these hospitals are part of a larger health system.<sup>1</sup> Tax-exempt nonprofit hospitals operate as  
18 501(c)(3) organizations, which by definition must be organized and operated exclusively for  
19 specific tax-exempt purposes and must have the following characteristics determined by the  
20 Internal Revenue Service (IRS): 1) no part of their net earnings is allowed to benefit any private  
21 shareholder or individual; 2) no substantial part of their activities can consist of carrying on  
22 propaganda or otherwise attempting to influence legislation; and 3) the organization should not  
23 participate or intervene in any political campaign on behalf of (or in opposition to) any candidate  
24 for public office.<sup>2</sup>

25  
26 Additional requirements were added following the passage of the Affordable Care Act and are  
27 codified in Section 501(r) of the Internal Revenue Code. To retain 501(c)(3) tax-exempt status,  
28 nonprofit entities must:

- 29 • Establish a financial assistance policy (FAP) that describes who is eligible for charity care,  
30 the level of assistance provided, and how patients can apply. The FAP must be easily  
31 accessible to patients and translated into the languages commonly spoken in the  
32 community served by the hospital or health care organization.
- 33 • Cap charges to patients eligible for charity care based on fee-for-service Medicare rates,  
34 Medicaid rates, and/or commercial plan rates.
- 35 • Conduct a community health needs assessment (CHNA) every three years and adopt an  
36 implementation strategy to address those needs.

- 1 • Make reasonable efforts to determine if a patient is eligible for charity care before  
 2 engaging in certain debt collection practices, including selling the patient’s debt to third  
 3 parties, reporting the debt to credit agencies, and taking legal action to control a patient’s  
 4 financial assets.<sup>3</sup>

5  
 6 Furthermore, to qualify as a 501(c)(3) tax-exempt organization, a nonprofit hospital must  
 7 demonstrate that it has provided benefits to a class of people that is broad enough to benefit the  
 8 community and operate to serve a public rather than a private interest. The IRS requires a tax-  
 9 exempt hospital to annually file Form 990 Schedule H to provide the public with information on its  
 10 policies and activities and the community benefits that its facilities provide. Schedule H broadly  
 11 categorizes community benefit spending as charity care, unreimbursed costs for providing services  
 12 to patients insured by government programs (Medicare and Medicaid), subsidized health services,  
 13 community health improvement services and community benefit operations, research, health  
 14 professions education, and financial and in-kind contributions to community groups.<sup>4</sup>

15  
 16 The IRS does not currently define specific types of services and activities that a hospital must  
 17 undertake to qualify for a tax exemption. Instead, the IRS provides guidance on the types of  
 18 activities that can demonstrate community benefits. IRS implementation of the Internal Revenue  
 19 Code can give tax-exempt hospitals broad latitude to determine the nature and amount of  
 20 community benefits they provide. Representatives from tax-exempt hospitals have shared that this  
 21 provides needed flexibility in demonstrating community benefits. For example, a hospital located  
 22 in a rural community may be the only hospital within hundreds of miles, making its existence the  
 23 primary benefit to the community.<sup>5</sup> However, that lack of clarity also creates a challenge for the  
 24 IRS in administering tax law. For example, a hospital could, in theory, maintain a tax exemption by  
 25 operating an emergency room open to all and accepting patients on Medicare and Medicaid, which  
 26 are common among hospitals while spending little to no money on charity care or other community  
 27 benefits. As a result, reporting is inconsistent on many community benefit factors. Several years  
 28 ago, the Government Accountability Office recommended that the IRS update Form 990 to ensure  
 29 that the information demonstrating which community benefits a hospital is providing is clear and  
 30 easily understood by Congress and the public. While the IRS has made minor adjustments to the  
 31 form, it continues to allow hospitals to describe their community benefits in narrative form.  
 32 Additionally, according to IRS officials, hospitals with little to no community benefit expenses  
 33 may warrant an audit; however, the IRS was unable to provide evidence that it conducted reviews  
 34 specifically related to hospital’s community benefits.<sup>6</sup>

35  
 36 Because there is no explicit definition of what constitutes a community benefit, policymakers and  
 37 others can reach different conclusions on whether a nonprofit hospital meets the requirements to  
 38 maintain tax-exempt status or fails to do so. According to one 2024 study, 24 percent of nonprofit  
 39 hospitals received more tax benefits than they spent on community benefits, but noted that the  
 40 characteristics and location of nonprofit hospitals influenced the provision and composition of  
 41 community benefits.<sup>7</sup> Some analyses on nonprofit hospital community benefits omit spending on  
 42 Medicaid shortfall which can significantly impact the total amount of hospital-reported spending  
 43 on community benefits. The IRS includes Medicaid shortfall as a community benefit on Form 990  
 44 Schedule H; therefore, many hospitals continue to report this amount and include it in calculations  
 45 on community benefit spending. However, the calculation of Medicaid shortfall may not be  
 46 reported in a standardized manner. Shortfall could be calculated using a hospital’s charge master  
 47 file, which may not accurately represent the actual cost of care.

48  
 49 Conversely, the lack of an explicitly defined list of appropriate community benefit activities can  
 50 provide flexibility for nonprofit hospitals to report activities and spending based on their individual  
 51 communities’ needs or the focus of the hospital itself. For example, a nonprofit academic medical

1 center may report higher spending on medical education and research, while a children’s hospital  
 2 may report higher spending on Medicaid shortfall due to serving many patients on Medicaid and/or  
 3 the Children’s Health Insurance Program. Those advocating for more stringent guidelines from the  
 4 IRS argue that the vague requirements allow for reporting of activities and spending that do not  
 5 show clear community benefit. However, when interviewed, hospital executives argue that the lack  
 6 of clarity leads many of their organizations to omit spending because they are not sure it would  
 7 qualify under the IRS guidelines, which can result in underreporting on community impact.  
 8 Examples of excluded spending include hiring local contractors, increasing supplier diversity, or  
 9 building a new office or facility to improve health care access.<sup>8</sup>

10  
 11 The estimated value of tax exemption for nonprofit hospitals is estimated to be \$28 billion, split  
 12 between \$14.4 billion from exempted federal taxes and \$13.7 billion from exempted state and local  
 13 taxes. According to KFF, the \$28 billion total estimated value of tax exemption exceeded the total  
 14 estimated charity care costs of \$16 billion for nonprofit hospitals.<sup>9</sup> Twenty-eight states mandate  
 15 some form of reporting on community benefit spending by nonprofit hospitals, although this varies  
 16 significantly from state to state and the impacts on spending and community health outcomes are  
 17 mixed. While states with reporting requirements often saw increases in total spending on  
 18 community benefits from nonprofit hospitals, there was less spending on charity care specifically,  
 19 as spending was spread across several different categories. Nonprofit hospitals in states with  
 20 reporting requirements spent 0.95 percent more on total community benefits (including Medicaid  
 21 shortfall) than nonprofit hospitals in states without reporting requirements.<sup>10</sup>

22  
 23 **AMA POLICY**

24  
 25 [Council on Medical Service Report 1-I-24](#), Nonprofit Hospital Charity Care Policies, addressed a  
 26 similar request to the one made in Resolution 221-I-25. CMS Report 1-I-24 generated [Policy H-](#)  
 27 [155.954](#), which states that the AMA advocates: 1) that all nonprofit hospitals be required to screen  
 28 patients for charity care eligibility and other financial assistance program eligibility prior to billing;  
 29 2) to encourage debt collectors to ensure a patient has been screened for financial assistance  
 30 eligibility before pursuing that patient for outstanding debt, provide an appeals process for those  
 31 patients not screened previously or deemed ineligible, and require the hospital to reassume the debt  
 32 account if an appeal is successful; 3) for the development of minimum standards for nonprofit  
 33 hospital financial assistance eligibility programs which are publicly accessible; 4) for a  
 34 standardized definition of what is considered a “community benefit” when evaluating community  
 35 health improvement activities; 5) for the development of transparent, publicly available,  
 36 standardized data set on community benefit including consideration of charity care-to-expense  
 37 ratios; and 6) for governmental oversight of nonprofit hospitals and enforcement of federal and/or  
 38 state guidelines and standards for community benefit requirements including the ability to enact  
 39 penalties and/or loss of tax-exempt status.

40  
 41 [Policy H-215.975](#) states that the AMA supports the concept that all hospitals be held to the same  
 42 standards of care, community service, professional education and commitment to their respective  
 43 communities.

44  
 45 **DISCUSSION**

46  
 47 The Council believes that nonprofit hospitals are not interchangeable, as each is part of a  
 48 community with unique needs. For example, a large nonprofit health system that operates hospitals  
 49 in multiple states is very different from a critical access hospital in a small rural town. While both  
 50 are technically 501(c)(3) nonprofit hospitals, it should not be expected that these entities have the  
 51 same resources to manage additional reporting requirements or other administrative burdens that

1 may result from increased scrutiny on maintaining tax-exempt status. Furthermore, as they likely  
 2 serve distinct communities, they may have different interpretations of what constitutes a  
 3 community benefit tailored to the needs of their respective communities. Some studies the Council  
 4 reviewed questioned the inclusion of Medicaid shortfall as a category for community benefit  
 5 spending. However, reimbursement for Medicaid shortfall can have a huge impact on small critical  
 6 access hospitals, and in some cases may allow the hospital to stay open to provide care to a  
 7 community that may not have access to another hospital nearby.

8  
 9 The Reference Committee heard mixed, but largely negative testimony on Resolution 221-I-25 and  
 10 recommended referral of this item due to concerns about vague language and the potential for  
 11 unintended consequences. Reference Committee testimony on Resolution 221-I-25 cautioned that  
 12 requiring new federal or state documentation mandates could divert limited resources from patient  
 13 care to compliance activities, force safety-net institutions to consider reductions in force or service  
 14 closures, and/or accelerate conversion or acquisition by for-profit or private equity-backed systems,  
 15 leading to greater market consolidation and diminished local control. The Council agrees with this  
 16 assessment and, thus, is not recommending a definition of what should be considered a community  
 17 benefit. In addition to being beyond the scope of the AMA, it is a nuanced issue where more  
 18 flexibility is likely beneficial, especially for smaller nonprofit hospitals that may have limited  
 19 resources. Instead, the Council recommends advocating for consistency and transparency when  
 20 defining these benefits to allow policymakers and the public to assess nonprofit hospital spending  
 21 on community benefits more clearly.

22  
 23 Physician employment by hospitals and health systems has been rising steadily in recent years. In  
 24 2024, 47 percent of physicians were directly employed by a hospital, contracted directly with a  
 25 hospital, or employed by a hospital-owned practice.<sup>11</sup> Given that physicians employed by hospitals  
 26 or health systems comprise nearly one-half of the medical community, finding a balanced solution  
 27 for addressing the level of community benefits provided by nonprofit hospitals is crucial. As the  
 28 AMA represents all physicians, the Council does not want to unintentionally burden those  
 29 employed by hospitals or health systems by placing additional mandates on their employers.  
 30 However, the Council does understand the importance of holding nonprofit hospitals accountable  
 31 for faithfully maintaining their tax-exempt status.

32  
 33 Accordingly, the Council continues to support the recommendations in [CMS Report 1-I-24](#) and  
 34 offers amendments to [Policy H-155.954](#), which are intended to clarify and strengthen the AMA's  
 35 position on this issue. The amendments offered call for increased transparency and consistency in  
 36 governmental oversight of nonprofit hospitals, so physicians and the public are better aware of  
 37 efforts undertaken by nonprofit hospitals and health systems to improve the health of their  
 38 communities and justify their tax-exempt status as 501(c)(3) organizations. In addition, the Council  
 39 recommends adding a new clause that encourages nonprofit hospitals to share results from their  
 40 federally-required CHNA, including progress that has been made since the previous assessment  
 41 and areas in need of improvement. This recommendation aims to achieve transparency and  
 42 consistency regarding benefits nonprofit hospitals provide their communities. It also provides an  
 43 opportunity for nonprofit hospitals to work with other individuals and/or organizations in their  
 44 community on projects where progress can be furthered. AMA policy supports efforts to reduce  
 45 administrative burdens in health care; therefore, although the Council does not recommend  
 46 increasing the level of mandated reporting by nonprofit hospitals on community benefit efforts, it  
 47 does encourage nonprofit hospitals to share accomplishments within their communities, including  
 48 but not limited to CHNA results.

1 RECOMMENDATIONS

2  
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
4 221-I-25 and the remainder of the report be filed.

5  
6 That our American Medical Association amend Policy H-155.954 by addition and deletion to read  
7 as follows:

8  
9 NONPROFIT HOSPITAL ~~CHARITY CARE~~ POLICIES, H-155.954

- 10  
11 1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be  
12 required to screen patients for charity care eligibility and other financial assistance  
13 program eligibility prior to billing.  
14 2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened  
15 for financial assistance eligibility before pursuing that patient for outstanding debt,  
16 provide an appeals process for those patients not screened previously or deemed  
17 ineligible, and require the hospital to reassume the debt account if an appeal is  
18 successful.  
19 3. Our AMA advocates for the development of minimum standards for nonprofit hospital  
20 financial assistance eligibility programs which are publicly accessible.  
21 4. Our AMA advocates for a standardized definition of what is considered a “community  
22 benefit” that includes addressing social drivers of health and population health when  
23 evaluating community health improvement activities and eligibility for nonprofit  
24 status.  
25 5. Our AMA advocates for the development of a transparent, publicly available,  
26 standardized data sets and/or reports on nonprofit hospital community benefit  
27 spending, including consideration of charity care-to-expense ratios.  
28 6. Our AMA advocates for transparency and consistency regarding the expansion of  
29 governmental oversight of nonprofit hospitals, ~~and~~ enforcement of federal and/or state  
30 guidelines, and standards for community benefit requirements and reporting, including  
31 the ability to enact penalties and/or loss of tax-exempt status.  
32 7. Our AMA encourages nonprofit hospitals to publicly share the results from  
33 assessments, such as the Community Health Needs Assessment (CHNA), including  
34 progress that has been made since the previous assessment, as well as areas where  
35 there is room for improvement. (Modify Current HOD Policy)

Fiscal Note: Minimal

REFERENCES

<sup>1</sup>Godwin, J., Z. Levinson, Scott Hulver. KFF. The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About \$28 Billion in 2020. March 14, 2023. <https://www.kff.org/health-costs/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/>

<sup>2</sup>IRS.gov. Exemption requirements – 501(c)(3) organizations. Accessed: February 10, 2026. <https://www.irs.gov/charities-non-profits/charitable-organizations/exemption-requirements-501c3-organizations>

<sup>3</sup>IRS.gov. Section 501(r) reporting. Accessed: February 10, 2026. <https://www.irs.gov/charities-non-profits/section-501r-reporting>

<sup>4</sup>Simmons, K. Nonprofit Hospitals’ Community Benefits Should Actually Benefit the Community: How IRS Reforms Can Improve the Provision of Community Benefits. Richmond Public Interest Law Review. Vol. 22, Issue 3. May 7, 2019. <https://scholarship.richmond.edu/cgi/viewcontent.cgi?article=1465&context=pilr>

<sup>5</sup>Conley, C. et al. Beyond community benefit: Unveiling hospitals' comprehensive efforts to improve community health. *Health Affairs Scholar*. May 5, 2025.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12050685/pdf/qxaf062.pdf>.

<sup>6</sup>United States Government Accountability Office. Testimony Before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives: IRS Oversight of Hospitals' Tax-Exempt Status. Statement of Jessica Lucas-Judy, Strategic Issues. April 26, 2023. <https://www.gao.gov/assets/gao-23-106777.pdf>

<sup>7</sup>Zare, H. and G. Anderson. Beyond the Bottom Line: Assessing Charity Care, Community Benefits, and Tax Exemptions in Nonprofit Hospitals. *Journal of Healthcare Management*. November 2024.

<https://pubmed.ncbi.nlm.nih.gov/39792847/>

<sup>8</sup>*Supra*. Note 5.

<sup>9</sup>*Supra*. Note 1.

<sup>10</sup>Zare, H., C. Logan, G. F. Anderson. When States Mandate Hospital Community Benefit Reports, Provision Increases. *Journal of Healthcare Management*. 2023.

<https://pmc.ncbi.nlm.nih.gov/articles/PMC9973432/pdf/jhcma-68-083.pdf>

<sup>1</sup>Kane, Carol K. Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties. *AMA Policy Research Perspective*. 2025. <https://www.ama-assn.org/system/files/2024-prp-pp-characteristics.pdf>

**Council on Medical Service Report 9-A-26  
Nonprofit Status  
Policy Appendix**

**Nonprofit Hospital Charity Care Policies, H-155.954**

1. Our American Medical Association (AMA) advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
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3. Our AMA advocates for the development of minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a “community benefit” when evaluating community health improvement activities.
5. Our AMA advocates for the development of a transparent, publicly available, standardized data set on community benefit including consideration of charity care-to-expense ratios.
6. Our AMA advocates for the expansion of governmental oversight of nonprofit hospitals and enforcement of federal and/or state guidelines and standards for community benefit requirements including the ability to enact penalties and/or loss of tax-exempt status.

(CMS Rep. 01, I-24)

**Uniform Standards for Not-For-Profit and For-Profit Hospitals, H-215.975**

The AMA supports the concept that all hospitals be held to the same standards of care, community service, professional education and commitment to their respective communities.

(Res. 705, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16)