

September 2008

NONPROFIT HOSPITALS

Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements





Highlights of [GAO-08-880](#), a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

Nonprofit hospitals qualify for federal tax exemption from the Internal Revenue Service (IRS) if they meet certain requirements. Since 1969, IRS has not specified that these hospitals have to provide charity care to meet these requirements, so long as they engage in activities that benefit the community. Many of these activities are intended to benefit the approximately 47 million uninsured individuals in the United States who need financial and other help to obtain medical care. Previous studies indicated that nonprofit hospitals may not be defining community benefit in a consistent and transparent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status. GAO was asked to examine (1) IRS's community benefit standard and the states' requirements, (2) guidelines nonprofit hospitals use to define the components of community benefit, and (3) guidelines nonprofit hospitals use to measure and report the components of community benefit. To address these objectives, GAO analyzed federal and state laws; the standards and guidance from federal agencies and industry groups; and 2006 data from California, Indiana, Massachusetts, and Texas. GAO also interviewed federal and state officials, and industry group representatives.

IRS stated that the report in general was accurate, but noted several concerns regarding the description of the community benefit standard. CMS did not have any comments.

To view the full product, including the scope and methodology, click on [GAO-08-880](#). For more information, contact A. Bruce Steinwald at (202) 512-7114 or steinwalda@gao.gov.

NONPROFIT HOSPITALS

Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements

What GAO Found

IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit. Furthermore, state community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail. For example, 15 states have community benefit requirements in statutes or regulations, and 10 of these states have detailed requirements.

GAO found that among the standards and guidance used by nonprofit hospitals, consensus exists to define charity care, the unreimbursed cost of means-tested government health care programs (programs for which eligibility is based on financial need, such as Medicaid), and many other activities that benefit the community as community benefit. However, consensus does not exist to define bad debt (the amount that the patient is expected to, but does not, pay) and the unreimbursed cost of Medicare (the difference between a hospital's costs and its payment from Medicare) as community benefit. Variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report.

Even if nonprofit hospitals define the same activities as community benefit, they may measure the costs of these activities differently, which can lead to inconsistencies in reported community benefits. For example, standards and guidance vary on the level at which hospitals may report their community benefit (e.g., at an individual hospital level or a health care system level) and the method hospitals may use to estimate costs of community benefit activities. State data demonstrate that differences in how nonprofit hospitals measure charity care costs and the unreimbursed costs of government health care programs can affect the amount of community benefit they report.

With the added attention to community benefit has come a growing realization of the extent of variability among stakeholders in what should count and how to measure it. At present, determination and measurement of activities as community benefit for federal purposes are still largely a matter of individual hospital discretion. Given the large number of uninsured individuals, and the critical role of hospitals in caring for them, it is important that federal and state policymakers and industry groups continue their discussion addressing the variability in defining and measuring community benefit activities.

Contents

Letter		1
	Results in Brief	7
	Background	8
	IRS's Standard Provides Broad Latitude for Nonprofit Hospitals to Determine Community Benefit Activities; State Requirements Vary Substantially in Scope and Detail	14
	Differences in the Activities Nonprofit Hospitals Define as Community Benefit Substantially Affect the Amount of Community Benefits They Report	19
	Differences in How Nonprofit Hospitals Measure Costs of Community Benefit Activities Can Affect the Amount of Community Benefits They Report	34
	Concluding Observations	39
	Agency Comments and Our Evaluation	40
Appendix I	Scope and Methodology	44
Appendix II	Other Activities That Benefit the Community Identified in Industry Guidance	49
Appendix III	State Community Benefit Requirements	52
Appendix IV	States with Community Benefit Requirements Related to Hospitals	57
Appendix V	Examples of States with Licensure-Related Community Benefit Provisions	65
Appendix VI	Examples of States with Only Community Benefit Reporting Provisions	67

Appendix VII	Examples of States with Community Benefit Provisions Located Outside of Statutes and Regulations	69
---------------------	---	----

Appendix VIII	GAO Contact and Staff Acknowledgments	70
----------------------	--	----

Tables

Table 1: Number of Nonprofit Hospitals and Their Average Total Operating Expenses in Selected States, 2006	10
Table 2: Charity Care and Bad Debt as Community Benefit—Analysis of Selected Government Agency and Industry Group Standards and Guidance	22
Table 3: Government Health Care Programs as Community Benefit—Analysis of Selected Government Agency and Industry Group Standards and Guidance	26

Figures

Figure 1: Geographic Distribution of Nonprofit Hospitals in 2006	9
Figure 2: State Community Benefit Requirements	17
Figure 3: Average Percentage of Total Operating Expenses Devoted to Charity Care Costs and Bad Debt among Nonprofit Hospitals in Selected States, 2006	23
Figure 4: Average Percentages of Total Operating Expenses Devoted to Charity Care Costs, Bad Debt, and the Unreimbursed Costs of Medicaid and Medicare among Nonprofit Hospitals in Selected States, 2006	28
Figure 5: Average Percentages of Total Operating Expenses Devoted to the Unreimbursed Costs of Other Activities That Benefit the Community among Nonprofit Hospitals in Selected States, 2006	31
Figure 6: Charity Care Costs, Bad Debt, Unreimbursed Cost of Medicaid and Medicare, and Other Activities That Benefit the Community as Percentages of Their Sum among Nonprofit Hospitals in Selected States, 2006	33

Figure 7: Average Percentages of Total Operating Expenses
Devoted to the Unreimbursed Cost of Medicaid and to the
Unreimbursed Cost of Medicaid Net of DSH Payments
among Nonprofit Hospitals in Selected States, 2006

Abbreviations

AHA	American Hospital Association
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
CBO	Congressional Budget Office
CCR	cost-to-charge ratio
CHA	Catholic Health Association of the United States
CMS	Centers for Medicare & Medicaid Services
DSH	disproportionate share hospital
EIN	employer identification number
HFMA	Healthcare Financial Management Association
IRS	Internal Revenue Service
JCT	Joint Committee on Taxation
MedPAC	Medicare Payment Advisory Commission

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

September 12, 2008

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Dear Senator Grassley:

In 2006, there were about 2,900 nonprofit hospitals in the United States.¹ These hospitals qualify for federal tax exemption from the Internal Revenue Service (IRS) if they meet certain requirements.² The exemption is based on the principle that the government's loss of tax revenues is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare.³ In addition to federal income tax exemption, these hospitals also have access to charitable donations that are tax deductible to the donor and tax-exempt bond financing. Nonprofit hospitals may also be exempt under state law from state and local income, property, and sales taxes. The Joint Committee on Taxation (JCT)—a nonpartisan committee that assists Congress with tax legislation—estimated that in 2002, nonprofit hospitals received tax benefits of \$12.6 billion at the federal, state, and local levels.⁴

To qualify for tax-exempt status, IRS requires nonprofit hospitals to be organized and operated exclusively for a charitable purpose. Before 1969,

¹For purposes of this report, nonprofit hospitals refer to nongovernmental, acute care, general hospitals organized and operated for a charitable purpose and not designed primarily for profit-making purposes. Nonprofit hospitals qualify for tax-exempt status if they meet the requirements of section 501(c)(3) of the Internal Revenue Code.

²These requirements include restrictions on the entity's organizational and operational structure, and political activities.

³See H.R. Rep. No. 1860, 75th Cong., 3d Sess., 19 (1938).

⁴JCT estimated the following values of exemptions for nonprofit hospitals and their supporting organizations in 2002: \$2.5 billion in federal income tax, \$1.8 billion in federal bond financing, \$1.8 billion in federal charitable contributions, \$500 million in state corporate income tax, \$2.8 billion in state and local sales taxes, and \$3.1 billion in local property tax. See Congressional Budget Office, *Nonprofit Hospitals and Tax Arbitrage* (Washington, D.C.: December 2006).

IRS specified that hospitals must provide charity care to meet this requirement.⁵ Since 1969, however, IRS has not specified that nonprofit hospitals have to provide charity care to meet this requirement, but they must provide a benefit to the community. This has become known as the community benefit standard and has remained substantially unchanged since 1969. In addition to charity care, services and activities that can qualify as community benefits include the provision of health education and screening to specific vulnerable populations within the community and activities that benefit the greater public good, such as education for health professionals and medical research.

Many of these community benefit activities—especially charity care—are intended to benefit individuals who need financial and other help to obtain medical care. In 2006, there were approximately 47 million uninsured individuals in the United States.⁶ These individuals are more likely than insured individuals to rely on hospital emergency rooms for medical care.⁷ Some of these individuals with serious illness or injuries are admitted as inpatients to the hospital, incurring substantial treatment costs.⁸ Because uninsured individuals may lack the ability to pay for their medical care, hospitals absorb some of the costs associated with providing uncompensated care—either through a charity care program or as

⁵Charity care is generally defined as care provided to patients whom the hospital deems unable to pay all or a portion of their bills.

⁶U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C., 2007). See also GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: Feb. 1, 2005), in which ensuring that all Americans have access to a defined minimum core of essential health services and allocating responsibility for financing such services are identified as major health care challenges for the 21st century.

⁷The Emergency Medical Treatment and Active Labor Act applies to hospitals participating in Medicare. See 42 U.S.C. § 1395dd (2000). According to federal regulations, a hospital that provides emergency services must medically screen all persons who come to the hospital seeking emergency care to determine whether an emergency medical condition exists. If the hospital determines that a person has an emergency medical condition, the hospital must provide treatment necessary to stabilize that person or arrange for an appropriate transfer to another facility. See 42 C.F.R. § 489.24 (2007).

⁸Institute of Medicine, *Hidden Costs, Values Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, 2003).

expenses written off as bad debt.^{9,10} Given the benefits available to tax-exempt hospitals, policymakers have been interested in determining the extent to which hospitals share the burden of caring for uninsured individuals.

In 2005, we reported on the amount of uncompensated care that nonprofit, for-profit, and government hospitals provided.¹¹ We found that nonprofit hospitals devoted only slightly more of their patient operating expenses to uncompensated care, on average, than their for-profit counterparts. We also found that the burden of uncompensated care was not evenly distributed among nonprofit hospitals—a small number of nonprofit hospitals provided substantially more uncompensated care than other hospitals receiving the same tax preference. In 2006, the Congressional Budget Office (CBO) also reported wide variation in the provision of uncompensated care among nonprofit hospitals.¹² These studies indicated that nonprofit hospitals may not be defining community benefit in a consistent manner that would enable policymakers to hold them accountable for providing benefits commensurate with their tax-exempt status.

⁹Hospitals may not absorb all the costs associated with caring for the uninsured because they receive direct payments from different government sources to help cover their unreimbursed costs, including those for charity care, bad debt, and low-income patients. For example, Medicare and Medicaid make payments to hospitals that serve a disproportionate share of low-income patients under their respective disproportionate share hospital programs. Other state payments may also be available to hospitals, although their specific types vary widely. For example, hospitals may receive payments from special revenues, such as tobacco settlement funds; uncompensated care pools that are funded by provider contributions; and payment programs targeted at certain services, such as emergency services.

¹⁰Bad debt is generally defined as the uncollectible payment that the patient is expected to, but does not, pay.

¹¹For this study, we analyzed 2003 data from five geographically diverse states—California, Florida, Georgia, Indiana, and Texas—with substantial representation of the three ownership groups. For each state, we determined the three ownership groups' percentages of total uncompensated care costs and patient operating expenses devoted to uncompensated care. See GAO, *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits*, GAO-05-743T (Washington, D.C.: May 26, 2005).

¹²CBO found that, on average, nonprofit hospitals provided more uncompensated care than otherwise similar for-profit hospitals, although the ranges of uncompensated care provided by the two types of hospitals largely overlapped. See Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (Washington, D.C.: December 2006).

Congress has since continued to raise questions about whether nonprofit hospitals sufficiently accept and share the burden of uncompensated care. As part of this effort, in 2007, you distributed a paper discussing potential reforms to the community benefit standard.¹³ Among other things, you sought feedback on whether hospitals should be required to devote a minimum percentage of patient operating expenses or revenues (whichever is greater) to charity care in order to continue to qualify for federal tax exemption. You also expressed interest in gaining a better understanding of nonprofit hospitals' provision of community benefits in relation to their tax-exempt status, and raised concerns about the extent to which nonprofit hospitals define, measure, and report community benefits in a consistent and transparent manner.

To obtain more information on these topics, you asked us to describe IRS's community benefit standard and the states' community benefit requirements, and to examine guidelines nonprofit hospitals use to define, measure, and report the components of community benefit. In this report, we (1) determine the community benefit standard and requirements that IRS and the states have established; (2) examine the standards and guidance nonprofit hospitals use to define community benefit activities and their effects on reported community benefits; and (3) examine the standards and guidance nonprofit hospitals use to measure the costs of community benefit activities and their effects on reported community benefits.

To determine the community benefit standard that IRS has established, we examined relevant provisions of the Internal Revenue Code, IRS regulations, revenue rulings, and federal case law. To review states' community benefit requirements, we examined codified statutes and regulations of the states.¹⁴

To examine what activities are defined as community benefit, we reviewed standards and guidance from the following government agencies and industry groups: the Centers for Medicare & Medicaid Services (CMS), IRS, the American Hospital Association (AHA), the Catholic Health

¹³U.S. Senate, Committee on Finance, minority staff, *Tax-Exempt Hospitals: Discussion Draft*, July 19, 2007.

¹⁴For purposes of this report, unless otherwise apparent, "states" refers to the 50 states and the District of Columbia.

Association of the United States (CHA), VHA Inc.,¹⁵ and the Healthcare Financial Management Association (HFMA). CMS, the agency that administers Medicare,¹⁶ requires cost information—including charity care costs and bad debt expenses—from hospitals that participate in Medicare.¹⁷ AHA officials stated that it represents over three-fourths of the hospitals in the nation, including nonprofit hospitals. CHA represents Catholic health care organizations, including hospitals, and is the nation’s largest group of nonprofit health care sponsors, systems, and facilities. VHA represents about 28 percent of the nation’s community-owned, nonprofit hospitals. In 2006, CHA and VHA jointly released a set of detailed community benefit guidelines—*A Guide for Planning and Reporting Community Benefit*.¹⁸ HFMA represents health care financial management executives and leaders in all areas of health care, including hospitals. In 2006, the organization issued financial reporting guidance on community benefit activities, including details on charity care and bad debt. In addition to examining standards and guidance from these organizations, we interviewed their officials and representatives. We also interviewed representatives from the Association of American Medical Colleges, which represents medical schools, teaching hospitals, and their faculty, residents, and students, as well as academic and professional societies; the Federation of American Hospitals, which represents for-profit community hospitals and health systems; the National Association of Children’s Hospitals; state hospital associations and state health officials from California, Indiana, Massachusetts, and Texas; and seven nonprofit health care systems.¹⁹

¹⁵For the remainder of this report, we will refer to VHA Inc., formerly known as Voluntary Hospitals of America, as VHA.

¹⁶Medicare, financed by the federal government, provides health care coverage to eligible individuals aged 65 years or older, certain individuals with disabilities, and individuals with end-stage renal disease.

¹⁷While CMS is not responsible for administering U.S. tax law, the agency was directed by Congress to collect data on costs incurred by hospitals for providing services for which the hospitals are not compensated. Many of these services and their associated costs are defined as community benefit by both IRS and industry groups.

¹⁸For purposes of this report, we refer to CHA and VHA in tandem because they jointly issued the guidance.

¹⁹For purposes of this report, we refer to the nonprofit health systems, hospital systems, and health care systems we interviewed as “health care systems.”

To examine the effects of including or excluding various community benefit activities on reported community benefit, we analyzed 2006 state data from California, Indiana, Massachusetts, and Texas. We selected these four states because they represent diverse areas both geographically and in the percentage of hospitals that are nonprofit, and because they collected data on nonprofit hospitals' community benefits, which not many states maintain.²⁰ The state data were also the most recent available at the time of our analysis. We limited our analysis to nonprofit, nongovernmental, acute care, general hospitals that reported gross patient revenues and total operating expenses. We calculated and compared a variety of hospital expenses, including charity care costs, bad debt, unreimbursed costs of government health care programs,²¹ and the costs of other activities that benefit the community, as percentages of total operating expenses. To assess the reliability of the state data from California, Indiana, Massachusetts, and Texas, we reviewed relevant documentation for each of the data sets and interviewed knowledgeable state officials about the accuracy of the data. Based on this information we determined that the state-collected data were reliable for the purposes of this report.

To examine practices nonprofit hospitals use to measure community benefit activities, we reviewed the standards and guidance from CMS, IRS, AHA, CHA and VHA, and HFMA. To examine the effects of these practices on reported community benefit, we analyzed 2006 state data from California, Indiana, Massachusetts, and Texas. Specifically, we compared the different ways hospitals calculate expenses, including charity care costs and the unreimbursed cost of Medicaid,²² as percentages of total operating expenses. Appendix I contains a more complete description of our methodology. We conducted our work from July 2007 through August 2008 in accordance with generally accepted government auditing standards.

²⁰Reliable, hospital-specific, nationwide data were not available.

²¹The unreimbursed costs of government health care programs—commonly referred to by industry groups as “shortfalls”—are generally defined as the difference created when a facility receives payments that are less than the facility’s costs of caring for public program beneficiaries.

²²Medicaid provides health care coverage to eligible low-income people, and is jointly financed by the federal government and the states.

Results in Brief

IRS's community benefit standard allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit. Furthermore, state community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail. For example, 15 states have community benefit requirements in statutes or regulations, and 10 of these states have detailed requirements.

Among the standards and guidance used by nonprofit hospitals, consensus exists to define charity care, the unreimbursed cost of means-tested government health care programs (programs for which eligibility is based on financial need, such as Medicaid), and many other activities that benefit the community as community benefit. However, consensus does not exist to define bad debt and the unreimbursed cost of Medicare as community benefit. Variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report.

Even if nonprofit hospitals define the same activities as community benefit, they may measure the costs of those activities differently, which can lead to inconsistencies in reported community benefits. For example, standards and guidance vary on the level at which hospitals may report their community benefit (e.g., at an individual hospital level or a health care system level); the method hospitals may use to estimate costs of all community benefit activities; and the methods hospitals may use to measure costs of charity care, government health care programs, and other activities that benefit the community. State data demonstrate that differences in how nonprofit hospitals measure charity care costs and the unreimbursed costs of government health care programs can affect the amount of community benefit they report.

With the added attention to community benefit has come a growing realization of the extent of variability among stakeholders in what should count and how to measure it. At present, determination and measurement of activities as community benefit for federal purposes are still largely a matter of individual hospital discretion. Given the large number of uninsured individuals, and the critical role of hospitals in caring for them, it is important that federal and state policymakers and industry groups continue their discussion addressing the variability in defining and measuring community benefit activities. An encouraging prospect for the future is the potential availability of two national data sources derived from mandatory reporting to IRS and CMS. National data should be helpful in standardizing reporting on community benefit activities and informing

public policy on the community benefit standard. However, the data from these two sources will not be available for analysis for several years, and it remains to be seen whether the data will be consistent and reliable.

CMS and IRS reviewed a draft of this report. CMS stated that it did not have any comments. IRS stated that the report in general was accurate, although the agency noted several concerns regarding the description of the community benefit standard. We addressed IRS's concerns as appropriate.

Background

In 2006, the majority—59 percent—of the roughly 4,900 nonfederal, acute care general hospitals in the United States were nonprofit. The rest included government hospitals (25 percent) and for-profit hospitals (17 percent).²³ States varied—generally by region of the country—in their percentages of nonprofit hospitals (see fig. 1). States in the Northeast and Midwest had relatively high concentrations of nonprofit hospitals, whereas the concentration was relatively low in the South. For example, 88 percent of Massachusetts' hospitals were nonprofit, whereas only 32 percent of Texas' hospitals were nonprofit.

²³Percentage total is greater than 100 due to rounding.

Table 1: Number of Nonprofit Hospitals and Their Average Total Operating Expenses in Selected States, 2006

	Number of hospitals	Average total operating expenses (in millions)
California	166	\$201.3
Indiana	78	141.3
Massachusetts	64	279.6
Texas	119	148.9

Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Note: Nonprofit hospitals include nongovernmental, acute care, general hospitals.

Federal Tax-Exemption Criteria for Nonprofit Hospitals

Federal tax exemption for charitable organizations has been in existence since the beginning of federal income tax law. This exemption is based on the principle that the government's loss of tax revenue is offset by its relief from financial burdens that it would otherwise have to meet with appropriations from public funds, and by the benefits resulting from the promotion of general welfare. Nonprofit hospitals have never been expressly categorized as tax-exempt organizations under section 501(c)(3) of the Internal Revenue Code. However, these hospitals are able to qualify for federal tax exemption under section 501(c)(3) of the Internal Revenue Code since IRS and courts have recognized the promotion of health for the benefit of the community—where medical assistance is afforded to the poor or where medical research is promoted—as a charitable purpose.²⁴ Specifically, nonprofit hospitals must be organized and operated exclusively for the promotion of health, ensuring that no part of their net earnings inure to the benefit of any private individual, and may not participate in political campaigns on behalf of any candidate or conduct substantial lobbying activities.²⁵

IRS has also issued revenue rulings specifying how nonprofit hospitals can meet the requirements of federal tax exemption.²⁶ In a 1956 revenue ruling, IRS required tax-exempt hospitals to provide charity care to the extent of

²⁴See, e.g., *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1216 (3rd Cir. 1993) (discussing IRS policy and cases construing exemption provisions for hospitals).

²⁵*Harding Hospital, Inc. v. U.S.*, 505 F.2d 1068, 1071-72 (6th Cir. 1974).

²⁶Revenue rulings are published IRS administrative decisions stating how the agency applies provisions of tax law to a particular set of circumstances.

their financial abilities, which was known as the financial ability standard.²⁷ However, through another revenue ruling in 1969, IRS established the community benefit standard, which modified the charity care-based financial ability standard as to how hospitals could qualify for tax-exempt status.²⁸ The community benefit standard specified that nonprofit hospitals were not required to provide charity care to qualify for federal tax exemption, but they must provide a benefit to the community.²⁹ Therefore, nonprofit hospitals could qualify for tax-exempt status so long as they benefited the community in a way that relieved a governmental burden and promoted general welfare, even if not every member of the community received a direct benefit.

In the 1969 revenue ruling that established the community benefit standard, IRS recognized five factors that would support a nonprofit hospital's tax-exempt status. These five factors were (1) the operation of an emergency room open to all members of the community without regard to ability to pay;³⁰ (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff³¹ with privileges available to all qualifying physicians. IRS further stated that tax-exempt status would be determined based on the facts and circumstances of each case, and that neither the absence of particular factors set forth in the 1969 revenue ruling nor the presence of other factors would be necessarily conclusive.

²⁷Rev. Rul. 56-185, 1956-1 C.B. 202.

²⁸Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁹Specifically, the 1969 revenue ruling removed the 1956 revenue ruling requirement relating to caring for patients without charge or at rates below cost, and indicated that hospitals could qualify for federal tax exemption if they provided a benefit to the community.

³⁰In a 1983 revenue ruling, IRS provided that at least in the case where a state health planning agency made an independent determination that operation of an emergency room would be unnecessary and duplicative, a hospital could still qualify for tax exemption even though it did not operate an emergency room. Rev. Rul. 83-157, 1983-2 C.B. 94.

³¹All qualified physicians who meet the hospital's guidelines can be part of the hospital staff.

Nonprofit hospitals that qualify for tax-exempt status are exempt from federal income taxation, have access to bond financing that generates tax-free interest earnings for the bondholder—allowing these hospitals to borrow funds at a lower cost than nonexempt entities—and are eligible to receive contributions that are tax deductible for the donors. In addition, these hospitals may also be exempt under state law from state and local income, property, and sales taxes, which in some cases are of a greater value than the federal income tax exemption.

Reporting of Community Benefit Information

Once nonprofit hospitals have applied for and are granted tax-exempt status by IRS, they must file Form 990 with IRS on an annual basis.³² Form 990 collects information such as revenues and expenses, and program service accomplishments. In December 2007, IRS released a revised Form 990 to include a schedule specific to hospitals—Schedule H—that requires nonprofit hospitals to report their provision of activities that benefit the community in specified categories: charity care, bad debt, unreimbursed cost of government health care programs, and other activities that benefit the community.³³ The new hospital schedule will be mandatory starting in filing year 2010 for tax year 2009, and IRS

³²Starting in tax year 2008, exempt organizations with gross receipts less than \$25,000 will need to file Form 990-N. Those with gross receipts less than \$1,000,000 (to be reduced to \$200,000 by tax year 2010) and total assets less than \$2,500,000 (to be reduced to \$500,000 by tax year 2010) will file Form 990-EZ, instead of the full Form 990. Forms 990-N and 990-EZ are shorter than the full Form 990.

³³We examined IRS's final version of the Form 990, which was pending the Office of Management and Budget's approval at the time this report was issued. Form 990's new Schedule H requires nonprofit hospitals to report their provision of bad debt, the unreimbursed cost of Medicare, and community-building activities in Parts II and III of the schedule, but not as part of the Part I quantifiable community benefit table. Prior to this revision, Form 990 did not collect and IRS did not have information on hospitals' provision of activities that benefit the community in specified categories. IRS officials indicated that for tax years 2001 to 2006, none of the nonprofit hospital examinations the agency conducted were selected specifically to ascertain whether these hospitals complied with the community benefit standard. Rather, IRS conducted these examinations in the course of the agency's other work. These officials also told us that some of these examinations were full-scale examinations where in addition to reviewing other issues, IRS conducted a limited review of community benefit focusing on the five factors listed in the 1969 revenue ruling.

officials have stated that complete data from the schedule may not be available until 2011, at the earliest.³⁴

In addition to meeting IRS's community benefit reporting requirements, hospitals that participate in the Medicare program—including nonprofit hospitals—must file hospital cost reports with CMS.³⁵ The required cost report includes Worksheet S-10, which collects revenue and cost information on Medicaid, state and local indigent care programs, the State Children's Health Insurance Program,³⁶ and other uncompensated care—defined by CMS as charity care and bad debt—provided by the hospitals. CMS, in consultation with the Medicare Payment Advisory Commission (MedPAC),³⁷ is revising Worksheet S-10 as part of broader efforts to update the Medicare hospital cost report.

Beyond these two federal requirements, some states also require hospitals to report their provision of community benefits using state-specific reporting instruments. In addition, when requested, some hospitals also report their community benefits to the state hospital associations or other trade organizations to which they belong.

³⁴While Part V, Facility Information, of Schedule H is required for tax year 2008, Parts I, II, III, IV, and VI do not become mandatory until tax year 2009. Depending on when a hospital's fiscal year begins, tax year 2009 can start on any date during calendar year 2009 and end 12 months later, which could be as late as November 30, 2010. IRS officials have noted that hospitals have until 5 months after the end of their fiscal year to file Form 990 and its schedules. Beyond this filing deadline, hospitals may also obtain filing extensions for an additional 6 months.

³⁵Medicare-certified institutional providers are required to submit an annual cost report. The cost report contains provider information, such as facility characteristics, as well as utilization, cost, charge, and financial statement data. For cost report periods beginning on or after October 1, 2001, section 112(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires short stay, acute care hospitals to submit cost reports containing data on costs incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. Pub. L. No. 106-113, App. F., § 112(b), 113 Stat. 1501, 1501A-330.

³⁶The State Children's Health Insurance Program provides health care coverage to uninsured children in families whose incomes exceed the eligibility requirements of Medicaid. States have some flexibility in how they design their programs.

³⁷MedPAC was established by the Balanced Budget Act of 1997, § 4022, 42 U.S.C. § 1395b-6 (2000), to advise Congress on issues affecting the Medicare program.

IRS's Standard Provides Broad Latitude for Nonprofit Hospitals to Determine Community Benefit Activities; State Requirements Vary Substantially in Scope and Detail

IRS's community benefit standard to qualify for tax-exempt status allows nonprofit hospitals broad latitude to determine the services and activities that constitute community benefit. Furthermore, state community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail.

IRS's Community Benefit Standard Provides Broad Latitude to Nonprofit Hospitals

IRS's community benefit standard that hospitals must meet to qualify for federal tax exemption provides broad latitude to the hospitals in determining the nature and amount of the community benefits they provide.³⁸ Specifically, IRS, in a 1969 revenue ruling that established the current community benefit standard, modified the existing tax-exemption requirement that focused primarily on the level of charity care that a hospital provided. This 1969 revenue ruling also listed the five factors that demonstrated how a nonprofit hospital could benefit the community in a way that relieved governmental burden and promoted general welfare.³⁹ While IRS recognized these five factors as supportive of a nonprofit hospital's tax-exempt status, it also stated that a nonprofit hospital seeking exemption need not meet all five factors to qualify for tax-exempt status; instead, the determination is based on all the facts and circumstances, and the absence of a particular factor may not necessarily be conclusive. As stated by the Commissioner of Internal Revenue, some of the five factors are now common practice in the hospital community and are less relevant

³⁸See *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1217 (3d Cir. 1993) (“[N]o clear test has emerged to apply to nonprofit hospitals seeking tax exemptions.”).

³⁹The five factors were (1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of independent civic leaders; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians.

in distinguishing tax-exempt hospitals from their for-profit counterparts.⁴⁰ For example, having an open medical staff, participating in Medicare and Medicaid, and treating all emergency patients without regard to ability to pay are common features of both tax-exempt and for-profit hospitals.

Although the focus of IRS policy is no longer the level of charity care that hospitals provide, the 1956 revenue ruling remains relevant, and IRS and various courts have continued to take into account the extent to which a hospital provides charity care when determining an organization's tax-exempt status. For example, among the factors that the Tax Court and several United States Courts of Appeals have considered in determining whether an organization met IRS's tax exemption requirements were existence of a charity care policy,⁴¹ provision of free or below-cost services to individuals financially unable to make the required payments,⁴² and provision of additional community benefit—other than making hospital services available to all in the community—that either further the function of government-funded institutions or would not likely be provided within the community without a hospital subsidy.⁴³

⁴⁰Statement of Mark Everson, Commissioner of Internal Revenue, testimony before the full House Committee on Ways and Means, May 26, 2005.

⁴¹*Harding Hosp. Inc. v. United States*, 505 F. 2d 1068, 1077 (6th Cir. 1974).

⁴²*IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188, 1197 n.16 (10th Cir. 2003) (citing *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1218 (3d Cir. 1993); *Fed'n Pharmacy Serv., Inc. v. Comm'r*, 625 F.2d 804, 807 (8th Cir. 1980); and *Sound Health Ass'n v. Comm'r*, 71 T.C. 158, 1978 WL 3393 (1978)).

⁴³*IHC Health Plans, Inc.*, 325 F.3d at 1197–98.

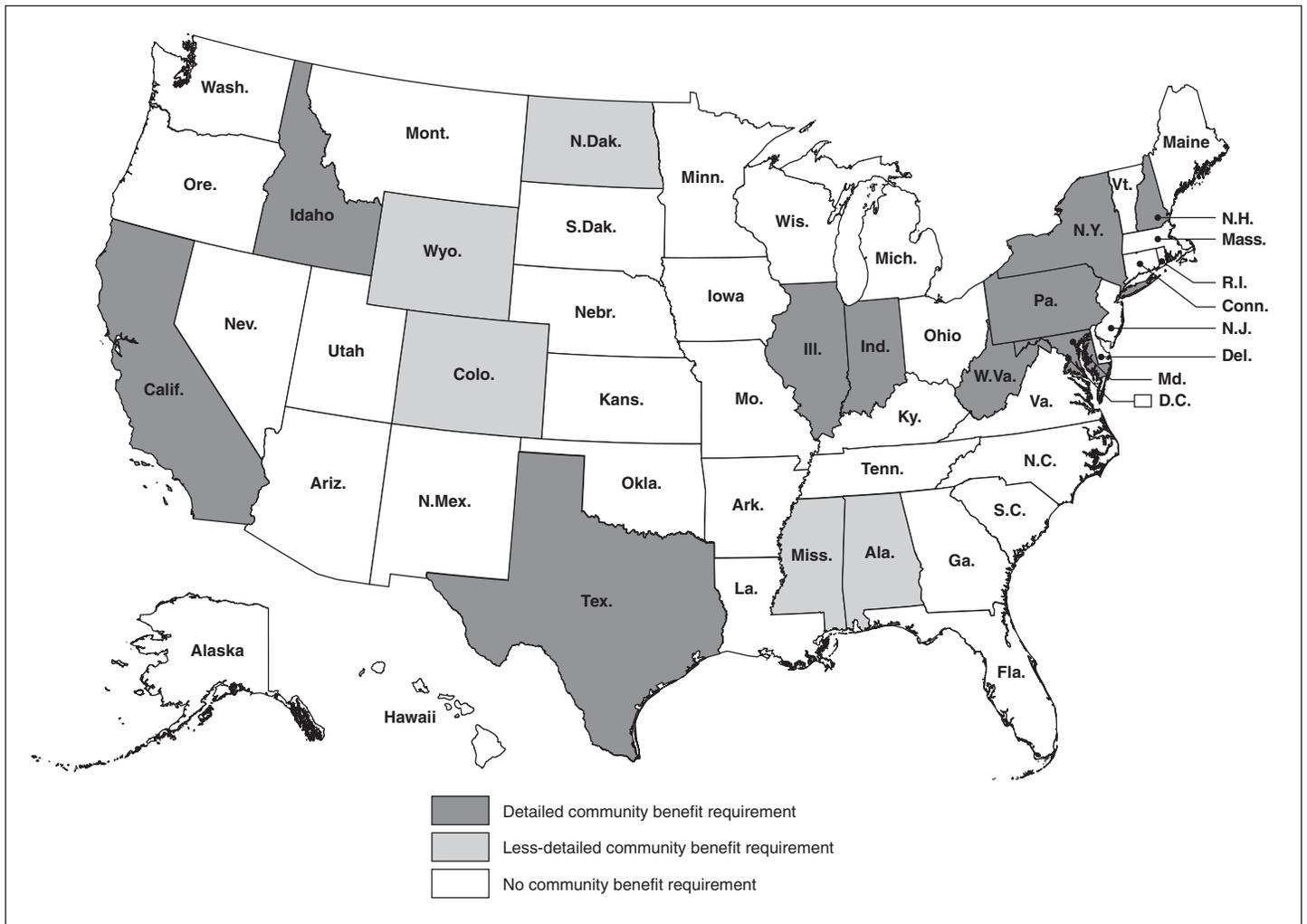
State Community Benefit Requirements That Nonprofit Hospitals Must Meet Vary Substantially in Scope and Detail

State community benefit requirements that hospitals must meet in order to qualify for state tax-exempt or nonprofit status vary substantially in scope and detail. Specifically, 15 of the states have community benefit requirements in statutes or regulations and 36 do not (see fig. 2).⁴⁴ Of the 15 states with requirements, 5 states—Alabama, Mississippi, Pennsylvania, Texas, and West Virginia—specify a minimum amount of community benefits required in order for hospitals to be compliant with state requirements. Another 4 of the 15 states—Illinois, Indiana, Maryland, and Texas—have penalties for hospitals that fail to comply with their community benefit requirements.⁴⁵ Appendixes III, IV, V, VI, and VII contain more information on state community benefit requirements and other related provisions.

⁴⁴Some of the 36 states that do not have community benefit requirements have provisions or other resources related to community benefit. Some states, including Massachusetts, New Mexico, and Rhode Island, have community benefit provisions tied to their hospital licensure requirements rather than requirements needed to obtain and maintain tax-exempt or nonprofit status. At least five states—Connecticut, Georgia, Minnesota, Nevada, and Oregon—require that hospitals periodically report to the relevant authorities the community benefits they provide but do not require that hospitals actually provide any community benefits. At least two states—Massachusetts and Utah—describe their community benefit provisions in sources other than statutes or regulations, such as attorney general guidelines or property tax exemption standards. We provide examples of states that fall into these categories as anecdotal evidence; they do not represent a comprehensive analysis of states without community benefit requirements as we define that term.

⁴⁵For state requirements tied to tax-exempt or nonprofit status, a hospital can be assessed a civil penalty if it fails to comply with state community benefit requirements. Hospitals in such states may also be denied tax exemption, although we did not consider that to be a penalty for purposes of this report. If a state has no community benefit requirement but ties community benefit provisions to licensure, such as Massachusetts, New Mexico, and Rhode Island, a hospital in that state may be denied licensure for failure to comply with state community benefit provisions (or if already licensed, its license can be suspended or revoked). Some state requirements do not provide any penalty for failure to comply.

Figure 2: State Community Benefit Requirements



Sources: GAO analysis of state statutes and regulations; Map Resources (map).

In addition to the variation in scope among state community benefit requirements, the level of detail among such requirements also varies substantially. Specifically, of the 15 states with community benefit requirements, 10 states have detailed requirements and 5 states have less-

detailed requirements.⁴⁶⁻⁴⁷ The community benefit requirements of the 10 detailed states typically include some combination of the following factors: a definition of community benefit, requirements for a community benefit plan that sets forth how the hospital will provide community benefits, community benefit reporting requirements, and penalties for noncompliance. For example, California requires its nonprofit hospitals to adopt and annually update a community benefit plan, and annually submit a description of community benefit activities provided and their economic values, among other things.⁴⁸ Similarly, Illinois requires its hospitals to develop an organizational mission statement and a community benefits plan for serving the community's health care needs, and to submit an annual report of its community benefits plan, including a disclosure of the amount and types of community benefits actually provided.⁴⁹ These states also typically define community benefit using examples of, and guidance on, the types of activities considered to be community benefit. For example, Illinois defines community benefit using examples of activities that the state considers to be community benefit and Maryland defines community benefit using both examples and guidance.⁵⁰ In contrast, the remaining five states with less-detailed requirements either only require the provision of charity care or do not provide guidance on what counts as community benefit. For example, Alabama's requirement only provides that charity care must constitute at least 15 percent of a hospital's business in order for the hospital to be exempt from property tax; and

⁴⁶The 10 states with detailed requirements are California, Idaho, Illinois, Indiana, Maryland, New Hampshire, New York, Pennsylvania, Texas, and West Virginia.

⁴⁷The five states with less-detailed requirements are Alabama, Colorado, Mississippi, North Dakota, and Wyoming.

⁴⁸Cal. Health & Safety Code §§ 127350, 127355 (2008).

⁴⁹210 Ill. Comp. Stat. 76/15, 76/20 (2008).

⁵⁰Illinois defines community benefit to include the unreimbursed cost of providing charity care, language assistant services, government-sponsored indigent health care, donations, volunteer services, education, government-sponsored program services, research, subsidized health services, and collecting bad debts. Illinois' definition explicitly excludes the cost of paying taxes or other governmental assessments. Maryland defines community benefit as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including health services provided to vulnerable or underserved populations, such as Medicaid, Medicare, or Maryland Children's Health Program enrollees; financial or in-kind support of public health programs; donations of funds, property, or other resources that contribute to a community priority; health care cost containment activities; and health education, screening, and prevention services.

Wyoming's requirement does not specify which activities its nonprofit hospitals must provide, but makes clear that hospitals must provide benefit to the community to obtain or maintain tax-exempt status.

Differences in the Activities Nonprofit Hospitals Define as Community Benefit Substantially Affect the Amount of Community Benefits They Report

Variations in the activities nonprofit hospitals define as community benefit lead to substantial differences in the amount of community benefits they report. Among the government standards and industry guidance used by nonprofit hospitals, consensus exists to define many activities and their associated expenses—charity care, the unreimbursed cost of means-tested government programs, and many other activities that benefit the community—as community benefit. However, consensus does not exist to define bad debt and the unreimbursed cost of Medicare—each of which represents a substantial cost for nonprofit hospitals, according to the state data we analyzed—as community benefit.

Community Benefits May Include Charity Care, Bad Debt, Government Health Care Programs, and Other Activities That Benefit the Community

Activities that benefit the community and their associated expenses, as defined by the community benefit standards and guidance that nonprofit hospitals use, generally fall into one of four categories: charity care, care for patients whose accounts result in bad debt (referred to as bad debt for the rest of the report), care for beneficiaries of government health care programs and their associated unreimbursed costs, and other activities that benefit the community. In these standards and guidance, charity care is generally defined as care provided to patients whom the hospital deems unable to pay all or a portion of their bills. Bad debt is generally defined as the uncollectible payment that patients are expected to, but do not, pay. The unreimbursed cost of government health care programs is generally defined as the shortfall created when a facility receives total payments that are less than the total costs of caring for public program beneficiaries. Government health care programs include both means-tested programs for which eligibility is based on financial need, such as Medicaid, and non-means-tested programs for which eligibility is not based on financial need, such as Medicare. Lastly, other activities that benefit the community typically include activities that address a community need, and exclude activities that generate revenue for the hospital or are provided primarily for marketing purposes. These other activities generally fall into one of seven groups that the CHA and VHA guidance has identified, such as health professions education and medical research. Appendix II contains descriptions and examples of all seven groups.

While Consensus Exists to Define Charity Care as Community Benefit, Disagreement Exists over Bad Debt, Which Is a Substantial Cost for Nonprofit Hospitals

Consensus exists among the standards and guidance that nonprofit hospitals use to define charity care as community benefit. Specifically, among the five government and industry guidance documents we examined, four—IRS, AHA, CHA and VHA, and HFMA—define charity care as community benefit, as did all four state hospital associations we interviewed. While CMS does not have a position on community benefit, its reporting instrument collects information on uncompensated care and defines the term to include charity care.⁵¹ In addition, of the 15 states with community benefit requirements, 14 either explicitly define community benefit to include charity care or, in the absence of a definition, mention charity care as an example of community benefit.

However, consensus does not exist among the standards and guidance that nonprofit hospitals use to define bad debt as community benefit. Among the five government and industry guidance documents we examined, two—CHA and VHA, and HFMA—specify that bad debt should not be defined as community benefit. CHA and VHA state that hospitals have the responsibility to better identify patients eligible for charity care, and thus distinguish charity care from bad debt.⁵² Citing the difficulty of obtaining appropriate documentation to determine charity care eligibility, HFMA, while it does not define bad debt as community benefit, has stated that hospital charity care policies should address how to determine eligibility when patients do not provide sufficient information to formally

⁵¹CMS added this reporting instrument pursuant to section 112(b) of the BBRA, which does not use the term “community benefit,” but requires short stay, acute care hospitals to submit data on costs incurred by the hospital for providing services for which the hospital is not compensated, including non-Medicare bad debt, charity care, and charges for Medicaid and indigent care.

⁵²Making such charity care determinations is based in large part on information supplied by the patient or on the patient’s behalf in the form of documentation, such as federal tax returns, pay stubs, bank statements, etc. There are many reasons that hospitals may be unable to obtain the necessary documentation. For example, a hospital association official we spoke with stated that hospitals are required to treat and stabilize emergency patients before inquiring about the patients’ need for charity care, but patients may leave the hospital before hospital officials can speak to them about financial assistance. Other reasons include patient embarrassment or a lack of understanding of the hospital’s charity care policy.

make a determination.⁵³ In contrast, AHA defines bad debt as community benefit, as do three of the four state hospital associations we interviewed. AHA asserts that it should be defined as community benefit because the majority of bad debt is attributable to low-income patients who would qualify for charity care if hospitals were able to obtain the necessary documentation to formally make this determination.

IRS, on the other hand, has not taken a position on whether to define bad debt as community benefit (see table 2). The agency recognizes the divergence of practices and views in this area and, as stated by its officials, would like more information on the amount of bad debt attributable to low-income patients. As a result, IRS's community benefit reporting instrument—Form 990, Schedule H—will collect data on bad debt separately from the list of hospital activities that are traditionally included as community benefit, permit hospitals to explain why certain portions of bad debt should be defined as community benefit, and allow hospitals to estimate how much bad debt is attributable to low-income patients. CMS does not have a position on community benefit; however, its reporting instrument collects information on uncompensated care and defines the term to include bad debt. State community benefit requirements vary in whether they define bad debt as community benefit. Of the 15 states with community benefit requirements, 3 states explicitly include bad debt as community benefit, 2 states explicitly exclude bad debt, and 10 states do not specify.

⁵³Specifically, HFMA stated that hospitals may refer to external sources, such as credit reports, to help support charity care determinations. Some of the hospital and hospital association officials we spoke with are either using or exploring the possibility of using external sources, such as zip codes in conjunction with per-capita income data, credit reports, and migrant worker status, as proxies to make charity care eligibility determinations in the absence of patient-provided documentation. HFMA further stated that providers should make every effort to determine charity care eligibility before or at the time of service, but such determinations can also be made during a specific time period following patient care.

Table 2: Charity Care and Bad Debt as Community Benefit—Analysis of Selected Government Agency and Industry Group Standards and Guidance

	Charity care	Bad debt
Government agencies		
CMS	○ ^a	○ ^a
IRS	✓	○
Industry groups		
AHA	✓	✓
CHA/VHA	✓	x
HFMA	✓	x

Source: GAO analysis of government agency and industry group standards and guidance.

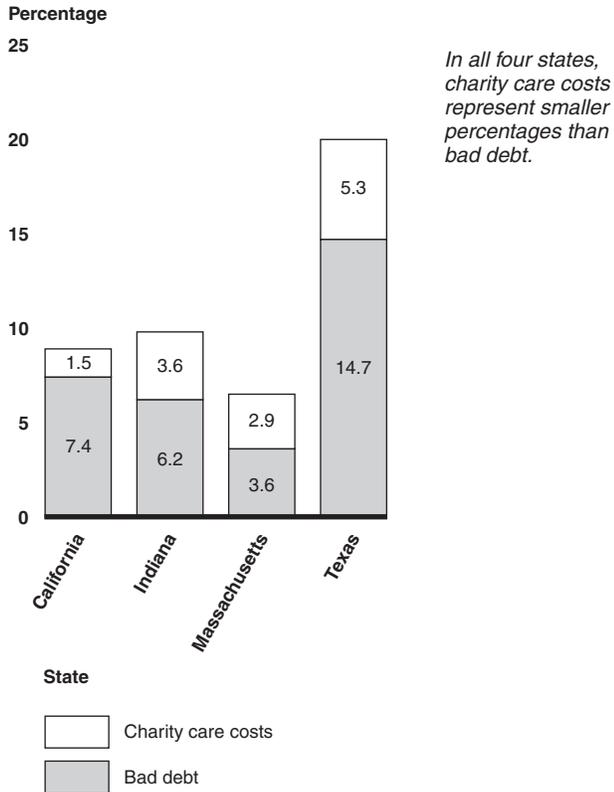
- ✓ Defined as community benefit
- x Defined as not community benefit
- No position on whether to define as community benefit

^aCMS does not have a position on community benefit; however, its reporting instrument collects information on uncompensated care and defines the term to include both charity care and bad debt.

Whether nonprofit hospitals define bad debt as community benefit has an important effect on the resulting amount of community benefit reported. Specifically, nearly all of the nonprofit hospitals in the four states we examined reported bad debt,⁵⁴ and the amounts were typically substantial when compared to charity care (see fig. 3). For example, in 2006 in California, the average percentage of total operating expenses devoted to bad debt was 7.4 percent—almost five times the average percentage devoted to charity care costs. Moreover, the amounts of hospitals’ bad debt varied widely across hospitals. For example, among nonprofit hospitals in Texas, which had the most variation, the middle 50 percent of hospitals reported bad debt ranging from 7.4 to 19.1 percent of total operating expenses in 2006. Among the middle 50 percent of nonprofit hospitals in Massachusetts, which had the least variation, the span was still notable with bad debt ranging from 2.2 to 4.6 percent of total operating expenses in 2006.

⁵⁴We did not reduce bad debt expenses to costs because we found that hospitals did not consistently report bad debt in costs or charges.

Figure 3: Average Percentage of Total Operating Expenses Devoted to Charity Care Costs and Bad Debt among Nonprofit Hospitals in Selected States, 2006



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals. Percentages are calculated only among those hospitals that reported having charity care costs and bad debt expenses. Ninety-six percent of hospitals in California, 81 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 100 percent of hospitals in Texas reported charity care costs. Ninety-nine percent of hospitals in California, 99 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 91 percent of hospitals in Texas reported bad debt.

While Consensus Exists to Define Means-Tested Programs, Such as Medicaid, as Community Benefit, the Unreimbursed Cost of Medicare, Which Is a Sizable Cost for Hospitals, Remains Contentious

Consensus exists among the standards and guidance nonprofit hospitals use to define the unreimbursed cost of means-tested government health care programs, such as Medicaid, as community benefit. Among the five government and industry guidance documents we examined, four—IRS, AHA, CHA and VHA, and HFMA—define the unreimbursed cost of such programs as community benefit, as did all four state hospital associations we interviewed. While CMS does not have a position on community benefit, its reporting instrument collects information on uncompensated care and includes the unreimbursed cost of such programs as a type of uncompensated care. In addition, state community benefit requirements generally include the unreimbursed cost of such programs as community benefit. Specifically, of the 15 states with community benefit requirements, 9 states explicitly include the unreimbursed cost of means-tested government health care programs as community benefit, none of the states explicitly exclude this cost, and 6 states do not specify.

Consensus does not, however, exist to define the unreimbursed cost of Medicare as community benefit. Among the five government agencies and industry groups we examined, only the CHA and VHA guidance specifies that the unreimbursed cost of Medicare should not be defined as community benefit because, among other reasons, Medicare losses for some hospitals may be associated with inefficiency and not underpayment.⁵⁵ CHA and VHA also note that all hospitals compete to attract Medicare beneficiaries, and CHA further stated that serving Medicare beneficiaries is not a differentiating feature of nonprofit hospitals.

In contrast, AHA defines the unreimbursed cost of Medicare as community benefit, and HFMA states that hospitals should decide, based on their circumstances, whether the unreimbursed cost of Medicare should be defined as community benefit.⁵⁶ AHA asserts that the unreimbursed cost of Medicare should be defined as community benefit because Medicare does not fully compensate hospitals for the cost of providing hospital care to Medicare beneficiaries. AHA also notes that Medicare, like Medicaid, serves a large number of low-income beneficiaries. HFMA states that the

⁵⁵CMS has stated that Medicare payments to hospitals under the prospective payment system cover the costs of an efficient provider.

⁵⁶HFMA states that hospitals that choose to define the unreimbursed cost of Medicare as community benefit should disclose that cost separately from charity care, accompanied by detail and context to help readers understand the reported cost.

unreimbursed cost of Medicare can be an important issue for many providers and that such losses can be material to the facility's financial status; therefore, each hospital should decide, based on its circumstances, whether to report these costs as community benefit. Similarly, all four state hospital associations we interviewed stated that they define the unreimbursed cost of Medicare as community benefit.

IRS has not taken a position on whether to define the unreimbursed cost of Medicare as community benefit (see table 3). Its officials have stated that, similar to IRS's position on bad debt, IRS's community benefit reporting instrument will collect revenue and cost information related to hospitals' Medicare beneficiaries separately from the list of hospital activities that are traditionally included as community benefit, and permit hospitals to explain why they believe all or a portion of these costs should be defined as community benefit. CMS, which does not have a position on community benefit, does not collect information on the unreimbursed cost of Medicare. State community benefit requirements vary in whether the unreimbursed cost of Medicare should be included as community benefit. Of the 15 states with community benefit requirements, 6 states explicitly include the unreimbursed cost of Medicare as community benefit,⁵⁷ none of the states explicitly exclude this cost, and 9 states do not specify.

⁵⁷Texas considers the unreimbursed cost of non-means-tested government health care programs, including Medicare, as community benefit.

Table 3: Government Health Care Programs as Community Benefit—Analysis of Selected Government Agency and Industry Group Standards and Guidance

	Unreimbursed cost of means-tested government health care programs, such as Medicaid	Unreimbursed cost of Medicare program
Government agencies		
CMS	○ ^a	○ ^a
IRS	✓	○
Industry groups		
AHA	✓	✓
CHA/VHA	✓	x
HFMA	✓	✓ ^b

Source: GAO analysis of government agency and industry group standards and guidance.

- ✓ Defined as community benefit
- x Defined as not community benefit
- No position on whether to define as community benefit

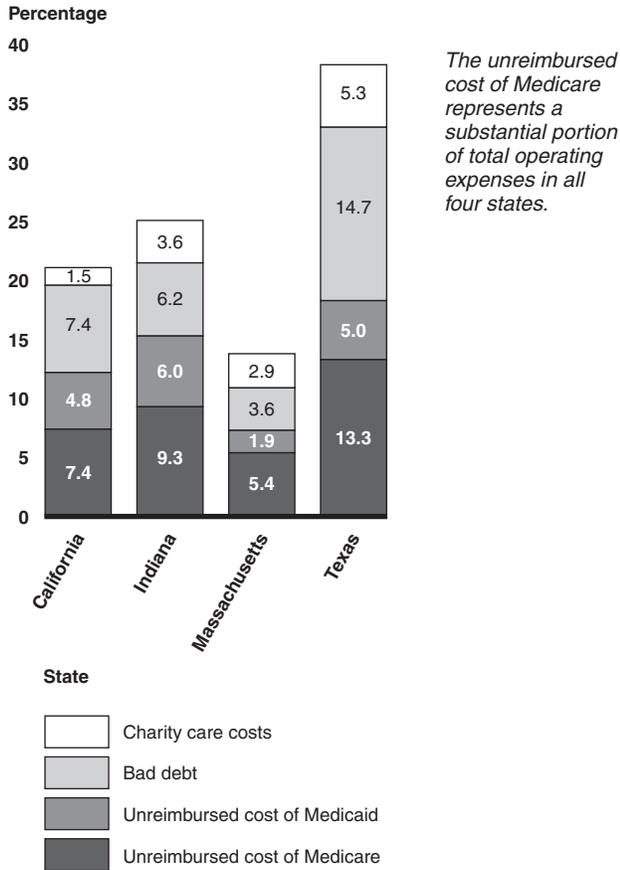
^aCMS does not have a position on community benefit; however, its reporting instrument collects information on uncompensated care and includes the unreimbursed cost of means-tested government health care programs, but not Medicare, as a type of uncompensated care.

^bHFMA asserts that hospitals should decide, based on their circumstances, whether the unreimbursed cost of Medicare should be defined as a community benefit.

Whether nonprofit hospitals define the unreimbursed cost of Medicare as community benefit has an important effect on the resulting amount of community benefit reported. Specifically, most of the nonprofit hospitals in the four states we examined—over 90 percent in Texas and over 80 percent in California, Indiana, and Massachusetts—reported having unreimbursed costs of Medicare, and the amounts were typically substantial compared to charity care costs and the unreimbursed cost of Medicaid (see fig. 4). For example, in all four states the unreimbursed cost of Medicare as a percentage of total operating expenses was at least 86 percent more than charity care costs as a percentage of the same expenses. Similarly, the unreimbursed cost of Medicare as a percentage of total operating expenses was at least 54 percent more than the unreimbursed cost of Medicaid as a percentage of the same expenses. Moreover, the amount of hospitals’ unreimbursed cost of Medicare varied widely across hospitals. For example, among nonprofit hospitals in Indiana, which had the most variation, the middle 50 percent of hospitals reported unreimbursed costs of Medicare ranging from 4.9 to 13.4 percent

of total operating expenses in 2006. Among the middle 50 percent of nonprofit hospitals in Massachusetts, which had the least variation, the span was still notable with unreimbursed costs of Medicare ranging from 2.4 to 8.0 percent of total operating expenses in 2006.

Figure 4: Average Percentages of Total Operating Expenses Devoted to Charity Care Costs, Bad Debt, and the Unreimbursed Costs of Medicaid and Medicare among Nonprofit Hospitals in Selected States, 2006



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals. Percentages are calculated only among those hospitals that reported having charity care costs, unreimbursed costs of Medicaid or Medicare, or bad debt expenses. Ninety-six percent of hospitals in California, 81 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 100 percent of hospitals in Texas reported charity care costs. Ninety-nine percent of hospitals in California, 99 percent of hospitals in Indiana, 97 percent of hospitals in Massachusetts, and 91 percent of hospitals in Texas reported bad debt. Eighty-one percent of hospitals in California, 88 percent of hospitals in Indiana, 89 percent of hospitals in Massachusetts, and 87 percent of hospitals in Texas reported unreimbursed costs of Medicaid. Eighty-four percent of hospitals in California, 83 percent of hospitals in Indiana, 81 percent of hospitals in Massachusetts, and 93 percent of hospitals in Texas reported unreimbursed costs of Medicare.

Consensus Exists to Define Most Other Activities That Benefit the Community as Community Benefit

Consensus exists among the standards and guidance nonprofit hospitals use to define six of the seven groups of other activities as community benefit: cash and in-kind contributions,⁵⁸ community benefit operations,⁵⁹ community health improvement services,⁶⁰ health professions education,⁶¹ medical research,⁶² and subsidized health services.⁶³ State community benefit requirements on these activities vary. For example, 13 of the 15 states with community benefit requirements cite additional activities—other than charity care, bad debt, or government health care programs—as community benefit. For these states, the most commonly cited type of activity appears to be subsidized health services, although the exact term used varies among the states.

In contrast, consensus does not exist to define the seventh group of activities—community-building activities—as community benefit.⁶⁴ AHA, CHA and VHA, and HFMA define community-building activities as community benefit because these activities provide opportunities to address the underlying causes of health problems, such as poverty, homelessness, and environmental problems. IRS, however, has not taken a position on whether to define community-building activities, which include activities such as physical improvements and housing programs, economic development, and environmental improvements, as community benefit. The agency recognizes that there appears to be widespread support for including these activities, and while the agency believes that certain of these activities might constitute community benefit, more data

⁵⁸Cash and in-kind contributions to others include cash donations, grants, and in-kind donations made to individuals or the community at large.

⁵⁹Community benefit operations include dedicated staff, community health needs assessments, and other resources.

⁶⁰Community health improvement services include programs for community health education, community-based clinical services, and health care support services.

⁶¹Health professions education includes education for physicians, medical students, nurses, nursing students, and other health professionals, and scholarships and funding for professional education.

⁶²Medical research includes both clinical and community health research.

⁶³Subsidized health services are clinical services provided at a financial loss and subsidized by the hospital; common examples include emergency and trauma services, and burn units.

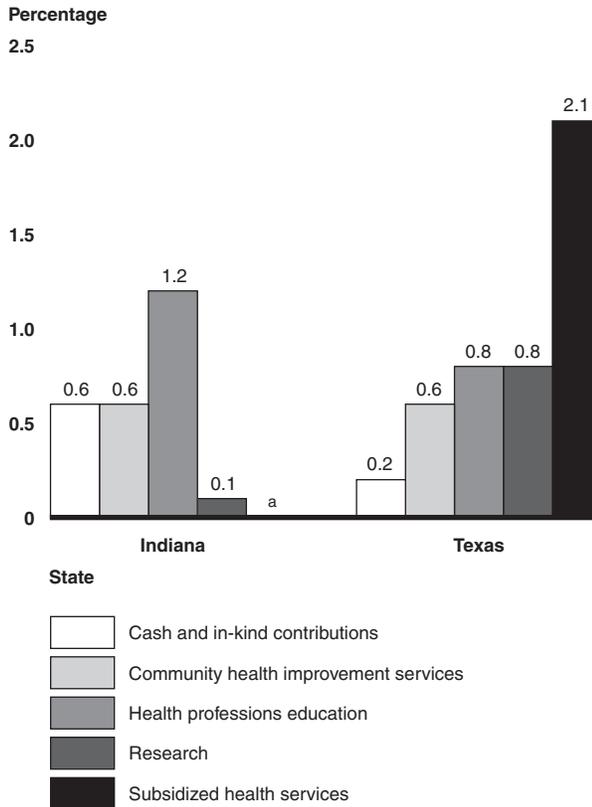
⁶⁴Community-building activities include physical improvements and housing programs, economic development, community support, environmental improvements, leadership development and leadership training for community members, coalition building, community health improvement advocacy, and workforce development.

and study are required. CMS also does not comment on what other activities should be defined as community benefit.

While data are not available to evaluate the effect of defining community-building activities as community benefit, data on groups of other activities that benefit the community indicate that they represent a relatively small proportion of total operating expenses for hospitals.⁶⁵ Only two of the four states we examined—Indiana and Texas—collect data on other activities that benefit the community, though even these states do not collect any data on two of the seven categories of other activities that benefit the community. For the five groups of other activities with data, fewer hospitals in Indiana and Texas generally reported having unreimbursed costs for these activities when compared with other types of community benefits, such as charity care, and the unreimbursed costs of most activities account for less than 1 percent each of total operating expenses, on average (see fig. 5). For example, more hospitals in these two states reported having unreimbursed costs for community health improvement services than for the other four groups—over two-thirds of Indiana nonprofit hospitals and almost three-quarters of Texas nonprofit hospitals reported having these costs. Among Texas and Indiana nonprofit hospitals, the unreimbursed costs of these services averaged only 0.6 percent in 2006. In contrast, few hospitals reported having unreimbursed costs for medical research—less than 15 percent of nonprofit hospitals in both states reported these costs. Among Indiana nonprofit hospitals reporting these costs, the unreimbursed costs of medical research averaged only 0.1 percent of total operating expenses in 2006. In Texas, however, these costs averaged 0.8 percent, and the top quarter of hospitals had unreimbursed costs at least twice the average—at 1.7 percent in 2006.

⁶⁵ Although there is consensus to include community benefit operations as community benefit, data are also not available to evaluate the cost associated with this activity compared to other community benefits.

Figure 5: Average Percentages of Total Operating Expenses Devoted to the Unreimbursed Costs of Other Activities That Benefit the Community among Nonprofit Hospitals in Selected States, 2006



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

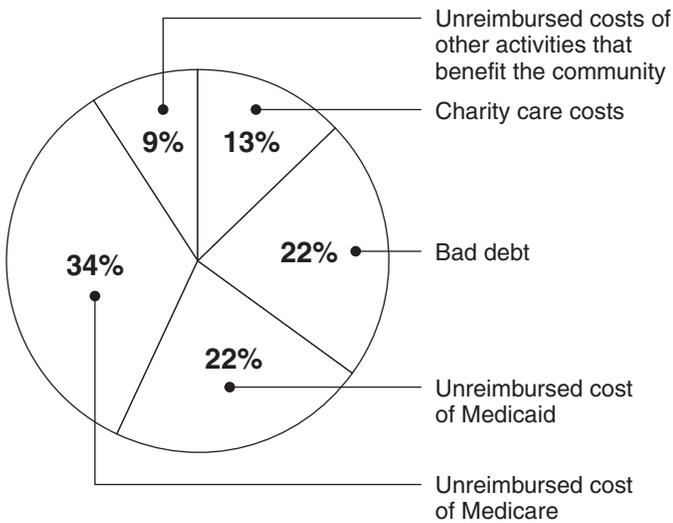
Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals that reported these other activities. We did not include California and Massachusetts because they do not collect data on these activities. Percentages are calculated only among those hospitals that reported having unreimbursed costs of that activity. Cash and in-kind contributions to others include cash donations, grants, and in-kind donations made to individuals or the community at large. Community health improvement services include programs for community health education, community-based clinical services, and health care support services. Health professions education includes education for physicians, medical students, nurses, nursing students, and other health professionals, and scholarships and funding for professional education. Medical research includes both clinical and community-health research. Subsidized health services are clinical services provided despite a financial loss and subsidized by the hospital; examples include emergency services and burn units. Fifty percent of Texas hospitals reported unreimbursed costs of subsidized health services; Indiana does not collect data on these costs. Sixty-nine percent of Indiana hospitals and 75 percent of Texas hospitals reported unreimbursed costs of community health improvement services Fifty-four percent of Indiana hospitals and 60 percent of Texas hospitals reported unreimbursed costs of cash and in-kind contributions. Thirteen percent of Indiana hospitals and 9 percent of Texas hospitals reported unreimbursed costs of research. Fifty percent of Indiana hospitals and 58 percent of Texas hospitals reported unreimbursed costs of health professions education.

^aIndiana does not collect data on subsidized health services.

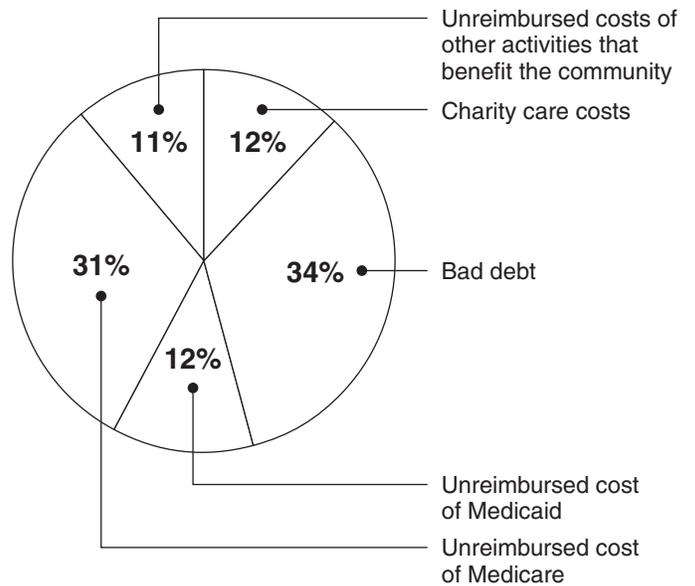
In addition to representing a small proportion of total operating expenses, the costs of other activities that benefit the community are generally smaller than the costs of other types of activities that benefit the community, such as charity care, bad debt, and the unreimbursed costs of Medicaid and Medicare (see fig. 6). For example, among nonprofit hospitals in Texas that incurred costs for providing other community benefits, the average cost of these activities—at 11 percent—is the smallest of the different groups of community benefits.

Figure 6: Charity Care Costs, Bad Debt, Unreimbursed Cost of Medicaid and Medicare, and Other Activities That Benefit the Community as Percentages of Their Sum among Nonprofit Hospitals in Selected States, 2006

Indiana



Texas



Source: GAO analysis of 2006 Indiana and Texas data.

Notes: Nonprofit hospitals include nongovernmental, acute care, general hospitals. We did not include California and Massachusetts because they do not collect data on other activities that benefit the community. Percentages are calculated only among those hospitals that reported having charity care costs; unreimbursed costs of Medicaid, Medicare, or other activities that benefit the community; or bad debt expenses. Other activities that benefit the community include cash and in-kind contributions to others, community health improvement services, health professions education, medical research, and subsidized health services. Eighty-one percent of hospitals in Indiana and 100 percent of hospitals in Texas reported charity care costs. Ninety-nine percent of hospitals in Indiana and 91 percent of hospitals in Texas reported bad debt. Eighty-eight percent of hospitals in Indiana and 87 percent of hospitals in Texas reported unreimbursed costs of Medicaid. Eighty-three percent of hospitals in Indiana and 93 percent of hospitals in Texas reported unreimbursed costs of Medicare. Fifty percent of Texas hospitals reported unreimbursed costs of subsidized health services; Indiana does not collect data on these costs. Sixty-nine percent of Indiana hospitals and 75 percent of Texas hospitals reported unreimbursed costs of community health improvement services. Fifty-four percent of Indiana hospitals and 60 percent of Texas hospitals reported unreimbursed costs of cash and in-kind contributions. Thirteen percent of Indiana hospitals and 9 percent of Texas hospitals reported unreimbursed costs of research. Fifty percent of Indiana hospitals and 58 percent of Texas hospitals reported unreimbursed costs of health professions education.

Differences in How Nonprofit Hospitals Measure Costs of Community Benefit Activities Can Affect the Amount of Community Benefits They Report

Nonprofit hospitals may use a variety of practices to measure the costs of community benefit activities, and differences in these practices can affect the amount of community benefits they report. For example, standards and guidance used by nonprofit hospitals specify a variety of levels at which hospitals can report their community benefit. Specifically, IRS requires hospitals to report community benefit on Form 990 by employer identification number (EIN) because tax exemption is determined by EIN.⁶⁶ An EIN may cover a single hospital, several hospitals, or other aggregates. In contrast, CMS requires hospitals to submit cost reports, which include Worksheet S-10 with data on uncompensated care, at an individual hospital level. Industry stakeholders, such as AHA and CHA, have stated that hospitals should have the choice to report community benefits on a health care system level or as individual hospitals. CHA has stated that hospitals should have this option because, for example, they may also have established foundations or free health clinics as separate taxable entities through which they provide community benefit; hospitals should therefore have the option to include this community benefit in their reports. HFMA does not specify the level at which hospitals should report community benefit. The percentage of expenses devoted to community benefit could differ for hospitals that belong to a system depending on whether they reported at a system or individual level, because reporting at a system level aggregates the percentages of each hospital. One official from a state hospital association noted that because individual hospital percentages would be aggregated when community benefits are reported at a system level, there is a potential for a health care system as a whole, and not necessarily each individual hospital, to meet a community benefit standard.

Data are not available that would allow us to evaluate the impact of differences in the level at which nonprofit hospitals report community benefit. IRS's forthcoming Form 990, Schedule H, which will collect community benefit data, will be of limited use for comparing individual hospitals' reported community benefits because, as noted, hospitals may report community benefit as a single hospital or a larger aggregate, such as a health care system. CMS's Worksheet S-10 collects data on an individual hospital level, but we have found the data to be unreliable. MedPAC has stated that Worksheet S-10 should be improved, calling specifically for

⁶⁶An EIN is an identification number used by IRS in the administration of tax laws.

differentiating charity care and bad debt.⁶⁷⁻⁶⁸ Although Worksheet S-10 could yield reliable data in the future, it does not currently collect data on all the activities IRS includes as community benefit, such as medical research or subsidized health services.

Standards and guidance used by nonprofit hospitals also differ in how they instruct hospitals to estimate costs of community benefit activities. Specifically, CHA and VHA and HFMA advocate calculating costs, if possible, using a cost-accounting system.⁶⁹ However, one state hospital association we spoke with stated that smaller hospitals may not be able to use this method. In contrast, CMS instructs hospitals to estimate costs on Worksheet S-10 using a cost-to-charge ratio (CCR).⁷⁰ CHA and VHA also suggest using a CCR when a cost-accounting system cannot be used. There are, however, many methods of calculating a CCR; CMS and CHA and VHA specify how hospitals should calculate the CCR used to determine charity care costs, but their formulas differ. AHA does not specify how to estimate costs, but supports the CHA and VHA guidance. IRS instructs hospitals to use a cost-accounting system, a CCR, or another cost-accounting method, whichever is most accurate in estimating costs. Data are not available that would allow us to evaluate the impact of the different practices hospitals use to estimate costs on the amount of reported community benefit.

In addition to the different practices on reporting levels and methodologies for estimating costs, which affect every aspect of reported community benefit, standards and guidance used by nonprofit hospitals also specify a variety of practices to measure the costs of charity care, government health care programs, and other activities that benefit the community, which can lead to inconsistent reporting of these activities.

⁶⁷Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C., 2007).

⁶⁸MedPAC has been consulting with CMS to revise Worksheet S-10 and the accompanying instructions.

⁶⁹A cost-accounting system is a continuous and systematic process designed to accumulate and assign costs routinely or as desired by management.

⁷⁰CCRs are ratios applied to charges in order to estimate costs, which are used in Medicare.

Measurement Practices for Charity Care

Consensus does not exist on whether to add to charity care costs a nonprofit hospital's contributions to uncompensated care pools or programs,⁷¹ or whether to offset charity care costs by payments to hospitals from uncompensated care pools or programs. AHA and CHA and VHA instruct hospitals to add their contributions and subtract the payments they receive to calculate charity care costs, but CMS and HFMA do not.⁷² IRS instructs hospitals to account for revenue from uncompensated care pools or programs as offsetting either charity care costs, the unreimbursed cost of Medicaid, or both, depending on the state's primary purpose for the revenue. If the state's primary purpose is unclear, IRS instructs hospitals to allocate portions of the revenue as offsetting either charity care costs or the unreimbursed cost of Medicaid, based on a reasonable estimate of the portions that are intended for charity care and Medicaid.

Differences in how nonprofit hospitals calculate charity care costs can have an important effect on the resulting amount of community benefit a hospital reports. For nonprofit hospitals in Massachusetts in 2006,⁷³ the average percentage of total operating expenses devoted to charity care would increase from 2.9 to 3.9 percent—a 34 percent increase—if hospital contributions to uncompensated care pools were added to charity care costs. If payments Massachusetts hospitals receive from uncompensated care pools are then subtracted from the sum, the average percentage of total operating expenses devoted to charity care would decrease from 3.9 to 1.8 percent, a 54 percent reduction.

⁷¹Uncompensated care pools are a financing mechanism to redistribute, within a state, hospitals' financial burdens of caring for patients who do not have the ability to pay. Uncompensated care programs can include, for example, programs outside the hospital that provide health care services to financially indigent patients.

⁷²HFMA specifies that while hospitals should not subtract payments from uncompensated care pools from charity care costs, these payments should be separately disclosed if they are of sufficient size. HFMA does not specify how hospitals should treat their contributions to uncompensated care pools.

⁷³California, Indiana, and Texas state data did not have data on both contributions to and payments from uncompensated pools or programs. The uncompensated care pool in Massachusetts is primarily funded by an assessment on hospitals, a surcharge on insurers, and an annual appropriation from the general fund.

Measurement Practices for Government Health Care Programs

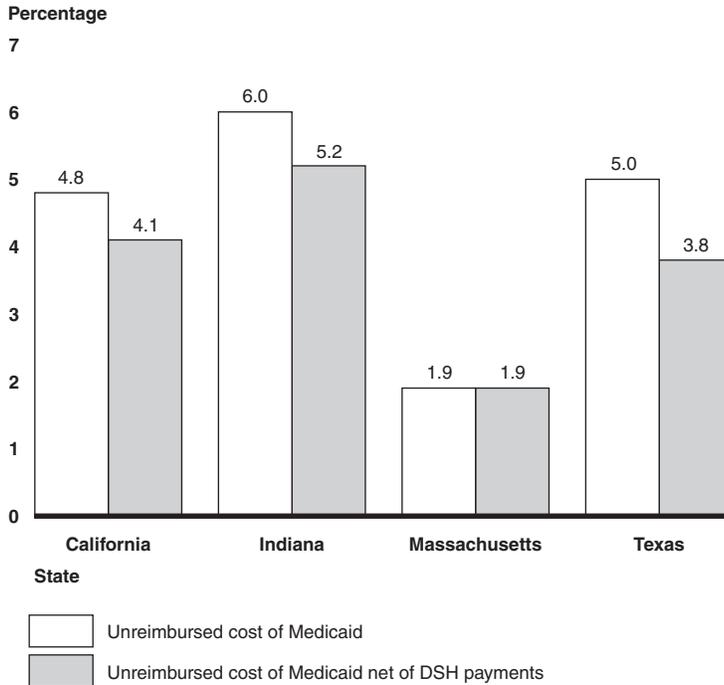
Consensus does not exist on how nonprofit hospitals are instructed to offset community benefit costs by Medicaid disproportionate share hospital (DSH) payments.⁷⁴ CHA and VHA specify that hospitals can account for these payments as offsetting either charity care costs or the unreimbursed cost of Medicaid. IRS instructs hospitals to account for Medicaid DSH payments as offsetting either charity care costs, the unreimbursed cost of Medicaid, or both depending on the state's primary purpose for the payment. If the state's primary purpose is unclear, IRS instructs hospitals to allocate portions of the payments as offsetting either charity care costs or the unreimbursed cost of Medicaid based on a reasonable estimate of the portions that are intended for charity care and Medicaid. CMS does not specify whether these payments should offset any specific costs. AHA and HFMA do not specify whether to include these payments, but support the CHA and VHA guidance.

Differences in how nonprofit hospitals calculate the unreimbursed cost of Medicaid can have an effect on the resulting amount of community benefit a hospital reports (see fig. 7). For example, in Texas, the unreimbursed cost of Medicaid (5.0 percent of total operating expenses) is 32 percent more than the unreimbursed cost of Medicaid net of DSH payments (3.8 percent of total operating expenses). In Massachusetts, however, the unreimbursed cost of Medicaid is the same as the unreimbursed cost of Medicaid net of DSH payments—1.9 percent of total operating expenses.⁷⁵

⁷⁴DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients.

⁷⁵The percentages remain the same because only four nonprofit hospitals reported Medicaid DSH payments in the Massachusetts state data and the amount these hospitals reported was small in comparison to the amount of unreimbursed cost of Medicaid.

Figure 7: Average Percentages of Total Operating Expenses Devoted to the Unreimbursed Cost of Medicaid and to the Unreimbursed Cost of Medicaid Net of DSH Payments among Nonprofit Hospitals in Selected States, 2006



Source: GAO analysis of 2006 California, Indiana, Massachusetts, and Texas data.

Notes: Nonprofit hospitals include nongovernmental, acute-care, general hospitals. Medicaid provides health care coverage to eligible low-income people and is jointly financed by the federal government and the states. DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Average unreimbursed costs of Medicaid are calculated only among those hospitals that reported having unreimbursed costs of Medicaid: 81 percent of hospitals in California, 89 percent of hospitals in Indiana, 89 percent of hospitals in Massachusetts, and 87 percent of hospitals in Texas.

Moreover, consensus does not exist on whether nonprofit hospitals should add provider taxes, which are used to match funds for federal Medicaid resources, to the unreimbursed cost of Medicaid.⁷⁶ CHA and VHA instruct hospitals to include “Medicaid taxes” as a cost of Medicaid, describing

⁷⁶States may receive federal matching funds for provider taxes only if such fees are broad-based (that is, imposed on all items or services in the class of services or providers thereof); uniformly imposed (that is, all items or services in the class or providers thereof pay the same rate of tax); and do not result in any taxpayers being held harmless (that is, receiving state funds to reduce the net payment to the state to below the amount of the tax). 42 U.S.C. § 1396b(w)(3), (6) (2000).

these taxes as the provider fees that are used to match federal funds. In contrast, IRS instructs hospitals to account for these taxes as an element of charity care costs, the unreimbursed cost of Medicaid, or both, depending on the state's primary purpose for payments to hospitals from an uncompensated care pool or Medicaid DSH program. HFMA officials stated that provider taxes for Medicaid should be defined as community benefit because they are assessed for a means-tested program. CMS does not specify whether to include these taxes. AHA does not specify whether to include these taxes either, but supports the CHA and VHA guidelines. State data we obtained did not contain information that would allow us to analyze the impact of including these taxes as part of the unreimbursed cost of Medicaid.

Measurement Practices for Other Activities That Benefit the Community

While consensus exists to define most other activities as community benefit, the calculation of their costs using differing or nonexistent instructions may foster inconsistency. For example, the unreimbursed costs of subsidized health services may overlap with other reported community benefits. To account for this overlap, IRS, CHA and VHA, and HFMA specify that when reporting subsidized health services costs, hospitals should subtract the portion already counted as part of charity care costs and the unreimbursed costs of Medicaid. AHA does not specify whether these costs should be subtracted, but supports the CHA and VHA guidelines. CMS does not state which other activities it considers community benefit and therefore does not have guidance on measuring their costs. State data we obtained did not contain information that would allow us to analyze the effect of this overlap for measuring the cost of subsidized health services.

Concluding Observations

Since we last reported on the provision of uncompensated care by hospitals in 2005, both policymakers and the hospital industry have devoted considerable time and effort to the issue of community benefit. In particular, distinguishing between charity care and bad debt—two expenses that have historically been considered together as uncompensated care due to the difficulty of obtaining documentation necessary to distinguish patients unable to pay from those unwilling to pay—has emerged as a key technical issue whose resolution will go far in harmonizing positions in the policy debate.

With the added attention to community benefit has come a growing realization of the extent of variability among stakeholders in what should count and how to measure it. At the national level, in particular, there is

substantial divergence of opinion on whether hospitals should be permitted to include bad debt and the unreimbursed cost of Medicare as community benefit. States vary considerably in the extent to which they have community benefit requirements, the nature of the requirements, and instructions on how to measure the components of community benefit. At present, determination and measurement of activities as community benefit for federal purposes are still largely matters of individual hospital discretion.

Given the large number of uninsured individuals, and the critical role of hospitals in caring for them, it is important that federal and state policymakers and industry groups continue their discussion addressing the variability in defining and measuring community benefit activities. An encouraging prospect for the future is the potential availability of two national data sources derived from mandatory reporting to IRS and CMS. National data should be helpful in standardizing reporting on community benefit activities and informing public policy on the community benefit standard. However, the data from these two sources will not be available for analysis for several years, and it remains to be seen whether the data will be consistent and reliable.

Agency Comments and Our Evaluation

CMS and IRS reviewed a draft of this report. CMS stated that it did not have any comments. The director of the Exempt Organizations Division of IRS provided us with oral comments, which are summarized below. IRS stated that the report in general was accurate, although the agency noted that it did not review GAO's analysis of state community benefit requirements for accuracy.

IRS Comments

IRS stated that the phrase "broad latitude to determine community benefit" overstates the looseness of the IRS standard and that such formulation is not supported by case law or published guidance. Specifically, IRS stated that the fact that hospitals may in practice exercise broad latitude does not make that the accepted IRS standard. In addition, IRS stated that the 1969 revenue ruling lists a specific set of factors, and court cases have closely followed the set of factors listed in that ruling. IRS stated that a correct characterization would be "some latitude" or "some flexibility," citing *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210, 1217 (3rd Cir. 1993). We believe that because the standard affords considerable discretion to hospitals in both the determination and measurement of activities that demonstrate community benefit for federal

purposes, the IRS standard allows nonprofit hospitals broad latitude to determine community benefit.

IRS commented that in the concluding observations section, the phrase “at present, determination and measurement of activities as community benefit for federal purposes are still largely matters of individual hospital discretion” was unclear as to whether the statement that follows “at present” refers to the state of things before or after IRS released the new Schedule H. IRS further stated that while in the years prior to IRS’s Form 990, Schedule H, the determination and measurement of community benefit was largely a matter of individual hospital discretion, the new Schedule H provides clear standards. Specifically these clear standards cover (1) the types of activities reportable or not reportable as community benefit; (2) the fact that community benefit must be reported at cost rather than charges or otherwise; (3) the fact that community benefit must be reported by EIN (not by hospital or by system); and (4) the fact that bad debt, the unreimbursed cost of Medicare, and community-building activities cannot be included in the Part I quantifiable community benefit table, although they are reported elsewhere on Schedule H and IRS allows hospitals to explain what they think should count as community benefit. IRS stated that, going forward with Schedule H reporting requirements, there will be very little or no discretion regarding these measurement points. IRS further stated that the area where Schedule H provides individual organizations discretion is in whether the organization estimates the cost of community benefit activities using a CCR, a cost-accounting system, or a blend, so long as it is the most accurate information the organization has available. We believe that while Schedule H provides guidance with respect to the types of activities reportable as community benefit, it does not provide clear guidance on whether these activities do or do not count as community benefit for purposes of complying with IRS’s community benefit standard. Schedule H indicates that bad debt, the unreimbursed cost of Medicare, and community-building activities cannot be included in the Part I quantifiable community benefit table; however, IRS has not clearly indicated whether it considers these items as counting toward meeting the community benefit requirement.

IRS noted that because its Form 990, Schedule H, requires reporting of bad debt and the unreimbursed cost of Medicare separately from items identified as community benefit, it is misleading to include these two items in the list along with charity care following the phrase “activities that benefit the community” because the phrase sounds like “community benefit,” and Schedule H does not treat these items on par with Part I community benefit items such as charity care or unreimbursed cost of Medicaid. We agree with IRS’s concern and have modified our text to clarify this distinction.

IRS stated that it would be an overstatement of the law to say uncategorically that a hospital need not meet all five factors to qualify for tax-exempt status.⁷⁷ IRS suggested that “the determination is based on all the facts and circumstances, and the absence of a particular factor may not necessarily be determinative,” and cited the 1969 revenue ruling and *IHC Health Plans, Inc. v. Comm’r*, 325 F.3d 1188 (10th Cir. 2003). We agree with IRS’s concern and have modified our text accordingly.

IRS also provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At the time, we will send copies to the Acting Administrator of CMS, the Commissioner of Internal Revenue, and interested congressional committees. We will also provide copies to others on request. The report is also available at no charge on GAO’s Web site at <http://www.gao.gov>.

⁷⁷These five factors are (1) the operation of an emergency room open to all members of the community without regard to ability to pay; (2) a governance board composed of community members; (3) the use of surplus revenue for facilities improvement, patient care, and medical training, education, and research; (4) the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid; and (5) an open medical staff with privileges available to all qualifying physicians.

If you or your staff have any questions, please contact me at (202) 512-7114 or steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VIII.

Sincerely yours,

A handwritten signature in black ink that reads "A. Bruce Steinwald". The signature is written in a cursive style with a large, stylized initial "A" and a long, sweeping underline.

A. Bruce Steinwald
Director, Health Care

Appendix I: Scope and Methodology

In conducting this study, we examined codified federal and state statutes and regulations. In addition, we analyzed state data on community benefits from California, Massachusetts, Indiana, and Texas. We selected these four states because they represent diverse areas geographically, and they collect data on nonprofit hospitals' community benefits, which not all states maintain.¹ We interviewed officials from the Internal Revenue Service (IRS) and the Centers for Medicare & Medicaid Services (CMS). We also interviewed representatives from the American Hospital Association (AHA); Association of American Medical Colleges; Catholic Health Association of the United States (CHA); Federation of American Hospitals; Healthcare Financial Management Association (HFMA); National Association of Children's Hospitals; VHA, Inc.; and state hospital associations and state health officials from California, Indiana, Massachusetts, and Texas. In addition, we interviewed representatives from seven nonprofit health care systems,² including health care systems in each of the four analyzed states that were referred to us by representatives from the state hospital associations.

To determine the community benefit standards IRS has established, we examined relevant provisions of the Internal Revenue Code, IRS regulations, revenue rulings, and federal case law. To review states' community benefit requirements, we defined "community benefit requirement" as a legal standard that expressly obligates a hospital to provide health care services or benefits to the community served by the hospital as a condition of maintaining tax-exempt status or qualifying as a nonprofit hospital. It is generally something that hospitals are required to do beyond their role of providing care for the sick and injured in exchange for remuneration or compensation. We considered the requirement to be one applicable to hospitals only if it either expressly referred to hospitals or expressly referred to care or services of the nature and type that one would reasonably expect to be provided by or performed primarily at acute care hospitals. We also limited our research concerning community benefit requirements to acute care, general hospitals. We looked only for codified state statutes and regulations that impose this type of requirement. If a statute or regulation described an activity that would fall into one of the commonly recognized "community benefit" categories identified by IRS, we considered it to present a community benefit activity.

¹Reliable, hospital-specific, nationwide data were not available.

²For purposes of this report, we refer to the nonprofit health systems, hospital systems, and health care systems we interviewed as "health care system."

We searched only for state statutes or regulations that require hospitals to perform relevant activities in order to maintain tax exemption or nonprofit status.³ Thus, we excluded statutes and regulations that require hospitals to perform activities that benefit the community as a condition of obtaining hospital licensure, or that have the indirect effect of benefiting the community, such as state analogues to the Emergency Medical Treatment and Active Labor Act⁴ and state vaccination provisions. We excluded standards that are very general, such as Hawaii's requirement that hospitals be "maintained to serve, and...do serve the public" in order to be exempt from property tax, although we did include requirements that specified that nonprofit hospitals do more than provide health care in exchange for compensation or remuneration. An example of the latter is Wyoming, which provides that "[t]he fundamental basis for [exemption from ad valorem taxation] is the benefit conferred upon the public by schools, orphan asylums and hospitals, and the consequent relief, to some extent, of the burden upon the state to educate, care and advance the interests of its citizens."

We limited our search to codified state statutes and regulations. In performing our search of state codes and regulations, we used some search terms, namely "community benefit," "charity care," "gift to the community," and "community service plan," but we did not limit our list of states with community benefit requirements to states that use only these terms. We then searched selected parts of state codes and administrative codes, limiting our search to the subject areas of hospitals, public health, tax, and corporations, to find community benefit requirements that do not use readily searchable terms. If we found one provision in a state code or regulation that imposed a community benefit requirement, we did not continue searching that state's authorities for additional or related provisions. Some state codes and regulations provided penalties for failing to comply with community benefit requirements. We noted penalty provisions only if the penalty provision made a direct and express reference to failure to comply with the community benefit requirement as the basis for the penalty.

³Examples of provisions that we excluded using this criterion include vaccination mandates and newborn screening requirements.

⁴42 U.S.C. § 1395dd (2000).

We did not include in our scope state statutes and regulations that address community benefits but do not amount to requirements. These states include those whose statutes explicitly state that having a community benefits program is voluntary (Connecticut⁵) and those that require that hospitals report on the community benefits that they provide but do not actually require that they provide any community benefits (Connecticut,⁶ Georgia,⁷ Minnesota,⁸ Nevada,⁹ and Oregon¹⁰). Although we did not include these states in our count, we noted them in the report.

Due to our selection criteria, we included some states that organizations such as CHA, VHA, and Community Catalyst do not list in their compendia of states with community benefit laws, guidelines, and standards, and excluded some states that those organizations do include. We chose to use a broader definition of community benefit requirement, one that encompasses state statutes and regulations that may not use common community benefit terms, but nonetheless encompasses the same goals and types of activities as states that do use those terms. This reasoning led us to include Alabama, Colorado, Mississippi, North Dakota, and Wyoming.

We excluded provisions dealing with hospital conversions, mergers, or sales. These provisions often require that hospitals going through one of these processes take steps to ensure that levels of community benefits are maintained or safeguarded. We feel that such provisions should not be included in a general compendium of state community benefit requirements.¹¹ This means that we excluded some provisions that actually use the term “community benefit” and may even provide a detailed definition. We did this because such provisions apply in a limited context. They apply only to a limited number of hospitals (those that are going

⁵Conn. Gen. Stat. Ann. § 19a-127k(a), (c) (West 2008).

⁶Conn. Gen. Stat. Ann. § 19a-127k(b) (West 2008).

⁷Ga. Code Ann. § 14-3-305(d) (2008).

⁸Minn. Stat. Ann. § 144.698, .699 (West 2008).

⁹Nev. Rev. Stat. 449.490(3)(b) (2008).

¹⁰2007 Or. Laws 3290.

¹¹This position is shared by Community Catalyst in developing its compendium of state community benefit requirements. See Community Catalyst, *Health Care Community Benefits: A Compendium of State Laws* (Boston, 2007).

through conversion, merger, or sale), and they apply for a limited amount of time.

We excluded provisions granting tax exemption by merely incorporating by reference the standard contained in section 501(c)(3) of the Internal Revenue Code and provisions that used section 501(c)(3)-like language restricting nonprofit hospital activities. However, we did include provisions that by their language incorporated the 501(c)(3) standard and had a reporting requirement. An example of the latter is Idaho, which grants property tax exemption only to hospitals that have received tax exemption from IRS pursuant to section 501(c)(3).¹² In addition, Idaho hospitals granted tax exemption must annually submit a community benefits report.¹³ An example of the former is Arizona, which grants tax exemption to organizations that are exempt from federal income tax.¹⁴

To examine what activities are defined as community benefits among the standards and guidance used by nonprofit hospitals, we reviewed the standards and guidance of federal agencies and industry groups.¹⁵ To examine the effects of these standards and guidance on reported community benefit, we analyzed 2006 state data from California, Indiana, Massachusetts, and Texas. The state data were the most recent available at the time of our analysis. We limited our analysis to nonprofit, nongovernmental, acute care, general hospitals that reported gross patient revenues and total operating expenses. We calculated and compared a variety of hospital expenses, including charity care costs, bad debt, unreimbursed costs of government health care programs, and the costs of other activities that benefit the community, as percentages of total operating expenses. Charity care is generally defined as care provided to patients who the hospital deems unable to pay all or a portion of their bills. Bad debt is generally defined as the uncollectible payment that the patient is expected to, but does not, pay. The unreimbursed costs of government health care programs are generally defined as the shortfall created when a facility receives payments that are less than the costs of caring for public program beneficiaries. Other activities that benefit the

¹²Idaho Code § 63-602D(4) (Michie 2008).

¹³Idaho Code § 63-602D(7) (Michie 2008).

¹⁴Ariz. Rev. Stat. § 43-1201 (2008).

¹⁵We examined IRS's final version of the Form 990, which was pending the Office of Management and Budget's approval at the time this report was issued.

community include health professions education and medical research. Not all of the four states we examined had data on all of these expenses; therefore, we calculated each expense as a percentage of total operating expenses whenever possible. We reduced charges to costs where possible in the data from all four states using cost-to-charge ratios. We did not reduce bad debt expenses because we found that hospitals did not consistently report bad debt in costs or charges.

To examine practices nonprofit hospitals use to measure community benefit activities, we reviewed the standards and guidance from IRS, CMS, AHA, CHA and VHA, and HFMA. To examine the effects of these practices on reported community benefit, we analyzed 2006 state data from California, Indiana, Massachusetts, and Texas. We compared the different ways hospitals calculate expenses, including charity care costs and the unreimbursed cost of Medicaid,¹⁶ as percentages of total operating expenses. Not all of the four states had data to compare the different practices to measure all of these expenses; therefore, we calculated each expense as a percentage of total operating expenses whenever possible.

We assessed the reliability of the state data from California, Indiana, Massachusetts, and Texas in two ways. First, we performed tests of data elements for all four states. For example, we examined the values for total operating expenses and gross patient revenues to determine whether these data were complete and reasonable. Second, we interviewed state officials knowledgeable about the data and reviewed documentation related to the data. We determined that all four states employed various data consistency checks, including outlier and trend analysis and targeted follow-up with hospitals on a case-by-case basis, to assess the quality of the data they collected. We determined that the data we used in our analyses were sufficiently reliable for our purposes.

We conducted our work from July 2007 through August 2008 in accordance with generally accepted government auditing standards.

¹⁶Medicaid provides health care coverage to eligible low-income people, and is jointly financed by the federal government and the states.

Appendix II: Other Activities That Benefit the Community Identified in Industry Guidance

Groups of other activities that benefit the community ^a	Description	Examples of activities included in the group	Examples of activities not included in the group
Cash and in-kind contributions	Donations and grants provided to individuals or the community at large, and fundraising for community programs.	<ul style="list-style-type: none"> • Contributions provided to charity events and individuals for emergency assistance. • Program, operating, and education grants; matching grants; and event sponsorship. • Meeting room overhead and space for nonprofit or community groups, emergency medical care at a community event, and provision of facility parking vouchers for patients and families in need. • Grant writing and other fundraising efforts specific to community programs. 	<ul style="list-style-type: none"> • Employee-donated funds and fees for sporting event tickets. • Employee community involvement when activities are on employees' own time and volunteer hours by employees on own time.
Community benefit operations	Community benefit strategic planning and operations.	<ul style="list-style-type: none"> • Staff costs to coordinate community benefit volunteer programs. • Community health needs assessment and community asset assessments, such as a youth asset survey. 	<ul style="list-style-type: none"> • Volunteer time of individuals for community benefit volunteer programs. • Market share assessment or marketing survey process.
Community-building activities	Activities intended to enhance the development of community health programs and partnerships.	<ul style="list-style-type: none"> • Community gardens, neighborhood improvement, and revitalization projects. • Small business development and participation in an economic development council or chamber of commerce. • Neighborhood watch groups and child care for community residents with qualified need. • Lead or radon programs and efforts to reduce community environmental hazards. • Training in conflict resolution, cultural skills, civics skills, or language skills, and community leadership development. • Hospital representation at community coalitions. 	<ul style="list-style-type: none"> • Housing for employees and health facility construction and improvements, such as a meditation garden or parking lot. • Routine financial investments. • Routine and mandated disaster preparedness. • Interpreter training programs for hospital staff as required by law. • Advocacy specific to hospital operations and financing. • Programs that address only the workforce needs of the health care organization rather than community-wide issues.

Appendix II: Other Activities That Benefit the Community Identified in Industry Guidance

Groups of other activities that benefit the community ^a	Description	Examples of activities included in the group	Examples of activities not included in the group
Community health improvement services	Programs for community health education, community-based clinical services, and health care support services.	<ul style="list-style-type: none"> • Local, state, and national advocacy related to access to health care and public health issues. • Recruitment of health professionals for areas identified by the government as medically underserved. • Prenatal and childbirth classes serving at-risk and low-income persons, public service announcements with health messages, support groups, and self-help programs. • Screenings, one-time or occasionally held clinics, clinics for underinsured and uninsured persons, and mobile units used to deliver primary care services. • Information and referrals to community services and assistance with enrollment in government health care programs. 	<ul style="list-style-type: none"> • Health education classes designed to increase market share, support given to patients and families in the course of their hospital visits, and employee wellness and health promotion provided as an employee benefit. • Screenings provided primarily for public relations or marketing, screenings and clinics for which a fee is charged and a profit is realized, volunteers' time, and mobile units that provide specialty care that is an extension of the hospital's outpatient department. • Routine discharge planning and enrollment assistance services designed to increase facility revenue.
Health professions education	Education for physicians, medical students, nurses, nursing students, and other health professionals, and scholarships and funding for professional education.	<ul style="list-style-type: none"> • Internships, clerkships, and residencies. • Providing a clinical setting for undergraduate training or vocational training to students enrolled in an outside organization, and the costs of high school student job shadowing and mentoring projects. • Nursing scholarships or tuition payments for professional education to non-employees and volunteers. 	<ul style="list-style-type: none"> • Continuing medical education restricted to members of the medical staff. • Education required of nursing staff and staff time spent delivering care that is concurrent with job shadowing. • Tuition reimbursement provided as an employee benefit.

Appendix II: Other Activities That Benefit the Community Identified in Industry Guidance

Groups of other activities that benefit the community^a	Description	Examples of activities included in the group	Examples of activities not included in the group
Medical research	Clinical and community-health research to be shared with persons outside the organization.	<ul style="list-style-type: none"> • Research development, using formal research protocols; studies on therapeutic protocols; evaluation of innovative treatments; and research papers prepared by staff for professional journals. • Studies on health issues for vulnerable persons, community health, and innovative health care delivery models. 	<ul style="list-style-type: none"> • Research where findings are used only internally.
Subsidized health services	Clinical services provided despite a financial loss, even after removing the effects of charity care and unreimbursed cost of Medicaid. If no longer offered, these services would either be unavailable in the area or fall to the responsibility of government or another nonprofit organization.	<ul style="list-style-type: none"> • Subsidies provided to maintain the availability of these clinical services. • Emergency and trauma services, neonatal intensive care, burn units, women’s and children’s services, renal dialysis services, subsidized continuing care, behavioral health services, and palliative care. 	<ul style="list-style-type: none"> • Charity care, bad debt, and unreimbursed cost of Medicaid. • Services provided in order to attract physicians or health plans. • Routine pain control program.

Source: Catholic Health Association of the United States, *A Guide for Planning and Reporting Community Benefit* (St. Louis, 2006).

^aActivities that benefit the community, as defined by the standards and guidance used by nonprofit hospitals, generally fall into one of four categories: charity care, bad debt, unreimbursed costs of government health care programs, and other activities that benefit the community.

Appendix III: State Community Benefit Requirements

As of March 2008, 15 states require that hospitals provide community benefits in order to receive tax exemption or achieve nonprofit status. However, state community benefit requirements¹ vary greatly in scope and level of detail (see app. IV).²

States with Detailed Community Benefit Requirements

Of the 15 states with community benefit requirements, 10 have detailed community benefit requirements.³ We considered states to provide a “detailed” definition if they provided some combination of the following: a definition of community benefit, requirements for a community benefits plan that sets forth how the hospital will provide community benefits, reporting requirements, and penalties for noncompliance. These states typically set forth a detailed definition of community benefit, specifying numerous categories of activities that qualify, and are consistent with the level of detail of community benefit definitions used by the Catholic Health Association of the United States and other similar entities (see app. II). Illinois, for example, includes the unreimbursed cost of providing charity care, language assistant services, government-sponsored indigent health care, donations, volunteer services, education, government-sponsored program services, research, subsidized health services, and collecting bad debts.⁴ Illinois specifically excludes the cost of paying taxes or other governmental assessments. Maryland defines community benefit as “an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including...[h]ealth services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children’s Health Program enrollees...[f]inancial or in kind support of public health programs...[d]onations of funds, property, or other resources that

¹We defined “community benefit requirement” as a legal standard that expressly obligates a hospital to provide health care services or benefits to the community served by the hospital as a condition of maintaining tax-exempt status or qualifying as a nonprofit hospital. It is generally something that hospitals are required to do beyond their role of providing care for the sick and injured in exchange for remuneration or compensation. We considered the requirement to be one applicable to hospitals only if it either expressly referred to hospitals or expressly referred to care or services of the nature and type that one would reasonably expect to be provided by or performed primarily at acute care hospitals.

²For purposes of this report, unless otherwise apparent, “states” refers to the 50 states and the District of Columbia.

³The 10 states with detailed community benefit requirements are California, Idaho, Illinois, Indiana, Maryland, New Hampshire, New York, Pennsylvania, Texas, and West Virginia.

⁴210 Ill. Comp. Stat. 76/10 (2008).

contribute to a community priority...[h]ealth care cost containment activities; and...[h]ealth education, screening, and prevention services.”⁵

These 10 states also tend to have very detailed instructions on how community benefits should be provided and reported. They may include a description of the required elements of and the process by which a hospital should compose its community benefits plan and the required elements to be provided in a hospital’s annual report to the relevant authority. A typical example is California, which requires each of its nonprofit hospitals to have a mission statement that requires that hospital’s policies to integrate and reflect the public interest in meeting its responsibilities as a nonprofit organization; complete a community needs assessment in consultation with community groups and government officials; update its community needs assessment every 3 years; adopt and annually update a community benefits plan for providing community benefits either alone or in conjunction with other entities; and annually submit its community benefits plan, including a description of the activities undertaken and the economic value of community benefits provided.⁶

Other States with Community Benefit Requirements

The remaining five states with community benefit requirements have provisions that are less detailed.⁷ Alabama requires that charity care constitute at least 15 percent of a hospital’s business in order for it to be exempt from property tax.⁸ Wyoming provides that “[t]he fundamental basis for [exemption from ad valorem taxation] is the benefit conferred upon the public by schools, orphan asylums and hospitals, and the consequent relief, to some extent, of the burden upon the state to educate, care and advance the interests of its citizens.”⁹ States such as Wyoming do not specify activities that their nonprofit hospitals must provide, but their

⁵Md. Code Ann., Health–Gen. § 19-303(a)(3) (2008).

⁶Cal. Health & Safety Code § 127350 (West 2008).

⁷Those five states are Alabama, Colorado, Mississippi, North Dakota, and Wyoming. These states typically do not use the term “community benefit” or similar terms such as “community service” or “gift to the community,” although they may refer to “charity care” or “charity patients.” Rather, the language of their provisions approximates the concept of community benefit, and so we consider them to have community benefit requirements. See our definition of “community benefit” in appendix I.

⁸Ala. Code § 40-9-1(2) (2008).

⁹Wyo. R. & Regs. Rev. Gen. Ch. 14 § 10(a) (2008).

provisions make clear that, in order to receive tax exemption or achieve nonprofit status, hospitals must provide benefit to the community. In contrast to the 10 detailed states, these 5 states typically either require the provision of a certain amount of charity care without mentioning other categories of community benefit or do not give guidance as to what counts as a community benefit. For the latter states, such as Wyoming, it is not always clear what types of community benefit activities would fulfill a hospital's obligations.

States without Community Benefit Requirements

The remaining 36 states do not have community benefit requirements in codified statutes or regulations that hospitals must meet to qualify for tax-exempt or nonprofit status. Among these states are three groups of states that address community benefit in some way but do not have "community benefit requirements" as we define that term. Some states apply their community benefits provisions to all hospitals, such as in the context of hospital licensure, rather than to tax exemption or nonprofit status (see app. V). Examples of states that fall into this category are Massachusetts, New Mexico, and Rhode Island, and they require all hospitals, both for-profit and nonprofit, to provide some form of community benefits. A second group requires that hospitals periodically report to the relevant authority the community benefits that they provide but do not require that hospitals actually provide any community benefits (see app. VI).¹⁰ A third group discusses community benefit in sources other than codified statutes or regulations, such as attorney general guidelines or property tax exemption standards (see app. VII). One state, Utah, discusses community benefit in a set of standards of practice for property tax exemptions and through its case law.¹¹ Although Massachusetts has a statute requiring community benefits for licensure purposes, the bulk of its community benefit discussion is found in a set of attorney general guidelines.¹² We did

¹⁰Examples of these states include Connecticut, Georgia, Minnesota, Nevada, and Oregon. Oregon is the most recent state to pass a community benefit law. Its law, passed in 2007, became effective on January 1, 2008. The law includes a detailed definition of community benefit, directs the Office for Oregon Health Policy and Research to adopt a cost-based community benefit reporting system for hospitals operating in Oregon that is consistent with established national standards for hospital reporting of community benefits, and sets forth civil penalties for health care facilities that fail to comply with the reporting system. 2007 Or. Laws 3290 (effective Jan. 1, 2008; to be added to Or. Rev. Stat. Ch. 442).

¹¹See Property Tax Division, Utah State Tax Commission, Property Tax Exemptions Standards of Practice (2007).

¹²See Office of Attorney General, Commonwealth of Mass., The Attorney General's Community Benefits Guidelines for Non-Profit Acute Care Hospitals (2007).

not include these groups of states in our count of states with community benefit requirements, and we provide information on these states as examples rather than as the product of a comprehensive analysis of state sources.

Penalties

Hospitals may be penalized if they fail to comply with community benefit requirements. Of the 15 states with community benefit requirements, 4 have explicit penalties for failure to comply and 11 states do not specify a penalty.¹³ Examples of states with explicit penalties include Indiana, Maryland, and Texas, where civil penalties may be assessed against nonprofit hospitals that fail to submit their annual reports in a timely fashion.¹⁴ Of the 11 states that do not specify a penalty, if the requirement is tied to tax exemption, a nonprofit hospital could be denied tax exemption for a period of time.

For states without community benefit requirements but with community benefit provisions tied to hospital licensure requirements, a hospital that has not complied with the community benefit provisions will not be licensed (or its license may be suspended or revoked).¹⁵ In addition, states may include explicit penalties for failure to comply with community benefit provisions tied to hospital licensure requirements. For example, in Rhode Island, a state that applies its community benefits provisions to all hospitals through licensure requirements, failure to comply with statewide standards for community benefits may result in criminal penalties: the Superior Court may, after notice and opportunity for a prompt and fair hearing, impose a prison term of up to 5 years for a person who knowingly violates or fails to comply with the requirements or willingly or knowingly gives false or incorrect information in connection with its licensure requirements.¹⁶

¹³Some state codes and regulations provided penalties for failing to comply with community benefit requirements. We noted penalty provisions only if the penalty provision made a direct and express reference to failure to comply with the community benefit requirement as the basis for the penalty. We do not include statutory or regulatory references to denial of tax exemption for failure to comply as a penalty.

¹⁴Ind. Code 16-21-9-8 (2008); Md. Regs. Code tit. 10, § 37.01.03(N) (2008); and Tex. Health & Safety Code Ann. § 311.047 (Vernon 2008).

¹⁵N.M. Admin. Code tit. 7, § 7.2.8(L) (2008) and R.I. Gen. Laws § 23-17.14-30 (2008).

¹⁶R.I. Gen. Laws § 23-17.14-30 (2008).

Quantity

Most states do not specify a minimum quantity of community benefits that must be provided in order to satisfy requirements. Five states require that hospitals provide a specified amount of community benefit.¹⁷ Alabama requires that “[t]o be exempt from ad valorem taxation, the treatment of charity patients must constitute at least 15 percent of the business of the hospital,”¹⁸ while Texas requires that its hospitals comply with one or more of three standards: a level reasonable in relation to community needs; at least 100 percent of its tax-exempt benefits, excluding federal income tax; or at least 5 percent of its net patient revenue (in which case charity care and government-sponsored indigent care must be at least 4 percent of net patient revenue).¹⁹ In other states, the required minimum quantity is not a specified dollar amount or percentage. For example, Mississippi requires that, to be exempt from property tax, hospitals must maintain at least one ward for charity patients.²⁰ West Virginia requires that charitable hospitals provide free and below-cost necessary medical services in an amount determined by their boards of trustees consistent with their ability to do so.²¹

In addition to states that specify a minimum quantity of community benefits that must be provided in order to satisfy community benefit requirements, the remaining states—those without minimum quantity requirements and those without community benefit requirements as we define that term—tend to require the submission of community benefits plans, annual reports, or both to relevant state authorities. Even without an explicit requirement to provide community benefits, these provisions may bring a measure of accountability as to quantity, since relevant authorities have an opportunity to review hospital activities. An example of a state without a minimum quantity requirement is California, which provides that hospitals must annually report on the economic value of community benefits provided in furtherance of their community benefits plans.²²

¹⁷These states include Alabama, Mississippi, Pennsylvania, Texas, and West Virginia.

¹⁸Ala. Code § 40-9-1(2) (2008).

¹⁹Tex. Health & Safety Code Ann. § 311.045(b)(1) (Vernon 2008).

²⁰Miss. Code Ann. § 27-31-1(f) (2008).

²¹W. Va. Code St. R. § 110-3-24.9.8 (2008).

²²Cal. Health & Safety Code § 127350(d) (West 2008).

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Alabama	To be exempt from ad valorem taxation on property up to \$75,000, the treatment of charity patients must constitute at least 15 percent of the business of the hospital. (Ala. Code § 40-9-1)	<ul style="list-style-type: none"> Charity. (Ala. Code § 40-9-1)	None specified.
California	<ol style="list-style-type: none"> Update community needs assessment at least once every 3 years. Annually adopt and update a community benefits plan, including mechanisms to evaluate its effectiveness, measurable objectives, and community benefits categorized into a specified framework. Annually submit the community benefits plan, including activities undertaken and economic value of community benefits provided. (Cal. Health & Safety Code §§ 127350, 127355)	<ul style="list-style-type: none"> Charity care and unreimbursed costs of health care services. Community-oriented wellness and health promotion services. Prevention service (screenings, immunizations, disease counseling, education). Adult day care and child care. Medical research and medical education. Nursing and other professional training. Home-delivered meals to the homebound. Sponsorship of free food, shelter, and clothing to the homeless. Outreach clinics in socioeconomically depressed areas. Financial or in-kind support of public health programs. Donations that contribute to a community priority. Health care cost containment. Enhancement of access to health care. Services offered without regard to financial return. Goods or services that help maintain a person's health. (Explicitly not limited to this list of activities.) (Cal. Health & Safety Code § 127345)	None specified.

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Colorado	Property must be owned and used solely and exclusively for strictly charitable purposes. (Colo. Rev. Stat. Ann. § 39-3-108)	<ul style="list-style-type: none"> • A gift for the benefit of an indefinite number of persons by relieving their bodies from disease, by assisting them to establish themselves in life, or by erecting or maintaining public buildings or works, or otherwise lessening the burdens of government. (8 Colo. Code Regs. 1304-2)	None specified.
Idaho	<ol style="list-style-type: none"> 1. Show that the hospital is organized as a nonprofit corporation in Idaho or another state and has received an exemption from taxation from IRS pursuant to § 501(c)(3) of the Internal Revenue Code. 2. Exempt hospitals with at least 150 patient beds must prepare and file an annual community benefits report that itemizes the community benefits provided and indicates the process the hospital used to determine general community needs. (Idaho Code § 63-602D)	<ul style="list-style-type: none"> • Charity care. • Bad debt. • Under-reimbursed care covered through government programs. • Services and programs provided below actual cost. • Donated time, funds, subsidies, and in-kind services. • Additions to capital. (Idaho Code § 63-602D)	None specified.
Illinois	<ol style="list-style-type: none"> 1. Organization mission statement. 2. Community benefits plan. 3. Annual report of the community benefits plan. 4. Statement noting that the annual report is public information. 5. Provide the report as a matter of community information. (210 Ill. Comp. Stat. 76/15, 76/20)	<ul style="list-style-type: none"> • Charity care. • Language assistant services. • Government-sponsored indigent health care. • Donations. • Volunteer services. • Education. • Government-sponsored program services. • Research. • Subsidized health services. • Bad debt. Does not include the cost of paying taxes or other governmental assessments. (210 Ill. Comp. Stat. 76/10)	<p>The Attorney General may assess a late filing fee against a nonprofit hospital that fails to file the annual report. The fee must not exceed \$100; the Attorney General may grant extensions for good cause. (210 Ill. Comp. Stat. 76/25)</p> <p>Other rights and remedies available to the state are retained. (210 Ill. Comp. Stat. 76/30)</p>

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Indiana	<ol style="list-style-type: none"> 1. Organization mission statement. 2. Community benefits plan. 3. Communitywide needs assessments in aid of community benefits plan. 4. Annual report of the community benefits plan. 5. Statement notifying the public that the annual report is public information. 6. Written notice about any charity care program. <p>(Ind. Code §§ 16-21-9-4, -5, -6, -7)</p>	<ul style="list-style-type: none"> • Charity care. • Government-sponsored indigent health care. • Donations. • Education. • Government-sponsored program services. • Research. • Subsidized health services. <p>Does not include the cost of paying taxes or other governmental assessments.</p> <p>(Ind. Code § 16-21-9-1)</p>	<p>The state department may assess a civil penalty against a nonprofit hospital that fails to submit its annual report. The penalty may not exceed \$1,000 for each day a report is late.</p> <p>(Ind. Code § 16-21-9-8)</p>
Maryland	<ol style="list-style-type: none"> 1. Identify community health care needs. 2. Annual community benefits report, which includes the hospital's mission statement, a list and costs of each community benefit initiative, a description of efforts undertaken to evaluate the effectiveness of each initiative, and a description of gaps in availability of specialist providers to serve the uninsured. <p>(Md. Code Ann., Health-Gen. § 19-303)</p>	<ul style="list-style-type: none"> • Health services provided to vulnerable or underserved populations, such as Medicaid, Medicare, or Maryland Children's Health Program enrollees. • Financial or in-kind support of public health programs. • Donations that contribute to a community priority. • Health care cost containment activities. • Health education, screening, and prevention services. <p>(Md. Code Ann., Health-Gen. § 19-303)</p>	<p>For failure to file the community benefits report: civil penalty of \$100 per day unless an extension is granted. The Health Services Cost Review Commission may refuse to grant a rate increase to any hospital that does not file a required report. Any substantially incomplete or inaccurate report may not be considered timely filed. Institutions may request reasonable extensions of time to file required reports.</p> <p>(Md. Regs. Code tit. 10, § 37.01.03)</p>
Mississippi	<p>Must maintain one or more charity wards for charity patients.</p> <p>(Miss. Code Ann. § 27-31-1(f))</p>	<ul style="list-style-type: none"> • Charity. <p>(Miss. Code Ann. § 27-31-1)</p>	<p>None specified.</p>

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
New Hampshire	<ol style="list-style-type: none"> Annual report of community benefits plan, which includes a mission statement, community needs assessment, community benefit activities expected to be undertaken or supported, community benefit activities undertaken in the previous year and a description of results or outcomes, means used to solicit community views, an evaluation of the plan's effectiveness, an estimate of the cost of each activity expected, and a report on the unreimbursed cost of activities undertaken in the previous year. Community needs assessment. Make the community benefits plan available to the public. <p>(N.H. Rev. Stat. Ann. §§ 7.32-e, -f, -g)</p>	<ul style="list-style-type: none"> Charity care. Financial or in-kind support of public health programs, including support of recommendations in any state health plan. Allocation of resources that promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities, or services to a vulnerable population. Medical research and education and training of health care practitioners, including the pooling of funds with other providers. <p>(Explicitly not limited to the listed activities.) (N.H. Rev. Stat. Ann. § 7.32-d)</p>	None specified.
New York	<ol style="list-style-type: none"> Issue an organizational mission statement. At least every 3 years: <ul style="list-style-type: none"> -review and amend the mission statement, -solicit community views, -demonstrate operational and financial commitment to meeting community health care needs, and -prepare and make available to the public a statement of the hospital's financial resources and allocation to hospital purposes, including the provision of free or reduced charge services. Annually prepare and make available to the public an implementation report. File with the Commissioner of Health its mission statement, annual implementation report, and 3-year report. <p>(N.Y. Pub. Health Law § 2803-l)</p>	<ul style="list-style-type: none"> Meeting community health care needs. Charity care. Improving access to health care services by the underserved. <p>(N.Y. Pub. Health Law § 2803-l)</p>	None specified.

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
North Dakota	<p>To receive sales and use tax exemptions, must be organized and operated exclusively in providing services for the purposes of preventing and alleviating human illness and injury.</p> <p>(N.D. Cent. Code §§ 57-39.2-04, 57-40.2-04)</p>	<ul style="list-style-type: none"> • Education. • Research. • Community service. • Direct patient services, income being derived solely from private donations with some exceptions of a minimal membership fee. <p>(N.D. Cent. Code §§ 57-39.2-04, 57-40.2-04)</p>	None specified.
Pennsylvania	<ol style="list-style-type: none"> 1. Must advance a charitable purpose. 2. Must donate or render gratuitously a substantial portion of its services. 3. Must benefit a substantial and indefinite class of persons who are legitimate subjects of charity. 4. Must relieve the government of some of its burden. <p>(10 Pa. Cons. Stat. § 375)</p>	<ul style="list-style-type: none"> • Charity care. • Goods or services to individuals eligible for government programs. • Donations to institutions of purely public charity or government agencies. • Uncompensated goods or services, including the difference between full cost and fee received for all goods or services provided, education and research programs, and unreimbursed costs of government programs, including Medicare and Medicaid, and unreimbursed community services. • Reasonable value of volunteer assistance. • Cost of goods or services provided to individuals who are unable to pay, provided that reasonable and customary collection efforts have been made. • Services to the public that directly or indirectly reduce dependence on government programs or relieve or lessen the burden borne by government for the advancement of social, moral, educational, or physical objectives. <p>(10 Pa. Cons. Stat. § 375)</p>	None specified.

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Texas	<ol style="list-style-type: none"> 1. Provide health care services to the community. 2. Comply with all federal, state, and local government requirements for tax exemption in order to maintain such exemption. 3. Provide a specified minimum amount of community benefits. 4. Admission policy must provide for the admission of financially indigent and medically indigent persons. 5. Organizational mission statement. 6. Community benefits plan. 7. Communitywide needs assessments to develop the community benefits plan. 8. Annual report of the community benefits plan, including amount and types of community benefits provided. <p>(Tex. Health & Safety Code Ann. §§ 311.043, 311.044, 311.045)</p>	<ul style="list-style-type: none"> • Charity care. • Government-sponsored indigent health care. • Donations. • Education. • Government-sponsored program services. • Research. • Subsidized health services. <p>Does not include the cost of paying taxes or other governmental assessments.</p> <p>(Tex. Health & Safety Code Ann. § 311.042; 25 Tex. Admin. Code § 13.13)</p>	<p>A nonprofit hospital that fails to make a report of the community benefits plan is subject to a civil penalty not exceeding \$1,000 per day. No penalty may be assessed against a hospital until 10 business days have elapsed after written notification to the hospital of its failure to file a report.</p> <p>(Tex. Health & Safety Code Ann. §§ 311.047, 311.048)</p> <ol style="list-style-type: none"> 1. Subject to a civil penalty of not more than \$1,000 for each day of noncompliance. 2. If a nonprofit hospital/system does not submit a report of the community benefits plan within the established reporting period, the Department of Health may institute the following procedures: <ol style="list-style-type: none"> A. Notify the entity that it is in noncompliance with the Department of Health's reporting requirements and that the Commissioner of Health may request that the Attorney General institute and conduct a suit in the name of the state to recover civil penalties if the hospital fails to submit the report to the Department of Health within 10 days of receipt of the letter. B. If the Department of Health does not receive the report of the community benefits plan from the nonresponding hospital within the specified time frame, the Commissioner of Health may notify the Attorney General in writing of the entity's noncompliance. The Department of Health will send a copy to the hospital. <p>(25 Tex. Admin. Code § 13.18)</p>

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
West Virginia	<ol style="list-style-type: none"> 1. Must provide an amount of free and below-cost necessary medical services as determined by its board of trustees, consistent with other provisions, to those who are unable to pay. 2. Charitable use (determined by an examination of several factors, including charity care, promotion of health, relief of burdens of government, and volunteer and community services). 3. Charity care plan that reflects specified minimum criteria. 4. Review charity care plan not less than every 2 years. <p>(W. Va. Code St. R. § 110-3-24)</p>	<ul style="list-style-type: none"> • Charity care. • Activities that promote the health of the community and/or decrease the burdens of state, county, and municipal governments. • Shortfall between approved charges and payments received from Medicaid and similar governmental programs. • Volunteer and community services. • Public education programs. • Donations. • Free, low-cost, or below-cost health screenings and assessments. • Social services assistance/counseling. • Free or reduced-charge medical clinics. • Operation of poison control centers. • Free or below-cost blood banking services. • Free or below-cost assistance, material, equipment and training to emergency medical services and ambulance services. • Disaster planning. • Unreimbursed costs for education and training. <p>(W. Va. Code St. R. § 110-3-24)</p>	None specified.

Appendix IV: States with Community Benefit Requirements Related to Hospitals

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Wyoming	<p>1. The fundamental basis for ad valorem tax exemption is the benefit conferred upon the public and the consequent relief, to some extent, of the burden upon the state to educate, care, and advance the interests of its citizens. Such institutions thus confer a benefit upon the general citizenry of the state and render an essential service for which they are relieved of certain burdens of taxation.</p> <p>2. Indigent care shall be afforded through admission to the institution based on the clinical judgment of the physician, not upon the patient's financial ability or inability to pay.</p> <p>(Wyo. Stat. Ann. § 39-11-105; Wyo. R. & Regs. Rev Gen Ch. 14 § 10)</p>	<ul style="list-style-type: none"> • Benefit conferred upon the public. • Consequent relief of the burden upon the state. • Indigent care. • Promote health care. • Provide health-related assistance to the general public. <p>(W.S. 1977 § 39-11-105; Wyo. R. & Regs. Rev Gen Ch. 14 § 10)</p>	None specified.

Source: GAO analysis of Alabama, California, Colorado, Idaho, Illinois, Indiana, Maryland, Mississippi, New Hampshire, New York, North Dakota, Pennsylvania, Texas, West Virginia, and Wyoming statutes and regulations.

Notes: We did not consider loss of tax exemption to be a penalty. We considered only those states whose statutes or regulations require the provision of community benefits for purposes of tax exemption or nonprofit status to have community benefit requirements.

Appendix V: Examples of States with Licensure-Related Community Benefit Provisions

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Massachusetts	<p>Applicants for a license to establish or maintain an acute-care hospital must agree to maintain or increase the percentage of revenues allocated to free care and submit a plan for the provision of community benefits.</p> <p>(Mass. Gen. Laws Ann. ch. 111, § 51G)</p>	<ul style="list-style-type: none"> • Identification and provision of essential health services. • Primary and preventive health care services. <p>(Mass. Gen. Laws Ann. ch. 111, § 51G)</p>	None specified.
New Mexico	<ol style="list-style-type: none"> 1. Acute-care or general hospitals can be licensed only if they agree to provide emergency services and general health care to nonpaying patients and low-income reimbursed patients in the same proportion as the patients are treated in acute-care general hospitals in the local community. The annual cost of this care shall not exceed 5 percent of the hospital's annual revenue. 2. These hospitals must annually report the cost of care for emergency and general health care to nonpaying and low-income reimbursed patients and the number of nonpaying and low-income reimbursed patients treated. <p>(N.M. Stat. Ann. § 24-1-5.8(C); N.M. Admin. Code tit. 7, § 7.2.8)</p>	<ul style="list-style-type: none"> • Emergency services and general health care provided to nonpaying patients and low-income reimbursed patients. <p>(N.M. Stat. Ann. § 24-1-5.8(C); N.M. Admin. Code tit. 7, § 7.2.8(D))</p>	<p>Failure to provide proportional services to nonpaying and low-income reimbursed patients in any year following licensure may result in the Department of Health's imposition of one or more of the following penalties:</p> <ol style="list-style-type: none"> 1. an approved plan of correction that remedies the failure through the additional provision of services in subsequent years, 2. a civil monetary penalty not to exceed \$500,000, 3. suspension or revocation of the hospital's license, and 4. referral to CMS for sanctions under the Medicare and Medicaid programs. <p>(N.M. Admin. Code tit. 7, § 7.2.8(L))</p>

**Appendix V: Examples of States with
Licensure-Related Community Benefit
Provisions**

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Rhode Island	<p>As conditions of initial and continued licensure, all licensed hospitals shall</p> <ol style="list-style-type: none"> meet the statewide community standard for the provision of charity care; meet standards for uncompensated care; meet the statewide standards for the provision of community benefits; not discourage persons who cannot afford to pay from seeking medical services; not encourage persons who cannot afford to pay to seek essential medical services from other providers; must annually report on compliance with these conditions, including (1) cost of charity care, (2) bad debt, (3) contract Medicaid shortfalls, and (4) any additional information demonstrating compliance with this section; and must have a formal, Board-approved plan for the provision of community benefits. The plan shall be updated and Board-approved at least every 3 years. <p>(R.I. Gen. Laws §§ 23-17-43, 23-17.14-15; R.I. Code R. 14 090 007, 14 090 028)</p>	<ul style="list-style-type: none"> Charity care. Uncompensated care. Bad debt. Medicaid shortfall. Programs, procedures, and protocols that meet the needs of the medically indigent. Linkages with community partners that focus on improving the health and well-being of community residents. Non-revenue-producing services made available to the community, such as fitness programs, health screenings, or transportation services. Public advocacy on behalf of community needs. Scientific or medical research, or educational activities. <p>(R.I. Gen. Laws §§ 23-17-43, 23-17.14-15; R.I. Code R. 14 090 007, 14 090 028)</p>	<p>If any person knowingly violates or fails to comply or willingly or knowingly gives false or incorrect information the Director of the Department of Health may, after notice and opportunity for a prompt and fair hearing, deny, suspend, or revoke a license, or may order the licensee to admit or provide health services to no additional persons to the facility or to take corrective action necessary to secure compliance under the act; or the Superior Court may, after notice and opportunity for a prompt and fair hearing, impose a fine of not more than \$1,000,000 or impose a prison term of not more than 5 years.</p> <p>(R.I. Gen. Laws § 23-17.14-30)</p> <p>If the Department of Health receives sufficient information indicating that a licensed hospital is not in compliance with this section, the Director of the Department of Health shall hold a hearing upon 10 days notice to the licensed hospital and shall issue in writing findings and appropriate penalties.</p> <p>(R.I. Gen. Laws § 23-17.14-15)</p>

Source: GAO analysis of Massachusetts, New Mexico, and Rhode Island statutes and regulations.

Note: Although these states have community benefit provisions tied to licensure requirements, we did not include them in our list of states with community benefit requirements because their community benefit provisions are not tied to tax exemption or nonprofit status.

Appendix VI: Examples of States with Only Community Benefit Reporting Provisions

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Connecticut	Biennial report on whether the hospital has in place a community benefits program. If the hospital has chosen to have a community benefits program, the report shall include a number of specified elements. (Conn. Gen. Stat. Ann. § 19a-27k)	<ul style="list-style-type: none"> Preventive care. Programs that improve the health status for working families and populations at risk in the community. (Conn. Gen. Stat. Ann. § 19a-127k)	The Commissioner of Public Health may, after notice and opportunity for a hearing, impose a civil penalty on any hospital that fails to submit the required report by the specified date. Such penalty shall be not more than \$50 a day for each day after the required submittal date that such report is not submitted. (Conn. Gen. Stat. Ann. § 19a-127k(f))
Georgia	Nonprofit hospitals must file an annual community benefit report disclosing the cost of indigent and charity care provided during the preceding year not later than 90 days after the close of the fiscal or calendar year. The report shall include a statement of the cost and type of indigent and charity care provided by the authority, including the number of indigent persons served, categorization of those persons by county of residence, as well as the cost of indigent and charity care provided by the authority, including the number of indigent persons served, categorization of those persons by county of residence, as well as the cost of indigent and charity care provided in dollars. (Ga. Code Ann. §§ 14-3-305; 31-7-90.1)	<ul style="list-style-type: none"> Indigent care. Charity care. (Ga. Code Ann. § 31-7-90.1)	None specified.
Minnesota	Annual report of services provided to benefit the community. (Minn. Stat. §§ 144.698, 144.699)	<ul style="list-style-type: none"> Services provided at no cost or for a reduced fee to patients unable to pay. Teaching and research activities. Community care. Underpayment for services provided under state health care programs. Research. Community health services. Financial and in-kind contributions. Community building activities. Community benefit operations. 	None specified.

**Appendix VI: Examples of States with Only
Community Benefit Reporting Provisions**

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Nevada	<p>Each hospital with at least 100 beds must file as required by the Director of the Department of Health and Human Services but at least annually the expenses incurred for providing community benefits, a statement of its policies and procedures for providing discounted services to persons without health insurance, and a statement of its policies regarding collection.</p> <p>(Nev. Rev. Stat. § 449.490)</p>	<ul style="list-style-type: none"> • Education. • Subsidized services. <p>Does not include bad debt and underpayment for Medicare services.</p> <p>(Minn. Stat. Ann. §§ 144.698, 144.699)</p> <ul style="list-style-type: none"> • Goods, services, and resources provided by a hospital to a community to address the specific needs and concerns of that community. • Services provided by a hospital to uninsured and underserved persons. • Training programs for employees. • Health care services provided in areas that have a critical shortage of such services. <p>(Nev. Rev. Stat. § 449.490)</p>	None specified.
Oregon	<p>Within 90 days of filing a Medicare cost report, a hospital must submit a community benefit report to the Office for Oregon Health Policy and Research of the community benefits provided by the hospital.</p> <p>(2007 Or. Laws 3290 (effective Jan. 1, 2008))</p>	<ul style="list-style-type: none"> • Charity care. • Losses related to Medicaid, Medicare, State Children’s Health Insurance Program, or other publicly funded health care program shortfalls. • Community health improvement services. • Research. • Financial and in-kind contributions to the community. • Community-building activities affecting health in the community. <p>(2007 Or. Laws 3290 (effective Jan. 1, 2008))</p>	<p>Any health care facility that fails to comply may be subject to a civil penalty, not to exceed \$500 per day of violation, determined by the severity of the violation. Civil penalties may be remitted or mitigated upon such terms and conditions as the Administrator of the Office for Oregon Health Policy and Research considers proper and consistent with the public health and safety.</p> <p>(2007 Or. Laws 3290 (effective Jan. 1, 2008))</p>

Source: GAO analysis of Connecticut, Georgia, Minnesota, Nevada, and Oregon statutes and regulations.

Notes: We did not consider these states to have community benefit requirements because their community benefit provisions do not require the provision of any community benefits. Connecticut’s community benefit provisions are voluntary. Georgia, Minnesota, Nevada, and Oregon’s community benefit provisions only require that hospitals report their community benefits without explicitly requiring the provision of community benefits.

Appendix VII: Examples of States with Community Benefit Provisions Located Outside of Statutes and Regulations

State	Description of requirements	Activities included in the definition of community benefit	Penalties
Massachusetts	Voluntary. (The Attorney General's Community Benefits Guidelines for Non-Profit Acute Care Hospitals at 1)	<ul style="list-style-type: none"> • Community health education. • Free preventive care or health screening services. • Mobile health vans. • Home care consistent with the definition of net charity care. • Medical and clinical education and research. • Support for and participation in community-oriented training programs. • Low- or negative-margin services offered in response to an identified community need. • Violence-reduction education and counseling. • Anti-smoking education. • Substance abuse education, prevention, and treatment. • Domestic violence reduction education and training. • Early childhood wellness programs. • Expanded prescription drug programs. • Volunteer services. • Net financial assistance to community health centers. • Unfunded services ancillary to Medicaid or Medicare services. (The Attorney General's Community Benefits Guidelines for Non-Profit Acute Care Hospitals at 10–11)	None specified (program is voluntary).
Utah	"Gift to the community" standard for property tax exemption: the hospital must establish that its total gift to the community exceeds on an annual basis its property tax liability for that year. (Property Tax Exemptions Standards of Practice at 2-35)	<ul style="list-style-type: none"> • Indigent care. • Community education and service, including research and professional education. • Medical discounts, including unreimbursed care covered by Medicare, Medicaid, or other similar government entitlement programs. • Donations of time. • Donations of money. (Property Tax Exemptions Standards of Practice at 2-35–2-36)	None specified.

Source: GAO analysis of the Massachusetts Attorney General's Community Benefit Guidelines for Non-Profit Acute Care Hospitals and Utah's Property Tax Exemptions Standards of Practice.

Note: Although these states have community benefit provisions outside of codified statutes and regulations, we did not include them in our list of states with community benefit requirements.

Appendix VIII: GAO Contact and Staff Acknowledgments

GAO Contact

A. Bruce Steinwald, (202) 512-7114 or steinwalda@gao.gov

Acknowledgments

In addition to the contact named above, Jenny Grover and Thomas Walke, Assistant Directors; Joanna L. Hiatt; Xiaoyi Huang; Jessica T. Lee; Drew Long; Kevin Milne; and Lisa Motley made major contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "E-mail Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, DC 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548