Executive Summary
Hospital Compliance Project
Interim Report

I. Introduction

Current law requires hospitals to satisfy the community benefit standard in order to qualify as tax-exempt charities under section 501(c)(3). The Hospital Compliance Project (the Project) was initiated in 2006 by the Internal Revenue Service (IRS) to study nonprofit hospitals and community benefit, as well as to determine how hospitals establish and report executive compensation. This Interim Report presents data gathered from the responses of 487 hospitals to a comprehensive compliance questionnaire and information reported on Forms 990 filed by those hospitals. The questionnaire requested information regarding the hospitals' activities, governance, expenditures, and executive compensation practices. The executive compensation component of the Project is not addressed in this Interim Report because examinations in that area are ongoing.

The Project gives the IRS a unique and valuable insight into the manner in which hospitals report on and attempt to meet the community benefit standard. The Interim Report summarizes expenditures data and other information as reported. The IRS is still analyzing the data. In compiling the data received, we are seeing that the respondents report similar information in different ways, and that there is variation in the level of expenditures hospitals report in furtherance of community benefit.

In particular, there is considerable variation in how hospitals report uncompensated care. The IRS questionnaire did not provide a definition of uncompensated care as the IRS was interested in learning the definitions and measurements in common use and expected there was likely to be variation. The reported data confirms that expectation and shows that hospitals vary in many respects. For example, hospitals use a range of income and asset criteria to establish eligibility for uncompensated care. They also vary in how they measure and incorporate bad debt expense and shortfalls between actual costs and Medicare or Medicaid reimbursements into their measures, and whether they use charges or costs in their measures.

The reported information on uncompensated care will be analyzed to determine the extent to which it includes amounts for free or discounted care provided to persons across various demographics, including low-income populations, uninsured persons, and persons covered by Medicaid, Medicare, and other government programs. Until this analysis is completed, it is premature to conclude that the reported community benefit expenditure amounts, over half of which in the aggregate include reported uncompensated care, accurately portray the community benefit actually provided by the respondent hospitals.

II. The Methodology and Process

In selecting the hospitals to be contacted, IRS queried its files to identify nonprofit hospitals exempt under section 501(c)(3). From an initial identified universe of approximately 6,000 entities, the IRS selected 544 organizations that it confirmed as hospitals. The IRS sent compliance questionnaire letters to each of these hospitals, which were of varying sizes and types, and were located in different regions and communities across the United States. Some judgment was used to identify hospitals which were not uniquely identifiable in the IRS data base. The resulting sample may or may not reflect the nonprofit hospital sector in general.

Fifty-seven entities were excluded from the original sample of 544 organizations to yield a total sample of 487 responding hospitals. Forty-six of the hospitals responded that they were not exempt under section 501(c)(3), generally because they had recently ceased operations and were in the process of winding down, or had recently merged with another hospital and were no longer a separate entity for tax reporting purposes. Eleven hospitals did not respond to the questionnaire, and these hospitals have been referred for additional follow-up.

The compliance questionnaire consisted of 9 pages and 81 questions. Information was requested regarding hospital type and patient demographics, governance, medical staff privileges, billing and collection practices, and types of programs that might constitute community benefit, such as uncompensated care, medical education and training, medical research, and other community programs conducted by hospitals. Not every hospital answered every question, resulting in a variation in the number of responses from question to question. The IRS derived revenue data from Forms 990 and IRS data bases.

There was a high response rate for most of the questions. For example, all 487 hospitals responded to the questions regarding type of hospital and frequency of board meetings. Over 480 hospitals responded to questions regarding whether they denied medical services to individuals based on insurance coverage, whether they operated an emergency room, medical staff privileges, medical research, medical education and training, uncompensated care, billing and collection practices, and community programs. Many hospitals provided attachments and other information to supplement their responses to certain questions.

III. Summary of Reported Data

General surgical and medical hospitals made up 89% of the respondents, with the remainder providing specialty care (e.g., psychiatric or rehabilitation services). Inpatients and emergency room patients accounted for 22% of the total patients, and outpatients comprised 78% of the total patients reported in the Project. It is unclear whether the reported patient data refers to the number of patient visits, the number of persons served, or the number of encounters, admissions, or other

measures a hospital might use for reporting or other purposes. Forty-six percent of patients were covered by private insurance and 46% were covered by public programs (Medicare, Medicaid, and other public insurance). Seven percent of reported total patients lacked insurance coverage.

In the aggregate, uncompensated care accounted for 56% of the total community benefit expenditures reported by the respondents. Significant variations were found in how hospitals reported uncompensated care. Although 97% of hospitals reported they had a written uncompensated care policy, there was no uniform definition of what constitutes "uncompensated care" among the respondents. The treatment of bad debt expense as uncompensated care was mixed, with 56% of the hospitals reporting they did not include bad debt expense as uncompensated care, and the remaining 44% including at least some bad debt expense as uncompensated care. Hospitals also varied in reporting uncompensated care on the basis of costs or charges, and the treatment of the difference between gross charges and amounts received for providing care (shortfalls) to Medicare, Medicaid, uninsured, and other patients. The IRS intends to analyze all of the data and, in particular, try to determine what criteria hospitals use to determine that bad debt expense is includible in expenditures for uncompensated care.

97% of the respondents reported making uncompensated care available to at least some persons. In narrative responses to certain of the questions, most hospitals reported providing some free care to low-income patients, many hospitals reported providing discounted care on a sliding income scale, and others reported providing discounts to the poor, uninsured, or other vulnerable persons. The median percentage of patient visits that resulted in the provision of uncompensated care was 3.5%, and the mean was 10%.

After uncompensated care, the next largest categories of expenditures reported as providing community benefit, ranked as a percentage of total reported community benefit expenditures, were medical education and training (23%), research (15%), and community programs (6%). A number of hospitals (76%) reported conducting medical education and training, and 21% of the hospitals reported that they conducted medical research. More than 75% of hospitals reported expenditures for producing publications and newsletters, medical screenings, and public educational programs. Many hospitals reported expenditures to study the unmet health needs of the community (28%), immunization programs (40%), programs to improve access to health care (54%), and other health promotion programs (32%).

To put the reported expenditures in perspective, the report summarizes the level of potential reported community benefit expenditures as a percentage of total revenue. The mean (average) community benefit expenditures reported by the hospitals, as a percentage of the individual hospital's total revenues, was 9%, and the median was 5%. Although it appears that the definitions of uncompensated care used by certain of the hospitals resulted in the inclusion of some items that might not constitute community benefit, the reported expenditures do not

necessarily reflect all aspects of community benefit that might have been provided by the respondents. Our preliminary work indicates that other measures, such as expenditures as a percentage of total expenses or direct medical care outlays, might help portray a more complete picture of the extent of community benefit provided by nonprofit hospitals.

High percentages of hospitals reported they did not deny medical services to individuals based on type of insurance or if they had no insurance. Ninety percent reported they did not deny medical services to any individuals who lacked insurance; even greater percentages reported they did not deny medical services to any individuals who were covered by government programs or private insurance. All of the 451 hospitals that reported they operated an emergency room also reported that their emergency room provided services to all members of the community regardless of their ability to pay.

The Interim Report also summarizes reported data regarding certain governance matters and practices, billing and collection practices, medical staff privileges, and emergency room operations.

IV. Recommendations Regarding Form 990 Reporting

A Project Team compiled the data, reviewed the responses, and prepared the Interim Report. In the Interim Report the Project Team recommends a separate schedule for the Form 990 to report community benefit expenditures. The Project Team used data from the Project to assist in the design of the draft Form 990 that was released for public comment on June 14, 2007. The draft Form 990 contains a Schedule H, *Hospitals*, which would require reporting at cost the charity care and other community benefits provided by the filing organization. Schedule H also would require information regarding the organization's charity care policies, revenue profile, bad debt expense, collection practices, and certain other activities. The IRS is currently working with interested stakeholders on possible modifications and refinements to the proposed Schedule H and will also consider future analysis of data reported in this Project.

V. Next Steps

The Interim Report is a summary of the data as it was reported. The data has not been independently verified, and analysis of the data is incomplete. The lack of uniformity in certain reporting practices and definitions, the failure by some hospitals to respond to all of the questions, deficiencies in the manner in which certain questions were asked, and ambiguous responses in many instances, limit the usefulness of some of the reported data. For these reasons, the data may not capture adequately the community benefit actually provided by the respondents or by the nonprofit hospital sector as a whole. To address these limitations, the Project Team will:

1. Analyze the reported data to determine whether differences in reporting, such as the treatment of bad debt and shortfalls as uncompensated care, may be isolated and adjusted to allow more meaningful comparisons across the respondents.
2. Obtain additional research and analyze the differences in community benefit expenditure amounts and types to take into account varying demographics, such as rural and urban communities and hospitals.
3. Test the reported community benefit amounts and types by conducting data analysis, compliance checks or examinations of individual hospitals, and by other means, including with respect to outliers in the reported data.