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Hospital Charity Care and Related Reporting Requirements Under Medicare and the Internal Revenue Code

Charity care is commonly understood to be, generally, an unrecovered cost written off by providers that results from providing care to individuals who are uninsured or who are otherwise unable to pay for the health care services they receive. To help offset the costs of hospital-provided charity care, Medicare and the Internal Revenue Code (IRC) convey payment and tax benefits, respectively, to qualifying hospitals. For example, under Medicare, charity care is used as one element in determining hospital eligibility for Medicare uncompensated care payments, which account for certain unrecovered costs such as charity care. For federal income-tax purposes, the degree of charity care provided by a hospital is a factor that may be used by the Internal Revenue Service (IRS) when determining whether that hospital qualifies for tax-exempt status under IRC Section 501(c)(3).

The amount of charity care provided by hospitals is sometimes discussed as a potential metric to determine a hospital's eligibility for various payments or programs. Given this interest, what follows is a summary of the ways in which Medicare and the IRC rules address hospital charity care differently. Specifically, although similar conceptions of hospital charity care underlie the two sets of rules, charity care's definition, its purpose, the nature and extent of data reporting, and public availability of information vary depending upon which context (Medicare or tax-exempt status) is being discussed.

Charity Care Definitions and Reporting Requirements

Hospitals that receive Medicare reimbursement are required to submit annually to the Centers for Medicare & Medicaid Services (CMS) a cost report that details the hospital's costs of health care services delivered to Medicare beneficiaries. (The cost report is used by CMS to "settle" or reconcile Medicare's payments with the hospital's actual costs after the end of the fiscal year.) Specifically, hospitals paid under the Medicare inpatient prospective payment system (IPPS) and critical access hospitals (CAHs) must use the cost report's *Worksheet S-10 - Hospital Uncompensated and Indigent Care Data* to report information about the hospital's charity care.

Under the Medicare IPPS, charity care is one component of a broader concept: uncompensated care. Medicare adjusts per-discharge IPPS payments to account for the amount of uncompensated care that an eligible hospital provides relative to all eligible hospitals that provide uncompensated care. A hospital must qualify to receive Medicare disproportionate share hospital (DSH) payments as a prerequisite for Medicare uncompensated care payments. To qualify for DSH payments, hospitals must meet certain

thresholds for serving a disproportionate number of low-income patients. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) modified Medicare DSH payments by, among other things, splitting Medicare DSH payments into two payments—DSH and uncompensated care payments.

The Medicare Provider Reimbursement Manual instructions for the S-10 worksheet define charity care as resulting "from a hospital's policy to provide all or a portion of services free of charge to patients who meet the hospital's charity care policy or financial assistance policy (FAP)." This includes full or partial discounts. Therefore, what constitutes charity care under Medicare is largely determined by an individual hospital's charity care policy or FAP.

A nonprofit hospital applying for, or seeking to maintain, tax-exempt status as a "charitable" organization under IRC Section 501(c)(3) must meet a "community benefit standard" developed by the IRS. Generally, this standard requires the hospital to show that it has provided benefits that promote the health of a broad class of persons to the community. (Some nonprofit hospitals may qualify under Section 501(c)(3) as educational organizations, rather than charitable organizations.) One way hospitals may demonstrate that they have met the community benefit standard is by providing charity care.

Section 501(c)(3) tax-exempt hospitals report various information about their activities—including charity care—on IRS Form 990 Schedule H. On IRS Form 990 Schedule H (and accompanying instructions) charity care is referred to as "financial assistance," which is defined in the instructions as "free or discounted health services provided to" people who meet the hospital's financial assistance criteria and are unable to pay for the services. In addition, nonprofit hospitals applying for, or seeking to maintain, Section 501(c)(3) tax-exempt status also must comply with ACA requirements. One such ACA requirement is that the hospitals have an FAP.

Use of Charity Care Information

In FY2018, CMS began to use information submitted by hospitals on the S-10 to determine a DSH-eligible hospital's Medicare uncompensated care payment. Through notice and comment, CMS proposed using S-10 information to calculate uncompensated care payments beginning in FY2014. However, CMS did not finalize its proposal, postponing use of the S-10 due to a number of factors. These factors included (1) the relative newness of the S-10, which had gone into effect May 1, 2010; (2) concerns about data standardization and completeness; and (3) the fact that

the most relevant data elements historically had not been publicly available or subject to audit.

Since then, CMS has undertaken a number of steps to address these limitations, including clarifying and standardizing the S-10 instructions. Based on these actions, CMS finalized through notice comment a two-year (FY2018 and FY2019) transition to using S-10 data to calculate a DSH-eligible hospital's Medicare uncompensated care payments. During the transition, CMS is to use a blend of S-10 data and proxy data (addressed below). Beginning FY2020, CMS is to use only S-10 data for determining Medicare uncompensated care payments.

Prior to FY2018, CMS allocated uncompensated care payments based solely on a proxy for uncompensated care that consisted of data related to certain insured low-income patients. Specifically, CMS used hospital services provided to Medicare beneficiaries who also receive Supplemental Security Income (SSI) and to Medicaid recipients.

Analyses have concluded that Medicare uncompensated care payments should be based on S-10 data. For example, in a 2016 report to Congress, the Medicare Payment Advisory Commission concluded that despite the imperfections at the time, S-10 data are a better predictor of uncompensated care costs than low-income insured proxies such as Medicare-SSI and Medicaid.

As previously discussed, a hospital with 501(c)(3) status as a "charitable" organization must meet the community benefit standard. Providing charity care is one way a 501(c)(3) hospital can meet that standard. In addition, all 501(c)(3) hospitals must comply with requirements imposed by the ACA, including having an FAP. There are no bright-line numerical thresholds for determining whether a hospital meets the legal requirements for 501(c)(3) status (e.g., there is no requirement that 501(c)(3) hospitals provide a specified amount of charity care or financial assistance). Thus, no specific amount reported on the Form 990 Schedule H is, by itself, sufficient evidence of compliance with the requirements. Further, the data on the Schedule H are not the basis for any calculations by the IRS with respect to assessing tax-exempt status or federal tax liability.

Audits of Charity Care Information

The Medicare Financial Management Manual states that cost reports are subject to audit, although not all cost reports are audited. However, *all* cost reports are reviewed for "adequacy, completeness, and accuracy and reasonableness of the data." The Worksheet S-10 is also subject to audit. Through the FY2019 IPPS proposed rule, CMS has stated that although S-10 audit protocols are confidential, it will review and identify hospitals that have high uncompensated care costs relative to total operating costs for purposes of determining Medicare uncompensated care payments in FY2019. As noted previously, charity care is one of three components of uncompensated care.

When filing the Form 990, hospitals must submit a copy of their audited financial statements (i.e., the financial statements audited by a public accounting firm). For

purposes of enforcement of federal tax laws, the IRS audits a relatively small proportion of tax returns, including those provided by tax-exempt organizations. For example, according to IRS data on enforcement activities, during FY2017, the IRS audited approximately 0.2% of all tax-exempt organization returns filed in tax year 2016.

Public Availability of Charity Care Information

Medicare cost report information, including charity care data, is publicly available on CMS's "Research, Statistics, and Data & Systems" web page. Downloading and using the data involves some level of technical proficiency with software such as Oracle, SAS, SPSS Statistical Package, or Microsoft SQL Server.

There is approximately a two- to three-year lag on cost report data public availability. For example, FY2016 cost report data for most, if not all, hospitals is posted on the CMS cost report web page by mid- to late FY2018. Based on CRS analysis of publicly available Medicare cost report data, of the 6,056 hospital cost reports available for FY2016, 4,327 (or 71.45%) reported charity care costs.

Under the IRC, the Form 990s filed by a 501(c)(3) hospitals are open to public inspection. The law requires that both the IRS and the hospital make the documents publicly available. The hospital must allow the public to inspect the documents and must provide copies upon request. Datasets of the entire population of Schedule H returns are available via the IRS's "SOI Tax Stats – Charities and Other Tax-Exempt Organizations Statistics" web page. Currently, only the populations of tax years 2011 through 2014 are available, as well as e-filed Schedule Hs for tax years 2009 and 2010. The SOI Schedule H population datasets are published in ASCII microdata files. These files must be read into a statistical software package, such as Stata or SAS with user-generated data dictionaries.

There are limitations to the microdata files stemming from lack of uniformity in data entry on Schedule H. For example, filers must indicate what percentage of the federal poverty guidelines is used for determining eligibility for free care. In the dataset, observations include such outliers as 1% or 18,500%. Presumably, these entries should have been recorded as 100% and 185%, respectively. Similar discrepancies occur across the entire dataset. In addition, not all data fields on the form are complete in the population data set.

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