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TAX ADMINISTRATION

IRS Oversight of Hospitals' Tax-Exempt Status

Statement of Jessica Lucas-Judy, Director, Strategic Issues

Accessible Version

GAO-23-106777

GAO Highlights

Highlights of GAO-23-106777, a testimony before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

April 26, 2023

TAX ADMINISTRATION

IRS Oversight of Hospitals' Tax-Exempt Status

Why GAO Did This Study

Slightly more than half of the approximately 5,000 community hospitals in the United States are private, nonprofit organizations. IRS and the Department of the Treasury have recognized the promotion of health as a charitable purpose and have specified that nonprofit hospitals are eligible for a tax exemption. IRS has further stated that these hospitals can demonstrate their charitable purpose by providing services that benefit their communities as a whole.

In 2010, Congress and the President enacted PPACA, which established additional requirements for tax-exempt hospitals to maintain a tax exemption.

This testimony discusses the requirements for a nonprofit hospital to qualify for tax-exempt status and challenges with verifying compliance with some of those requirements, and is based on a report that GAO issued in September 2020. This testimony reflects updated information GAO obtained from IRS regarding its implementation of the recommendations made in that report.

What GAO Recommends

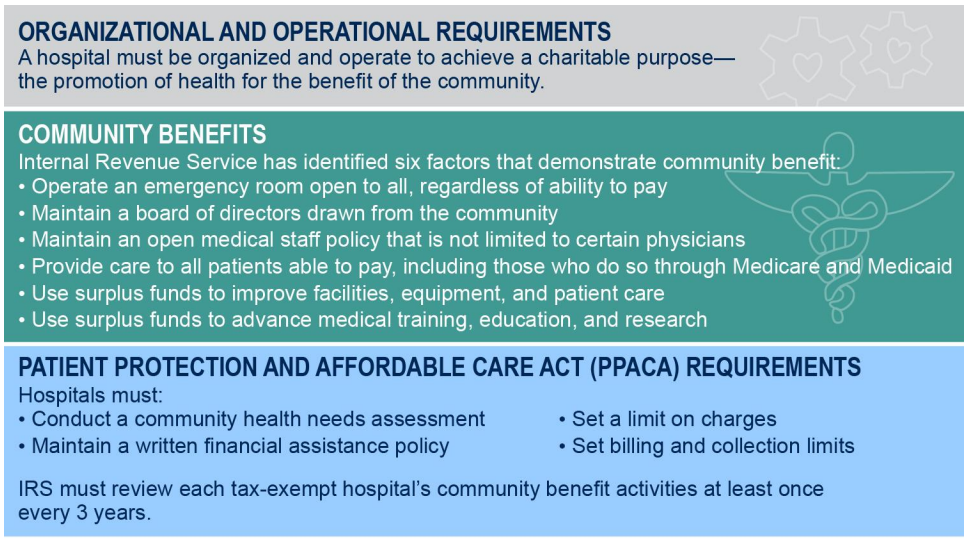
In September 2020, GAO recommended Congress consider specifying what services and activities demonstrate sufficient community benefit. As of April 2023, Congress had not enacted such legislation. GAO also recommended IRS update tax forms to increase transparency about hospitals' community benefits. IRS agreed and made minor adjustments to the form's instructions, but the form still relies on a narrative description of community benefits that hospitals provide.

View GAO-23-106777. For more information, contact Jessica Lucas-Judy at (202) 512-6806 or lucasjudyj@gao.gov.

What GAO Found:

Hospitals must satisfy three sets of requirements for a nonprofit tax exemption (see figure) but hospital community benefits are not defined in law.

Requirements for Nonprofit Hospitals to Obtain and Maintain a Tax Exemption



Source: GAO review of relevant laws and regulations. | GAO-23-106777

Text of Requirements for Nonprofit Hospitals to Obtain and Maintain a Tax Exemption

- **ORGANIZATIONAL AND OPERATIONAL REQUIREMENTS:** A hospital must be organized and operate to achieve a charitable purpose—the promotion of health for the benefit of the community.
- **COMMUNITY BENEFITS.** Internal Revenue Service has identified six factors that demonstrate community benefit:
  - Operate an emergency room open to all, regardless of ability to pay
  - Maintain a board of directors drawn from the community
  - Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians)
  - Provide care to all patients able to pay, including those who do so through Medicare and Medicaid
  - Use surplus funds to improve facilities, equipment, and patient care
  - Use surplus funds to advance medical training, education, and research

- **PATIENT PROTECTION AND AFFORDABLE CARE ACT REQUIREMENTS**
  - Hospitals must:
    - Conduct a community health needs assessment
    - Maintain a written financial assistance policy
    - Set a limit on charges
    - Set billing and collection limits
  - IRS must review each tax-exempt hospital's community benefit activities at least once every 3 years.

Source: GAO review of relevant laws and regulations. | GAO-23-106777

In 1969, the Internal Revenue Service (IRS) identified factors that can demonstrate community benefits, but they are not requirements. IRS does not have authority to specify activities hospitals must undertake and makes determinations based on facts and circumstances. As a result, tax-exempt hospitals have broad latitude to determine the community benefits they provide, but the lack of clarity creates challenges for IRS in administering tax law.

Additionally, the form on which hospitals report community benefits solicits that information inconsistently, resulting in a lack of transparency. For example, hospitals may describe the use of surplus funds to improve facilities, equipment, and patient care narratively. This qualitative reporting format does not require tax-exempt hospitals to specify the amount of surplus funds used to improve facilities, equipment, and patient care. It could also result in incomplete information on how hospitals are providing community benefits.

GAO's 2020 analysis of IRS data identified 30 hospitals that reported no spending on community benefits in 2016. According to IRS officials, hospitals with little to no community benefit expenses would indicate potential noncompliance. IRS is required to review hospitals' community benefit activities at least once every 3 years, but was unable to provide evidence that it did so because it did not have a well-documented process to ensure those activities were being reviewed. Consistent with GAO's September 2020 recommendations, in 2021 IRS updated its overall guidance instructing its employees to document whether a hospital organization satisfies the community benefit standard and established an audit code to track that review.

Chairman Schweikert, Ranking Member Pascrell, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Internal Revenue Service's (IRS) oversight of hospitals' tax-exempt status. Slightly more than half of the approximately 5,000 community hospitals in the United States are private, nonprofit organizations.[1] Nonprofit organizations can obtain and maintain a federal tax exemption if they are organized for one or more purposes specified in the Internal Revenue Code section 501(c)(3). The Joint Committee on Taxation estimated the total revenue loss from the tax exemption of hospitals at $12.6 billion in 2002.[2] Hospitals reported that they provided $76 billion in community benefits in 2016—the most recent data available when we reviewed this issue in 2020.[3]

Nonprofit hospitals can be tax-exempt if they provide certain community benefits, such as an emergency room open to all.[4] They must also meet legal requirements in the Patient Protection and Affordable Care Act (PPACA), such as maintaining a written financial assistance policy.

My remarks today are based on our September 2020 report on IRS oversight of tax-exempt hospitals.[5] I will focus on three aspects of this report—(1) the requirements that must be met for a nonprofit hospital to qualify for tax-exempt status, (2) challenges with verifying compliance

[1]American Hospital Association, Fast Facts, accessed April 17, 2023, https://www.aha.org/statistics/fast-facts-us-hospitals. Community hospitals exclude nonfederal psychiatric hospitals and other hospitals, including long-term care hospitals and those within an institution.

[2]Congressional Budget Office, *Nonprofit Hospitals and the Provision of Community Benefits* (Washington, D.C: December 2006) reports the Joint Committee on Taxation estimate.

[3]GAO, *Tax Administration: Opportunities Exist to Improve Oversight of Hospitals' Tax-Exempt Status,* GAO-20-679 (Washington, D.C.: Sept. 17, 2020). For the purposes of this statement, we use the term "tax-exempt hospitals" to refer to nongovernmental, nonprofit, and tax-exempt hospitals. Government hospitals—including those at the federal, state, tribal, and local levels—are also exempt from federal taxation.

[4]IRS defines a hospital organization as an entity that operated at least one hospital facility during a tax year. A hospital facility is an entity that is required to be licensed, registered, or similarly recognized by a state as a hospital. Nonhospital health care facilities may include, but are not limited to, rehabilitation and other outpatient clinics, mobile clinics, and skilled nursing facilities.

[5]GAO-20-679.

with some of those requirements, and (3) IRS's oversight of the community benefit standard and PPACA requirements.

To conduct our prior work, we reviewed relevant provisions of the Internal Revenue Code, Department of the Treasury regulations, revenue rulings, and guidance. We also reviewed IRS policies, procedures, audit plans, and determining factors for reviewing tax-exempt hospitals, and we interviewed IRS officials. We examined the most recent data available at the time of that report (tax year 2016) from forms hospitals are required to file with IRS documenting the community benefits they provide and their compliance with PPACA. More detailed information on our objectives, scope, and methodology can be found in the 2020 report. Since the issuance of that report, we received and reviewed information from IRS on actions taken in response to our recommendations.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Requirements for Hospitals' Tax-Exempt Status

Nonprofit hospitals must satisfy three sets of requirements to obtain and maintain federal tax-exempt status (see fig. 1).

Figure 1: Requirements for Nonprofit Hospitals to Obtain Federal Tax-Exempt Status

Source: GAO review of relevant laws and regulations. | GAO-23-106777

Text of Figure 1: Requirements for Nonprofit Hospitals to Obtain Federal Tax-Exempt Status

- **ORGANIZATIONAL AND OPERATIONAL REQUIREMENTS:** A hospital must be organized and operate to achieve a charitable purpose—the promotion of health for the benefit of the community.
- **COMMUNITY BENEFITS.** Internal Revenue Service has identified six factors that demonstrate community benefit:
  - Operate an emergency room open to all, regardless of ability to pay
  - Maintain a board of directors drawn from the community

- Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians)
- Provide care to all patients able to pay, including those who do so through Medicare and Medicaid
- Use surplus funds to improve facilities, equipment, and patient care
- Use surplus funds to advance medical training, education, and research

- **PATIENT PROTECTION AND AFFORDABLE CARE ACT REQUIREMENTS**
  - Hospitals must:
    - Conduct a community health needs assessment
    - Maintain a written financial assistance policy
    - Set a limit on charges
    - Set billing and collection limits
  - IRS must review each tax-exempt hospital's community benefit activities at least once every 3 years.

Source: GAO review of relevant laws and regulations. | GAO-23-106777

The Internal Revenue Code requires that all organizations seeking a tax exemption under section 501(c)(3) be organized and operated for one or more purposes, which can be charitable, religious, or educational, among others.[6] The code does not specifically identify hospitals as being eligible for a tax exemption. However, IRS and federal courts have recognized that the promotion of health for a community's benefit is a charitable purpose.[7]

IRS has also identified factors—referred to as the community benefit standard—for how hospitals could demonstrate that they provide benefits to the community. As described below, the types of benefits they could

[6]Section 501 of the Internal Revenue Code covers the majority of these organizations, which include public charities, social welfare organizations, business leagues, and private foundations. Other types of organizations, such as education-oriented programs, farmers' cooperatives, and political organizations, are also wholly or partially tax exempt. 26 U.S.C. §§ 501(c)(3), 521, 527, 529-530.

[7]See Geisinger Health Plan v. Comm'r, 985 F.2d 1210, 1216 (3d Cir. 1993) (discussing IRS policy and cases construing exemption provisions for hospitals).

provide are not detailed in the Internal Revenue Code and are not mandatory by law.

Lastly, as shown in figure 1, PPACA established four additional requirements that tax-exempt hospitals must meet to maintain a tax exemption.[8]

Development of the Community Benefit Standard

In a 1956 revenue ruling, IRS required tax-exempt hospitals to provide charity care to the extent of their financial abilities.[9] IRS determined in the ruling that only hospitals that operated for the benefit of those not able to pay, and not exclusively for the benefit of those who were able and expected to pay, could qualify for a tax exemption.

In 1959, Treasury updated its regulations to establish that organizations can receive tax-exempt status by demonstrating a charitable purpose, such as the promotion of health.

In 1969, 4 years after Congress and the President created Medicare and Medicaid, IRS removed the requirement for tax-exempt hospitals to provide charity care—patient care without charge or at rates below cost—when it issued Revenue Ruling 69-545.[10] The ruling compares the extent to which two hypothetical hospitals satisfy the Internal Revenue Code's requirements for a tax exemption. In making that comparison, the ruling identifies six factors that distinguish how one hospital satisfies the requirements and how the second does not. IRS says that although a hospital is no longer required to provide charity care, it considers doing so to be a significant factor indicating community benefit.

There is no specific definition of community benefit. These six factors currently serve as the primary examples of community benefits that hospitals can provide to obtain and maintain a tax exemption. The factors are commonly referred to as the community benefit standard. IRS describes the six factors on its website:

[8]Pub. L. No. 111-148, tit. IX, § 9007, 129 Stat. 119, 855 (2010), *codified at* 26 U.S.C. § 501(r).

[9]Rev. Rul. 56-185, 1956-1 C.B. 202. Charity care is generally defined as care provided to patients whom the hospital deems unable to pay all or a portion of their bills.

[10]Rev. Rul. 69-545, 1969-2 C.B. 117.

- **Operate an emergency room open to all, regardless of ability to pay.** A hospital that does not operate a full-time emergency room may not be fulfilling the community's need for emergency health care. If that emergency room is not open to everyone regardless of ability to pay, the hospital may not be serving a significant segment of the community.[11]
- **Maintain a board of directors drawn from the community.** A hospital board of directors comprised of independent civic leaders helps to ensure that the hospital serves public, rather than private, interests, and therefore operates for the benefit of the community.
- **Maintain an open medical staff policy (i.e., not restrict medical staff privileges to a limited group of physicians).** A hospital that restricts its medical staff privileges to a limited group of physicians is likely to be operating for the private benefit of the staff physicians rather than for the public interest.
- **Provide care to all patients able to pay, including those who do so through Medicare and Medicaid.** A hospital that restricts admissions to patients of staff members, or otherwise discriminates against patients with the ability to pay for nonemergency services, is not operating for the benefit of the community.
- **Use surplus funds to (1) improve facilities, equipment, and patient care; and (2) advance medical training, education, and research.** The use of surplus funds for these purposes demonstrates that a hospital is promoting the health of the community.[12]

The standard states that a hospital need not meet all of the factors to qualify for a tax exemption. The absence of any one factor, or the presence of others, may not necessarily be conclusive of the hospital's community benefits. Furthermore, IRS considers all of a hospital's facts and circumstances relevant when determining whether a hospital's community benefits are sufficient to warrant a tax exemption.

[11]IRS Revenue Ruling 83-157 established that if a state health planning agency determined that additional emergency facilities would be unnecessary and duplicative, or if the hospital offers medical care limited to special conditions unlikely to necessitate emergency care, such as eye or cancer hospitals, then the fact that a hospital organization does not operate an emergency room will not, by itself, disqualify it from a tax exemption. Rev. Rul. 83-157, 1983-2 C.B. 94.

[12]IRS, *Charitable Hospitals — General Requirements for Tax-Exemption Under Section 501(c)(3)*, accessed April 30, 2020. https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

Patient Protection and Affordable Care Act Requirements

PPACA established four additional requirements that tax-exempt hospitals must meet to maintain a tax exemption.[13]

- **Conduct a community health needs assessment.** Every 3 years, each tax-exempt hospital must identify the community's health needs and develop an implementation plan for how it will address those needs.[14]
- **Maintain a written financial assistance policy.** Each tax-exempt hospital must publish a written policy that identifies who can qualify for financial assistance for medical services, how the hospital calculates costs for those services, and the actions the hospital will take in the event of nonpayment.
- **Set a limit on charges.** A tax-exempt hospital cannot charge individuals eligible for financial assistance more for medical services than they do patients with insurance.
- **Set billing and collection limits.** A tax-exempt hospital may not take extraordinary collection actions against an individual, such as filing a lawsuit, before the hospital determines whether that individual is eligible for financial assistance.

In addition, the law established a new requirement for IRS to review the community benefit activities of each tax-exempt hospital at least once every 3 years.[15]

Congress Could Clarify the Law to Improve Oversight of Tax-Exempt Hospitals

Congress has taken actions that convey an expectation that hospitals, in exchange for a tax exemption, should provide services and activities that benefit the immediate communities in which they operate. Specifically, in PPACA, Congress required tax-exempt hospitals to identify each

[13]Pub. L. No. 111-148, tit. IX, § 9007, 129 Stat. 119, 855 (2010), *codified at* 26 U.S.C. § 501(r).

[14]PPACA establishes that a tax-exempt hospital that does not meet the community health needs assessment requirement must pay an excise tax. See 26 U.S.C. § 4959.

[15]PPACA, Pub. L. No. 111-148, tit. IX, § 9007(c), 129 Stat. 119, 857 (2010).

hospital's community's health needs, indicating an expectation that hospitals provide benefits to the immediate community.

However, a broad range of activities fall within the Internal Revenue Code's requirement for a tax exemption for charitable organizations, making it challenging to ensure that the community benefits that hospitals provide justify their tax exemption.

IRS does not have authority to define specific types of services and activities that a hospital must undertake to qualify for a tax exemption. Instead, it provides guidance on the types of activities that can demonstrate community benefits. In this regard, the Internal Revenue Code does not identify explicit community benefit activities required for tax-exempt status, and the factors IRS identified in its 1969 ruling are examples and not requirements.

Furthermore, some of the factors may have lost relevance. For example, in 2005, the Commissioner of Internal Revenue told Congress that some community benefit factors, such as maintaining an open medical staff policy and accepting patients on Medicare and Medicaid, are now common features of all hospitals.[16] Additionally, the Emergency Medical Treatment and Active Labor Act, signed into law in 1986, requires that all hospitals that operate emergency rooms provide emergency treatment to all, regardless of ability to pay.[17] As a result, these standards may be a less useful gauge for measuring community benefit than they once were.

The Internal Revenue Code and IRS's implementation of it gives tax-exempt hospitals broad latitude to determine the nature and amount of community benefits they provide. Representatives of tax-exempt hospitals told us that current law and the community benefit standard offer hospitals needed flexibility in demonstrating community benefits. For example, a hospital located in a remote rural community may be the only hospital within hundreds of miles, making its existence the primary benefit to the community.

However, that lack of clarity also creates challenges for IRS in administering tax law. For example, given this ambiguity, a hospital could, in theory, maintain a tax exemption by operating an emergency room

[16]*The Tax-exempt Hospitals Sector before the Committee on Ways and Means U.S. House of Representatives*, 109th Cong. 8-18, (2005) (statement of Mark W. Everson, Commissioner of Internal Revenue).

[17]Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, tit. IX, § 9121(b), 100 Stat 164 (1986).

open to all and accepting patients on Medicare or Medicaid, which are common among hospitals, while spending little to no money on charity care or other community benefit activities. In our September 2020 report, we identified 30 hospitals that reported no spending on community benefits in 2016, and other hospitals that could have been at risk for noncompliance with the community benefit standard during a similar period (see table 1).[18]

Table 1: Number of Hospital Organizations with Little to No Community Benefit Spending, Tax Years 2014-2016

	2014	2015	2016
No financial assistance	64	68	48
No community benefit spending	48	45	30
Less than 1 percent community benefit spending	142	137	108

Source: GAO analysis of Internal Revenue Service data. | GAO-23-106777

Note: Financial assistance includes financial aid (i.e., charity care), Medicaid, and other means-tested government programs. The calculation of community benefit corrects for hospitals that reported negative spending values due to excess off-setting revenues, such as grants or Medicaid reimbursements.

IRS officials told us that the agency had not revoked a hospital's tax-exempt status for failing to provide sufficient community benefits in the previous 10 years.

We recommended that Congress consider amending the Internal Revenue Code to specify services and activities Congress believes would provide sufficient community benefits, which could improve IRS's ability to oversee tax-exempt hospitals. As of April 2023, Congress has not enacted such legislation.

[18]We examined data on community benefit information that hospitals report from Forms 990, Schedule H, which hospitals are required to file with IRS. Those data were obtained from IRS Statistics of Income (SOI) public microdata files that covered the entire population of tax-exempt hospitals for tax year up to 2016, the most recent year available at the time of our review.

IRS Could Improve Transparency of Community Benefit Information but Has Taken Action to Improve Its Oversight Ability

Reporting on Community Benefits

IRS requires a tax-exempt hospital to file Schedule H with its Form 990 annually to provide the public with information on its policies and activities and the community benefits that its facilities provide. IRS has stated a tax-exempt organization's Form 990, along with its schedules, can be the primary or sole source of information the public uses to understand a tax-exempt organization's operations, such as the community benefits a hospital provides.

However, Form 990, Schedule H solicits information inconsistently, resulting in a lack of clarity about the community benefits hospitals provide. The schedule includes questions intended to capture information on each of the six factors of the community benefit standard. However, these questions are located on different parts of the schedule and hospitals are instructed to address them in different ways.

For three of the six factors, IRS explicitly directs tax-exempt hospitals to report the extent to which they have addressed them. For the other three factors, IRS provides a space for hospitals to describe in a narrative the community benefits they provide, noting those factors as examples of community benefits.

For example, IRS directs hospitals to identify the specific costs they incur by providing health education and medical research. However, hospitals may describe the use of surplus funds to improve facilities, equipment, and patient care in a narrative format.

This qualitative reporting format does not require tax-exempt hospitals to specify the amount of surplus funds used to improve facilities, equipment, and patient care. It could also result in potentially incomplete information on how hospitals are providing community benefits.

In our analysis of hospitals' Form 990, Schedule H filings for tax years 2015 through 2018, we found inconsistencies in what hospitals reported in the narrative description. Some provided numerous examples of how they used surplus funds to improve their facilities and patient care, while others did not address any of the suggested factors.

Furthermore, the quantitative, machine-readable publicly available data IRS releases on the community benefits reported by tax-exempt hospitals on Form 990, Schedule H do not contain information that hospitals describe narratively.[19] Therefore, this reporting results in information on half of the factors that is inconsistent and difficult to obtain.

We recommended IRS update Form 990, including Schedule H and instructions where appropriate, to ensure that the information demonstrating the community benefits a hospital is providing is clear and can be easily identified by Congress and the public, including the community benefit factors. IRS agreed with this recommendation.

In response to our recommendation, IRS made minor adjustments to Form 990, Schedule H instructions to indicate that responses should include all of the community benefit factors. However, IRS still asks hospitals to describe narratively additional information important to understanding the full scope of the community benefits they provide. IRS could fully implement our recommendation through further updates to its forms. This would help ensure that community benefit information is clear and can be easily identified by Congress and the public.

Reporting by Facility

Form 990, Schedule H directs tax-exempt hospitals to report their community benefit expenses at the hospital organization level rather than at the facility level. Therefore, hospital organizations that operate multiple facilities report community benefits in the aggregate for all of their facilities.

For example, a hospital organization reports the amount of charity care it provides and its costs for medical training, education, and research for all of its facilities as a whole, not for each facility. In doing so, it is not transparent how much each facility contributes to the total. A few facilities could contribute the majority of community benefit expenses, while others contribute little to none. In tax year 2016, 46 percent of hospital facilities were part of a hospital organization, and therefore those facilities' community benefit expenses were reported as part of the organization as a whole.

We recommended IRS assess the benefits and costs, including the tax law implications, of requiring tax-exempt hospital organizations to report

[19]Forms 990 are disclosable to the public and can be requested by submitting Form 4506-A.

community benefit expenses on Schedule H by individual facility rather than by collective organization and take action, as appropriate.

In response to our 2020 recommendation, IRS qualitatively assessed the benefits and costs of requiring community benefit reporting on a facility-by-facility basis. According to IRS's assessment, such reporting would impose greater burdens on tax-exempt hospitals and IRS with no tax administration benefit. Specifically, IRS determined that because the tax exemption is granted at the organization level, reporting community benefits at the facility level would provide no additional tax administration benefit. While reporting at the facility level would increase transparency, we closed our recommendation as implemented, recognizing the tradeoffs between the burdens and benefits of more detailed reporting.

Improvements in IRS Review of Hospitals' Community Benefits

IRS verifies many aspects of hospitals' reports during its triennial Community Benefit Activity Reviews (CBAR), but it did not have a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard. IRS requires hospitals to self-report compliance with all four PPACA requirements on Form 990, Schedule H, Part V. Hospitals must answer a series of yes or no questions for each of the four PPACA requirements. In addition PPACA required IRS to review information about hospitals' community benefit activities at least every 3 years.

IRS referred almost 1,000 hospitals to its audit division for potential PPACA violations from fiscal years 2015 through 2019. However, IRS could not identify whether any of these referrals related to community benefits.

IRS stated that it sends back forms that are materially incomplete and requests that hospitals complete the missing information; however, we found that some of the hospitals left the required community benefit section of Form 990, Schedule H blank. These hospitals may have actually spent funds on community benefit activities, but did not complete the form. Other hospitals reported spending amounts that were approximately 0 percent of expenses.[20]

[20]IRS agents in the Statistics of Income group in the Research Applied Analytics and Statistics Division correct some of the Form 990, Schedule H data for obvious errors before posting the public files onto IRS's website. However, those changes do not extend to the forms themselves that IRS officials would review in a CBAR.

IRS's guidance contained specific questions that address the community benefit factors, but there was no direction on when a hospital should be referred for audit if the revenue agent is unable to verify the factor.

According to IRS officials, hospitals with little to no community benefit expenses may warrant an audit. However, IRS was unable to provide evidence that it conducted reviews specifically related to hospitals' community benefits.

For example, according to IRS officials, of the 37 hospitals that reported zero or negative community benefit spending in tax year 2016:

- 21 were referred for examination or compliance check as a result of their CBAR reviews.[21]
- Six of these hospitals were referred for audit based on CBAR review of the 2016 Form 990.
- The other 15 referrals were made based on other tax years.

However, in all these cases, the referrals were made as a result of possible issues with the financial assistance policy or community health needs assessment but not issues with the community benefit standard. IRS officials said the other 16 hospitals that reported no spending on community benefits were not referred for audit because they met the PPACA requirements.

Furthermore, IRS did not have a way to determine if hospitals were being selected for audit for potential noncompliance related to community benefits during a CBAR. While it used audit issue codes that differentiate between PPACA-related noncompliance and other noncompliance, there were no codes related to potential noncompliance with the community benefit standard. According to IRS, from 2016 through 2019, fewer than 10 cases each year were referred to its audit division during the CBAR for an issue not related to PPACA.

We recommended IRS establish a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard that would ensure hospitals' community benefit activities are being consistently reviewed. We also recommended IRS establish specific audit codes for identifying potential noncompliance with the community benefit standard.

[21]We provided IRS with a list of 37 hospitals that, based on our review of Form 990, Schedule H data, reported zero or negative net community benefit spending for tax year 2016. This number is larger than the amount reported in table 1, because the values in table 1 correct for the cases for which hospitals reported negative spending in Medicaid.

In response, in 2021 IRS updated the guidance for CBAR reviews to include instructions for employees to document case files with relevant facts and circumstances considered during their review that determine whether the hospital organization satisfies the community benefit standard for exemption. IRS also established an audit code in its Case Management System under Healthcare Issues 18010.000 for "Healthcare - Community Benefit Standard for Exemption." These actions will help IRS ensure it is effectively reviewing hospitals' community benefit activities.

In summary, IRS can easily verify whether the legal requirements in PPACA are met. However, it is harder for IRS to verify community benefits because IRS does not have the authority to define specific services and activities hospitals must undertake to qualify for a tax exemption. Additional clarity about specific services and activities Congress believes would provide sufficient community benefits could improve IRS's ability to oversee tax-exempt hospitals.

In addition, IRS action to update and revise Form 990, Schedule H that enables tax-exempt hospitals to present community benefit information clearly, consistently, and comprehensively could help IRS, Congress, and the broader public better understand the full scope of the community benefits a hospital provides and whether they justify a tax exemption.

Chairman Schweikert, Ranking Member Pascrell, and Members of the Subcommittee, this concludes my prepared remarks. I look forward to answering any questions that you may have.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-6806 or lucasjudyj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Sonya Phillips (Assistant Director), Jennifer G. Stratton (Analyst-in-Charge), Caitlin Cusati, Steven Flint, Robert Gebhart, James A. Howard, Matthew Levie, Ed Nannenhorn, Sonya Vartivarian, Peter Verchinski, Daniel Webb, and Alicia White.

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