A Report
to the
Montana
Legislature

Performance Audit

Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals

Department of Public Health and Human Services

September 2020

Legislative Audit
Division

18P-07

Performance Audits

Performance audits conducted by the Legislative Audit Division are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy.

We conducted this performance audit 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Members of the performance audit staff hold degrees in disciplines appropriate to the audit process.

Performance audits are conducted at the request of the Legislative Audit Committee, which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

Audit Staff

Sarah A. Carlson
Julia Conelley
William Soller

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LEGISLATIVE AUDIT DIVISION

Angus Maciver, Legislative Auditor
Deborah F. Butler, Legal Counsel

Deputy Legislative Auditors:
Cindy Jorgenson

September 2020

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of community benefit spending, including charity care, by Montana nonprofit hospitals. There is no Montana law regarding overall community benefit spending, but state law requires some Montana hospitals to have charity care policies. The Department of Public Health and Human Services (DPHHS) is tasked with monitoring the charity care law. This report provides the legislature information about hospital charity care programs, nonprofit hospital tax exemption benefit, and community benefit spending.

It includes one recommendation to the legislature for improving information available to the public about nonprofit hospital community benefit spending, and one recommendation to DPHHS related to the implementation of the state law requiring some hospitals to provide charity care to patients. A written response from DPHHS is included at the end of the report.

We wish to express our appreciation to DPHHS and employees and representatives of Montana's nonprofit hospitals for their cooperation and assistance during the audit.

Respectfully submitted,

/s/ Angus Maciver

Angus Maciver
Legislative Auditor

Room 160 • State Capitol Building • PO Box 201705 • Helena, MT • 59620-1705
Phone (406) 444-3122 • FAX (406) 444-9784 • E-Mail lad@mt.gov

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Appointed and Administrative Officials

Department of Public Health and Human Services	Sheila Hogan, Director
	Laura Smith, Deputy Director
	Erica Johnston, Manager, Operations Services Branch
	Carter Anderson, Administrator, Quality Assurance Division
	Chad Hultin, Chief, Internal Audit Bureau

Performance Audit 18P-07 September 2020

Montana Legislative Audit Division

Community Benefit & Charity Care Obligations at Montana Nonprofit Hospitals

Department of Public Health and Human Services

Background

There are 47 nonprofit hospitals in Montana. "Nonprofit" is a tax status exempting hospitals from paying local, state, and federal taxes. This is intended to be an acknowledgment of the community benefit provided by non profit hospitals. State law requires the Department of Public Health and Human Services (DPHHS) ensure large hospitals provide a particular category of community benefit, charity care, which assists qualified patients pay their hospital bills.

Agency:
Department of Public Health and Human Services

Director:
Sheila Hogan

Division:
Quality Assurance

Bureau:
Licensing

Montana nonprofit hospitals receive more than $146 million in tax exemption benefit. In exchange, hospitals are obligated to benefit their community. Hospitals currently demonstrate they are meeting this responsibility by self-reporting annual spending on community benefit programs to the Internal Revenue Service (IRS). Each hospital individually determines which of their activities qualify. Montana hospitals self-reported more than $257 million in community benefit spending. However, the public has limited information about these activities beyond the total amount of what the hospitals have determined they have spent.

KEY FINDINGS:

A lack of consistent community benefit reporting by hospitals reduces transparency for policymakers and the public. There is no generally-accepted guidance on specific activities hospitals should consider community benefit. Montana nonprofit hospitals measure and self-report on the value of community benefit spending in varying ways, making meaningful assessment difficult.

Community benefit spending has no clear impact on the health of Montanans. Implicit in the IRS's definition of community benefit is the notion that the overall health of a hospital's community is generally better because of the hospital being located there. The addition of Community Health Needs Assessments (CHNA) work focuses this general concept to specific health priorities. Our analysis found community benefit spending has no clear impact on four priorities identified in most recent CHNAs of the 47 nonprofit hospitals.

DPHHS has not developed a process to ensure hospitals provide charity care. DPHHS management reported their focus regarding hospital oversight has historically been focused on quality of care, with limited attention given to the financial aspects of hospital operations. Consequently, DPHHS has not developed a process to ensure hospitals have charity care.

RECOMMENDATIONS:

In this report, we issued the following recommendations:
To the department: 1
To the legislature: 1

(continued on back)

For the full report or more information, contact the Legislative Audit Division.

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Room 160, State Capitol
PO Box 201705
Helena, Montana 59620
(406) 444-3122

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Recommendation #1 (page 29):
Community Benefit Expectations
The legislature should enact law defining expectations regarding detailed reporting of community benefit spending and its impact on community health and the state government entity responsible for actively reviewing community benefit spending.

Department response: N/A

Recommendation #2 (page 37):
Charity Care Review and Oversight
The Department of Public Health and Human Services should:

A. Define spending and eligibility expectations related to charity care.

B. Develop an active oversight and review process that will ensure hospitals have charity care polices consistent with industry standards.

Department response: Concur

Chapter I – Introduction and Background

Introduction

According to the American Hospital Association (AHA), 48 percent of the more than 6,000 hospitals in the United States are organized as nonprofits. The remaining 52 percent are operated by governmental entities or organized as for-profit businesses. "Nonprofit" is a federal tax status exempting hospitals from paying federal taxes. Most states extend the exemption benefit to state and local taxes. This favored tax status is intended to be an acknowledgement of the community benefit provided by hospitals. The AHA also reports the value nationwide of hospital federal tax exemption benefit was an estimated $9 billion in 2016. Self-reported community benefit spending by hospitals was $95 billion in 2016. Examples of community benefit spending includes services such as free immunizations, providing residency opportunities for new medical doctors, and charity care. Charity care involves hospitals reducing or eliminating bills for those patients the hospital determined are unable to pay their bill. Increased public and legislator interest in healthcare transparency includes scrutiny of this connection between the tax-exempt status of nonprofit hospitals and the benefit they provide to the community. There is concern that while still experiencing tax-exempt status under current requirements, nonprofit hospitals may not be fully achieving the policy objective of benefiting the community. The Legislative Audit Committee prioritized an examination of community benefit spending and charity care decision-making for a performance audit. This chapter provides background information on the topic and describes scope and objectives of the audit.

Montana's 47 Nonprofit Hospitals Exempt From Federal, State, and Local Taxes

Montana extends state and local tax exemption benefit to the 47 nonprofit hospitals located here. In addition to federal tax exemption benefit, nonprofit hospitals are not required to pay state corporate income tax, state property tax, state personal property tax (often referred to as the business equipment tax), or local property taxes. The estimated tax exemption benefit value of all nonprofit hospitals we reviewed was more than $146 million in calendar year 2016. This was the most recent year all necessary Internal Revenue Service (IRS) documents, including annual IRS-990 forms with accompanying Schedule Hs, were available for every nonprofit hospital in Montana. Table 1 (see page 2) lists the name of each hospital, the city and county in which the hospital is located, and the estimated total federal, state, and local tax exemption benefit values for each in calendar year 2016.

Table 1

Estimated Nonprofit Hospital Federal, State, and Local Tax Exemption Benefit - 2016

Hospital Name	City	County	Total Exemptions
Barrett Hospital and Healthcare	Dillon	Beaverhead	$1,011,297
Beartooth Billings Clinic	Red Lodge	Carbon	$404,188
Benefis Hospital	Great Falls	Cascade	$14,571,871
Benefis Teton Medical Center	Choteau	Teton	$67,689
Big Horn County Memorial Hospital	Hardin	Big Horn	$430,313
Big Sandy Medical Center	Big Sandy	Choteau	$222,479
Billings Clinic	Billings	Yellowstone	$36,592,399
Bozeman Health Deaconess Hospital	Bozeman	Gallatin	$6,172,421
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Community Hospital of Anaconda	Anaconda	Deer Lodge	$441,585
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Daniels Memorial Hospital	Scobey	Daniels	$4,817
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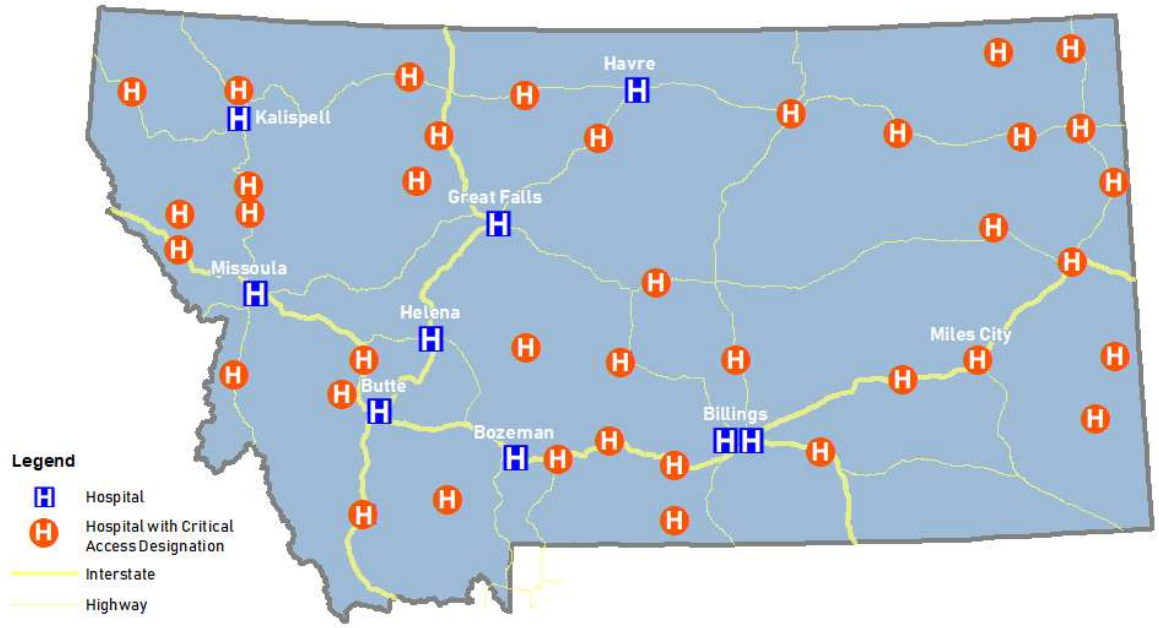
Fallon Medical Complex Hospital	Baker	Fallon	$744,302
Frances Mahon Deaconess Hospital	Glasgow	Valley	$2,067,732
Glendive Medical Center	Glendive	Dawson	$244,250
Holy Rosary Healthcare	Miles City	Custer	$1,655,447
Kalispell Regional Medical Center	Kalispell	Flathead	$8,125,243
Liberty Medical Center	Chester	Liberty	$136,090
Livingston Healthcare	Livingston	Park	$5,966,247
Madison Valley Medical Center	Ennis	Madison	$320,781
Marcus Daly Memorial Hospital	Hamilton	Ravalli	$2,277,688
McCone County Health Center	Circle	McCone	$11,127
Mineral Community Hospital	Superior	Mineral	$486,300
Mountainview Medical Center	W. S. Springs	Meagher	$65,442
North Valley Hospital	Whitefish	Flathead	$1,461,260
Northern Montana Hospital	Havre	Hill	$11,740,513
Northern Rockies Medical Center	Cut bank	Glacier	$129,207
Phillips County Hospital	Malta	Phillip	$32,377
Pioneer Medical Center	Big timber	Sweet Grass	$228,410
Pondera Medical Center	Conrad	Pondera	$15,938
Poplar Community Hospital	Poplar	Roosevelt	$50,266
Roosevelt Medical Center	Culbertson	Roosevelt	$3,817
Rosebud Health Care Center Hospital	Forsyth	Rosebud	$67,818
Roundup Memorial Healthcare	Roundup	Musselshell	$139,684
Sheridan Memorial Hospital	Plentywood	Sheridan	$97,967
Sidney Health Center	Sidney	Richland	$1,056,930
St. James Healthcare	Butte	Silver Bow	$2,864,769
St. Joseph Medical Center (Providence)	Polson	Lake	$228,748
St. Luke Community Hospital	Ronan	Lake	$1,570,426
St. Patrick Hospital (Providence)	Missoula	Missoula	$1,181,218
St. Peter's Health	Helena	Lewis and Clark	$10,722,817
St. Vincent Health Care	Billings	Yellowstone	$29,394,471
Stillwater Billings Clinic	Columbus	Stillwater	$113,945
Wheatland Memorial Hospital	Harlowton	Wheatland	$50,490
		Total	**$146,581,097**

Source: Compiled by the Legislative Audit Division from Internal Revenue Service, Department of Revenue, and DPHHS records.

Thirty-eight of the nonprofit hospitals in Montana are Critical Access Hospitals (CAH). CAH is a federal designation indicating the facility is a rural primary healthcare hospital giving limited services to patients in low population areas. The remaining nine hospitals are larger facilities located in more populated areas. The following figure illustrates the location of the 47 nonprofit hospitals across the state, with critical access hospitals designated with an orange circle.

Figure 1

Nonprofit Hospital Locations



Source: Compiled by the Legislative Audit Division from Internal Revenue Service and Department of Public Health and Human Services records.

What Is Community Benefit Spending?

The "nonprofit" tax status of nonprofit hospitals and accompanying tax exemption benefit is intended to be an acknowledgement of the community benefit provided by hospitals. Community benefit spending activities by a hospital include things like free immunizations, providing residency opportunities for new medical doctors, and charity care, which is related to hospitals reducing or eliminating the bill of those patients the hospital has determined are unable to pay their bill. Nonprofit hospitals receiving tax exemption benefit are required to report to the federal government about their community benefit efforts annually. The IRS requires all nonprofit hospitals to file IRS-990 Forms with an accompanying Schedule H once a year. These forms and schedules provide self-reported organizational and financial information about the hospital, including what the hospital has determined it has spent in fulfilling its community benefit obligation. In addition, the IRS has defined eight different

categories into which community benefit spending may fall. Hospitals must also report the level of spending in each category for the year. The categories are briefly described below:

- **Charity care** provides free or discounted health services to patients.
- **Subsidized health services** relate to money spent on clinical services provided despite a financial loss to the hospital.
- **Medicaid** is the funding hospitals identify as required to off-set the cost of providing Medicaid services to patients.
- **Health profession education** is education funding for hospital staff.
- **Community health improvement and community benefit operations** covers programs with the purpose of improving community health.
- **Cash and in-kind contributions** are made by the hospital to organizations promoting community benefit activities.
- **Research** is the funding used for salaries and benefits of researchers and staff whose work generates increased generalizable medical knowledge.
- **Other means-tested government program** is the funding hospitals identify as required to offset the cost of a government health program, other than Medicaid, for which eligibility depends on the recipient's income or asset level.

Charity Care Framework

As noted, one of the categories for which hospitals may report community benefit spending is charity care. The framework of charity care implementation is similar at each hospital. After a patient receives treatment, they receive a bill from the hospital. Often, a third-party payer, such as an insurance company, pays a large portion of the bill and the patient is required to pay the remaining amount. Frequently, when there is no third-party payer to cover a large portion of the bill, the amount owed is insurmountable for the patient. In some cases, even when a third party does pay part of the bill, the patient is still unable to pay the remainder of their bill. At this point, there are several paths the resolution of this outstanding bill could take, including a collections process for bad debt or access to the hospital's charity care program. If a patient indicates their bill is unmanageable to the hospital, the hospital determines if the patient fits the hospital's criteria for receiving assistance in paying the remaining balance via charity care. This decision is usually based on a review of the patient's family size, household income, and available assets, such as investments or real estate. If the hospital determines the patient meets the criteria for assistance, they will reduce or eliminate the bill depending on the level of assistance for which the patient is eligible.

For example, a patient with a $50,000 hospital bill may have insurance coverage that pays $30,000, leaving $20,000 as the patient's responsibility. If the patient is single with an income of $23,000 and has no real estate or other investments, they would

qualify for charity care at some Montana nonprofit hospitals. Hospitals generally use the Federal Poverty Level (FPL) to help make assistance decisions. In our example, an annual income of $23,000 is just under 200 percent of the FPL for a single person. Charity care can include reducing a patient's bill up to 100 percent. The exact level of assistance would vary based on each hospital's policy. Hospitals would reduce the bill based on an assessment of the patient's income and assets via the FPL. In the above example, a reasonable expectation is the patient with the remaining $20,000 bill would receive a 50 percent reduction in their bill. The hospital would reduce the bill by $10,000, leaving the patient responsible for paying the remaining $10,000 balance. The amount the hospital reduces bills for patients qualifying for charity care assistance, $10,000 in our example, is identified as community benefit spending. This is the amount the hospital would report to the IRS in the charity care category.

Montana Law Requires Patient Charity Care Policies

In addition to the federal government requirement for hospitals to report their community benefit spending, there are requirements in Montana for hospitals related to charity care. The Department of Public Health and Human Services (DPHHS), through their Licensure Bureau and Certification Bureau, both located in the Quality Assurance Division, is responsible for licensing and certifying Montana's hospitals among many other kinds of facilities including ambulatory surgical centers, rural health clinics, hospices, and intermediate care facilities for individuals with intellectual disabilities.

Specifically related to hospitals, the work includes a review of hospital-submitted renewal of licensure applications, which are required every three years. Hospital inspections are conducted to see if the facility is meeting standards related to issues of quality of care such as maintaining a sterile environment and working safety equipment. Department staff or other entities conduct inspections at hospitals, which must occur every three years. If another entity conducts the inspection, department staff review a report of the inspection and keep it on file. Any problems with inspections are noted by the department. Depending on the magnitude of an identified problem, a corrective action plan may be developed and implemented by the hospital. Department staff are available to assist hospitals with that process. In state fiscal year 2018, the total budgeted for hospital-related activities was $362,100.

A difference between CAH and larger hospitals in Montana is CAH are exempt from some requirements identified in state law related to hospitals. For example, §50-5-121 (1)(b), MCA, states a hospital must have, in writing, "a charity care policy consistent with industry standards applicable to the area the facility serves and the tax status of the hospital." CAH are exempt from this requirement, but it applies to the nine

larger hospitals. Nonetheless, DPHHS currently asks all hospitals to self-attest to the requirement as part of licensure review activities.

Audit Scope

The focus of our audit was examining the community benefits and charity care activities of Montana's hospitals. Based on audit assessment work, we determined there were questions related to how the value of community benefits are self-reported by hospitals as well as how the effects of community benefit spending are measured. We also identified risks related to how DPHHS ensures applicable hospitals provide charity care based on industry standards. Through our assessment work, we determined DPHHS's activities regarding hospitals focus on certification and licensure related to quality of care. At the time of our assessment work, DPHHS staff were unaware of their statutory obligation related to charity care.

To understand how nonprofit hospitals meet their obligation to Montana communities and analyze DPHHS's role in the process, we examined the 47 nonprofit general hospitals operating in Montana in 2016. We chose hospitals operating during all of calendar year 2016 because this was the most recent year all necessary IRS documents were available for every nonprofit hospital in Montana. We excluded other kinds of hospitals from our review because we wanted to look only at institutions similar in IRS classification and function. For example, we did not include government funded hospitals as they fall under different IRS regulations. We also did not include hospitals serving unique populations because their mission is different than that of a general hospital's mission to provide care to all members of a community. Determining to what extent community benefit spending affects the health of Montanans is a challenging task because of the magnitude and complexity of factors associated with the health of all individuals. However, a source of data frequently used by healthcare researchers in this kind of work is the County Health Rankings program, which we used as well.

Our review work focused on two main areas. We examined the relationship between the estimated tax exemption benefit received by hospitals and the impacts of community benefit spending. We also examined the role of DPHHS in ensuring hospitals provide charity care.

Audit Objectives

Based on our assessment work, we developed two objectives to understand how Montana's nonprofit hospitals meet their obligations to the community and analyze DPHHS's role in the process:

1. Does hospital community benefit spending compare equitably to tax-related benefit relief and impact community health?

2. Does the Montana Department of Public Health and Human Services ensure hospitals provide charity care policies consistent with industry standards, as required by state law?

Audit Methodologies

To answer questions posed in our objectives, we conducted the following audit work:

- Obtained and reviewed state and federal law and regulations related to community benefit spending to determine requirements and guidance on identifying and reporting charity care and community benefit spending generally.
- Traveled to six hospitals to interview management and staff to determine their perspectives on tax exemption benefit, community benefit spending, and its effect on community health, Community Health Needs Assessments (CHNA) and hospital charity care; the hospitals varied in size and location in the state.
- Created and distributed a survey to management at the nonprofit hospitals in Montana to determine their perspectives on tax exemption benefit, community benefit spending and its effect on community health, CHNAs, and hospital charity care; 47 surveys were distributed and 23 responses were received, resulting in a 49 percent response rate.
- Acquired and examined calendar year 2016 IRS 990 and Schedule H forms of Montana's 47 nonprofit hospitals to acquire data necessary to determine estimated tax liabilities and self-reported community benefit spending amounts.
- Obtained and reviewed a list of "nonprofit medical exempt" properties in the state to determine which belong to hospitals, the hospitals' properties market values, and taxable values, and then calculated the value of each hospitals' tax exemption benefit.
- Interviewed Department of Revenue staff to determine reasonable assumptions related to estimating the tax value of tax-exempt properties.
- Obtained and reviewed the most recent CHNA of the 47 hospitals to determine the health priorities of each hospital.
- Analyzed the most recent five years' reports (2015-2019) of Montana County Health Rankings to determine if county health, related to health priorities identified in the 47 hospital CHNAs, was affected during the time reviewed.
- Interviewed DPHHS Quality Assurance Division, Certification Bureau and Licensure Bureau management and staff to determine processes used to ensure hospitals have charity care consistent with industry standards.
- Reviewed applicable DPHHS hospital licensure and certification documents related to the 47 hospitals to ascertain if the department requests charity care-related information from hospitals.
- Acquired and examined charity care policies of 47 nonprofit hospitals in Montana to determine eligibility conditions and other specific requirements of the policies including excluded procedures and use of collection agencies.

- Examined 2008-2014 Montana Department of Justice reports on community benefit and charity care by Montana hospitals.
- Reviewed policies related to community benefit and charity care of various state, regional, and national organizations.
- Reviewed programs related to community benefit and charity care in the federal and 30 other state governments.

Report Contents

The remainder of the report presents our audit findings and recommendations in the following areas:

- Chapter II compares the value of tax-exempt status of nonprofit hospitals to the benefit they provide their communities and explores the relationship between hospital community benefit efforts and improving community health. This chapter offers a recommendation for the legislature to define reporting expectations for community benefit spending.
- Chapter III examines various charity care policies and presents information related to the need to more clearly define charity care expectations for all hospitals, including developing an oversight process requiring large hospitals to have a charity care policy consistent with industry standards.

Chapter II – Community Benefit Spending Inconsistently Reported

Introduction

This chapter addresses our first objective regarding whether hospital community benefit spending compares equitably to tax-related benefit relief and impact community health. We found Montana nonprofit hospitals generally self-report more community benefit spending than their estimated tax liability. We also found the processes hospitals use to determine community benefit spending are varied, and the results are unclear to the public and policymakers. We also found county health ranking measures were not clearly connected to the heath priorities identified by hospitals. This chapter discusses our work and recommendation related to assessing the value of the tax exemption benefit and impacts to community health regarding community benefit spending.

Estimating the Value of Tax Exemption Benefit

Montana nonprofit hospitals receive tax relief in exchange for providing community benefits. Montana extends federal tax exemption benefit to state and local taxes for the 47 nonprofit hospitals located in the state, resulting in nonprofit hospitals being exempt from paying the following:

- Federal corporate income tax
- State corporate income tax
- State property tax
- Local property tax
- State personal property tax, often referred to as the business equipment tax

Using similar research methods as applied in the 2008-2014 Montana Department of Justice reports on these issues, we estimated the various tax liabilities of the 47 nonprofit hospitals in Montana for calendar year 2016 to compare that information with the value of community benefit spending reported by each hospital. We used 2016 because during fieldwork this was the most recent year all necessary Internal Revenue Service (IRS) documents, including annual IRS 990 forms with an accompanying Schedule H, were available for every nonprofit hospital in Montana. We estimated the tax liabilities by obtaining and reviewing those IRS forms as well as Department of Revenue (DOR) information related to tax-exempt property. Here are the processes we used to estimate the hospitals' federal, state, and local tax liabilities:

- **Federal corporate income tax liability** was estimated using data in the hospitals' 2016 IRS 990 reports. Specifically, the revenue minus expenses figure. This figure was multiplied by the applicable federal corporate tax rate. The federal corporate income tax rate in 2016 was based on a formula

dependent on the amount being taxed. In our work, the estimate of the federal tax exemption benefit for Montana hospitals ranged from $0 to almost $74 million. The average was approximately $5 million. The federal tax rate for $5 million in 2016 was 34 percent on any amount more than $335,000, plus $113,900.

- **State corporate income tax liability** for each of the 47 hospitals was estimated with a similar process. The revenue minus expenses figure from IRS documents was multiplied by the state tax rate in 2016, which was 6.75 percent.
- **State property tax liability** was estimated with information from DOR. Data, including market value, related to all nonprofit medical exempt properties, which include hospital properties, were obtained from DOR. After interviews with DOR, we determined a reasonable assumption is that all hospital properties would be moved to Class 4 Commercial if they were no longer tax-exempt. Taxable value for a property is determined by applying 1.89 percent to the property's market value. The state's property tax for this type of property is currently 101 mills. The estimated state property income tax liability for each of the 47 hospitals was determined by multiplying the taxable value of their property by 101 mills.
- **Local property tax liability** was estimated using the same data. The taxable value of the hospital's property was multiplied by 2.9 mills, which DOR estimates for local mills statewide.
- **State personal property tax liability** was also estimated using data in the hospitals' most recent IRS documents on which hospitals must report the value of their equipment. This figure was multiplied by the appropriate percentage rate based on this formula:
    - ◊ Up to $100,000 was not taxed
    - ◊ $100,001 to $6,000,000 was taxed at 1.5 percent
    - ◊ More than $6,000,000 was taxed at 3 percent

Self-Reported Community Benefit Spending

We used data in the hospitals' 2016 IRS 990/Schedule H reports to determine community benefit spending. This data includes the hospitals' estimates of their total amount of community benefit spending as well as spending in each of the eight IRS-defined categories described below:

- **Charity care programs** provide free or discounted health services to patients the hospital determines, via its assistance policy, are unable to pay their bill.
- **Subsidized health services** relate to money spent on clinical services provided despite a financial loss to the hospital. To qualify as a subsidized health service, the hospital must provide the service because it meets an identified community need, and if the hospital did not provide it, the community would lack the service. Examples include neonatal intensive care, inpatient psychiatric units, emergency services, home health programs, palliative care, and hospice.

- **Medicaid** is the funding hospitals identify as required to offset the cost of providing Medicaid services to patients.
- **Health profession education** is funding hospitals spend, for example, on providing residency opportunities for new medical doctors. The funding must be for education resulting in a degree, certificate, or training necessary to be licensed to practice as a health professional, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty.
- **Community health improvement and community benefit operations** covers programs with the express purpose of improving community health. An example is a reduced cost or free immunization event. Community benefit operations means activities associated with conducting the hospital's IRS-required Community Health Needs Assessments (CHNAs) every three years, and general administration of the community benefit spending program.
- **Cash and in-kind contributions** are made by the hospital to organizations promoting one or more of the community benefit activities identified by the hospital.
- **Research** is the funding used for salaries and benefits of researchers and staff whose work generates increased generalizable medical knowledge made available to the public.
- **Other means-tested government program** is the funding hospitals identify as required to offset the cost of a government health program, other than Medicaid, for which eligibility depends on the recipient's income or asset level. An example is Healthy Montana Kids, a children's health insurance program based on income.

Hospital Utilization Fee and Supplemental Payments

In 2016, hospitals in Montana paid a utilization fee for each inpatient bed-day. The state collected the fees and used the money to acquire a federal match. The funding then went back to the hospitals in the form of supplemental payments. In 2016, the hospitals paid approximately $22 million in this process, and received about $66 million in supplemental payments. As our audit is focused on estimated tax liability exemption benefit, these fees and payments are outside of our scope, and excluded from our analysis.

Self-Reported Community Benefit Spending Exceeds Estimated Tax Liability

Table 2 (see page 12) summarizes the total estimated tax exemption benefit value and self-reported community benefit spending for all 47 nonprofit hospitals in calendar year 2016. The information comes from IRS and DOR documents. The table lists the name of the hospital, the city and county where the hospital is located, the hospital's estimated tax exemption benefit value and its self-reported community benefit

spending value. The table illustrates hospitals generally report their community benefit spending exceeds their tax-exempt benefit. Ten of the 47 estimates of tax exemption benefit exceed self-reported community benefit spending. There is no apparent pattern regarding hospitals with a higher estimated tax liability compared to its self-reported community benefit spending. In Table 2, they are indicated with gray shading. Overall, as reported by hospitals, their community benefit spending exceeded their estimated tax exemption benefit by more than $110 million.

Table 2
Estimated Nonprofit Hospital Tax Exemption Benefit and Self-Reported Community Benefit Spending
2016

Hospital Name	City	County	Estimated Tax Exemption (Gray shading indicates estimate larger than community benefit spending)	Community Benefit Spending
Barrett Hospital and Healthcare	Dillon	Beaverhead	$1,011,297	$2,657,346
Beartooth Billings Clinic	Red Lodge	Carbon	$404,188	$271,938
Benefis Hospital	Great Falls	Cascade	$14,571,871	$25,413,553
Benefis Teton Medical Center	Choteau	Teton	$67,689	$283,088
Big Horn County Memorial Hospital	Hardin	Big Horn	$430,313	$678,464
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Billings Clinic	Billings	Yellowstone	$36,592,399	$28,582,326
Bozeman Health Deaconess Hospital	Bozeman	Gallatin	$6,172,421	$27,756,734
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Clark Fork Valley Hospital	Plains	Sanders	$442,579	$501,127
Community Hospital of Anaconda	Anaconda	Deer Lodge	$441,585	$5,208,531
Dahl Memorial Healthcare Association	Ekalaka	Carter	$1,460	$144,020
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Liberty Medical Center	Chester	Liberty	$136,090	$177,959
Livingston Healthcare	Livingston	Park	$5,966,247	$513,924
Madison Valley Medical Center	Ennis	Madison	$320,781	$595,370
Marcus Daly Memorial Hospital	Hamilton	Ravalli	$2,277,688	$6,158,732
McCone County Health Center	Circle	McCone	$11,127	$486,378

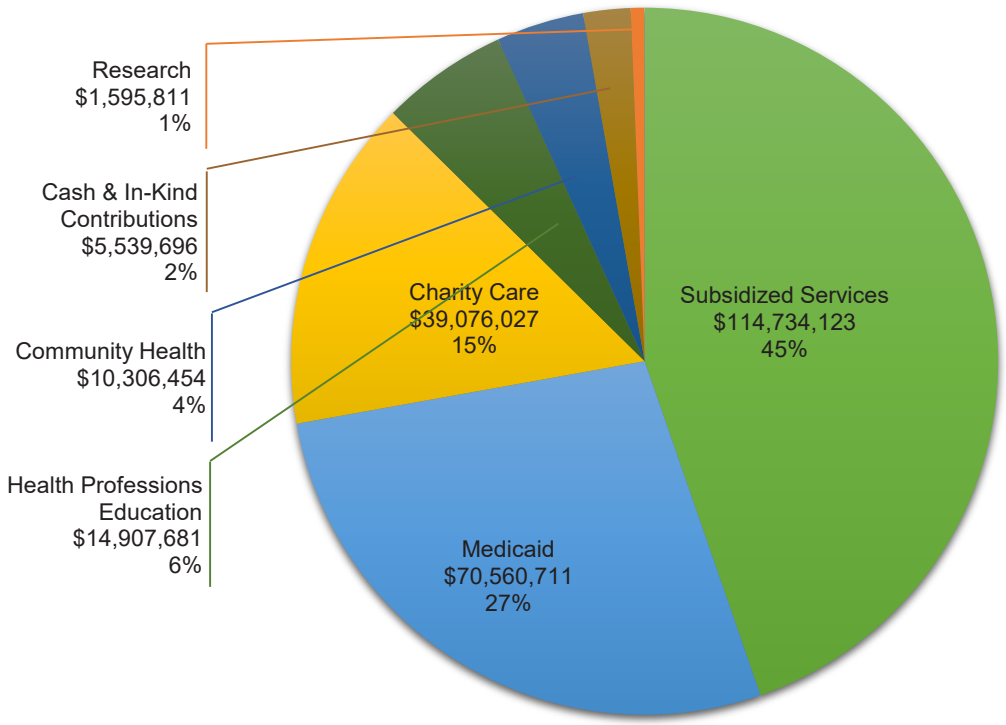
(continued on page 13)

Hospital Name	City	County	Estimated Tax Exemption Gray shading indicates estimate larger than community benefit spending	Community Benefit Spending
Mineral Community Hospital	Superior	Mineral	$486,300	$146,784
Mountainview Medical Center	W. S. Springs	Meagher	$65,442	$336,094
North Valley Hospital	Whitefish	Flathead	$1,461,260	$891,035
Northern Montana Hospital	Havre	Hill	$11,740,513	$6,954,285
Northern Rockies Medical Center	Cut Bank	Glacier	$129,207	$663,926
Phillips County Hospital	Malta	Phillip	$32,377	$241,720
Pioneer Medical Center	Big Timber	Sweet Grass	$228,410	$1,446,717
Pondera Medical Center	Conrad	Pondera	$15,938	$2,303,576
Poplar Community Hospital	Poplar	Roosevelt	$50,266	$1,950,016
Roosevelt Medical Center	Culbertson	Roosevelt	$3,817	$363,433
Rosebud Health Care Center Hospital	Forsyth	Rosebud	$67,818	$1,682,927
Roundup Memorial Healthcare	Roundup	Musselshell	$139,684	$217,328
Sheridan Memorial Hospital	Plentywood	Sheridan	$97,967	$1,307,747
Sidney Health Center	Sidney	Richland	$1,056,930	$5,598,177
St. James Healthcare	Butte	Silver Bow	$2,864,769	$11,464,651
St. Joseph Medical Center (Providence)	Polson	Lake	$228,748	$465,261
St. Luke Community Hospital	Ronan	Lake	$1,570,426	$7,518,997
St. Patrick Hospital (Providence)	Missoula	Missoula	$1,181,218	$35,356,245
St. Peter's Health	Helena	Lewis & Clark	$10,722,817	$17,977,055
St. Vincent Health Care	Billings	Yellowstone	$29,394,471	$27,446,993
Stillwater Billings Clinic	Columbus	Stillwater	$113,945	$120,635
Wheatland Memorial Hospital	Harlowton	Wheatland	$50,490	$515,509
		Totals:	**$146,581,097**	**$257,048,529**

Source: Compiled by the Legislative Audit Division from Internal Revenue Service, Department of Revenue, and DPHHS records.

To perform additional analysis on community benefit spending we also assessed the distribution of community benefit spending across all eight IRS-defined categories. Figure 2 (see page 14) illustrates that distribution in 2016.

Figure 2
Self-Reported Community Benefit Spending by IRS Category - 2016



The 8th category, Other Means Tested Government Programs, does not appear on this figure as it is approximately $30,000, making it is less than 1 percent of the overall spending of $250 million.

Source: Compiled by the Legislative Audit Division from Internal Revenue Service records.

Subsidized Services, the large green slice of the pie, and Medicaid, the large blue slice, together make up 72 percent of community benefit spending in the state; charity care spending is the next largest category at 15 percent. The other five categories collectively account for less than 17 percent of all community benefit spending in the state. Additional details regarding our tax benefit estimate, and the eight community benefit spending categories are in Appendix A. The hospital names and locations are listed on the left side with tax benefit estimate and self-reported community benefit information in each column.

Community Benefit Spending Information Varies

While hospitals generally self-report that community benefit spending exceeds the value of the tax relief they receive, we found Montana nonprofit hospitals measure and report the value of community benefit in varying ways. To gather information about what types of activities hospitals consider to be community benefit spending and how these decisions are made, we traveled to six hospitals of varying size around the state to interview hospital management. The responses were diverse. Some stated they use

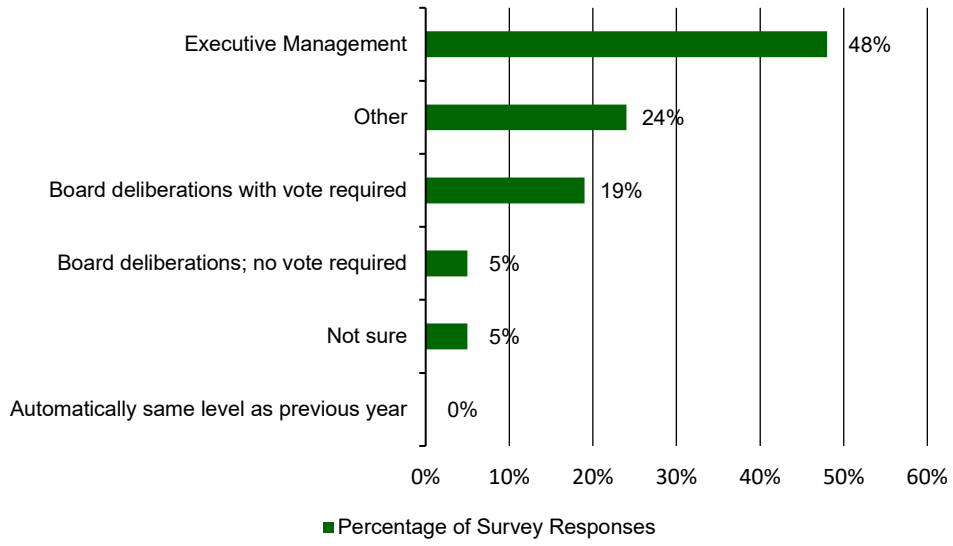
a widely available health association's guide regarding community benefit spending to determine what kinds of activities are allowable as community benefit spending. However, this does not help them determine in which of those allowable activities the hospital is going to engage, or which have the highest priority.

Another hospital reported it was not familiar with the guide discussed by others, adding they usually use the current year's community benefit budget as a guide to develop the next year's community spending budget. For example, if they sponsored a free immunizations event the previous year, they will automatically do it again the next year. If something else community benefit-related comes up throughout the year, they will likely pay for it, if they have the financial capacity to do so. When asked how they determine if something is community benefit-related, they stated if it was good for the community, they considered it a community benefit. They provided no specific criterion to further define it.

In addition to interviewing, we surveyed management of the 47 hospitals about these and related issues. We received 23 responses to the survey which was a 49 percent response rate. One question related to processes hospitals use to determine community benefit spending. We received 21 responses to this question. Almost half of the responses said community benefit spending was an executive management decision. The percentage of responses on how community benefit spending is determined is illustrated in the figure below.

Figure 3

Hospital Processes for Making Community Benefit Decisions



Source: Compiled by the Legislative Audit Division from nonprofit hospital management survey data.

As illustrated in the figure, the way hospitals determined their overall community health benefit spending varied. When responding in the "other" category, one respondent stated each year's community benefit spending level was determined by several factors. These included the hospital's financial standing, regional comparisons, and community need. In contrast, another respondent in the "other" category responded they do not limit the amount of community benefit available. They said it is determined by the needs of their patients, meaning they do not limit a community benefit category to any specific dollar amount. Responses to this question also identify the variance in hospital decision-making processes used to make determinations about community benefit. Four respondents indicated it was a hospital board decision requiring a vote, while another stated their board deliberated on the issue, but a vote was not required. Half of the respondents stated it was an executive management decision. When discussing these variable processes, hospital staff stated flexibility is needed at each hospital, so they can respond to specific local needs in their community.

IRS and DOR Oversight Limited

Passage of the Affordable Care Act (ACA) in 2010 changed hospital community benefit obligations and requires the IRS to audit nonprofit hospitals at least every three years for compliance with the new Community Health Needs Assessment (CHNA) requirements. IRS staff stated they could not release any information about Montana hospital audits but did describe nonprofit hospital audits generally. They are initially office or correspondence audits in which hospitals, at the IRS's request, send information and IRS staff review the documents at their desk. The IRS does not review activities characterized as community benefit by the hospital to determine if the characterization is accurate, or if the cost of the activity is reasonable. It does not compare tax exemption benefit estimates to community benefit spending reported by hospitals, nor does it assess if the hospital's community benefit spending has resulted in any measurable benefit to the community. The Montana Department of Revenue's (DOR's) oversight related to nonprofit organizations is also limited. It depends on nonprofit organizations to send proof of its nonprofit status determined by the IRS, and any changes to its status, to the department. DOR then changes the organization's tax status based on information received from the organization. It is not surprising community benefit information is inconsistent; there is no widespread and well-known direction fostering it. Voluntary guidelines developed by a nationwide hospital association regarding what kind of activities should, and should not be, reported as community benefit spending exist but not all hospitals know about or use them. Some hospitals use an ad hoc process with undefined criteria to determine their community benefit spending. A few hospitals require a vote by their Board of Directors to determine community benefit spending. DOR and the IRS do not provide substantive oversight. The present environment lacks the necessary structures that would encourage the transparency

needed to determine if hospitals are meeting their obligations as nonprofit entities and fully achieving the policy objective of benefiting the community.

Montana Office of Consumer Protection Has Tracked Community Benefit Spending

As discussed, the information presently provided by hospitals is required by the IRS, but it does not engage in substantive review or oversight related to this information. There is no prohibition on states using the federally-gathered information, and many do. In the past, the Montana Department of Justice (DOJ) did this in a limited way. From 2008 to 2014 the Montana Attorney General published the Montana Hospitals Report. Stating the "Attorney General's Office has the dual role of protecting consumers and monitoring nonprofit corporations" as the basis for producing the report, it listed tax exemption benefit estimates and community benefit spending. In 2008 there were specific concerns expressed nationally among state Attorneys General about how hospitals handled account collections, charity care, and patient bankruptcies. Special funding for the project, and the publishing of the reports, concluded in 2014. DOJ staff does not anticipate producing more nonprofit hospital community benefit reports, stating DOJ's role related to nonprofit hospitals has returned to information sharing and investigating complaints.

Public Needs Additional Information Regarding Community Benefit Spending

Without guidance regarding how to consistently report the value and impact of community benefit spending, hospitals individually decide what to do. While it is important for hospitals to have some flexibility to respond to local community needs, it is also important for the public and policymakers to have transparent and understandable information about the effort and impacts of community benefit spending by Montana hospitals. Information on a hospital's overall level of community benefit spending, as well as the spending levels in each category, needs to be readily accessible so members of the hospital's community can easily determine if they concur with the hospital's priorities, or if they need to provide feedback to the hospital about other community issues that could be addressed with community benefit spending. Legislators and other community decision-makers need to know what the hospitals are prioritizing and putting resources toward, so they can make informed public funding decisions. Passage of the Affordable Care Act (ACA) resulted in significant changes in healthcare policy, and Medicaid expansion in Montana has the potential to make more changes. One goal of expansion is to provide more low-income adults with access to health care services, which would then result in improved health outcomes. The public needs accurate, comparable, and consistent information about how the healthcare infrastructure is responding to these changes. This includes data related to hospital

community benefit spending. For example, with this information from the hospitals, we could determine if increasing Medicaid coverage has resulted in a reduction in charity care spending because more patients have government program insurance coverage. This had been projected but without more consistent review of information from the hospitals, it is not possible to ascertain if this is occurring as projected. In an interview with one hospital's management, they commented the IRS information does not provide the complete story related to community benefit spending. Our interviews and reviews of other hospital-produced community benefit documents found some hospitals track outputs, such as the number of free immunizations given, but do not track broader impacts. While tracking the impact of community benefit spending can be difficult, some effort in this area would provide a more meaningful evaluation of hospitals' community benefit activities.

Conclusion

Montana nonprofit hospitals measure and self-report on the value of community benefit spending in varying ways. There is no generally accepted guidance on specific activities hospitals should consider community benefit. This lack of consistent valuation determinations in hospital reporting on community benefit spending and tax exemption benefit received makes analysis difficult, which reduces transparency for policymakers and the public.

Analyzing Community Benefit Impact on Community Health

Federal law requires nonprofit hospitals to conduct a CHNA every three years to identify health priorities of the community in which the hospital is located. Identification of priority health needs can provide some of the basis for how hospitals determine where to allocate their community health benefit spending. While activities related to the priorities are locally based, the data we used to analyze progress of these priorities by Montana hospitals was organized by county. It was not possible to accurately align each hospital to the appropriate county to approximate the hospital's community, so we looked at the entire state rather than an individual hospital-by-hospital basis. We reviewed the priorities identified in the most recent CHNAs of the 47 nonprofit hospitals; the number of priorities identified by each hospital varied, but most had three. We categorized the priorities and listed them in Table 3 (see page 19).

Table 3
Priorities Identified in Hospital Community Health Needs Assessments

Category	Number of Hospitals Identifying as Priority	Percentage of Hospitals Identifying as Priority
Mental Health	36	77%
Access to Healthcare	34	72%
Healthy Living	29	62%
Chronic Disease	12	26%
Education	10	21%
Senior Issues	10	21%
Other	7	15%
Community Collaboration	4	9%
Dental	3	6%
Workforce Issues	3	6%
Emergency Care	2	4%
Child Abuse	2	4%

Source: Compiled by the Legislative Audit Division from nonprofit hospital Community Health Needs Assessments.

We found 77 percent of the hospitals identified mental health, including substance abuse and suicide, as a priority. Access to healthcare was identified by 72 percent of the hospitals as a priority. Healthy lifestyle choices, including nutrition and exercise, was identified by 62 percent of the hospitals, followed by chronic disease prevention and management, including diabetes and heart disease, identified by 26 percent of the hospitals. Improving Montanans' health is the goal of community benefit spending, and mental health, access, healthy living, and chronic disease have been identified as health priorities by many of the hospitals' CHNAs. Consequently, we focused our review of progress related to improving Montanans' health on these four categories. Determining the extent community benefit spending affects the health of Montanans is a challenging task because of the magnitude and complexity of factors associated with the health of all individuals. However, a source of data frequently used by healthcare researchers in this kind of work is the County Health Rankings program, which we describe in further detail below.

County Health Rankings Program

The County Health Rankings program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. One of the goals of the program is to provide a reliable, sustainable source of local data and evidence to help identify opportunities to improve health. The county rankings are based on a model of population health factors that, if improved, can help make

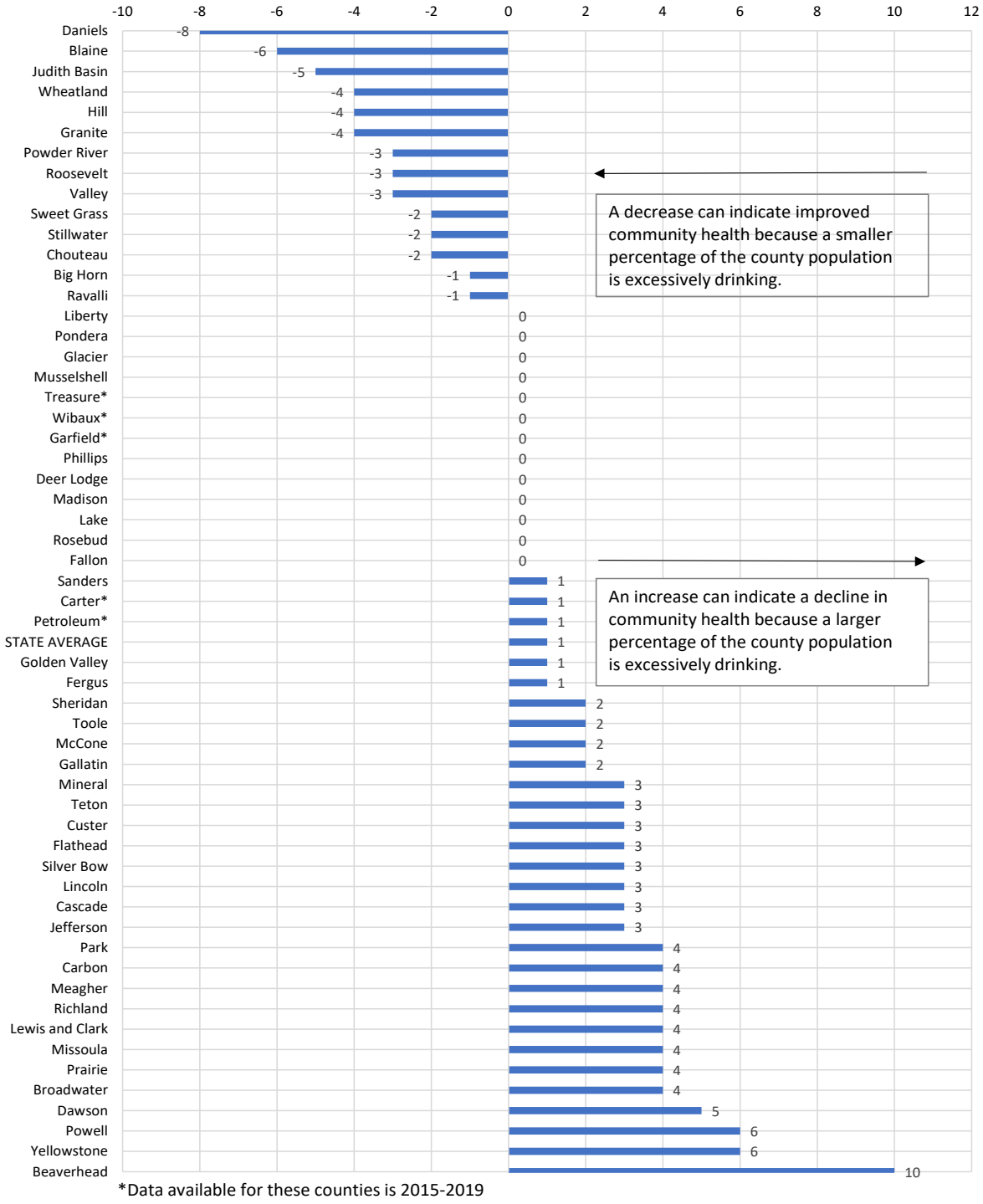
communities healthier places. Specifically, the rankings use survey data for more than 30 measures to help communities understand how healthy their residents are today, and what is impacting their health in the future. The program collects information in a variety of ways including information on health behaviors from individuals via surveys and interviews on an annual basis. To analyze progress of Montana hospitals on the most commonly identified health priorities in their CHNAs noted above, we chose to review County Health Rankings data related to four of the program's specific measures that relate directly to those priorities. Each is described below.

Assessing Substance Abuse Reduction Efforts With Excessive Drinking Rates

Adult excessive drinking, tracked by the County Health Rankings Program, is related to mental health, a priority identified by most hospitals across the state. To analyze progress of Montana hospitals on this issue we reviewed the County Health Rankings data related the percentage of a county's adult population reporting binge or heavy drinking in the past 30 days. The County Health Rankings had data related to all 56 counties for 2015–2019, except 5 counties for which no 2015 data was available. Those counties are marked with an asterisk in Figure 4 (see page 21), and four years of data, 2016–2019, is used. A decrease in excessive drinking, as shown toward the top of the figure, can be an indication of progress on mental health and addiction issues, and an increase in excessive drinking, as shown toward the middle and bottom of the chart can be an indicator of a lack of progress on those issues. Many hospitals prioritized mental health and addiction in their recent CHNAs. As seen in Figure 4, 13 counties saw a decrease in excessive drinking from 2015-2019 and 14 remained the same. However, most counties, 29, saw excessive drinking increase from 2015-2019. Due to the variety of results like these, it is not clear if community benefit spending is improving mental health issues in Montana.

Figure 4

County Population Excessively Drinking Percentage Change 2015*-2019



*Data available for these counties is 2015-2019

Source: Compiled by the Legislative Audit Division from County Health Ranking Program records.

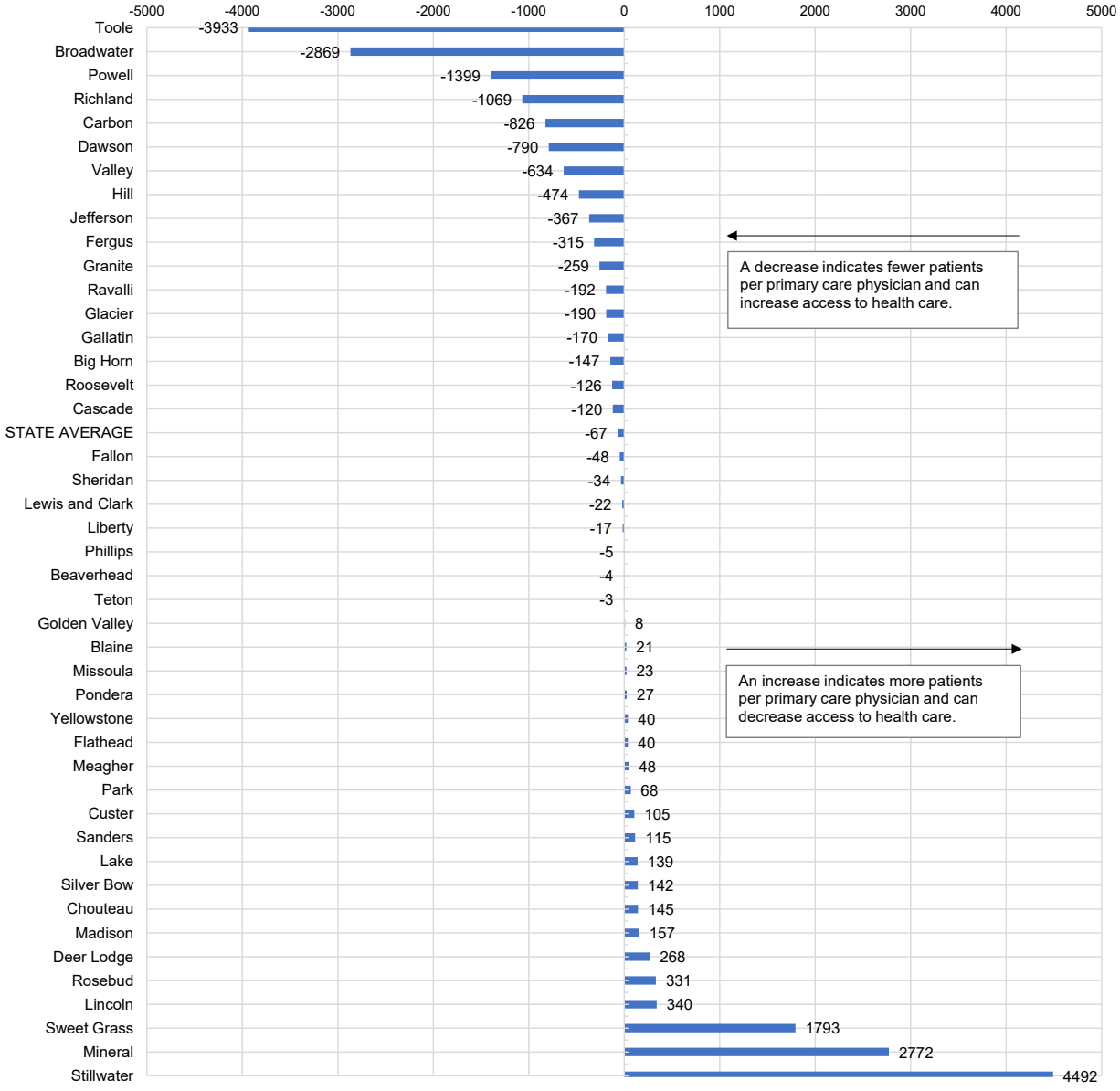
Measuring Access to Health Care With Ratios of Population to Physicians

The primary care physicians' ratio, tracked by the County Health Rankings Program, is related to healthcare access, a priority identified by most hospitals across the state. The ratio represents the number of individuals served by one physician in a county, if the population were equally distributed across physicians. For example, if a county has a population of 50,000 and has 50 primary care physicians, its ratio would be 1,000:1.

The 44 counties represented in Figure 5 (see page 23) all had at least one primary care physician in the 2015-2019 reports. Twelve counties were not included by the County Health Rankings information due to a lack of data on this issue; they are Carter, Daniels, Garfield, Judith Basin, McCone, Musselshell, Petroleum, Powder River, Prairie, Treasure, Wheatland, and Wibaux. A decrease in the population served per primary care physician, as shown toward the top of the figure, means fewer patients per physician and can be an indicator of increased access to healthcare. In contrast, an increase, as shown toward the bottom of the figure, means more patients per physician and can signal decreased access to healthcare for individuals living in that county. Many hospitals prioritized access to health care in their recent CHNAs. As seen in Figure 5, 24 counties decreased in population per physician from 2015-2019 and 20 increased. Due to the variety of results like these, it is not clear if community benefit spending is improving access to health care for Montanans.

Figure 5

Change in County Population Per Primary Care Physician 2015–2019



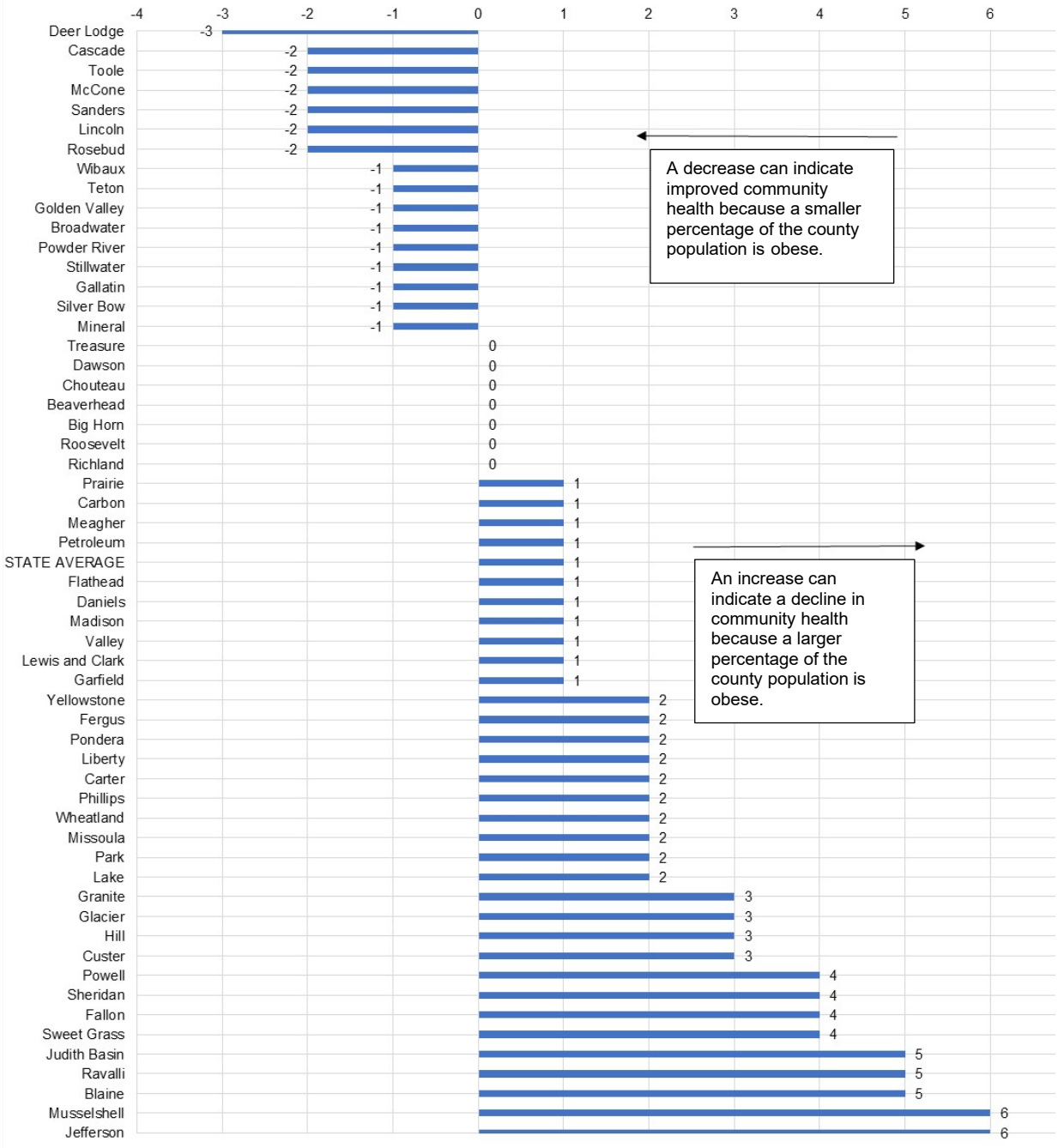
Source: Compiled by the Legislative Audit Division from County Health Ranking Program records.

Evaluating Community Healthy Lifestyle Choices With Obesity Rates

Measuring adult obesity relates to healthy lifestyle choices, a priority identified by most hospitals across the state. The County Health Rankings Program expresses it as the percentage of the adult population reporting a body mass index (BMI) greater than or equal to 30. A decrease in obese BMIs in a county, as shown toward the top of Figure 6 (see page 25) can be an indication of progress on healthy lifestyle issues, and an increase, such as shown on the bottom of the figure, can indicate a lack of progress on those issues. Many hospitals prioritized healthy lifestyle choices in their recent CHNAs. As seen in the figure, obese populations in 16 counties decreased, 7 remained the same, and 33 counties saw their obese populations increase from 2015-2019. Due to the variety of results like these, it is not clear if community benefit spending is improving Montanans' ability to make health lifestyle choices.

Figure 6

County Population Obese Percentage Change 2015–2019



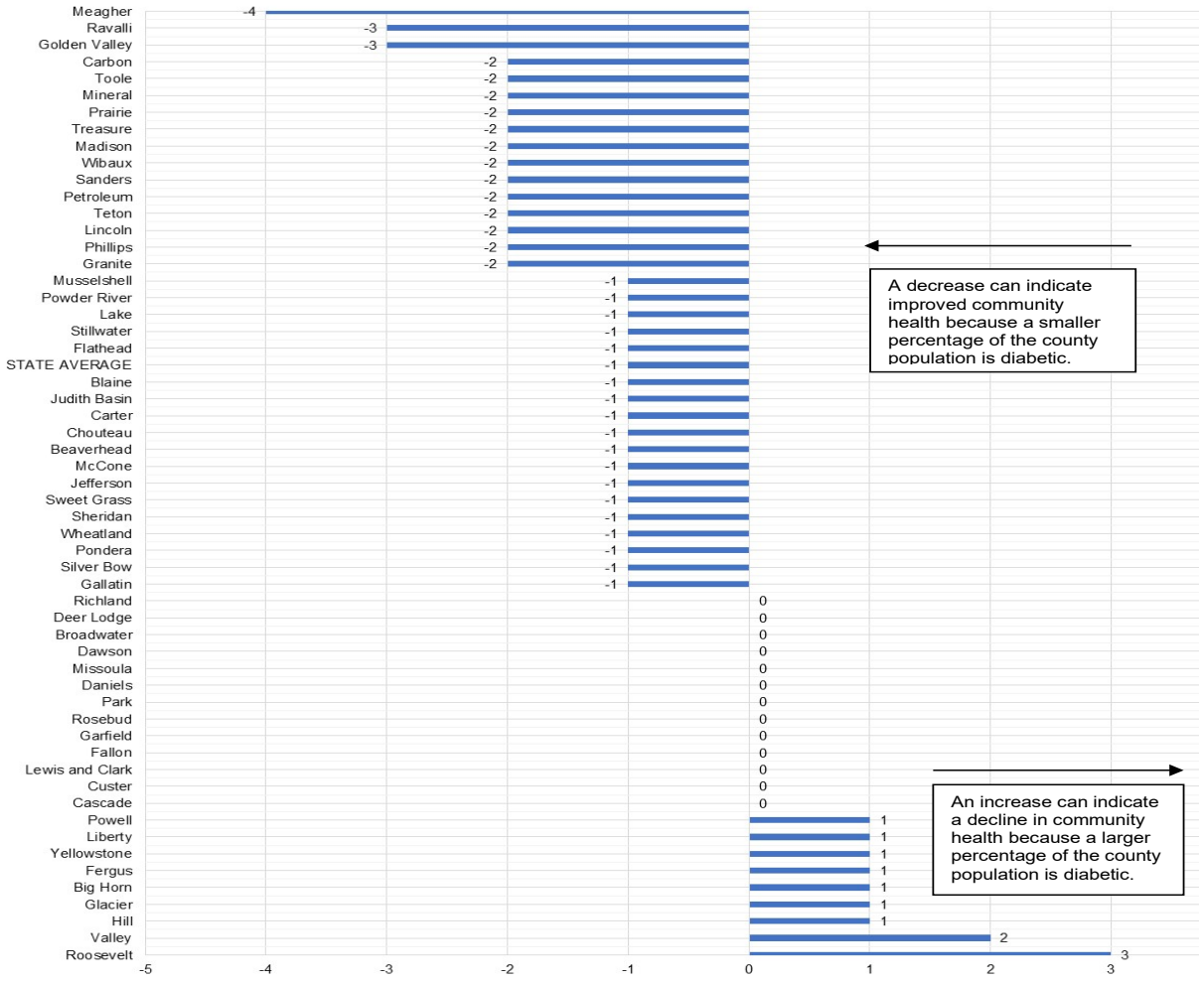
Source: Compiled by the Legislative Audit Division from County Health Ranking Program records.

Evaluating Chronic Disease Prevention Efforts With Diabetes Rates

The prevalence of adult diabetes relates to chronic disease prevention, a priority identified by most hospitals across the state. The County Health Rankings Program expresses it as the percentage of adults with diagnosed diabetes in a county. A decrease in diabetes, as seen toward the top of Figure 7 (see page 27), can be an indication of progress on chronic diseases, and an increase, as shown toward the bottom, is lack of progress on those issues. Many hospitals prioritized chronic disease prevention in their recent CHNAs. As seen in Figure 7, 34 counties saw a decrease from 2016-2019, 13 remained the same, and 9 counties saw increases in diabetes. While showing some progress, due to the variety of results like these, it is not clear if community benefit spending is improving Montanans' health related to chronic diseases.

Figure 7

County Population Diabetic Percentage Change 2016–2019



Source: Compiled by the Legislative Audit Division from County Health Ranking Program records.

No Clear Impact of Community Benefit Spending on Community Health

The ACA places a new requirement on hospitals to conduct a CHNA every three years to identify health priorities of the community in which the hospital is located. Information regarding the health needs of the community found in the CHNA can provide the basis for how hospitals determine where to allocate their community health benefit spending. While activities related to the priorities are locally based, the data we used to analyze progress of these priorities by Montana hospitals were organized by county. We looked at the entire state rather than at an individual hospital-by-hospital basis. Our analysis found that four priorities identified in most of the recent CHNAs

of the 47 nonprofit hospitals have not been clearly impacted by community benefit spending. We found there is not a clear connection between the health priorities identified by hospitals and publicly available health rankings. While some counties have experienced improvement in some of the identified priority areas, many counties have seen those health factors stay the same or deteriorate. The range of results regarding measures related to identified priorities makes the impact of community benefit spending on community health in Montana communities unclear. Medicaid expansion in Montana has the potential to make large changes in healthcare. One stated goal of expansion is to provide more low-income adults with access to health care services, which would then result in improved health outcomes. The public needs accurate, comparable, and consistent information about how the healthcare infrastructure is responding to these changes. This includes data related to the effect of hospital community benefit spending. Information on the progress of community health is necessary to determine if Medicaid expansion is generally working as intended. The public and policymakers need to know the status of community health over time to determine if it has improved with low-income individuals having more access to healthcare; this knowledge is only possible with consistent information from the hospitals. This information is not currently being collected and analyzed in any meaningful way in Montana.

Conclusion

Implicit in the Internal Revenue Service's definition of community benefit is the notion that the overall health of a hospital's community is generally better because of the hospital being located there. The addition of CHNA work focuses this general concept to specific health priorities. However, our analysis found community benefit spending has no clear impact on the general health of Montanans, nor is it having a clear impact in four priorities identified in most recent CHNAs of the 47 nonprofit hospitals.

Other States Provide Guidance on Community Benefit Spending and Reporting

We analyzed the community benefit processes in various states. We found some have defined minimum guidelines for community benefit spending and reporting on the values of those efforts. For example, Utah requires nonprofit hospitals to contribute annual community benefit in an amount exceeding the value of its annual local property tax liability. In 2019, Oregon passed legislation requiring the Oregon Health Authority to establish a community benefit spending minimum for hospitals. Pennsylvania law permits most nonprofit hospitals to choose from seven alternative community benefit standards to qualify as tax-exempt. Six of these standards specify

a minimum level of community benefit. The oversight function related to different aspects of community benefit spending varies among states. We found the placement of this function is sometimes in a consumer-protection oriented regulatory agency. However, in other circumstances, the oversight of this function is located within a public health agency. In all circumstances, a common characteristic we identified in other states is that the oversight agency has financial-oriented expertise to review community benefit spending activities.

Montana Provides No Direction to Hospitals Regarding Community Benefit Reporting

In Montana, there are no laws regarding community benefit spending and reporting and, consequently, there is no regulatory agency responsible for oversight of these issues. While there has been public and legislative interest in the activities of nonprofit hospitals, the oversight of community benefit spending has received limited attention. There is also no state-level review nor verification of federal tax information regarding community benefit spending hospitals report. Currently, there is limited oversight of charity care, as described in the following report chapter, but this represents just a small portion of overall community benefit spending activities. We recognize what hospitals spend on community benefits may vary, based on differing local priorities. However, there are no requirements in Montana for hospitals to report on population health outcomes of their community benefit activities. Nor are there reporting requirements in the state related to the taxable benefit hospitals receive in exchange for community benefit spending. Improving oversight of information related to community benefit spending is necessary to increase its transparency to the public and policymakers, as well as ensuring the compilation of accurate and comparable data about impacts of community benefit spending. Our work found it is currently impractical for the public and legislators to make an informed assessment of a hospital's fulfillment of its community benefit obligations as a nonprofit entity. It is also unclear if community benefit spending improves community health despite the millions of dollars in tax exemption benefit hospitals receive to do so.

RECOMMENDATION #1

We recommend the Legislature enact law defining:

A. *Expectations regarding detailed reporting of community benefit spending and its impact on community health.*

B. *The state government entity responsible for actively reviewing community benefit spending.*

Chapter III – Active Oversight Needed for Charity Care Programs

Introduction

This chapter addresses our second objective to determine if the Montana Department of Public Health and Human Services (DPHHS) ensures hospitals provide charity care policies consistent with industry standards, as required by state law. Charity care refers to healthcare provided for free or at reduced prices to low income patients. To answer the objective, we reviewed licensing and other certification documents hospitals must submit to DPHHS. We found DPHHS does not ensure hospitals provide charity care policies consistent with industry standards. We also found state law does not define what charity care industry standards are or provide guidance regarding what those standards should be. This chapter describes the work we conducted to assess how hospitals provide charity care in Montana and makes a recommendation to clarify charity care expectations.

DPHHS Does Not Ensure Hospitals Provide Patient Charity Care Policies

We found 47 nonprofit hospitals operating in Montana in calendar 2016, the most recent year all necessary Internal Revenue Service (IRS) documents were available for every nonprofit hospital in Montana. Thirty-eight are smaller Critical Access Hospitals (CAH) in less populated areas and nine are larger hospitals in more populated areas. Federal IRS law requires all 47 nonprofit hospitals to provide community benefit spending, and charity care is a type of community benefit spending.

Section 50-5-121(1)(b), MCA, requires a hospital to have in writing, "a charity care policy consistent with industry standards applicable to the area the facility serves and the tax status of the hospital." The nine large hospitals fall under this requirement. However, CAHs are excluded, by state law, from the charity care requirement. To determine how DPHHS is implementing this law for the nine large hospitals, we interviewed management and staff in its Licensure Bureau and Certification Bureau. These bureaus are responsible for implementing state laws related to hospital requirements. Their work generally includes reviewing hospital-submitted license renewal applications. They also review hospital inspections related to quality of care, such as maintaining a sterile environment and working safety equipment.

Unlike these other areas, we found DPHHS conducts no review of hospital charity care policies at the large hospitals as required by state law. Rather they rely on self-attestation documents provided by hospitals as part of licensing where hospitals broadly attest to

their compliance with state law. Based on our interviews, we found DPHHS staff were unaware this responsibility had been given to them by the legislature. In addition to interviews, we reviewed licensing renewal forms and related documents submitted by the nine large hospitals and none showed information was requested or gathered by DPHHS related to charity care.

More Guidance on Charity Care Programs Available

State law presently gives the responsibility of implementing the charity care law to DPHHS but there is no guidance regarding expectations of most hospitals beyond simply having a policy aligning with industry standards. In contrast to the hospitals we reviewed, there is guidance in the Administrative Rules of Montana (ARM) for specialty hospitals and these can provide some guidance for the hospitals reviewed. The Rules regarding specialty hospitals are in Subchapter 8 of ARM 37.106. A specialty hospital is defined in ARM 37.106.801 as a subclass of a hospital that is intended to diagnose, care, or treat patients with: a) cardiac conditions; b) orthopedic conditions; c) patients undergoing surgery; or d) patients being treated for cancer-related diseases and receiving oncology services. Charity care requirements of specialty hospitals are listed in ARM 37.106.811. It states the policy should include a mixture of factors such as the patient's net worth; earning capacity; and other financial obligations, as well as the source of the payment for services, whether the service was elective or emergency, and if costs to provide services exceeds third-party payments. Review of licensing documents and interviews with department staff indicate there are currently no specialty hospitals in Montana; none of the 47 hospitals reviewed for our audit were specialty hospitals. We found other states generally have more clearly defined expectations for all hospitals for charity care. The following bullets provide examples of established charity care guidance in other states and from the federal government:

- Oregon recently passed legislation requiring nonprofit hospitals to provide some level of assistance to patients with incomes up to 400 percent of the FPL.
- Other states' laws created a charity care eligibility floor. In Washington, single patients with a salary between 100 percent and 200 percent of the FPL qualify for discounted charges.
- One state we reviewed created a charity care eligibility ceiling. In Georgia, patients making more than 125 percent of the Federal Poverty Level (FPL) cannot receive assistance.
- A federal program, the National Health Service Corps, provides guidance on charity care. This program helps hospitals in Health Professional Shortage Areas, which includes many of the rural areas of Montana. It assists these areas in finding healthcare professionals to staff facilities in those areas. To

participate in the program, a hospital must meet certain criteria, including a charity care policy providing free services for patients at or below 100 percent of FPL, and reduced charges for patients between 101 and 200 percent of FPL.

- Other states provide guidance beyond eligibility. Texas, for example, requires nonprofit hospitals to have a charity care program satisfying one of a specific list of standards. Requirement examples include charity care spending in an amount equal to at least 100 percent of the hospital's tax-exempt benefit, excluding federal income tax; or charity care spending in an amount equal to at least 4 percent of the net patient revenue.

Charity Care Spending and Eligibility Fluctuates Throughout State

When reviewing the hospitals' spending on charity care as they reported it to the Internal Revenue Service (IRS), we found it fluctuates. For example, one hospital reports spending close to $7 million on its charity care program while another spent a little more than $3,300. Some of this variance is due to the diversity in hospitals, but the difference is also evident when comparing charity care as a percentage of each hospital's overall community benefit spending. Table 4 (see page 34) lists this information for each hospital. As seen in the table, one hospital reports spending 76 percent of their community benefit spending on charity care. Eleven report spending 5 percent or less on charity care.

Table 4

Charity Care Spending as Amount and Percentage of Overall Community Benefit Spending

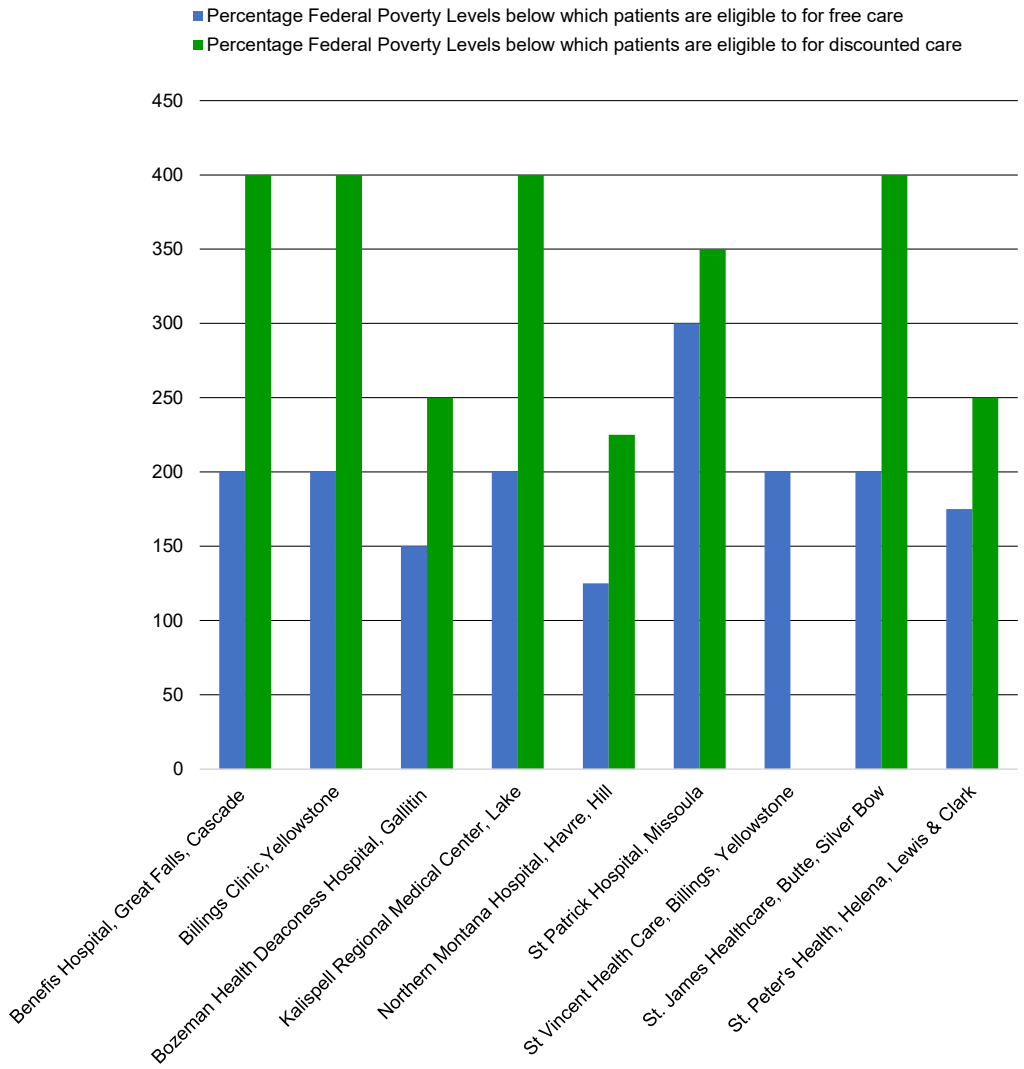
Hospital Name	Location of Hospital - City	Location of Hospital - County	Community Benefit - Charity Care as Spending Amount	Community Benefit - Charity Care as Percentage of Total Community Benefit Spending	Total Community Benefit Spending
Barrett Hospital and Healthcare	Dillon	Beaverhead	$141,000	5%	$2,657,346
Beartooth Billings Clinic	Red Lodge	Carbon	$103,869	38%	$271,938
Benefis Hospital	Great Falls	Cascade	$3,501,065	14%	$25,413,553
Benefis Teton Medical Center	Choteau	Teton	$13,937	5%	$283,088
Big Horn County Memorial Hospital	Hardin	Big Horn	$113,314	17%	$678,464
Big Sandy Medical Center	Big Sandy	Choteau	$3,360	2%	$147,168
Billings Clinic	Billings	Yellowstone	$6,210,582	22%	$28,582,326
Bozeman Health Deaconess Hospital	Bozeman	Gallatin	$5,296,809	19%	$27,756,734
Cabinet Peaks Medical Center	Libby	Lincoln	$393,200	57%	$690,037
Central Montana Medical Center	Lewistown	Fergus	$416,000	10%	$4,309,504
Clark Fork Valley Hospital	Plains	Sanders	$349,513	70%	$501,127
Community Hospital of Anaconda	Anaconda	Deer Lodge	$239,331	5%	$5,208,531
Dahl Memorial Healthcare Association	Ekalaka	Carter	$3,480	2%	$144,020
Daniels Memorial Hospital	Scobey	Daniels	$28,065	14%	$206,755
Deer Lodge Medical Center	Deer Lodge	Powell	$44,000	32%	$138,094
Fallon Medical Complex Hospital	Baker	Fallon	$54,000	4%	$1,363,261
Frances Mahon Deaconess Hospital	Glasgow	Valley	$248,738	11%	$2,183,710
Glendive Medical Center	Glendive	Dawson	$62,000	1%	$9,660,687
Holy Rosary Healthcare	Miles City	Custer	$1,076,430	35%	$3,096,659
Kalispell Regional Medical Center	Kalispell	Flathead	$6,925,215	64%	$10,854,053
Liberty Medical Center	Chester	Liberty	$15,155	9%	$177,959
Livingston Healthcare	Livingston	Park	$336,534	65%	$513,924
Madison Valley Medical Center	Ennis	Madison	$62,271	10%	$595,370
Marcus Daly Memorial Hospital	Hamilton	Ravalli	$162,371	3%	$6,158,732
McCone County Health Center	Circle	McCone	$98,193	20%	$486,378
Mineral Community Hospital	Superior	Mineral	$78,792	54%	$146,784
Mountainview Medical Center	W. S. Springs	Meagher	$53,167	16%	$336,094
North Valley Hospital	Whitefish	Flathead	$679,144	76%	$891,035
Northern Montana Hospital	Havre	Hill	$356,262	5%	$6,954,285
Northern Rockies Medical Center	Cut bank	Glacier	$81,299	12%	$663,926
Phillips County Hospital	Malta	Phillip	$24,000	10%	$241,720
Pioneer Medical Center	Big timber	Sweet Grass	$61,938	4%	$1,446,717
Pondera Medical Center	Conrad	Pondera	$32,000	1%	$2,303,576
Poplar Community Hospital	Poplar	Roosevelt	$580,467	30%	$1,950,016
Roosevelt Medical Center	Culbertson	Roosevelt	$28,434	8%	$363,433
Rosebud Health Care Center Hospital	Forsyth	Rosebud	$13,857	1%	$1,682,927
Roundup Memorial Healthcare	Roundup	Musselshell	$55,372	25%	$217,328
Sheridan Memorial Hospital	Plentywood	Sheridan	$161,421	12%	$1,307,747
Sidney Health Center	Sidney	Richland	$542,299	10%	$5,598,177
St. James Healthcare	Butte	Silver Bow	$1,170,823	10%	$11,464,651
St. Joseph Medical Center (Providence)	Polson	Lake	$335,046	72%	$465,261
St. Luke Community Hospital	Ronan	Lake	$462,248	6%	$7,518,997
St. Patrick Hospital (Providence)	Missoula	Missoula	$3,470,020	10%	$35,356,245
St. Peter's Health	Helena	Lewis and Clark	$921,840	5%	$17,977,055
St. Vincent Health Care	Billings	Yellowstone	$3,947,670	14%	$27,446,993
Stillwater Billings Clinic	Columbus	Stillwater	$29,496	24%	$120,635
Wheatland Memorial Hospital	Harlowton	Wheatland	$92,000	18%	$515,509

Source: Compiled by the Legislative Audit Division from Internal Revenue Service.

We reviewed the nine large hospital IRS 990/Schedule H forms and found varying levels of charity care eligibility also. Charity care can reduce a patient's bill by 1-100 percent. One hundred percent charity care assistance is called free care because it eliminates the patient's bill. Discounted care is the hospital reducing the patient's bill by 99 percent or less. Eligibility for free and discounted care are both largely based on how the patient's income compares to the FPL. Figure 8 illustrates the eligibility requirements we found at the nine large hospitals. If a patient's income expressed as a percentage of the FPL on the left side of the figure is within the blue columns, they would qualify for free care. If their income is within the green columns, they would qualify for discounted care. As illustrated by the figure, the eligibility requirements for charity care vary widely at the nine large hospitals in Montana.

Figure 8

Large Hospital Charity Care Eligibility Limits by Percentage of the Federal Poverty Level



Source: Compiled by the Legislative Audit Division from Internal Revenue Service records.

The law provides each hospital latitude to meet the needs of the local area it serves. However, when we compare the poverty levels or median income of the county in which hospitals are located, there is not clear correlation between charity care eligibility and the needs of the community. For example, according to the Montana Department of Commerce Census and Economic Information Center, during the time we reviewed, the median income in Butte/Silver Bow was $42,237 and the percentage of people living below the FPL was 19 percent. The hospital located there provides partial charity care up to 400 percent of the FPL and full charity care up to 200 percent of the FPL. These are the same levels as a hospital located in Yellowstone County that has a median income of $59,117 and 10 percent living below the poverty level. This is not surprising given there is no expectation of consistency. This is because DPHHS has not developed a process to ensure the nine large hospitals have consistent charity care, nor has guidance related to charity care expectations been defined. We found when interviewing department staff and management they focus on oversight of hospital operations related to issues of quality of care. This includes areas such as maintaining a sterile environment and properly working safety equipment. DPHHS oversight does not include financial policies such as charity care. This lack of charity care oversight creates inconsistencies between hospitals in providing patients assistance based on their ability to pay. This is because hospitals use different criteria to determine if patients qualify for charity care. More specific charity care criteria is needed to reduce this.

Charity Care Program Needs Standards

While state law places the responsibility with DPHHS to ensure nonprofit hospitals have written charity care policies consistent with industry standards on charity care, the law does not define what those standards are, including spending and eligibility requirements related to charity care. The result is a lack of consistent expectations and oversight, and hospitals independently determining the level of support they provide. Wide variances between nonprofit hospitals on when and how much assistance they will provide to lower income patients is the result. In addition, DPHHS staff expressed a lack of knowledge and awareness this responsibility had been placed with them by the legislature. According to department management, their focus regarding hospital oversight has historically been focused on quality of care, with limited attention given to the financial aspects of hospital operations. Consequently, DPHHS has not developed a process to ensure hospitals have charity care.

RECOMMENDATION #2

We recommend the Department of Public Health and Human Services:

A. *Define spending and eligibility expectations related to charity care.*

B. *Develop an active oversight and review process that will ensure hospitals have charity care polices consistent with industry standards.*

Estimated Nonprofit Hospital Tax Exemption Benefit and Self-Reported Community Benefit Spending Details - 2016

Hospital Name	Location of Hospital - City	Location of Hospital - County	Estimated Tax Exemption Benefit - Federal	Estimated Tax Exemption Benefit - State and Local	Estimated Tax Exemption Benefit - Total	Community Benefit - Subsidized Services	Community Benefit - Medicaid	Community Benefit - Charity Care	Community Benefit - Health Professional Education	Community Benefit - Community Health	Community Benefit - Cash and In-Kind Contributions	Community Benefit - Research	Community Benefit - Other Means Tested	Community Benefit - Total	Difference Between Total Estimated Tax Exemption Benefit and Total Self-Reported Community Benefit. A negative number indicates higher community benefit spending.
Barrett Hospital and Healthcare	Dillon	Beaverhead	$789,352	$221,945	$1,011,297	$1,809,590	$0	$141,000	$672,156	$29,796	$4,804	$0	$0	$2,657,346	-$1,646,049
Beartooth Billings Clinic	Red Lodge	Carbon	$211,922	$192,267	$404,188	$0	$86,886	$103,869	$76,383	$0	$4,800	$0	$0	$271,938	$132,250
Benefis Hospital	Great Falls	Cascade	$9,117,754	$5,454,116	$14,571,871	$19,757,760	$0	$3,501,065	$109,574	$624,337	$1,235,039	$185,778	$0	$25,413,553	-$10,841,682
Benefis Teton Medical Center	Choteau	Teton	$0	$67,689	$67,689	$0	$249,553	$13,937	$12,413	$5,950	$1,235	$0	$0	$283,088	-$215,399
Big Horn County Memorial Hospital	Hardin	Big Horn	$343,261	$87,051	$430,313	$0	$565,150	$113,314	$0	$0	$0	$0	$0	$678,464	-$248,151
Big Sandy Medical Center	Big Sandy	Chouteau	$192,145	$30,334	$222,479	$0	$143,808	$3,360	$0	$0	$0	$0	$0	$147,168	$75,311
Billings Clinic	Billings	Yellowstone	$25,801,923	$10,790,476	$36,592,399	$9,151,817	$0	$6,210,582	$6,160,227	$3,143,488	$2,781,792	$1,134,420	$0	$28,582,326	$8,010,073
Bozeman Health Deaconess Hospital	Bozeman	Gallatin	$3,172,902	$2,999,519	$6,172,421	$13,450,839	$8,786,460	$5,296,809	$19,269	$57,017	$146,340	$0	$0	$27,756,734	-$21,584,313
Cabinet Peaks Medical Center	Libby	Lincoln	$749,273	$560,801	$1,310,075	$281,220	$0	$393,200	$3,227	$12,069	$521	$0	$0	$690,037	$620,038
Central Montana Medical Center	Lewistown	Fergus	$731,549	$178,626	$910,175	$3,876,010	$0	$416,000	$73	$11,824	$5,597	$0	$0	$4,309,504	-$3,399,329
Clark Fork Valley Hospital	Plains	Sanders	$362,139	$80,439	$442,579	$73,829	$0	$349,513	$9,023	$14,887	$53,875	$0	$0	$501,127	-$58,548
Community Hospital of Anaconda	Anaconda	Deer Lodge	$307,179	$134,406	$441,585	$4,526,580	$0	$239,331	$4,000	$408,137	$30,483	$0	$0	$5,208,531	-$4,766,946
Dahl Memorial Healthcare Association	Ekalaka	Carter	$0	$1,460	$1,460	$140,540	$0	$3,480	$0	$0	$0	$0	$0	$144,020	-$142,560
Daniels Memorial Hospital	Scobey	Daniels	$0	$4,817	$4,817	$34,587	$28,591	$28,065	$0	$56,656	$0	$0	$0	$206,755	-$201,938
Deer Lodge Medical Center	Deer Lodge	Powell	$534,813	$211,215	$746,029	$0	$0	$44,000	$1,000	$90,157	$2,937	$0	$0	$138,094	$607,935
Fallon Medical Complex Hospital	Baker	Fallon	$574,061	$170,241	$744,302	$601,182	$431,037	$54,000	$217,448	$52,582	$3,546	$0	$3,466	$1,363,261	-$618,959
Frances Mahon Deaconess Hospital	Glasgow	Valley	$1,611,822	$455,910	$2,067,732	$1,906,897	$0	$248,738	$0	$0	$28,075	$0	$0	$2,183,710	-$115,978
Glendive Medical Center	Glendive	Dawson	$0	$244,250	$244,250	$8,205,289	$833,398	$62,000	$0	$0	$0	$0	$0	$9,660,687	-$9,416,437
Holy Rosary Healthcare	Miles City	Custer	$1,070,690	$584,758	$1,655,447	$1,512,740	$0	$1,076,430	$140,546	$311,469	$55,474	$0	$0	$3,096,659	-$1,441,212
Kalispell Regional Medical Center	Kalispell	Flathead	$6,008,174	$2,117,069	$8,125,243	$53,875	$3,856,823	$6,925,215	$9,700	$8,440	$0	$0	$0	$10,854,053	-$2,728,810
Liberty Medical Center	Chester	Liberty	$96,687	$39,403	$136,090	$0	$162,804	$15,155	$0	$0	$0	$0	$0	$177,959	-$41,869
Livingston Healthcare	Livingston	Park	$4,945,279	$1,020,968	$5,966,247	$0	$0	$336,534	$0	$161,544	$15,846	$0	$0	$513,924	$5,452,323
Madison Valley Medical Center	Ennis	Madison	$264,316	$56,465	$320,781	$79,810	$88,564	$62,271	$228,906	$118,344	$300	$0	$17,175	$595,370	-$274,589
Marcus Daly Memorial Hospital	Hamilton	Ravalli	$1,731,327	$546,361	$2,277,688	$1,239,891	$4,381,998	$162,371	$43,881	$279,637	$50,954	$0	$0	$6,158,732	-$3,881,044
McCone County Health Center	Circle	McCone	$3,786	$7,341	$11,127	$388,185	$0	$98,193	$0	$0	$0	$0	$0	$486,378	-$475,251
Mineral Community Hospital	Superior	Mineral	$360,981	$125,319	$486,300	$0	$45,378	$78,792	$1,658	$18,256	$2,700	$0	$0	$146,784	$339,516
Mountainview Medical Center	W. S. Springs	Meagher	$0	$65,442	$65,442	$0	$276,787	$53,167	$0	$6,140	$0	$0	$0	$336,094	-$270,652
North Valley Hospital	Whitefish	Flathead	$983,010	$478,250	$1,461,260	$0	$0	$679,144	$139,106	$9,990	$62,795	$0	$0	$891,035	$570,225
Northern Montana Hospital	Havre	Hill	$11,397,683	$342,830	$11,740,513	$1,680,738	$4,885,231	$356,262	$2,761	$6,531	$22,762	$0	$0	$6,954,285	$4,786,228
Northern Rockies Medical Center	Cut bank	Glacier	$105,691	$23,516	$129,207	$0	$359,519	$81,299	$0	$223,108	$0	$0	$0	$663,926	-$534,719
Phillips County Hospital	Malta	Phillip	$14,124	$18,254	$32,377	$0	$62,328	$24,000	$109,234	$46,158	$0	$0	$0	$241,720	-$209,343
Pioneer Medical Center	Big timber	Sweet Grass	$202,978	$25,432	$228,410	$86,188	$1,287,769	$61,938	$0	$10,822	$0	$0	$0	$1,446,717	-$1,218,307
Pondera Medical Center	Conrad	Pondera	$0	$15,938	$15,938	$2,262,372	$0	$32,000	$0	$9,204	$0	$0	$0	$2,303,576	-$2,287,638
Poplar Community Hospital	Poplar	Roosevelt	$0	$50,266	$50,266	$1,132,061	$229,088	$580,467	$0	$0	$8,400	$0	$0	$1,950,016	-$1,899,750
Roosevelt Medical Center	Culbertson	Roosevelt	$0	$3,817	$3,817	$190,557	$0	$28,434	$0	$144,442	$0	$0	$0	$363,433	-$359,616
Rosebud Health Care Center Hospital	Forsyth	Rosebud	$0	$67,818	$67,818	$1,578,323	$90,747	$13,857	$0	$0	$0	$0	$0	$1,682,927	-$1,615,109
Roundup Memorial Healthcare	Roundup	Musselshell	$106,791	$32,894	$139,684	$0	$147,536	$55,372	$0	$14,420	$0	$0	$0	$217,328	-$77,644
Sheridan Memorial Hospital	Plentywood	Sheridan	$60,780	$37,190	$97,969	$49,933	$1,045,166	$161,421	$0	$49,642	$1,585	$0	$0	$1,307,747	-$1,209,778
Sidney Health Center	Sidney	Richland	$730,444	$326,486	$1,056,930	$4,933,086	$0	$542,299	$14,318	$108,474	$0	$0	$0	$5,598,177	-$4,541,247
St. James Healthcare	Butte	Silver Bow	$2,095,245	$769,523	$2,864,769	$1,922,100	$6,659,393	$1,170,823	$296,645	$1,266,743	$148,947	$0	$0	$11,464,651	-$8,599,882
St. Joseph Medical Center (Providence)	Polson	Lake	$0	$228,748	$228,748	$73,273	$0	$335,046	$500	$337,075	$37,606	$0	$2,029	$465,261	-$236,513
St. Luke Community Hospital	Ronan	Lake	$786,562	$783,864	$1,570,426	$4,770,312	$1,728,732	$462,248	$356,608	$73,989	$0	$127,108	$0	$7,518,997	-$5,948,571
St. Patrick Hospital (Providence)	Missoula	Missoula	$0	$1,181,218	$1,181,218	$11,913,972	$14,683,588	$3,470,020	$4,942,142	$283,762	$27,708	$28,085	$6,968	$35,356,245	-$34,175,027
St. Peter's Health	Helena	Lewis and Clark	$6,626,812	$4,096,005	$10,722,817	$13,364,111	$2,526,559	$921,840	$0	$1,087,749	$76,796	$0	$0	$17,977,055	-$7,254,238
St. Vincent Health Care	Billings	Yellowstone	$22,314,977	$7,079,494	$29,394,471	$3,184,646	$16,917,818	$3,947,670	$1,336,883	$1,216,865	$722,691	$120,420	$0	$27,446,993	$1,947,478
Stillwater Billings Clinic	Columbus	Stillwater	$1,066	$112,879	$113,945	$78,301	$0	$29,496	$0	$6,750	$6,088	$0	$0	$120,635	-$6,690
Wheatland Memorial Hospital	Harlowton	Wheatland	$0	$50,490	$50,490	$423,509	$0	$92,000	$0	$0	$0	$0	$0	$515,509	-$465,019
		Totals	**$104,407,498**	**$42,173,599**	**$146,581,097**	**$114,734,123**	**$70,560,711**	**$39,076,027**	**$14,907,681**	**$10,306,454**	**$5,539,696**	**$1,595,811**	**$29,638**	**$257,048,529**	**-$110,467,432**

Source: Compiled by the Legislative Audit Division from Internal Revenue Service and Department of Revenue records.

Unless noted below, all data is from tax forms related to 01-01-2016 to 12-31-2016:

* Due to a reorganization, no 2016 data is available; data relates to 01-01-2017 to 12-31-2017.

** This hospital does not file based on a calendar year; this data relates to 07-01-2015 to 06-30-2016.

***This hospital does not file based on a calendar year; this data relates to 04-01-2016 to 03-31-2017.

****This hospital does not file based on a calendar year; this data relates to 07-01-2016 to 06-30-2017.

Department of Public Health & Human Services

Department Response

MONTANA DPHHS Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970♦ www.dphhs.mt.gov

Steve Bullock, Governor

Sheila Hogan, Director

September 22, 2020

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SEP 22 2020
LEGISLATIVE AUDIT DIV.

Angus Maciver
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

Re: Performance Audit of Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals

Dear Mr. Maciver:

The Department of Public Health and Human Services has reviewed the *Performance Audit of Community Benefit and Charity Care Obligations at Montana Nonprofit Hospitals* completed by the Legislative Audit Division. Our responses and corrective action plans for each recommendation are provided below.

Recommendation #1:

We recommend the Legislature enact law defining:

A. Expectations regarding detailed reporting of community benefit spending and its impact on community health.
B. The state government entity responsible for actively reviewing community benefit spending.

Response: N/A

Corrective Action: N/A

Planned Completion Date: N/A

Recommendation #2:

We recommend the Department of Public Health and Human Services:

C. Define spending and eligibility expectations related to charity care.
D. Develop an active oversight and review process that will ensure hospitals have charity care policies consistent with industry standards.

Response: Concur

Corrective Action: Implement administrative rules to identify the minimum criteria for charity care policies in nonprofit hospitals. Strengthen monitoring activities to ensure the existence of written charity care policies in these facilities.

Planned Completion Date: June 30, 2021

Sincerely,

Sheila Hogan, Director
Department of Public Health and Human Services

cc:
Erica Johnston, Operation Services Branch Manager
Carter Anderson, Quality Assurance Division Administrator
Chad Hultin, Audit Liaison