BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES
OF THE STATE OF MONTANA

In the matter of the adoption of NEW RULES I through V and the amendment of ARM 37.106.138 pertaining to financial assistance and community benefit provided by certain types of hospitals and related certificate of need requirements	)	NOTICE OF ADOPTION AND AMENDMENT

TO: All Concerned Persons

1. On May 24, 2024, the Department of Public Health and Human Services published MAR Notice No. 37-1096 pertaining to the public hearing on the proposed adoption of the above-stated rules at page 1160 of the 2024 Montana Administrative Register, Issue Number 10.

2. The department has amended ARM 37.106.138 as proposed.

3. The department has adopted the following rules as proposed: NEW RULE III (37.106.203), NEW RULE IV (37.106.204), and NEW RULE V (37.106.205).

4. The department has adopted the following rules as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

NEW RULE I (37.106.201) PURPOSE OF COMMUNITY BENEFITS AND FINANCIAL ASSISTANCE RULES (1) through (3) remain as proposed.
(4) Financial assistance and other community benefits are reported at cost, not charges, in reports and other documents submitted under this subchapter.

AUTH: 50-5-106, 50-5-121, MCA
IMP: 50-5-106, 50-5-121, MCA

NEW RULE II (37.106.202) DEFINITIONS For the purposes of this subchapter, the following definitions will apply:
(1) remains as proposed.
(2) "Community benefit plan" means the detailed outline of specific initiatives, activities, actions, and/or steps planned to be taken by a nonprofit hospital, critical access hospital, or rural emergency hospital to improve the health of the community(ies) it serves. This plan may include community benefit information contained in the facility's community health needs assessment implementation plan.
(3) "Community benefit policy" is the written policy (i.e., set of principles, guidelines, or rules) that directs how decisions of the nonprofit hospital, critical

access hospital, or rural emergency hospital on specific actions to improve the health of the community it serves will be made or carried out.

(2) and (3) remain as proposed, but are renumbered (4) and (5).

AUTH: 50-5-106, 50-5-121, MCA
IMP: 50-5-106, 50-5-121, MCA

4. The department has thoroughly considered the comments and testimony received. A summary of the comments received and the department's responses are as follows:

COMMENT #1: A commenter stated that patients feel trapped by medical debt as many receive medical bills they cannot afford and are forced to pay the bill with a credit card. Those patients who made the effort to challenge bills experienced negative impacts. As a result, some patients delay medical care because they want to avoid further debt. The proposed rules will provide important new protection for patients incurring medical expenses, but they could go further. A financial assistance policy that is readily available to the public is an essential step toward reducing medical debt for patients who cannot pay. Section 50-5-121, MCA, allows the department to adopt rules to implement the act and establish standards for nonprofit health care facilities to provide community benefit and financial assistance consistent with federal standards. The department could, and should, go beyond federal protections to provide greater access and protections to Montanans who need and apply for medical financial assistance. The commenter asked the department to consider the following suggestions based on the Model Medical Debt Protection Act as part of its rulemaking:

- Add additional requirements for financial assistance policies.
- Mandate screening for all patients and automatically enroll those patients found eligible.
- Set income levels where financial assistance must be provided.
- Establish patient eligibility requirements.
- Prohibit junk fees or interest.
- Require increased access/easy access to financial assistance policies and ways to apply for financial assistance.

RESPONSE #1: The department thanks the commenter for their comments. As noted in the proposal notice, the department plans to adopt standards for community benefit and financial assistance based on the data that it will collect, validate, and analyze. In this process, the department will consider the commenter's recommendations, although the department notes that the purpose of the Model Medical Debt Protection Act, from which the commenter drew its recommendations, is different from the purpose of H.B. 45. In addition, the department notes that most of Montana is made up of health professional shortage areas (HPSAs), and many critical access hospitals and rural emergency hospitals operate on very thin margins in remote, rural, and/or frontier areas. The department needs to keep these facts in mind when establishing the standards and requirements for community benefit and

financial assistance, so that the standards and requirements do not negatively impact the ability of critical access hospitals and rural emergency hospitals to continue to operate.

COMMENT #2: Another commenter contended that the department failed to satisfy the statutory requirements established in House Bill 45, and failed to meet the recommendations of the audit findings in the September 2020 legislative performance audit. The commenter also offered specific criticisms of a number of provisions of the proposed rules. The commenter contended that NEW RULE I(3) has no mention that community benefits must have a measurable impact on population health as recommended in the 2020 audit, and proposed requiring this in the purpose section of the rules. The commenter also contended that financial assistance and other community benefits should be reported at charge, rather than cost, as proposed in NEW RULE I(4), because a hospital could claim to provide financial assistance while still charging (and seeking to collect) from a patient more than the cost of service.

The commenter further contended that NEW RULE II(1) would make it easy for hospitals to count financial assistance as community benefits, double dipping [sic] the service for both requirements, and proposed that the department should set standards that delineate where financial assistance can and cannot be counted as a community benefit. With respect to NEW RULE II(2), the commenter contended that the proposed language does not prohibit hospitals from categorizing unpaid charges sent to collections as financial assistance, and recommended a provision that charges that have been sent to collections cannot qualify as financial assistance. The commenter also contended that NEW RULE III(2) and (3) are not how rules are to be structured because they just restate the statute. The commenter also contended that the "in writing" for a community benefits policy was confused with the community benefits plan requirement and recommended that "community benefit plan" should be replaced with "community benefit policy" in NEW RULE III(2)(a). The commenter noted that NEW RULE III(4) fails the statutory requirement imposed by H.B. 45 of adopting rules by July 1, 2024. The commenter further contended that NEW RULE III(5) effectively grants a waiver of all financial assistance or community benefits requirements (including reporting requirements) for years with operating losses, suggesting that this will always be the case, indicated that this may conflict with federal laws and regulations, and urged that NEW RULE III(5) be eliminated. On NEW RULE IV, the commenter again complained that the reporting requirements restate H.B. 45's language and do not mention community health needs assessment (CHNAs). The commenter argues that IRS reporting lacks detail on what constitutes community benefits or any measurable benefits to communities, contending that the new rule will not provide relevant information reporting on actual benefits provided and their impacts, and that the department should start over. Finally, on NEW RULE V, the commenter contends that NEW RULE V(1) and (4) violate the statutory language of H.B. 45, noting that if the standards are not established, the penalties cannot be either; the commenter also argues that NEW RULE V(3) benefits the "big guys" and hurts the "small guys," incentivizes hospitals not to comply, and only serves as a source of minor revenue for the department. The proposed solution is to

eliminate the proposed penalties and instead set escalating penalties based on size and resources of hospitals in tiered categories like taxes. Alternately, since these requirements are a component of nonprofit tax benefits, the department should establish penalties to revoke the property tax benefits past a certain size of those who fail to comply.

RESPONSE #2: The department thanks the commenter for their continued interest in H.B. 45 and the provision of community benefits and financial assistance by nonprofit hospitals, critical access hospitals, and rural emergency hospitals. The commenter is correct that findings from a 2020 audit caused the department to seek legislative adoption of draft legislation introduced as H.B. 45. There are, however, significant differences between H.B. 45 as introduced and H.B. 45 as enacted, which the commenter may not have considered. To name a few, as enacted, H.B. 45 (unlike H.B. 45 as introduced):

- Limited the reports that the department could require any health care facility, including nonprofits, to provide. The department further notes that S.B. 307, codified at 35-2-129, MCA, arguably further limits the information that the department can require such nonprofits to provide.
- Specified the limited documents and information that the nonprofit hospitals, critical access hospitals, and rural emergency hospitals could be required to submit in connection with community benefit and financial assistance requirements.
- Required that the definitions of, and standards for, community benefit and financial assistance be consistent with federal standards, whenever possible.
- Required that the financial assistance and community benefit requirements be specific to the hospital and the area(s) it serves.

While the 2020 audit findings provided the impetus for the department to seek legislative authority to address the issues identified in the audit, now that H.B. 45 has been enacted, it is the department's job to implement H.B. 45. Audit recommendations (such as that community benefits must have a measurable impact on population health) are relevant and will be considered in developing the community benefit and financial assistance standards to the extent that they are consistent with the regulatory authority provided to the department through H.B. 45.[1]

With respect to several proposed rules (NEW RULES III and V), the comment complained that the department has not yet established the required standards for community benefit and financial assistance, despite a July 1, 2024 deadline, and voiced concern that the department does not intend to do so.[2] The department

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[1] The recommendation on NEW RULE I(3) that the proposed purpose include the requirement that community benefits have a measurable impact on population health could artificially elevate one type of community benefits over other types of community benefits.

[2] In this regard, the comment argued that the department "has the authority to collect any information the agency needed to collect from the hospitals to develop these standards." But the cited statutory provision does not appear to be an

would have preferred to be able to adopt such standards in 2024. However, it currently lacks the data necessary for it to do so – especially since H.B. 45, as enacted, requires the financial assistance and community benefits standards and requirements to be specific to the hospital and the area(s) it serves. The delay in developing the standards will enable the department to obtain the data needed to individualize the standards/requirements in accordance with the statute. Similarly, the comments on several proposed provisions (NEW RULE III(2) and (3) and NEW RULE IV) complained that the department restates H.B. 45, suggesting that this is improper. The department believes that this is a mistaken idea: Given the manner in which H.B. 45 was drafted and the subtle differences in the requirements imposed on nonprofit hospitals, as compared to nonprofit critical access hospitals and rural emergency hospitals, the department believes that it is necessary to clearly set forth in implementing regulations the applicable requirements related to community benefit and financial assistance for nonprofit hospitals, critical access hospitals, and rural emergency hospitals. The Montana Administrative Procedure Act bars only the unnecessary repeating of statutory language. *See* 2-4-305(2), MCA.

The department disagrees with the recommendation on NEW RULE I(4) that financial assistance and other community benefits be reported at charge, rather than cost: Hospital chargemasters tend to establish rates (charges) for hospital services that are higher than the cost to the hospital for providing the service. Thus, reporting financial assistance at charge, rather than cost, would tend to inflate the value of financial assistance for reporting purposes. The department's proposed requirement to report financial assistance at cost would also preclude the scenario (posited in the comment on the definition of "financial assistance," in NEW RULE II(2)) that a hospital could consider unpaid charges sent to collections as financial assistance.

The comment appears to complain about the inclusion of "financial assistance" in the definition of "community benefit," suggesting that this would permit double dipping/double counting of amounts provided in financial assistance. As indicated in the proposed rule's statement of reasonable necessity, the proposed definition of "community benefit" is based on the Internal Revenue Service's (IRS) definition, in which financial assistance is a subset of community benefit. Nevertheless, when the department establishes the standards for community benefit and financial assistance, it will consider whether any measures would need to be adopted to prevent the comment's hypothetical situation.

The commenter appears to misunderstand NEW RULE III(2)(a); it would require a nonprofit hospital, critical access hospitals, and/or rural emergency hospital to have

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authorization to collect information – which, in any event would be limited to "information and statistical reports . . .necessary . . .for health planning and resource development activities" – but, rather, a requirement to make publicly available the information and data collected. *See* 50-5-106(6), MCA ("Information and statistical reports from health care facilities that are considered necessary by the department for health planning and resource development activities must be made available to the public and the health planning agencies within the State.").

a written community benefits plan, a written community benefits policy, and a written financial assistance policy, consistent with the statute. The recommendation to replace "community benefits plan" with "community benefits policy" is, thus, unnecessary. The rule recognizes that both a community benefit plan and a community benefit policy should prove to be important tools for decision-making and goal-setting for nonprofit hospitals, critical access hospitals, and rural emergency hospitals, on these issues. A plan is a detailed outline of specific actions and steps that need to be taken to achieve a particular goal or objective. A policy is a set of guidelines or rules that dictate how certain decisions should be made or how certain actions should be carried out within an organization. While plans focus on the how of achieving a goal, policies focus on the rules and procedures that govern decision-making and behavior. Both plans and policies are essential for effective organizational management and ensuring that goals are achieved in a consistent and efficient manner.

The comments on NEW RULE III(5) also demonstrate a misunderstanding of the rule text, as well as of the interests that the department must balance. First, the provision recognizes the fact that most of Montana consists of HPSAs and that many critical access hospitals and rural emergency hospital operate on very thin margins in remote, rural, and/or frontier areas; imposing specific community benefit or financial assistance requirements on such nonprofits in a year in which they experience operating losses could jeopardize their ability to continue to operate. Second, the provision would not affect such hospitals' obligation to comply with federal I.R.S. tax-exempt requirements. Finally, contrary to the comment, they would still have to comply with the reporting requirements - and if it appears to the department that a nonprofit certain hospital(s) is abusing the compliance waiver, the department would take appropriate steps to address the issue.

The comment criticized NEW RULE IV, on reporting requirements, for merely restating reporting requirements from H.B. 45 and not requiring nonprofit hospitals, critical access hospitals, and rural emergency hospitals to report other information (e.g., community health needs assessments and other nonspecified information). However, H.B. 45 limited the information relating to community benefit and financial assistance that such nonprofits are required to submit to the department to certain information specified in the statute (50-5-106(3), MCA) – and, in fact, removed certain departmental authority to require health care facilities to make reports as required by the department (*see* H.B. 45, section 1, amending 50-5-106(1)). H.B. 45 does require such a nonprofit to submit, to the department, the workpapers supporting its IRS Form 990 Schedule H, which may enable the department to better understand the information presented on the Schedule H. And, of course, in developing the standards and requirements, the department anticipates that it will use all the relevant information that it has or can obtain.

Finally, the commenter may have misread NEW RULE V on penalties. The only instance in which the penalties for noncompliance will be the same, regardless of size, is with respect to the reporting requirements. This is sensible because the documents required to be submitted to the department, as the comment noted in

another section, for the most part already exist.[3] With respect to noncompliance by nonprofit hospitals with the community benefit and financial assistance standards, the department proposed that the penalties be determined at the same time that the standards are established – so that the penalties for noncompliance will be consistent with and align with the standards themselves. In contrast, if a nonprofit critical access hospital or rural emergency hospital fails to comply with its community benefits and financial assistance policies, the department will provide technical assistance and may require corrective action. The department lacks the statutory authority to temporarily revoke the property tax benefits of nonprofit hospitals that fail to comply, contrary to the commenter's suggestion.

COMMENT #3: On NEW RULE I, several commenters agreed generally with reporting financial assistance at cost, but sought clarification, stating that generally accepted accounting principles (GAAP) require that gross charges related to financial assistance are not reported as revenue on the financial statements, and that gross revenue related to financial assistance is used to reduce the total revenue reported; in Form 990 reporting, financial assistance is reported at cost. In asking for clarification as to where financial assistance should be reported at cost, one commenter noted that in hospitals' annual reports to the department, financial assistance is reported consistent with GAAP, which does not record it at cost. However, on IRS Form 990 Schedule H, financial assistance is reported at cost.

RESPONSE #3: The department appreciates the commenters' support for reporting financial assistance at cost. The department will provide further guidance and clarification on the requirement as it develops the standards for financial assistance, but notes that the requirement in NEW RULE I was not aimed at the annual report, which is required under different administrative rules, but was focused on the Form 990 Schedule H and related reporting; in this adoption notice, the department modifies NEW RULE I(4) to make that clear. By requesting that financial assistance be reported at cost, the department recognizes and emphasizes the IRS Form 990 Schedule H reporting requirements.

COMMENT #4: A commenter requested that the department add, in NEW RULE I, a statement that the rules are consistent with IRS requirements and guidance on financial assistance and community benefit.

RESPONSE #4: The department thanks the commenter for their comment, but declines to add the requested statement to NEW RULE I. H.B. 45 requires only that the department (1) "define financial assistance and community benefit consistent with federal standards, *wherever possible,*" and (2) "establish the standards for community benefit and financial assistance applicable to hospitals operating as nonprofit health care facilities consistent with federal standards, *wherever possible.*" 50-5-121(4)(a) and (b), MCA (emphasis added). While the department intends to

[3] If the department finds that nonprofit hospitals, in contrast to nonprofit critical access hospitals or rural emergency hospitals, are not submitting the required reports and documents, the department will consider changing the penalty structure.

adopt definitions and standards consistent with the federal IRS standards and definitions whenever possible, the department recognizes that it may not always be possible to do so and, thus, cannot put the requested statement into these rules.

COMMENT #5: One commenter recommended that the department define "community benefit" to include the IRS's reportable categories, ensuring consistency with IRS requirements.

RESPONSE #5: The department thanks the commenter for their recommendation, but declines to do so at this time since insufficient information was provided to enable the department to make an informed decision on the commenter's recommendation. The department will continue to consider the issue.

COMMENT #6: One commenter requested that the rules use the term "community health improvement plan" or "community health implementation strategy" instead of "community benefit plan" that was used in H.B. 45, stating the IRS 990 rules do not reference a "community benefit plan." Another commenter, acknowledging that the proposed rules used that term to comply with the language in H.B. 45, requested that the department provide a definition of the term and include references to "community health improvement plan" and "community health implementation strategy." Yet another commenter requested that the department provide a definition of "community benefits policy," or expand on the requirement for a written "community benefits policy," noting that, since it is a new concept for nonprofit hospitals, it would be helpful to understand the department's expectations on the content of such policy.

RESPONSE #6: The department declines to accept the comment to use terms not in H.B. 45. Consistent with the statute, the department will continue to use the term "community benefit plan" in the rules. In response to the comments, however, the department adopts a definition of "community benefit plan," to provide clarity on its expectations for community benefit plans.[4] The department similarly adopts a definition of "community benefit policy." As the department develops standards for community benefits, it will consider further refinements to the definitions or requirements with respect to "community benefit plan" and/or "community benefit policy."

COMMENT #7: On NEW RULE III, one commenter noted the department's thoughtfulness in gathering information before setting standards and indicated that the department's acknowledgment of each hospital's gains and losses and individual community factors in setting standards is appreciated. The commenter requested that the department consider looking at averages over a longer period to allow hospitals to adjust to changes in their environment/trends. The commenter noted that hospitals are not always able to control the factors that lead to the amount of

[4] As the department noted in the proposal notice, it understands that a community health improvement plan or implementation strategy would likely meet the requirement for a community benefit plan.

community benefit, especially financial assistance, offered in any given period and will often not know until the end of the period their final net revenue, financial assistance, or overall community benefit. Another commenter made a similar comment.

RESPONSE #7: The department thanks the commenter for their recognition of the thoughtfulness of the department's approach. As proposed, based on stakeholder input, the department is planning to use a three-year average to set the initial standards and to adjust such standards in future years with a rolling three-year average. It, thus, believes that its approach to setting and updating community benefit and financial assistance standards is consistent with the comments.

COMMENT #8: On NEW RULE III(2)(b), one commenter suggested changing "written community benefit policy and financial assistance policy" to "financial assistance and emergency medical care policies."

RESPONSE #8: The department appreciates the suggestion, but declines to make the suggested wording change, to ensure consistency with the statute.

COMMENT #9: With respect to NEW RULE IV's requirement to submit Form 990 with Schedule H and "associated worksheets," several commenters noted that nonprofit hospitals compile worksheets to calculate various reportable community benefits, but since the IRS does not require any particular form or format, such worksheets will vary from hospital to hospital. As a result, several commenters recommended that the department develop a standardized worksheet, report, or form for hospitals to complete and submit with their reports, to ensure consistency across all hospitals. One commenter requested the department adjust the wording to reference "supporting workpapers."

RESPONSE #9: Consistent with H.B. 45, the department proposed to require submission of the Schedule H "associated worksheets," which it views as the same as "supporting workpapers." The department is aware that the IRS does not require a particular format for the worksheets used to calculate the information provided in Schedule H and does not require submission of such worksheets to it. The department understands that there is no uniformity to the worksheets, but since the worksheets show how hospitals report community benefit and financial assistance, they should enable the department to understand and unpack each hospital's Schedule H reported community benefit and financial assistance. As it reviews and analyzes the data to establish the community benefit and financial assistance standards, the department will consider whether it needs more standardized data, whether it can develop a standardized worksheet to collect the data, and whether, in light of the additional burden it may impose on hospitals, it should. The department does not believe that it is necessary to change the term to "supporting workpapers."

COMMENT #10: One commenter argued that the language in NEW RULE IV(3) contradicts the proposed definition of "community benefit," and suggested that the conflict could be avoided if that definition includes the IRS reportable categories.

RESPONSE #10: Since the commenter failed to explain the asserted contradiction, the department is unable to assess the comment and make an informed decision on the recommendation. However, as noted in the response to Comment #5, it continues to consider including the IRS reportable categories in the definition of "community benefit."

COMMENT #11: One commenter suggested that the department may lack understanding of the accounting, financial reporting, and GAAP standards applicable to nonprofit hospitals and offered its assistance to the department.

RESPONSE #11: The department acknowledges the comment, and notes that it is always willing to hear from stakeholders.

COMMENT #12: One commenter noted its long tradition of care and dedication to the communities it serves, stating that community benefit is integral to its mission. It recognized that there are several approaches to managing the program and respectfully requested the department consider opportunities to limit administrative burden on the state and hospitals. It noted that community benefit investments are highly regulated at the state and federal level; community health needs assessments (CHNAs) and community health improvement plans (CHIPs) are required as well as multiple other requirements by the IRS. It argued that Montana's hospitals also provide an important safety net that should not be overlooked, and comply with EMTALA.

RESPONSE #12: The department appreciates the comments. The department's intent in these rules implementing H.B. 45 is not to add unnecessary administrative burden for nonprofit hospitals, critical access hospitals, and rural emergency hospitals, but to implement the statute with as little administrative burden as possible.

/s/ Paula M. Stannard
Paula M. Stannard
Rule Reviewer

/s/ Charles T. Brereton
Charles T. Brereton, Director
Department of Public Health and Human Services

Certified to the Secretary of State September 10, 2024.