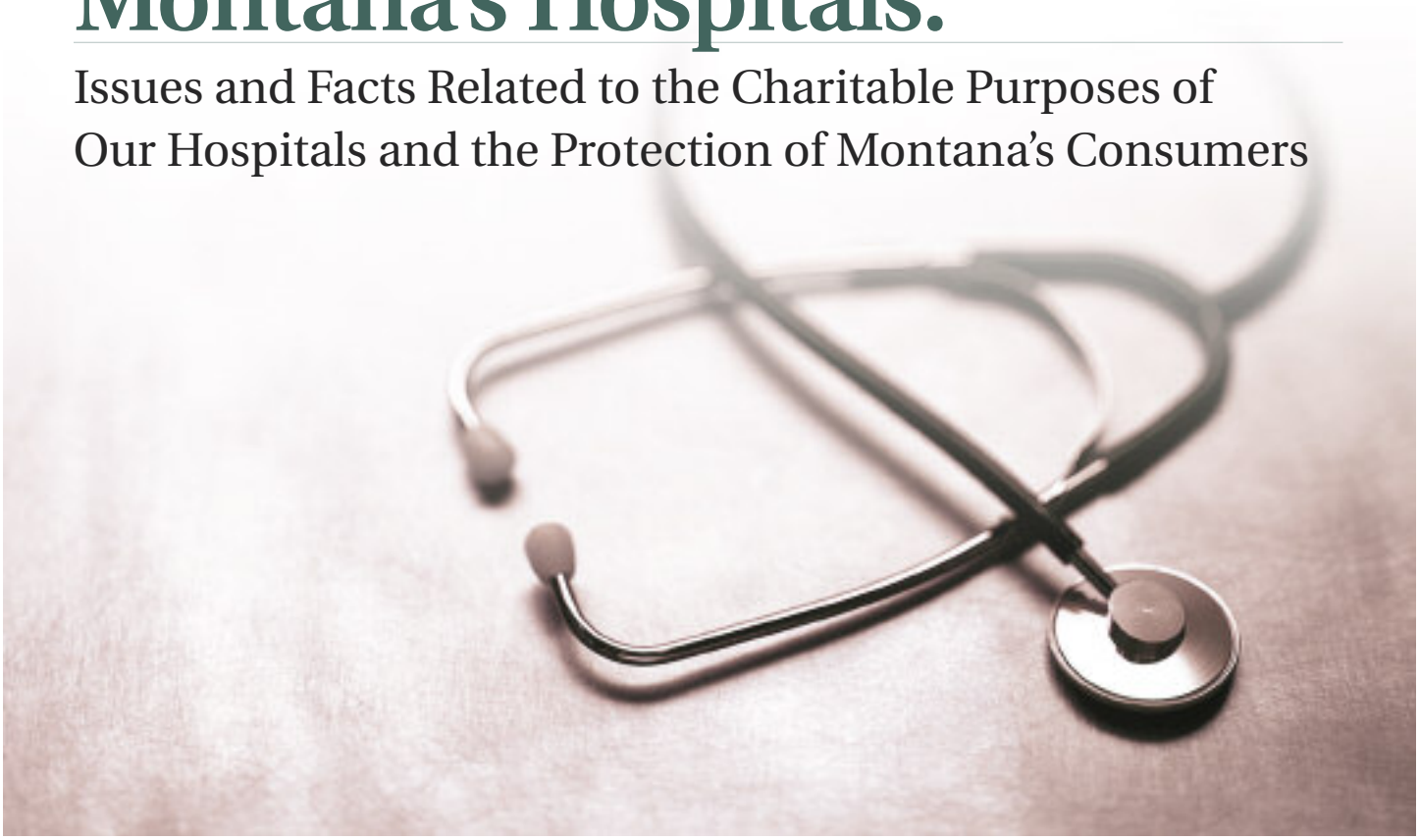
REPORT

Montana's Hospitals:

Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers



MONTANA OFFICE OF
CONSUMER PROTECTION

A Report Prepared for
Montana Attorney General Mike McGrath

January 2008

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I. Background

Under law, Montana's tax-exempt hospitals (those organized under section 501(c)(3) of the U.S. tax code) are obligated to provide community benefits in return for their tax exempt status. In Montana, the Attorney General is charged with the responsibility to monitor nonprofit corporations. In addition, the Attorney General is responsible for consumer protection from unfair methods of competition and unfair or deceptive trade practices.

In 2006, the Attorney General began an evaluation to determine the extent to which nonprofit hospitals fulfilled their obligation to provide community benefit. Montana has 63 licensed, acute care hospitals. Of these, 52 are federal, critical access (rural hospitals with fewer than 25 beds), or for-profit hospitals. For this study, the federal, critical access, and for-profit hospitals were excluded, leaving 11 major nonprofit hospitals. These hospitals[1] were contacted and asked to provide the information detailed in Section Ic.

In September 2007, with the information from the hospitals in hand and having made a preliminary assessment of the data, the Office of the Attorney General contracted with the author to conduct an analysis of the information and write this preliminary report.

Ia. Tax Exemption and Community Benefit – A Summary of the Law

The federal tax code provides that nonprofit hospitals that qualify under Internal Revenue Code section 501(c)(3) are exempt from federal income taxes and that donations to these hospitals are tax deductible. Montana state law further provides that property used exclusively for nonprofit health care facilities is exempt from property taxes (MCA 15-6-201) and from income tax (MCA 15-31-102).

After the enactment of the Medicare and Medicaid programs in 1965, the Internal Revenue Service (IRS) revised its guidelines for determining if a hospital qualifies as a charitable organization under section 501(c)(3) by creating a "community benefit" standard. Many factors go into the IRS determination and, over time, the courts have ruled that "…community benefit is a flexible standard based on the totality of the circumstances and that a hospital need not demonstrate every factor to be exempt." [2]

Factors that have historically been used to demonstrate benefit to the community include charity care for those unable to pay, medical training programs, education programs, medical research, and emergency services.

Ib. Recent History of the Assessment of Community Benefits by Nonprofit Hospitals

Beginning about 2000, some state jurisdictions as well as the IRS began questioning whether hospitals were providing a community benefit proportionate to their tax exemption.[3] About this time, the definition of what constituted a community benefit came under active discussion. In 2006, at the federal level the Senate Finance Committee and the IRS, as well as many states including Minnesota, Washington and Montana, launched evaluations of nonprofit hospitals' community benefits.[4] The reasons for and the scope of these evaluations differed, however, common elements included the definition of community benefits, the charity care policies of hospitals, and the collection practices and pricing transparency of hospitals.

Particularly at the federal level, the definition of community benefit was vigorously debated in 2007 when the IRS invited comment about a proposed revision to the IRS Form 990 "Return of Organization Exempt From Income Tax." The American Hospital Association, the Catholic Health Association (CHA) and VHA (an association of nonprofit hospitals) were prominent among the many organizations that provided comment about the proposed changes. On December 20, 2007, the IRS formally promulgated a final decision regarding the proposed changes to Schedule H wherein hospitals are required to file an annual report of their community benefits beginning in 2009. As a result, the ambiguity about what constitutes community benefit as well as the variation in hospital reports will be significantly reduced or eliminated.

Ic. Evaluation Focus and Information Available

The Attorney General's inquiry to Montana's hospitals asked for information about:

1. the hospital's charity care policies and procedures
2. the hospital's admission paperwork
3. the amount of charity care provided in 2004 and 2005
4. the amounts included under charity care resulting from uncollectible debt
5. the hospital's debt collection policies and procedures
6. the amounts billed, collected and payor mix for the hospital's 10 highest volume procedures, known as diagnosis related groupings (DRGs), in 2004 and 2005.

In addition to this information, the author collected the IRS Form 990, the charity amounts and the Medicaid costs and reimbursement for the hospitals' fiscal year which ended during 2006.

As will be discussed later, the full measure of a hospital's community benefit can consist of at least eight factors. Like most hospitals in the United States, Montana's community hospitals have not measured and reported on all of them before now. In this assessment, the hospitals' cost of charity care and unreimbursed Medicaid costs are available to compare to the value of the hospitals' tax exemptions. Undoubtedly each of the hospitals in this study has provided community benefits in other ways; however, these have not been consistently reported and therefore are not available for this analysis. Finally, all of the analysis contained in this report looks at just one year, usually 2006. Hospital financial performance can vary significantly from year to year and therefore to obtain a complete picture of a hospital's community benefit, a three- or five-year average would be necessary.

II. Executive Summary

All of Montana's nonprofit hospitals are required to provide a benefit to the communities they serve in return for their tax-exempt status. This study analyzes Montana's eleven largest hospitals to assess their community benefit contributions as reflected by charity service and Medicaid cost in excess of reimbursement. In addition, the study evaluates these hospitals' collection and pricing practices.

The hospitals' charity policies vary greatly. The most liberal provide charity care on a sliding scale for families with income levels between 200% and 400% of the federal poverty guidelines (FPG). The most stringent offer charity care when income levels are between 100% and 200% of FPG, which for a family of four, equates to an income between $20,650 and $41,300. See Table 1.

Compared to the surplus (excess of revenues over expenses) hospitals earned in 2006, the study hospitals provided charity care in a range from 128% to 9.5%. St. James Healthcare in Butte provided $1.9 million in charity care and had a $1.5 million surplus (128%). Bozeman Deaconess Health Service provided $1.5 million in charity care and had a $15.8 million surplus (9.5%). See Table 4.

Uncompensated care is the sum of charity care and bad debts expense. Because it is often difficult to determine when charity service is warranted, this sum is the measurement used nationally to compare hospitals' "write-offs." Nationally, in 2006, uncompensated care averaged 5.7% of hospital total expenses. In 2006, three of the eleven Montana hospitals studied had uncompensated care amounts at the national average. The remaining hospitals were below the national average of 5.7%. See Table 2.

The study was able to evaluate only two of the components of community benefit because the others were not uniformly reported. Charity care and Medicaid costs in excess of reimbursement were compared to the estimated tax exemptions of the hospitals. Four of eleven study hospitals – Billings Clinic, Holy Rosary Healthcare in Miles City, St. James Healthcare in Butte, and St. Patrick Hospital and Health Sciences Center in Missoula – provided these two benefits at costs in excess of the taxes they would have paid if they were not tax exempt. The remaining seven hospitals studied provided less of these two community benefits than the taxes they would have paid had they not been tax exempt. Refer to Table 3.

The collection practices followed by the hospitals are in conformance with state law. However, virtually no information was available about billing and collection complaints as the hospitals do not keep track of them. Of the $19.1 million the study hospitals pursued through bankruptcy for 2004 through 2006, they collected only $193,000 – a return rate of merely 1.01%.

Finally, there is significant variability in hospital charges, but the health care consumer has no simple way to compare charges or to obtain information about the quality of services. Without this information, the Montana consumer cannot identify the highest health care value.

III. Montana's Hospitals Community Benefits

In June 2007, after studying the matter for about one year, the Internal Revenue Service promulgated a draft of proposed changes to the informational tax return reporting requirements of tax-exempt hospitals. Schedule H to the IRS Form 990 proposed the following as includable in the community benefits report.[5]

1. Charity care at cost – The cost of free or discounted health services provided to individuals unable to pay and who meet the hospital's criteria for charity care. Does not include bad debts.
2. Unreimbursed Medicaid costs – The costs of providing care to Medicaid patients in excess of the reimbursements received.
3. Unreimbursed costs of other government programs – The costs of providing care to patients paid for by other government programs (such as SCHIP) in excess of reimbursements received. Does not include Medicare.
4. Community health improvement services and community benefit operations – The cost of activities carried out to improve the health of the community, such as health education programs, free clinics, self-help groups (i.e.: weight loss, smoking cessation), and community health needs assessments.
5. Health professions education – The unpaid costs of clinical training programs for physicians, nurses and other health professionals.
6. Subsidized health services – The unreimbursed costs of clinical services provided as a community benefit to meet identified community needs such as burn units, renal dialysis, addiction treatment and mental health. Such services would not include any services required as a condition of licensure.
7. Research – The unreimbursed costs of clinical and community health research.
8. Cash and in-kind contributions – The cost of donations to individuals or community groups.

On December 20, 2007, the IRS issued the final instructions regarding hospital community-benefit reporting. The new Schedule H report will be required for fiscal year 2009 and is optional for fiscal 2008 filings. The most significant change from the June proposal is to require hospitals to report aggregate bad debts expense at cost and an estimate of amounts attributable to persons who qualify for charity care together with a rationale for what portion of the debt the hospital believes should be attributed to community benefit. As Montana begins discussing community benefits in return for tax exemption, it appears prudent to use items on this list as the measure of community benefit.

Unfortunately, hospitals, for the most part, have not reported on these matters in a consistent manner on the IRS Form 990. Consequently, this report is only able to assess the items which follow.

IIIa. Charity Care

The most prominent benefit a hospital can provide its community is charity care for individuals without the means to pay for medical services. All hospitals have a charity care policy which governs the administration of this benefit and all have a sliding scale based on income level. Inspection of these policies from the study hospitals revealed that eligibility for charity ranged from 400% of federal poverty guidelines (FPG) to 200%. For a family of four in 2007, this equates to an income between $82,600 and $41,300.[6] The maximum income for full write-off of the medical bill ranged from 100% to 200% of FPG. The individual hospitals' guidelines are as shown in Table 1:

Table 1
Income Level to Qualify for Partial and Full Charity Service

Hospital Name	City	% FPG Charity Begins	% FPG for full write off	No. Patients Benefiting-2006
Benefis Healthcare	Great Falls	200%	150%	3493
Billings Clinic	Billings	300%	110%	4323
Bozeman Deaconess Health Services	Bozeman	200%	100%	1209
Community Medical Center	Missoula	300%	200%	1586
Holy Rosary Healthcare	Miles City	400%	200%	1226
Kalispell Regional Medical Center	Kalispell	200%	125%	1868
Northern Montana Healthcare	Havre	200%	100%	531
St. James Healthcare	Butte	400%	200%	6091
St. Patrick Hospital and Health Sciences Center	Missoula	400%	200%	2773
St. Peter's Community Hospital	Helena	200%	125%	1212
St. Vincent Healthcare	Billings	400%	200%	3001

Each hospital has a detailed procedure governing the administration of its charity policy. Common elements include the requirement that the patient provide a written application to include verification of income and assets, and the utilization of all available insurance coverage including Medicaid. All hospitals report charity care amounts both as charges written off (gross charges) as well as the cost to the hospital of the care provided.

IIIb. Medicaid Cost in Excess of Reimbursement

Medicaid is the federal/state medical program for the poor. Not only are payments under this program less than the cost of the care provided, often the co-insurance and deductible payments required of the patient go unpaid as bad debts. For these reasons, the IRS as well as the hospital industry and states that regulate community benefits all agree that the difference between the cost of Medicaid services and the reimbursement for these services is a community benefit. In Montana, the so-called "bed tax" provides additional Medicaid reimbursement to hospitals. This amount must be added to the regular Medicaid reimbursement to calculate cost in excess of reimbursement. Similarly, any disproportionate share (DSH) payments to hospitals are added to Medicaid reimbursement.

IIIc. Other Community Benefits

In addition to charity care and the cost of Medicaid services, the community benefits to be recognized by the IRS are items three through eight identified on page 4. As stated previously, the Form 990s filed by the study hospitals do not provide sufficient and consistent information to allow these factors to be measured and therefore they cannot be included in this report. Nevertheless, it should be understood that all hospitals provide at least some of these benefits to their communities. In the future, it will be very important that these activities be accounted for and reported in a manner similar to charity care.

IIId. Uncompensated Care

Except for elective services, hospitals have the obligation to provide care to anyone presenting for service. For individuals who do not qualify or fail to apply for charity care and who do not pay, the charges for services result in bad debts. Depending on the individual hospital's charity policy and the diligence with which it is administered, a bad debt could be categorized as charity and vice versa. As the hospital pursues collection efforts on amounts that could, under other circumstances, be regarded as charity, it can put a cascade of events into motion. These will be examined in Section IV. Suffice to say, it often is difficult to determine if a collectable should be categorized as charity or a debt.

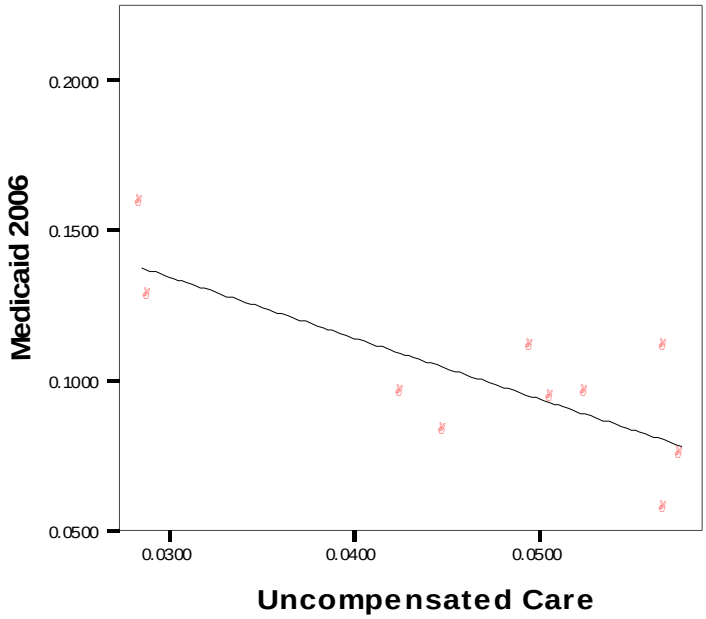
The combination of charity care and bad debts comprise the total amount of charges for services that the hospital writes off. This sum is called uncompensated care, and its calculation allows a comparison between hospitals. Nationally, in 2006, uncompensated care averaged 5.7% of hospital total expenses.[7] The amount of charity and bad debts a hospital incurs compared with another is also affected by the affluence of the community it serves. A good measure of this is the amount of Medicaid care provided as reflected in its Medicaid percentage of payor mix. Table 2 displays these factors for the study hospitals. As can be seen, just three hospitals have uncompensated care at or approaching the national average: Billings Clinic, St. James Healthcare, and St. Patrick Hospital and Health Sciences Center.

Table 2
Uncompensated Care Percent of Operating Expense and Medicaid Payor Mix

Hospital Name	City	Charity Care % Opr. Exp.	Bad Debts % Opr. Exp.	Percent Medicaid 2006	Uncompensated Care % Opr. Exp.
Billings Clinic	Billings	3.42%	2.34%	7.4%	5.76%
St. James Healthcare	Butte	2.90%	2.78%	11.0%	5.68%
St. Patrick Hospital and Health Sciences Center	Missoula	2.86%	2.82%	5.6%	5.68%
Bozeman Deaconess Health Services	Bozeman	1.37%	3.88%	9.5%	5.25%
Kalispell Regional Medical Center	Kalispell	1.61%	3.46%	9.3%	5.07%
Holy Rosary Healthcare	Miles City	2.07%	2.89%	11.0%	4.96%
Northern Montana Healthcare	Havre	0.75%	4.09%	22.1%	4.84%
St. Peter's Community Hospital	Helena	1.57%	2.92%	8.2%	4.49%
St. Vincent Healthcare	Billings	1.57%	2.69%	9.5%	4.26%
Benefis Healthcare	Great Falls	1.51%	1.38%	12.7%	2.89%
Community Medical Center	Missoula	0.88%	1.97%	15.8%	2.85%

When analyzing this data in light of charity policy in Table 1, some general observations can be made. First, the hospitals with the most liberal charity policies do not always have the greatest percentage of charity care. This could be explained by differences in Medicaid payor mix or by how effectively the charity policy is administered. Second and surprisingly, there is a tendency for uncompensated care to decline as the Medicaid percent of total revenue increases. The following scatter graph with trend line shows this inverse relationship[8]:

Relationship Between Medicaid Percent Revenue and Uncompensated Care Expense



From the scatter graph, one can infer that the two hospitals with uncompensated care percentages below 3% in Table 2 cause the trend line to be negative.

IIIe. Charity Care and Medicaid Costs Compared to the Value of Tax Exemption

It can be logically argued that the amount of community benefit provided by the nonprofit hospital should be roughly proportionate to the value of the tax exemption conferred upon it by society. Whether the benefits should be equal to the exemptions in any given year is arguable, but over time, the two amounts should be very similar if benefits do not exceed the exemptions.

Remembering that there are unreported community benefits besides charity care and Medicaid costs, but also recognizing that amounts of these two benefits constitute the lion's share of community benefits, the following table compares the value of each hospital's tax exemption to the cost of charity care and Medicaid costs in excess of reimbursement. The charity data has been taken from the hospitals' financial reports for the fiscal year that ended in 2006. Because Medicaid costs in excess of reimbursements are not reported in the IRS Form 990 filed by hospitals, these amounts have been estimated based on data from 2007 collected by the Department of Public Health and Human Services (DPHHS). From these costs have been subtracted disproportionate share hospital payments (DSH) and the net proceeds of the provider tax. This payment data is from MHA (the Montana Hospital Association). Where the amount is zero, this is because reimbursements exceeded costs.

Table 3
Montana Hospitals' Charity Care and Medicaid Costs Compared to Tax Exemption

Hospital Name	City	Charity Care Cost FY2006	Medicaid Cost in Excess of Reimbursement 2006[9]	Total Charity and Medicaid Costs	Est. Total Tax Exempt. 2006[10]	Percent Charity & Medicaid to Est. Tax
St. James Healthcare	Butte	$ 1,926,539	$ 1,048,628	$ 2,975,167	$ 614,616	484%
St. Patrick Hospital	Missoula	$ 4,888,729	$ 3,115,525	$ 8,004,254	$ 3,177,593	252%
Holy Rosary Healthcare	Miles City	$ 635,645	$ 207,057	$ 842,702	$ 381,982	221%
Billings Clinic	Billings	$ 11,919,000	$ 0	$ 11,919,000	$ 7,740,993	154%
Northern Montana Healthcare	Havre	$ 363,355	$ 0	$ 363,355	$ 415,331	87%
Kalispell Regional	Kalispell	$ 1,866,068	$ 1,363,930	$ 3,229,998	$ 3,976,289	81%
Community Medical Center	Missoula	$ 1,068,774	$ 0	$ 1,068,774	$ 1,341,342	80%
Benefis Healthcare	Great Falls	$ 4,689,491	$ 0	$ 4,689,491	$ 7,502,999	63%
St. Peter's Hospital	Helena	$ 1,455,258	$ 939,838	$ 2,395,096	$ 4,746,083	50%
St. Vincent Healthcare	Billings	$ 3,880,704	$ 1,359,748	$ 5,240,452	$ 12,381,337	42%
Bozeman Deaconess	Bozeman	$ 1,499,315	$ 425,073	$ 1,924,388	$ 6,465,659	30%

Looking at only fiscal year 2006 data, four of the 11 study hospitals contributed more in charity care and Medicaid cost than they would have paid in taxes if they were for-profit institutions. They are Billings Clinic, Holy Rosary Healthcare, St. James Healthcare, and St. Patrick Hospital and Health Sciences Center. It is important to re-emphasize that the value of five community benefit items discussed in Section III above are not included in this analysis. Likely, at least three more hospitals would be at 100% or greater if complete community benefit data were available.

The author was asked to examine charity care in relationship to the hospital's surplus of revenue over expense (profit). This analysis is shown in Table 4.

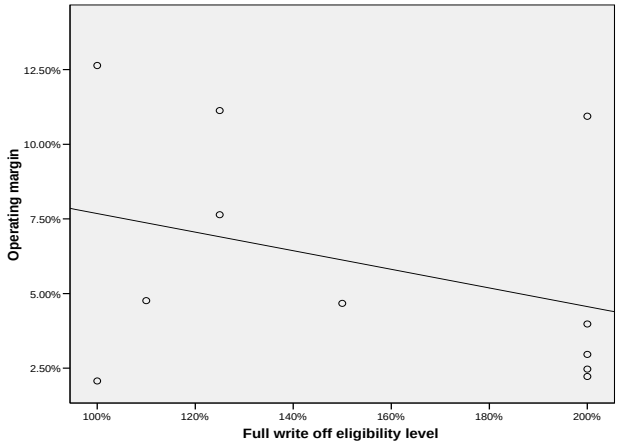
Table 4
Charity Care Cost Percent of Surplus – 2006

Hospital Name	City	2006 Surplus	Charity Care Cost FY2006	Charity % of Surplus
St. James Healthcare	Butte	$ 1,508,261.00	$ 1,926,539.00	127.73%
St. Patrick Hospital and Health Sciences Center	Missoula	$ 7,090,762.00	$ 4,888,729.00	68.95%
Billings Clinic	Billings	$ 17,438,188.00	$11,919,000.00	68.35%
Holy Rosary Healthcare	Miles City	$ 937,378.00	$ 635,645.00	67.81%
Northern Montana Healthcare	Havre	$ 1,017,966.00	$ 363,355.00	35.69%
Community Medical Center	Missoula	$ 3,078,299.00	$ 1,068,774.00	34.72%
Benefis Healthcare	Great Falls	$ 15,203,389.00	$ 4,689,491.00	30.85%
Kalispell Regional Medical Center	Kalispell	$ 9,572,734.00	$ 1,866,068.00	19.49%
St. Vincent Healthcare	Billings	$ 30,383,649.00	$ 3,880,704.00	12.77%
St. Peter's Community Hospital	Helena	$ 11,602,335.00	$ 1,455,258.00	12.54%
Bozeman Deaconess Health Services	Bozeman	$ 15,814,269.00	$ 1,499,315.00	9.48%

After eliminating the highest and lowest charity percentage, the average for this group of hospitals is 39.02%. Interestingly, only four of the 11 were at or above this average and these are the same four hospitals that exceeded their tax benefit with charity care and Medicaid in Table 2. While there are no national or regional averages or standards to compare charity care percent of surplus against, clearly Montana hospitals demonstrate a wide variation on this metric.

Another view of charity care provided by hospitals is the relationship between the eligibility for charity (Table 1) and the amount of money the hospital has available to fund charity care as measured by percent operating margin (surplus).[11] A graph of these data points follows:

Relationship Between Eligibility for Full Charity Write Off and Operating Margin



This scatter graph shows a moderately negative correlation between a hospital's charity policy and its operating margin; that is, hospitals with the most liberal charity policies tend to have lower profitability. This is as would be expected.

IV. Hospital Billing and Collection Practices

As was mentioned in Section IIId, hospitals have the obligation to provide care for non-elective services without regard to ability to pay. Generally speaking, the study hospitals follow similar billing and collection practices. For elective admissions, there is a pre-registration process which includes, among many other things, an inquiry regarding health insurance coverage. When patients have no insurance, usually they are referred to a financial counselor who consults with them about payment options for the impending bill and provides assistance with applications for charity care, Medicaid coverage, or any other options for coverage. For non-elective admissions, the same process is followed but it occurs after the acute event has been managed and sometimes only at the time of discharge.

Upon discharge, any amounts not covered by insurance including any co-pays and deductibles are the responsibility of the patient. If the patient applies for and is found qualified, charity allowances and any policy discounts[12] are applied to the bill. Monthly installment payment terms are then negotiated and/or the patient is referred to a local banking institution for a loan. Amounts owed after 60 to 90 days bear an interest charge. If the account is unresponsive for a period of between 90 to 120 days, hospitals turn the outstanding balance over to an outside collection agency.

The Attorney General's inquiry about collection practices asked hospitals to report the number of cases turned for collection, the dollar value of cases turned, amounts received on cases turned, amounts involved in and received from civil suits (judgments), and numbers of cases and amounts involved in bankruptcy proceedings. Finally, hospitals were asked about the number of complaints they receive pertaining to billing and collection. Table 5 is a summary of this information for all study hospitals for the years 2004 through 2006.

Table 5
Montana Hospitals Debt Collection Activity 2004 – 2006

All Study Hospitals	2004-2006	3-Year Average
Number of Cases Turned for Collection	194,136	64,712
Amounts Turned	$ 189,576,461	$ 63,192,154
Amount Returned to Hospitals	$ 33,132,639	$ 11,044,213
Return Rate	17.5%	17.5%
Amounts in Judgments	$ 27,058,193	$ 9,019,398
Amounts Returned to Hospitals from Judgments	$ 8,782,565	$ 2,927,522
Return Rate	32.5%	32.5%
Number Cases involved in Bankruptcy	17,719	5,906
Amounts involved in Bankruptcy	$ 19,151,658	$ 6,383,886
Amounts collected from Bankruptcy	$ 193,688	$ 64,563
Return Rate	1.01%	1.01%

This debt collection data must be understood within the following context:

1. The amounts turned for collection represent approximately 3.6% of all hospital revenues.
2. The return rate on amounts turned for collection of 17.5% compares to a return rate of approximately 25% on non-medical accounts.[13]
3. The return rate on amounts involved in judgments, 32.5%, is about the same as that returned on non-medical accounts.[13]

There is no information to report regarding billing and debt collection complaints because only one of the study hospitals was able to report the number of complaints received. At this time, hospitals simply are not tracking this data.

The return rate of 1.01% on bankruptcies is so low that it calls into question whether any hospital should pursue a debtor into bankruptcy. Additionally, it has been reported that medical problems contribute to about half of all bankruptcies in the nation.[14] A re-evaluation of hospital debt collection procedures related to bankruptcies could result in a significant decline in bankruptcies in Montana with almost no economic impact on the hospitals. Particular attention to catastrophic debt in households above the federal poverty guidelines for possible charity care consideration is warranted.

Ultimately bad debts have the same economic effect on the hospital as does charity care. Once a hospital begins attempts to collect a bill, it can no longer categorize the account as charity. It is sometimes clear in retrospect that an account should have been treated as charity. If better administration of the hospital's charity policy can identify individuals up front who deserve charity care, then collection efforts could be avoided for some and the hospital would have recorded more community benefit.

V. Hospital Pricing, Consumer Information and Transparency

There is wide agreement among health policy experts that an informed consumer is essential to any health care reform initiatives in the U.S.[15] The availability of usable quality and cost information is necessary for this to happen. The inquiry to hospitals by the Attorney General's Office asked for the average charge of the 10 highest volume procedures or diagnosis related groupings (DRGs). The information returned showed that there is significant variation in the prices charged for a given procedure. Attachment 1 displays the charges for 11 selected high volume DRGs.

Unfortunately, there is no quality data that can accompany this price data to enable the consumer to identify the highest value health care services. Whether health care consumers would avail of this kind of information when making a choice of provider is genuinely open to question.[15] Opinion leaders agree, however, that information about quality and price would do no harm to consumerism in health care and that it would certainly stimulate provider performance improvement activity. They also agree it could encourage payors to recognize quality and efficiency.[17]

How to make price and quality information available is the more difficult issue. Most certainly, in this day and age, the data needs to be on the web. National web sites such as those available from HealthGrades and Healthia are moderately useful but their comparisons are to national averages and for only a limited number of procedures. For state information, two approaches seem to be emerging; web sites sponsored by the departments of health and by the hospital associations. The Utah Department of Health site, MyHealthCare in Utah is a good example as is the Texas Hospital Association's Texas PricePoint. Either approach would seem to serve Montana well.

VI. Issues for Further Discussion

Historically, there have been no standards and few guidelines for how hospitals should meet their obligations to provide benefit to their communities in return for their tax-exempt status. Ever higher health care costs and the government's concern about the "big business" of hospitals has resulted in a need for Montana hospitals to demonstrate that they provide community benefits in proportion to their means as charitable institutions. The following issues warrant discussion by hospital boards of directors and their senior management staffs together with state officials, hospital association representatives, and the consumer public:

1. What shall be the definition of "community benefit" in Montana and how shall these be calculated?
2. How much community benefit should hospitals be expected to provide in relationship to which economic measures?
3. Within community benefits, how much charity care should hospitals be expected to provide?
4. Should there be elements common to all hospital charity policies?
5. Can there be training programs for billing and collection staff to enable better administration of charity policies?

6. How should community needs be objectively determined?
7. When should debts be pursued into bankruptcy?
8. How can boards and senior management monitor billing and collection complaints?
9. Can comparative hospital prices and quality be made available to the public at a web site sponsored by the state or by the hospital association?

Endnotes

1. The hospitals included in this evaluation are:

Benefis Healthcare	Great Falls
Billings Clinic	Billings
Bozeman Deaconess Health Services	Bozeman
Community Medical Center	Missoula
Holy Rosary Healthcare	Miles City
Kalispell Regional Medical Center	Kalispell
Northern Montana Healthcare	Havre
St. James Healthcare	Butte
St. Patrick Hospital and Health Sciences Center	Missoula
St. Peter's Community Hospital	Helena
St. Vincent Healthcare	Billings

2. Internal Revenue Service, "Hospital Compliance Project Interim Report", July 2007.

3. Mairo, Schneider, Bellows, "Endangered Species? Not-for-Profit Hospitals Face Tax-Exemption Challenge", *Healthcare Financial Management,* September 2004.

4. Minnesota Department of Health, "Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions", January 2007.
State of Washington, "2007 Full Tax Preference Performance Reviews", July 2007.

5. Internal Revenue Service, Draft Form 990 Redesign Project – Schedule H, IRS Tax Exempt Entities Division, June 14, 2007.

6. United States Department of Health and Human Services, http://aspe.hhs.gov/poverty/07poverty.shtml.

7. American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet", October 2007.

8. One outlier data point was removed from this scatter graph.

9. Calculated by subtracting bed tax and DSH reimbursement from Medicaid costs in excess of Medicaid reimbursement. Hospitals with zero had reimbursements greater than their costs.

10. Calculated by multiplying surplus by 34% for federal income tax, 6.75% for Montana income tax, and adding Montana property tax from tax rolls. Does not include the value of tax-exempt debt. The estimated tax savings from exempt personal property is underestimated to the extent that hospitals use exempt property that is titled in the name of another entity. The Montana Department of Revenue cannot attribute estimated tax savings to a specific hospital from property that is not titled in the name of the hospital. For example,

the calculation of a hospital's tax exemption would not include a CAT scanner or a helicopter the hospital leased from a leasing entity. Further, the tax exemption is passed on to the leasing entities, so they do not pay Montana's business equipment or property taxes on this equipment either.

11. Percent operating margin calculated by dividing surplus by net operating revenue.

12. Some Montana hospitals have charity and collection policies which provide discounts to self-pay patients at levels which mirror discounts given to preferred provider organizations and purchasers.

13. Based on data received by the author from two prominent Montana collection agencies.

14. Himmelstein, Thorne & Woolhandler, "Illness and Injury As Contributors to Bankruptcy", *Health Affairs*, Feb. 2005.

15. The Commonwealth Fund, "Framework for a High Performance Health System for the United States", August 2006.

16. Strategic Health Perspectives, Harris Interactive Poll, 2006

17. The Commonwealth Fund, "Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the U.S.", November 2007.

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Attachment 1

Charges for High Volume Procedures-2005

Reason for Hospitalization - DRG	Benefis	Billings Clinic	Bozeman Deac.	Comm. Med.Cntr.	Holy Rosary	Kalispell Regional	Northern Montana	St. James	St. Patrick	St. Peter's	St. Vincent	Average
Normal Newborn - 391	$1,191	$1,389	$1,504	$1,267	$1,377	$990	$1,607	$1,498			$1,268	$1,343
No. Cases	1009	938	819	1228	198	654	285	318	NA	NA	928	
Vaginal Delivery - 373	$3,235	$4,791	$3,290	$4,633	$4,300	$3,043	$3,983	$4,673		$3,161	$4,565	$3,967
No. Cases	723	752	620	986	143	498	208	271	NA	419	737	
Psychosis - 430	$2,917	$8,470				$6,803	$4,817		$11,568			$6,915
No. Cases	537	1551	NA	NA	NA	335	136	NA	380	NA	NA	
Heart Failure and Shock - 127		$10,227	$6,067		$11,987	$9,188	$21,776	$10,734	$12,118	$8,783	$9,998	$11,209
No. Cases	NA	242	139	NA	44	143	77	115	147	96	290	
Simple Pneumonia and Pleurisy - 89	$10,413		$8,331		$13,171	$9,126	$12,409	$12,364	$12,002	$11,031	$9,429	$10,920
No. Cases	229	NA	105	NA	84	181	107	169	185	215	318	
Major Joint/Limb Procedure Lower - 209	$22,900	$25,140	$27,036	$23,997	$36,453	$18,837		$26,890	$23,419	$24,022	$25,414	$25,411
No. Cases	344	290	220	310	101	364	NA	158	190	127	677	
Esophagitis, Gastroenteritis - 182		$9,089	$5,786		$8,107	$8,385	$6,865	$7,851		$6,623		$7,529
No. Cases	NA	255	133	NA	38	125	94	98	NA	141	NA	
Cesarean Section - 371	$7,604	$10,300	$6,959	$8,045	$8,251	$7,996	$7,636			$7,008	$8,783	$8,065
No. Cases	312	228	220	349	62	133	56	NA	NA	139	225	
Uterine & Adnexa Procedure - 359		$9,033		$8,579	$10,672			$13,635		$8,977	$9,212	$10,018
No. Cases	NA	219	NA	229	89	NA	NA	101	NA	132	219	
Rehabilitation - 462	$17,702			$20,672		$21,571			$8,651		$18,269	$17,373
No. Cases	453	NA	NA	357	NA	215	NA	NA	230	NA	407	
Chest Pain - 143	$5,657		$3,280		$6,518			$5,281		$4,379		$5,023
No. Cases	275	NA	184	NA	59	NA	NA	171	NA	89	NA	

NA= Not Reported