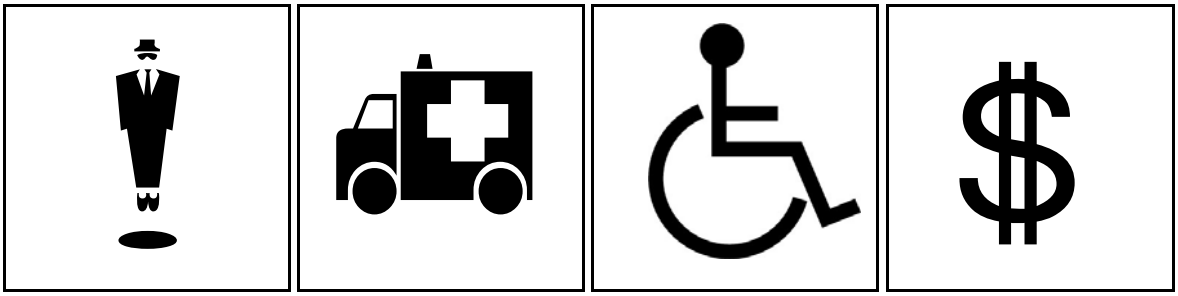
Consumers, Providers, and the State: Their Roles in Health Care Access and Costs



A Final Report on the Senate Joint Resolution No. 15 Study on Access to Health Care, Including an Examination of Economic Credentialing and Specialty Hospitals

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Overview

Senate Joint Resolution No. 15 (SJR 15), a study assigned to the Children, Families, Health, and Human Services Committee (the Committee) during the 2007-2008 interim, listed numerous issues related to access to health care. The title of the resolution referenced the impact of the health care delivery system on health care services in Montana, including physician-owned health care facilities and specialty hospitals. The body of the resolution included issues ranging from the potential efficiencies to be gained in health care through the use of information technology to how to empower Montanans to take a more active role in their health care and to be better health care consumers. Many stakeholders considered the SJR 15 study as having just two main targets: a review of the economic credentialing statute, 50-5-117, MCA, and the moratorium on specialty hospitals. The Committee saw the study as an opportunity to consider all types of access to health care, especially from the perspective of the consumer. On that basis, access to health care includes consumer awareness of when and where to obtain care, including which services provide the best quality and at what cost.

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During work plan discussions, Committee members requested various types of information related to consumer-directed health care. As a result, the SJR 15 study included not only information spelled out in the study resolution about facility prices for certain types of procedures but the availability of charity care by hospitals for those in need, billing efficiencies, the role of school nurses in the health care continuum, the uses of information technology to improve health care efficiency and quality, and the options provided by hospice and end-of-life care without intensive medical procedures.

The five major sections of this report are:

- credentialing by both hospitals and insurers;
- specialty hospitals;
- consumer-directed health care options;

- the uses of information technology in health care and the work of the HealthShare Montana group; and
- information gathered from the health care survey regarding not-for-profit and for-profit health care facilities.

A Subcommittee comprised of Sen. Dan Weinberg and Rep. Ernie Dutton studied the issues of economic credentialing by hospitals and ambulatory surgical centers and the question of whether to extend a moratorium on licensing specialty hospitals or provide specific regulations for licensing. They convened four stakeholder meetings and produced a bill draft, LC38, that:

- revised portions of the economic credentialing statute;
- included a requirement for all health care providers who make referrals to disclose to patients any investment, ownership, or employment interest related to the referral; and
- provided for protections against conflicts of interest and restrictions on kickbacks. The antikickback provisions would extend federal prohibitions against kickbacks to all health care providers regardless of how they received payment. (Federal law bans kickbacks only in cases where the federal government is the payor in Medicare, Medicaid, and some child-related cases.)

The full Committee at its August 2008 meeting decided to break these components of LC38 into separate bill drafts:

- LC341, addressing economic credentialing, which became Senate Bill (SB) 26;
- LC342, regarding expansion of antikickback provisions regardless of payors, which became SB 52; and
- LC343, requiring health care providers making a referral to disclose investment, ownership, or employment interests, which became SB 51.

Stakeholder panels and informational presentations on the other SJR 15 topics covered various topics mentioned above. The SJR 15 study also resulted in various staff reports and reports on related subjects prepared by others and presented to the Committee. SJR 15 staff reports are listed: in Appendix C of the final report of the CFHHS Committee, *Time for a Check-Up: Monitoring Health Care Services in Montana;* in Appendix C of this report along with related reports; and on the Committee's website, http://leg.mt.gov/css/Committees/Interim/2007_2008/child_fam/default.asp.

Section 1: Credentialing by Hospitals and Insurers

Economic credentialing

One main emphasis of the SJR 15 study was to review the economic credentialing statute enacted in 2007. As originally drafted, SB 312[1] prevented hospitals from denying credentials

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[1]SB 312, after being signed into law, became 50-5-117, MCA: (Temporary) Economic credentialing of physicians prohibited -- definitions. (1) A hospital may not engage in economic credentialing by:

(a) except as may be required for medicare certification or for accreditation by the joint commission on accreditation of healthcare organizations, requiring a physician requesting medical staff membership or medical staff privileges to agree to make referrals to that hospital or to any facility related to the hospital;

(b) refusing to grant staff membership or medical staff privileges or conditioning or otherwise limiting a physician's medical staff participation because the physician or a partner, associate, or employee of the physician:

(i) provides medical or health care services at, has an ownership interest in, or occupies a leadership position on the medical staff of a different hospital, hospital system, or health care facility; or

(ii) participates or does not participate in any particular health plan; or

(c) refusing to grant participatory status in a hospital or hospital system health plan to a physician or a partner, associate, or employee of the physician because the physician or partner, associate, or employee of the physician provides medical or health care services at, has an ownership interest in, or occupies a leadership position on the medical staff of a different hospital, hospital system, or health care facility.

(2) Notwithstanding the prohibitions in subsection (1), a hospital may refuse to appoint a physician to the governing body of the hospital or to the position of president of the medical staff or presiding officer of a medical staff committee if the physician or a partner or employee of the physician provides medical or health care services at, has an ownership interest in, or occupies a leadership position on the medical staff of a different hospital, hospital system, or health care facility.

(3) For the purposes of this section, the following definitions apply:

(a) "Economic credentialing" means the denial of a physician's application for staff membership or clinical privileges to practice medicine in a hospital on criteria other than the individual's training, current competence, experience, ability, personal character, and judgment. This term does not mean use by the hospital of:

(i) exclusive contracts with physicians;

(ii) medical staff on-call requirements;

(iii) adherence to a formulary approved by the medical staff; or

(iv) other medical staff policy adopted to manage health care costs or improve quality.

(b) "Health care facility" has the meaning provided in 50-5-101 and includes diagnostic facilities.

(c) "Health plan" means a plan offered by any person, employer, trust, government agency, association, corporation, or other entity to provide, sponsor, arrange for, indemnify another for, or pay for health care services to eligible members, insureds, enrollees, employees, participants, beneficiaries, or dependents, including but not limited to a health plan provided by an insurance company, health service organization, health maintenance organization, preferred provider organization, self-insured health plan, captive insurer, multiple employee welfare arrangement, workers' compensation plan, medicare, or medicaid.

(d) "Physician" has the meaning provided in 37-3-102.

(4) For the purposes of this section, the provisions of 50-5-207 do not apply. (Terminates June

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to a physician who had an economic interest in another health care facility. Amended in the Senate Public Health Committee, SB 312 allowed some leeway for hospitals to address conflicts of interest by excluding from the definition of economic credentialing the use by hospitals of exclusive contracts, on-call requirements, and certain other medical staff policies or adopted ways of operating (formularies). Another amendment provided a termination date of June 30, 2009, which was intended to give the statute time to work but also give interested parties an opportunity to iron out their disagreements over the terms. SJR 15, provided in Appendix A, specifically included as one of its provisions[2] a directive to analyze and develop public policy recommendations regarding physician credentialing.

At the first Committee meeting, as part of the discussion of the SJR 15 work plan (included in Appendix B), staff provided discussion points on credentialing, specialty hospitals, and a glossary of terms. (See Appendix C for links to Committee reports on SJR 15.) Given the Committee's decision to address consumer-related access and information issues presented in SJR 15, the presiding officer appointed a subcommittee to separately delve into economic credentialing and specialty hospital issues. From January through June (longer than originally anticipated), a subcommittee used a "roundtable" approach to hear from interested persons (a list of participants is available in Appendix D) and to work to obtain consensus on

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30, 2009--sec. 6, Ch. 351, L. 2007.)

[2]SJR 15 states in subsection (3) that the appropriate interim or statutory committee or staff: "analyze and develop public policy recommendations associated with Montana's health care delivery system and Montana's health care consumers for consideration by the 61st Legislature, including but not limited to:

(a) physician self-referral, which means referral for medical treatment by a physician to a facility in which the referring physician has an ownership interest;

(b) the increase in hospital-employed physicians;

(c) physician credentialing, or the process that hospitals use for granting privileges to physicians to practice in their facilities, including use of hospitals by physicians who may be in competition with that hospital;

(d) whether a need exists to impose or continue moratoriums on specialty hospitals...."

revisions to the economic credentialing statute. The specialty hospital issue had much more limited discussion. In the end, only a few issues related to economic credentialing divided physicians and hospitals (others participated in these sessions but these were the main stakeholder representatives). These issues keyed on:

- conflict-of-interest concerns; and
- the use of on-call duties to determine who is or is not able to get credentials at a hospital.

Conflict-of-interest concerns — The conflict-of-interest issue as seen from the hospitals' perspective focused on the fact that a hospital's medical staff, comprised of physicians who have practice privileges at a hospital, vote on the chief of the medical staff. At some hospitals, the bylaws allow or perhaps even require the chief of staff to serve on the board of directors. Thus, if an elected chief of staff happened to be a physician who has an economic interest in an alternate facility in competition with hospital services, such as an imaging center or an ambulatory surgery center, that chief of staff would have access to financial information that could be used to benefit the alternative facility and potentially harm the hospital financially.

From the independent practicing physician's perspective,[3] the issue centers on control of the medical policies at a hospital. To better understand this viewpoint, it is first necessary to understand how hospitals have changed from the model with which many Montanans are familiar (either in person or from television shows featuring private practice doctors like Marcus Welby, MD). In this traditional approach, a physician received privileges to practice at a hospital and use its facilities but retained health care management for an admitted patient. Today's model often includes a mix of independent practicing physicians granted privileges at a hospital, which also may have hired as employees a certain number of specialists and hospitalists (family practitioners or internists). The Billings Clinic represents the new model. That Clinic is a multi-specialty not-for-profit practice of physicians and nonphysicians associated with a not-for-profit hospital that essentially is their employer (in terms of television shows think Grey's Anatomy). At the hybrid version prevalent at most Montana hospitals, independent practicing physicians might work under the old model but physicians

[3]This term is used to distinguish physicians who are in solo private practice or in group practices that are not members of a not-for-profit hospital's medical group, in contrast to physicians employed by hospitals or in the hospital's medical group.

This shift in hospital practices is key to understanding much of the tension between independent practicing physicians and hospitals on several issues studied by the Committee.

employed by the hospital have options, depending on the terms of their agreement with the hospital. For example, a hospital may sign into its medical group a doctor who works solely outside the hospital while hospitalists or specialists employed by the hospital treat that doctor's patients after admission to a hospital. Or the agreement may allow a doctor who generally sees patients in an office to adopt the traditional option of treating the patient on both an outpatient and an inpatient basis. One of the reasons that use of hospitalists has become popular is that a hospitalist allows better time management for physicians who do not need to split their time between an office practice and hospital rounds. The hospitalist option also allows physicians with an office practice to live a more normal life than being on call several days a week, with the associated "call" expectation of having to work at any hour (and thus be away from family celebrations and, if so inclined, unable to drink alcohol at social events).

This shift in hospital practices is key to understanding much of the tension between independent practicing physicians and hospitals on several issues studied by the Committee. For conflict-of-interest purposes, the hybrid approach means that two types of physicians may be working and struggling for control of the medical policies at a hospital: the independent practicing physicians and the hospital-employed physicians. Differing philosophies between these groups generate discussion, but the potential for disagreement increases if independent physicians can make money from a pursuit that potentially threatens the viability of a practice at the hospital — through ambulatory surgery centers, imaging centers, or some other type of practice. Conversely, hospitals occasionally are accused of saying to independent practitioners "the hospital's way or the highway", and if hospital-employed physicians have control of the medical staff policies, that option is more assured. The independent practicing physicians see this as potentially running them out of town.

Independent practicing physicians also voice frustration over Medicare and Medicaid payment practices in which the combined payment for use of a hospital facility and the practitioner's fees is higher than a payment for the same service that the independent practitioner provides on an outpatient basis — not from a quality perspective but simply

because the procedure was performed in the hospital, with its myriad costs. In other words, a procedure performed at a hospital generally generates a better Medicare or Medicaid payment (combined for facility and practitioner) than the same procedure at a physician's office (combined for practice and practitioner).[4]

Amendments to SB 312 that inserted conflict-of-interest protections for hospitals into what had been an economic credentialing protection bill for physicians resulted in one of the reasons behind the formation of a subcommittee to study economic credentialing. The question facing the subcommittee was: how to balance both concerns? "No action" would mean that the economic credentialing statute would expire, with lawsuits among the options for physicians who feel their right to practice is being limited.[5]

The proposed solution — Subcommittee members suggested using language that recognized a hospital board's fiduciary responsibility by allowing the hospital board not to seat as a board member a physician who has a conflict of interest or not to appoint as a chief of staff a physician who has a conflict of interest. (The conflict also exists if a physicians' partner or employee has an ownership or leadership position on the medical staff at another hospital or health care facility.) The hospital board also could require recusal from financial decisions of a physician member of a board, the president of the medical staff, or a presiding officer of a committee if any of the listed persons had a conflict of interest related to that decision or information.

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[4]Actual payment to an independent practitioner for the professional service may be higher than to a practitioner in the hospital-based clinic/outpatient facility/emergency room. But the overall payment to a hospital-based facility and practitioner is higher than the combined professional fee, practice fee, and malpractice fee paid to the independent practitioner, according to Bob Olsen of MHA. The situation is different for rural health clinics.

[5]In "An examination of the right of hospitals to engage in economic credentialing", *77 Temp L. Rev.* 705, 2004, Beverly Cohen, a law professor at the Albany Law School at Union University, discussed three potential lawsuit options for physicians who feel they are being inappropriately credentialed by a hospital: "(1) antitrust claims asserted against a hospital with market power, where the hospital's use of economic credentialing forecloses competition or harms consumers; (2) breach of contract claims asserted against a hospital where the hospital's application of a conflict-of-interest policy to current staff members breaches the credentialing procedures guaranteed by the medical staff bylaws; and (3) fraud and abuse claims asserted against a hospital where the hospital has expressed conditional staff privileges upon a mandated volume or value of referrals...." Provided in summary. For more information on court cases related to these subjects see the report provided to the Committee by Legislative Staff Attorney Lisa Mecklenberg Jackson, cited in Appendix C.

The "solution" partially hinged on the definition of "conflict of interest", which basically boiled down to a financial interest in a health care facility that could compromise a hospital board's fiduciary responsibility. Financial interest is further defined as a business or investment interest directly or indirectly that is greater than 5% in any health care facility licensed under Montana statutes in Title 50, chapter 5, that offers similar services. (At various places in federal law and in other states' conflict-of-interest statutes a 5% threshold is often used.)

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Under this solution, a 100% owner of an imaging facility with privileges at a hospital that also had imaging capabilities could be prevented from serving on the board, as chief of staff, or as a presiding officer of a medical committee. However, a physician who had a 2% interest in an ambulatory surgery center that does the same types of surgeries as the hospital could hold any of those offices.

Main arguments — MHA, an Association of Montana Health Care Providers, indicated that financial interest was not the only conflict-of-interest concern. The organization protested state involvement in how a hospital board determines eligibility for board membership or for being an officer of the medical staff. The role of the board also was a concern of subcommittee member Sen. Weinberg, who voiced concerns that the community-based board required for not-for-profit hospitals under Medicare conditions of participation may not be entirely representative of all aspects of the community, including all the physicians in the community. Independent practicing physicians who participated in the subcommittee discussions voiced concerns about being excluded from medical staff policymaking by virtue of being excluded from leadership positions and their fears about being treated inequitably regarding on-call duties.

Other issues — Also in the bill as proposed by the subcommittee and adopted as a committee bill were:

- "equitable" on-call criteria, with "equitable" not being defined;
- authority for the Department of Public Health and Human Services (DPHHS) to enforce the statute; and

- application of the economic credentialing statute to ambulatory surgery centers as well as hospitals. Although some ambulatory surgery centers are either owned or co-owned by hospitals, the potential exists for them to be independently owned.

Use of on-call duties related to credentialing — As indicated earlier, the old model of an independent practicing physician receiving hospital privileges involved a symbiotic relationship. A hospital needed physicians to provide services, and the physicians needed the hospital to provide round-the-clock care for patients who may have needed more attention or specialized services like surgery. Today, however, some hospitals are hiring the physicians, thereby providing more reasonable hours for the physicians hired as hospitalists or specialized staff. The hospitals gain in a competitive environment by being able to advertise a broader range of services. Also, there is more assurance that the hospital can meet a type of *non-sequitur* federal requirement, in which federal regulations may require some type of physician presence for a service but enforce failure to provide the service by sanctioning the hospital and not the physician.

For the hospital with physicians on staff, as hospitalists or specialists, the requirements of "call" can be overseen by the hospital, with rules determined by the medical staff. "Call" requirements for the independent practicing physician must be met by the individual physician (if in sole private practice) or for a group practice by a physician with the same specialty, usually on a rotating basis. The irritation for the independent practicing physician is that the hospitals might play favorites with certain nonhospital employed physicians by allowing them to contract to use hospitalists, which means that these nonhospital physicians do not have to be on call. Hospitalists are in high demand, so the ability to assign call to a hospitalist is a big benefit for an independent practicing physician over having to be consistently on call or on call every other day or every 3 days. For more information about "call", see a report presented to the Committee, "Physician Credentialing: Staffing, On-Call, and Insurance Issues".

Department enforcement — Little discussed by the subcommittee or the physicians or hospital representatives was a request by a DPHHS representative to allow enforcement as provided for the rest of Title 50, chapter 5, which includes letters of correction as well as facility closure for repeated failures to correct a violation of Title 50, chapter 5. Enforcement was put into the bill draft, with the expectation that the credentialing activities of a hospital or ambulatory surgery center would never actually lead to its closure.

Expansion to ambulatory surgery centers — Also discussed very little was a suggestion by stakeholders to expand the economic credentialing limitations to ambulatory surgery centers. No one commented on this change, which was seen as being an equitable approach.

Insurer credentialing

As part of the review of credentialing, the full Committee also heard from insurers about their credentialing processes and considered issues related to the hospital-physician relationship such as on-call requirements (discussed above). The following issues related to insurer credentialing: who is allowed into insurer networks and how that relates to patient flow and how insurers handle credentialing.

Insurer role in directing patient flow — Examined briefly at the subcommittee's Feb. 11, 2008, meeting was how insurers could block some providers from participating in care networks (independent physical therapists, for example). Tanya Ask, representing New West Health Services, said the insurer was in the process of putting together panels throughout the state and that the review process was a continuous one but not necessarily designed to exclude any particular provider.

The issue of networks and panels is more complicated than simply a review of credentials. In the past, prior to creation of New West, there was an accusation that Blue Cross Blue Shield of Montana was including in its network only one hospital in a two-hospital town, thus encouraging all its insured population to go to whichever hospital provided Blue Cross Blue Shield with the best rates or conditions. As a result of this concern, hospitals in various larger Montana towns formed their own insurer, which became New West. Now both Montana's major non-profit health services corporations negotiate with providers to be in their networks, although discounts or offsets against charges may be better for some health care providers than for others. And, not all providers want to participate in insurer networks, preferring to negotiate with patients directly as a way of either getting paid more quickly or eliminating the costs of insurer paperwork and credentialing.

Other insurer credentialing issues — Questions raised during the discussions of insurer credentialing, as related to health care costs and efficiencies, included whether insurer credentialing:

- results in increased costs and inefficiencies as insurers duplicate some of the activities required for health care provider licensing;
- provides a better way of predicting quality care by further examining physician records in ways that licensing boards do not; or
- serves as an alternative to hospital credentialing for assuring such issues as on-call requirements.

Reasons for insurer credentialing — Insurers credential to encourage a better quality of physicians and other health care providers in their networks, according to insurer presenters at a June 11, 2008, Committee meeting. Although 33-22-1705, MCA, prohibits health care insurers from requiring hospital staff privileges of a health care provider as a condition for being in a preferred provider network, the insurers say they must be able to show that physicians can provide continuity of care either through their own privileges at a hospital or through an agreement with someone who does have privileges at a hospital, such as a hospital-employed hospitalist.

Insurers also can require a physician who is a specialist to be accredited by the specialty or may ask for proof of continuing education requirements, neither of which is required by the licensing entity for physicians, the Board of Medical Examiners. Although the Board of Medical Examiners does the due diligence of checking medical school credentials and whether the applicant for a license has been sanctioned in any other state, the insurers who credential say they go beyond that investigation. Dr. Bob Shepard of New West suggested that insurer credentialing can be more strict than the review done by the Board of Medical Examiners (BME). One difference in the review is that BME provides due process if there are complaints and does not act on a license without providing an opportunity for the accused licensee to go before a screening and an adjudication panel.

Also at the June 11, 2008, meeting the Committee heard a concern by Dr. Patsy Vargo of Great Falls that insurers may be inappropriately sanctioning physicians for their approaches to "call" or other medical decisions. Dr. Vargo, a family practitioner, told the committee she had arranged for a hospitalist to admit her patients so that she could devote more time to family issues and not be on call all the time as an independent practicing physician in a small

practice. She pointed out that both she and her part-time partner had received letters telling them they would be excluded from the insurers' panel of providers because of a failure to provide continuity of care. Her explanation that a hospitalist had agreed to provide the continuity of care gave her a reprieve, but she voiced concern that the insurer could interfere in the relationship between her and her patients, including patients on other insurance, like the military Tri-Care that uses credentialing by Blue Cross Blue Shield of Montana in lieu of its own credentialing. Although patients could continue to see her if they paid the full cost of services, they were more likely to go in search of a health care provider credentialed by their insurer and thus be eligible for discounted allowable costs and co-pays. A letter from Frank Cote of Blue Cross Blue Shield of Montana went out to members of the Committee after the meeting and responded to some of Dr. Vargo's concerns. That letter is in Appendix E, with samples of other correspondence received by the Committee and subcommittee.

Referral/disclosure and antikickback issues

After the first subcommittee meeting at which members Sen. Weinberg and Rep. Dutton heard about various concerns related to economic credentialing, conflict of interest, physician self-referral and specialty hospitals, Rep. Dutton asked the full Committee to request a bill draft. That bill draft, LC38, was to address economic credentialing concerns and conflict-of-interest issues.

As subcommittee discussions continued, the conflict-of-interest concerns, which relate to specialty hospitals as well as to credentialing and physician self-referral, developed as both an economic concern and an ethical concern.

As subcommittee discussions continued, the conflict-of-interest concerns, which relate to specialty hospitals as well as to credentialing and physician self-referral, developed as both an economic concern and an ethical concern. Within the economic credentialing discussions, there was an effort to define conflict of interest. A separate effort to define conflict of interest developed along with references to self-referral and kickbacks from an ethics perspective, aided by material that had been developed for the ethics committee of the American Medical Association and provided to staff for the subcommittee by Dr. Jack McMahon of Helena.

During discussions at the Jan. 24, 2008, meeting of the subcommittee, physical therapists and a representative of a free-standing imaging center noted that hospitals and physician group practices also may be engaged in conflicts of interest by not informing patients that they have choices regarding where they can access services such as physical therapy or imaging. The conflict-of-interest issue thus expanded to include the potential that any health care provider might be channeling patients to facilities in which they have either a financial or an employment interest. The employment interest included a concern that the employer might expect referrals and base bonuses or employment contracts on the number of referrals, thereby not giving patients full information on where they can receive services. As a result of this discussion, the subcommittee included a referral and disclosure section and a section prohibiting kickbacks based on referrals or other potential conflicts of interest into a bill draft that the Committee requested. At its Aug. 22, 2008, meeting the Committee divided all three issues into separate bill draft requests: LC341 for economic credentialing (SB 26); LC342 for prohibiting kickbacks and conflict of interest among health care providers (SB 52); and LC343 (SB 51) for disclosing economic and employment interests when making referrals.

Kickback concerns — In recommending within LC38 a ban on certain forms of kickbacks among health care providers, the subcommittee suggested dealing with conflicts of interest in part by expanding to all payors (insurers and those who directly pay) the essence of federal laws that prohibit kickbacks to any health care provider receiving Medicare, Medicaid, or certain other federal funds. After various iterations, many of the stakeholders participating in the subcommittee meetings said that the proposed legislation needed to reflect federal antikickback statutes and the Stark Act, which together primarily seek to define remuneration in a way that prohibits kickbacks or decreases their use and prohibits physician self-referral. One of the reasons for the parallel structure, they said, was that federal law also provides safe havens for various types of remuneration to avoid conditions that some people would call kickbacks and other people would call discounts or bonuses. The reason for reflecting these two federal provisions was to prevent confusion between federal and state requirements and to include the "safe harbors" or exclusions that federal law allows.[6] In the end, the LC38 kickback ban went further than federal law by specifying limits on bonuses or

[6]For a review of the Stark Act and Antikickback federal statutes, see: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/stark_act_review.pdf.

incentives associated with referrals as a condition of employment. Federal law allows leeway for rural areas recruiting physicians, for example.

The problem with the eventual proposal outlined in LC342, according to the physical therapists in private practice who were among the main opponents, is exactly those "safe havens", which the opponents said are too extensive to do much to prohibit kickbacks or physician self-referral. The opponents would have preferred stronger language because they claim that physicians in group practices that include physical therapists refer patients only to their own employees. Another main opponent, MHA, protested the inclusion of bonuses within the employment relationship as being a potential kickback. MHA noted that the language on bonuses might impede a hospital's ability to contract with physicians or establish a business plan that requires hiring more physicians based on the expectation that there would be a certain number of referrals either in the community or among the hospital-employed physicians.

Proponents of the prohibition on kickbacks (although not necessarily proponents of LC342) noted that the federal prohibition on kickbacks applies only to programs like Medicare and Medicaid. They suggested that extending the prohibition to all procedures would remove the added cost of bonuses and discounts or kickbacks of any kind from the cost of health care as well as deter a health care provider from a conflict of interest based on financial or employment incentives.

Disclosure and self-referral issues — The ethics concerns about kickbacks and self-referral have implications for consumers in their efforts to choose the best health care provider and one that is the most cost effective. Knowing whether a health care provider might have a self interest in prescribing certain tests or procedures or making certain referrals is one way for consumers to have a hand in their own health care decisions. Rep. Dutton in particular emphasized the importance of consumers being able to choose their health care providers but choose with a maximum amount of information available to them. This would include being aware of whether a consumer had options on where to obtain referred services. With material provided by the Montana Physical Therapists Association, staff drafted a separate bill proposal based on New Hampshire law to address disclosure by health care providers making a referral who had a financial or employment interest related to that referral. This was ultimately not presented to the Committee.

Knowing whether a health care provider might have a self interest in prescribing certain tests or procedures or making certain referrals is one way for consumers to have a hand in their own health care decisions.

Over time, the language in LC38 changed to require only health care providers who are making referrals (for example, dieticians referring to physicians or vice versa) to disclose any financial or employment conflicts. This could be done in the paperwork at the beginning of a patient contact or could be handled with notices displayed in a prominent place in the health care provider's office. Health care providers employed by Bozeman Deaconess Hospital, St. John's Lutheran Hospital in Libby and certain other health care providers sent letters to the Board of Medical Examiners[7] and to Committee members protesting the disclosure requirements. The letter from St. John's Lutheran Hospital suggested a poster at an entrance or an additional clause attached to the "Conditions of Admission" as sufficient to alert consumers about their choices and the potential for conflict of interest. The final bill draft allowed signs posted in a facility, which Sen. Weinberg noted already is done in some health care facilities, such as Health Center Northwest in Kalispell. For the most part, MHA and various hospitals and hospital-employed health care providers protested the paperwork and other problems associated with making the disclosure.

Some states link a ban on self-referral to health care provider licensing provisions. Through various iterations of LC38,[8] the disclosure and referral sections of LC38 intertwined with the conflict-of-interest and antikickback concerns as being unprofessional conduct under healthcare provider licensing.

[7]At the request of staff for the SJR 15 subcommittee, the Board of Medical Examiners provided a notice on its website to alert physicians about the SJR 15 discussions. The Board was not involved in promoting any of the ideas under discussion and forwarded comments received to the SJR 15 staff.

[8]For an explanation of the last set of changes to LC38, as provided to the Committee, see: http:// leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/ assigned_studies/sj15pricingcomparison.pdf.

Section 2: Specialty Hospitals and Conflicts of Interest

Another main focus of the SJR 15 study was how to deal with the one or two hospitals that currently might be considered specialty hospitals[9] or with potential new specialty hospitals. Under 50-5-245, MCA, DPHHS was not allowed to license new specialty hospitals until July 1, 2009, when a moratorium on licensing is set to expire. The subcommittee heard from proponents and opponents of specialty hospitals. Although not all who testified would agree, the issue of conflicts of interest between hospitals and health care providers who own for-profit health care facilities was an element of discussion for both economic credentialing and specialty hospitals. One conflict-of-interest concern was that health care providers who have an economic interest in a facility may encourage greater utilization for profit purposes than is necessary for medical purposes. (For more on the development of the conflict-of-interest issue, see the previous chapter, including the portions on disclosure/referral and kickback concerns, and below.)

As related to specialty hospitals, proponents of a moratorium or a ban contended that ultimately health care costs increase when specialty hospitals begin competing for patients with nonprofit community hospitals. The reason, as stated above, is that the owners of the specialty hospitals, usually physicians, have incentives to encourage more surgeries or procedures at the for-profit hospitals. Those opposed to specialty hospitals also contended

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[9]Although there is a current definition of specialty hospital in 50-5-101(55), MCA, that might cover the Central Medical Hospital in Great Falls and Health Center Northwest in Kalispell, Montana's two for-profit hospitals, there also is a grandfather clause in 50-5-245, MCA, excluding from specialty hospital licensure after the moratorium expires, a health care facility licensed by the department and in existence on May 8, 2007, a condition that applies to both hospitals. The definition of specialty hospital in 50-5-101(55), MCA, is: "(a) "Specialty hospital" means a subclass of hopsital that is exclusively engaged in the diagnosis, care, or treatment of one or more of the following categories:

(i) patients with a cardia conditions;
(ii) patients with an orthopedic condition;
(iii) patients undergoing a surgical procedure; or
(iv) patients treated for cancer-related diseases and receiving oncology services.

(b) For the purposes of this subsection (55), a specialty hospital may provide other services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick individuals as otherwise provided by law if the care encompasses 35% or less of the hospital services.

(c) The term "specialty hospital" does not include:
(i) psychiatric hospitals;
(ii) rehabilitation hospitals;
(iii) children's hospitals;
(iv) long-term care hospitals; or
(v) critical access hospitals.

that the for-profit surgery centers, cardiac hospitals, and other specialized care facilities tend to refer the more healthy patients to the specialty hospital and those with better health insurance coverage. As a result, a specialty hospital earns more profit, provides less charity care, and can document fewer days of hospitalization, which is a plus from the patient's perspective if not from the facility's viewpoint of earning more income from more days of hospitalization.

Another main focus of the SJR 15 study was how to deal with the one or two hospitals that currently might be considered specialty hospitals or with potential new specialty hospitals.

Those who favor specialty hospitals contended that specialty hospitals could decrease an individual's cost of care because specialization would increase efficiency and potentially the quality of care associated with performing the same procedure frequently, which theoretically means that the person performing the procedure improves with repetition. Proponents also argue that the shortened hospitalization time decreases the potential exposure to diseases in a hospital not associated with cardiac, orthopedic, or surgery in general. Yet another bonus, from the perspective of specialty hospitals, is that the profit motive and the potential for physicians to be their own boss may also encourage innovation in procedures.

Opponents of specialty hospitals also pointed out that few specialty hospitals have the capability to respond to emergency situations. Criticisms of specialty hospitals have included a failure to provide emergency care other than to rely on a 9-1-1 call for an ambulance to transfer the patient to a full-service hospital.

Subcommittee activities — The subcommittee considered a proposal in February 2008 that attempted to address some of the concerns raised at the Jan. 24, 2008, subcommittee meeting related to the current definition of specialty hospitals.[10] The working bill draft presented to the subcommittee included in the current definition of specialty hospitals under 50-5-101, MCA, a requirement that those applying for a specialty license self-attest (rather than require the Department of Public Health and Human Services to investigate) whether

[10]See the working bill draft, LC8888, at the Committee website under the SJR 15 Studies page: http://leg.mt.gov/css/Committees/Interim/2007_2008/child_fam/assigned_studies/sjr15.asp.

the applicant was primarily involved in cardiology, orthopedics, cancer treatment, or surgery. The definition also specified that the applicant must meet new licensing terms amended into 50-5-245, MCA. The amendments would have required applicants to:

- provide copies of letters of invitation sent to nonprofit community hospitals in a 35-mile radius to participate in a joint venture with the specialty hospital, along with any replies to the invitation;
- provide a description of charity care guidelines, which would have to meet a basic standard if not a joint venture or match the charity care guidelines and patient mix of the partner community hospital if a joint venture;
- demonstrate that a transfer agreement is in place for transferring patients from the specialty hospitals to a nonprofit community hospital (suggested by Medicare);
- provide a conflict-of-interest policy limiting a physician investor's interest to 2%; requiring that the physician investor be involved in any referred patient's direct care; and prohibiting the use of dummy companies to expand a physician's share.

Although neither the subcommittee nor the Committee acted on any of the issues related to specialty hospitals, except through the antikickback and disclosure and referral proposals, the expectation was that Congress might take action in the future to limit specialty hospitals. However, Congress took no action during the fall of 2008 on specialty hospitals. The 2009 Legislature entertained two bills related to specialty hospitals — SB 446 that provided conditions (some of them similar to those listed above) for licensing new specialty hospitals and SB 439, which extended the moratorium for 2 years. Both bills passed both chambers. A coordination instruction states that if both bills pass and are approved by the governor, then SB 439 is void, which means that the moratorium would expire July 1, 2009.

Conflict-of-interest concerns — As mentioned above, the opponents of specialty hospitals expressed concerns about specialty hospitals channeling the least complicated cases and the best-insured patients to for-profit specialty hospitals. The concern is not just with competition but with a practice model in which general, community hospitals rely on the relatively profitable surgeries and treatments associated with cardiac, orthopedic, and general surgery to cross-subsidize money-losing services — such as emergency and maternity services[11] — that the general, community hospitals offer but that specialty hospitals

[11]Maternity cases may not be money-losing but roughly 50% of births in Montana are paid under Medicaid and Medicaid does not pay the full charges.

do not. If this type of "cherry-picking" of better-paying cases occurs, the opponents say, then general, not-for-profit community hospitals may be at a greater risk of survival.

More information on specialty hospitals is available in minutes from SJR 15 meetings, available on request from the Legislative Services Division, and on the Committee website: http://leg.mt.gov/css/Committees/Interim/2007_2008/child_fam/assigned_studies/sjr15.asp.

Section 3: Consumer-Directed Health Care Options

Directions from the Committee and from the study resolution resulted in inclusion of the following subject areas within the SJR 15 study, particularly as they related to information by which consumers can direct their health care:

- options for receiving health care (disclosures and conflict-of-interest provisions) — discussed in Section 1;
- facility pricing and quality of care information;
- facility billing and collection procedures;
- the availability of charity care; and
- the role of hospice programs, school nurses, and community health centers.

Pricing transparency

Pricing transparency is shorthand for several terms that relate to ways to improve consumer awareness of health care costs and quality. Several states have adopted legislation to enhance the ability of consumers to compare costs and quality.[12] The Committee studied various issues related to pricing transparency during the 2007-2008 interim.

Typical options for transparency include information on:

- costs for inpatient and outpatient procedures at area hospitals and for outpatient procedures at ambulatory care centers;
- mortality, error rates, and other quality issues for the procedures; and
- cost calculators provided by insurance companies to help an insured person determine out-of-pocket costs for a procedure.

Several states have adopted legislation to enhance the ability of consumers to compare costs and quality.

A work group associated with the informal Montana Health Care Forum, which originated in October 2007, maintained pressure on the transparency issue. That work group included representatives of

[12]For more information on other states' transparency activities, see "Requirements in Selected States for Health Care Facility Pricing/Quality & Insurance Info", staff report for SJR 15, at: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/sj15pricingcomparison.pdf.

hospitals, doctors, insurers, the CFHHS chair, and health care organizations. In July the board of directors of MHA, an Association of Health Care Providers, agreed to independently pay for participation in the Price Point system, which gathers from health care facilities such data as costs for procedures and facility room charges. Hospital associations in approximately 10 states have opted to use the Price Point system. MHA demonstrated the future website capabilities at an August 21, 2008, Committee meeting and formally unveiled the website in January 2009. The website can be found at: http://www.mtinformedpatient.org. The Committee wrote letters to insurers and providers, including ambulatory surgery centers, urging their cooperation and use of the website to provide information for consumers or portals that consumers could access for further specific information. See Appendix E for a copy of the letter.

Some states prefer maintaining more control over the transparency issues than a private-sector entity like Price Point provides. States such as Pennsylvania have spent millions of dollars providing analysis on both pricing and quality among hospitals in that state. Arizona contracts with the Rand Corp. to handle analysis of its health care providers' pricing and quality comparisons.

Charity care

Montana's not-for-profit hospitals receive a tax exemption under both federal and state laws. That tax exemption generally is associated with the idea that hospitals provide a community benefit, which includes charity care, education, and research, among other items recognized by the Internal Revenue Service in its Form 990H. In exchange for the community benefit, the community does not tax the hospital for health care-related revenues.

During the 2007-2008 interim as part of its SJR 15 study of health care facilities and access, the Committee reviewed tax policies related to hospitals[13] as well as a charity care report conducted for the first time by the Montana Attorney General's Office.[14] Several other states' attorneys general conducted similar studies out of a concern that the community benefits

[13]See Sept. 24, 2007, memo from Legislative Services Division attorney Lee Heiman to the Committee: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15nonprofittaxreport..pdf.

[14]For the first report on charity care at Montana hospitals, dated January 2008, see: http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport200801.pdf. A second report came out in December 2008: http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport200812.pdf.

In addition to finding that charity care varies at the state's major hospitals, the report pointed out that some hospitals in Montana have a much higher percentage of Medicaid patients than do other hospitals.

provided were not comparable to the value of the income tax deductions. A second report noted that, in fact, the tax exemptions were much lower than what hospitals contributed to the community, either through actual charity or the cost of services rendered for Medicaid patients that were greater than what Medicaid paid. The second report, in contrast to the first report, included educational contributions and other values allowed by the IRS to be counted toward a community benefit. The first report, however, indicated that at 3 of the 11 hospitals that were reviewed, the tax exemption was greater than the charity and Medicaid shortfalls combined. After the initial report came out, disagreements arose over the definition of charity care and whether the base revenue analysis was appropriate. An addendum helped to clarify the numbers.[15] The report's author, Lawrence White, a professor at the University of Montana and former chief executive officer of St. Patrick Hospital in Missoula, recommended in the first report that hospitals improve their efforts to determine whether a patient is eligible for charity care in advance and avoid the cost of trying to collect after the fact (see more about the collections topic below). In addition to finding that charity care varies at the state's major hospitals, the report pointed out that some hospitals in Montana have a much higher percentage of Medicaid patients than do other hospitals.

Billing and collections

Billing efficiencies — One goal of consumer-directed health care is to provide sufficient information for a consumer to make wise decisions regarding health care purchases. One aspect of information is being able to understand hospital and provider bills. A presentation by legislative staff attorney Eddye McClure at a January 25, 2008, Committee meeting highlighted the problems that consumers have in deciphering billing, particularly when many of the consumers are dealing with illnesses that make them less than combat-ready for doing battle with accounting departments. McClure showed one small stack of bills for her treatment by the Virginia Mason Clinic in Seattle, which incorporated both facility and provider charges in one bill where procedures and charges lined up. She contrasted that with

[15]See the Committee website under the Jan. 25, 2008, meeting materials: http://test.leg.mt.gov/ css/Committees/Interim/2007_2008/child_fam/meeting_documents/materials.asp.

several file folders of bills for treatment from a Montana hospital, each with a different accounting clerk, which featured only hospital bills. Her provider bills came separately. Although part of the difficulty arises from different types of hospital systems (Virginia Mason uses employed doctors and the other features doctors with privileges to work in the hospital but not employed by the hospital), the confusion is exacerbated by difficulties in obtaining itemized statements and a lack of standardized billing.

Various states have targeted standardized billing by health care providers as one way of encouraging consumer awareness of health care costs and creating cost-efficiencies through standardization.

Various states (for example, Illinois, Texas, and Vermont) have targeted standardized billing by health care providers as one way of encouraging consumer awareness of health care costs and creating cost-efficiencies through standardization. Montana law, specifically 50-4-505, MCA, allows but does not require the commissioner of insurance to adopt "by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims...". The statute covers only health insurers but is in Title 50 under health care policy and not in Title 33, which governs most of the insurance commissioner's actions.

Improved billing efficiencies are estimated to save anywhere from 10% to 30% by reducing health care spending, according to various studies.[16] One thesis is that a multi-payor system increases the complexities for provider offices that submit bills to insurers on behalf of patients. Some providers have bowed out of the multi-billing effort by requiring the patient to pay directly and submit for reimbursement to the insurer. Referencing a Utah Health

[16]See James G. Kahn, et al., "The cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals", *Health Affairs*, vol. 24(6), 2005, for the 25% figure and a study by Stephanie Woolhandler et al. in "Costs of Health Care Administration in the United States and Canada", *New England Journal of Medicine*, vol. 349(8), 2003, for the 10% to 15% figures. A third report provided by the Washington Office of Insurance Commissioner to a January 2008 legislative hearing in that state estimated that administrative costs could be as high as 30% of health care spending, including medical receptionists, medical records, and other calculations. See: http://www.insurance.wa.gov/ legislative/documents/Jan-16-08 _admin_expense_overview.ppt#256,1,OIC Health Care Administrative Expenses Analysis and Report

Information Network's achievements, a Washington state study of administrative efficiencies included among its recommendations:

- common claim adjudication edits/payment policies and standard use of codes;
- single, online, streamlined credentialing for both plans and hospitals;
- electronic remittance advice, posting, and reconciliation; and
- common forms and administrative rules.[17]

Collection procedures — The Attorney General's report from January 2008 on hospitals' use of collection procedures to recover unpaid charges indicated a lack of information about collection complaints. In trying to determine how much money is written off as bad debt (not as charity care), the report's author determined that bad debt as a percentage of operating expenses ranged from a low of 1.38% to a high of 4.09%.[18] Whether a patient enters a hospital through the emergency room or for elective procedures can impact the patient's financial awareness of impending costs. Those who plan elective surgery can contact hospitals in advance to obtain financial counseling and learn about payment options, including a possible discount for paying at the time of discharge or how much copayment the insured patient is responsible for. An emergency room patient not only suffers the reason for the emergency visit but the impact of unexpected costs.

If a patient cannot pay at the time of receiving services, hospitals vary as to how they approach collecting the charges due. Times vary regarding how long Montana hospitals carry a bill on their books before turning it over to a collection agency. Full payment generally is due within 30 days of the initial bill or within 30 days of when the insurer paid its share. See Appendix F regarding varying hospital payment arrangements, ranging from 90 days to about 12 months.

A question related to hospital billing and payments arose during the SJR 15 study regarding whether hospitals collaborated with credit card companies for a hospital-type of credit card, by which a patient could put hospital charges on the credit card. This situation benefits a

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[17]See slide 19 from the Washington Office of Insurance Commissioner report cited above.

[18]See Table 2, Lawrence L. White, Jr., *Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers. A report prepared for Montana Attorney General Mike McGrath*, January 2008. http://www.doj.mt.gov/consumer/consumer/ hospital/hospitalreport200801.pdf.

hospital because it can earn interest on the unpaid charges and helps to assure payment; a patient benefits from a longer term to pay. However, a July 2008 *Consumer Reports* article[19] pointed out that, if a patient missed a payment deadline, some of these hospital-linked credit cards charged higher interest rates, which helped to propel into medical bankruptcy patients already having trouble making payments. A memorandum to the committee on Montana hospital payment policies noted that no Montana hospitals issued their own medical credit cards to patients.[20]

Hospice and end-of-life care

The Committee requested information on hospice services in Montana as part of the committee's focus on consumer-directed health care. A main concern voiced by one of the Committee members was that the greatest health expenditures in a person's life typically come in the last 6 months of life. The hospice philosophy is to avoid extraordinary health care measures to extend a person's life in favor of palliative care and better qualify of life. In March the Committee received updates on the number of people who have signed up with the Montana Attorney General's Office since creation of the end-of-life registry (6,800).[21] The end-of-life registry was created under HB 742 in the 2005 legislative session. Hospice employees from Billings (by phone) and Helena elaborated on their programs at a June 10, 2008, Committee meeting, discussing funding among other issues.

School nurses and early childhood access to care

School nursing is unevenly available in Montana, with only certain school districts dedicating resources to providing the services of a school nurse. These services include not only help with medical emergencies but assistance in connecting families with health care if the families do not have health insurance. School nurses also monitor children for early signs of mental illness, in an attempt to catch problems before they become serious. The president of the Montana Association of School Nurses, Sue Buswell, and a representative of the National Association of School Nurses, Kathy Boutilier, asked the Committee at its March 18,

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[19] *Consumer Reports,* "Overdose of Debt", July 2008.

[20] See Appendix F or http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/sj15hospitallending. pdf.

[21] For more information on hospice and the end-of-life registry, see the staff report provided at the March 17, 2008, meeting: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15hospicemarch2008.pdf.

2008, meeting, to consider recommending to the Legislature that school nursing be a greater priority in Montana school districts.

Community health centers

Federally qualified health centers offer a wide range of primary health care services on a sliding scale based on ability to pay. In Montana there are 12 federally funded Community Health Centers plus a Migrant Health Program and a Health Care for the Homeless Program. Satellite clinics provide services in an additional 12 communities. A report compiled by Lil Anderson of the Yellowstone City-County Health Department and presented to the Committee on Jan. 25, 2008, noted that 1 in 12 Montanans receive care from a Community Health Center.[22]

A report presented to the Committee on Jan. 25, 2008, noted that 1 in 12 Montanans receive care from a Community Health Center.

The requirement to serve regardless of ability to pay results in Montana Community Health Centers serving a patient population of which 56% are uninsured, 19% have private insurance, 14% are on Medicaid, 9% are on Medicare, and 2% are on the Children's Health Insurance Program (CHIP), according to Anderson's information. The Deering Clinic in Yellowstone County, as one example, had 17,930 patients in 2006, of which 77% paid based on the sliding fee scale. The clinic charges a $10 minimum fee for a medical visit or service and $20 for a dental visit.

Health care providers who work at the clinics qualify for coverage under a federal tort protection act, which means that these providers do not have to carry malpractice insurance. For the community of Libby, that provision has allowed two doctors to remain in practice delivering babies when the cost of malpractice insurance threatened to drive them out of practice.

[22] Lil Anderson-prepared powerpoint presentation, "Delivering Health Care through Community Health Centers", presented to the Children, Families, Health, and Human Services Committee, Jan. 25, 2008. http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15commhealthcntrsjan2008.pdf.

In the 2007 session the Legislature provided $1.3 million for the biennium that could be used either to create and support a community health center or to expand services or infrastructure at existing community health centers. An advisory group established by HB 406 requested proposals from communities for a state-funded community health center model that included primary care services. The goal was to ultimately move the state-funded community health center to a federally qualified and funded community health center. The community of Kalispell received the grant out of the three communities that applied. (Hamilton and Lewistown also bid).

The 2009 session included bills passed by both chambers that allowed the state to provide funding for up to six years or until federal funding was provided to nonprofit community health centers (HB 280) and extended limits on liability for physicians and dentists practicing voluntarily at community health centers (SB 368).

Section 4: Information Technology in Health Care

Throughout the 2007-2008 interim a nonprofit organization, HealthShare Montana, reported to the Committee on its proposal to use information technology to improve disease and preventive care management in Montana. Specifically, the volunteer group representing 55 organizations[23] has been working to implement an electronic continuity of care record[24] that would allow health care providers to share information about a patient's medical history in a secure (privacy-protected) environment. Improved efficiency and higher quality care plus lower costs from improved chronic disease outcomes and fewer repeated tests were among the benefits that proponents said electronic health records could provide.

HealthShare Montana asked the Committee for legislative support for a demonstration project that would serve up to 100 providers. The group requested that the governor include $1.5 million for the demonstration project in his 2010-2011 budget and also has requested that Montana's Congressional delegation include an appropriation for at least half of that amount (which would lower the state's investment to $750,000). The Committee sent a letter to Governor Schweitzer supporting the budget request[25] and voted at its August 2008 meeting to sponsor a committee bill supporting funding for the demonstration project (LC339, which became HB 86). The bill missed transmittal, but $750,000 for the biennium was included in HB 645 to match a similar amount made available in federal funds.

As one example of potential cost savings from better chronic disease management, information presented by HealthShare Montana indicated that savings of $2,000 per patient per year could be expected from "avoided complications" just by using a continuity of care record to track and monitor the estimated 60,000 diabetics in Montana, of whom 32,400 are

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[23]HealthShare Montana has a 21-member board that includes representatives from state government, health insurance payers, consumer groups, physicians, and health care facilities. See www.healthsharemontana.org or http://healthinfo.montana.edu/healthit.html) for more information.

[24]An explanation about the continuity of care record is available on the Committee website: http:// leg.mt.gov/content/committees/interim/2007_2008/child_fam/meeting_documents/ sj15hitletterjan08.pdf.

[25]The CFHHS letter to Governor Schweitzer regarding budget inclusion of a continuity of care demonstration project is at: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sjr15schweitzer-hitltr.pdf.

estimated to have less than ideally controlled illnesses. The overall cost savings for improved diabetes management, the group estimated, could be up to $65 million a year once disease management systems are fully deployed.[26]

Although internet firms Google and Yahoo both offer the opportunity for users to establish personal health records, these records are not accessible if a person is in an emergency room and unresponsive. They also are not necessarily helpful if information is not current or comprehensive. Nor do they offer any disease management capabilities. The HealthShare Montana proposal is for a system that allows health care providers and hospitals to use their current software but link to a server that would be accessible to other participants.

As stated on the Transparency Work Group page of the Montana Health Care Forum,[27] a continuity of care record would make available clinical information to a provider or a health care facility where a patient is receiving care. The patient also may have access to the information. HealthShare Montana anticipates that the continuity of care record and electronic health records would become self-sustaining by 2011 (either through payments by providers or sale of aggregated data).

According to the HealthShare Montana proposal, the pilot project would take place at 5 to 10 sites and include a mix representing a hospital, hospital emergency department, clinic, long-term care facility, primary care provider savvy enough to handle health information technologies, and a provider who has no health information technology access. HealthShare Montana estimates that invitations to participate would be extended across the state and appropriate participants selected from respondents.

Electronic health records

Part of the HealthShare Montana proposal involves the use of electronic health records. Billings Clinic in 2008 received recognition nationally for its use of electronic health records to improve patient safety and reduce medical errors. The Billings Clinic has invested over the past eight years in clinical information systems, including hospital inpatient, emergency

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[26]HealthShare Montana, An Overview, August 2008. PowerPoint presentation, slide titled "Preventable Complications of Diabetes."

[27]Click on "Recommendation to Support Healthshare Montana" at: http://www.montanahealthcareforum.com/workgroup-transparency.htm.

settings, and physician offices. A spokesperson for Billings Clinic, Kristianne Wilson, said the clinical information systems have prevented errors in medication administration and drug interactions in addition to alerting physicians about evidence-based care processes for chronic and acute conditions. The budget over this period has topped $15 million for the clinical information systems, she said.[28]

[28]Information provided in a telephone call, January 7, 2009.

Section 5: Availability of Health Care Services

The survey of not-for-profit and for-profit health care facilities indicated that even in Montana's largest cities, not all services are available. The question arises in terms of access to care: how much access is possible in a sparsely populated state like Montana and what is the role of the state in assuring access?

Montanans who live in rural communities and who need sophisticated health care services know that those services are in limited supply. Even Montanans living in the state's major cities may know that certain hospitals have more experience than other hospitals with certain operations. For example, anyone having a baby in Missoula is likely to head to Community Medical Center but if they have cardiac concerns they are likely to go to St. Patrick Healthcare Center in the same city, based on each hospital's long-time areas of expertise. As hospitals look at their bottom line, however, more are moving toward offering elective procedures that are profitable, which may mean increased competition within a community as well as with communities within 200 miles.

A survey of Montana's health care facilities, specified as one of the study targets in SJR 15, showed that many Montanans travel out of their community to have babies in a hospital with a birthing center and that specialized services are limited to major hospitals. See Appendices G through J.

In terms of mental health services, distribution of providers is uneven in Montana. Even without the benefit of a major mental health care study funded by the 2007 legislature[29], it has been clear for many years that mental health care is extremely limited in Montana. The final report of DMA Health Strategies, the contractor for the Mental Health Study, included among its recommendations:

- improved coordination by the state in administering a mental health system and perhaps a restructuring of the system;

[29]This report is available at: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/finalmhreport.pdf.

- pursuit of expanded Medicaid eligibility for adults with serious and disabling mental illness and certain other groups, in addition to more funding for crisis response and stabilization services;
- increased community crisis services and psychiatry services supported by more attractive rates and telepsychiatry; and
- increased collaboration between the Department of Public Health and Human Services and tribes in Montana, whether through the Indian Health Service or tribally operated clinics and services.[30]

> Even without the benefit of a major mental health care study funded by the 2007 legislature, it has been clear for many years that mental health care is extremely limited in Montana.

[30]For more information see the Committee website under Legislative Mental Health Study: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/finalmhreport.pdf

Appendix A

SJR 15

SENATE JOINT RESOLUTION NO. 15

INTRODUCED BY K. GILLAN, BROWN

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING AN APPROPRIATE INTERIM COMMITTEE TO STUDY THE IMPACT OF MONTANA'S HEALTH CARE DELIVERY SYSTEM, INCLUDING PHYSICIAN-OWNED HEALTH CARE FACILITIES AND SPECIALTY HOSPITALS, ON HEALTH CARE SERVICES IN MONTANA.

WHEREAS, physicians, hospitals, and other health care providers have a long history of working in concert to provide access to high-quality medical care for Montanans; and

WHEREAS, changes in the health care delivery system, such as the development of physician ownership of health care facilities and services and of specialty hospitals, have challenged cooperation and collaboration between these groups of providers; and

WHEREAS, concerns about these changes raise serious public policy issues that MAY affect the future and financial viability of Montana's health care delivery system, including the cost of health care and providers' ability to guarantee access to affordable, high-quality health care; and

WHEREAS, the Montana Legislature in 2005 approved a moratorium on licensure of new specialty hospitals for the purpose of giving the United States Congress time to address nationwide concern about the impact of specialty hospitals; and

~~WHEREAS, Congress has expressed an interest in examining these issues during its 2007-08 session.~~

WHEREAS, SOME MEMBERS OF CONGRESS, AS WELL AS SOME MEMBERS OF THE MONTANA LEGISLATURE, HAVE INDICATED AN INTEREST IN FURTHER EXAMINATION AND STUDY OF THESE ISSUES DURING THE BIENNIUM.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council be requested to designate an appropriate interim committee or statutory committee, pursuant to section 5-5-217, MCA, or direct sufficient staff resources to:

(1) ~~analyze the impact of physician-owned health care facilities and specialty hospitals, as defined in the introduced version of Senate Bill No. 417 in the 60th Legislature, on Montana's health care system~~ STUDY AND ANALYZE THE IMPACTS OF VARIOUS MODELS FOR THE DELIVERY OF HEALTH CARE SERVICES ON THE COST OF HEALTH

CARE, THE QUALITY OF CARE, AND ACCESS TO HEALTH CARE SERVICES, including but not limited to:

(a) the percentage of Medicare, Medicaid, private pay, and charity and uncompensated care that these ~~facilities~~ HEALTH CARE FACILITIES, AS DEFINED IN 50-5-101, provide compared to the percentage provided by nonprofit, community-based hospitals;

(b) the range of services ~~that these facilities provide~~ PROVIDED BY PHYSICIAN-OWNED AND PRIVATELY OWNED HEALTH CARE FACILITIES AND SPECIALTY HOSPITALS AND THE BENEFITS AND IMPACTS OF THOSE SERVICES compared to the services provided by nonprofit, community-based hospitals; ~~and~~

~~(c) the impact on a community's health care safety net of the diversion of services and resources away from nonprofit, community-based hospitals to specialty hospitals or special-service facilities;~~

(C) THE COMPARATIVE COST OF SERVICES RENDERED BY THE PRIVATE FACILITIES AND SPECIALTY HOSPITALS COMPARED TO THE NONPROFIT, COMMUNITY-BASED HOSPITALS; AND

(D) THE COMPARATIVE IMPACT ON A COMMUNITY'S HEALTH CARE SAFETY NET OF THE OPERATIONS OF HEALTH CARE PROVIDERS IN EACH OF THE CATEGORIES IN SUBSECTION (1)(C);

(2) identify the number and operating characteristics of nonprofit, community-based hospitals; physician-owned hospitals and physician-owned health care facilities; and nonhospital, for-profit facilities that perform surgical, imaging, and diagnostic procedures, including those owned jointly with hospitals; and

(3) analyze and develop public policy recommendations ASSOCIATED WITH MONTANA'S HEALTH CARE DELIVERY SYSTEM AND MONTANA'S HEALTH CARE CONSUMERS for consideration by the 61st Legislature, including but not limited to:

(a) physician self-referral, which means referral for medical treatment by a physician to a facility in which the referring physician has an ownership interest;

(B) THE INCREASE IN HOSPITAL-EMPLOYED PHYSICIANS;

~~(b)~~(C) physician credentialing, or the process that hospitals use for granting privileges to physicians to practice in their facilities, INCLUDING USE OF HOSPITALS BY PHYSICIANS WHO MAY BE IN COMPETITION WITH THAT HOSPITAL; ~~and~~

~~(c)~~(D) whether a need exists to impose or continue moratoriums on specialty hospitals;

~~(d)~~(E) QUALITY OF CARE FOR PATIENTS;

~~(e)~~(F) QUALITY IMPROVEMENT AND COST CONTAINMENT INITIATIVES; ~~AND~~

~~(f)~~(G) HEALTH INFORMATION TECHNOLOGY;

(H) HEALTH CARE COSTS AND WAYS TO REDUCE THOSE COSTS; AND

(I) HOW TO EMPOWER MONTANANS TO TAKE A MORE ACTIVE ROLE IN THEIR HEALTH CARE AND TO BE BETTER HEALTH CARE CONSUMERS.

BE IT FURTHER RESOLVED, that if the study is assigned to staff, any findings or conclusions be presented to and reviewed by an appropriate committee designated by the Legislative Council.

BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review requirements, be concluded prior to September 15, 2008.

BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions, comments, or recommendations of the appropriate committee, be reported to the 61st Legislature.

- END -

Appendix B
Draft Work Plan for SJR 15

Draft Work Plan for SJR 15

Study of impacts of certain services on health-care delivery

Introduction

This Draft Work Plan for Senate Joint Resolution No. 15, a study of health-care delivery service impacts, involves examining who provides health care services in Montana, what role the state has in providing a level playing field for competing types of health services, and how state regulation can help citizens gain access to and be assured of quality health care services.

The options for conducting the study range from having the Children, Families, Health and Human Services Interim Committee (CFHHS) spend part of its meeting time on this study or placing the study with the joint subcommittee recommended to study House Joint Resolution No. 48, a study of reforms in the system of paying for health care. Such a subcommittee most likely would consist of 4 members of the Economic Affairs Interim Committee (EAIC) and 4 members of CFHHS and would meet 4 to 5 times.

I. *Scope of study*

The Legislative Council on May 15, 2007, assigned Senate Joint Resolution No. 15, a study of the impacts of certain services on the health care delivery system, to the Children, Families, Health and Human Services Interim Committee (CFHHS). SJR 15 commonly has been referred to as the specialty hospital study, but the resolution contains more issues than delivery of health care services. Because many of the interested persons involved in SJR 15 will be involved in the HJR 48 health insurance study, staff recommends that primary responsibility for the SJR 15 study be given to the joint subcommittee, if one is appointed. The two issues would be studied separately but at the same meetings. A joint subcommittee depends on action by the Economic Affairs Interim Committee to establish a subcommittee for HJR 48. If it does, CFHHS might recommend the use of the same subcommittee of EAIC and CFHHS members to study SJR 15. Or CFHHS could choose to incorporate the SJR 15 study into its regular meetings. The following key issues were presented to the Economic Affairs Committee regarding the choice between a subcommittee or a committee approach:

- Budget and staffing of a joint subcommittee reduces the main committees' budgets and staffing. For a joint subcommittee, each committee would contribute from its budget. The key staffing consideration is the secretary's time because research duties and coordination would be handled by a research analyst assigned to the studies and not EAIC or CFHHS.

- Scheduling can be done to coincide with either main committee or can be completely separate.
- Participation by members from 2 committees expands the expertise.

The study has three parts: 1) research informed by a range of interested persons and provided to the committee/subcommittee for further action; 2) panel discussions of topics chosen by the committee/subcommittee; and 3) possible legislation.

II. *Issues as listed in SJR 15*

SJR 15 requests a study that compiles information on the number and characteristics of various health care facilities and the types of services provided by health care facilities, including nonprofit, community-based hospitals and specialty hospitals, along with the costs, accessibility, and quality of care of each. The study asks for a comparative review of how various health care providers ensure a community's health care safety net. Also requested are: policy recommendations related to the impact on health care costs and the quality of care of the various health care facilities; the use of hospital-employed physicians and physician credentialing; the issue of moratoriums on specialty hospitals; and the use of health information technology, personal wellness programs, and personal consumer education to improve Montanans' health.

Among the public policy considerations to be reviewed, with a view to the future financial viability of health care providers in Montana and quality, affordability, and access to care, are the roles of government as a regulator of competition and as a payor of health care services. Quality is subjective and difficult to quantify, so staff recommends that the committee seek out quantifiable measures, such as malpractice complaints, license suspensions, and complication rates.

The issue of specialty hospitals, physician credentialing, safety nets, and other aspects of the study involves valid concerns on all sides for which policies may or may not be appropriate. First, hyperbole must be replaced by solid information. Then committee members will have the opportunity to decide whether to recommend policies or other solutions.

Specific issues related to the impacts of cost, quality, and access to health care facilities include:

- a review of the types and ownership of health care facilities throughout the state;
- a review of the percentages of public and private payment at all health care facilities along with the comparative costs of services and the provision of charity or uncompensated care;
- a review of the range of services and any advantage or disadvantage of services provided by:
  - physicians who refer to facilities in which they have an ownership interest;
  - other for-profit facilities; and
  - nonprofit, community-based hospitals;

- the use or misuse of economic credentialing to address quality of care issues and the impacts; and
- the role of government in addressing the impacts on a community's health care safety net of the various health care facilities in competition with each other or standing alone.

III. *Study schedule*

June to September	1) Development of an interested party list with recommendations for relevant background reading materials. 2) Background reading by staff to provide requested information in comparison form to help determine how broad to make the study, including information analyzing national trends or trends in other states regarding: the impacts of nonprofit versus for-profit hospitals, including specialty hospitals; of physician credentialing; of increased use of health information technology; and whether utilization increases (pro and con) with physician self-referrals and the availability of specialty hospitals. 3) Summary by staff of relevant state data from the Montana State Planning Grant, the Montana Medicaid Program, and related reports. 4) Work with interested persons to gather specific information not available elsewhere, particularly related to costs of services. 5) Provide reports to committee members and determine committee members' policy goals based on reports provided to them.
1st meeting	1) Committee/subcommittee to adopt operating guidelines, determine topics for further consideration, types of deliverables (goals), and a proposed schedule of speakers or panel discussions. 2) Committee/subcommittee to adopt work plan and operating guidelines.
2nd meeting	1) Panel on types of competing health care services: joint venture and physician-owned surgery centers, imaging centers, community health care centers, clinics, and nonprofit community hospitals. Include panel discussion of moratorium, the role of physician referrals, and the role of insurance and other payment incentives/disincentives. 2) Review of quality issues and economic credentialing.
3rd meeting	1) Panel discussions/reports on how other states handle quality versus supply issues, physician credentialing/licensure, and the use of prevention programs and technology in decreasing the costs for health care services. 2) Discussion of proposed legislation or revisions to existing legislation.
4th meeting	Review legislation and remaining SJR 15 issues.
5th meeting	Consider final report and legislation changes/recommendations.

IV. *Study deliverables and end products*

- An interested party list.
- Working papers on issues listed in SJR 15, including background information on types, characteristics, and locations of health care providers in Montana; reimbursement mechanisms for the various types of payors; the providers' treatment of unreimbursed costs (as far as available); a review of other factors associated with the health safety nets; reports on regulatory practices that can provide a level playing field among various providers; reports on quality issues; and a report on policies considered or adopted in other states that reflect committee members' policy goals.
- Panel discussions.
- A final report that will include recommendations for new legislation, if any, and revisions to existing statutes, if needed.
- Legislation if requested by the committee.

Appendix C
Reports for the SJR 15 study
from
staff and presenters

Reports for the SJR 15 study from staff and presenters

Staff Reports:

- *Statutory Requirements in Selected States: Health Care Facility Pricing, Quality, and Insurance Information*, Pat Murdo, August 2008 http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/sj15pricingcomparison.pdf
- *Hospital Lending Practices: Memo and Summary Table*, Pat Murdo, August 2008. For the Memo: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/ assigned_studies/sj15hospitallending.pdf For the Table: http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/sj15hospitalcollectionpractices.pdf
- *Physician Credentialing: Staffing, On-Call, and Insurance Issues*, Pat Murdo, June 2008 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15nsurer_credentialing. pdf
- *Health Care Facility Survey Summary and Table*, Pat Murdo (these reports are available in Appendix F).
- *Hospices and End-of-Life Care in Montana*, Pat Murdo, March 7, 2008: http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15hospicemarch2008.pdf
- *Charity Care and Other Community Benefits*, Pat Murdo, March 7, 2008 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15charitycaremarch2008.pdf
- *State Statutes: Specialty Hospitals and Economic Credentialing*, Jan. 24, 2008 (from the National Conference of State Legislatures: http://www.ncsl.org/programs/health/shn/2007/sn506a.htm)
- *Tax Treatment of Nonprofit Entities*, Lee Heiman, September 2007 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15nonprofittaxreport..pdf
- *Review of Related Court Cases,* Lisa Mecklenberg Jackson, September 2007 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15courtcasereviewsept2007.pdf
- *Glossary of Terms*, September 2007 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/SJ15definitions_issuestable.pdf

Other Reports Related to the SJR 15 Study and Provided to the Committee:

- Lawrence L. White, Jr., *Montana's Hospitals: Issues and Facts Related to the Charitable Purposes of Our Hospitals and the Protection of Montana's Consumers. A report prepared for Montana Attorney General Mike McGrath*, January 2008. http://www.doj.mt.gov/consumer/consumer/hospital/hospitalreport200801.pdf
- Lil Anderson, "Dellivering Health Care through Community Health Centers", powerpoint presentation, Jan. 25, 2008 http://leg.mt.gov/content/committees/interim/2007_2008/child_fam/assigned_studies/sj15commhealthcntrsjan2008.pdf

Appendix D
List of participants in the SJR 15 Subcommittee on Economic Credentialing and Specialty Hospitals

List of participants in the SJR 15 Subcommittee on Economic Credentialing and Specialty Hospitals

Participants in the SJR 15 Subcommittee on Economic Credentialing and Specialty Hospitals. Not all participants attended every meeting. Names in italics were notified but did not attend although they may have contributed information. (In some cases they were intermediaries to notify others.)

Name	Representing
Robert Allen	Montana Nurses Association
Jerome Anderson	Yellowstone Orthopedic Associates, Montana Orthopedic Society
Tanya Ask	New West Health Services
Amy Astin	Benefis Healthcare
Andy Beck	Montana Association of Ambulatory Surgery Centers
Webb Brown	Montana Chamber of Commerce
Sally Buckles	MEMSA
Jeff Buska	Department of Public Health and Human Services
Chuck Butler	self
Paul Byorth, MD	self
Jim Crichton, MD	Montana Medical Association
Frank Cote	America's Health Insurance Plans / Blue Cross Blue Shield of MT
Michael Dixon, MD	Montana Otolaryngology
Tom Ebzery	Sisters of Charity Hospitals in Montana
Jim Elliott, MD	Billings Physician Alliance
Jeff Fee	CEO, St. Patrick Healthcare
John Flink	MHA, an Association of Montana Health Care Providers
Mary Beth Frideres	Montana Primary Care Association
Mike Foster	Sisters of Charity Hospitals in Montana
Rob Gagnon	*Yellowstone Surgery Center*
Colette Gray	Opportunities, Inc.
Aimee Grmoljez	Billings Clinic
Jim Haley, MD	St. Peter's Hospital
John Harlan, MD	self
Gloria Hermanson	MSO-HNS
Mona Jamison	Great Falls Clinic/Central Montana Surgical Hospital
Bert Jones, MD	*Flathead Orthopedic Center*
Kevin Kelly, MD	Great Falls Clinic
Roy Kemp	Department of Public Health and Human Services
Tamim Khaliqi, MD	Great Falls Clinic/Central Montana Surgical Hospital
Tate Kreitinger	Health Center Northwest
Kurt Kubicka, MD	Montana Medical Association Legislative Committee
Patti Jo Lane	Great Falls Clinic, group practice physical therapist
Pauline Lingell	MEMSA
Mary McCue	Montana Medical Association
Edward McEachern, MD	Utah health services researcher on cardiology and pediatrics (guest)

Jim McLean	Frenchtown Physical Therapy
Jack McMahon Sr., MD	Mountain Pacific Quality Health and Montana Medical Association
Audrey Mendenhall	Sound Health Imaging, Butte and Helena
Margaret Morgan	Montana Physical Therapists Association
Jerry Morse	Board of Medical Examiners
Tim Nagel	Open MRI, Billings
Mark Nash	Credit Associates
Bob Olsen	MHA, an Association of Montana Health Care Providers
Albert Olszewski, MD	*Flathead Orthopedic Center*
Jim Paquette	CEO, St. Vincent Healthcare
Lorena Pettet	Montana Physical Therapists Association
Bill Pfingsten	Bozeman Deaconess Hospital
Keith Popovich, MD	self
Mark Rumans, MD	Billings Clinic
Marty Sinclair	Great Falls Clinic
John Solheim	St. Peter's Hospital
Velinda Stevens	Kalispell Regional Medical Center/HealthCenter Northwest
Virginia Summey	Montana State Auditor's Office
Cory Swanson	Yellowstone Orthopedic Associates, Montana Orthopedic Society
Mark Taylor	MHA, an Association of Montana Health Care Providers
Patsy Vargo, MD	self
Owen Voigt	Montana Association of Counties Health Care Trust
Mark Wakai	St. Patrick Healthcare/Providence Health
Kristianne Wilson	Billings Clinic
Susan Witte	Allegiance Benefit Plan Management Inc. and Allegiance Life and Health Insurance Co.
Jeanne Worsech	Board of Medical Examiners
Bob Wynia, MD	self
Brian Zins	Montana Medical Association

Contacted but not participating (except in the survey of health care facilities): CEOs for St. James Hospital in Butte, Community Medical Center in Missoula, Community Hospital in Anaconda

Appendix E
Samples of letters to and from committee

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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RICK LAIBLE
TERRY MURPHY
DAN WEINBERG

HOUSE MEMBERS
EDITH CLARK
ERNIE DUTTON
TERESA HENRY
DIANE SANDS

COMMITTEE STAFF
SUE O'CONNELL, Lead Staff
LISA JACKSON, Staff Attorney
FONG HOM, Secretary
PAT MURDO, Staff for SJR 15

September 8, 2008

MEMO

To: Montana Community Health Centers, Ambulatory Surgery Centers, Health Care Providers, Insurers, Insurance Regulators, Health Facility Regulators, and Health Care Licensing Boards

From: The Children, Families, Health, and Human Services Interim Committee

Re: New Consumer Health Care Information Website

As of January 2009, a new website will become available containing information for Montana consumers on health care, including facility pricing for various procedures, health insurance, long-term care options, and related health care information. The website, http://www.mtinformedpatient.org, is being sponsored by MHA, an Association of Montana Health Care Providers, but will contain information on more than MHA's members as soon as that information is voluntarily made available.

The Children, Families, Health, and Human Services Interim Committee voted unanimously at its August 22 meeting to encourage broad participation in this new website. The hope is that, with more information, Montana consumers will make more educated health care decisions and be more aware of health care costs. Participation of regulating bodies will provide contacts for consumer complaints as well as a way for consumers who access the regulators' websites to go directly to a one-stop shop for health care information.

The Children, Families, Health, and Human Services Interim Committee sees this private sector effort to improve access to health care information as an important step that can be made better by broader participation. MHA announced at the committee's August 22 meeting that MHA would include links or information for entities that are not MHA members. The committee urges your organization or agency to take up that offer and help improve the information available to Montana consumers.

Roberta Yager at MHA is developing the website and getting approvals for links or other information posted at the site. Please contact her directly at roberta@mtha.org to include your links or information on the website. Thank you.

CI0425 8252pmxa.

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Helena, Montana 59604
(406) 444-8200
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July 21, 2008

Honorable Edith Clark
Chairwoman, Children, Families, Health and Human Services Interim Committee
P.O. Box 34
Sweetgrass, MT 59484-0034

Representative Clark;

At the last meeting of the Children, Families, Health and Human Services Interim Committee, a series of questions regarding the Blue Cross Blue Shield of Montana (BCBSMT) credentialing process were raised. As promised, I am writing this letter to answer those questions.

First, let me begin by saying BCBSMT has provider credentialing for multiple reasons. First, and the reason BCBSMT instituted the process initially, is that it is mandated by the Montana State Legislature (Title 33, chapter 36.) Secondly, BCBSMT is contracted to provide insurance or claims paying services for various government programs, including the TriCare, Federal Employee Program (FEP), Children's Health Insurance Program (CHIP) and Medicare Advantage provider networks. These government programs request various amounts of provider credentialing. Third, employer groups want credentialing. Most requests for proposal (RFP) received from groups question the plan's credentialing standards. Credentialing has truly become an industry standard for health plans. Most importantly however, BCBSMT credentials for quality purposes for the BCBSMT **members**.

Next, I would like to address some apparent misinformation that the Committee received at the June meeting. There are currently 27 practicing Gastroenterologists (physicians who do colonoscopies) in Montana, all are participating providers with BCBSMT. All three of the physicians in Great Falls that provide colonoscopy services are BCBSMT Participating Professional Providers. Therefore, each professional provider accepts the same allowable amount from BCBSMT. Therefore, assuming all else is equal (deductibles, co-pays, etc.), each professional provider would receive the same payment from BCBSMT for his professional services.

However, it is my understanding, that prior to May 1, 2008, **because the overall costs to the members' plan were less**, the doctor using his office suite (Great Falls Clinic) was paid more per procedure. The apparent difference in overall costs can be attributed to the fact that there is one charge and one reimbursement for the services done in the office suite, which covers the room, administrative overhead and the professional fees. For the hospital based procedure there are separate charges for the surgery room and for the professional fees, thereby creating a higher cost to the members' plan. This explains any discrepancy in charges. Deductibles and co-pays of the specific benefit plan also apply.

After hearing the testimony presented to your committee, we were quite shocked and concerned for our members regarding what we heard about the waiting times for colonoscopies. We immediately requested our staff to investigate what was told to the committee. Our staff contacted each of the three offices in Great Falls that provide colonoscopy services. According to scheduling staff members of the three physicians in Great Falls that do colonoscopies, their current procedures are as follows:

- The Great Falls Clinic provider schedules **routine** screening colonoscopies 10 to 12 months out, the procedure date is scheduled in the order the request is received and there is no special treatment for anybody. Referred colonoscopies for bleeding, chronic cases of diarrhea, bowel changes, anemic, iron deficiencies, etc. **are scheduled in 7 to 10 days and sooner** if they can get them in. Five year and ten year follow-ups are scheduled out up to 6 weeks. They are receiving many patients from Helena and their current routine screening list has about 480 individuals on it. We are told they even double book if necessary to get a patient in. The doctor also has privileges at Benefis and does a couple a week over at Benefis as a back up. Keep in mind that the additional charge applies for the surgery room if the doctor performs this procedure at Benefis.

- As for the two independent doctors, one doctor's staff member states that they do two **routine** screenings a day and are scheduling them out 1 to 2 months. **Referrals for bleeding and chronic conditions, etc., are scheduled within a few days.**

- The other independent provider's staff member states that **routine** screenings and call backs are being scheduled 3 to 4 months out. While diagnostics - **Bleeding and chronic conditions are being scheduled 2 to 3 weeks out.**

Therefore, contrary to the information which was provided to the committee, it appears that if there is a **referral** for bleeding or otherwise, a patient will be seen by a Great Falls Physician for a colonoscopy anywhere from a few days to a few weeks, regardless of which provider they choose.

If there is need for concern, it appears the biggest concern is the shortage of Gastroenterologists in Montana. As mentioned earlier, there are only 27 statewide. Three of these physicians are located in Great Falls, 1 affiliated with the Great Falls Clinic and 2 others practicing independently. Others are located in Kalispell, Billings, Missoula, Bozeman, Shelby and Butte. There are none in Helena. There is no difference among the 27 physicians in their participation with BCBSMT from a contracting standpoint. There are no exclusive agreements with any GIs, including those in Great Falls.

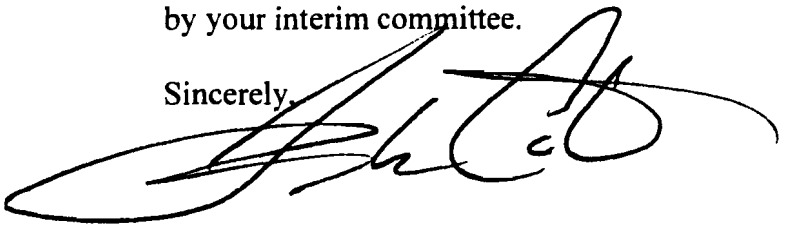
As for the statement that BCBSMT directs care, that is simply not a true statement in any sense. BCBSMT operates on the principles of patient choice and physician referral. We develop our participating provider networks with our members' quality care and convenience in the forefront. BCBSMT has 95% of all physicians in Montana as part of our network (not the 93% I told the committee- -my apologies to the committee.) I don't see how anyone can reasonably make the assumption that BCBSMT directs care when 95% of all physicians in Montana are part of the

BCBSMT participating provider network. I am unaware of any insurance carrier operating in Montana that has a more extensive network. All physicians in Montana are able to request participation in our network. BCBSMT would like to have 100% of all the physicians in Montana in the network, but that is not feasible, as some physicians don't wish to participate and others don't meet the standards to ensure our members receive quality care.

I hope this letter clears up any confusion that may have been thrust upon the committee. If you, or members of the committee, have additional concerns or questions, or need additional clarification, please do not hesitate to contact me. I can be reached at: 444-8340 or 431-3869.

Thank you for your attention top this matter, and for the important and difficult work being done by your interim committee.

Sincerely,



Frank G. Cote'
Senior Director, Government Relations
Blue Cross Blue Shield of Montana

Cc:

Representative Ernie Dutton
Representative Teresa Henry
Representative Diane Sands
Senator Carol C. Juneau
Senator Rick Laible
Senator Terry Murphy
Senator Dan Weinberg

May 19, 2008

Jeannie Worsech, Executive Director
C/O Montana Board Of Medical Examiners
P.O. Box 200513
Helena, MT 59620-0513

Dear Ms. Worsech,

This letter is written to voice my objection to language in LC 38. Specifically my concerns are:

1. The bill requires "all health care practitioners" to tell patients if they are employed by a hospital, critical access facility or hold an investment interest in a health care facility. Currently we, as physicians, are required by Federal Law to disclose financial interests in any health care facility. We currently comply with this guideline. However, to require us to formally tell patients that we are employed is senseless. The fact that we are employed has no bearing whatsoever on the manner in which we treat patients. In addition, think of how you would react if every physician, nurse, lab tech, and radiology tech you came in touch with had to first inform you of his or her employment relationship. This simply has no impact on the care we provide.
2. The bill requires "all health care providers" who make a referral to provide a written disclosure of their employment by a health care facility or investment interest in a health care facility. Again, in one contact with your physician you could receive numerous of these "notices". Imagine how many places you go before or after a visit to a health care facility: lab, x-ray, physical therapy, and pathology. At each of these places you will be receiving a written notice. And for what reason? If we have ownership interests in a health care entity, which most of us as employed physicians do not, we are already required to post our interests and inform our patients.
3. If we fail to do any of the above, again which have nothing to do with our credentials as health care providers, we risk the chance of being reported to the Board of Medical Examiners or for our staff, their licensing bureau for unprofessional conduct. Again for what reason?
4. We became employed physicians for various reasons. We have no problem if our employment contracts direct us to use the hospital for services, if those services are provided in a quality manner. This would be expected in an employer/employee relationship. It does not imply that we are being "directed" to use services needlessly. So again, there is no logic to this restriction.

I hope that you will take into consideration the difficulties that will be caused in my practice if this bill passes. If this bill passes we will be spending more of your office time with us complying with "regulatory" issues than on your health care needs.

Thank you for considering my concerns.

James Attarian, MD

Appendix F
Report on hospital payment arrangements

Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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DIANE SANDS

COMMITTEE STAFF
SUE O'CONNELL, Lead Staff
LISA JACKSON, Staff Attorney
FONG HOM, Secretary
PAT MURDO, Staff for SJR 15

August 13, 2008

MEMO

TO: **Children, Families, Health, and Human Services Committee Members**
FROM: **Pat Murdo, staff for SJR 15 study**
RE: **Lending and Collection Practices at Montana's Largest Hospitals**

At the request of Rep. Diane Sands, staff contacted Montana's largest hospitals to determine if any of the hospitals encouraged patients to take out a credit card associated with the hospital or used other forms of lending that either may impede a patient's access to charity care or increase the potential that a patient ends up in greater debt than if the patient had taken out some form of fixed-rate loan. The inquiry related to a July 2008 *Consumer Reports* article, Overdose of debt".

Findings:
No Montana hospital of the 11 contacted offers its own credit card arrangement to patients.

Some hospitals associate with or recommend specific banks for outside loans. These are:
- Billings Clinic and First Interstate Bank
- St. James Healthcare and First Citizens Bank
- St. Patrick Hospital and Health Sciences Center and First Interstate Bank
- St. Vincent Healthcare and Western Security Bank

Two hospitals work with management companies:
- Benefis Healthcare
- Kalispell Regional Medical Center

All hospitals have some arrangements that extend payments over a period for certain cases at no interest. Two hospitals specify differences between outpatient and inpatient arrangements: Community Medical Center, which extends payments for up to 24 months for outpatient services, and Bozeman Deaconess Health Services, which extends payments for 90 days for outpatients and up to 12 months with a $100 minimum charge for inpatients.

Six hospitals provide up to 12 months at 0% interest. The rest range between 90 days (for St. Peter's Hospital) up to 6 months. Benefis provides 0% interest for between 90 and 120 days and potentially longer on a case by case basis.

Most of the information on the table was included in the original questionnaire sent by the Attorney General's office to hospitals for the AG report on hospitals' use of charity care. The information was not in the final report issued in 2007. However, the question is being asked for the next iteration of that report. The final column was developed to show what types of information hospitals provide on their websites regarding the patient's financial responsibility and information about charity care.

A search to find out if other states are regulating so-called predatory lending or the use by hospitals of in-house potentially high interest credit cards for medical services did not yield any current legislation.

Hospital Collection Policies/Practices Summary, as of 8/12/08

Hospital	City	Payment in Full Due	Arrangement Terms w/No Interest	Term Beyond which Outside Loan Required	Loan Source(s)	Internal Financing or Hospital-arranged credit card	Website Financial Information
Benefis Healthcare	Great Falls	30 days following all insurance payment	90 - 120 days, extends payment terms on case-by-case basis	90 - 120 days	1) encourage arranging own financing 2) work with patients on long-term payments through a management company	90 - 120 days with no interest	1) Patient billing & insurance information 2) Financial assistance program. 3) Self-pay discount program. On-line bill pay
Billings Clinic	Billings	30 days from 1st statement after insurance has paid	12 months	12 months	1st. Interstate Bank	None specified	Provides Insurance Finder. Patient/Visitor information lists financial terms & First Care Loan contacts.
Bozeman Deaconness Health Services	Bozeman	Upon final billing if patient can pay in full. Payment arrangements for those that can't pay in full.	12 months ($100 minimum), Outpatients 90 days	None specified	None specified	After 12 mos. at 10% annual interest	On-line bill pay. Glossary of terms.
Community Medical Center	Missoula	30 days from 1st statement	Up to 24 months for outpatient services	No use of outside financing companies	No use of outside financing companies	Inpatient 9.6% per year from due date	Charity Policy under "About". Other financing terms not obvious
Holy Rosary Healthcare	Miles City	30 days from 1st statement	12 months	12 months	None specified	None specified	Financial assistance policy under "Patients and Guests"
Kalispell Regional Medical Center	Kalispell	Prompt pay discounts for all payments made in full during the first 30 days	12 months ($50 minimum)	no limit	Encourage patients to arrange own financing. Refer to managed care divisions of 2 account management companies.	0% financing up to 12 months. No credit card	Under "Patient Info", "Your Bill" gives contacts, what is on bill. New website due 3/31/09 to include on-line bill pay and application, additional financial assistance programs.
Northern Montana Healthcare	Havre	30 days following all insurance payment	"Payment schedule may be scheduled"	None specified	outside loan sources not used	None specified	Couldn't find billing information. "Admitting" mentions financial counseling.
St. James Healthcare	Butte	30 days from 1st statement	12 months	12 months	First Citizens Bank	None specified	Financial assistance policy under "Patients and Visitors". Lists sample prices.
St. Patrick Hospital & Health Sciences Center	Missoula	not specified	6 months	12 months	First Interstate Bank		Under "Patient and Visitor" Information. Charity care listed separately and under understanding your bill.
St. Peter's Community Hospital	Helena	45 days from final statement	90 days	No use of outside financing companies	No use of outside financing companies	After 90 days, at 10% annual interest	Billing info under "services" section. Notes help available if can't pay a bill. Sample prices, patient assistance policy in "especially for patients" section.
St. Vincent Healthcare	Billings	30 days from 1st statement	12 months	12 months	Western Security Bank	prime + 4%	Financial assistance policy listed under "Patients and Families". Discount availability noted

Appendix G
Health care survey findings

Health Care Survey Findings

By Pat Murdo
Legislative Services Analyst

A health care facility survey sent in January to 65 Montana hospitals, 13 ambulatory surgical centers and other outpatient centers for surgical services, plus staff-identified diagnostic centers and certain laboratories had as its goals to provide legislators with information on:

- the availability of various types of services across the state;
- staffing patterns;
- the payor mix at various facilities.

Some of this information is available in various forms from other surveys. The purpose of asking similar questions was to keep the survey simple to increase chances of response and provide a reasonable expectation that responses were in a similar time frame. Thirteen hospitals did not respond. Thirteen outpatient surgery centers or diagnostic centers responded. Responders had the choice of sending a paper copy of the responses or responding online. Most of the responses were made online.

Findings from the survey:

- **Services:**
  - Most of Montana's largest hospitals offer a wide range of services, but not all services are offered at every hospital.
  - Montana's large number of smaller hospitals offer limited services. The majority of these small hospitals are critical access hospitals, which generally offer general medical, required emergency services (for CAHs), and skilled nursing and laboratory services. The survey did not distinguish between beds used for skilled nursing and beds used for acute care, although some of the critical access hospitals offered that information. (Swing beds can serve either acute or skilled nursing populations.)
- **Staffing:**
  - For the most part, larger Montana hospitals have a mix of employed physicians on staff as well as physicians with privileges who are not employees.
  - Few Montana hospitals use locum tenens physicians. The question was not specific, and given the occasional nature of locum tenens physicians employment, the answers may have been incomplete for some of the hospitals because no locum tenens physicians were there at the time the survey was answered.
  - Contract physicians are used occasionally, but the question was not specific. Phone conversations with responders indicated that contract physicians include radiologists with the Night Hawk service in Australia. Without more specificity, this response is unclear.
- **Payor Mix**
  - At both hospitals and ambulatory surgical centers, the payor mix varies. In general, ambulatory surgical centers (ASCs) had a higher rate of commercial payors and a lower rate of Medicaid patients, although the highest percentage of commercial payors at an ASC was at an ASC in a 50-50 joint venture with a hospital.

(More)

Other Findings of Interest:
Emergency Room Visits – One of the highest cost places to receive health care, emergency rooms, registered visits to admissions in Montana ranging from 11.28% in a rural health center to 53.4% at one of the state's trauma centers. A 2003 Agency for Healthcare Quality and Research Statistical brief indicated that hospitals in the West averaged a 17.4% rate of admissions to emergency room visits. The overall AHQR finding was that 55% of 29.3 million hospitalizations, excluding pregnancy and childbirth, began in the emergency room. People in West were less likely to enter a hospital through the emergency department than people in the Northeast (23%). See http://www.hcupus.ahrq.gov/reports/statbriefs/sb1.pdf.

More exploration of the use of emergency rooms in rural Montana and Montana's population centers might help to determine whether people are using emergency rooms more in larger cities because they perceive no other options to receive care or they perceive that use of emergency rooms equates to "free" care, even though the Emergency Medical Treatment and Active Labor Act, which requires a person requesting emergency care to be evaluated and treated or stabilized if necessary, does not say that a hospital has to provide that care free of charge.

Other findings may be hidden in the survey, but in general the effort was one of compiling information to see where services are provided, how staffing is done, and what types of payors are represented in what ratios at various facilities.

Information in the survey report includes:

- Montana Hospitals and Critical Access Hospitals by Types of Services Offered
- Hospitals and Health Care Facilities by Physician Employment Situation, Nurse Staffing, Admissions, Outpatient Procedures, ER Visits, Operating Rooms, and Births
- Health Care Facility Ownership, Imaging Services, Revenues from Payors by Region
- Comparison of Hospitals and Outpatient/Ambulatory Surgical Centers in Large and Selected Small Montana Cities with Payor Mix (highs and lows highlighted)

Appendix H
Health care survey findings

Montana Hospitals and Critical Access Hospitals by Types of Services Offered

Inpatient Service Types	Obstetrics	Psychiatric services/ beds	General Medical	Surgical	Pediatric medical	Pediatric surgical	General ICU	Cardiac ICU	Pediatric ICU	Cardiology	Open-heart surgery	Orthopedics	Neurology	Skilled nursing	Acute LTC	Hospice/ palliative care	Infection isolation room	Pain Management	Physical Rehabilitation
Anaconda (Community Hospital)																			
Baker (Fallon MedicalComplex)			x										x						
Big Sandy Medical Center			x										x						
Big Timber	no report																		
Billings Clinic	x	x	x	x	x	x	x	x		x	x	x	x	x		x	x	x	x
Billings (St. Vincent's)	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Bozeman Deaconess	x		x	x	x		x			x		x	x		x	x	x	x	
Browning	no report																		
Butte (St. James)	x		x	x	x	x	x	x		x		x	x	x			x	x	x
Chester (Liberty Med. Cntr)			x	x	x	x	x	x						x	x		x		
Choteau (Teton Med. Cntr)	x		x		x									x	x	x		x	x
Circle	no report																		
Columbus	no report																		
Conrad (Pondera Med Cntr)	x		x	x	x		x							x			x	x	x
Crow Agency	no report																		
Culbertson	no report																		
Cut Bank	no report																		
Deer Lodge	no report																		
Dillon (Barrett Hospital & Healthcare)	x		x	x	x	x	x	x				x		x		x			x
Ekalaka (Dahl Memorial Healthcare)			x											x					
Ennis	no report																		
Forsyth (Rosebud Health CC)			x		x		x							x	x	x	x	x	
Fort Benton (Missouri River Med C)			x		x		x							x	x				x
Glasgow (Frances Mahon Deac)	x		x	x	x	x	x	x				x		x			x	x	x
Glendive Medical Center	x		x	x	x	x	x					x		x		x	x	x	x
Great Falls Benefis	x	21 beds	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x
Great Falls Central MT Surgical			x	x	x	x						x	x				x	x	
Hamilton (Marcus Daly)	x		x	x			x					x		x		x			x
Hardin (Big Horn Memorial)	x		x	x										x					x
Harlem	no report																		
Harlowton (Wheatland Mem)			x		x									x					
Havre (Northern MT Hospital)	x	5 behav.	x	x	x	x	x					x		x		x	x		x
Helena (Fort Harrison VA)		x	x	x			x			x		x	x	x		x	x	x	x
Helena (St. Peter's)	x	safe rm	x	x	x	x	x	x		x		x	x	x		x	x	x	x
Helena (Shodair Children's)		88 beds																	
Jordan (Garfield County Health Cntr)			x											x					
Kalispell (Healthcenter NW)			x	x	x	x						x				x	x	x	
Kalispell Regional Medical Center	x	16 beds	x	x	x	x	x	x		x	x	x	x			x	x	x	x
Lame Deer	no report																		
Lewistown (Central MT Med)	x		x	x	x	x	x	x				x	x	x		x	x	x	x
Libby (St. John's Lutheran Hospital)	x	x	x	x	x	x	x					x				x	x	x	x
Livingston Healthcare	x		x	x	x		x	x				x				x	x	x	x
Malta (Phillips County)			x		x		x	x							x	x			x
Miles City (Holy Rosary Hospital)	x		x	x	x	x	x	x				x		x	x	x	x		x
Missoula Community	no report																		
Missoula St. Patrick		34 beds	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x
Philipsburg (Granite Co. Med)			x											x	x			x	x
Plains (Clark Fork Valley Hosp.)	x		x	x			x			x		x		x	x	x	x		
Plentywood (Sheridan Mem.)	x		x	x	x		x	x						x		x	x		x

Montana Hospitals and Critical Access Hospitals by Types of Services Offered

Inpatient Service Types	Obstetrics	Psychiatric services/ beds	General Medical	Surgical	Pediatric medical	Pediatric surgical	General ICU	Cardiac ICU	Pediatric ICU	Cardiology	Open-heart surgery	Orthopedics	Neurology	Skilled nursing	Acute LTC	Hospice/ palliative care	Infection isolation room	Pain Management	Physical Rehabilitation	
Polson (St. Joseph)	x		x	x	x	x						x			x		x	x	x	
Poplar	no report																			
Red Lodge (Beartooth Hospital)			x				x							x		x			x	
Ronan (St. Luke Community Hospital)	x		x	x	x	x						x		x			x	x	x	
Roundup	no report																			
Scobey (Daniels Memorial Healthcare)			x		x									x						
Shelby (Marias Medical Center)	x	x	x	x	x		x	x		x				x	x	x	x	x	x	
Sheridan (Ruby Valley)		stabilize*	x		x		x							x						
Sidney	no report																			
Superior (Clark Fork Valley)	x		x	x			x			x		x		x	x	x	x			
Terry (Prairie Community Health Cntr)			x											x	x					
Townsend			x		x									x			x		x	
Warm Springs (MT State Hospital)		174 beds 35 behav.																		
Whitefish	no report																			
White Sulphur Springs (Mntnview Med Cntr)			x		x									x	x		x		x	
Wolf Point	no report																			
*stabilize and transfer																				
Colored lines reprsent: yellow - critical access hospitals; blue - larger hospitals; orange - state hospital; peach - Veterans hospital; purple - for profit hospital; white - no response to survey																				

Montana Hospitals and Critical Access Hospitals by Types of Services Offered

Outpatient Services	Alternative medicine	Alzheimer center	Angioplasty	Arthritis center	Bariatric weight center	Breast cancer screening	Cardiac catheterization	Dental services	Dermatology	Diabetes management	Ear, nose, and throat	ECS lithotripsy	Emergency	Endoscopy	Fertility counseling	Gastroenterology	Geriatric
Anaconda (Community Hospital)																	
Baker (Fallon Medical Complex)						x							CAH	x			
Big Sandy Medical Center													CAH				
Big Timber																	
Billings Clinic	x		x	x		x	x		x	x	x	x	LV2	x	x	x	x
Billings (St. Vincent's)	x	x	x	x	x	x	x	x	x	x	x		LV3	x		x	x
Bozeman Deaconess	x		x			x	x	x		x		x	LV3	x		x	
Browning																	
Butte (St. James Healthcare)			x				x					x	x	x			
Chester (Liberty Medical Cntr)						x				x	x		CAH	x			
Choteau (Teton Medical Cntr)						x				x			CAH				
Circle																	
Columbus																	
Conrad (Pondera Med Cntr)						x				x	x		CAH	x	x		x
Crow Agency																	
Culbertson																	
Cut Bank																	
Deer Lodge																	
Dillon (Barrett Hospital & Healthcare)						x			x	x	x		CAH	x			
Ekalaka (Dahl Memorial Healthcare)											x		CAH				
Ennis																	
Forsyth (Rosebud Health CC)						x							CAH	x			
Fort Benton (Missouri River Med Cntr)													CAH				x
Glasgow (Frances Mahon Deac)					x	x			x	x	x		CAH	x	x	x	x
Glendive Medical Center						x			x	x	x		CAH	x	x		x
Great Falls Benefis		x	x		x	x	x		x	x	x	x	LV2	x		x	x
Great Falls Central MT Surgical																	
Hamilton (Marcus Daly)						x							CAH	x	x		
Hardin Ibig Horn County Mem)													CAH				
Harlem																	
Harlowton (Wheatland Mem)													CAH				
Havre (Northern MT Hospital)						x				x			x	x		x	
Helena (Fort Harrison VA)	x					x	x	x	x	x	x	x	x	x		x	x
Helena (St. Peter's)			x			x	x			x	x	x	x	x		x	
Helena (Shodair Children's)																	
Jordan (Garfield County Health Cntr)																	
Kalispell (Healthcenter NW)						x		x	x		x	x	x	x			
Kalispell Regional Medical Center	x		x			x	x	x	x	x	x	x	x	x	x	x	x
Lame Deer																	
Lewistown (Central MT Med)						x			x	x	x		x	x		x	x
Libby (St. John's Lutheran Hospital)						x			x	x	x		CAH	x	x	x	x
Livingston Healthcare						x				x	x		CAH	x	x		
Malta (Phillips County)									x	x	x		CAH	x			x
Miles City (Holy Rosary Hospital)						x			x	x	x		x	x		x	
Missoula Community																	
Missoula St. Patrick			x		x	x	x			x		x	LV2	x			
Philipsburg (Granite Co. Mem)										x			CAH				
Plains (Clark Fork Valley Hosp.)										x			CAH	x			
Plentywood (Sheridan Mem.)						x							CAH	x			
Polson (St. Joseph Hospital)						x					x		CAH	x		x	x
Poplar																	
Red Lodge (Beartooth Hospital)						x				x			CAH	x		x	
Ronan (St. Luke Community Hospital)						x							CAH	x			x
Roundup																	
Scobey (Daniels Memorial Healthcare)													CAH				
Shelby (Marias Medical Center)										x			CAH	x		x	
Sheridan (Ruby Valley)													CAH				
Sidney																	
Superior (Clark Fork Valley)										x			CAH	x			
Terry (Prairie Community Health Cntr)													CAH				
Townsend (Broadwater Health Center)													CAH				x
Warm Springs (MT State Hospital)																	
Whitefish																	
White Sulphur Springs (Mntnview Med Cntr)										x			CAH			x	
Wolf Point																	

Montana Hospitals and Critical Access Hospitals by Types of Services Offered

Outpatient Services	HIV-AIDS services	Home health services	Kidney dialysis	Laboratory services	Oncology services	Opthalmological	Orthopedics	Physical rehabilitation	Podiatry	Reconstructive surgery	Sleep center	Smoke cessation assistance	Sports medicine	Urology	Women's health services	Wound mngmt
Anaconda (Community Hospital)																
Baker (Fallon Medical Complex)	x	x		x				x							x	
Big Sandy Medical Center		x		x												
Big Timber																
Billings Clinic	x		x	x	x	x	x	x	x		x	x	x	x	x	x
Billings (St. Vincent's)	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x
Bozeman Deaconess				x	x		x	x			x	x		x	x	x
Browning																
Butte (St. James Healthcare)		x	x	x	x			x					x			
Chester (Liberty Medical Cntr)				x	x		x	x	x		x			x	x	
Choteau (Teton Medical Cntr)		x		x		x	x	x				x	x		x	
Circle																
Columbus																
Conrad (Pondera Med Cntr)		x		x				x	x		x	x			x	x
Crow Agency																
Culbertson																
Cut Bank																
Deer Lodge																
Dillon (Barrett Hospital & Healthcare)		x		x			x	x	x		x	x	x	x		x
Ekalaka (Dahl Memorial Healthcare)				x												
Ennis																
Forsyth (Rosebud Health CC)				x				x								
Fort Benton (Missouri River Med Cntr)		x						x								
Glasgow (Frances Mahon Deac)				x	x		x	x	x		x	x	x	x	x	x
Glendive Medical Center		x		x	x	x	x	x	x			x		x	x	x
Great Falls Benefis	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Great Falls Central MT Surgical																
Hamilton (Marcus Daly)		x		x		x	x	x		x			x	x	x	
Hardin Ibig Horn County Mem)				x			x	x				x				
[redacted]																
Harlowton (Wheatland Mem				x												
[redacted]		x	x	x	x	x	x	x	x		x					x
Helena (Fort Harrison VA)	x	x		x	x	x	x	x	x		x	x		x	x	x
Helena (St. Peter's)	x	x	x	x	x		x	x		x	x	x	x	x	x	x
Helena (Shodair Children's)																
Jordan (Garfield County Health Cntr)																
Kalispell (Healthcenter NW)				x		x	x		x	x				x	x	x
Kalispell Regional Medical Center		x	x	x	x	x	x	x	x	x		x		x	x	x
Lame Deer																
Lewistown (Central MT Med)		x		x	x	x	x	x	x		x		x	x		x
Libby (St. John's Lutheran Hospital)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Livingston Healthcare		x		x	x		x	x			x	x	x		x	x
Malta (Phillips County)		x		x	x		x	x	x						x	
Miles City (Holy Rosary Hospital)				x	x	x	x	x			x	x	x	x	x	x
Missoula Community																
Missoula St. Patrick			x	x	x			x			x	x			x	x
Philipsburg (Granite Co. Mem)				x				x							x	
Plains (Clark Fork Valley Hosp.)		x		x		x	x	x	x		x	x			x	
Plentywood (Sheridan Mem.)		x		x				x								
Polson (St. Joseph Hospital)		x		x		x	x	x					x	x	x	
Poplar																
Red Lodge (Beartooth Hospital)		x		x			x	x				x	x			
Ronan (St. Luke Community Hospital)				x			x	x				x	x		x	
Roundup																
Scobey (Daniels Memorial Healthcare)		x		x				x								x
Shelby (Marias Medical Center)		x		x				x	x		x	x		x	x	x
Sheridan (Ruby Valley)				x				x								
Sidney																
Superior (Clark Fork Valley)		x		x		x	x	x	x		x	x			x	
Terry (Prairie Community Health Cntr)				x												
Townsend (Broadwater Health Center)				x				x	x							
Warm Springs (MT State Hospital)																
Whitefish																
White Sulphur Springs (Mntnview Med Cntr)				x		x	x	x								
Wolf Point																

Appendix I
Hospitals and health care facilities by physician employment situation, etc.

Hospitals and Health Care Facilities by Physician Employment Situation, Nurse Staffing, Admissions, Outpatient Procedures, ER Visits, Operating Rooms, and Births

Hospitals with 100 or more inpatient beds	# of employed physicians	# of physicians not employed	# of contract physicians	# of locum tenem physicians	# of staff "travelers"	# of full-time/part-time RNs	# of full-time/part-time LPNs	# of Admissions*	# of Outpatient Procedures	# of ER Visits	# of Operating Rooms	# of Births
Billings Clinic - 272 beds	179	217	217	no report	no report	337/162	173/38	13,947	no report	31,222	12	1,307
Billings (St. Vincent Healthcare) - 314 beds	110	112	40	0	no report	306/128	57/19	13,943*	2,523	26,109	10	1,296
Butte (St. James Healthcare) - 100 beds	4	75	4	44	no report	93/24	13/0	4,893	54,752	14,542	6	492
Great Falls Benefis - 511 inpatient, 19 outpatient beds	15	156	39	0-2 average	0	238/352	42/44	14,286	124,381	38,463	13	1,406
Kalispell Regional Medical Center - 110 beds	0	166	0	0	0	186/133	8/1	7,952	2,439	24,270	7	954
Missoula Community Hospital												
Missoula St. Patrick Hospital - 237 beds	0	230	37	3	0	362/116	37/15	8,585	145,438	24,031	9	0
Warm Springs (MT State Hospital) - 174 beds	10.9	0	0	0	0	39.4/8	24/0	682	0	0	0	0
Hospitals with 75 to 99 beds												
Bozeman Deaconess - 86 beds	30	77	32	9	0	108/115	15/3	6,078	no report	23,270	7	1,245
Helena (St. Peter's Hospital) - 99 beds	34	120	0	1	0	no report	no report	5,200	no report	22,925	4	832
Helena (Shodair Children's Hospital) - 88 beds	11	0	0	0	0	16/12	14/7	666	0	0	0	0
Hospitals with 46-74 beds												
Havre (Northern MT Hospital) - 49 acute beds	22	38	6	23	55	103/32	9/6	2,823	77,852	9940	3	388
Helena (Fort Harrison VA) - 50 beds	na	133	32	0	0	88/28	47/5	528	na	1,483	3	na
Lewistown (Central MT Medical Center) - 47 beds	4	12	0	10	0	16/24	4/2	1,148	749	5,014	2	96
Miles City (Holy Rosary Hospital) - 49 beds	3	13	0	0	0	51/39	0/2	1,922	45,000	3,970	3	285
Hospitals with 25-45 beds												
Baker (Fallon Medical Complex)	1	6	1	2		8/4	1/1	258	30	930	1	0
Glasgow (Frances Mahon Deaconess) - 25 beds	7	17	2	0	10	39/10	4/1	951	960	3,315	3	186
Glendive Medical Center - 25 beds	9	2	0	0	1	34/15	3/5	938	32,356	3,873	2	100
Great Falls (Central MT Surgical Hosp) - 20/11	0	93	0	0	0	16/4	1/0	707	1,212	0	3	0
Hamilton (Marcus Daly) - 25 beds	11	11	7	2	0	48/27	13/5	2,098	27,.238	8,903	3	149
Hardin (Big Horn County Mem) - 25 beds	0	4	0	0	0	10/5	7/3	278	15	3,094	no report	29
Harlowton (Wheatland Mem) - 25 beds	5	0	0	0	0	5/6	1/1	68	13,845	572	0	na
Jordan (Garfield County Health Center) - 28 beds	0	1 PA	2	0	0	2/2	1/0	10	0	151	0	0
Libby (St. John's Lutheran Hosp.) - 25 beds	6	11	2	0	0	no report	no report	1,099	no report	5,956	3	86
Livingston HealthCare - 25 beds	15	28	1	2	0	51/26	11/3	1,226	997	6,093	2	151
Ronan (St. Luke Community Hospital) - 25 beds	11	23	5	0	0	29/21	2/5	921	40,879	8,284	2	169
Shelby (Marias Medical Center) - 25 beds	0	~14	0	0	0	7/8	6/5	513	no report	2,434	no report	28
White Sulphur Springs (Mountainview Med Cntr)-25 beds	3	1	0	1	0	3/7	2/1	70	47	699	no report	0
Hospitals with 2-24 beds												
Big Sandy Medical Center - 8 beds	1	2	0	0	0	8/3	0/0		0	273	0	0
Chester (Liberty Medical Center) - 11 beds	3	24	0	0	0	4/2	1/1	148	145	461	1	0
Choteau (Teton Medical Center) - 12 beds	0	1	0	3	3	6/2	5/1	278	6,054	780	0	0
Conrad (Pondera Medical Cntr) - 20 beds	4	8	0	0	0	19/0	6/--	335	6,688	2,422	1	45
Dillon (Barrett Hospital & Healthcare) - 20 beds	5	22	10	0	2	18/12	3/3	730	23,000	3,800	2	82
Ekalaka (Dahl Memorial Healthcare) - 8 inpt, 2 outpt	1	0	0	0	0	3/1	2/0	18	no report	128	0	0
Forsyth (Rosebud Health Care Cntr) - 11 beds	0	1	0	0	0	4/1	0/0	469	0	1,597	0	0
Fort Benton (Missouri River Med Cntr) - 11 beds	2	1	1	0	0	7/4	3/4	159	no report	528	no report	0
Kalispell (Healthcenter NW) - 12 beds	0	154	0	0	0	10/31	2/1	955	5,537	0	6	0
Malta (Phillips County) - 6 inpt/6 outpt beds	1	no report	0	0	0	5/1	2/--	222	64	915	0	1
Philipsburg (Granite County Mem) - 9 beds	0	3	1	0	0	3/1	2/0	51	no report	241	0	0
Plains (Clark Fork Valley Hosp.) - 16 beds	4	26	1	2	0	20/2	4/3	656	0	2,602	2	50
Plentywood (Sheridan Mem) - 19 beds	1	10	4	2	no report	4/11	2/0	334	56	824	1	21
Polson (St. Joseph Hospital) - 22 beds	10.5	0	1	1	0	35/14	2/0	627	41,624 visits	5,316	2	153
Red Lodge (Beartooth Hospital & Health Cntr) - 22 beds	0	5	0	1	0	10/7	3/1	208	88	1,743	1	0
Scobey (Daniels Memorial Healthcare Cntr) - 24 beds	1	1	0	0.03	1	8/9	1/3	95	0	381	0	0
Sheridan (Ruby Valley) - 10 beds	1	3	no report	no report		5/0	3/0	336	no report	670	no report	na
Superior (Clark Fork Valley) - 16 beds	4	26	1	2	0	20/2	4/3	656	0	2,602	2	50
Terry (Prairie Community Health Cntr) - 21 beds	0	0	1	1	0	5/5	0/0	78	no report	158	no report	0
Townsend (Broadwater Health Center) - 9 beds	0	2	0	0	0	4/3	6/3	100	1,500	886	0	0
*Discharges instead of admissions												
Non-Hospital Facilities with Outpatient Beds												
Billings Advanced MRI	0	0	1	0	0	0/1	no report	na	~1400/year	0	na	na
Billings Cataract & Laser Clinic	0	0	0	0	0	0/3	0/0	590 outpt	637	0	1	na
Billings (Northern Rockies Surgery Center)	0	0	0	0	0	8/4	no report	2,161	2,161	0	4	0
Billings (Yellowstone Surgery Center)		81				30/3		7,553	7,553	na	7	na
Bozeman (Same Day Surgery Center)	0	3	0	0	0	1/7	0/0	1,113		0	2	na
Butte (Summit Surgery Center)	0	0	0	0	0	4/1	0/0	1,891	1,891	0	3	na
Great Falls Clinic Surgery Center	0	35	0	0	0	2/7	0/1	3,370	3,058	0	3	0
Helena Surgi Center	0	35	0	0	0	6/9	0/0	3,020	0	0	2	0
Kalispell (Orthopedic Surgery Center)	0	9	0	0	0	3/8	0/0	2,462	2,462	na	2	na
Missoula Bone and Joint (Inpatient beds - 4, outpatient 3)	0	0	8	0	0	7/4	0/0	1,700		0	2	0
Missoula (Providence Surgery Center)	no report								2,585	no report	2	na
Missoula (Rocky Mountain Eye Center)	0	6	0	0	0	--/7			2,963	0	2	na
Missoula (Rocky Mntn Women's Health Cntr- The Birth Center)	0	2	0	0	0	1/--	1/--	no report	no report	0	no report	431

NOTE 1: Hospitals and health care facilities not listed here were either: 1) not included because of a difficulty in finding them; or 2) did not respond to the survey. NOTE 2: Regions are somewhat arbitrary.

Appendix J
Health care facility ownership, imaging services, revenue from payers by region

Health Care Facility Ownership, Imaging Services, Revenues from Payers by Region

			Imaging Services							Percentage of Revenues**							
Provider	Profit/NFP Other	Ownership	CT Scans	Diagnostic Radioisotopes	PET Scans	MRI	Multislice Spiral CT	Ultrasound	Other	Commercial Insurance	Medicare	Medicaid	Self-pay	Workers' Compensation	Military Insurance	Indian Health Service	Other
South Central/ South East																	
Baker (Fallon Medical Complex	NFP	na	x			x		x		24%	42%	22%	11%	1%	0%	0%	
Big Sky Diagnostic Imaging	Profit	Physicians 61% Other holders 35% Principals/holders 4%	x			x		x		53%	35%	4%	2%	4%	1%	0%	attorney/motor vehicle insurance 1%
Billings Advanced MRI	Profit	Physicians 45% Other Holders 1.25% Principals/owners 54.75%				x				47.5%	25%	5%	15%	5%	2.5%		
Billings Cataract & Laser Center	Profit	Physicians 100							OCT	30.5%	47%	2%	14%	1%	0.5%	5%	
Billings Clinic	NFP	na	x	x			x	x		36.7%	42.2%	6.9%	9.4%	w/ other	w/ other	w/other	4%
Billings (Northern Rockies ASC)	Profit	Physicians 20.25% Surgical Care Affiliates 79.75%	no report	no report						47%	40%	6%	4%	3%	Included in commercial insurance		
Billings (St. Vincent Healthcare)	NFP	na	x	x	x	x	x	x		32.3%	44.3%	9.1%	7.3%	3.2%	0.7%	1.4%	1.7%
Billings (Yellowstone ASC)	Profit	Physicians 50% Other Holders 50%	no report							34%	15%	4%	5%	9%	<1%	<1%	2%
Ekalaka (Dahl Memorial)	NFP	na								38%	13%	39%	5%	5%			
Forsyth (Rosebud Health Care Cntr)	NFP	na	x							26%	62%	2%	8%				
Glendive Medical Center	NFP	na	x	x		x	x	x		no report							
Hardin (Big Horn Cnty Mem Hosp)	NFP	na	x				x	x		16%	39%	27%	13%	1%	1%	2%	1% contract, local businesses
Harlowton (Wheatland Memorial)	NFP	na	x	x				x		16.7%	37.7%	21.9%	19%	0.3%	1%		
Livingston HealthCare	NFP	na		x		x	x	x	dexascan	32%	44%	6%	13%	4%	1%	0%	
Miles City (Holy Rosary Hosp)	NFP	na	x			x	x	x		34.6%	42.6%	10.6%	3.7%	4%	4%	0.5%	
Red Lodge (Beartooth)	NFP	na	x					x		29%	40.7%	14.7%	12.6%	2.1%	0%	0%	0.9% government
Terry (Prairie Community Health Cntr)	NFP	na							basic radiology	20%	25%	26%	26%	0.01%	2%	0%	0%
White Sulphur Springs (Mntnview Medical Cntr)	NFP	na							gen'l radiology	19%	49%	20%	12%	0%	0%	0%	0%
Southwest																	
Bozeman Deaconess Hosp.	NFP	na	x	x	x	x	x	x		47.1%	35.4%	5.1%	7.0%	4.0%	1.0%	0.4%	
Bozeman (Same Day Surgery)	Profit	Physicians 100%	no report							27.5%	69.4%	1.5%	1.4%	0.1%	0%	0.1%	
Butte (Sound Health Imaging)	Profit	Other holders 50% Principals/owners 50%						x		69%	3%	21%	9%	0%	0%	1%	1.4% accident
Butte (Summit Laboratory)	Profit	Physicians 100%	na							33%	35%	20%	10%	2%	-	-	
Butte (St. James Healthcare)	NFP	na	x	x	x	x	x	x		28.4%	44.8%	11.3%	7.9%				7.6% managed care
Butte (Summit Surgery Center)	Profit	Physicians 50% Other holders 50%	no report							32%	42%	6%	7%	10%	2%	0%	1% charity
Dillon (Barrett Hospital)	NFP	na	x	x		x	x	x		40%	47%	6%	7%	0%	0%	0%	
Helena (Elkhorn Mntn Cytology)	Profit	Other holders 100%	na							49%	12%	18%	17%	-	2%	2%	
Helena (Shodair Hospital)	NFP	na	no report							32.8%	0.8%	57.5%	3.3%	0.0%	5.5%	0.0%	0.2% charity
Helena (Sound Health Imaging)	Profit	Other holders 50% Principals/owners 50%						x		88%	2%	7%	5%				
Helena (St. Peter's Hospital)	NFP	na	x	x	x	x	x	x		40.4%	42.1%	8.4%	5.4%	0.5%			2.5% misc.
Helena Surgi Center	Profit	Physicians 50% Other holders 50%							X-rays during surgery	50%	31%	7%	3%	6%	3%		
Helena (Veterans Admin Hosp)	G'vt	na	x	x		x	x	x		0%	0%	0%	0%	0%	0%	0%	VA
Philipsburg (Granite Cnty Med Cntr)	NFP	na							flat x-ray	6%	41.95%	32.52%	17.8%	1.73%	0%	0%	
Sheridan (Ruby Valley Hosp)	NFP	na						x		25%	62%	2%	7%	2%	2%	0%	
Townsend (Broadwater Health)	NFP	na							Simple X-ray	8%	55%	20%	12%	4%	1%	0%	0%
Warm Springs (MT State Hosp)	State	State	no report	no report						5%	35%	15%	5%	0%	<2%	<5%	Montana Counties

Health Care Facility Ownership, Imaging Services, Revenues from Payers by Region

			Imaging Services							Percentage of Revenues**							
Provider	Profit/NFP Other	Ownership	CT Scans	Diagnostic Radioisotopes	PET Scans	MRI	Multislice Spiral CT	Ultrasound	Other	Commercial Insurance	Medicare	Medicaid	Self-pay	Workers' Compensation	Military Insurance	Indian Health Service	Other
Northwest																	
Hamilton (Marcus Daly Hosp)	NFP	na	x			x	x	x		26.87%	49.37%	8.68%	11.66%				3.42% Gov't & other
Kalispell (Healthcenter NW)	Profit	Physicians 39.994% Other holders 60.006%	x		x	x	x	x	mammography, needed guided biopsy & localization, gen'l diagnostic	38.1%	37.5%	5.4%	11.8%	5.1%	0.2%	0.4%	1.4% attorney, client, EMASH, MVA, pending charity
Kalispell (Orthopedic Surgery Cntr)	Profit	Physicians 100%							Fluoroscopy, arthrograms	49.8%	23.8%	1.9%	3.4%	18.0%	0.9%	1.0%	1.4% accident
Kalispell Regional Med. Cntr	NFP	na	x	x	x	x	x	x		26.39%	47.56%	9.26%	8.66%	2.18%	1.69%	1.29%	AG/MVA 2.97%
Libby (St. John's Lutheran Hosp)	NFP	na	x	x		x	x	x		21%	64%	5%	3%	1%			6%
Missoula Bone and Joint	Profit	Physicians 100%				x			X-ray	40%	20%	4%	4%	15%	0%	0%	
Missoula (Providence Surgery)	Profit	Physicians 49% Other holders 51%	no report							44.33%	31.22%	9.52%	4.53%	8.78%		0.23%	1.39% auto
Missoula (Rocky Mntn Eye Cntr)	Profit	Physicians 100%	no report							38%	58%	0.5%	3%	0.3%	0.1%	0.2%	
Missoula (Rocky Mntn Women's Health - The Birth Center)	Profit	Physicians 100%						x		30%	1%	60%	5%		2%	2%	
Missoula (St. Patrick Hosp.)	NFP	na	x	x	x	x	x	x		29.3%	55.3%	5.2%	5.9%				4.3% work comp, HIS, other gvt
Plains (Clark Fork Valley Hosp.)	NFP	na	x			x	x	x		20.4%	49.4%	16.2%	9.8%	1.3%	1.8%	1.1%	
Polson (St. Joseph Hospital)	NFP	na	x			x	x	x	Echocardio	4%	44%	14%	5%	w/ other	1% (gvt)	5%	27% BCBS, PPO, & other work comp
Ronan (St. Luke Com.Hosp)	NFP	na	x			x	x	x		24.85%	28.9%	24.4%	9%	2.6%	0.65%	10%	
North Central/ Central/North East																	
Big Sandy Medical Center	NFP	na	no report		na	na	na	na		11%	65%	3%	21%				
Chester (Liberty Medical Cntr)	NFP	na	x					x		35%	32%	4%	28%	0.5%	0.5%	0%	0%
Choteau (Teton Medical Cntr)	NFP	na							gen'l x-ray, dexascan	10%	81%	2%	4%	3.0%			
Conrad (Pondera Medical Cntr)	NFP	na	x	x				x		30%	47%	8%	15%				
Fort Benton (Missouri River Med Cntr)	NFP	na	no report							7%	87%	3%	4%				
Glasgow (Frances Mahon Deac. Hosp)	NFP	na	x	x		x	x	x		30%	43%	13%	6%	1%	1%	5	1% Veterans
Great Falls Benefis	NFP	na	x	x	x	x	x	x	cyberknife	28%	48%	12%	4%	2%	4%	2%	
Great Falls Central Med Surg. Hosp	Profit	Physicians 50% Principal/owners 50%	no report							51%	30%	5%	2%	6%	6%	0%	0%
Great Falls Clinic Surgery Center	Profit	Physicians 50% Principal/owners 50%	no report							29%	45%	7%	12%	1%	6%		
Havre (Northern MT Hospital)	NFP	na	x	x		x	x	x	mammography, diagnostic radiology	25.76%	35.83%	20.46%	9.42%	1.41%	0.82%	5.90%	
Jordan (Garfield Cnty Health Cntr)	NFP	na							X-ray	no report							
Lewistown	NFP	na	x	x	x	x	x	x		2%	51%	27%	18%	1%	1%		
Malta (Phillips County Hospital)	NFP	na	x						computerized radiography	15%	47%	3%	35%				
Plentywood (Sheridan Memorial)	NFP	na	x			x	x	x		13%	41%	21%	24%	1%			
Scobey (Daniels Memorial)	NFP	na		x						23%	69%	2%	5%	0%	0%	0%	0%
Shelby (Marias Medical Cntr)	NFP	na	x			x		x	Nuke Med, Ultrasound Mamo	15%	60%	5%	10%	5%	3%	2%	0%
NOTE 1: NFP = not for profit																	
NOTE 2: **By taking percentage of revenues, rather than patients eligible for certain insurance programs, the figures do not reflect any write-offs providers may make if the patient is unable to make up the difference.																	