This report provides summary information for the utilization and financial performance for the hospital industry overall, and the impact on Montana hospitals of Medicaid expansion. The report does not isolate the impact of Medicaid expansion since there are many other factors influencing health care. Rather, this data reveals how Medicaid expansion fits within the overall hospital sector. The report compares the 12 months ending September 30, 2017 with the 12 months ending September 30, 2016.

This analysis relies upon data from the MHA Databank Program. There are 34 Montana hospitals with data reported for both time periods. There are 8 hospitals and 26 critical access hospitals represented in the database. These 34 hospitals represent just over 50% of total hospital revenue, expense and service utilization. As such, the data provide a fair representation of the hospital market overall. The data are self-reported and are not subject to audit. New to this report are Northeast Montana Health Services in Wolf Point and Poplar, and Rosebud Health Center in Forsyth. A list of participating hospitals is included with the report.

Billings Clinic, Benefis Health System (Great Falls), Bozeman Health have not reported to the database. Critical access hospitals including Big Horn Memorial Hospital (Hardin) and Glendive Medical Center are not included.

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Executive Summary

Hospitals reported nearly breaking even on patient services revenue in this period, posting a 0.5% loss on patient care. This is a significant improvement over 2016 when hospitals reported a 4% loss on patient services. Total margin, which includes revenues from sources other than patient care, increased to 6.2%. Critical access hospitals continued to experience lower financial results, posting a 10.9% loss on patient care, and a total margin just below breakeven at minus .2%.

Uncompensated care continued to fall as hospitals reported charity and bad debt costs fell below 2.5% of gross patient charges. Charity and bad debt fell by 32% in 2017 over the same period in 2016. Uncompensated care fell by 45% in the previous year.

Hospital operating expense per adjusted day increased by 1.96% in 2017, following a 7.31% increase over 2015. Net patient revenues increased 11% over 2016, following an increase of just 2.2% over 2015. Total expenses grew by 7.48% over 2016, with payroll costs climbing by 7.8% and other costs, including medical supplies and pharmaceuticals increasing by similar amounts. Hospitals supplied 1.7% more inpatient stays corresponding to a 2.8% increase in total acute patient days. Hospitals reported a 2% reduction in overall outpatient visits, but emergency department visits increased 2.3% and ambulatory surgery visits by 12.7%.

Expanded Medicaid coverage continues to be an important change to Montana's health care providers.

Revenues and Payer Mix

Net patient revenues increased by 11.7% to $2.17 billion, compared to $1.94 billion in 2016. But discounts to payers grew even faster, increasing by 12.9%. See Table 1. This phenomenon occurs when payers like Medicare and Medicaid provided almost no rate increase, and major insurers insist on steeper discounts. Hospital revenue gains were offset by higher treatment costs, and policy changes including the requirement to accept Medicaid payment amounts for treating persons being treated in state and local institutions and prisons as part of the legislation to expand Medicaid coverage.

Table 1	CAH			Hospitals			All Facilities		
Revenues (in $000s)	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**
Inpatient	209,532	199,407	5.08%	1,638,417	1,516,210	8.06%	1,847,949	1,715,617	7.71%
Outpatient	742,182	664,550	11.68%	2,132,212	1,891,441	12.73%	2,874,394	2,555,991	12.46%
Deductions	314,540	278,563	12.91%	2,066,049	1,830,142	12.89%	2,380,589	2,108,705	12.89%
Charity/Bad Debt	31,049	50,302	-38.28%	85,104	119,729	-28.95%	116,154	170,031	-31.69%
Net Patient Rev	**606,125**	**535,092**	**13.27%**	**1,619,476**	**1,403,661**	**11.58%**	**2,225,600**	**1,992,872**	**11.68%**

Persons who may have carried private commercial insurance on the ACA exchange, whose incomes were within 100 – 138% of federal poverty level are now eligible for Medicaid. Moving from commercial coverage to Medicaid means that a hospital is paid below the cost to provide care rather than at amounts above treatment costs.

MHA expects that most, if not all, of the income gains will be eliminated by recent payment cuts announced by Montana Medicaid. Critical access hospital payments will drop by 2.99% beginning January 1, 2018, worsening the loss on patient services. Hospitals also face the 2.99% reduction in January, and an additional 5% reduction to inpatient care and 10% reduction to outpatient payments. Other policy changes will further reduce payments for specific services delivered in hospital clinics.

The most significant changes in payer mix include the significant increase in Medicaid, coupled with a steep decline in self-pay and an additional drop in the share of hospital care consumed by those with commercial insurance. See Table 2. Medicaid has more than 91,000 people enrolled in the expansion population. The percent of total patient charges attributed to Medicaid jumped 21% over 2016 to

Table 2	CAH			Hospitals			All Facilities		
Payer Mix (% of Total Patient Charges)	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**
Medicare	41.47%	41.21%	0.63%	47.30%	45.64%	3.64%	46.10%	44.72%	3.09%
Medicaid	19.45%	16.29%	19.40%	17.34%	14.21%	22.03%	17.78%	14.64%	21.45%
Self-Pay	4.49%	5.76%	-22.05%	1.74%	2.62%	-33.59%	2.31%	3.27%	-29.36%
All Other	34.59%	36.74%	-5.85%	33.62%	37.54%	-10.44%	33.82%	37.37%	-9.50%

17.78% of total charges, while the self-pay category dropped 29.3% to 2.31%.

Other commercial and government payers dropped by 9.5% to 33.8% of total charges. Medicare remained the single largest payer with a 46.1% share of the total patient charges, 3% more than in 2016.

Hospitals now depend on Medicare and Medicaid – two payers whose rates are set below the cost to provide care - for about 64% of all revenue. The increased reliance on the government programs is mitigated by lower charity and bad debt costs.

Some policymakers predicted that expanding Medicaid coverage would produce a financial windfall for all hospitals as formerly uninsured patients would have a pay source. Instead, the data show a combination of positive and negative changes in the revenue picture. Uninsured patients gaining Medicaid coverage has no doubt produced additional revenue for hospitals. This change is offset by some patients covered by commercial insurance prior to expansion becoming Medicaid eligible.

Individual hospitals have reported disparate impacts on financial performance due to expansion. Some hospitals are reporting much improved financial performance, while others have lost ground due to the changes in coverage. Very small rural communities only saw a few people gain coverage, a change that did not provide an impact on frontier hospitals. Overall, the industry has benefitted from the expansion.

The drop in self-pay and commercial insurance offsets the gains attributed to fewer insured patients as higher paying commercial patients are replaced by Medicaid. Medicaid payments to hospitals are set below the cost to provide care.

Uncompensated Care

Uncompensated care includes the charges written off to bad debt and charity care. Bad debt is considered to be those charges left unpaid by patients who could pay, but refuse to do so. Charity care is charges unpaid by patients for whom there is a determination of financial need. Industry experts suggest that much of what is considered to be bad debt may qualify as charity, but there is no determination of financial need. See Table 3.

While the amount of patient charges attributed to bad debt appears to be declining the source of bad debt is changing. The fastest growing source of bad debt today is the considerable out-of-pocket costs borne by patients with large deductible health plans and those plans with significant beneficiary coinsurance. Still more patients bear a higher share of their costs due to so-called skinny provider networks that offer few network opportunities for some patients.

Table 3	CAH			Hospitals			All Facilities		
Uncompensated Care (in $000s)	2017	2016	Percent Change	2017	2016	Percent Change	2017	2016	Percent Change
Charity	9,125	18,886	-51.68%	36,445	65,349	-44.23%	45,571	84,235	-45.90%
Bad Debt	21,923	31,416	-30.22%	48,659	54,380	-10.52%	70,583	85,796	-17.73%
Total	31,048	50,302	-38.28%	85,104	119,729	-28.95%	116,154	170,031	-31.69%

Charity care, reported here as charges, dropped nearly 46% over 2016 amounts, and bad debt has declined by nearly 17% over 2016. The net financial impact is $54 million less in uncompensated care provided by these 34 hospitals. Charity care amounted to 0.9% of gross patient charges, down from 1.9% a year ago. Bad debt is 1.4%, also down from 1.9% of gross charges in the prior year.

Profitability

MHA reports three profitability measures, including patient service margin, operating margin and total margin. Patient service margin is a measure of the profit or loss incurred by the hospital due solely to the revenues collected for providing medical care. This measure can reveal whether payers are being charged, collectively, at rates that are reasonably related to the cost to provide care. See Table 4.

Operating margin includes the revenues earned by other revenue generating activities such as cafeteria sales and rental of office space. Total margin includes gifts and donations to the hospital, local tax subsidies and gains or losses on investments.

Hospitals reported improved financial results in 2017, compared to 2016. Patient service margin improved to -.54% in the period. Patient service margins historically moves within 2% above or below break-even from year to year. This period showed a considerable improvement over the 3.83% loss in 2016.

Table 4	CAH			Hospitals			All Facilities		
Margin	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**
Patient Service Margin	-10.88%	-16.28%	33.17%	3.09%	0.51%	505.88%	-0.54%	-3.83%	85.90%
Operating Margin	-3.87%	-8.81%	56.07%	6.80%	4.52%	50.44%	3.97%	1.00%	297.00%
Total Margin	--0.20%	-4.97%	95.98%	8.49%	6.17%	37.60%	6.16%	3.19%	93.10%

It is reasonable to expect any hospital to earn a 5% return on operations over time. A positive margin provides the funds necessary to boost employee salaries, purchase and replace equipment and provide reserves for future use. Hospitals posted a collective 6.16% total margin in 2017, compared to 3.19% in 2016. But critical access hospitals as a group posted much lower returns in both periods. Montana's rural hospitals continue to face considerable pressure to provide a stable financial operating environment and assure that services are maintained in rural Montana.

This report provides aggregate data for the 34 reporting hospitals. Within this aggregate data individual hospitals may have far different financial performance. Some hospitals may report that the amount of uncompensated care, especially bad debt, has not substantially declined. Some hospitals report that their facilities have produced better financial performance since Medicaid expansion while others have not experienced positive impacts.

The aggregate financial performance shows hospitals must continue to find cost reductions and other operating efficiencies as current payer policies provide little new revenues. Simultaneously, hospital

costs are increasing in part due to additional state and federal government regulatory actions. Hospitals are also facing higher supply costs, including significant cost increases for drugs and medical supplies.

Utilization

Reducing the number of uninsured Montanans – through the establishment of subsidized policies on the insurance exchange and the expansion of Medicaid coverage to low income adults – created an expectation that utilization of medical care would spike and then set in at a more stable, albeit somewhat higher, level. Increased use of health services by newly insured patients is tempered by reduced utilization of those who have insurance, but whose out-of-pocket share of costs is unaffordable.

Inpatient acute hospital admissions increased 1.68% over 2016, while patient days increased by 2.8%. Hospitals provided 3,120,827 outpatient visits during 2017, 2% fewer than 2016. Ambulatory surgery increased by 12.7% to 41,251 procedures and emergency department visits increased to 256,301, a 2.61% increase. See Table 5.

As hospital service volumes increased additional staff and expenses related to medical supplies and other services increased as well.

Table5	CAH			Hospitals			All Facilities		
Utilization (in 000s)	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**	**2017**	**2016**	**Percent Change**
Acute Admissions	14.4	15.0	-3.75%	44.1	42.6	3.59%	58.5	57.6	1.68%
Inpatient Acute Days	58.3	56.3	3.52%	190.3	185..4	2.62%	248.6	241.8	2.83%
ED Visits	100.67	98.23	2.49%	155.63	152.41	2.11%	256.30	250.64	2.26%
Ambulatory Surgery	12.21	11.60	5.31%	29.31	25.24	16.11%	41.52	36.84	12.71%
Outpatient Visits	1,484	1,541	-3.70%	1,637	1,648	-0.65%	3,121	3,189	-2.13%

Hospital Employment

Hospitals, like the various other medical facilities and providers, were expected to increase jobs as more services were demanded by the newly insured. The 34 hospitals included in this report, increased paid hours by 2.6%, or 668,930 additional paid hours in 2017 over 2016. The additional paid hours is equivalent to 321 FTEs.

Hospitals continue to report shortages of licensed personnel, especially registered nurses. Shortages persist in primary care providers, as well as physical, occupational and speech therapists, pharmacists and certified nurse aides.

Overcoming staff shortages is more difficult to in our most rural communities.

Hospitals Reporting to MHA Databank	
Hospital	**Community**
Community Medical Center	Missoula
Kalispell Regional Medical Center	Kalispell
Northern Montana Hospital	Havre
The Health Center	Kalispell
St. Peter's Hospital	Helena
St. James Healthcare	Butte
St. Patrick Hospital	Missoula
St. Vincent Healthcare	Billings

Critical Access Hospitals Reporting to MHA Databank	
Critical Access Hospital	**Community**
Sidney Health Center	Sidney
Roosevelt Medical Center	Culbertson
Providence St Joseph Hospital	Polson
St. Luke's Community Health Network	Ronan
Barrett Hospital and HealthCare	Dillon
Beartooth Billings Clinic	Red Lodge
Benefis Teton Medical Center	Choteau
Northeast Montana Health Services	Wolf Point
Northeast Montana Health Services	Poplar
Cabinet Peaks Medical Center	Libby
Central Montana Medical Center	Lewistown
Clark Fork Valley Hospital	Plains
Community Hospital	Anaconda
Daniels Memorial Healthcare Center	Scobey
Fallon Medical Complex	Baker
Rosebud Health Center	Forsyth
Frances Mahon Deaconess Hospital	Glasgow
Holy Rosary Healthcare	Miles City
Livingston Healthcare	Livingston
North Valley Hospital	Whitefish
Marcus Daly Memorial Hospital	Hamilton
Northern Rockies Medical Center	Cut Bank
Pioneer Medical Center	Big Timber
Roundup Memorial Healthcare	Roundup
Sheridan Memorial Hospital	Plentywood
Stillwater Billings Clinic	Columbus