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Introduction

Whether we're concerned about the quality of our medical treatment, its cost or how we're going to get to where it's provided, for most of us, health care is a very personal issue. But, there's a lot more to health care in Montana.

The health care sector is the largest private employer in the state and accounts for more than 16 percent of the state's domestic product. And the more than 45,000 jobs in hospitals, nursing homes and physicians' offices generate an additional 30,000 jobs in the communities they serve.

Health care programs – chiefly Medicare and Medicaid – are among the largest segments of the state and federal budget, and health care public policy issues are a major item on the agenda for Congress, the Montana Legislature and state and federal regulatory agencies.

Much of the public debate about health care is focused on the cost of health insurance and medical treatment. Recent studies indicate that as health insurance costs have increased, fewer Americans can afford insurance coverage. Meanwhile, increased utilization of health services, driven by an aging population, has contributed to an overall increase in health spending.

Providers have little control over most of their costs, including those for staffing, medical liability insurance, prescription drugs and basic supplies such as utilities.

Montana's health care delivery system faces other challenges, which we have outlined in the following pages. These include ensuring an adequate supply of health care professionals, protecting the community health safety net from those who would cherry-pick profitable services and filling the major gaps in the mental health delivery system.

Protecting the health safety net is potentially one of the most significant new trends in health care. At issue is whether physicians and private for-profit corporations should be able to develop and own specialty hospitals, imaging centers, ambulatory surgery centers and other facilities.

In areas where these facilities have been given free rein, they have attempted to capture the market for procedures that pay well, including imaging services, cardiac and orthopedic procedures and some forms of cancer treatment.

These facilities usually don't provide services that don't pay as well – such as emergency room care and mental health services – nor do they tend to serve a high percentage of Medicaid and indigent patients.

Physician-owned facilities present an additional public policy issue – should physicians with an ownership interest in a hospital, imaging center or other facility be permitted to refer patients to this facility.

Studies are beginning to conclude that physician self-referral can result in increased utilization of services. In addition, development of these facilities drives up health care costs because community hospitals are forced to increase their charges to offset lost revenue that results from skimming the high-paying procedures away from the hospital.

This issue most likely will be the focus for continued federal and state legislative and regulatory action in the months ahead.

MHA's ***Health Care At-A-Glance*** provides a snapshot of Montana's health care system. Our hope is that the information in this book will help readers gain a better understanding of the forces affecting health care in our state, and, thereby, promote a cooperative effort to ensure access to high quality and affordable health care.

The data in the ***Health Care At-A-Glance*** is statewide and national in scope. For a better picture of what is going on locally, readers should visit with the staff and board members at their local hospital, nursing home, home health agency and hospice.

Data for this book was gathered from a variety of sources, including the MHA/AHA Annual Survey of Hospitals for 2005, state and federal agencies and MHA's national strategic partners.

MHA's Public Policy Agenda

MHA has developed a comprehensive agenda to address the public policy challenges facing member facilities and organizations. This includes federal and state legislative and regulatory initiatives in areas listed below and reflects the fact that members provide inpatient and outpatient hospital, nursing home, home health, hospice and physician care.

Equitable Reimbursement Rates. One of the most effective ways to control health care costs is to make sure Medicare, Medicaid and other government insurance programs pay the full cost for treating their beneficiaries. When they don't, providers must recover these unpaid costs by raising rates for privately-insured Montanans.

For this reason, one of MHA's top priorities is to ensure equitable Medicare and Medicaid payment rates. The Medicaid hospital user fee program has significantly reduced the cost-to-payment gap for Medicaid, and the Medicare Modernization Act of 2003 contained several key Medicare payment reforms. However, more remains to be done. Specifically, MHA advocates:

- Annual Medicare and Medicaid reimbursement rate increases for all providers equal to the actual increase in the cost of providing care and preservation of the MMA payment reforms.
- Preservation of the hospital and nursing home user fee programs and continued use of intergovernmental transfers to supplement Medicaid payments to nursing facilities.
- Special payment rate policies that take into account the unique needs of low-cost, low-volume providers in rural states, especially those providing home health and skilled nursing services.
- Additional vehicles to make capital available to rural hospitals to replace and upgrade their aging physical plants.

Strengthening the Health Delivery System. The recent development of for-profit physician-owned specialty hospitals, imaging centers, ambulatory surgery centers and other facilities could pose a grave threat to Montana's health care safety net. Physician owners of these facilities tend to refer higher-paying procedures to their facilities, relegating procedures that don't pay as well to the community hospital.

In our view, physician self-referral raises conflict of interest issues and could lead to inappropriate delivery of care. MHA also is concerned that it will raise the overall cost of health care and could weaken the community health safety net.

A federal moratorium on the licensure of new specialty hospitals expired on August 8, 2006. A state moratorium runs through June 30, 2007.

Several measures are needed to address this problem, including prohibiting physician self-referral, a permanent federal moratorium on licensure of specialty hospitals and more effective approaches to determining the need for niche providers.

An Ample Supply of Health Care Professionals. Ensuring an adequate supply of health care professionals to meet the future health care needs of an aging population will require a major effort involving state and federal officials in partnership with health care providers. Specifically, MHA advocates:

- Increasing the supply of health care workers by expanding current training programs and developing new, innovative ways to train health care professionals.
- Shaping the professional licensure system to today's needs and easing the regulatory and paperwork burdens that take caregivers away from providing care to patients.

Access to Mental Health Services. The mushrooming demand for mental health services has created a crisis at the state hospital in Warm Springs as well as in local hospitals all over the state.

MHA is working with the Department of Public Health and Human Services to develop a comprehensive response to this crisis. This could include providing additional crisis intervention services in local communities as well as expanding the capacity at the state hospital.

The Benefits of Tax-Exempt Status. Recent scrutiny of hospitals' charity care policies and billing and collections practices has stimulated discussion of the responsibilities of tax-exempt health care organizations.

MHA's member organizations – nearly all of which are not-for-profit, community-based entities – recognize their responsibility to serve the health care needs of their communities. MHA strongly advocates preserving the current system that allows not-for-profit health care entities to enjoy a tax exemption in return for their service to their communities.

A Common Sense Regulatory Approach. Even though health care is one of the most highly-regulated sectors of the economy, new regulatory mandates seem to be imposed every year.

While MHA has not advocated repeal of these mandates, we do strongly support efforts to streamline the regulatory process and provide facilities with financial resources to offset the cost of meeting new regulatory requirements. Regulatory compliance falls hardest on small, rural facilities; federal policies should take this into account.

Health Care Coverage for All Montanans. The number of Montanans without health care coverage remains troublingly high, resulting in high levels of charity and uncompensated care and often leads the uninsured to delay or put off appropriate medical attention.

MHA consistently has supported efforts to expand the Children's Health Insurance Program and proposals – such as Insure Montana – that use pooling and tax credits to expand coverage among the state's small businesses and uninsured individuals.

MHA also urges businesses and consumers to join its effort to ensure adequate Medicare and Medicaid reimbursement rates. Ensuring that government payers pay their fair share of the health care tab will help stabilize insurance rates for privately-insured persons.

Social Accountability

Montana's not-for-profit health care providers have a long and rich history of serving the health care needs of their communities. While each is unique in its community, they all hold one characteristic in common: they provide millions of dollars of free and subsidized medical treatment and community services.

All but two of Montana's hospitals are not-for-profit and most of the state's home health and hospice care is provided by not-for-profit organizations.

In 2005, these hospitals provided roughly $60 million in charity care – care delivered to patients whose income is generally below the federal poverty level – and millions more in subsidized care to patients with special financial needs.

Hospitals also provided a host of other services to their communities ranging from supplying ambulances at sporting and other events to special educational sessions and day care services. Montana's not-for-profit nursing homes, home health agencies and hospices provide similar services.

MHA's not-for-profit members differ from for-profit corporations in significant ways. First, a not-for-profit reinvests whatever profits it makes in the organization and the community – rather than paying shareholders.

Second, not-for-profit health care providers often are the only health care organizations willing to locate in Montana's small and rural communities and provide services based on community need rather than profitability.

But while not-for-profit health care providers are the cornerstone of Montana's health care system, they are not held in such high regard elsewhere. Some members of Congress believe the community benefit standards should be more specific and that hospitals should be required to provide a certain percentage of their revenue as charity care.

Others in Washington are pressing the Internal Revenue Service to beef up reporting and disclosure requirements for these providers.

The MHA Board of Trustees has adopted policies that spell out the responsibilities of MHA's not-for-profit members. These specify that members are expected to:

- Provide financial assistance and counseling for uninsured persons of limited means. This includes providing care at no charge for uninsured patients below 100 percent of the federal

poverty level, providing financial assistance to uninsured persons persons between 100 and 200 percent of the FPL and considering offering financial assistance to uninsured patients over 200 percent of the FPL.

- Work with patients to ensure that they understand their bill for services and make sure any debt collection procedures are performed in compliance with the Fair Debt Collection Practices Act and ethical standards for the industry.
- Assess their community's medical needs periodically and compile and report publicly the community benefits they provided in the past year.

MHA also is working on policies aimed at helping patients better understand pricing for their services. MHA already provides some pricing information on its Web site – www.mtha.org – and is working on improvements to that information.

MHA recognizes that consumers often are responsible for choosing where they receive their medical treatment. Our goal is to provide as much information as possible to help them make intelligent choices.

Health Care in Montana's Economy

For years, the conventional wisdom has been that Montana's economy is built around agriculture and the natural resources industries. While that was certainly true at one time, it is no longer the case.

In today's economy, health care is arguably the most powerful economic force in Montana's economy and a key ingredient in any recipe for future economic growth.

According to a 2005 analysis by the University of Montana's Bureau of Business and Economic Research, health care spending totaled $4.9 billion and accounted for more than 16 percent of the State Domestic Product.

The health care industry also is one of the state's largest employers, accounting for more than 45,000 jobs, according to the Montana Department of Labor and Industry's Research and Analysis Bureau.

Anecdotal evidence reinforces these findings. In most communities with a medical facility, health care is the cornerstone of the local economy. The facility usually is one of the largest employers in town – often the largest – and its jobs the highest paying.

Hospitals in Montana's larger communities have become regional centers for specialty medicine, fueling even more economic growth.

The charts in this section illustrate that:

- Hospitals are the largest part of Montana's health care economy, accounting for more than 20,000 jobs.
- Jobs in hospitals grew by 9.6 percent between 2001 and 2005 and jobs in ambulatory settings grew by 10.2 percent during this period. Jobs in health care are projected to continue to grow at this rapid pace for the next decade.
- Average annual wages in ambulatory care and hospital settings are significantly higher than the average for all jobs in the state.

Health Care & Economic Development

Too often we think of health care as just another cost of doing business. While that's certainly true, health care must play another role in our state's economy: as a key element in Montana's economic development strategy.

A sound health care infrastructure is essential to economic development. Businesses won't locate in Montana or expand once they're here if the health care system is substandard. Nor will retirees locate here if they the health care system doesn't provide the kinds of medical services they need.

For these reasons, MHA continues to urge policymakers to invest in the state's health care infrastructure – it's good for business and good for our seniors.

The charts show that nearly 45,500 Montanans are employed in the three main sectors of the state's health care delivery system. These workers collect more than $1.5 billion in wasges.

In addition, as the second chart indicates, the average annual wage for workers in ambulatory health care and hospital settings is well above the state average for all jobs. Workers earning these wages are critical to the economic health of their communities.

Employment & Payroll for the Montana Health Care Industry (2005)

Sector	***Employment***	***Payroll (in Millions)***
Ambulatory health care	14,387	$576
Hospitals	20,962	819
Nursing & residential care	10,120	204
All health care jobs in Montana	***45,469***	***$1,599***

Average Annual Wages

Industry	***Average Annual Wage***
Ambulatory health care	$40,010
Hospitals	$39,062
Nursing & residential care	$20,131
All jobs in Montana	$29,156

Source: Research and Analysis Bureau, Montana Department of Labor and Industry.

Montana's Largest Employers

Industry	*Number of Jobs*
Education services	38,037
Food services & drinking places	35,019
Hospitals	***20,962***
Executive, legislative, & other government support	18,416
Professional & technical services	17,738
Administrative & support services	15,644
Specialty trade contractors	14,459
Ambulatory health care services	***14,387***
General merchandise stores	10,450
Accommodation	10,155
Nursing & residential care facilities	***10,120***

In the aggregate, health care is the largest employer in the state, and health care employment is among the fastest-growing sectors of the state's economy.

As the chart on the next page indicates, jobs in health care fuel job creation in the non-health care sectors of our state's economy. Using a Department of Labor and Industry model, these charts indicate that an additional 30,000 jobs are created in the state as a result of the jobs in health care.

Growth Rates of Montana's Largest Employers

Industry	*Percent Change in Employment (2001-2005)*
Specialty trade contractors	37.6%
Professional & technical services	12.9%
Ambulatory health care services	***10.2%***
Food services & drinking places	10.1%
Administrative & support services	9.7%
Hospitals	***9.6%***
Educational services	6.8%
General merchandise stores	6.5%
Nursing & residential care facilities	***4.3%***
Accommodation	3.2%
Executive, legislative, & other government support	2.5%

Source: Research and Analysis Bureau, Montana Department of Labor and Industry.

Total Employment Impact of Montana's Hospitals

Hospital Employment	20,962
Hospital multiplier	1.79
Jobs created in other businesses	16,560
Total Jobs	***37,522***

Total Employment Impact of Montana's Nursing & Residential Care Facilities

Nursing & residential care facilities employment	10,120
Nursing & residential care facilities multiplier	1.38
Jobs created in other businesses	3,846
Total Jobs	***13,966***

Total Employment Impact of Montana's Ambulatory Health Care Services

Jobs from home health care services	
Home health care services jobs	2,154
Home health care services multiplier	1.30
Jobs created in other businesses	646
Total Jobs	***2,800***
Jobs from offices of physicians, dentists, etc.	
Jobs in physicians, dentists, etc. offices	9518
Offices of physicians, dentists, etc. multiplier	1.66
Jobs created in other businesses	6,282
Total Jobs	***15,800***
Jobs from other ambulatory health care services	
Other ambulatory services employment	2,714
Other ambulatory services multiplier	1.90
Jobs created in other businesses	2,443
Total Jobs	***5,157***

Source: Research and Analysis Bureau, Montana Department of Labor and Industry.

The Financing of Health Care

If there is one constant in health care, it is concern about the cost of medical treatment. Health care spending increased by roughly 7.2 percent nationwide between 2003 and 2004. According to the Center for Health System Change, hospital outpatient and prescription drugs are the biggest drivers of these increases.

The increase in overall health care spending has been fueled by several factors, including increased utilization of services, increased costs for providing services (including the cost of staffing, technology, drugs and other products), population growth and an increasing population of seniors, who tend to require higher intensity medical treatment.

As we have said in the past, "health care costs" means different things to different people.

- To most privately-insured persons, the cost of health care is the amount of the copayment, deductible and other out-of-pocket expenses they incur when they see a doctor or require hospitalization.
- To an employer, it's the cost of insurance for workers.
- To an insurer, it's the amount paid for medical treatment for its insureds.
- To a self-insured business or local government, it's the amount they pay directly for medical treatment for their employees.
- To Medicare and Medicaid program administrators, it's budget outlays for services to beneficiaries.

To providers, health care costs means the cost of all that goes into providing medical treatment – wages and benefits for staff, medical liability insurance, the price of utilities, prescription drugs and other necessary products and services, the cost of new technology and other capital improvements and the expense of complying with regulatory requirements.

MHA member facilities share the public's concern about rising health care costs. As major employers, health care facilities have faced the same pressures caused by health insurance premiums as businesses all over Montana. In addition, providers have faced continual reductions in reimbursement rates as public and private insurers have attempted to reduce their health care outlays.

The Public Policy Debate...

Over the years, public policymakers have tried a variety of strategies to curb the growth in health

care spending. In the 1970's, the federal and state governments relied on health planning programs to limit costs by limiting the number of providers and the spread of technology.

In the 1980's, cost containment strategies shifted to limiting payments. The federal government instituted diagnosis-related groups –DRGs – as the payment mechanism for the Medicare program. In the 1990's, Congress attempted to reduce Medicare spending by limiting provider payment increases to less than the rate of inflation.

The Medicare Modernization Act of 2003 (MMA) included the first pay-for-performance mandate, a requirement that hospitals report data from certain quality indicators to be eligible for a payment update equal to the full market basket inflation rate. By improving quality, proponents argued, Medicare would reduce its overall expenditures and get greater value for the money it spends.

Meanwhile, the MMA also restructured Medicare managed care – now called Medicare Advantage – in an attempt to encourage more beneficiaries to enroll in these plans, thus shifting more of Medicare's risk to the private insurance market.

Today's debate focuses on what has been called "consumer-directed health care." In essence, this model requires participants to purchase a catastrophic health insurance policy – one with a deductible typically in the $5,000 to $10,000 range. This policy is coupled with a health savings account (HSA), a tax-exempt account that can be used to pay the deductible and insurance premiums.

As its name implies, in this model, the burden for paying for health care is shifted to the consumer.

Some policymakers believe this new model will bring market incentives more directly into health care. When consumers have to pay a greater share of the price of health care, they will make decisions that keep their costs down.

For this model to work, consumers must have the information they need to make informed choices about their health care – hence the recent interest in providing additional pricing information to consumers.

In addition, providers must have the means to collect payments for the services they provide when the patient's share is below the threshold for the insurer to pay. If patients don't pay, providers' only choice will be to raise rates.

Throughout the debate over health care costs, MHA has advocated several core policies:

- Payers – especially major government payers – should pay for the reasonable costs of treating their beneficiaries. An end to cost-shifting would mean more stability in the price of health insurance for everyone else.
- Insurance plans must balance plan design and provider contracts to assure reasonable access to treatment locally, pay providers in a timely fashion and protect beneficiaries from unreasonable economic risk.
- Employers should continue their efforts to provide employer-sponsored health coverage. Tax policy should continue to support group health coverage.

The Bottom Line

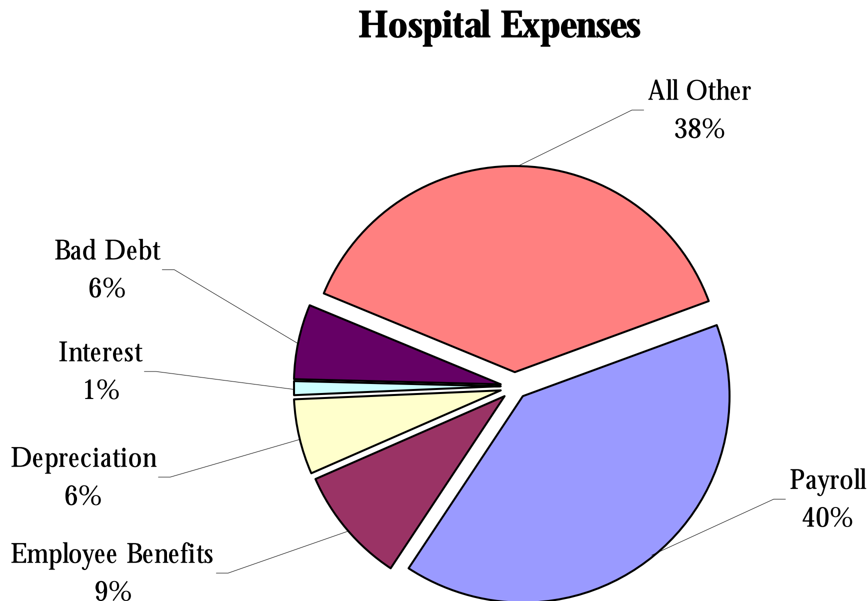
Hospitals, collectively, managed to barely cover the cost of serving patients in 2005, which means that hospitals are not overcharging for the services they provide.

To close the gap between payments and the cost of providing care, hospitals obtain revenue from a variety of other services. Rent for office space, meals sold to visitors and other operations help provide a small profit margin. For county- or district-owned facilities, tax subsidies often make up for operational losses.

Meanwhile, health care facilities continue to work hard to control their expenses and to keep their rate increases to minimal levels – at or below 5 percent for hospitals over the past several years.

That's the good news. The bad news is that as Montana's population ages – and uses more health care services – it is almost certain that health care spending will increase faster than the consumer price index.

Hospital Expenses



Hospital expenses consist largely of payroll and benefit costs, plus the costs of medical supplies used to care for patients. Rising health costs reflect greater and more intense utilization of hospital care combined with persistent shortages of trained health care professionals. While many focus on the investment by hospitals in plant and high tech equipment, just 7 percent of hospital costs are related to capital costs. Historically hospitals spend about 10 percent of their costs on capital outlays.

Source: AHA/MHA Survey of Hospitals, 2005.

Financial Highlights

	2005	*2004*
Funds Available		
Charges for Inpatient Services	$1,551,993,467	$1,436,688,278
Charges for Outpatient Services	1,296,933,451	1,134,140,147
Funds from Other Operations	63,130,277	65,406,268
Funds from Tax Subsidies	3,773,360	4,107,129
Funds from Nonoperating Activities	45,326,977	39,885,143
Total	***$2,961,157,532***	***$2,680,226,965***
Full Payment Not Received From		
Medicare	$649,645,336	$592,113,901
Medicaid	138,886,794	113,997,612
Other Government	34,046,052	24,257,426
Other Payers	214,804,489	132,933,086
All Other Discounts	29,330,281	29,351,069
Charity Services	59,568,094	42,377,240
Total Revenue Deductions	1,067,620,484	935,030,334
Total Funds Available	***$1,893,537,048***	***$1,745,196,631***
Funds Spent		
Salaries, Wages	$719,518,327	$675,996,466
Employee Benefits	163,583,528	151,955,922
Depreciation	101,122,562	95,550,986
Interest	16,602,485	16,405,507
Bad Debt	102,482,960	96,280,538
Medicaid Bed Tax	11,141,200	8,757,917
All Other Expenses	660,606,898	587,587,761
Total Funds Set Aside for Future Services (including Investments)	$118,479,088	$112,661,534
Total Funds Spent	***$1,893,537,048***	***$1,745,196,631***
Patient Service Margin	***0.35%***	***0.20%***
Total Margin**	***6.67%***	***6.90%***

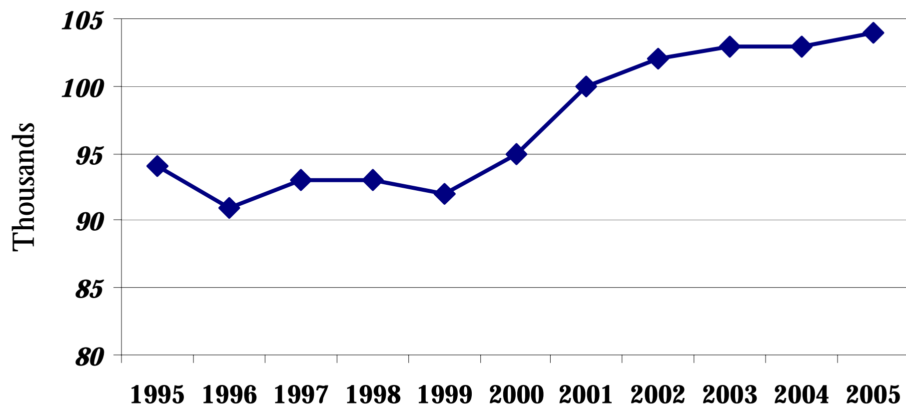
**The operating margin differs from the patient service margin by including revenues earned from sources other than patient treatment, such as rent, meals served to visitors, etc.

Source: AHA/MHA Annual Survey of Hospitals, 2005.

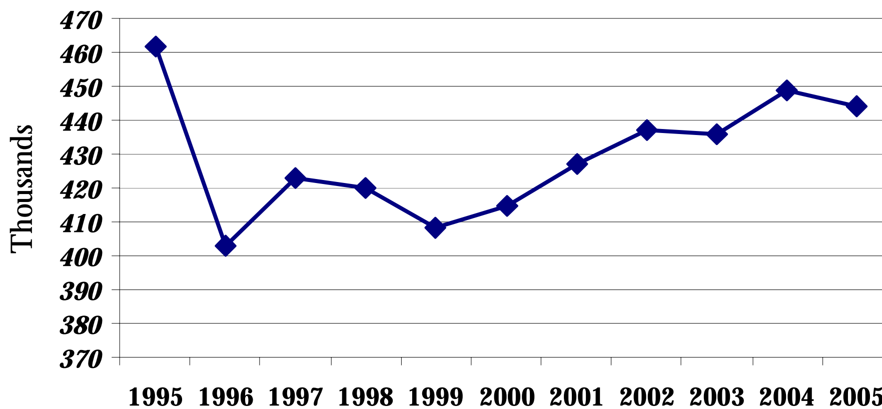
With two exceptions, hospitals in Montana are licensed as non-profit organizations. Despite the non-profit label, being non-profit does not mean operating at a loss. Hospitals, like any business entity, must earn at least a 5 percent margin to maintain its services and have funds to reinvest in operations, equipment and employee salaries and benefits. As was the case in 2004, hospitals collected payments from their patients that barely covered the cost to deliver care. Hospital profit margins were bolstered by a variety of other operating activities such as renting office space, selling meals to hospital visitors and other similar activities. Taxpayers provided a small amount of revenue to support local hospitals.

Non-profit hospitals provided over $160 million of uncompensated care to Montana residents who either did not, or could not, pay for their care. Charity costs jumped by $17 million or 40% in one year. Bad debt expense increased by $6.2 million, or about 6.4 percent. Providing free or discounted care to uninsured and low-income Montanans is one way that non-profit hospitals provide a benefit to their community in exchange for exemption from taxes.

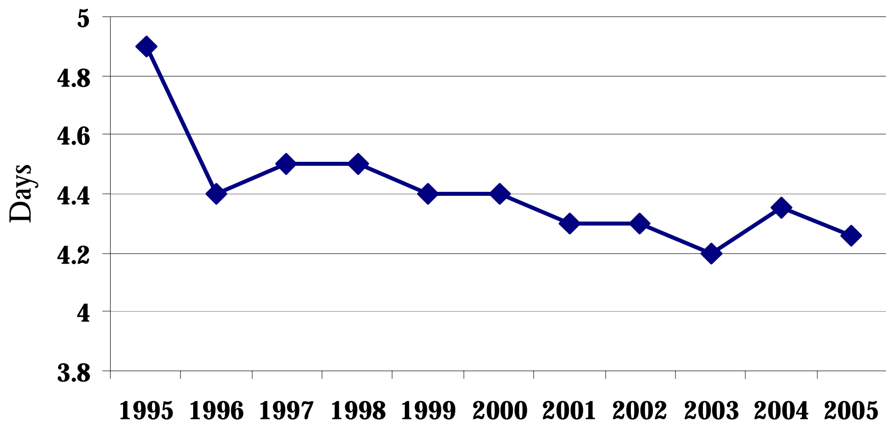
Hospital Admissions



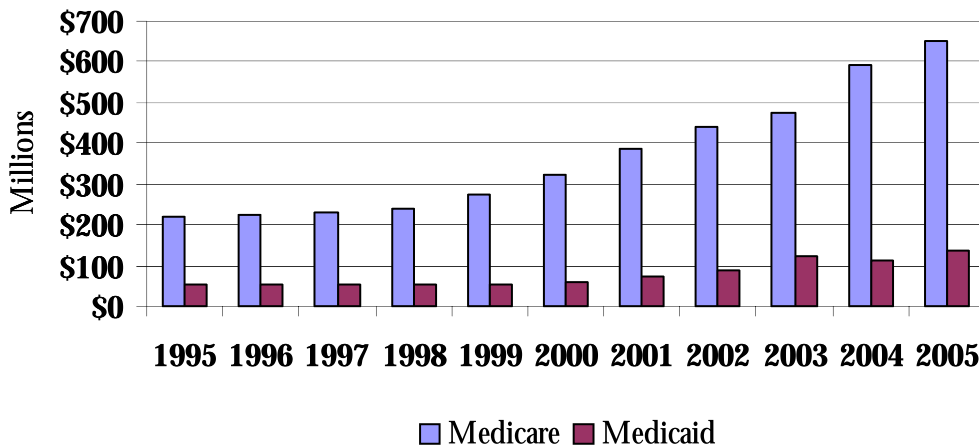
Inpatient Days



Source: AHA/MHA Annual Survey of Hospitals, 2005.



Hospitals saw total inpatient days decrease slightly over 2004, after several years of modest growth in service volume. This decline in patient days occurred even though total admissions increased in 2005. Hospitals continue to manage patient days in the hospital as a key strategy to hold down health costs.



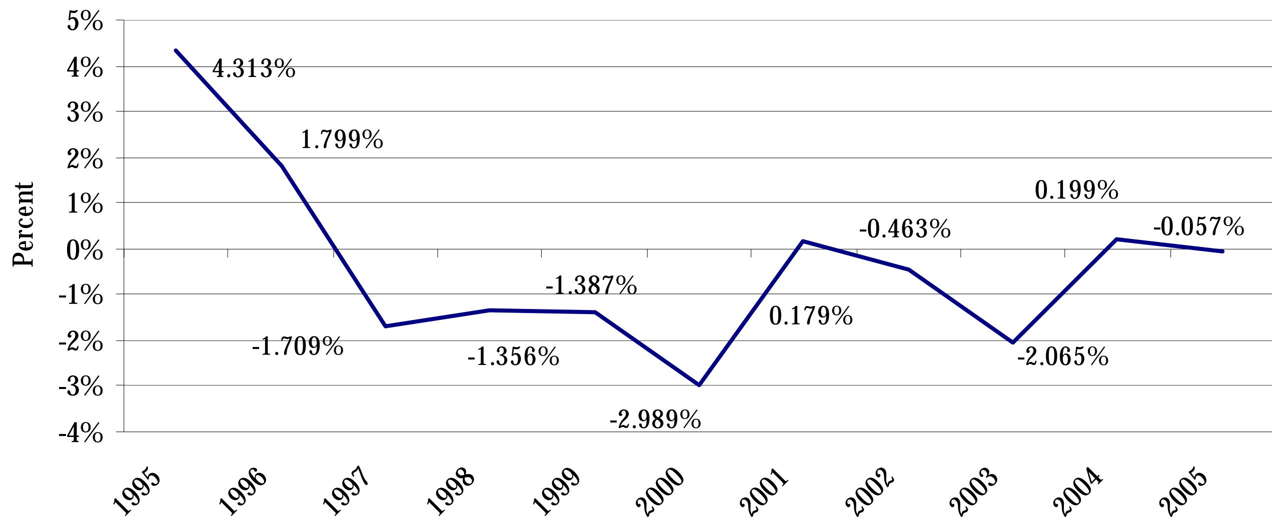
Source: AHA/MHA Annual Survey of Hospitals, 2005.

The discounts demanded by the Medicare and Medicaid programs are one reason for skyrocketing health insurance costs. The chart reports ever-increasing discounts from full charges that go to government programs.

These discounts, the difference between what a hospital charges for services and the amount government pays for care, grow larger every year.

The moderation of the discount provided to Medicaid is the result of the hospital utilization fee that helps reduce the gap between Medicaid's payments and hospitals' actual costs.

When government programs don't pay the full cost for beneficiary services, the loss is passed onto other consumers, primarily onto employers and individuals who purchase insurance, and those who pay their medical costs out of their own pockets.



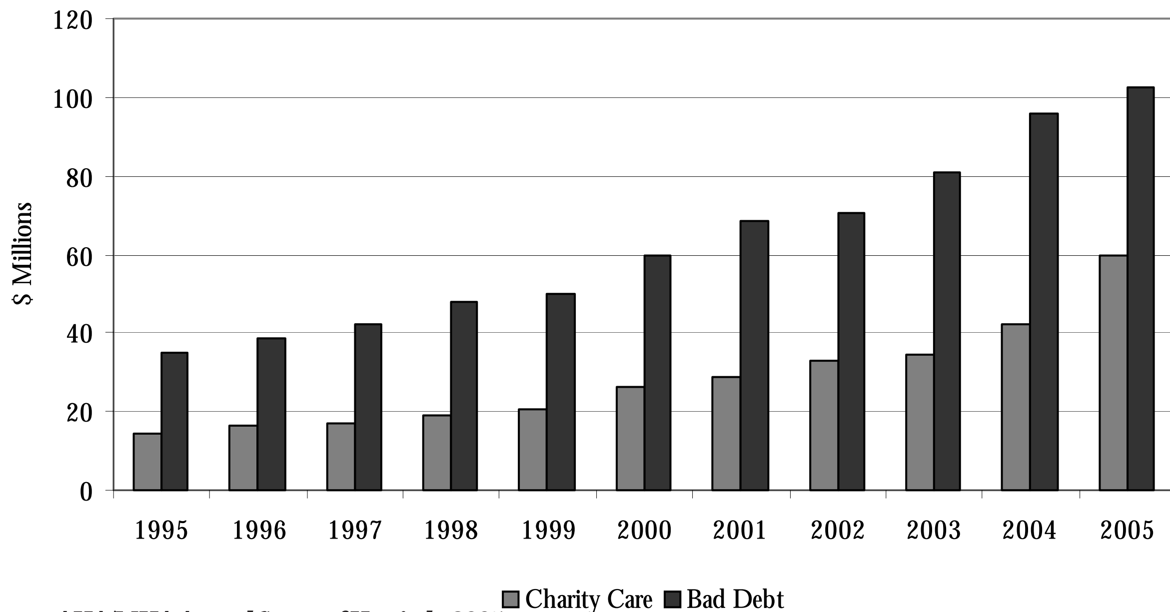
Source: AHA/MHA Annual Survey of Hospitals, 2005.

Patient service margin is a key indicator that measures hospital profitability. An ideal margin for patient care is about 5 percent, meaning that hospitals would receive 5 percent more than their costs for caring for patients.

Although most patients feel they are paying high prices for their care, this indicator shows that hospitals aren't overcharging for these services. In fact, in most years, hospitals barely cover their patient care costs, or lose money providing services.

Although the patient service margin is nearly zero, hospitals make some money from other operations, such as renting office space or selling meals in the cafeteria. Some hospitals receive interest payments on investments and savings. Hospitals owned by counties or hospital districts often receive subsidies from local government.

Bad Debt & Charity Care



Source: AHA/MHA Annual Survey of Hospitals, 2005.

Charity care and bad debt continue to grow each year as more Americans lose their health insurance coverage or fall below federal poverty guidelines. Most people believe that government programs foot the bill for low-income people. But Medicare only covers the elderly and some disabled people, while Medicaid covers low-income beneficiaries who meet other criteria for gaining coverage, including being aged, blind, disabled, pregnant or having dependent children.

Hospitals provide free or discounted price care for those who have limited means, but aren't covered by government insurance plans. In 2006, that amount of free care topped $160 million, three times more than was provided in 1995.

Free care is not free. When patients can't, or won't, pay for their care, the costs are shifted onto those who do pay. Like growing discounts for government programs, these higher uncompensated care costs are shifted to those who do pay, making their health care costs even higher.

Montana's Health Care Workforce

Imagine a scenario in which you or a member of your family required hospital or nursing home care but couldn't get it because the facility didn't have an adequate staff. Sound farfetched? Not in today's health care marketplace.

One of the biggest unknowns in Montana's health care future is whether there will be an adequate supply of health care professionals to serve our state's population. Today there is no guarantee that this will be the case.

MHA's annual workforce survey shows that in certain parts of the state, turnover and vacancy rates remain high for nursing staff. The survey also found shortages of clinical laboratory technicians, radiological technicians, pharmacists and some kinds of therapists.

In addition, the survey and independent data from the state Department of Labor & Industry conclude that demand for health care workers is expected to increase in the future as the current supply of workers retires or leaves the workforce.

Finally, the survey confirmed that the cost of hiring temporary health care workers continues to dramatically increase staffing costs for hospitals, nursing facilities and home health agencies.

There are some bright spots in this picture. For example, the Office of the Commissioner of Higher Education, working with MHA and other health care organizations, has launched a major initiative aimed at strengthening the state's health care professions training programs. The governor's Workforce Investment Board also has shown strong interest in this area.

MHA has been pursuing a multifaceted strategy for addressing the workforce needs of our state's health care providers.

In addition to working with the University system and other education agencies to expand education and training programs at the state's two- and four-year colleges and universities, we are working to develop new training approaches, such as using the state's extensive videoconferencing capabilities and adding clinical training slots in rural areas that are funded in part by providers.

Through MHA Ventures, MHA is helping facilities recruit and retain health care professionals.

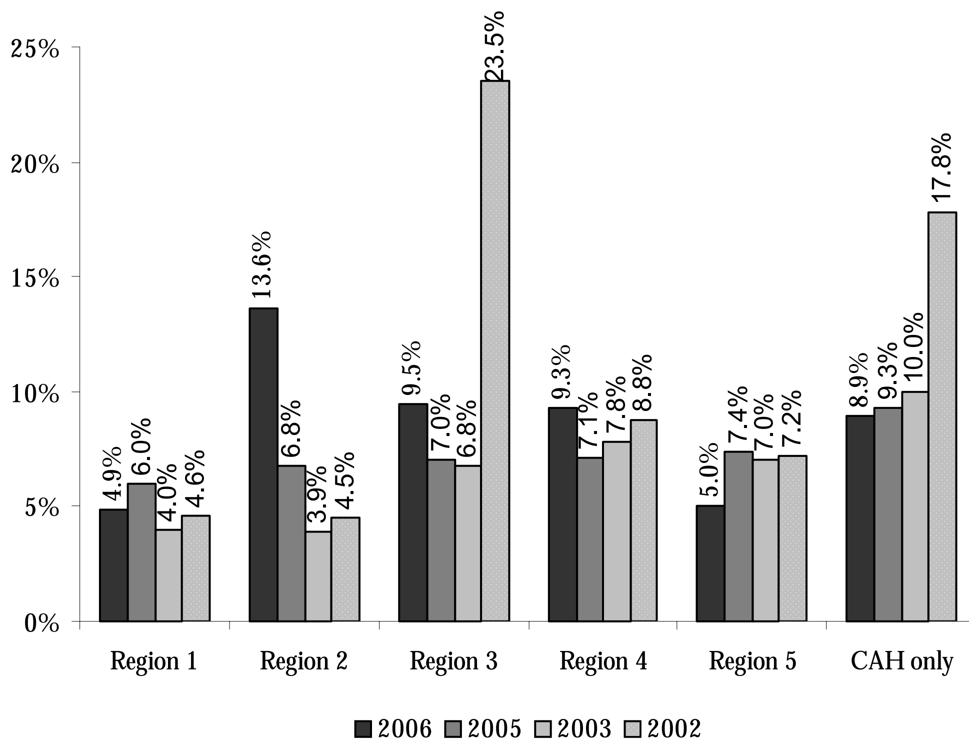
Finally, MHA recognizes the need to bring state health care professions licensing requirements more in line with the realities of today's health care workplace.

The need for an adequate number of caregivers is only part of the workforce story. The impact of health care workers on the state's economy is also compelling.

For example, as noted earlier in this publication, every hospital job generates one non-health care job. In fact, in an average rural Montana county, the closing of a health care facility with 150 jobs would result in the loss of nearly 155 non-health care jobs.

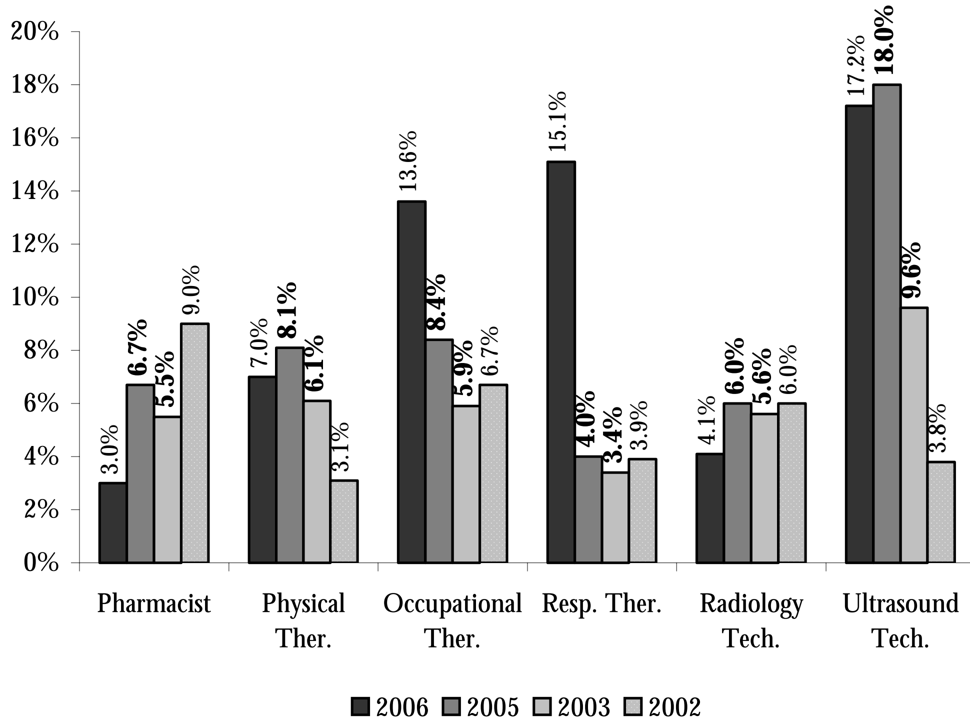
For these reasons, ensuring an adequate health care workforce will continue to be a top priority for MHA in the years ahead.

Vacancy Rates for RNs by MHA Region

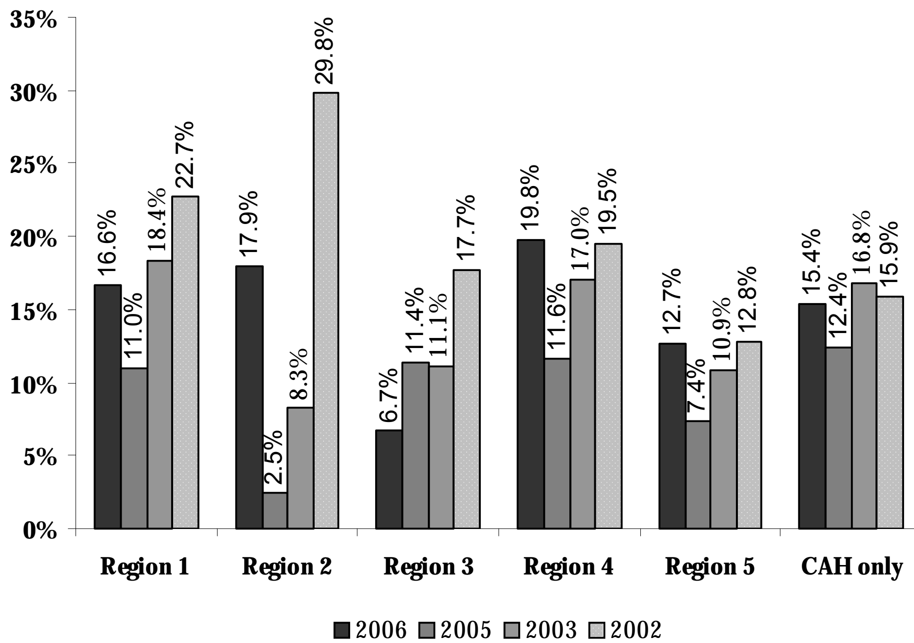


Source: MHA Workforce Staffing Survey.

Vacancy Rates for Allied Health Professionals



Turnover Rates for RNs by MHA Region



Source: MHA Workforce Staffing Survey.

Montana Occupational Job Projections, 2004-2014

Occupation	*Total % Change*
Registered Nurses	29.7%
Licensed Practical and Licensed Vocational Nurses	16.0%
Nursing Aids, Orderlies & Attendants	27.1%
Pharmacists	26.2%
Pharmacy Technicians	41.3%
Physical Therapists	30.2%
Physical Therapist Assistants	41.1%
Occupational Therapists	29.5%
Occupational Therapist Assistants	32.1%
Respiratory Therapists	44.4%
Respiratory Therapy Technicians	40.0%
Radiologic Technologists & Technicians	21.8%
Surgical Technologists	30.9%
Medical & Clinical Laboratory Technicians	17.1%
Medical & Clinical Laboratory Technologists	20.2%
Medical Records & Health Information Technicians	41.4%

	Base	*Projected*
Registered Nurses	8,344	10,821
Licensed Practical and Licensed Vocational Nurses	2,836	3,289
Nursing Aids, Orderlies & Attendants	6,052	7,695
Pharmacists	982	1,402
Pharmacy Technicians	736	1,040
Physical Therapists	797	1,038
Physical Therapist Assistants	146	206
Occupational Therapists	271	351
Occupational Therapist Assistants	53	70
Respiratory Therapists	354	511
Respiratory Therapy Technicians	60	84
Radiologic Technologists & Technicians	669	815
Surgical Technologists	298	390
Medical & Clinical Laboratory Technicians	304	356
Medical & Clinical Laboratory Technologists	506	608
Medical Records & Health Information Technicians	647	913

Source: Research and Analysis Bureau, Montana Department of Labor and Industry

Wages in Health Care Professions

Occupations	*Mean Wages*
Pharmacists	$78,785
Physical Therapists	57,694
Occupational Therapists	52,565
Registered Nurses	48,461
Medical & Clinical Laboratory Technologists	45,676
Respiratory Therapists	43,300
Radiologic Technologists & Technicians	42,089
Surgical Technologists	36,211
Respiratory Therapy Technicians	31,355
Physical Therapist Assistants	30,472
Medical & Clinical Laboratory Technicians	29,992
Licensed Practical and Licensed Vocational Nurses	29,919
Pharmacy Technicians	26,784
Occupational Therapist Assistants	26,547
Medical Records & Health Information Technicians	24,283
Nursing Aids, Orderlies & Attendants	19,145

Projected Future Growth (2002 – 2012)

I*ndustry*	*Projected change in Employment (2002 – 2012)*
Administrative & support services	44.1%
Specialty trade contractors	40.2%
Nursing & residential care facilities	35.4%
Ambulatory health care services	33.1%
Food services & drinking places	30.6%
Professional & technical services	30.5%
Hospitals	24.9%
Accommodation	21.8%
General merchandise stores	18.0%
Educational Services	10.5%
Executive, legislative, & other government support	9.0%e

Source: Research & Analysis Bureau, Montana Department of Labor & Industry

The Deartment of Labor and Industry's job projections reflect the growth in the demand for health care workers as well as the expected increase in the state's senior population. In addition, all but three of these professions pay more than the average annual wage for all jobs in Montana of $29,156.

Extended Care Services

Over the past century the number of Americans aged 65 and over has increased at a rate that exceeds the overall population growth in our country. In 1900, persons aged 65 and older represented less than 5 percent of the U.S. population. By 2002, this segment represented 12.4 percent of Americans; by 2020, that percentage will climb to 16.6 percent – one in every six Americans will be aged 65 and older.

- Life expectancy has increased dramatically. In 1900, an American male could expect to live 47.3 years; in 2004, he could easily see his 77th birthday.
- In the 2000 census, 13.4 percent of Montana's population was aged 65 or older, giving Montana the 14th highest percentage of seniors in the nation. In the 1990 census, Montana ranked 23rd.
- The proportion of persons over age 65 is expected to continue to increase. By 2025, Montana is expected to be in the top three states in this category.
- Between 1993 and 2003, Montana's population aged 85 and older has increased 66 percent, compared to 34 percent nationwide.

Montana's aging population will have a profound effect on the state's health care system. For example, by the mid-1990's, more people died of chronic disease than of acute illness.

Moreover, advances in medical treatment and treatment techniques, which will enable us to live longer, will bring a new set of demands for health care providers.

The aging of the population is expected to result in a tripling of long-term care expenditures in the next 40 years from $115 billion to $346 billion annually, putting an even greater strain on the health care system and payers of extended care services.*

Although financing is at the center of long-term care providers' concerns, it is clear that other issues are also critical in building an effective system for meeting the needs of Montana's seniors. These include ensuring an adequate supply of health care workers, maintaining and improving the quality of services, improving access to services and supporting caregivers.

Skilled Nursing Facilities (SNFs)

In this milieu, several trends are worth noting.

- Medicaid continues to be the largest payer for skilled nursing facility services in Montana,

accounting for almost 60 percent of nursing facility revenues.

- Montana's Medicaid program spends 42 percent of its budget on long term care, 30 percent of which pays for SNF care. Yet only 11 percent of Medicaid beneficiaries are elderly.
- The intergovernmental transfer (IGT) program, which has helped SNFs survive for the last six years, has been severely curtailed due to changes in federal regulations governing Montana's plan.
- Montana's current nursing home bed tax rate is near the current federal cap for provider taxes. However, the Bush administration would like to lower that cap, which could result in a $20 a day cut in Medicaid SNF rates.
- Montana's federal Medicaid matching payment rate continues to decrease – to somewhere near 67 percent – which means state contributions must increase just to maintain the status quo.
- Although a smaller percentage of SNF payments, Medicare reimbursement rates play a key role in retaining the staff needed to effectively complete the Minimum Data Set that generates facility' payment rates and measures quality of care.
- Medicare is beginning to link payment to quality outcomes. While SNFs do not currently receive any payment incentive to improve quality, they are expected to deliver high quality services.
- Establishing statutory or regulatory staffing ratios – i.e. setting limits on the number of residents staff can serve – would severely limit many facilities' operations and could lead to facility closures.
- Due to the rapid growth in assisted living facilities – currently there are 184 licensed in Montana – over the past several years, SNFs are experiencing decreasing occupancy rates (average 75 percent in 2005*). However, because of shorter hospital stays, those residents being admitted to nursing homes are more acutely ill and require more intensive use of (sometimes scarce) resources—thereby raising the cost per resident, per day.

Average annual costs per SNF resident are $50,000 per year and rising. The reasons: regulations require increasingly burdensome compliance measures, staffing shortages drive up labor costs and medical liability insurance premiums have skyrocketed. On the other hand, reimbursement methodologies haven't responded to these cost drivers. Nor have they kept pace with inflation and increases in the cost of doing business.

In fact, Medicare's recent "increase" in SNF reimbursement actually resulted in decreased reimbursement to many of Montana's facilities because of a fall in the wage index.

Without fundamental reform, Medicaid can be expected to remain the major funding source for long-term care for elderly and disabled Montanans.

Finally, Montana's nursing facilities remain at risk; two closed in 2003, with others taking drastic measures to remain open. In many locations, wages have been frozen and benefits and hours cut, further diminishing the workforce and decreasing access to beneficiaries.

Home Health and Hospice

While many people equate extended care with nursing homes or other institutional facilities, almost 80 percent of the elderly and 41 percent of severely disabled individuals live at home or in community-based settings.

Many people with functional limitations or cognitive impairments choose to remain at home, or in supportive housing if they can receive assistance with activities of daily living (i.e. eating, dressing, bathing, etc.).

While seniors and disabled persons are entitled to receive Medicaid services in a SNF, states must apply for waivers to keep people in community settings. Medicare pays for most of the in-home, skilled care in Montana, although these are almost exclusively short-term services meant to help rehabilitate patients after an acute illness or injury.

Changes to the Medicare reimbursement process over the last eight years so severely reduced the payments for home care that these services are no longer available in 13 Montana counties. In many other counties, these services are severely limited.

Home care agencies also have suffered financially due to a freeze in payment updates at a time when their costs – especially for gas – have increased dramatically in recent years.

If the current payment add-ons are allowed to expire, Montana residents are at risk of losing additional access to these services.

Hospice is a philosophy of care that considers the dying patient and family as one unit, and focuses on relieving symptoms (palliation) rather than attempting to cure the underlying disease. The care is multifaceted, attending not only to physical symptoms, but also to psychological, emotional, and spiritual needs. A patient must have an estimated six months or less to live and must forgo curative treatments.

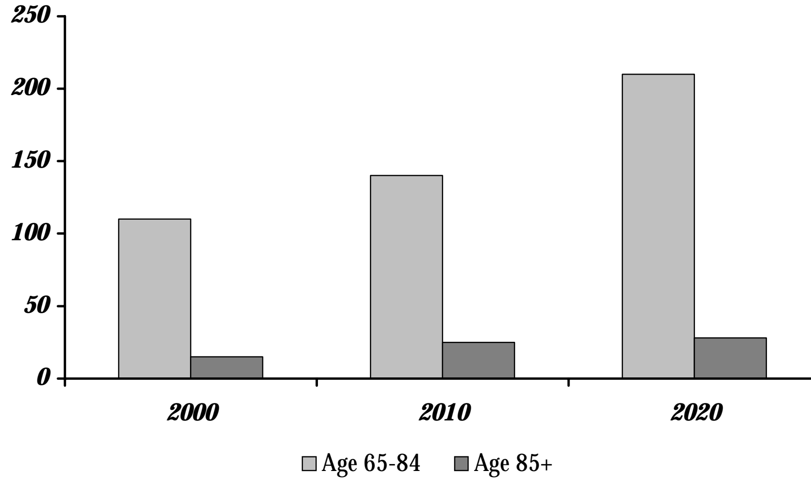
Hospice care and the use of advance directives such as living wills and medical powers of attorney could save up to 10 percent of the cost of care in a patient's last year of life, 10-17 percent in the last six months, and 25-40 percent in the final month.

Medicare pays for a significant amount of the hospice care provided, but for those who are not Medicare-eligible, states can opt to provide a Medicaid hospice benefit.

It is essential to preserve this service for our dying residents, as it is proven to improve both the quality of end-of-life experiences and the economic health of the state's health care budget.

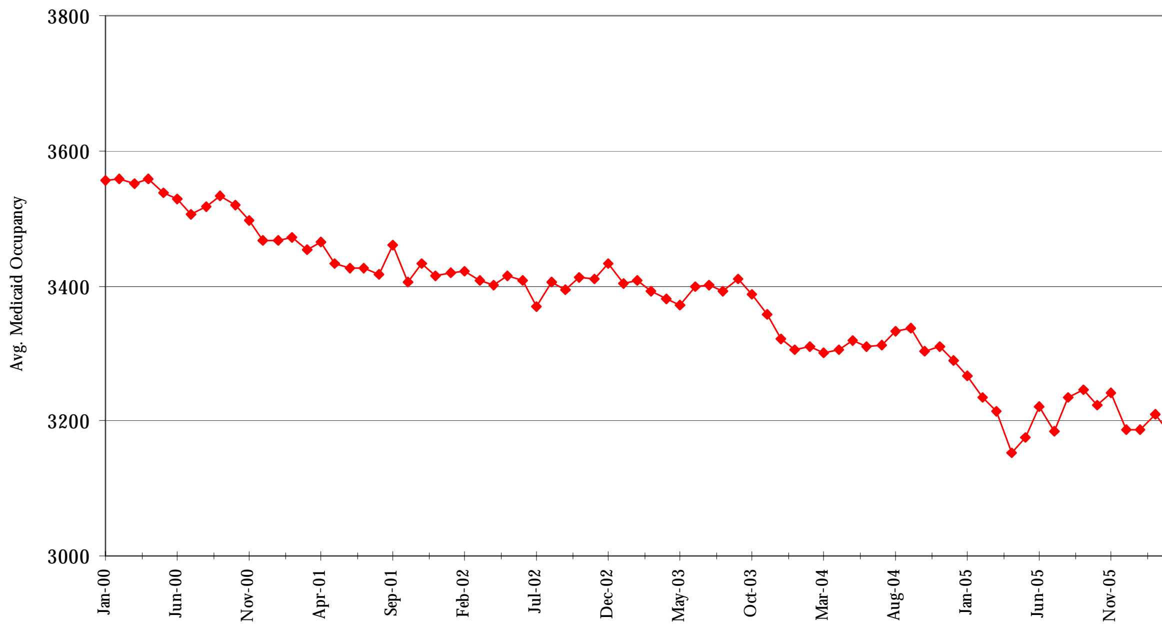
***DPHHS State of Aging Report, 2003**

Growth of Montana's Senior Population



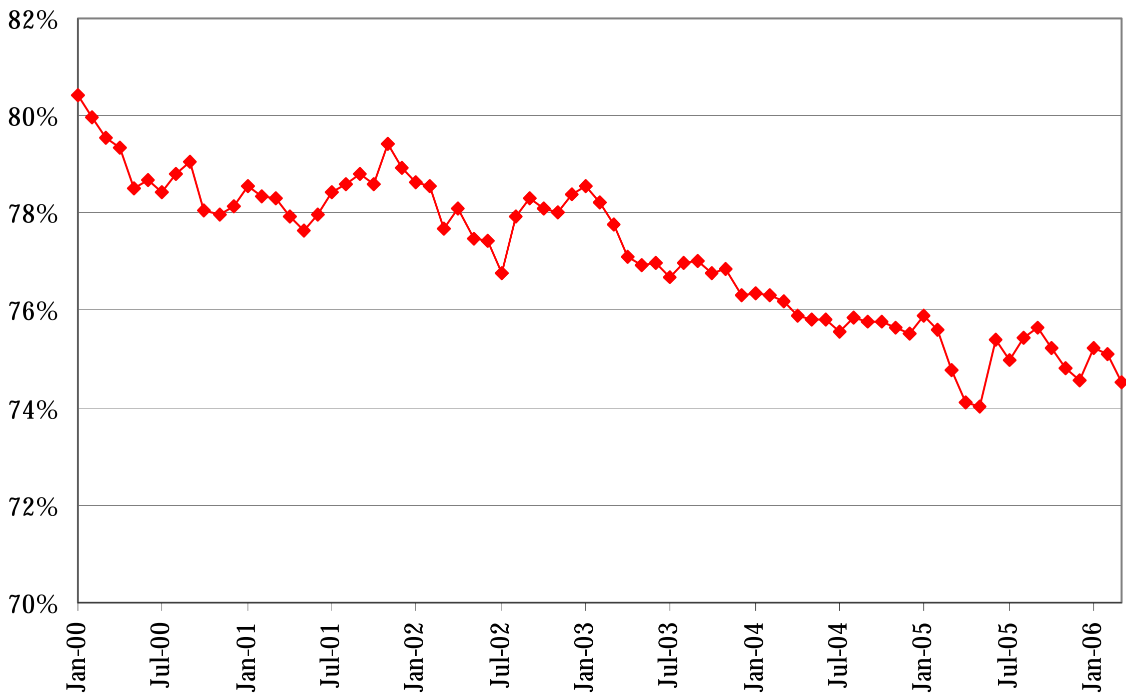
Source: AAHSA state data, 2000; U.S. Department of Housing and Urban Renewal, U.S. Census Bureau.

Average Medicaid Bed Days



Source: DPHHS, Senior and Long-Term Care Division.

Montana Nursing Home Total Occupancy



Source: DPHHS, Senior and Long-Term Care Division.

Expanding Health Care Coverage

The number of Americans without health care coverage remains persistently high. Nationwide, in 2005, 46.6 million people – 15.9 percent of the population – were without health insurance coverage, up from 45.3 million – 15.6 percent – in 2004, according to U.S. Census Bureau data released in late August.

Montana's uninsured rate continues to run higher than the national average, ranging between 18.4 and 19.3 percent of the state's population between 2003 and 2005. This seems due to the large percentage of small employers and self-employed persons in the state. In addition, the steady escalation in insurance premiums has begun to make it difficult for some employers to afford the cost of insurance.

The uninsured population affects the health care system in several ways. First, because the uninsured are often less able to pay for their health care services, providers aren't compensated for a significant amount of the care provided to this population. This is reflected in the amount of charity care provided by hospitals, which in 2005, amounted to about $40 million. Because the cost of this care has to be recovered, hospitals are forced to raise charges to cover these unpaid costs.

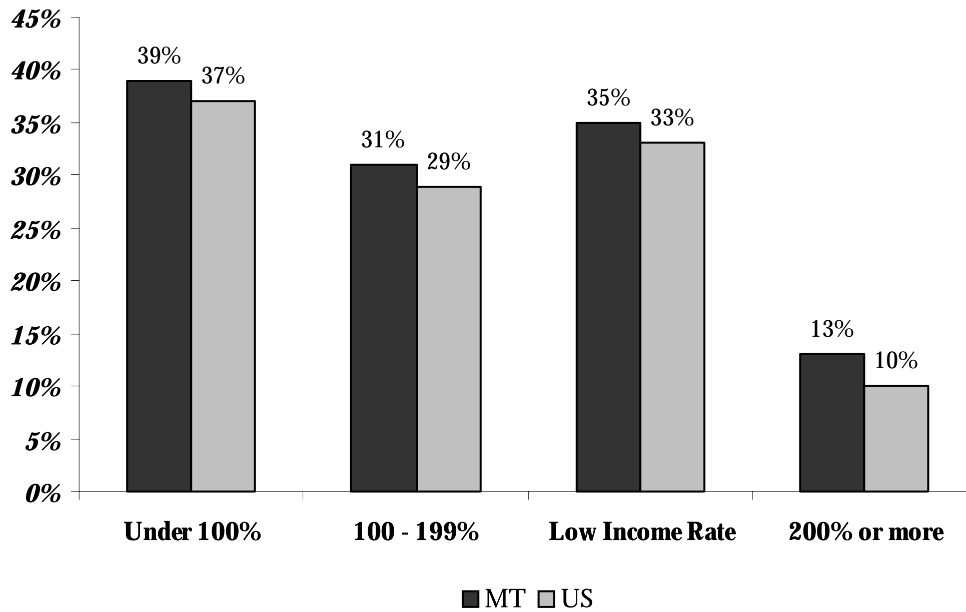
Second, persons who are uninsured or underinsured often skip routine and preventive care and only seek medical treatment when a serious illness occurs. Not only are these serious illnesses more expensive to treat, treatment is often provided in hospital emergency rooms – the most expensive venue in which to provide care. The failure of uninsured persons to obtain preventive care adds to the overall cost of medical treatment.

Montana's not-for-profit community-based hospitals treat all patients regardless of their ability to pay. In addition, hospitals have policies that allow them to offer discounted prices and financial assistance to patients who meet certain income qualifications. In most cases, persons with a family income at or below 100 percent of the federal poverty level are provided care free-of-charge.

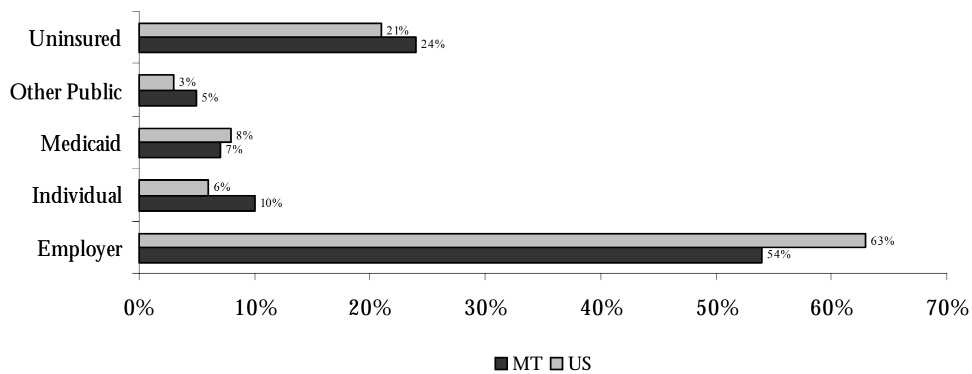
Providing medical treatment to the uninsured comes at a cost. For this reason, MHA has long advocated legislation that would increase the number of Montanans with health care coverage.

One of the easiest ways to accomplish this goal is to expand the Children's Health Insurance Program (CHIP) to cover more kids and the parents of CHIP-eligible kids. A variety of other proposals has been discussed, including tax subsidies to encourage businesses to purchase coverage for their employees and subsidize premiums for certain populations.

Non-Elderly Uninsured by Federal Poverty Level

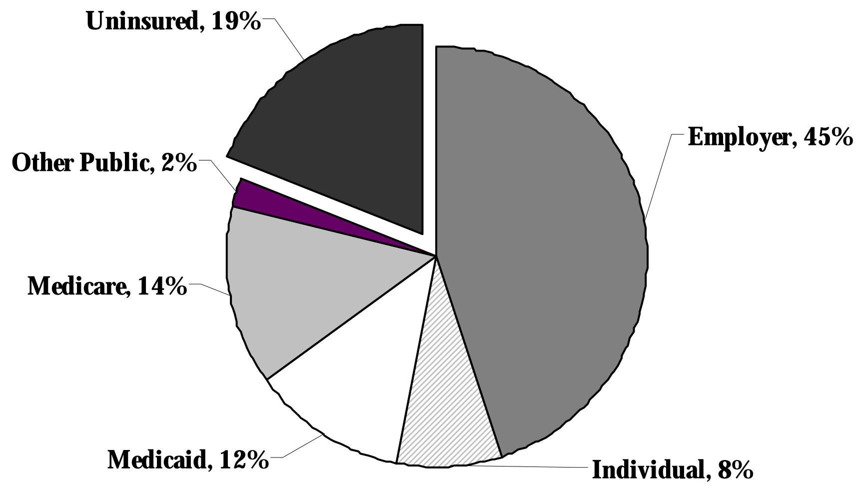


Montana's Population Age 16 - 64 by Insurance Status

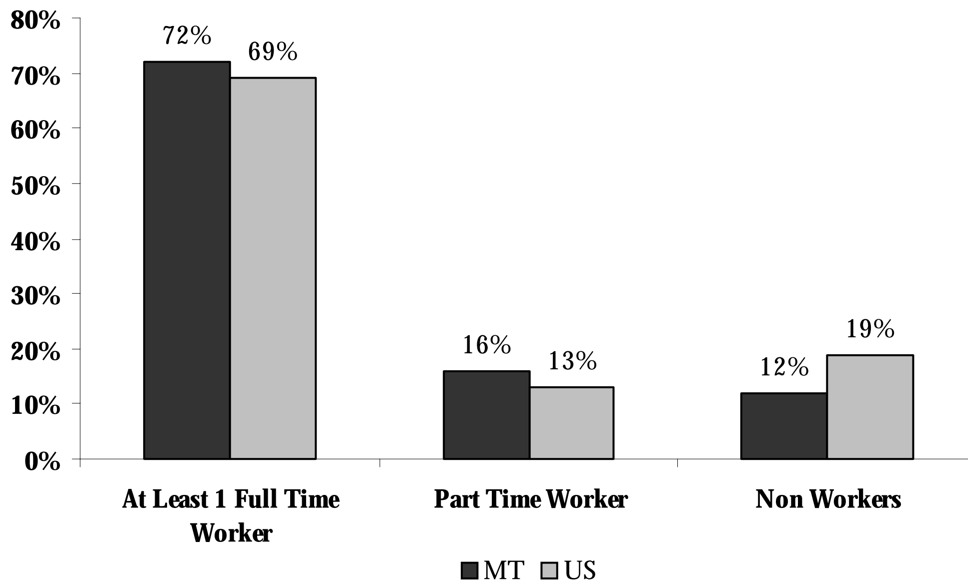


Source: Henry J. Kaiser Family Foundation, State Health Facts, ***State Data 2003-2004, U.S. Data 2004.***

Montana Insurance Coverage by Type of Insurance



Non-Elderly Uninsured by Employment Status



Source: Henry J. Kaiser Family Foundation, State Health Facts***, State Data 2003-2004, U.S. Data 2004.***