

Transcript of Provena Decision Teleconference (see : <http://www.healthbusinessandpolicy.com/TeleconfOct4.htm>)
This Teleconference Took Place on October 4, 2006 and The Participants Included:
Steve Weyl, Attorney and Partner, Hinckley, Allen & Snyder LLP
Claudia Lennhoff, Executive Director, Champaign County Health Care Consumers
Stan Jenkins, Member and Former Chair, Champaign County Board of Review
Mark Wiener, Former CEO, Provena Covenant Medical Center
James Unland, Moderator, Executive Editor, Health Business And Policy **Note: Audio Selections Are Italicized**

Unland: Thank you very much, thank you all for doing this; it is a very timely topic and we are going to get right to it. I want to say how delighted I am to have, especially the three principals in the Champaign County Provena situation who have been on the ground during the controversy: Claudia Lennhoff, head of the Champaign County consumers group Champaign County Health Care Consumers; Stan Jenkins, who was at that time chairman of the Champaign County Board of Review; that board chairmanship rotates every year but the three same members who were on the Board of Review at that time during these controversies from 2002 until now are still there—Stan Jenkins, Laura Sandefur and Dan Stebbins. Mark Wiener also joins us who is no longer the CEO of Provena Covenant but who was the CEO who kind of landed in Champaign/Urbana and joined Provena Covenant basically after the die had been cast in the spring of 2003 with respect to the Champaign County Board of Review's filing to the State of Illinois but who, as we will discuss, then undertook some very proactive efforts with the community group there.

I want to start out with the fourth presenter, Steve Weyl, the attorney who we are delighted to have who has a national perspective on these issues. He is with Hinckley, Allen & Snyder headquartered out of Boston. Steve also works out of their New Hampshire office and happens to be counsel to the New Hampshire Health and Educational Facilities Authority. Steve does a lot of work helping hospitals issue bonds, undertake new transactions and address regulatory matters. He has studied these controversies; he has spoken before the American Bar Association, in fact just written a brief to them on these controversies which is linked on the website of this teleconference. He has a lot of expertise, and he just last week, actually, made a speech on the whole subject of the controversy surrounding pricing, collections and charity care in the context of community hospitals to the national convention of all the bond issuing authorities. This matter has been raising great attentiveness in the investment community.

Steve, I would like to start with you if we could. From your point of view, give us just a very brief reason why people outside of the State of Illinois should be concerned about this in terms of the similarities of state law.

Weyl: Well, Jim, thank you very much. Basically, this is not—in a state law sense—a new controversy. The first principle that people need to keep in mind, as the Provena decision indicated, is the fact that a hospital or health care system holds 501(c)(3) status under the code is really irrelevant to what its status is for property or other tax exemptions under state laws. Those exemptions are really the result of constitutional or statutory provisions as well as case law in each of the jurisdictions, and if you go back over twenty years to 1984, you will find the Utah Supreme Court decision which ruled at that time that Intermountain Healthcare System was not entitled to property tax exemption. So this has been an issue that has been addressed in many states over the years and hasn't always risen to the same level of controversy that this particular case has, but as state taxing and local taxing authorities look for more sources of revenue—fueled on by what is going on at the federal level in congress with the hearings about tax-exempt status and their relationship between not-for-profit and for-profit hospitals—this is only going to increase as we go forward and it really is a 50-state issue, not a Provena issue or a State of Illinois issue.

Unland: Steve is it correct to say that there is really a major fork in the road here? On one hand we have the so-called pricing and collections controversy—hospitals charging list price to and pursuing aggressive collection practices particularly against uninsured persons—and on the other hand we have the so-called provision of charity care. On the first point you might have consumer fraud issues as well as charitable use issues, but on the second point, the issue of charity care, that has other implications in terms of whether state legislatures or anybody else for that matter including Congress should be starting to require some standard of charity care. Am I correct in bifurcating this?

Weyl: Yeah, although there is one quick relationship, which I will get to, and I think the other panelists can speak about more. The quick relationship is that in the Provena case, I think that the charity care issue arose because of a big concern about billing practices. On a more general level, we have seen for example, in New Hampshire, Dartmouth Hitchcock Medical Center which is the teaching hospital for Dartmouth College, which was subject to a tax challenge by the city of Lebanon about five to seven years ago having

nothing to do with the level of indigent care. It is critical to remember that however the issue of state tax exemption comes up, what constitutes a charity under state law and what elements go into determining charity care are really elements of state law. As a general proposition as this case indicated, those statutes are very strictly in favor of taxation. I think what we have seen in the past few years is greater inquiry into what constitutes charity care and what constitutes charitable use of facilities.

Unland: Is it correct, Steve, that a lot of state law is quite similar in terms of both charitable organizations as well as consumer fraud?

Weyl: It really varies from state to state. You have seen split decisions among the states as to whether this type of billing practices, either charging the usual and customary rates or aggressive collection practices, is a consumer fraud issue, but the two are linked in the sense one inexorably leads to the other.

Unland: And then finally, in some states there are requirements for hospitals to file so-called community benefit reports. In fact, a story is going to break tomorrow, that I can't go into detail, in of all places Amarillo, Texas, where a major health system there is evidently being looked into for a community benefit report and reporting two to three times the amount of Medicaid reimbursement as compared to state records and so on. The point is the whole community benefits thing is also a backdrop on this, is it not, Steve?

Weyl: Oh, absolutely. More states are getting aggressive in what constitutes community benefit and looking at that would certainly factor into this. Briefly in the charity care issue, the types of issues the states have looked at are what amount of free care is given, what sort of guidelines are used, as was the case in Provena. Certain hospitals and health care systems will say there is a difference in what we were paid by Medicare and Medicaid and what it actually costs to provide the service; that's pretty much gone nowhere. A lot of states have looked into whether bad debt constitutes charity care and bad debt in and of itself is not charity care. The Provena decision affirmed that. It also affirmed that health screenings and health fairs, things of that nature, although they have the community benefit, are so similar to what for-profit hospitals do that they should not come into it. So, at Provena, it actually came down to what the actual cost to the system was of actually providing care or reduced care to those folks who got it in the year 2002.

Unland: All right, I want to turn now to a little bit about how this became incendiary even though, Steve, in text of the ruling itself there is not that much discussion of collection practices and so on. As I have been indicating to the industry for several years now, the incendiary issues—the door opener on the part of investigations—appears to have been collection practices and pricing to the uninsured and I want to play a couple of very brief sound clips from different people around the country. These are all public officials.

Weyl: I just want to say that the decision itself did say that the widespread use of collection agencies by Provena to collect unpaid portions of bills was inconstant with charitable activities. So there is another direct link. Sorry to cut you off.

Unland: That's all right, no problem. Here are a few public officials from around the country commenting on this.

(Sound Clip #1 from public official)

It makes you wonder how anybody from the lowliest billing clerk in a hospital to the highest CEO could ever think it would be fair to take a working class, blue-collar struggling person and say to them 'well for you it is twice what it is for Uncle Sam, the bill is twice what it is for a private insurance company.' That is dead wrong.

(Sound Clip #2 from Chair of North Attleborough, Mass. Board of Review)

They were not providing any services they had to provide under the laws of Massachusetts to qualify to be tax exempt. The only thing that they stated that they did for the indigent was that they said that they gave 2% of the income coming out of the office which was really a bad debt, so they didn't collect 2% of their bills, so that was considered to be their charitable work. But it was just bad debt that any business would have.

(Sound Clip #3 from Treasurer of Cuyahoga County, Ohio)

(interviewer) Are you basically trying to convince these hospitals and medical centers that it's in everybody's best interest including them to come to some accommodation rather than get into revoking their property tax exemption and getting into protracted litigation?
(response) I'm not threatening them but clearly that's an option.

Unland: Those last two sound clips were county officials, county taxing officials, and I want to turn now to a very brief sound clip to introduce the situation at Provena Covenant. I want to stress again that Mark Wiener did not arrive on the scene until a lot of these events had transpired. Some people, including myself, wish he had gotten there a couple of years earlier. This is a very brief indication of some of the things that were going on; you'll hear the voice of Claudia Lennhoff who is with us here now:

(Following below is the transcript of sound from the February 2004 interview conducted by James Unland with Claudia Lennhoff and Laura Sandefur; Sandefur was a member of the Champaign County Board of Review and is now its Chair)

Lennhoff: What we were seeing (in the late 90s) was that our hospitals seemed to be acting more aggressive with coercive debt collection practices and they were failing to work out reasonable payment agreements with patients and they were failing to inform patients of the hospital's charity care program.

Sandefur: I remember sitting through that particular press conferences and there was a lady who spoke about what she had gone through in terms of her medical debt experience and it ... I took my oath very seriously about serving the people of the county and I walked out of there wondering what kind of service we were really giving the people of the county unless we paid some attention to this, unless we actually addressed the issue. It was something we had to do, I felt. It weighed on Dan as well, from conversations that we had; he indicated that this is something we really needed to look at.

Lennhoff: What happened was that in January 2002, I received a phone call from somebody who I had never met or even known about before, a gentleman by the name of Stan Jenkins, who worked for the Champaign County Board of Review, and he called me up and said that he wanted to speak with me about lawsuits by Carle Foundation Hospital against consumers and, in particular, against low income consumers; and he had followed the work that we had been doing around medical debt collection and he was wondering if we had information or where we got our information and what kind of information we had documenting that Carle Hospital was suing low income customers and whether that was a practice that was still going on.

Unland: The first voice you heard was Claudia Lennhoff and then you heard Laura Sandefur who is the present Chair of the Board of Review; as I said, this chair rotates. And then you hear Claudia again. Claudia, I am assuming that you did not know Stan Jenkins, he didn't know you and you were basically for several years, including going back to the 90's, investigating billing and collection practices and pricing practices by hospitals?

Lennhoff: That is correct. The first time, as I said in that sound clip, the first time that I had ever heard of or met Stan Jenkins was when he called me. Prior to that, we had been working to try to research consumers who had been victims of harmful and aggressive debt practices. My organization, Champaign County Health Consumers, has a consumer help hotline and consumers can call us with any questions or problem they are having with the health care system. And in the late 90's after Covenant Hospital had become part of the Provena System, we started getting phone calls from Provena Covenant patients of the sort that we had never heard of before in regard to Covenant. And these were patients who were being sued by the hospital, who had never been informed about charity care, and were clearly low-income patients. We had heard some of those same problems with Carle Foundation Hospital, but never Covenant until after Provena took over. And so we said there is a systemic issue going on here. We need to look into it and our goal was, of course, to assist the consumers, but also we started trying to document the problems. And one of our first steps after documenting the problem is that we turned to the hospitals and wanted to speak to them about their debt collection practices and we got nowhere with those efforts at that time.

Unland: All right, we will come back to that. Stan Jenkins, I am hearing then from all this including Laura's and Claudia's quotes that you sitting there in 2001 and 2002, I am hearing that the hospitals were not on your radar screen.

Jenkins: At that point that is correct.

Unland: In other words, you were not sitting there trying to figure out how to shake down the hospitals or anything else; and in fact, this was brought to your attention by, in essence, the work of Claudia's group, and Laura and Dan attending press conferences ... in other words, going after the hospitals or anything like that was not your motivation. Am I correct?

Jenkins: Oh, absolutely correct. I mean, initially, when we first looked at this issue with the Carle Foundation Hospital, with over five parcels of property, they were seeking tax exemption on those five parcels. At that point in time, we had an entirely different issue that a spokesperson at the Department of Revenue had told us. This is almost a verbatim statement (referring to the Dept. of Revenue person's statement):

"If you evict people you are not charitable. If you sue people you are not charitable."

Now at that point in time, it was pretty common knowledge in Champaign that Carle Foundation Hospital had pursued pretty aggressive debt collection methods and at that point, I did contact Claudia and it was a real turning point for us. When I called Claudia, I said 'what questions do we need to be asking?' We were not even sure at that point; we knew there was a discrepancy in the overall concept of 'if you are suing people you are not charitable' and knowing that suits were being filed on a pretty regular basis by Carle Foundation Hospital ... but we were not even sure where to start. We were literally walking into a dark room blind, but we knew we had to enter that because we had an obligation to.

Unland: But the door-opener that led you into the house, so to speak, was the issue of pricing, collections and all this and Claudia bringing this to people's attention. The reason I am making a big deal about this is that there are a lot of community groups, there has been a lot of publicity about this ... and these issues are the same issues that three weeks ago—four years into this controversy—Grassley's committee, both Grassley and a democrat, Max Baucus, what did they do? They trotted out people to tell their horror stories. It seems like this has had a resonance nationally in every level of government, Stan.

Jenkins: Well it has. No doubt about it, it has. Now originally, with this Provena case, at that point in time, the issue of discriminatory pricing practices wasn't even on the radar screen. At that point in time the big issue was the collection methods that were being used against the uninsured.

Unland: Mark Wiener has to catch a plane in a few minutes so I want to turn to him. Mark Wiener landed (in Champaign-Urbana, Illinois) in the spring of 2003. The Board of Review had filed or was imminently going to file their thing to the State of Illinois so at that point, there wasn't a lot he could do to reverse the prior hospital administrator's actions or stonewalling of the board as it has been described to me. But here is Mark's attitude. I want you all to hear Claudia Lennhoff and Mark Wiener in a very short philosophical discussion of their philosophy toward community hospitals.

(Sound Clip From Claudia Lennhoff and Mark Wiener, respectively, at the University of Illinois symposium on whether hospitals should be tax-exempt, held on April 29, 2004)

Lennhoff: I want to make very clear that hospitals' charitable tax exempt status comes with obligations that hospitals have to the community. Charitable status is a social, legal and financial contract with the community and the public, and comes with obligations to the community and the community has a right to expect accountability, transparency, fair labor practices and community benefits including free and discounted care for those who need it.

Wiener: The exemption to pay property tax is, in my estimation, a contract and that contract obligates the two hospitals to continually be held accountable for how they are dealing with or, in this case, enjoying this exemption.

Unland: So Mark, you arrived at Champaign/Urbana in what can only have been a difficult situation, and I am told that you reached out to the community group. Tell us a little bit about what happened.

Wiener: The situation was one where there was no communication ... there were no visible conduits of any kind of meaningful communication between the hospital and the community at all. And literally having been there only a few weeks, I reached out to Claudia through a person-to-person direct meeting. As CEO of the hospital, I felt that it would be appropriate to talk directly with Claudia as the leader of her organization to at least establish a dialog and identify opportunities for improving communication. It was my understanding that previous to that there had been no meaningful communication between the community and the hospital, up to the point where the hospital refused, allegedly, to even share the composition of the community members that made up the board of directors.

Unland: I interviewed about three or four hundred patient accounts people in 2004, and all of them said, "we are just collecting but a tiny percentage from the uninsured, why are we charging these prices?" Did you talk to your CFO and basically look into the issue of 'are we getting a huge yield or very little yield' from the uninsured, Mark?

Wiener: As you can imagine, being the newly arrived CEO of an organization that had a number of operational challenges, the CFO and I were looking at a number of different things, specifically in the area of collections. We looked at a complete wholesale review of all of the policies, practices and procedures that had been and were, in fact, still being followed and the end result was that we came up with a lot more user-friendly—I should say patient-oriented—set of practices, and I really credit a lot of the improvement to the direct input suggestions that we received from the community.

Unland: Claudia, didn't the hospital basically invite you into meetings and even form a committee to sit down with the hospital regularly?

Lennhoff: Yes, actually when Mark and I met for the first time Mark had said, 'if there are problems at the hospital, I would rather hear them from you first rather than read them in the media' and so on; and, as it happened, we do community organizing, we had a group of affected consumers who were willing to sit down and form a committee with the hospital and meet with them regularly. We started to have what we called 'medical debt committee' meetings in October of 2003, and we sat down with the CFO of the hospital and a couple of other people in leadership and I was there and members of our community organization including consumers who had been victims of the very aggressive debt collection practices, and we basically rolled up our sleeves and started working on the Provena Covenant charity care policy. And it was amazing ... we found tremendous common ground and that both sets of people were there because we wanted to make improvements for the lives of people in the community, and once the hospital opened up to the community members and offered them the opportunity to participate and to be at the table and have a voice, people were interested in moving forward. To this day, we continue to meet on a regular basis.

Unland: The number of lawsuits declined dramatically, did it not, Claudia?

Lennhoff: They are down to zero now.

Unland: Down from several hundred a year, or something?

Lennhoff: Yes.

Unland: Mark, can I ask you a blunt question? I am assuming from your behavior ... because there was litigation, a lot of controversy ... you would agree no matter how bad somebody thinks relations are with a community group or what somebody thinks of a hospital, it is never too late to establish rapport?

Wiener: Absolutely. I would say in my estimation that is probably one of the biggest lessons learned from what happened in Champaign/Urbana. It has universal applications to all community-oriented organizations; that is, you must establish and improve this very positive communication and dialogue with the constituents that your organization serves. And the benefits, as Claudia alluded to, the benefits were really significant and they came about in a multitude of various ways, some of which we never anticipated at the front end.

Unland: Do you have a few more minutes, Mark?

Wiener: About five minutes.

Unland: All right. So I am correct when Claudia tells me that the number of lawsuits at Provena Covenant went down from hundreds per year to zero. I am taking from what you and Cheryl Harmon experienced, Mark, that people through the fairness approach, took their bills more seriously? Is that close Mark?

Wiener: Yes, I think people genuinely appreciated the overture and the overt action taken by the hospital to get them or their representatives involved. In the case of actual billing practices, we just made wholesale changes. For example, we dropped the minimum amount required for routine payments; simply lowering that amount took something that had been a very difficult obstacle or barrier for many people and suddenly allowed for people to make demonstrable payments to the hospital that previously the system would not tolerate. We also allowed for continual updates and review of an individual patient's status throughout the billing process. Previously that had never been done before. It would allow individuals to make sure that any change or update or significant event in their life that would impact their eligibility for any kind of financial assistance to be considered at any time by the hospital. This is wholly in the patients' best interest.

Unland: Before you leave, I have two quick questions, Mark. The first question is, I know that there were concerns at one point that if Provena Covenant did certain things and if the other hospital did not meet those things, that Provena Covenant might become what has been called a 'magnet for the uninsured.' From your point of view, Mark, if there had been in place, for example, a statewide or national level of consistency in terms of pricing more fairly and some of these other policies, would this have helped you? In other words, if the hospitals in the region or the hospitals in Illinois or, for that matter, the hospitals in the United States had said 'we know that list price is a contracting reference point that has gotten out of whack, we know that some people have been harmed by our farming all of these accounts out to collection' ... in other words, if a number of hospitals or even just a few hospitals in your region had done the same kinds of things in the fairness realm, would that have helped you prior to coming to Covenant?

Wiener: If we had had the luxury of having what you describe in place in the year 2001, 2002 ... I think it is very safe for me to say that a lot of the problems we encountered in 2003 would have been avoided.

Unland: And Stan Jenkins, if those policies had been in place and Claudia's group had not had to conduct investigations and have press conferences ... in other words, if the whole pricing/collections had not even been on the table as an issue, what do you think would have been the effect in terms of your attentiveness to these matters and the Department of Revenue's attentiveness, Stan?

Jenkins: To a large part, they may have never gotten on the radar screen because there would not have been those controversies that would have drawn attention to them. I would like to go back one step, too, not only when Mark arrived on the scene did he reach out to Claudia's group ... Mark contacted the Board of Review at that time and wanted to meet with us. I think that is so important, for whatever hospital authorities to do this, to get with local authorities and have some dialogue over these issues. As it turned out, I think Mark will recall, we declined to meet because our state attorney's office said 'no, we do this at a certain level of litigation, we don't want you to be meeting on a face-to-face level with these people unless the state's attorney's office is also present.' The point is when Mark got there, it wasn't just Claudia's group; he was really proactive in reaching out to the entire community in trying to address these issues that were playing then.

Unland: And part of the reason, by the time Mark Wiener ended up in Champaign/Urbana the die had been cast, Stan. That is one of the reasons you could not meet with him or were advised not to.

Jenkins: That's exactly right.

Unland: Whereas now, hospitals sitting out there, if their county board of review makes an inquiry 'what are your billing collection practices' and so on ... when you made those initial inquiries a year or two before Mark arrived, what was Provena Covenant's response to your Board of Review?

Jenkins: We were stonewalled, plain and simple; I mean this was literally a textbook sample of how not to do it.

Unland: If a CEO had been in place with Mark's attitude, would you have met him with during the beginning of the investigation to exchange views, better understand the industry and so on, Stan?

Jenkins: Absolutely. And, in fact, we really would have had a statutory obligation to them if they wanted to meet with us. So the short answer is yes, we most certainly would have met with them and I think that is not just my opinion, that is the opinion of the members of the Board of Review.

Unland: There is an e-mail link for questions on the website. Mark Wiener, I know you have to leave. Do you have any final thoughts at the moment, Mark?

Wiener: No.

Jenkins: I would like to say this while Mark is still on the line, Jim. Mark's departure from the Champaign/Urbana area, I mean this is a real loss for our community as a whole because I think what Provena did, and excuse me for opining here for a moment ... it seems like rather than heeding the message, they chose to shoot the messenger and that is one of the reasons we don't have Mark in our community and that is a loss for the entire community.

Unland: Mark, thank you very much for being with us today. Please, everybody else stay on the line. Mark thanks a million.

Wiener: Signing off, thank you, Jim.

Unland: All right. He is taking off, so let's go back now for a minute, Stan. You have looked at this ruling now, Stan, the DOR's final ruling, we have a lot of hospitals on the line here. We have obviously established that the pricing, billing and collections issues, in turn, opened the door to the charity care issue and so on. A lot of people have called this the 'charity care' controversy, but what has galvanized this clearly in Champaign and now elsewhere, all over the country has been the pricing/collections part. I could play ten sound clips, which I won't do, of other people around the country and they all talk about the same things. But from your point of view, Stan, hospitals looking at this and their county boards looking at this, what kind of interchange do you think should take place and what kinds of policy changes do you think hospitals should do to mitigate the possibility of other Provenas?

Jenkins: Well, I think first and foremost, I would say when you (referring to hospitals) have local authorities that are looking into this, deal with them honestly in a straightforward manner rather than to shoo them away so-to-speak and not place any credence in their authority to make rulings or recommendations on these issues. Secondly, I'd say you have to revisit the charity care policy and see if it is a policy that truly is trying to promote charity care to those that are truly in need of it. Too often it seems that charity care policies have evolved into a policy of 'just how little we can get by with'? And I think hospitals need to look at those charity care policies with a brand new set of eyes from the outside looking in to see just exactly how those policies are impacting the people who are truly affected by them. The use issue, the use of the property, is also a major issue. In Illinois, for a property to be exempt it has to be in exempt ownership and in exempt use. Let's say hypothetically; let's use the example of a church that might lease the back portion of the church out to a daycare center during the week. The church might be exempt, but that portion may not be exempt as being used for a for-profit daycare center. The hospital, even if they have certain outside service providers that are in there, maybe those particular areas may not be exempted but the rest of the hospital may well be exempted. However, that is on the use side. On the ownership side, if the entire ownership is deemed to be not a charitable institution, then that is a deal breaker for the entire institution at that point and it doesn't matter what the use is, it doesn't matter if part of it is in charitable use and part is not in charitable use ... if that overall concept that the ownership is deemed not charitable, that is where the problem begins and that is where these modifications of policies really needs to start and that is the basis for needing these changes.

Unland: I understand. Claudia, you broke a lot of ground with Mark Wiener and I don't know how many other communities there are where there is a medical debt committee between a community group and a hospital, but I want to ask you a blunt question. I am taking by inference that your constituents, if you will, the people that you are in touch with, are taking their hospital bills more seriously because they feel treated more fairly?

Lenhoff: That is correct. You know, our experience is that people who have been hospitalized want to pay their hospital bills; you know, we feel that medical debt is not voluntary debt. People do not know when they are going to end up in the hospital. And they certainly have no knowledge or control of what the total cost of their hospitalization is going to be. So when they get out of the hospital, people want to be able to pay that debt. But they have to have a sense of hope that they will be charged fairly and they will be worked with in a way that is fair and not harmful and that they will be able to make meaningful progress in paying their debts. So, by having reasonable payment agreements and also, of course, assistance available if the person needs help with charity care and so on makes a huge difference. And you are right; what we have seen is when people are worked with fairly and can set up payment agreements that they can live with and that don't jeopardize their whole financial status, they do pay their bills and they want to pay their bills.

Unland: As I said a minute ago, I interviewed hundreds of people in 2004 and not one patient accounts manger, Steve, told me that they were making over 5% net yield from the people they were charging these goofy list prices ... and by net yield, I don't mean the yield to collection agents and so on, I mean the net yield to hospitals. And many CFO's and people did not know who they were suing and why. In fairness to the hospital industry, I think a lot of individual hospitals have changed their policies, Steve, but isn't this a bit of exposure in terms of this kind of repeated behavior in over-charging and pursuing people who really never paid much of these bills to begin with?

Weyl: I think it is an issue and I think, Jim, it is what opens the door to a consumer fraud or unfair business practices complaint.

The Provena decision noted that there is a disparity between the 'usual and customary charges' and what was being charged a third party payor such as Medicare, Medicaid and private insurers. The other thing that was interesting to me (in the Provena decision) that was a new wrinkle was looking at how two patients similarly situated in terms of poverty income levels or percentage of that might deal with bills: one having a \$50,000 bill reduced by 50% and the other having a \$1000 bill reduced by 50%. And clearly the patient who comes out with a \$500 bill is more likely to pay that than the other patient.

What was interesting about that, in my view, was the suggestion in there that you (a hospital) may not only have to take into account the federal poverty level—which many institutions do or some ratio of the federal poverty level—to apply a discount, but also look in absolute dollar terms of the patient's ability to pay.

I think that is a bit different from what we have seen across the country and it doesn't necessarily bode well for hospitals, but when you tie that into the fact that your research shows that virtually none of these dollars are collected, and you bring back in Claudia's comment that people want to pay their bills to the extent they are able, that may certainly be a factor that we would ask our hospitals to look at ... not just a percentage reduction and not just where they start from in terms of the reduction, but what in fact is the patient's overall ability to pay and how that should figure into things.

Unland: I am now being told by hospitals that have actually reformed their pricing policies but also gone in depth into Claudia's issue of the payment terms and what you just mentioned Steve, I am being told that fair practices are generating more revenue from this population. That shouldn't be a shock, should it, Claudia?

Lenhoff: No it shouldn't. And look, any of us who draw a paycheck, for the most part, have to have some predictability and frequently have some predictability in our income. We know what we have coming in. We need to know what we have going out and we need to know that we can continue to afford rent, utilities, telephone and all of the other things that are necessary to live. So I think having a reasonable payment plan where you feel you are being treated fairly and the rules aren't going to change once you have gotten that payment plan set up ... people are willing and eager and capable of committing to that payment plan.

Again, I think it is important to understand that people who incur debt from hospitalization don't necessarily get back to their lives immediately. A lot of times when people have massive debt as result of hospitalization it is obviously because something significant has happened to them and they may be incapacitated from working and so on, so there has to be a recognition that the transaction that took place isn't the same as the transaction of going and purchasing furniture.

Hospital debt is like no other debt on the consumer side of things and so the reasonableness is critical.

Unland: It *is* involuntary debt. I want to ask you, Claudia and Stan, a question here. If hospitals, from their points of view, have questions of either of you or want to bounce things off of you, Stan Jenkins and Claudia Lenhoff ... Claudia is the head of a community group and Stan is the member of and was chairman of the Champaign County Board of Review, could I put them in touch with you guys?

Lenhoff: Absolutely. From the perspective of health care consumers, and I know Stan wants to answer as well, from the perspective of health care consumers, we see this as a nationally significant issue and any hospital that has questions or is willing to work with us, we are very happy to help out in any way. We think that not only the community members will benefit but the hospital will benefit as well.

One of the things that I wanted to say that was not in the sound clip that you played earlier but that I said at that meeting is that communities want, need and value their non-profit charitable hospital. We would rather have non-profit charitable hospitals in our community than for-profit hospital and that is because of the social contract and because we think it benefits the community overall. So yes, we are always happy to help any hospital that thinks we can be helpful to them.

Unland: Stan Jenkins, I am assuming that if a hospital wanted to ask you, to run some things by you as to how a county board looks at some things, you would be willing to talk to them?

Jenkins: Absolutely.

Unland: I wanted to ask you a question about the other consumer groups around the country, Claudia. In a lot of places there are consumer groups. Have you heard from a lot of people around the country on this decision and the events at Provena Covenant?

Lenhoff: Yes ... whether people realize it or not, there is a whole network of organizations that are doing consumer health advocacy. Many of them are not consumer health organizations but are social service organizations that have had to take on this issue. So just as the hospitals nationally have been keeping an eye on this issue, so have the consumer health advocates as well. And a lot of people are asking about this and are asking about the implications of this and are very interested.

Unland: And, Stan, I am told that you are getting a lot of calls not just from Illinois but a lot of counties around the country. This has raised a lot of interest.
I have a question from a reporter and here is the question about the ruling. It relates to the issue of the doctors and other entities working inside the hospital walls. How prevalent, and maybe this is best put to Steve, how prevalent is this kind of contracting work? And are some hospitals looking at moving out these contractors or maybe they will have to draw a circle around some of these for-profit contractors and deem that percentage of space as taxable, Steve? Maybe Steve and Stan could address that. How concerned should hospitals be in continuing these arrangements?

Weyl: Jim, my view is that if these arrangements are structured properly then they should not be a concern and, in fact, as you and I have discussed for several years, in many cases contracting with an outside for-profit provider presents a lower cost of care than the hospital carrying employees on its staff.
I think, coming back to Stan's point, the first question is: do you have a charitable provider and do they have the proper charity care policies in effect? If they do, then I think you can clearly educate a county board, state taxing authority, whatever it is, to the concept that the use of facilities by a private group, in and of itself, should not be a reason to deny tax exemption. The ultimate issue is whether to the extent necessary these patients who are using these groups are receiving charity care.

Unland: Stan, If the pricing/collections thing had been off the table and I had been the CEO of Provena Covenant and you guys had come to me and talked about this, if I could have demonstrated that the use of certain types of businesses, as Steve says, generated more efficiency for the hospital and, therefore, more net cash flow to plow back into community benefit, even though you might still have had some concern about the way the law is written in Illinois, would you have listened to that argument?

Jenkins: Oh, of course. I think it is a very relevant argument. I mean, no one wants a poor quality health care or less health care in the community. I think these private physician groups and these private on-site providers enhance the level of health care that communities have and I think it is becoming more and more the best medical care for the lowest possible price. But, they do have to be dealt with in a different way than the hospital bed up in a room that is, in fact, part of the larger hospital organization.

Weyl: If I could make one other quick comment about the Provena ruling, which I think comes out of it. The director concluded that this is really a revenue-generating facility; while that is true, I don't think that is inconsistent with holding charitable status under state law. The fact of the matter is that these are no longer the types of hospitals we had at the turn of the century, that are staffed in that particular way. I think that the critical issue, again, is not whether it is a revenue-generating facility but whether it has a viable charity care policy, whether it is putting the right amount of resources into charity care and carrying out the community benefit the way it needs to. One of the critical issues is: does this system help alleviate a burden that government otherwise would bear? ... and that is why you need to take a global look at it rather than 'this section is used by these doctors'. As an overall matter, are you there? And if Provena Covenant had had a charity care level of 4%, 5% that was truly cost to Provena Covenant, I think you should have had a different result. I am not saying you would have, but I think in those situations you are having an institution that is really giving back to those in need.

Unland: Claudia, do you have a point?

Lenhoff: Yeah, I just wanted to comment on the issue of the doctors and contracting with the doctors and what I wanted to say is that from a community and a consumer perspective ... what we don't want to see is patients getting admitted to the hospital with no control over who the doctors are who are going to see them, and then coming out of the hospital and finding out that the charity care policy only applies to the hospital bed but does not apply the physician's bill. And one of the things we have been very glad to see with Provena Covenant is that Provena Covenant with many of their docs has made arrangements whereby part of the contract with the docs is that the doctors also abide by Provena Covenant's charity care policy so that if a patient qualifies for a 50% discount on their hospital bill, they will also qualify for a 50% discount on their doctor's bill which will come to them separately.

From a community perspective that is very important because when you are admitted to the hospital you are often going to end up with more than one bill, and how meaningful is a charity care policy if it only applies to 40% or 50% of your total bill?

Unland: And that is becoming more and more true as is evidenced by people's higher co-pays and deductibles as well, isn't it Claudia?

Lenhoff: Yes, and personally I understand and we all understand that the health care market is different now and there are these contractual relationships and there are efficiencies that can be generated through these contractual relationships. We are not opposed to the contractual relationships. It is just that from the consumer perspective we want to make sure that if you should qualify for charity care assistance as a result of being hospitalized, it should apply to the entire cost of your hospitalization including physician bills and lab x-ray bills and so on.

Unland: I can understand that.

Jenkins: I would also add to that that I think in terms of a proactive strategy in risk reduction in terms of: are you going to continue to enjoy an exempt status or not enjoy that exempt status; what Claudia is suggesting is going to become a norm rather than the exception in the hospital industry. It is almost going to have to become the norm and the way of doing business; otherwise, they are going to be under constant attack as a result of this disparity and how people are treated within the same hospital walls but by two different entities within those hospital walls.

Unland: A good point, Stan. I want to ask you a question, Stan. I am going to read to you and get your reaction and Steve's, to part of the last paragraph of this ruling (referring to the Illinois Department of Revenue's ruling in the Provena Covenant matter):

... the record does not permit me to conclude that Covenant, the applicant, dispenses charity to all who need it and I cannot conclude that it does not place obstacles those who need and would avail themselves of the charity it dispenses.

And here is a sentence that I want to read to focus on:

*Nor can I conclude from this record that the owner of the property, Provena Hospitals, dispenses charity to all who need it or that it does not place obstacles of any character in the way of those who need it and would avail themselves of the charitable benefits it dispenses. In summary, given the very limited amount of charitable care offered, I cannot conclude that **Provena's** primary purpose is the provision of charity. (emphasis added)*

Is the director of the Illinois Department of Revenue saying that the entire Provena system should be looked at, Stan?

Jenkins: Well, he is very much on point with his comments. I am not saying that he is suggesting that that happen, but it is certainly an open door invitation to any other county that has any Provena facility in it.

Unland: So it is possible that with a multi-hospital system, if one of the hospitals gets into a dispute and loses its property tax exemption in one county where there is a tax review board, that possibly other counties' tax review boards of such a multi-hospital system might also be galvanized by this reasoning to look at their respective hospital situations?

Jenkins: Absolutely. And, you know, going back a few years to one of the first meetings we had with the Provena people, it was suggested at that point in time, 'you might be better off just paying the property tax rather than having your entire charitable status come under scrutiny, because if you are deemed not charitable, then it brings in the whole question of sales tax exemptions, brings into question state corporate income tax, federal income tax' ... because we could foresee a ripple effect of what impact this could have on various hospitals.

The director's comment is very much on point with regard to Provena.

Unland: Steve Weyl, did you react the same way to those phrases?

Weyl: They gave me an ominous feeling. I think that without having seen the entire record, it is clear from the decision, there is an enormous amount there. Certainly the ownership of the facilities for which you are seeking exemption is one particular issue. Going back to Stan's earlier comment, you are either a charity coming out of the gate or you are not. And if you are not, all of these things fall away. One the things that seemed to trouble the director (referring to the director of the Illinois Department of Revenue, Brian Hamer) which is not uncommon—and I think has to be evaluated in a broader context—is the laboratory relationship between a for-profit affiliate of Provena and the hospital itself. My view of those things is that you take a look, again, and see if this is the most cost-effective and efficient way to deliver services and if so, I think it is hard to argue in and of itself that the institution not charitable. Now, to the extent that space is occupied by a for-profit entity that is freestanding such as a pharmacy, you may have somewhat of an argument as to whether that space is entitled to exemption or not. But, I think that what the director was saying very clearly is that as I look at this I am really looking ... and this is so similar to what the Utah courts decided in 1984, they said we just can't see a meaningful difference between for-profit and not-for-profit hospitals and the Intermountain System to us is being run to us as a business and is not giving back the way that it should. And I think that this is a very similar type of wording to that. The other thing that the director said that is similar to Utah, remembering that we are talking of twenty-something years of case law, was that we are not going to give a tax exemption where the amount of the property tax exceeds the cost of the charity care given ... and Utah ultimately came into a system where you had to give at least one dollar for every property tax exemption dollar, which is not necessarily the standard but it became the Utah standard.

Unland: That leads me to my next question and that is this. The Eden Retirement Center decision which is cited in this decision ... the Supreme Court of Illinois decided on Eden Retirement, basically the message that they were transmitting was 'hey folks, "used exclusively for" means just that.' Is it possible that if Provena appeals and this goes all the way to the Illinois Supreme Court ... is there a risk that the Illinois Supreme Court could say: 'look, we don't expect 501(c)(3) corporations or tax-exempt entities to be used exclusively for charitable purposes,' meaning 100% of their revenue and stuff goes to charitable purposes, 'but we do expect them to be used for *primarily* charitable purposes as was the phrase used in this ruling so lets go with 70%' ... is there a risk that in appealing this (referring to an appeal by Provena of the Illinois DOR's administrative decision into the regular court system) a very, very much stricter charitable level could come out of the Supreme Court of Illinois, Steve?

Weyl: The extent to which 'exclusive' means 'primarily' may well be refined by the Illinois Supreme Court. You see the same analog in the federal 501(c)(3) where the term exclusive means primarily. I don't think if that is the standard you are going to have many institutions that are going to qualify for a charitable exemption. And I think the recognition is that there has to be some purpose, that you do not have to be entirely charitable but that being 'primarily' charitable doesn't take away from the charitable nature of the institution; otherwise, you have got a situation that I think is simply unrealistic.

Jenkins: In fact that is exactly right. The Supreme Court Eden Retirement Center ruling basically upheld a previous set of criteria handed down in a case called Methodist Old People's Home. Methodist Old People's Home defined that 'exclusively' means that the 'primary' purpose and not some 'secondary or incidental' purpose is charitable activities. So the Methodist case modified the word "exclusively" down to "primarily" and the Illinois Supreme Court in the Eden case upheld the criteria in the language of the Methodist Old People's Home case.

Unland: Lisa Madigan proposed this year that the standard be 8% (referring to the Illinois Attorney General's proposed legislation in the winter of 2006 that set forth a standard in which the amount of 'charity care' provided by a hospital had to equal at least 8% of the hospital's expenses, subject to some exceptions and qualifiers). I am just a little bit concerned that the Supreme Court may make that 8% look like a great deal.

Jenkins: It could. I mean that is pure speculation, but it absolutely could, because then you could get into what is 'primarily'? Is it 51% or is it 21% or is it 12%?

Weyl: You know Jim, coming back this is the same type of issue in an analogous way that entities are facing at the federal level. What is the community benefit standard? What do your standards have to be? And I think what we are going to see out of Congress is some sort of refinement of what constitutes a 501(c)(3) entitled to tax exemption. I think we are going to get a whole body of case law that also refines it. But whether we are going to get a break-line like in Utah where it is a dollar-for-dollar or Madigan's proposal for 8% ... I don't know. I think that these ultimately somewhat subjective judgments have tiers, in fact, and others will have to come, too.

Unland: Well, look you all have been most gracious with your time. I would like to invite each of you to make closing comments. Thank you all for getting together. I would also like to thank Mark Wiener who had to leave.

Claudia, Claudia Lennhoff head of the Champaign County Health Care Consumers, thanks a million for joining us.

Lennhoff: Thank you very much, and I just wanted to close by again saying that the community organizations and community members truly do value their non-profit charitable hospitals and I think the best way for community hospitals to be strong and communities to be strong is for us to work together.

Unland: Thank you very much. Stan Jenkins.

Jenkins: I would agree with what Claudia said. There is no question and at the Board of Review level, these hospitals are great assets to the community. We have no agenda in trying to harm them. It started out as an issue of Champaign County and Illinois law. It is, obviously, growing into issues much broader than that.

I would welcome the opportunity ... as you know, Jim, I have spoken several times in various meetings. If individual hospitals or executives want to discuss our perspective in this, we don't mind sharing our thoughts and offering whatever advice we can give them.

Unland: Thank you very much Stan. Steve Weyl.

Weyl: Well, Jim, first thanks again for the opportunity to discuss this. I would say the most important things you can do (as a hospital) is to be proactive as to what your charity care policies are. How you reach out to community groups, how you reach out to taxing authorities. This is an issue that anyone would be foolish to wait and see what comes out from the Illinois Supreme Court on the Provena case, if in fact it goes that far. It is a national issue and it is something where scrutiny is going to be greater rather than lesser and I think that there are standards and other things that people can look at and that people should consider implementing—particularly in light of the Provena decision which you, Jim, have been good enough to link to the website for this teleconference—that should be taken into account by hospitals and their professionals.

Unland: Thank you all very much. I am going to close with a very quick comment by reading something:

"Members of hospital managements and boards and the executives of hospital associations are urged to coordinate decisive action in order to forestall more widespread and very serious trouble at the local hospital level. What happened in Champaign Illinois is a grave warning to all hospitals and needs to be impelling action now. The hope would be that an expeditiously forged set of explicit and specific national policies from hospital associations would mitigate the class action suits and local challenges to hospitals' exempt status."

I wrote that in February 2004. These issues unfortunately, from a risk analyst's standpoint, involve a lot of trouble over a low yield population, and Claudia and Mark Wiener both indicated that the yield on this population to the hospital was horrible and it actually has improved; and frankly, being fair to people is really hard to beat.

I am sorry to see that this controversy has continued to move including in Congress just a few weeks ago at Grassley's hearing and also including state attorneys' general investigations and all kinds of things. It is too bad that this continues on and on and on.

This has been a risk management and leadership challenge from day one, at the national hospital association level and certainly at the state hospital association level. That's my closing comment. Thank you all for participating: Steve Weyl, Stan Jenkins, Claudia Lennhoff and Mark Wiener.

Email Questions to James Unland at: healthbusinessandpolicy@yahoo.com

