

the team behind your team



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March 4, 2008

Senator Dan Weinberg
Representative Ernie Dutton
SJR 15 Subcommittee

Dear Sirs:

On behalf of the physicians of the Great Falls Clinic, this letter is in response to the subcommittee's invitation to all parties to submit comments and proposed amendments on economic credentialing (LC 0038) and specialty hospitals (LC 8888). We thank you for the opportunity.

1. LC0038—Economic Credentialing/Discrimination

Although section 1 deals with conflicts of interest on the part of a physician, it does not in any form address the equally important matter of conflicts of interest on the part of a hospital. Anytime an entity can influence referral patterns of patients, either directly or indirectly, the potential for conflict of interest exists. Hospitals are increasingly becoming more powerful in indirectly mandating those referrals by 1) employing the referring physicians, or 2) developing and running health plans. Both of these activities can be used to significantly influence where a patient receives care and thus would be a conflict of interest on the part of hospitals. This conflict of interest should also be disclosed.

We find the wording in Subsection 1(5) particularly troublesome. This paragraph assumes on its face that a financial interest on the part of a physician impacts quality. The two have no relationship in fact: Quality is not defined by one's financial portfolio. In truth, it has been shown throughout the U.S. that physician ownership in a healthcare facility increases the quality of care and decreases cost.

Subsections 1 (6) and (7) would cede too much power to the hospitals. As written, these subsections authorize the hospital to determine when a conflict of interest occurs. This is analogous to the fox guarding the henhouse. Even with the arbitration provision, hospitals would merely need to threaten an allegation of conflict of interest to affect physician behavior and thus reduce the medical staff to nothing more than "good foot soldiers."

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In essence this wording indirectly gives back to hospitals what the 2007 legislature found unacceptable and lead to the development of SB 312. This wording effectively eliminates competition and patient choice in their healthcare.

2. LC8888—Specialty Hospitals

We recommend that the language proposed for Montana Code Ann. 50-5-101 (55)(a)(ii) and (iii) be deleted because it is confusing. With regard to (55)(a)(ii), the clear implication is that for a specialty hospital to be defined as a specialty hospital, it must be a joint venture with physician owners and a hospital. This is nonsensical. With regard to (55)(a)(iii), the language is nebulous and would likely lead to further confusion.

One could imagine scenarios where an applicant could meet neither (ii) nor (iii) and, therefore, be prevented from pursuing the establishment of a specialty hospital. Thus, the wording leads to anticompetitive interpretation.

As the proposed language in Mont. Code Ann., 50-5-245 now stands, a community hospital could indefinitely hold up approval of a specialty hospital license by refusing to cooperate with the proposed requirements. Perhaps a better way of approaching this would be a general requirement that the applicant, not the community hospital, be responsible for submitting evidence that an offer of joint venture was indeed made and declined.

Sincerely,

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Chief Medical Officer
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Cc: Mona Jamison