Children, Families, Health, and Human Services Interim Committee

60th Montana Legislature

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Minutes
SJR 15 Subcommittee

March 17, 2008

Room 137, Capitol Building
Helena, Montana

Please note: These minutes provide abbreviated information about committee discussion, public testimony, action taken, and other activities. The minutes are accompanied by an audio recording. For each action listed, the minutes indicate the approximate amount of time in hours, minutes, and seconds that has elapsed since the start of the meeting. This time may be used to locate the activity on the audio recording.

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COMMITTEE MEMBERS PRESENT

SEN. DAN WEINBERG
REP. ERNIE DUTTON

STAFF PRESENT

PAT MURDO, Staff for SJR 15
LISA JACKSON, Staff Attorney
FONG HOM, Secretary

PANEL MEMBERS AT THE TABLE

Dr. Tim Khaliqi
Dr. Bob Wynia
Dr. Kurt Kubicka
Dr. Jim Elliott
Dr. Mark Rumans
Dr. Keith Popovich
Tim Nagel
John Flink
Mark Taylor
Jeff Fee
Jeff Buska
Lorena Pettet
John Solheim

Visitors

Visitors' list, Attachment #1.

CALL TO ORDER AND ROLL CALL

00:00:01 Sen Weinberg called the meeting to order at 8:04 a.m. The committee secretary took roll visually.

AGENDA

Overview of LC 38 on economic credentialing, conflict of interest

00:04:31 Pat Murdo, Research Analyst, LSD, discussed several sections in the draft of LC0038 **(Exhibit 1)**:

- the referral clause, which was put into Title 37 as a requirement for all health care practitioners.
- Subsection (2) states that health care professionals may enter contractural relationships. The health care practitioners' primary responsibility is the welfare and well-being of the patient. Practitioners may not engage in intentional conduct that is detrimental to a patient's health.
- Conflict of Interest section in Title 50 restates that the primary concern of licensees must be the welfare of the patient.
- Section 3 which is the same statute that currently exists in law, updated to remove the economic credentialing temporary language.
- Concern about how on call requirements are used and whether there could be discrimination. The original statute excluded on call requirements and left that discretion to a hospital.
- The changes in subsection (2)(a) that are intended to meet the concerns of people who said that some Boards of Directors require participation by the Chief of the Medical Staff. That language attempts to say that the governing board can decide if a conflict of interest exists and limits access to the information.
- The definition of health care provider that references people licensed under Title 37, except for veterinarians.
- A provision regarding exclusive contracts between a health care provider.

Ms. Murdo noted changes regarding enforcement language because the Department of Public Health and Human Services had said that there was some concern about who enforces this. She put in the Attorney General for investigation of unlawful practice, under 30-14-103, which is an unfair trade practice for consumer protection issues. The new version says that the Department of Justice the DPHHS can work together and adopt rules. She said that the remaining sections are standard language for repealing the termination date, plus providing codification language. The effective date would be upon passage and approval.

Discussion on LC0038

Section 1 - Disclosure required.

00:23:18 Sen. Weinberg asked Jeff Buska, Administrator of the Quality Assurance Division, DPPHS, whether the Department could help define what must be disclosed and the extent of the disclosure. In response to Sen. Weinberg's question, Pat Murdo said that actually would be under the Department of Labor and Industry for Section 1 of the draft. She said that as a condition of licensing in Title 37, chapter 1, licensees could fact an unprofessional conduct charge if they did not comply with disclosure and referral requirements.

00:24:22 Rep. Dutton asked Mr. Buska if the definition of health care facility would in fact include hospitals.. Mr. Buska said the definitions of health care facilities in Title 50 does include hospitals and other health care facilities that are typically provided in the state; i.e., assisted living facilities, nursing facilities, hospitals, as well as critical assess hospitals.

Dr. Kurt Kubicka, representing the Montana Medical Association (MMA), provided written comments **(Exhibit 2)** from the MMA on each section of the bill draft. He said that MMA would propose striking Section 1, or limiting disclosure requirements to instances of a proven abusive referral pattern and/or limit disclosure specifically to non-urgent, elective referrals.

Sen. Weinberg asked Dr. Kubicka to explain why this would be difficult in emergent circumstances. Dr. Kubicka said that, for example, if somebody is in an emergency room requiring surgery, it doesn't seem timely at that point to be pointing out the fact that there is an alternative surgical hospital or other hospital within the community that might provide that service. In the instances of a bonafide emergency, the care of the patient has to come first. A concern would be that in an emergent situation, if full disclosure wasn't made, that could open the opportunity for litigation.

Sen. Weinberg asked if most of the paperwork that is presented to the patient when they enter an emergency room done to protect the hospital and not the patient? Dr. Kubicka said that he could not speak for the hospital, but he would say that was a fair characterization.

Sen. Weinberg and Dr. Kubicka discussed the balance between protecting the hospital and the doctors on one hand and protecting the patient and informing the patient on the other. Dr. Kubicka said MMA can abide by the disclosure elements in the latest draft in the bill but would want it clearly defined and enforced only in elective, non-urgent circumstances. He talked about disclosure for independent physicians versus physicians employed by the hospital. He said that if there is a proven abusive referral pattern, then these disclosures should be made along with a host of repercussions.

00:35:14 John Flink, Montana Hospital Association, said that they would agree with some of Dr. Kubicka's comments about the practicality of a provision like this, but more important to MHA is a discussion about what to do with economic credentialing once the current statute sunsets. MHA prefers to separate those provisions from

a bill that deals with economic credentialing. He also said MHA would like to see the reference to the employment relationships stricken from this draft.

Lorena Pettet, Montana Physical Therapy Association, asked for a point of clarification on Dr. Kubicka's statement that independent physicians seldom have investment interest in some free standing alternative facilities or other health care facilities. She discussed SB 312's core issue of conflict of interest and felt strongly that the conflict of interest and its definition should be included as well as the disclosure regulation. She said that Section 1 should also include that definition of conflict of interest.

Jerome Anderson, Montana Orthopedic Association, reinforced from his own experience, the difficulty of understanding all that goes on when a patient is in an emergency room..

Dr. Mark Rumans, Billings Clinic, commented on the paperwork that patients get. Some of the information benefits the patients. He discussed the difference between employed physicians and their practice patterns. He said this particular language is unclear as to what would and would not need to be disclosed. He would be a strong supporter of pulling the disclosure out of this bill and getting back to the full intent of the bill, which is to talk about economic credentialing.

Sen. Weinberg asked Dr. Rumans if keeping disclosure and referrals in Section 1 change practice patterns? Dr. Rumans said the changes would not affect practice patterns as much as work flow. An independent practitioner without any investment interests is not going to have to do anything different when making an MRI referral. If this section stays, he said, the language about emergencies needs to be put in and also the difference between employed physicians versus physicians with an investment interest. He would prefer that it be pulled out completely and dealt with in a separate manner.

Dr. Kubicka said that MMA's position would be that if disclosures and referrals are to remain in Section 1 of the bill, they can abide by that, but it needs to cover both independent physicians and employed physicians. If there is going to be disclosure requirement for an independent physician, MMA feels that a similar disclosure requirement should apply to an employed physician as well.

<u>Section 2 - Contracts -- referrals -- primary responsibility -- definition.</u>

00:44:22 Dr. Tim Khaliqi, Great Falls Clinic and Central Montana Medical Hospital, said that as a physician it is distasteful to have codified that his primary responsibility is to take care of the patient, and to have a specific statement that says he may not engage in any intentional conduct that is detrimental to a patient's health is something that a physician does not need to be told.

Sen. Weinberg said that he would agree with him, but at the same time, it is distasteful that some physicians have patterns of prescribing medication based upon the medication representatives buying them lunch, reviewing their records and giving them some kind of perks or kickbacks because they are using their products. He said that what they are trying to do is look out for the patient and

make the system fair. The fact that we have to raise the issue, he agrees, is distasteful.

Dr. Bob Wynia said that this is a situation that occurs on all walks of life in the sense that a very small minority creates difficulties for the majority.

Mona Jamison, representing Great Falls Clinic and Central Montana Hospital, supports Dr. Khaliqi's statement. In referring to the provision regarding intentional conduct, she said that intentional conduct that is detrimental to a patient equates to a criminal act and there is criminal prosecution available for that. Action also could be taken under Title 37 with the Board of Medical Examiners for revocation or suspension of a license. She doesn't believe it belongs in this bill and believes that it is more than adequately taken care of in other laws.

Sen. Weinberg said that one of the reasons this subcommittee was formed and this legislation is under consideration is because abuses do occur or are perceived to have occurred, and the fact that it is handled elsewhere in code has not fixed the problem. Ms. Jamison said that she agrees but there is no law on the books that totally addresses every issue or violation of a particular statute. In discussing the prescription drug issue, Ms. Jamison said that there could be a situation where a particular drug is both beneficial and an economic interest to the physician. She said that she does think that the issues are separate and may set up conflicts under the statute. She asked which agency is going to be responsible for establishing and proving that a physician is intentionally acting detrimental to a patient, and where is the authority to pursue criminal action?

Sen. Weinberg asked staff to comment on how this would be challenged. Pat Murdo said that she believes that the section relies on the unprofessional conduct statutes. The licensing boards would have the authority to basically strip someone of their license if they violated the unprofessional conduct statute. It would be the boards that handle this. If it is criminal, she said, they could refer it but they would also be able to strip away the license.

Rep. Dutton asked whether subsection (b) really adds that much to the language given that it is covered in subsection (a). In fact, subsection (b) would seem to set a higher bar than what is already covered in subsection (a). Ms. Murdo said that it was put there for discussion purposes. She asked that the committee tell her what they want changed or taken out or added.

Sen. Weinberg asked whether or not referrals were being made that are ethically inappropriate. He said that if we want to move this system and make it more fair, we are going to have to do this and that he is reluctant to take out the ethical standards.

<u>Section 3 - Primary responsibility -- arbitration.</u>

00:56:29 Dr. Kubicka said that MMA agrees with the importance of coming up with a mechanism to define an abusive referral pattern and to establish repercussions when an abusive referral pattern exists **(see Exhibit 2)**. Dr. Kubicka discussed

MMA's proposed changes to Section 3.

Jeff Buska, DPHHS, said that the Department doesn't have a licensing board but has a unit that upholds the licensing requirements of healthcare facilities. This would be an administrative activity as it relates to conflicts of interest that could be difficult for staff. Sen. Weinberg asked if that process would be more difficult than the process of arbitration as spelled out in the draft? Mr. Buska said that the process of an arbitration involves an independent entity taking a look at the facts.

Rep. Dutton said that it is contemplated that the Department of Labor would actually be reviewing the facts because it is the department that licenses doctors. Pat Murdo said that if the abuse is by someone licensed under Title 37, then as MMA said, that person's licensing board would be able to take action. She noted that a health care provider employed by a health care facility might have an abusive referral pattern that could be grounds for disciplinary action against the health care facilities if the physician is being told to make those referrals by the health care facility. That information would come out in the disciplinary action under Title 37 and then the Department of Public Health would be asked to investigate.

John Flink, Montana Hospitals Association, agreed that the place to adjudicate these kinds of disputes involving physicians and health care practitioners is the licensing board. He voiced concern over the issue where a hospital employed physician could be accused of abusive referrals, stating that assuming some things that aren't ready to be assumed.

Dr. Mark Rumans, Billings Clinic, agreed that the Board of Medical Examiners is the right place for enforcement. He voiced concern over the referral patterns of hospital employed doctors. The first step is at the physician level to deal with a pattern of abusive behavior.

Sen. Weinberg asked whether institutions require their employees to follow certain patterns of referral behavior. Dr. Rumans said that the Billings Clinic, as a group, refer to one another but their physicians are told that they can refer to whomever is the most appropriate clinical provider for that patient. Dr. Rumans said that he didn't believe that other institutions actually require it because the patient's care has to come first. Sen. Weinberg said a mechanism may be necessary to determine if abusive referrals happen and this is what this legislation is set up to do.

Rep. Dutton said that he is hearing agreement on the new Section 3. He asked if the last sentence should say: "may be grounds for disciplinary action".

John Flink, MHA, said that MHA doesn't think that it belongs in Section 3 and that the responsibility for referral patterns rests with the referring physicians.

Mona Jamison pointed out that to maintain credibility, the process needs to address both physicians and abusive patterns that exist institutionally, either

directly or indirectly, by the hospitals. She said that if the abusive referral pattern is by physicians, then proceed under Title 37's licensure provisions. But if a hospital is exhibiting an abusive referral pattern, then enforcement should be under Title 50 because the Department of Public Health has jurisdiction since they are the ones who license. She said to make sure that the agency with the licensing jurisdiction has jurisdiction to deal with these issues.

Sen. Weinberg asked Ms. Murdo to work on the revisions.

01:14:30 Dr. Bob Wynia said that based on his 42 years of experience with 20 of those years spent on the Executive Committee of the medical staff, he saw effective work in changing the practice patterns of good physicians. He said that between 40 and 50 physicians' patterns of practice, their attitudes, or abuse of drugs or alcohol were effectively addressed by the medical staff. He questioned how effective the state or the Board of Medical Examiners has been in containing physicians.

01:17:23 Dr. Kubicka, MMA, said that MMA would agree with Dr. Wynia that the medical staff has a role in policing the clinical judgment of a practitioner within the staff. He commented that an abusive referral pattern should not be dealt with at the medical staff level. The medical staff level deals with clinic issues and this is an economic issue. MMA thinks that there is too much potential for economic conflict within the medical staff for that to be the appropriate adjudicating body.

Sen. Weinberg said that Pat Murdo will work on clarifying Section 3.

John Solheim, President of St. Peter's Hospital, referenced the semantics of health care provider, health care facility or clinic. He noted that a clinic is not defined in statute as a health care facility. He said that the clinic body needs to be added to that.

Pat Murdo asked if it is necessary to have the current language that says the primary concern for a health care facility is the welfare of the patient except in public health concerns. Sen. Weinberg said that we want to leave that in as well as Sections 1 and 2.

Dr. Khaliqi pointed out that clinics, not being licensed, have no regulating body [for enforcement]. He noted that at the Great Falls Clinic, if there is an abusive referral pattern, it would fall to the individual physicians because they are not technically employed by the Clinic. That adds ambiguity. He reiterated that not only do physicians have to be held accountable for abusive referral patterns but facilities as well.

Sen. Weinberg asked what they should do about clinics? John Solheim said that that point goes to parity. A clinic is an organization that could direct behavior and that should be held accountable. Mona Jamison said that parity already exists because individual physicians are responsible. She noted that no enforcement mechanism exists for clinics. Sen. Weinberg said that he thinks what Ms. Jamison is saying is that we have it covered even if we don't mention clinics. We

are still covered because the doctors are responsible. Ms. Jamison said that the proposal puts additional burdens on physicians in terms of contracts and abusive referral patterns than it does on hospitals and more than adequately addresses abuses by doctors through contracts and other practice measures.

01:25:42 Mr. Flink said that the comments that Dr. Khaliqi and Ms. Jamison made reinforces the point that he made earlier about the primary responsibility for referral patterns being on the physicians. He said that even though it is unlicensed, a clinic could just as easily be directing patients to clinic-owned services as not. Sen. Weinberg and Mr. Flink debated the differences between hospitals and clinics and how employment and ownership of physicians impact referrals.

01:27:53 Pat Murdo said under section 1(b), page 2, a contractural relationship may not require referrals or an expected volume of referrals. That is proposed to be in Title 37 but should be in Title 50, and might resolve the issue of hospitals or ambulatory surgical centers requiring any health care provider, to make a certain number of referrals. She questioned the best placement of the subsection.

Sen. Weinberg emphasized his concern about pressure from an employer to refer in a certain pattern, which has as much power as a contract..

Section 4 - Discrimination prohibited.

01:29:54 Pat Murdo said that the Hospital Association has revised language for Sections 4 and 5 (see handout) **(Exhibit 3)**.

Mark Taylor, representing the Hospitals Association, said that Section 4 in both drafts are the same. He stated that in creating a separate draft, they relied upon comments and panel discussions over the last several months in addition to meetings with the Montana Medical Association. He said they looked at statutes within Montana and outside of Montana to come up with a mechanism for economic credentialing, as was contemplated by the last legislature.

Mr. Taylor outlined the difference between the drafts. He said that he thinks there is a consensus on their language regarding physician leadership or physicians sitting on the governing boards of a hospital, specifically on the ability of physicians that have conflicts of interest or ownership interest in other facilities still being able to sit on leadership positions within the medical community. They came up with a definition of conflict of interest that is consistent with other aspects of state law.

Sen. Weinberg asked with whom is the "consensus"? Mr. Taylor said with the Montana Medical Association, adding the caveat that Dr. Kubicka could speak for himself as a part of that discussion.

Dr. Kubicka said that MMA feels that the committee has made tremendous progress with the existing draft, LC0038. He said that MMA feels that the best approach is not to go back to the original bill (SB 312) and redraft it, which he believes the MHA draft is.

Section 5 - Economic credentialing of physicians prohibited -- definitions.

01:35:20 Mark Taylor criticized the LC0038 draft reference to call requirements or other scheduling. From MHA's perspective, that language does not work because it essentially says that a hospital can't have on call requirements without a concern that a physician could claim to be economically credentialed for even having to take call.

Sen. Weinberg asked if on call is an issue. John Flink of MHA said that he didn't think any physician likes to be required to take call but the reality is that hospitals need physician coverage 24 hours a day, 7 days a week. MHA's view is that the current LC0038 draft language about on call or scheduling requirements really makes it impossible for hospitals to insure 24/7 call. He said that it is common for hospitals to have some on call requirements as part of the credentialing process. If hospitals aren't allowed to do that, he said, that cuts a hospital's ability to provide the services that communities need to have.

01:39:20 Dr. Keith Popovich, private practice physician in Butte, called this a red herring because all hospitals have the ability under their bylaws and medical staff admission process to require on call. He said the only request is that it be equitable, that every physician be treated the same. LC0038 would prohibit them from economically singling out one physician's extra requirements on call.

Mr. Flink said that he doesn't disagree with what Dr. Popovich said but if that's the intent, then a statement that just says "on call requirements should be fair and equitable" should be added. He said the current language of LC0038 puts on call requirements in the same category as economic credentialing and therefore takes away hospitals' ability to require call by physicians who have credentials.

Sen. Weinberg said that what they are doing is recognizing that on call requirements can be used as a means for economic credentialing and he doesn't want that to happen. He asked for the language to reflect that.

Mark Taylor suggested that "fair and equitable" be inserted in front of "medical staff on call requirements". Mr. Taylor proposed changes that deal with the governing board issue associated with conflicts of interest. From MHA's standpoint, this is a cleaner language and gets to the same point.

Sen. Weinberg noted general consensus with that.

Mr. Taylor inserted under (3), a definition of conflict of interest, which is based on a couple of different sources, including the nonprofit statutes as well as the Internal Revenue Service. He noted that the partner, employee, family member language is consistent what was used in other places within the bill.

Sen. Weinberg asked what MHA's intent was. Mr. Taylor said that the intent is that this definition is then used in other places within the bill; i.e., subsection (2)(a), dealing with governing bodies of the hospitals and other references from a statutory construction standpoint.

Sen. Weinberg questioned whether there is any other intent in this change? Mr. Flink said that this is a common definition of what a conflict of interest is and it is designed to lay the foundation for the use of the words "conflict of interest" in other parts of the bill. He said MHA members felt there was a lack of clarity about the term they wanted it put into statute.

Rep. Dutton said that looking at the initial LC0038 draft, it covers items other than having an investment, an ownership interest, such as referral fees. It seems to him that it is a broader definition that would cover more circumstances.

Ms. Jamison said that her reading of this as an attorney is that the definition of conflict of interest proposed by the hospitals only has to do with the physicians. In terms of applicability, this makes the economic credentialing and conflict of interest only apply to the doctors. She said the MHA draft is an attempt to exempt hospitals from institutionally having coverage under this bill and that the LC0038 draft definition be kept.

Mr. Taylor said that because the statute addresses the credentialing and privileging processes associated with hospitals, this definition only applies to this statute. He said it would be inappropriate to broaden the definition. He noted that the last legislative session created a separate definition section within this statute, which is appropriate because the issue is conflicts of physicians that have ownership interest in competing health care facilities.

Sen. Weinberg asked if it is appropriate to exclude the responsibility of the hospital in this section? Mr. Taylor said that they aren't specifically excluding the hospitals within this because employed physicians have to comply with any policies that are adopted by the medical staff as well. Sen. Weinberg said that that puts the onus upon the employees, not upon the hospitals and reiterated his question about the responsibility of the hospital.

Referring to Ms. Jamison's comments, Sen. Weinberg asked if MHA is trying to exclude the responsibility of the hospital by making this change. Mr. Taylor said that he would say there is no justification to that statement.

Pat Murdo pointed out that in the LC0038 draft, the health care provider reference physician or anyone licensed under Title 37 does not reference the hospitals and in that sense, that is the difference between the approaches. The differences are in the types of fees, promises to pay, that constitute the conflict but not on whom the conflict is based.

A discussion followed about the LC0038 draft referring to the health care provider, licensed under Title 37, which is broader than just physician but does not include the hospital which is not licensed under Title 37.

Dr. Popovich said that he applauds the current LC0038 draft which omits the language in the document from MHA, which says "may refuse to appoint". He said that he liked the current language because it leaves the medical staff independent to do its function and allows proper recusal in areas of conflict of

interest. He noted a need for an independent medical staff assuring the quality of care issues.

Dr. Kubicka said that regarding Section 5, MMA feels that a two-tiered definition of a conflict of interest is appropriate; the first tier recognizing that there may be physicians within a medical staff who have outside investment interests that potentially could be in conflict with the hospital. MMA's proposal suggests that an earlier draft recognized a 5% or more interest in a competing entity and that would define a first-tier conflict of interest. The second tier of conflict is the abusive referral pattern. He said that MMA and the MHA thinks that an economic referral pattern is a better choice of words than abusive or a profit-driven referral pattern. He said that SB 312 [existing statute] doesn't include repercussions for the hospital. MMA proposes, based on the notion of the two-tiered conflict, to simplify the definition of a conflict of interest on pages 8 and 9, Section 5. Dr. Kubicka discussed MMA's thoughts on what a conflict of interest means with regard to an ownership interest by a health care provider at 5% or more in a health care facility licensed under Title 50.

Sen. Weinberg asked Dr. Kubicka which elements he thought might cloud the issue. Dr. Kubicka said, for example, the definition of conflict of interest on page 8 under section (d), is a broader definition, which could be codified elsewhere. He said that MMA does not object to the ethical principles defined here but sees the definition as making it even more difficult for a hospital to police the functions of their board. Dr. Kubicka said that MMA is proposing that if a physician has an economic conflict with a hospital, it is reasonable for the hospital to ask that physician not participate in governing its decisions where that conflict exists.

Sen. Weinberg referred to the need to be balanced and see to it that all sides are protected and addressed. He asked how the percentage of ownership moved from 2% to 5%? Dr. Kubicka said that the 2% ownership is actually in LC8888 and that the 2% figure came from proposed, not yet completed federal criteria. The 5% threshold that MMA used is a threshold that was used in earlier drafts of the bill.

Dr. Khaliqi agreed with Dr. Kubicka's comments but is still concerned about denial of privileges on criteria other than the individual's education, training, current competence, experience, ability, personal character and judgment. Dr. Khaliqi said that he would like to see that abusive referral patterns not be used as a reason to deny privileges or credentialing, because privileges and credentialing are based on education competence as defined by this bill. He said that Sections 2 and 3 should address abusive referral patterns and not be a point of credentialing.

Mark Taylor said that page 5 of the MHA's draft, subsection (iv) provides for disciplinary actions premised upon a determination by the Board of Medical Examiners that a physician or physician group has engaged in an abusive referral pattern based on a patient's health insurance coverage or ability to pay. He referred to two footnotes and noted that legislative authority may need to be provided to the board. He suggested that the Board of Medical Examiners would

be a better place to define abusive or economic referral pattern because the board would use that as part of its complaint review process.

Ms. Jamison said that defining these issues is a legislative responsibility, that it is the legislature that sets the public policy addressing these issues and a delegation to any board to start defining terms subjects it to a whole different kind of pressure. These bills are about economic credentialing, she said, adding that the bills have been expanded to address collateral issues.

Sen. Weinberg asked if the Legislature makes a policy decision, is it up to the department speaking for the board to make changes to adjust to that new policy? Ms. Jamison said yes and that with specific rulemaking authority, the Board of Medical Examiners could implement but not define the crux of what it is that they must implement.

Dr. Kubicka said that it is imperative that this statute define what an abusive referral pattern is and that the Board of Medical Examiners can then determine whether or not a physician is acting in violation of that definition.

Ms. Murdo said that Sen. Weinberg and Rep. Dutton need to decide whether to apply the statutes only to physicians or to all licensed health care providers because it would not be just the Board of Medical Examiners, it would be the Board of Nursing, the Board of Physical Therapists. Sen. Weinberg said that they want to broaden it.

Dr. Rumans commented on the section denying privileges. He said that hospitals are asked to look at physicians' behavior issues. He is not sure that he would be quick to remove that final language but that this could potentially address character aspects of a physician if they are making referrals on economic issues that subsequently are addressed by the Board of Medical Examiners. As a physician who is looking at privileges and credentials of other physicians for his organization, he may find the issues relevant.

<u>Section 6 - Denial, suspension, or revocation of health care facility license -- provisional license.</u>

02:15:50 Dr. Kubicka discussed MMA's comments on Section 6 **(see Exhibit 2)**.

Mr. Flink said that MHA objects to that inclusion, stating that the proposed language affects the employee/employer relationship in a way that isn't consistent with other places in the statute. Sen. Weinberg said that if his business was one of making tires or some other product, he would agree with Mr. Flink, but in talking about a non-profit community based organization that lives on federal reimbursement, the issue is not the same. He added that the discussion is not about an independent and private company that can make certain kinds of demands on their employees, but instead involves public benefit, community based, non-profit organizations, and the rules are different.

Pat Murdo questioned whether enforcement should be under the "provisional status" instead of the hammer of suspension and revocation, to give somebody

time to straighten out the problem instead of a suspension. Sen. Weinberg said that he would agree with that.

Sections 7 - Enforcement -- rulemaking.
Dr. Kubicka said if the licensure boards are to be used for enforcement, then Section 7 can be removed and the Attorney General doesn't need to be involved.

Jeff Buska, Department of Public Health and Human Services, said that if the Department is able to substantiate that there was a deviation from licensing standards, then those deficiencies are pointed out and a plan of correction from the facility is requested. Based on the information that comes back in terms of a plan of correction, then they either accept or deny or ask them to change the plan.

Sen. Weinberg asked if the proposed language would work and Mr. Buska said that some guidance in terms of rulemaking authority to identify those standards would be needed. Sen. Weinberg asked if the Attorney General language were removed, would the Department still have the ability to go to the Attorney General if there were abuses to be reported? Mr. Buska said that DPHHS often works with the Department of Labor, Board of Medical Examiners in investigations. But he said, trying to figure out where the authority lies is part of the challenge. Whose responsibility is it to do the investigation? The AG's Office probably would get involved in investigating a criminal aspect. Sen. Weinberg asked if the language, as it exists in the bill draft, still leave that option open? Mr. Buska said yes.

Ms. Jamison asked that this section be reviewed to make the enforcement clear. Ms. Jamison clarified what entities are investigated under which titles. She said that the enforcement provision and the rulemaking provision, since they apply to different licensing jurisdictions, are under Title 37 with the Department of Labor. For the facilities and hospitals, they are under Title 50.

Mr. Flink said that MHA agrees with striking this section for all the reasons heard.

Public Comment on LC0038

02:26:33 **Dr. Michael Dixon, Ear, Nose and Throat Physician**, commented on the attempts to gain economic advantages for hospitals at the expense of the community which will likely cripple or ruin health care in Montana. He discussed his concerns regarding the draft bill. Dr. Dixon said that Montana needs strong medical services, both hospitals and physicians, serving a community where primary and specialty physicians want to live and practice, where they can attract and retain the best physicians and where they can be a leader in providing excellent cost-efficient health care.

Mike Foster, Sisters of Charity Hospitals in Billings, Butte, and Miles City, talked about his frustration in the way that the meeting has gone. He said that he had hoped that he would see a presentation showing agreement by both MMA and MHA so that could be the starting point of a bill that could be considered to

resolve some differences between physicians and hospitals.

Dr. Popovich asked Mr. Foster what his thoughts are about the issue of a hospital using its force within a market place through an exclusive contract to economically credential the ability of physicians to work in a community. Mr. Foster said that he is not personally aware of what he is referencing and he would think that any time that a hospital conducts its operations, that its board of directors is intimately involved in any major decisions that wouldn't involve administrations. He said that he would think that there would always be board input as a protection for a community and since physicians typically belong to a hospital board of directors, there would always be input on that.

Sen. Weinberg voiced concerns about Mr. Foster's comments about what we are doing here and how we are doing it. He noted that there is some agreement between the hospital people and the doctors and that the process brings out areas of disagreement. Looked at its entirety, he said, there are some good areas of agreement. He also noted that all entities have had ample time to get together and find areas of agreement. He said that the Legislature asked for the issue to be moved along. Mr. Foster said that he doesn't disagree with what Sen. Weinberg is saying, but the fact that it took this long, has been frustrating to everyone. At least there has been discussion and that is very positive.

BREAK

02:39:00 Sen. Weinberg said that after talking with Rep. Clark, the subcommittee will take the work that was done this morning to the full Children and Families Interim Committee, however, the bill draft on specialty hospitals, LC8888b, will not be taken to the committee. Action will be delayed in part because the federal government is still working on the issue of specialty hospitals.

Overview on LC 8888: Specialty Hospitals - Pat Murdo, Research Analyst, LSD

02:40:21 Pat Murdo talked about LC8888 **(Exhibit 4)** and the changes that were made to the bill draft.

Comments and Questions

02:48:58 Dr. Kubicka said that MMA is happy with the progress that is being made on these two issues. Dr. Kubicka discussed MMA's proposed changes **(see Exhibit 2)**.

03:03:18 Mona Jamison discussed MMA's concern that MHA has made it clear that the moratorium was intended to prevent ambulatory surgical centers (AMCs) from converting to or trying to get licensed as specialty hospitals. She talked about what the language in LC8888 intended to say and that the Great Falls Clinic and Central Montana Hospital hopes that the moratorium will expire and that the bill will resemble a bill that is similar to what Ms. Murdo has drafted. She said that the concerns of her clients is that if the moratorium looks like this, that there is a provision that will say that an ASC cannot convert and that a regular hospital can.

Regarding charity care policies, Ms. Jamison said that MMA objects to the last

sentence calling for a basic standard for a for-profit specialty hospital. In reference to the transfer agreement, she offered support with the definitions that Dr. Kubicka provided and that they have to be fair and equitable. She noted confusion over transfer agreements as they relate to ASCs and to hospitals. She said that if the committee feels or is predisposed to have that sentence, then they would ask that Dr. Kubicka's language on fair and equitable be inserted.

Sen. Weinberg and Ms. Jamison had a discussion on specialty hospitals doing their share of providing charity care and the benefits of tax-exempt status and what the public policy is that requires a charity care policy for non-tax exempts versus for-profits.

03:29:42 **Dr. Jim Elliott, Montana Orthopaedic Society**, said that from the Montana Orthopaedic Society's standpoint, they do not have any conflicts with charity care and that they have been overwhelmed by the support and the actions of the Montana Medical Association. He talked about the fact that if this is to be tabled, to wait and see what is going to happen on the federal level, that is not what the committee was challenged to do. He feels that the committee needs to look at this at the state level. He also said that he is dismayed that the Montana Hospital Association would not sit down and discuss this issue.

03:30:01 Rep. Dutton commented that he is a little frustrated with the MHA , that the fact that it appears that MHA is grounding their heels. He asked Ms. Murdo how many states define specialty hospitals. Ms. Murdo said that as far as she knows, there are definitions in the Washington state statutes. Rep. Dutton asked Ms. Murdo how many states have certificates of need. Ms. Murdo said that in most of the literature there is a divide between states that have or don't have certificate of need requirements and those with certificate of need requirements don't have the issue of specialty hospitals.

Dr. Khaliqi, Great Falls Clinic and Central Montana Hospital, said that the work done by the committee is a good compromise and is something that would benefit Montana. He referenced a comment by Sen. Weinberg at a previous session about getting back to the patient and who is at the center of things. There is evidence that specialty hospitals can provide a choice, better care, quality care, and is something that should be seriously looked at in providing better care for Montanans.

03:35:16 Sen. Weinberg asked Mr. Flink if he thought that Dr. Elliott's suggestion that MHA has been reluctant to come to the table for discussion was a fair characterization. Mr. Flink said that their board, for the last five or six years, has supported a moratorium at the federal level because that is an issue that needs to be dealt with at the federal level, and until it is resolved there, the board says that they need to work at the federal side. Mr. Flink said that he appreciates the good efforts that the subcommittee has made, as well as the physician groups. He also said that he appreciates the concern that the physicians have expressed about protecting community hospitals. One of their primary concerns in this debate is the impact that specialty hospitals would have on community hospitals.

Sen. Weinberg asked Mr. Flink to comment on the discussions in Washington, D.C. Mr. Flink talked about a provision in a House Medicare bill passed in July of 2007 that includes language that deals with physician ownership of hospitals and self-referral. That language remains pending in Congress. He talked about another Medicare physician payment cut and a mental health parity bill that had passed the House that includes a prohibition on specialty hospitals.

Sen. Weinberg asked Mr. Flink, if the draft LC8888 would consider allowing specialty hospitals, would MHA become interested in that draft? Mr. Flink said that they would still have questions about the language in LC8888 even though MHA will continue to support the moratorium.

Sen. Weinberg asked Mr. Flink if MHA would help to sort through those definitions to understand what charity care is and how it is arrived at in institutions. Mr. Flink said that MHA would provide assistance, but first, he wanted to comment on some of Ms. Jamison's comments and noted that the changes on the Form 990 that the IRS has mandated indicates that a standardization has happened regarding what constitutes community benefit. It is a much broader definition than just charity care. He said that in addition to being care provided to the indigent, it is the costs of services like mental health that hospitals don't recover. Hospitals fill out forms that have been developed and have been standardized by the Catholic Hospital Association and by VHA. He said it is not in his purview to say what a for-profit hospital should be doing but it would be helpful to have a standard understanding of what community benefit is, which is emerged in the Form 990, Schedule H.

04:42:30 Rep. Dutton said that he wanted to reiterate that the Form 990 has been revised and that in the near future it will be clear how the comparisons will be more valid. He said that he doesn't understand the strategy of waiting until the federal government makes a decision because whatever the state does will be trumped by the federal government.

00:43:44 **John Solheim, St. Peter's Hospital, Helena**, said that there has been some improvements in LC8888 and he appreciates the work. He talked about charity care from the Hospital's perspective and the issue is level playing field. He said that people think that a hospital, whether it be a specialty hospital or not, have certain basic services. He said that if a hospital has a dedicated ER, with the physicians onsite, not on call, and hospitals that are non-critical be required to have emergency rooms, then it is a level playing field that everyone can work from.

03:46:06 Dr. Kubicka said that he thinks it would be a disservice to the public to require that a specialty hospital, for example, an orthopaedic specialty hospital, to be required to have an emergency room if it deals solely with orthopaedic conditions, inviting people to come there with all sorts of emergency circumstances because that specialty hospital wouldn't have the staff to meet those needs. He said that by definition, if it is a specialty hospital, it means that it provides care on a limited scope and you can't have a limited scope emergency room. He also wanted to make clear that MMA does wish to go forward with

LC8888 with the caveat that in the section dealing with the specific percentage of ownership, if that is going to be dealt with at the federal level, he doesn't want to muddy the state level discussion while awaiting federal input. He does however think that the state needs to move forward so that come July 1, 2009, there will be a mechanism to go forward in the state of Montana.

Dr. Khaliqi said that requiring emergency rooms in every hospital would actually increase the transfer rates. A specialty hospital would not be ready to deal with an acute stroke or an acute heart attack, and if someone with those types of emergency conditions were to be in an emergency room in a specialty hospital, you would still have to transfer the patient.

03:49:29 **Jeff Fee, St. Patrick's Hospital, Missoula**, said that the problem is that EMTALA [the federal Emergency Medical Transfer and Labor Act] creates an obligation for a hospital that has an ER to provide a safety net. As long as that safety net is required, there needs to be some level in every playing field and if hospitals are to continue to provide a safety net for our communities, then they also need to have some level of protection. He said that St. Patrick's Hospital supports the ongoing moratorium. He applauded the work that has been done. He talked about his concerns regarding the actual licensing requirements, specifically as it relates to the percentage that could be offered up to a hospital, a half percent or 5%, that no hospital would necessarily agree to and when you couple that with what the MMA is recommending relative to forcing a hospital to sign a transfer agreement, you are in essence forcing a hospital to do business with an entity that would be directly competing with it and it could ultimately be economically damaging to that organization.

Sen. Weinberg asked if Mr. Fee could suggest some language if they were to include his thoughts in this legislation. Mr. Fee said that there would need to be language dealing with minimum percentage. Sen. Weinberg said that the reason that the bill draft looks the way it does is that we are trying to encourage cooperation and once the negotiations begin, the details will come out. In an effort not to over-regulate, we are inviting people to cooperate, setting up the mechanism, and hopefully in some instances, people would be able to do that.

03:54:38 **Mike Foster, Sisters of Charity Hospitals, St. Vincent, St. James and Holy Rosary**, commented on the economic impact to community hospitals if a specialty hospital does open up. There has to be a good faith effort in putting together any type of offer on a joint venture and ownership percentages are important. Mr. Foster said that it is important to get the economic credentialing issue wrapped up with as much agreement as humanly possible.

03:59:24 **Jerome Anderson, Montana Orthopaedic Society and Yellowstone Physicians Association**, agreed with the comment that was made that Montana should arrive at its own decision of the definition of a specialty hospital is. He said that as to the equity standard between community hospitals and specialty hospitals, everybody has to recognize that community hospitals are funded by the community itself. They have a tax free status and in return for that, a community expects special treatment from a standpoint of an emergency room

facility, full hospital expectations of treatment as a full hospital. Specialty hospitals are privately funded, they pay taxes. Specialty hospitals handle one small part of the medical services provided.

04:03:07 Sen. Weinberg asked Rep. Clark for time for the SJR 15 Subcommittee to meet one more time to wrap up the discussion on specialty hospitals. Rep. Clark, Chair of the Children and Families Interim Committee, said that whatever time Sen. Weinberg wants will be set aside. Sen. Weinberg suggested that interested parties forward their thoughts to Ms. Murdo regarding specialty hospitals before their next meeting.

04:05:29 Dr. Rumans talked about a physician ban on self-referral to specialty hospitals because of potential inherent conflict of physician self-referral. He said that there are some consumer groups that actually support that ban, not just hospitals and physicians. He spoke on the issue of transfer agreements and suggested language be added for those specialty hospitals that are taking care of Medicare patients, that they specifically meet Medicare conditions of participation because of the recent OIG report that said that certain specialty hospitals across the country were not meeting basic Medicare conditions of participation.

04:06:32 Mark Burzynski, Blue Cross Blue Shield of Montana, said that all that Blue Cross Blue Shield is trying to do is provide an affordable product. He wanted to make clear that physicians and hospitals working together is to their members' and groups' benefit. He noted that one physician mentioned that they could do it more or less expensively than they can at the hospital. That may occur for one patient and that services may be cheaper because there is competition across the street, but that doesn't add up for the entire community. He explained that to the extent that excess capacity becomes prevalent in a marketplace, the costs to BCBS members and groups goes up. Payors have to cover more and more fixed costs to the extent that excess capacity exists in a marketplace. He said that BCBS is dismayed at the argument that competition will create choice without knowing what it will do for their costs. BCBS supports making sure that the resources that are available in the marketplace are consistent with the demand in that marketplace because costs will go up regardless of what happens to an individual.

Sen. Weinberg asked Mr. Burzynski who the entity is that determines that resources equal demand. Mr. Burzynski said that he would hope that in each local community, hospital administration and hospital executives and their boards would work with the physicians who would like to pursue alternatives in a particular marketplace.

Sen. Weinberg said that to some degree this bill draft goes in that direction to encourage cooperation. He added that if there is a better way to do it, the committee needs to know about it.

Adjournment

01:13:40 Sen. Weinberg thanked everyone for their hard work. He adjourned the meeting at 12:20 p.m.

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