**MINUTES**

**MONTANA HOUSE OF REPRESENTATIVES**
**57th LEGISLATURE - REGULAR SESSION**
**COMMITTEE ON HUMAN SERVICES**

**Call to Order:** By **CHAIRMAN BILL THOMAS**, on March 9, 2001 at 3:00 P.M., in Room 172 Capitol.

**ROLL CALL**

**Members Present:**
Rep. Bill Thomas, Chairman (R)
Rep. Roy Brown, Vice Chairman (R)
Rep. Trudi Schmidt, Vice Chairman (D)
Rep. Tom Dell (D)
Rep. John Esp (R)
Rep. Tom Facey (D)
Rep. Daniel Fuchs (R)
Rep. Dennis Himmelberger (R)
Rep. Larry Jent (D)
Rep. Michelle Lee (D)
Rep. Brad Newman (D)
Rep. Mark Noennig (R)
Rep. Holly Raser (D)
Rep. Diane Rice (R)
Rep. Rick Ripley (R)
Rep. Clarice Schrumpf (R)
Rep. Jim Shockley (R)
Rep. James Whitaker (R)

**Members Excused:** None.

**Members Absent:** None.

**Staff Present:** David Niss, Legislative Branch
Pati O'Reilly, Committee Secretary

**Please Note:** These are summary minutes. Testimony and discussion are paraphrased and condensed.

**Committee Business Summary:**
Hearing(s) & Date(s) Posted: SB 309, SB 107, 3/6/2001
Executive Action: SB 38, HB 486, SB 107

## EXECUTIVE ACTION ON SB 38

**Motion**: **REP. LEE** moved that **SB 38 BE CONCURRED IN.**

**Motion**: **REP. LEE** made a substitute motion that **SB 38 BE AMENDED. EXHIBIT(huh54a01)**

**Discussion**: **Rep. Lee** explained that the amendment clarifies that pertaining to the medical support order, if the department is providing child support enforcement services, they will notify the obligated parent about the CHIP program. If there is a medical support order issued and it's been determined that there is not insurance available at a reasonable cost to the obligated parent, then the primary parent will be notified of that determination and will also be notified of possible eligibility for CHIP and/or Medicaid. Since the bill gives the department authority to enroll children in health insurance programs, the amendment extended that authority to the department to enroll the child into CHIP. Although CHIP is presently full, the child would be placed on the waiting list. **Rep. Brown** asked **Rep. Lee** if the department supports the amendment. She said she had consolidated their proposed language with her proposed language, and they had come to an agreement on the amendment. **Rep. Ripley** asked if she had defined "reasonable cost." **Rep. Lee** said that was already determined in administrative rules and child support guidelines and also in the context of the bill. The question was called for.

**Substitute Motion/Vote**: **REP. LEE** made a substitute motion that **SB 38 BE AMENDED. Substitute motion carried unanimously.**

**Motion**: **REP. LEE** moved that **SB 38 BE CONCURRED IN AS AMENDED.**

**Discussion**: **Rep. Esp** asked for clarification of the bottom of page 4, subsection 8 of the bill. **Rep. Jent** said the bill stated that the department shall adopt rules to determine whether health insurance is presumed to be available at reasonable cost, so he interpreted it to mean that there would be some comparison between the cost of the insurance and the income level of the person paying for it. Further discussion was held on this section. The question was called for.

**Motion/Vote**: **REP. LEE** moved that **SB 38 BE CONCURRED IN AS AMENDED. Motion carried 17-1 with Esp voting no. Rep. Brown** will carry the bill.***{Tape : 1; Side : A; Approx. Time Counter : 0 - 10.6}***

## EXECUTIVE ACTION ON HB 486

**Rep. Newman** said that based on the vote they took on February 19, **HB 486** had been postponed until a date certain, and that date certain was today, so executive action needed to be taken on that bill.

**Motion: REP. LEE** moved that **HB 486 DO PASS.**

**Substitute Motion/Vote: REP. LEE** made a substitute motion to **postpone action on HB 486 until a date certain, specifically March 12. Substitute motion carried 17-1 with Newman voting no.** ***{Tape : 1; Side : A; Approx. Time Counter : 10.6 - 13.1}***

## HEARING ON SB 309

**Sponsor: SEN. MIKE HALLIGAN, SD 34, Missoula**

**Proponents: Bob Olsen, Mt. Hospital Assn.**
**Craig Eddy, St. Patrick's Hospital & Providence Surgi-Center, Missoula**
**Joseph Knapp, cardiologist, Western Mt. Clinic, Missoula**
**Denzel Davis, Dept. of Public Health & Human Services**
**Mary Lou Jorns, Director, Helena Surgi-Center**
**Jani McCall, Deaconess Billings Clinic**

**Opponents: Daniel Boatman, Central Mt. Surgery Center, Gt. Falls**
**Ron Peterson, Missoula Orthopedic Associates**
**Dr. Melton Pitts, Great Falls Clinic Surgery Center**
**Dr. David Hafer, Great Falls**
**Gary Mermel, Billings, Anesthesiology Partners of Montana**
**Dr. Dean Sukin, orthopedic surgeon, Billings**
**Dr. Greg McDowell, Billings, Orthopedic Surgeons PSC**
**Susan Good, Mt. Orthopedic Society and Mt. Society of Anesthesiologists**

**Informational Witnesses: Lionel Tapia, V.P., Medical Affairs, St. Vincent Health Care, Billings**

**Opening Statement by Sponsor:**

**SEN. MIKE HALLIGAN, SD 34, Missoula,** said that SB 309 is a bill about turf battles, although he didn't want the committee to characterize it as that. The bill tries to define in some logical way the important role that hospitals have in the provision of

medical services, and all of us have probably had day surgery in a surgi-center, which is a vital part of the delivery of medical services. There has been an increasing number of surgi-centers developing across Montana and the nation, because they do provide cheaper and very good, very efficient medical services for day surgery. This bill is about balance, defining the difference between inpatient and essentially outpatient services. It would simply cap the length of stay for a patient that they could recover in an ambulatory surgery center at 24 hours. Medicare regulations state that procedures performed in a surgery center ought to last no longer than 90 minutes and have a recovery period of four hours. Most surgi-centers operate from 6 a.m. to 6 p.m. five days a week. They aren't attempting to be full-service, 24-hour-a-day, seven-day-a-week facilities like hospitals. This bill gives surgi-centers the flexibility to be able to operate for the 24 hours, and it also recognizes the important role that hospitals play in providing services. Often when someone has to stay longer in a surgery center, it's because of pain management. The patient is experiencing pain; they don't want to move the patient because it isn't appropriate, and that's important. If the pain lasts more than 24 hours, something more is going on; something's gone awry with the surgery that the doctor needs to be paying attention to. That gets into the patient safety side, so there is definitely patient safety in this bill. Obviously there is money here. He doesn't mind if the surgery centers make a lot of money. They're for profit. Usually the hospitals are not for profit. So it's a good thing to have that kind of economic development, and he's not trying to stifle that. This bill deals with an important public policy. He has learned that opponents' testimony is a very critical part of the legislative process. In the Senate, this bill had some excellent proponents and some excellent opponents. Based on the testimony, the committee can make the best possible public policy decision. ***{Tape : 1; Side : A; Approx. Time Counter : 13.1 - 24.5}***

**Proponents' Testimony**:

**Bob Olsen, Mt. Hospital Assn.**, presented written testimony in support of the bill. In addition, he explained that presently there are quite a few ambulatory surgery centers throughout Montana, and the MHA support of this bill is not intended in any way to cause them any harm in doing the things they are doing today. They aren't trying to reduce the number of surgeries, restrict the kinds of surgeries they can do or take anything away from them that they have today. This bill looks into the future. The MHA had asked the sponsor to carry this bill because they found articles on developments in big cities. He quoted from a recent article that said surgeons want to do more surgeries in ambulatory settings on an outpatient basis. Many hospitals have investments in ambulatory

surgery centers. Patients like them, they are cost effective and they deliver high quality care. The article also stated that by adding recovery care capability, the surgery center has been transformed into a mini-orthopedic hospital. That's what at stake with SB 309. If ambulatory surgical facilities want to start doing surgeries that require in-patient care, and 72 hours of recovery care is in-patient care, MHA thinks they should be required to meet the hospital licensure requirements. **EXHIBIT(huh54a02)** ***{Tape : 1; Side : A; Approx. Time Counter : 24.5 - 28.4}***

**Craig Eddy, St. Patrick's Hospital & Providence Surgi-Center, Missoula,** said that he is a cardio-vascular surgeon, attorney, administrator, teaches health law at the U. of M., and advises the American College of Surgeons on matters of rural health policy. He was here to testify on why limiting patient stays in ambulatory surgery centers is good health policy, and to speak on patient safety and patient oversight issues. There are two recent studies from the Institute of Medicine that show that system problems are the primary problems that cause patient injury in health care facilities. Despite the fact that the Joint Commission and hospitals have spent many years and many dollars to insure the quality of care delivered to patients, injuries still occur. His institution spends a considerable amount of money on quality management. The business of quality and safety does not come cheaply and cannot be dabbled in. Patients sick enough to require more than a 24-hour stay are complicated enough to require complex and fast-reacting systems to meet their needs. Many of these patient care needs arise urgently and unexpectedly. If a center keeps patients longer than 24 hours, it should be adequately regulated and regularly inspected in order to insure that it is prepared to deal with the emergent complications that may arise. If pain can't be controlled within a 24-hour period, that can be interpreted as in indication that those patients should be in a facility that can deliver a higher level of care. If ambulatory care centers want to become for-profit, short-stay hospitals, let them do so. There is nothing to prevent them from doing this except the expense of meeting regulatory scrutiny and quality control. The real issue here is not a turf battle. It's really that more complex surgeries should not be permitted to be performed on more physiologically-compromised patients without paying the necessary price to guarantee that potential patient needs will be rapidly and efficiently met, and that patient safety is guarded by sufficient regulatory oversight. ***{Tape : 1; Side : A; Approx. Time Counter : 28.4 - 30}***

**Joseph Knapp, cardiologist, Western Mt. Clinic, Missoula,** said he is Chairman of Medicine at St. Patrick's Hospital in Missoula and

Chairman of the Board of Montana Health, which is a managed care organization in western Montana. He supports this bill from a little different standpoint, and gave an example of a 79-year old patient who had entered the hospital yesterday for surgery and would be dismissed tomorrow. The surgery was the successful removal of a brain tumor. Nearly 35 of her 48 hours in the hospital would be spent in an intensive care situation. He thinks this bill has merit because there clearly needs to be a distinction and a delineation between where is appropriate for care to be provided. He has been in medicine for 26 years and has seen the scope of change in the way patients are cared for. It is not uncommon at all for individuals to have coronary bypass surgery and be home in 72 hours. At this time, coronary artery bypass surgery would not be considered to be an appropriate outpatient procedure, but in the future, it may be. The length of time that people spend in hospitals has shortened dramatically. The type of services that are being provided in ambulatory care will continue to expand, but there clearly is a distinction between the types of services that belong in an outpatient setting versus that of an inpatient setting. Another thing that is very important to the state of Montana is that we do have a hospital system that is in some jeopardy. Hospitals clearly do rely upon the services they provide to keep them afloat. With the cutbacks that have occurred from the federal government, Medicare reimbursement, that clearly wreaked havoc in Montana in 1997 and with the limits in the state's capabilities of covering patients under Medicaid, hospitals do have to have sources of revenue to maintain their viability. Surgical procedures still remain the basis of hospital viability. To the extent that is removed, we bring into jeopardy the entire hospital structure in the state of Montana. There is merit in this bill.***{Tape : 1; Side : B; Approx. Time Counter : 0 - 6.1}***

**Denzel Davis, Dept. of Public Health & Human Services,** supports the bill for two reasons. It is an area that his division has to regulate, both from the licensure perspective and the certification perspective. They don't have a cap on the licensure side. This bill would put a cap on the licensure side not to exceed 24 hours. It changes the definition of observation beds in ambulatory surgeries to recovery beds, which is really what they are. Currently every ambulatory surgery center in Montana is licensed and certified by Medicare for service, and when they sign that agreement, they agree to meet the strict requirements of Medicare. They have to screen their patients to make sure, or at least have some reliability, that they're going to fall within the requirements of the ambulatory surgery center, and that's 90 minutes and four hours recovery. There also are other conditions, one of which is that if there is a failure, they have to be able to have an agreement with a hospital somewhere adjacent to accept medical emergency cases if there are problems in the ambulatory surgery center, either during

the surgery or in the post-operative state. He had heard there would be discussion about a 72-hour model, in which the patient has surgery and then some kind of in-patient stay, but that would move from an outpatient model to an inpatient model, and that isn't what this bill is about. This is about needing a cap on ambulatory surgery centers.***{Tape : 1; Side : B; Approx. Time Counter : 6.1 - 9.5}***

**Mary Lou Jorns, Director, Helena Surgi-Center**, presented written testimony in support of the bill. **EXHIBIT(huh54a10)*{Tape : 1; Side : B; Approx. Time Counter : 9.5 - 10}***

**Jani McCall, Deaconess Billings Clinic**, said they believe that ambulatory surgical centers are a growing and important component of the health care services in Montana. They offer a convenient and cost-effective model for an increasing number of medical procedures that can be done basically on an outpatient basis. By definition, these surgery centers are designed, staffed and equipped for uncomplicated procedures requiring minimal post-operative recovery time. They are very concerned about quality and safety for patients. Any facilities who desire to do services beyond 24 hours need to be defined as hospitals and to be licensed as such.***{Tape : 1; Side : B; Approx. Time Counter : 10 - 12.7}***

**Opponents' Testimony**:

**Daniel Boatman, Central Mt. Surgery Center, Great Falls**, said he had been a hospital administrator for 20 years, and he and a partner have established a free-standing ambulatory surgery center. Great Falls had gone through a consolidation of hospitals and a consolidation of choice so there were no other alternatives for people. The genesis of this bill definitely was a local fight, which started in Missoula but has ramifications for his center. He is the President of the Association of Ambulatory Surgery Centers, and they as an organization are split on this bill, simply because some of them are free standing and others are hospital sponsored. There are only 10 centers in Montana, located in the population centers, and about half are free standing, He started his center to be innovative and worked with the department and clarified regulations. From the opening bell, they took on patients that could stay overnight. The real effect of this bill is to limit or suppress competition, and by doing that, it suppresses price competition. It would quash and squash innovative new ways of delivering care. There is an opportunity here to demonstrate some pioneer thinking. A few years back the legislature was lobbied by the Hospital Association to establish critical access hospitals, a concept nobody had thought of before. Those critical access

hospitals were enabled in state legislation, and then the federal legislation, through our Congressional delegation, was able to open up demonstration projects and now there are enabling rules for critical access hospitals in all of the states. So we don't have to be afraid of doing those kinds of things in Montana; we've obviously done them before. He suggested stretching the limits of imagination and looking at a number that nobody's thrown out before, 36 hours. In his operation, right now there is the 24-hour clock and they haven't had the threat of penalties and fines and the kinds of things that go with putting this into statute. Give the centers, the physicians and the patients a little more breathing room for completing the recovery phase of a procedure. There would be no extra cost to the patient for the extra 12 hours, because ambulatory surgery centers are reimbursed on a specific, fixed dollar figure. Their patient satisfaction is in excess of 99 percent; and he doesn't think patient safety is an issue as he thinks their patient safety and staffing ratios are much tighter than would be found in any of the major hospitals. ***{Tape : 1; Side : B; Approx. Time Counter : 12.7 - 14}***

**Ron Peterson, Missoula Orthopedic Associates,** presented written testimony and other letters of opposition to the bill, graphs showing the growth of ambulatory surgery centers and the shift from inpatient to outpatient surgeries, and patient satisfaction questionnaires. Currently they do not plan to do a recovery center, but having invested the money and taken the risk, they feel this bill is anti-competitive, restricts their future flexibility, restricts consumer choice and promotes higher costs.**EXHIBIT(huh54a03)** **EXHIBIT(huh54a04)*{Tape : 1; Side : B; Approx. Time Counter : 14 - 21}***

**Dr. Melton Pitts, Great Falls Clinic Surgery Center,** said he opposes the bill. He thinks the time limit of 24 hours is somewhat arbitrary, and you really need to start thinking about the future, when ambulatory surgery centers and short stays may increase. As far as patient safety is concerned, the same surgeons and anesthesiologists that work in the hospitals in the inpatient setting work in the surgery centers. *(Tape ended, cutting off part of his testimony.)* **EXHIBIT(huh54a05)*{Tape : 1; Side : B; Approx. Time Counter : 21 - 30}***

**Dr. David Hafer, Great Falls,** said he has practiced for 25 years in Great Falls as an oral maxilla facial surgeon. He does the type of cases that are probably ideally situated for the ambulatory surgi-center, including jaw surgeries on congenital facial deformities, for the most part on young, healthy patients. He evaluates his patients and decides if they need to be operated on in the hospital or in the surgi-center. He can't believe that Medicare or anybody else is going to put a time limit like 90 minutes for a surgery. If

he is performing surgery that he thinks will take 90 minutes, he might run into problems that cause him to take extra time. Patients often need more than 24 hours recovery time, and he would not like to see a cap. He knows costs are higher in the hospital than in the surgi-centers, which are cost effective for the patients. Patients continually have decreased reimbursements on their insurance and are concerned about costs. ***{Tape : 2; Side : A; Approx. Time Counter : 0 - 7.2}***

**Gary Mermel, Billings, Anesthesiology Partners of Montana,** presented written comments in opposition to the bill. **EXHIBIT(huh54a06)** ***{Tape : 2; Side : A; Approx. Time Counter : 7.2 - 7.9}***

**Dr. Dean Sukin, orthopedic surgeon, Billings,** representing a group of six orthopedic surgeons, opposes the bill. ***{Tape : 2; Side : A; Approx. Time Counter : 7.9 - 8.2}***

**Dr. Greg McDowell, Billings, Orthopedic Surgeons PSC,** presented written testimony in opposition to the bill. **EXHIBIT(huh54a07)**

**Susan Good, Mt. Orthopedic Society and Mt. Society of Anesthesiologists,** said this is a Missoula problem and everybody else is going to get sucked into their mess over there, and she urged the committee to vote no or at least to consider a strong amendment. **EXHIBIT(huh54a08)** ***{Tape : 2; Side : A; Approx. Time Counter : 8.2 - 9}***

**Informational Testimony:**

**Lionel Tapia, physician & Vice Pres. for Medical Affairs, St. Vincent Health Care, Billings,** appeared as an informational witness and presented written testimony. **EXHIBIT(huh54a09)** ***{Tape : 2; Side : A; Approx. Time Counter : 9 - 11}***

**Questions from Committee Members and Responses:**

**Rep. Whitaker** asked **Susan Good** to further explain her comments. **Ms. Good** said that we're talking about clinical medical decisions that should be made by physicians and not by the legislature, and surely not by Medicare. She said not to get spooked by this Medicare stuff, because those rules are going to be under revision, they're kind of silly, and they aren't necessarily even followed particularly stringently now. People are being kept a lot longer than four hours. If the committee is looking at quality, cost, accountability and competition, SB 309 does not do one thing to further any of those important factors that should be considered.

This is an anti-competition bill and is localized to one part of the state.

**Rep. Dell** asked **Mr. Boatman** about accreditation for surgi-centers. **Mr. Boatman** said there are voluntary accreditations and then there is sort of a mandatory accreditation that is the Medicare certification, which everybody has to go through. As a hospital administrator, he had been through the Joint Commission on Accreditation innumerable times. His surgi-center decided to simply go with Medicare certification. The survey forms are almost identical to those of the Joint Commission. They chose for a number of economic reasons, including being a start-up center. Other centers in the state have recently gone to some voluntary accreditations. He's not sure if any non-hospital centers are JCAHO accredited. They are very expensive, and he doesn't know that they are any more meaningful.

**Rep. Dell** asked in terms of Medicare certification, what the policy is with regard to keeping patients 24 hours or less, and if there is a concern about either not keeping patients long enough or keeping them too long. **Mr. Boatman** said it would call for speculation on his part, but his understanding is that their concern is with their beneficiaries, and they look specifically to how Medicare patients are handled. They're worried about the cost and quality issues for Medicare beneficiaries. Although Medicare is a significant part of his business, it's not the majority; and most of the types of Medicare patients that they would see would be people in for cataract surgery. Often they'll leave within an hour or two postoperatively.

**Rep. Dell** asked **Mr. Boatman** if he had some sort of professional liability insurance. **Mr. Boatman** said absolutely. **Rep. Dell** asked if the insurance providers take any of this into consideration, such as sending patients away prematurely if they weren't quite ready to leave. Mr. Boatman said he could only speculate since he isn't in the insurance business, but he thought that on a proportional basis, the insurance risk is less in an ambulatory surgery center than in a hospital. Physicians inherently pre-screen the types of patients that they're going to bring to a surgery center and they don't necessarily bring a high-risk patient to an ASC. **Rep. Dell** said there was talk about with hospitals there are comfortable over-night stays and the environment is meant for individuals who are there for longer than 24 hours. He asked how these issues are typically addressed in a surgery center and if they have accommodations. **Mr. Boatman** said their center is relatively new, and they do have beds that look like hospital beds, which can be used rather than the patient lying on a gurney. They don't have a full-fledged dietary program and they don't need one, but they do have nutritional support. The most people will want

after surgery is juice or toast or something like that, not a full meal.

**Rep. Himmelberger** asked **Dr. Mermel** if he would like to add to his earlier brief testimony. **Dr. Mermel** said he wanted to emphasize the arbitrary nature of the 23-hour limit. If a patient is hurting or happens to be nauseated after surgery, it seems inappropriate to be watching a clock to get them comfortable and "street ready." In Billings, his colleagues have patients that travel a long distance, an average of two hours away. The biggest problem his group has with the bill is the arbitrary nature of that 23 hours, and it doesn't take into account individual patients.

**Rep. Schmidt** asked the sponsor about the title of the bill not referring to "ambulatory," and she wondered if that was necessary. **Sen. Halligan** said he didn't know whether the title referred to existing statutes or rules, and deferred the question. **Mr. Davis** said that two sessions ago the legislature allowed the department to redefine ambulatory surgery center as an outpatient center for surgical services, and then defined an outpatient services "clinic" as just that, an outpatient service. **Rep. Schmidt** asked what we're talking about here, and **Mr. Davis** said we are talking about an outpatient center for surgical services. That's a state licensure definition, but Medicare still calls them ambulatory surgical centers. **Rep. Schmidt** asked if the title is correct and **Mr. Davis** said yes. **Rep. Schmidt** asked **Mr. Boatman** what other states do with these hours. **Mr. Boatman** said he hadn't researched that, but it was his impression that most other states would be non-defined or somewhere in the 24-hour category. **Dr. Sukin** said he didn't have national statistics, but has traveled to Idaho and South Dakota, and both have ambulatory surgical centers with 72-hour-stay beds. **Ron Peterson** said that there are recovery centers in 35 states. In 18 of the 35, there are capacities beyond 24 hours. The majority of the longer stay recovery centers are in states close by us, such as Colorado.

**Rep. Raser** asked **Mr. Davis** what the difference is in certification procedures for a hospital and an outpatient surgical center. **Mr. Davis** said there are a number of differences and he'd try to explain the major ones. In a surgical center you go in and have an operation not to extend 90 minutes, but that isn't a magic number and it says "generally" so there is movement even in the federal regulations to go beyond 90 minutes and the four hours. The regulations are clear that it isn't an overnight model. You've got your end to the surgery, your recovery, and you go home. A hospital, on the other hand, has a set of regulations in which essentially 24 hours a day, seven days a week, emergency room, dietary, radiation, pharmacy, you're required to have all of those

kinds of things in place. *(Tape ended and cut off part of the next question and answer.)*

**Rep. Raser** asked what process a center would go through if it wanted to go into a recovery center model, and could they extend their hours to keep somebody for a couple of days. **Mr. Davis** said no, they could not. This bill isn't talking about some other model but about restrictions on ambulatory surgery. If we are talking about some new kind of model called 72 hour inpatient, currently the state could not even consider licensure of those because we have no statutory authority to do that. **Rep. Raser** asked if part of the cost-effectiveness of the surgery centers is due to not having all the costs incurred by going through all the things that hospitals are required to do. **Mr. Davis** said he thinks she is right.

**Rep. Schrumpf** asked **Dr. Sukin** what other Billings physicians he was representing and he named six orthopedic surgeons. **Rep. Schrumpf** asked how many hospitals have an outpatient clinic; are they totally separate or semi-contained? **Dr. Sukin** said in Billings there are outpatient capabilities in both hospitals and a free-standing ambulatory surgery center. The two different models around the country are completely independent ambulatory surgery centers that are free standing, and those within hospitals.

**Rep. Facey** asked **Mr. Boatman** if centers could be accused of skimming patients off the top in rural areas, taking patients that might be easier to serve and hurting the rural hospitals. **Mr. Boatman** said that is an argument that hospitals would proposition. It depends upon your political view of the world. In his case, they look to serve people in rural areas if they choose to come to them, but Great Falls is a major population center. His center pays taxes, and Montana hospitals are tax exempt and pay no taxes. So it is a philosophical question as to whether there is a difference between someone who is paying taxes basically in support of those hospitals, or someone who is enjoying the advantages of tax exemption. **Rep. Facey** asked how many of the 11 centers in Montana are open 24 hours a day. **Mr. Boatman** said his center is probably the only one, and that is a flexible 24 hours. For example, if a patient comes in at 5 p.m., they'll start a case and then the patient will stay overnight. **Rep. Facey** asked what the different types of relationships are between the centers and hospitals, such as if they are contractual or on a per case basis. **Mr. Boatman** explained the problems he went through with the hospital in getting his surgery center established, but he finally was able to get a transfer agreement signed with the hospital. He didn't explain any other types of relationships.

**Rep. Facey** asked **Dr. Tapia** why this is a Missoula problem. **Dr. Tapia** said he isn't certain and didn't know the situation in Missoula. **Rep. Facey** asked **Bob Olsen** if there are any amendments to the bill that the MHA would be willing to live with. **Mr. Olsen** said no. The policy question in front of the committee is that a group of providers who deliver outpatient services want to create a licensure standard to become an inpatient facility but still be an outpatient facility. **Rep. Facey** asked **Dr. Eddy** to explain the problems addressed by this bill because he doesn't quite understand it yet. **Dr. Eddy** repeated previous testimony and said that although 24 hours is somewhat arbitrary, the line has to be set somewhere in order to insure patient safety. If a surgery center chooses to keep patients longer than 24 hours, they should live up to the same standards as an inpatient facility. The bill tries to define the difference between inpatient and outpatient, in the name of patient safety.

**Rep. Esp** asked **Bob Olsen** if in a typical hospital the emergency room is a profit or a loss center. **Mr. Olsen** said it is a loss center. **Rep. Esp** asked if the surgical center is a profit or a loss center. **Mr. Olsen** said surgical services for a hospital tend to be a profitable service. **Rep. Esp** asked about a statistic that 30 percent of deaths in a hospital setting were the result of improper medications delivered by staff and wondered if that seemed reasonable. **Mr. Olsen** said the in-hospital mortality data from the Institutes of Medicine talks about the types of preventable deaths, or deaths due to hospital errors, and studies suggest that there are a number of deaths that occur throughout the country. One of the reasons for those deaths is medication. 30 percent of the deaths in hospitals sounds too high. He would obtain the study for the committee if they wished.

**Rep. Noennig** asked **Dr. McDowell** what number of hours would be the longest time necessary to stay in an outpatient surgery center. **Dr. McDowell** said most cases incur less than four to five hour stays in a recovery suite. A small minority might extend to 23 hours. The foreseeable future for ambulatory surgery, within the coming decade, might allow some of the stays to be extended beyond the 23-hour limit into what would be considered extended stays, perhaps two to three days. **Rep. Noennig** asked **Mr. Davis** if he understood correctly that the current statute defines an outpatient center for surgical services to include an institution for patients not requiring hospitalization; and he thought **Mr. Davis** had said that if a patient stays there for any extended period of time, this facility isn't licensed and qualified to do that currently. **Mr. Davis** said that is basically right. **Rep. Noennig** said he was confused as to why we need a bill that adds recovery care beds and then limits the time period, because he thought Mr. Davis had said

they weren't trying to extend it to a new kind of use, and it sounds like the law already limits it to a time period that doesn't require hospitalization. **Mr. Davis** said currently statutorily he doesn't really have any cap on this. Current licensing laws for outpatient surgical services are very weak. They could be strengthened, but it's nice to have a statutory limitation with regard to what ambulatory surgical centers' outside limits will be. It hasn't been an issue in the past because all of these facilities are certified for Medicare and have to follow the Medicare requirements, so there's been no pressure on the licensure side. The definition of the observation bed, which has been in law for a long time, really is a hospital determination, so they just changed that definition to a recovery bed because essentially that's what it is. **Rep. Noennig** asked **Mr. Davis** if he was referring to statutes or regulations, and he said the department regulations. **Rep. Noennig** asked why it hadn't been changed if it is too weak. **Mr. Davis** said because there had been no pressure to change it.

**Rep. Dell** asked **Dr. McDowell** how they decide which patients to send to the surgi-center. **Dr. McDowell** said the centers are environments in which elective, outpatient types of procedures are done in which relatively short stays are anticipated.

**Rep. Raser** asked **Mr. Davis** if this could be resolved by rule rather than by law. **Mr. Davis** said the honest answer is yes, but it is brought before the legislature because it is a policy issue with regard to the amount of time. He wants legislative input so it isn't a department kind of limiting factor. If he put it in rule, the battle would be longer. If the legislature chooses not to deal with it, he will deal with it in a rule.

**Chairman Thomas** asked **Mr. Peterson** about a compromise that was broken that he had alluded to previously. **Mr. Peterson** said at different intervals this discussion had involved Mt. Medical Assn., Mt. Hospital Assn., surgery centers, individual physicians, and hospital-employed physicians; and there was good support for a 48-72 hour compromise, but St. Patrick's Hospital rejected that compromise, which is why they are using this forum.***{Tape : 2; Side : A; Approx. Time Counter : 11 - 30}{Tape : 2; Side : B; Approx. Time Counter : 0 - 27.1}***

**Closing by Sponsor**:

**Sen. Halligan** said he didn't say it was going to be easy, and it's not going to be. The hospitals didn't create this problem, the legislature created it by saying hospitals had to follow certain regulations. With new equipment, new technology and new training, they "pushed the envelope" in all these professions, so the turf is

constantly shifting. Surgi-centers are established, and great doctors come in and are able to do these things in ways that are more efficient, more effective and less costly, which is exactly what is supposed to happen. It is the legislature's responsibility to look at the public policy and say, maybe the hospitals shouldn't be as regulated as they are. Let's make sure that we even out the playing field. Should it be 24 hours? Should it be 36 for the surgi-centers? At some point they have to provide inpatient care, and they don't want to; they want the hospitals to do that, but they want somehow this hybrid out there. *(Tape ended, cutting off part of closing.)* Surgi-centers are the wave of the future. At the same time, rural hospitals are affected because people are coming to the larger centers to be able to take advantage of the cheaper, more efficient, more effective day surgeries that ought to be done. So rural hospitals are more at risk, because the centers cherry-pick; they take the healthy patients, they screen them, and that's what they're supposed to do. And the sicker patients go to a hospital. At some point we have to realize how to change the regulations for hospitals to let them compete. We've created the problem; how do we create the balance? Is it 24, 36, or do we say, if you're going to do it, DPHHS, do it by rule. The turf will continue to change as technology changes. The legislature created the turf battle addressed in this bill, and the legislature has to solve it. ***{Tape : 2; Side : B; Approx. Time Counter : 27.1 - 30}***

## HEARING ON SB 107

**Sponsor: SEN. EVE FRANKLIN, SD 21, Great Falls**

**Proponents: Charles Brooks, Billings, Yellowstone County Board of Commissioners**
**Bob Olsen, Mt. Hospital Assn.**
**Jani McCall, Deaconess Billings Clinic**
**Sami Butler, Mt. Nurses Assn.**

**Opponents:** None

**Opening Statement by Sponsor:**

**SEN. EVE FRANKLIN, SD 21, Great Falls,** said this bill came out of the Legislative Finance Committee and deals with an issue that had been kicked around for quite awhile in the mental health community. The issue is, when individuals are in a compromised state, they are not well, they are experiencing psychiatric symptoms and in some instances have to be transported and have to travel long distances back and forth from the State Hospital to their county of origin in

order to go through the mental health proceedings. This bill allows for the use of two-way electronic audio-video equipment so that the hearings can be conducted using electronics rather than in all cases the individuals having to travel. The purpose of it, from her perspective as a nurse and health care provider, is really from a humane aspect. There are times when people, who may be civilly committed, in jail, in a hospital, in a community setting, are transported to Warm Springs and then have to come back, a six or three hour trip, depending on where you are in the state. It is not unheard of for people to be traveling round trip, in the company of a sheriff, in a police car or sheriff's vehicle, sometimes in handcuffs, and it's inappropriate and not humane and doesn't really serve the patient very well in many instances. The idea is not that the person would have their assessment done telecommunicatively, but that the actual civil hearing or aspects of it could be done. She has experienced this situation personally as a clinical specialist in psychiatric nursing, who also teaches nursing, and she used to work part-time in a jail setting, where there were people who had to be transferred back and forth. Other county hearings were done over telecommunications from the jail to downtown, and she thought they ought to be able to do that. Often there is hesitancy, because of not being sure what the implications are, when it isn't explicitly stated in statute. Maybe the letter of the law doesn't prohibit it, but if there is no precedent for it, particularly in instances with mental health hearings, there is understandable discomfort. It is up to the patient, and if they object or don't want to do it, they don't have to do it. The other piece of the bill is the financial piece, which was brought to the Legislative Finance Committee by a sheriff. Transporting someone ties up sheriff's vehicles, time, overtime and the cost of transportation. She didn't sign the fiscal note because she wasn't sure it was entirely accurate. It is the best case speculation that the folks could make. She thinks the cost depends on at what point the hearing actually happens. If it is an initial hearing, the county pays for it. If the person is already committed and it's at a later stage, then the state is going to pay for it. She isn't sure that this will be an impact on the general fund. Certainly it will be a savings to the county, and any cost to the state would be negligible, if any. She has heard varying things about the cost per hour of METNET, which, according to the fiscal note, is $100 per hour. The bottom line is, it's going to mean incredible savings for the counties, in terms of their transportation costs. Sen. Franklin explained the amendments that were made in the Senate, and said there was no opposition to the bill in the Senate.***{Tape : 3; Side : A; Approx. Time Counter : 0 - 11.6}***

**Proponents' Testimony**:

**Charles Brooks, Billings, Yellowstone County Board of Commissioners,** said they see this as a sensitivity issue, a safety issue, a cost-savings issue, and effective use of technology. They already have the capability in Yellowstone County to use the audio-video teleconferencing method of counseling with mental patients, and they would urge support to get this into the code.***{Tape : 3; Side : A; Approx. Time Counter : 11.6 - 13.7}***

**Bob Olsen, Mt. Hospital Assn.,** said they support the bill. Through the METNET system, there are a lot of hospitals out there with this interactive video equipment, so the State Hospital in Warm Springs can be in contact with others on the network. Through this system, the individual can be put in face-to-face contact with their attorneys, with the judge, with the patients using that technology. The bill makes a lot of sense for everyone involved.***{Tape : 3; Side : A; Approx. Time Counter : 13.7 - 14.2}***

**Jani McCall, Deaconess Billings Clinic,** said they have a psychiatric center in Billings and they are very much in support of this bill. It is very progressive, creative and it uses a wonderful system. When you're looking at people who have mental illness, you want to look at four things: safety, access, quality and cost effectiveness. When these individuals start de-compensating and they're having problems with medications and not feeling well and have a lot of fear, it becomes a really distressful situation when they need to be transported. So, by offering this kind of tele-medicine and networking, it makes a tremendous difference for patients. There are many networks available now through the state, whether with hospitals or mental health centers, and we need to be able to access all of those to continue the cost effectiveness.***{Tape : 3; Side : A; Approx. Time Counter : 14.2 - 15.8}***

**Sami Butler, Mt. Nurses Assn.,** said they agree with what's already been said, particularly the compassionate approach of this bill; and the bonus is that it is cost effective.***{Tape : 3; Side : A; Approx. Time Counter : 15.8 - 18.5}***

**Opponents' Testimony**: None

**Informational Testimony**: None

**Questions from Committee Members and Responses**:

**Chairman Thomas** asked if there was any history of this happening anywhere else in this field. **Sen. Franklin** said she had not done any research on the literature so she didn't have the background. She wouldn't be surprised, based on where other rural states are going, and it would be interesting to find out.***{Tape : 3; Side : A; Approx. Time Counter : 18.5 - 19.6}***

**Closing by Sponsor**:

**Sen. Franklin** said the committee could feel comfortable that this is a positive thing. County commissioners would be pleased, as well as some of the folks she had talked to who've recognize this as a major issue for their communities in terms of transport. ***{Tape : 3; Side : A; Approx. Time Counter : 19.6 - 21}***

## EXECUTIVE ACTION ON SB 107

**Motion/Vote**: **REP. ESP** moved that **SB 107 BE CONCURRED IN. Motion carried unanimously. Rep. Newman** will carry the bill.***{Tape : 3; Side : A; Approx. Time Counter : 21 - 22}***

**ADJOURNMENT**

Adjournment: 5:40 P.M.

_____
REP. BILL THOMAS, Chairman

_____
PATI O'REILLY, Secretary

BT/PO/JB Transcribed by Jan Brown

**EXHIBIT(huh54aad)**