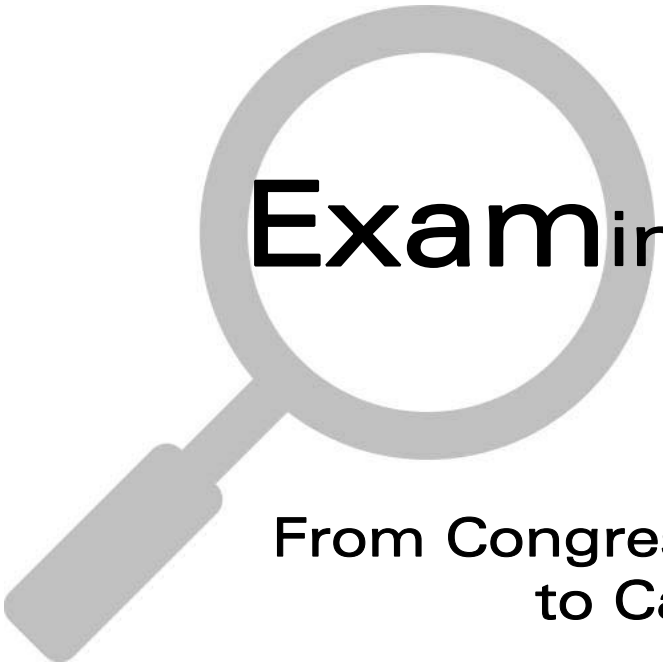

Examining Health Care

From Congressional Reforms to Cannabis

A Final Report of the Children, Families, Health, and Human Services Interim Committee
2009 - 2010 Interim

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Introduction

In between legislative sessions, the Children, Families, Health, and Human Services Interim Committee (Committee) typically works on a variety of wide-ranging issues that touch on the health, welfare, and safety of thousands of Montanans. The Committee undertakes studies involving health and human services. It also monitors the Department of Public Health and Human Services (DPHHS), an agency that provides services to Montanans in every corner of the state and from many walks of life.

Thus the Committee in any given interim has a full plate. However, the 2009-2010 interim gave the Committee an opportunity to be involved in two top-of-the-news issues — one at the national level and one at the state level.

The Committee was assigned the Senate Joint Resolution No. 35 study of health care, including monitoring of federal health care reform efforts. Committee members closely followed developments at the national level as Congress worked for months on legislation making significant changes to the nation's health insurance laws and health insurance programs.

In April 2010, members decided to take up the emerging issue of medical marijuana — also known as medical cannabis — in Montana. The decision came as the number of people with medical marijuana cards ballooned, creating new issues for local governments, schools, law enforcement, and the medical marijuana industry itself.

This final report summarizes the Committee's work on its assigned studies, on the emerging issue of medical marijuana, and on its oversight activities related to DPHHS.

At the same time, the Committee carried out its DPHHS oversight activities and reviewed the House Joint Resolution No. 39 staff study of community services for people with developmental disabilities and mental illness.

These wide-ranging activities resulted in eight pieces of committee legislation, a white paper report, a published objection to an administrative rule, and several letters related to a variety of health care issues. This final report summarizes the Committee's work on its assigned studies, on the emerging issue of medical marijuana, and on its oversight activities related to DPHHS.

Summary of Committee Activity and Actions

The Committee met seven times over the interim, starting with a June 2, 2009, meeting at which it adopted a work plan for carrying out its assigned studies and its oversight duties. The Legislative Council assigned two studies to the Committee:

- SJR 35, which called for a study of matters related to health care. The study was to include monitoring and evaluating federal health care reform efforts, as well as considering reforms proposed by Montana groups.

- HJR 39, which called for a study to assess the availability of community services for people who have developmental disabilities and also have mental health problems. The Council directed that this study be conducted primarily by staff, with the information presented to the Committee as a white paper.

In April 2010, the Committee added a review of Montana's Medical Marijuana Act to its work plan. Issues related to the law — and the many gray areas of the law that were beginning to come to light — prompted the Committee to determine that the law warranted further review and possible action during the interim.

Issues related to Montana's Medical Marijuana Act prompted the Committee to determine that the law warranted further review and possible action during the interim.

In addition, at each meeting, the Committee received updates about DPHHS activities and reviewed administrative rules proposed and adopted by the Department. The Department's updates included regular reporting on how the Healthy Montana Kids Plan was being developed and put into place. The program was approved by voters in 2008 when they passed Initiative 155, which expanded state-provided health insurance coverage to children with family incomes at or below 250% of the federal poverty level. The agency updates also touched on many of the other services the Department provides, from foster care to mental health programs and programs for the needy.

By the end of the interim, the Committee had approved the following legislation, by topic area:

- **SJR 35 Study of Health Care**: LC 283, to provide monitoring of childhood Body Mass Index trends, and LC 297, to allow certain dental hygienists to conduct school-based sealant programs.

- **Medical Marijuana**: LC 284, to revise the Medical Marijuana Act and create a regulatory structure for the industry; LC 295, to clarify that the Clean Indoor Air Act applies to the smoking of medical marijuana; and LC 296, to clarify an employer's rights related to an employee's use of medical marijuana.

- **DPHHS Oversight**: LC 46, to clarify the commitment laws for people with developmental disabilities; LC 65, to clarify that mental health diversion grant awards are based on a county's admissions to the Montana State Hospital; and LC 293, to amend a DPHHS administrative rule reducing Medicaid reimbursement rates for physicians.

The Committee also published in the Montana Administrative Register its objection to the adoption of the DPHHS rule reducing the statutory Medicaid reimbursement rate for physicians.

Finally, the Committee made other public officials at the national and state levels aware of its concerns related to health care workforce and childhood health issues by sending letters asking those officials to take action on items that fell within their jurisdictions.

Assigned Studies

Each legislative session, lawmakers approve a number of resolutions asking that interim committees study various topics and develop recommendations for the next Legislature. During the 2009 Legislature, lawmakers passed 17 such resolutions. Study topics ranged from workers' compensation to fire suppression to methods of filing income taxes.

At the end of each session, legislators are polled and asked to rank each study in order of importance to the individual legislator. The poll results are compiled and presented to the Legislative Council, with staff recommendations on how the studies should be assigned among the interim committees. Studies that rank relatively low in the poll often are not carried out.

The SJR 35 study of health care ranked second out of the 17 studies, guaranteeing it a spot among the studies to be conducted. The Legislative Council assigned it to the Children and Families Committee.

The HJR 39 study of community services for people with developmental disabilities and mental health problems ranked 13th among the 17 study resolutions. The Council assigned it to the Committee, but directed that it be conducted primarily by staff and presented to the Committee as a white paper.

The SJR 35 study of health care ranked second out of the 17 studies, guaranteeing it a spot among the studies to be conducted.

As a result, the Committee devoted time at each of its meetings to hear about issues related to the SJR 35 study. The activities included speakers or panel presentations on many health care topics, as well as staff briefing papers on issues that were either defined in the study resolution or requested by Committee members. The HJR 39 white paper, meanwhile, was presented at the Committee's April 2010 meeting. The Committee approved the white paper and asked that it be forwarded to DPHHS for consideration of the recommendations it contained.

This section of the report provides additional information on each of the assigned studies.

◘ SJR 35: Examining Health Care Issues Nationally and Locally ◘

When lawmakers convened in January 2009, Montana voters had recently passed Initiative 155 to expand publicly funded health insurance programs to cover children with a family income at or below 250% of the federal poverty level. Previously, children with family incomes of up to 175% of the poverty level were covered by the programs. In addition, the recently concluded presidential and congressional campaigns had made it clear that health care reform would be on the national agenda.

Against that backdrop, the 2009 Legislature approved Senate Joint Resolution No. 35 to allow for a broad study of health care issues. The resolution directed that the study look at:

- the extent to which Montanans lack health insurance coverage and the extent to which publicly funded programs provided coverage;
- issues involving Montana's health care workforce, including medical education opportunities;
- state and federal efforts related to preventing disease and promoting health;
- efforts to develop a health information technology system;
- ways to reduce health care costs;
- proposals by Montana groups working on health care issues; and
- how any health care changes at the federal level might affect Montanans and whether the 2011 Legislature would need to take action as a result of those changes.

Based on the resolution, the Committee undertook a number of activities related to SJR 35 at each of its meetings. The activities and the resulting action is summarized by study topic.

Insurance Coverage for Montanans

The Committee began its interim work by looking at information already available on the number of Montanans with and without insurance. However, as the Committee learned, estimates of those numbers often vary widely. Some groups look at multi-year averages to determine if a person lacks insurance coverage. Others consider persons to be uninsured if they lacked coverage for 1 or 2 months out of a year. These different methods and time periods for measuring whether a person is or has been uninsured predictably result in different coverage rates. Many national studies also do not look specifically at Montana's population but instead distill estimates for the state based on the national figures.

Surveys in recent years have resulted in reports that put Montanan's uninsured rate at anywhere from 15% to 34% of the population.

In 2009, the U.S. Census Bureau's most recent report on health insurance coverage put the state's uninsured rate at 16.1%, based on a 3-year average from 2005 through 2007. A widely cited University of Montana Bureau of Business and Economic Research survey of 5,074 Montana households put the uninsured rate at 19% in 2003. The survey stated that the rate was as high as 22% if Montanans who are under 65 and typically eligible for Medicare were removed from the survey. However, the rate dropped to 15.9% when it measured only people under 65 who had been without insurance for all of the previous 12 months. Thus the UM survey and the Census Bureau figures consistently show that about 16% of Montanans generally lack health insurance coverage. That amounts to about 150,000 of the state's 933,000 residents.

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Of the people with health insurance, about 56% to 58% are covered by policies offered by their employer — slightly lower than the national rate of 61%. About 9% of Montanans buy insurance coverage on their own, higher than the 6.5% national average. People buying insurance coverage in the individual market sometimes pay more for policies that may offer fewer benefits, depending on their age and their health status. That's because they

generally don't benefit from the pooling of risk that occurs when a policy covers a group of people, some of whom may have relatively few health problems and are less costly to insure. Many small businesses in Montana don't offer insurance coverage to employees or offer it only to those employees who work a certain number of hours per week.

While about 150,000 Montanans may lack insurance coverage, about another 272,000 are covered by publicly funded programs that cover elderly, poor, or disabled adults or that cover children. Medicare primarily covers people who are 65 years of age or older. Medicaid primarily serves low-income children, pregnant women, blind or disabled adults, and extremely low-income adults under the age of 65 if they have dependent children. Children covered by either the Children's Health Insurance Program (CHIP) or Medicaid are in what is now known in Montana as the Healthy Montana Kids Plan. Medicare is a federally funded program, while Medicaid and CHIP are funded through a mix of federal and state dollars.

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The state also subsidizes coverage for a small number of Montanans who are unable to obtain insurance coverage because of their existing medical conditions. The Montana Comprehensive Health Association provides a range of high-deductible insurance plans with costs that are based on a person's age. The plans are open to any person who is unable to obtain health insurance coverage; fewer than 300 of the approximately 3,000 enrollees were receiving a state subsidy during the 2009 plan year.

Some Montanans receive coverage subsidized by the state through the Insure Montana program, which offers tax credits and subsidies to businesses that employ two to nine people. The program also helps pay the premium costs for some employees.

Of the approximately 272,000 Montanans who were receiving coverage or some assistance through these publicly funded insurance programs in 2009, about 160,000 received Medicare coverage, while another 82,000 received Medicaid coverage.

The Committee reviewed information on the uninsured population as Congress debated how to extend insurance coverage to more people. Based on the final federal health care legislation, lawmakers can expect the state's Medicaid enrollment and costs to increase. In addition, many individuals who would be required to purchase insurance coverage may be doing so through the individual insurance market because they work for small businesses that don't currently offer insurance.

However, the federal legislation also includes tax incentives to encourage small businesses to start offering insurance coverage to their employees.

Montana's Health Care Workforce

Knowing that congressional action could extend insurance coverage to about 150,000 Montanans, the Committee was keenly interested in learning whether the state's health care workforce would be ready to see more patients. The availability of primary care practitioners was of particular concern, because these practitioners are typically the first contact a patient has for a new health care problem or need. They also provide continuity of care over time and coordinate care when a patient has more than one health care provider. In addition to physicians, physician assistants and many advanced practice registered nurses offer primary care in Montana.

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Numerous studies in recent years have concluded that many areas of the country already lack an adequate number of primary care providers. Montana is among those. A 2009 study by the Office of Rural Health Policy at Montana State University showed that 33 of Montana's 56 counties have a lower ratio of primary care physician to patients than the national average of 1 physician for every 1,160 residents. Twelve counties had no primary care physician, while nine counties had no physicians.

The study also showed that 862 of the state's 2,139 licensed physicians were primary care physicians. Meanwhile, the state had 326 licensed physician assistants, 411 licensed nurse practitioners, and 41 nurse midwives.

To complete this portion of its study activities, the Committee:

- reviewed information on the number of primary care physicians, physician assistants, and advanced practice registered nurses;
- heard from primary care physicians about the issues preventing medical students from entering primary care or doctors from remaining in the field;
- learned about the federally qualified community health centers that primarily serve lower-income or uninsured Montanans;
- reviewed a Montana Hospital Association survey of allied health professionals;
- learned about the state-funded medical education opportunities for Montana students and the Montana program that allows medical school graduates to complete their family medicine residency programs in Montana; and
- heard about the incentive programs that the state and federal governments fund for physicians and mid-level practitioners who practice in underserved areas.

Committee members also reviewed proposals within the congressional legislation that were designed to increase access to primary care. These included increasing Medicare payments to primary care doctors who practice in designated Health Professional Shortage Areas, increasing the number of residency slots for training primary care medical graduates, redistributing the residency slots around the country, and increasing federal scholarships for medical students and loan repayments for doctors who agree to practice in shortage areas.

Although the Committee did not take action to expand any of Montana's state-supported medical education or incentive programs, members did ask the congressional delegation to:

- consider changing the reimbursement system used by Medicare to pay for primary care services, in order to better reflect the costs of providing the services; and

- lift the freeze on Medicare funding for medical residency positions.

The Committee also sent a letter to the Montana Department of Labor and Industry asking that the state health care licensing boards begin collecting data related to primary care practitioners, including expected retirement dates. The information would allow the Montana University System and the Legislature to better predict where workforce shortages might occur and to take steps to offset the shortages by expanding curriculum offerings in certain allied health fields, expanding the programs that subsidize medical school education for Montana students, or adjusting the loan repayment programs offered as incentives to some providers.

The Department of Labor and Industry agreed to ask health care licensees to voluntarily fill out an online survey when renewing their licenses.

Members stressed throughout the interim that preventing disease and promoting good health could do more in the long run to reduce health care costs than many other types of actions.

Disease Prevention and Health Promotion

Committee members spent much of the interim looking at the steps that state and local entities are taking to prevent disease and promote good health. Members stressed throughout the interim that these activities could do more in the long run to reduce health care costs than many other types of actions, by reducing the rate of chronic disease and preventing people from developing health problems over their lifetimes.

The Committee heard from DPHHS and from local public health officials about ongoing efforts at the state and local levels, as well as about activities that could use legislative support. The Committee narrowed its focus on these topics to childhood health promotion.

Speakers on this topic stressed the problems posed by the increase in childhood obesity. They also discussed the need to encourage good nutrition and physical activities in the schools, because children spend so much of their time at school. Speakers discussed ways in which schools could incorporate nutrition and physical fitness into their curriculums. They also suggested that schools could limit the availability of unhealthy food choices, by setting stricter guidelines for meals served at schools and for items available in vending machines.

Committee members noted that schools already have a great deal of authority to undertake the suggested activities. As a result, the Committee sent a letter to the Board of Public Education encouraging it to promote good nutrition and physical activity as a way of preventing childhood obesity.

Members also agreed to introduce LC 283, a bill to allow DPHHS to collect and analyze Body Mass Index scores from schools that test students. DPHHS will be able to use the information to analyze statewide trends in childhood obesity.

Health Information Technology

The health care industry has slowly been gearing up to use computerized health care records as a way to share information about patients seen by more than one health care provider. The use of so-called "health information technology," or HIT, is seen as a way to reduce health care costs by:

- reducing duplication of medical tests;
- encouraging the use of lower-cost generic drugs;
- reminding doctors about a patient's preventive care needs;
- helping doctors manage care for patients with chronic conditions; and
- eliminating the need for medical transcription.

However, some health care providers have been slow to warm up to the idea of widespread HIT use because of the costs of setting up a system and training people to use it. In addition, if providers have different types of computer systems, the systems may not be able to easily share records.

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However, the federal government has been laying the groundwork for HIT in recent years. Congress heightened the stakes for providers when it passed the American Recovery and Reinvestment Act in February 2009. The stimulus bill set aside $2 billion for state or regional efforts to increase the use of HIT and another $17.2 billion for incentive payments to health care providers who use the technology in a meaningful way.

In Montana, a nonprofit group of about 50 organizations has been working on HIT issues for several years. HealthShare Montana has received state and federal funds for a health care information exchange pilot project. It also has applied for and received, on behalf of the state, a $5.77 million federal grant to plan for and put into effect widespread sharing of electronic health care information. In addition, Mountain-Pacific Quality Health received a federal grant of slightly more than $5 million to serve as an HIT Regional Extension Center for both Montana and Wyoming.

Committee members heard about those efforts and also heard that DPHHS is developing a plan for how the state Medicaid program will use HIT. That plan will include the Medicaid incentive payment program for providers who use electronic records in a meaningful way.

Health Care Costs

People involved in both the health care industry and in revising laws related to it acknowledge that increasing health care costs must be addressed as a part of overall health care reform. However, finding agreement on how to do that has proven difficult over the years.

The Committee examined two issues related to costs as part of its SJR 35 study — malpractice insurance costs and defensive medicine costs.

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The nonpartisan Congressional Budget Office (CBO) periodically analyzes the effects that a specific package of tort reform laws might have on health care costs. The office had concluded in the past that the reforms would slightly reduce the amount of money that health care providers pay for medical malpractice insurance coverage. In October 2009, the office decided that studies also have proven that the reforms could prompt providers to reduce the use of tests and other health care services. The CBO said those changes could save another 0.3% in national health care spending. The combined savings of 0.5% would equal $11 billion in 2009, according to the CBO.

The Montana Legislature has studied and acted on a number of tort reforms since the 1980s. The Committee reviewed information about Montana's malpractice laws as they compare to the benchmark package used by the CBO. A comparison showed that Montana already has approved laws that are the same or similar to those used by the CBO in analyzing the potential savings of tort reforms.

In addition, Montana created a system in 1977 for reviewing all medical malpractice claims before they're filed in court. For each claim, the Montana Medical Legal Panel appoints three attorneys and three health care providers to review all medical and hospital records related to the claim. The panel also holds a hearing at which both the claimant and the health care provider may call witnesses and submit written materials. The review panel then determines whether the claimant has presented substantial evidence of the alleged acts, whether the acts constitute malpractice, and whether a reasonable medical probability exists that the acts injured the patient.

The panel may recommend an award and approve or discuss settlement agreements. But its decision is not binding on either party and is not admissible as evidence in court.

The Medical Legal Panel Annual Report for 2008 shows that an average of 250 health care providers were named in malpractice claims that either went to a hearing or were resolved before the hearing from 1998 to 2008. The claims against 54 providers were abandoned, settled, or subject to a special ruling without a hearing. The claims against 80 of the remaining 196 providers were dropped or settled after a hearing before the review panel but before a lawsuit was filed. Lawsuits were filed against 88 of the 196 providers. Of those claims, 73% were dropped or settled before a trial. Claims against 3.5 providers, on average, resulted in a summary judgment by the court or a dismissal of the case, while claims against two providers went to a jury trial. Most of the cases that went to trial were settled in favor of the health care provider.

Representatives of the two largest insurers providing medical malpractice coverage to Montana physicians talked with the Committee about the claims history and tort reform in general. They said that the laws passed in Montana have created more stability for physicians and medical malpractice insurers.

Based on the information presented, the Committee did not pursue any further action related to medical malpractice. But members also wanted to examine the issue of defensive medicine.

Defensive medicine may be practiced in a couple of different ways. Doctors who want to reduce their exposure to lawsuits may order tests or treatments that they might not otherwise request. Doctors also may refuse to accept or treat patients they believe are likely to file lawsuits. Various, limited studies have shown that 73% to 83% of doctors have reported practicing defensive medicine.

The Committee focused most of its attention on the idea of creating a "safe harbor" for physicians who follow generally accepted medical guidelines in treating a patient. Under this idea, a physician would not be held liable for failure to order a particular test or treatment if the decision was made according to evidence-based medical guidelines.

At least five states have enacted safe harbor legislation, with Maine passing such a statute in 1990. Most states have limited the programs to pilot projects that involved certain medical

specialties. However, none of the laws have remained on the books; in at least two states, no legal case was ever filed that would have tested the effectiveness of the laws.

The idea still has supporters. The American Medical Association adopted principles in 2009 related to safe harbor for physicians who practice in accordance with evidence-based medical guidelines. Meanwhile, Oregon has received a federal grant to develop and put in place a method for setting priorities for creating evidence-based practice guidelines and to develop a safe harbor legislative proposal that will define a legal standard of care. As part of the grant, the state also must develop a plan for evaluating the effectiveness of any legislative proposal that may be enacted.

Committee members did not pursue the idea of safe harbor legislation after hearing about the spotty record for similar legislation in other states and after speakers on the topic generally discouraged the idea of legislatively established medical guidelines.

Federal Health Care Reform

The Committee began its SJR 35 study knowing that Congress was working on federal health care legislation that could result in numerous changes at the state level. Thus throughout the interim, Committee members followed with interest the health care developments at the national level. This monitoring began at the Committee's first meeting in June 2009, when members received an overview of the congressional efforts from Kelly Whitener of the U.S. Senate Finance Committee staff. It continued with briefings from the National Conference of State Legislatures and others on various aspects of the legislation that are expected to have the greatest impact on states. And it lasted until the final meeting in August 2010, when members heard from State Auditor Monica Lindeen, who also serves as the state's insurance commissioner, about how her office is complying with and planning for provisions of the new law.

Committee activity in this area focused on collecting information that lawmakers may need to make decisions in the future. The final federal health legislation was not approved until March 2010. The most significant provisions won't go into effect until 2014, including an expansion of the Medicaid program to cover childless adults between the ages of 18 and 65 and a

requirement that all adults have health insurance. Those two provisions, alone, however, will affect both the state budget and state laws.

Committee members heard presentations from DPHHS Director Anna Whiting Sorrell about the potential effects of the Medicaid expansion. In April 2010, the Department was estimating that the expansion would double the number of Medicaid recipients by 2019, when about 84,000 additional Montanans are expected to be covered by the program. DPHHS was also estimating that the expansion would cost the state an additional $71 million a year by 2019. The federal government is paying the full costs of the expansion for the first 3 years, with states gradually picking up a share of the costs.

The change in Medicaid eligibility is significant because childless adults generally don't qualify for Medicaid right now unless they're blind or disabled. Expanding Medicaid was seen as a way to insure thousands of people through an existing health insurance program.

Committee activity in the area of federal health legislation focused on collecting information that lawmakers may need to make decisions in the future.

Predicting costs to the states at this time is difficult, however, because the federal government has not yet established the benefit package that must be offered to the newly eligible Medicaid enrollees.

The new law also requires states to set up health insurance exchanges, which will essentially be Internet-based marketplaces where individuals and small businesses can shop for an insurance policy. Policies offered in the exchange must provide a minimum level of benefits, but a range of policies can be offered that provide richer benefits at a higher price. People with an income under 400% of the federal poverty level will qualify for subsidies to help them purchase the policy.

Committee members heard from Massachusetts and Utah officials about the health insurance exchanges that have been created in those states. The states took widely differing approaches to the idea, and Committee members learned the reasons behind those approaches. The

background information will be useful during the 2011 Legislature, when State Auditor Lindeen plans to propose legislation for the framework of a state insurance exchange.

The insurance exchanges must be operating by 2014. However, states must submit their plans to the federal government by January 1, 2013. The Montana Legislature is scheduled to meet only once before that deadline, making it likely that various pieces of legislation related to an insurance exchange will come before lawmakers in 2011.

In addition to monitoring the federal efforts, the Committee received information about state efforts challenging the federal law.

Please see Appendix D for committee correspondence related to the SJR 35 study.

◘ HJR 39: Reviewing Community Services for the Dually Diagnosed ◘

More than 4,200 Montanans with developmental disabilities live in communities around the state, where they receive a variety of services to assist them in their daily activities. The Montana Legislature has funded community services with the stated purpose of allowing developmentally disabled individuals to live in the least restrictive environment possible.

HJR 39 sought a study of the types of community services that would be needed for a small percentage of developmentally disabled individuals who also have mental health problems. These individuals are considered to have a dual diagnosis. Because they need both developmental disability (DD) and mental health services, their individual situations may pose greater challenges for community placements.

The staff study conducted for HJR 39 included interviews with key stakeholders, a survey of agencies that provide community services to the developmentally disabled, and a review of efforts at both the national level and in selected states to better serve this dually diagnosed population. The study resulted in a white paper report that was presented to the Committee in April 2010.

The study activities found that DPHHS was able to identify about 410 adults and 30 children who have a dual diagnosis. While the numbers represent only a fraction of the total number of Montanans receiving DD and mental health services, the consequences of inadequate community services could be significant. A key consequence could be inappropriate placement in a more restrictive environment than necessary. In fact, 73% of the residents of the Montana Developmental Center, the state's institution for severely developmentally disabled adults, had a dual diagnosis in March 2010. One-third of those individuals were waiting for a community placement because they did not need the intensive services and restrictive setting the Boulder facility provides.

Stakeholders identified several barriers to providing adequate and appropriate community services. The shortage of mental health providers was cited as a key barrier. Others included:

- some mental health providers are unwilling to accept DD clients;
- mental health providers often lack the training to work with DD clients;
- DD providers may experience additional or hidden costs in accepting a client with a mental illness;
- DD providers have difficulty averting and responding to crisis situations;
- many direct-care workers for DD providers are unaware of their role in the mental health treatment process;
- workers in both the DD and mental health systems know little about the other system; and
- funding requirements for the two systems allow little flexibility in providing services that cross traditional jurisdictional boundaries.

Stakeholders also offered a number of suggestions for reducing or eliminating the barriers. In addition, the report discussed best practices in other states and an effort by a national group to

create a certification program for employees, clinicians, and facilities that meet the criteria for working with dually diagnosed individuals.

After hearing the report and reviewing its proposed recommendations, the Committee approved the report. However, members decided against undertaking any other activities related to the study. Instead, they directed that the report be sent to DPHHS with the recommendation that the Department review the proposals it contained. Committee members determined that DPHHS could pursue any of the recommendations without further Committee action.

The report contained the following proposed recommendations:

- ask the Governor and DPHHS Director to develop a plan for cross-training DPHHS staff in issues related to dual diagnosis and report back to the Legislature and the Committee on the agency's efforts;

- ask DPHHS to take the lead in identifying and arranging educational opportunities for providers in the mental health and the DD systems, in order to prepare both types of providers to better serve dually diagnosed individuals;

- create a special revenue account that would allow various agencies and programs to pool funds to meet the needs of dually diagnosed individuals in certain instances; and

- provide the final white paper report to other state-level entities funded under the federal Developmental Disabilities Assistance and Bill of Rights Act for their consideration as they work on issues involving people with developmental disabilities.

Emerging Issue: Medical Marijuana

The state law outlining the duties of interim committees allows the committees to work on issues that emerge as the interim unfolds, if the committee believes the activity is "pertinent to the adequate completion of its work."

In April 2010, the Committee decided to take a closer look at Montana's Medical Marijuana Act. Members raised the issue as they saw medical marijuana businesses opening up storefront locations, at least one business organizing traveling clinics that drew hundreds of people at a time, and some patients smoking marijuana in public. These activities occurred as DPHHS saw a sudden and sharp increase in the number of people applying for and receiving authorization to use medical marijuana.

The Medical Marijuana Act was approved by voters in November 2004, when they passed Initiative 148. The law allowed a person to apply to DPHHS to use medical marijuana if a physician provided a written certification that the person had one of the debilitating medical conditions listed in the law and that the benefits of using marijuana may outweigh the potential risks. A person who received a registry card could also name someone to act as a "caregiver" to grow or provide the medical marijuana for the named patient. Both a patient and a caregiver could possess 6 plants and 1 ounce of usable marijuana without violating the state's drug laws.

In the first year after passage, DPHHS issued medical marijuana registry cards to 176 individuals. The number of patients remained relatively low in the next 2 years and did not reach 1,000 until June 2008. A year later, there were 2,923 registered patients.

But just 6 months after that, in December 2009, the number had increased to 7,339. As of March 31, 2010 — just before the Committee took up the issue — 12,081 people had registry cards and 2,797 people were authorized to provide medical marijuana to one or more patients.

At its April meeting, the Committee heard from speakers on four panels about issues affecting state agencies, local governments, schools, law enforcement, and the medical marijuana

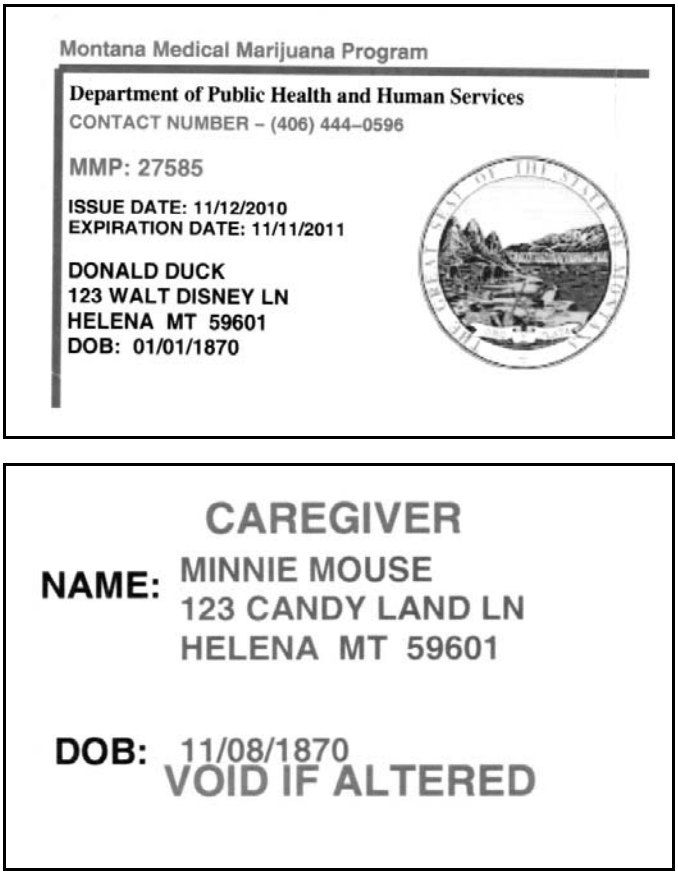

Figure 1: Front and back of sample medical marijuana card.

industry itself. Based on the comments by speakers and the public, the Committee decided to continue working on the issue during the remainder of the interim.

In April, Committee members asked staff to meet with a work group of interested parties to develop recommendations for ways to clarify the law and deal with issues raised during the April meeting. The work group members represented law enforcement, local governments, schools, medical marijuana patients, and medical marijuana caregivers.

The group met three times to discuss issues of interest and concern to the various members. Its work resulted in a set of 27 recommendations that had some level of support among the work group members. Members also discussed but did not agree on 20 additional ideas that were raised by participants or state agency representatives. All of the recommendations that received any level of support were presented to the Committee in June, along with an indication of the level of support each proposal received. The Committee also received the list of issues raised but not resolved. In addition, the Committee heard from a cross section of work group members who discussed the process and the proposals.

After reviewing the work group proposals, the Committee created a subcommittee to continue working on the proposals, gather additional information, and develop draft legislation. Subcommittee members were Rep. Diane Sands of Missoula, Rep. Penny Morgan of Billings, Rep. Gary MacLaren of Victor, and Sen. Trudi Schmidt of Great Falls. Sen. Rick Laible of Darby also attended meetings as his schedule allowed.

The subcommittee met three times over the summer. The panel reviewed and acted on many of the work group recommendations at its first meeting. At its second meeting, it considered law enforcement recommendations. At its third and final meeting, it heard more about local government and workforce issues and also approved creation of a new regulatory structure for the medical marijuana industry. Members working on the issue consistently expressed their desire to keep in place the protections afforded to medical use of marijuana by I-148. But they also wanted to clear up the gray areas within the law and put in place provisions designed to provide more guidance for patients, physicians, caregivers, law enforcement, and others.

Subcommittee members also shared concerns they had about information contained in the medical marijuana registry statistics for June 30. By then, 19,635 people were registered as patients and 3,940 as caregivers. Subcommittee members expressed particular concern that the statistics showed:

Committee members working on the issue of medical use of marijuana wanted to clear up the gray areas within the law and put in place provisions designed to provide more guidance for patients, physicians, caregivers, law enforcement, and others.

- People aged 21 to 30 made up nearly 25% of the registered patients. When patients ages 18 to 20 were added in, 28% of cardholders were adults 30 years of age or younger.

- Two-thirds of the cardholders had received their cards for the debilitating medical condition of "chronic pain." The condition making up the next-highest percentage of cardholders was severe or chronic pain and muscle spasms, at 16%. Those figures compared to the 2.5% of patients who had received their cards because they had been diagnosed with cancer, glaucoma, HIV, or AIDS.

- Slightly more than 100 caregivers had more than 20 patients as of June 30.

Subcommittee members considered two legislative approaches to resolving their concerns. They discussed, but decided against, limiting the number of patients each caregiver may have. This option was seen as a way to reduce the potential for the highly visible businesses that

have appeared in many cities and the number of caregivers who have dozens of patients and thus may have hundreds of plants at a growing site.

Members instead chose to create a regulatory structure for the existing medical marijuana industry in an effort to better track the marijuana that is being grown and sold legally for medical use and to identify people engaged in illegal activities.

The Subcommittee proposed three pieces of legislation for the Committee's consideration in August. The full Committee reviewed the proposals and made some changes before approving all three bill drafts for introduction in the 2011 Legislature.

LC 284 contains the bulk of the changes to the existing law and creates a new regulatory structure modeled on one adopted by the Colorado Legislature earlier in 2010. Among other things, the bill:

- creates a licensing and regulatory structure for individuals and businesses that grow, sell, or distribute marijuana. The Department of Revenue would oversee the licensing process. It also would inspect and monitor licensees to make sure they're complying with the law.

- allows for the creation of dispensaries, which would be businesses providing medical marijuana to more than five medical marijuana cardholders;

- allows a cardholder to grow marijuana for the cardholder's use and obtain it from either a dispensary or an individual, who would be known as a provider. However, a provider is limited to serving five cardholders.

- prohibits a person from being licensed as a provider, dispensary, or grower if they've been convicted of any felony criminal offense. Current law prohibits someone from growing and selling medical marijuana only if they've had a felony drug conviction. The bill draft also requires a fingerprint background check for applicants, to allow the state to conduct broader criminal history checks.

- prohibits people who are on probation or parole or youth under the jurisdiction of a youth court from obtaining a medical marijuana registry card or a license to grow or sell medical marijuana;

- allows local governments to regulate medical marijuana businesses through zoning regulations, business licensing requirements, and building codes and standards. However, a local government may not ban medical marijuana within its boundaries.

- requires physicians to have an office that is located in Montana and that is not in a location where medical marijuana is grown or sold. The bill also prohibits a doctor from having any financial ties to a medical marijuana business if the doctor provides written certifications for medical marijuana use.

- revises the existing law to clear up gray areas. Changes include requiring that people who apply for registry cards and licenses are Montana residents, requiring a person seeking a card for chronic pain to obtain written certification from two physicians, capping the amount of medical marijuana a person may obtain at 2 ounces a month, and prohibiting smoking of medical marijuana in public.

- repeals the so-called "affirmative defense" that a person may raise in court even if the person isn't registered to use or grow medical marijuana or possesses more than the allowable amount of marijuana.

Agency Oversight

As part of its interim duties, the Committee has oversight responsibility for DPHHS. This agency is made up of 11 divisions and has more than 3,000 employees. It provides public health services to all Montanans and a wide array of assistance to vulnerable Montanans, including children and the elderly, needy, disabled, abused, neglected, and mentally ill.

The Committee heard regular updates on Department activities, including:

- implementation of the Healthy Montana Kids Plan, which was approved by voters in 2008. The program combines state and federal funds from the Medicaid and CHIP programs to provide health insurance to children with a family income at or below 250% of the federal poverty level. Before passage of Initiative 155 in November 2008, coverage through the CHIP program was limited to children with a family income of 175% of the poverty level. The Committee closely followed the outreach and other activities DPHHS undertook to get the new program off the ground.

- the Medicaid program, which provides insurance coverage for medical services to low-income children, blind and disabled adults, and some extremely low-income adults with children. Enrollment in the program increased steadily over the interim, reflecting the number of people affected by the stagnant economy. About 97,300 people were covered by the program in May 2010, compared with 84,000 in May 2009.

- efforts to put in place a new grant program for community mental health programs that are designed to divert people from the Montana State Hospital and allow them to be treated and stabilized in their community or region, instead. The program was created through House Bill No. 130 in the 2009 Legislature, following an interim study conducted in 2007-2008 by the Law and Justice Interim Committee.

- efforts to reduce the out-of-state placement of children with mental health needs. Senate Bill No. 399 in the 2009 Legislature required the Department to provide reports to the Committee twice a year on the number of children in out-of-state

care, the measures that DPHHS was taking to reduce that number, and its efforts to create treatment opportunities within the state.

- steps taken by the Child and Family Services Division to improve its placement of children in permanent living situations. The Division reported on its development of a registry of relatives who could be notified if a child is removed from the home, as proposed in House Bill No. 397, and on the training that its staff was receiving on ways to find relatives with whom foster children could establish ties.

In addition, the Committee's legal counsel brought to the Committee's attention a Montana Supreme Court ruling in a case involving the recommitment of a developmentally disabled woman to the Montana Developmental Center in Boulder. The Court overturned a District Court order recommitting the woman to the institution. In a concurring opinion, Justice James Nelson suggested that the Legislature review the laws governing the commitment process for developmentally disabled individuals.

The Committee agreed in September 2009 to have staff work with interested parties on a review of the law. The review identified a number of suggested changes. After reviewing the suggestions, the Committee authorized the drafting of legislation to incorporate the idea. The changes include requiring an initial hearing on a petition for commitment, clarifying the rights of the respondent, clarifying the duration of the commitment period and how it's calculated, and clarifying the emergency admission and commitment statutes. LC 46 reflects the changes made as a result of the review process.

The Committee also followed the implementation of HB 130, the grant program for counties that establish mental health services designed to divert people from admission to the Montana State Hospital or from jail. It reviewed the rules proposed for the new program and asked DPHHS to describe the process used for determining interest in the program and for determining the grant amounts. In addition, several Committee members joined the Law and Justice Interim Committee (LJIC) during a June 29 meeting at which DPHHS officials went into more detail about the grant program and two other mental health bills approved during the 2009 session. House Bill No. 131 and House Bill No. 132, along with HB 130, were developed by LJIC during the 2007-2008 interim, when that committee reviewed mental health services related to people

in the criminal justice system. HB 131 allowed DPHHS to contract with mental health providers for psychiatric treatment beds, to the extent that funds are available. The beds would be used to provide crisis intervention for people facing a commitment petition or for emergency detention after a commitment petition is filed but before a hearing is held. HB 132 allowed a person to voluntarily agree to a short-term treatment program in lieu of being involuntarily committed to the State Hospital.

The Committee also reviews administrative rules as part of its oversight activities. The review is intended to ensure that the proposals comply with a sponsor's intent (if the rules are related to newly passed legislation) and that the rules comply with state law governing administrative rules. Interim committees have the authority to step into the rulemaking process if members have concerns about an agency's proposed or adopted rules.

During the interim, the Committee reviewed administrative rules proposed and adopted by DPHHS. Committee members received a summary of each proposed and adopted rule. The summary contained the key elements of the rule, any public comment received on the rule, and — if applicable — any issues raised by the Committee's staff attorney or by Committee members.

The Committee intervened in administrative rules on two occasions:

- In November 2009, the Committee sent a letter to DPHHS to be considered as public comment on proposed rules for the grant program being established under HB 130. The program was to provide grants to counties for crisis intervention and jail diversion efforts for people with mental illness. The letter questioned the formula devised by DPHHS for awarding grants to counties and raised other questions. DPHHS replied in January 2010 and delayed adoption of the rules until the Committee had time to review the Department's response at its January 25, 2010, meeting.

- At its June 28, 2010, meeting the Committee voted to formally object to the Department's adoption of rules that reduced the Medicaid reimbursement rates for physicians. The reduction was made despite language in 53-6-125, MCA, that

established a rate increase of 6% for fiscal year 2011. The statute was approved by the 2007 Legislature. However, DPHHS reduced the statutory reimbursement rate as part of the 5% budget reductions the Governor asked all state agencies to make after the ending fund balance for the current 2-year budget period fell below the minimum amount required in law.

The Committee determined that the rule's adoption did not comply with the 2-4-305, MCA, which requires that rules may not be adopted when they conflict with statute. DPHHS declined to modify the adopted rule and asked the Committee to withdraw its objection.

However, at its August 2010 meeting, the Committee voted to publish its objection in the Montana Administrative Register and to request a committee bill to amend the rule at issue. The bill draft is LC 293.

Please see Appendix E for the Committee's correspondence related to DPHHS administrative rules.

Appendix A
Summary of Committee Legislation

The Committee approved eight bills for introduction in the 2011 Legislature, as follows:

- LC 46, to clarify the commitment laws relating to people with developmental disabilities;
- LC 65, to clarify that mental health diversion grants to counties are awarded on a county's admissions to the Montana State Hospital, rather than the number of people committed to the Hospital from each county;
- LC 283, to provide for the voluntary reporting of childhood Body Mass Index scores to DPHHS to allow for analysis of statewide trends in childhood obesity;
- LC 284, to revise the Medical Marijuana Act and create a regulatory structure for the medical marijuana industry;
- LC 293, to amend the DPHHS administrative rule reducing the statutory Medicaid reimbursement rate increase for physicians;
- LC 295, to clarify that the Clean Indoor Air Act applies to the smoking of medical marijuana;
- LC 296, to clarify an employer's rights related to employee use of medical marijuana; and
- LC 297, to allow certain dental hygienists to conduct school-based sealant programs.

Appendix B
Stakeholder Presentations

Committee members heard from a number of stakeholders when working on both the SJR 35 study of health care and the emerging issues related to the Medical Marijuana Act. Following is a list of the topics covered at Committee meetings and the people who presented information during formal presentations.

SJR 35 Study of Health Care

June 2, 2009

Federal Health Care Reform Status Update
Kelly Whitener, Health Policy Fellow, U.S. Senate Finance Committee

Sept. 21, 2009

Who Has Insurance and What Kind?
Medicaid/CHIP/Healthy Montana Kids: *Mary Dalton, DPHHS*
Insure Montana: *Jill Sark, State Auditor's Office*
MCHA Insurance Plans: *Carol Roy, State Auditor's Office*

Primary Care: Issues in Montana
Kris Juliar, Office of Rural Health Policy, Montana State University
Dr. Jay Larson, Helena
Dr. Kurt Kubicka, Montana Medical Association
Mary Beth Frideres, Montana Primary Care Association
Dick Brown, Montana Hospital Association

Introduction to the Montana HealthCare Forum
Mark Burzynski, Blue Cross Blue Shield
Claudia Clifford, AARP Montana
Mary Beth Frideres, Montana Primary Care Association

Health Care Reform Priorities: Patient Advocacy and Consumer Advocacy Perspectives
Erin McGowan Fincham, American Cancer Society Cancer Action Network

Nov. 16, 2009

Health Information Technology
Kris Juliar, HealthShare Montana
Gail Briese-Zimmer, DPHHS Office of Planning, Coordination, and Analysis

Health Insurance Exchanges
John Mudd, Executive Counsel, State Auditor's Office

Federal Health Care Reform Efforts: Potential Impacts on the States
Joy Johnson Wilson, Health Policy Director, National Conference of State Legislatures

Jan. 25, 2010

Chronic Disease Prevention and Health Promotion

Todd Harwell, Chief, DPHHS Chronic Disease Prevention and Health Promotion Bureau
Melanie Reynolds, Association of Montana Public Health Officials

Medical Education and Provider Incentives

Sylvia Moore, Deputy Commissioner for Academic Affairs, Montana University System
Dr. Roxanne Fahrenwald, Program Director, Montana Family Residency Program
Jo Ann Dotson, Chief, DPHHS Family and Community Health Bureau

April 26-27, 2010

Federal Health Care Legislation: Items with Imminent Effective Dates or Requiring Legislative Action

Monica Lindeen, State Auditor
Anna Whiting Sorrell, Director, DPHHS

Updates from Montana Health Care Groups

Barbara Schneeman, RiverStone Health (Montana HealthCare Forum)
Rep. Chuck Hunter, Montana HealthCare Forum
Kristin Page Nei, American Cancer Society (Montana HealthCare Forum)
Larry White, Montana HealthCare Forum and Montana Healthcare Workforce Advisory Council

Pharmacy Profession: Trends and Role in Health Care

Starla Blank, Chair, Montana Pharmacy Association

Childhood Health Promotion

Steve York, Assistant Superintendent, Office of Public Instruction
Ellen Leahy, Missoula City-County Health Department
Katie Bark, Montana Action for Healthy Kids

Costs of Defensive Medicine

Dr. Carter Beck, Missoula

Medical Malpractice and Data for Montana

Mona Jamison, The Doctors Company
Leo Berry, Utah Medical Insurance Association
Erin MacLean, Montana Medical Association

June 28, 2010

Safe Harbor Legislation for Physicians

Dr. Brett Kronenberger, President, Montana Medical Association
Bob Olsen, Montana Hospital Association
Al Smith, Montana Trial Lawyers Association

Health Insurance Exchanges Among the States

Cheryl Smith and Dan Schuyler, Utah Health Exchange
Rosemarie Day, Massachusetts Health Insurance Connector Authority
Robert Carey, Public Consulting Group

Monica Lindeen, State Auditor

Workforce Issues: Dental Hygienist Limited Access Program

Colleen Grass, Montana Dental Hygienists' Association

Aug. 23-24, 2010

Federal Health Care Legislation: Update on Montana Action

Monica Lindeen, State Auditor

Childhood Health Promotion

Katie Bark, Montana Action for Healthy Kids
Steve Meloy, Executive Director, Board of Public Educaiton
Christine Emerson, Office of Public Instruction

Access to Dental Care

Mary McCue, Montana Dental Association
Colleen Grass, Montana Dental Hygienists' Association

Emerging Issue: Montana's Medical Marijuana Act

April 27, 2010

State Regulatory Issues

Jeff Buska, Administrator, DPHHS Quality Assurance Division
Dr. Dean Center, Board of Medical Examiners
Ronald Klein, Executive Director, Montana Board of Pharmacy

Law Enforcement Issues

Mark Long, Montana Narcotics Investigation Bureau, Department of Justice
Kevin Myhre, Lewistown City Manager/Chief of Police
Annalivia Harris, State Crime Lab

Community Issues

James Santoro, Great Falls City Attorney
Greg Sullivan, Bozeman City Attorney
Joe Brott and Aaron Bouschor, Montana School Boards Association

Medical Marijuana Business Representatives

Tom Daubert, Patients and Families United and Montana Cannabis
Jim Gingery, Executive Director, Montana Medical Growers Association
Jason Christ, Montana Caregivers Network

June 28, 2010

Work Group Perspectives on Stakeholder Recommendations

Lewis Smith, Powell County Attorney
Jason Christ, Montana Caregivers Network
Tom Daubert, Patients and Families United and Montana Cannabis

Appendix C
Summary of Reports

Committee staff prepared a number or reports related to Committee studies and other health and human services issues.

SJR 35 Study of Health Care

Swimming in Murky Waters: Thoughts on "Safe Harbor" Legislation, Lisa Mecklenberg Jackson, June 2010
Summary of Selected Elements of the Federal Health Care Legislation, Sue O'Connell, April 2010
State Reaction to Federal Health Reform, Lisa Mecklenberg Jackson, April 2010
Defensive Medicine: Recent Study Results, Sue O'Connell, April 2010
Medical Malpractice Insurance Data for Montana, Sue O'Connell, April 2010
Federal Tort Claims Act and Community Health Centers, Sue O'Connell, April 2010
Medical Malpractice: Montana's Approach to Limiting Liability, Sue O'Connell, January 2010
Montana's Medical Education, Training, and Incentive Programs, Sue O'Connell, January 2010
Federal Reforms: A Look at Health Insurance Exchanges, Sue O'Connell, November 2009
The ABCs of HIT: Health Information Technology, Sue O'Connell, November 2009
The Insured and Uninsured in Montana, Sue O'Connell, September 2009
Primary Care Issues and Health Care Reform, Sue O'Connell, September 2009
Comparison of Selected Elements of Federal Health Care Reform Efforts, Sue O'Connell, September 2009 and December 2009 (updated)
A Glossary of Federal Health Care Reform Terms, Sue O'Connell, September 2009

HJR 39 Study of Community Services for the Dually Diagnosed

HJR 39 White Paper, Sue O'Connell, April 2010

Emerging Issue: Montana's Medical Marijuana Act

Summary of Public Comment, August 2010
Dispensary States vs. Caregiver States, Sue O'Connell, August 2010
Variations Among State Laws, Sue O'Connell, August 2010
Local Government Authority, Sue O'Connell, August 2010
Key Changes to Colorado's Medical Marijuana Laws, Sue O'Connell, July 2010
Review of Law Enforcement Issues, Sue O'Connell, July 2010
Ambiguities in the Qualifying Patient Definition, Sue O'Connell, July 2010
Updated Registry Statistics, July 2010
Recommendations from Interested Parties, Sue O'Connell, June 2010
General Provisions for DOLI Boards, June 2010, Sue O'Connell,
Proposed Changes to Definitions in the Medical Marijuana Act, Sue O'Connell, June 2010
SJR 7 Study: Disqualifying Offenses for Direct-Care Workers, June 2010
Updated Registry Statistics, June 2010
Montana Medical Marijuana Program: Emerging Issues, Sue O'Connell, April 2010

Other Staff Reports

Commitment Laws for Persons with Developmental Disabilities: Summary of Review by Staff and Stakeholders, Sue O'Connell, January 2010
Legal Memo: Analysis of the Montana Supreme Court Ruling in the Matter of T.P., Lisa Mecklenberg Jackson, Sept. 11, 2009

Copies of all staff reports are available on the Staff Reports page of the Committee's Web site:
http://leg.mt.gov/css/Committees/interim/2009_2010/Children_Family/Staff_Reports/reports.asp

Appendix D
Committee Correspondence Related to SJR 35

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

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MARY CAFERRO
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COMMITTEE STAFF
SUE O'CONNELL, Research Analyst
LISA JACKSON, Staff Attorney
FONG HOM, Secretary

October 1, 2009

The Honorable Max Baucus
United States Senate
511 Hart Senate Office Building
Washington, D.C. 20510-2602

Dear Senator Baucus:

As Congress works on changes to the nation's health care delivery and insurance systems, our legislative committee is closely following the efforts and the impacts changes at the national level may have on Montanans. The committee has not taken a position on the proposed health care reform bills but has discussed the current state of primary care in Montana and the potential effects an increase in the number of insured people could have on our primary care system.

The Children, Families, Health, and Human Services Interim Committee heard presentations this month from a number of people involved in primary care services. Among other things, the speakers discussed:

- the benefits of primary care health services and the role these services play in keeping health care costs down;
- the issues driving the current shortage of primary care practitioners and the expected continuation of that trend;
- the problems the shortage could create if more people gain health insurance coverage and seek medical care; and
- the important role that community health centers have played in providing care to Montanans, particularly those who lack insurance or are underinsured.

Montana's primary care workforce is already shrinking, as noted in a just-released report by the Montana State University Office of Rural Health. Twelve of our 56 counties have no primary care doctor, while nine counties have no doctor at all.

Two physicians who spoke to the committee emphasized the disincentive built into the current Medicare reimbursement system. As you know, Medicare's Resource-Based Relative Value Scale determines the payment that Medicare will provide physicians for each service they perform. The system gives each medical procedure a Relative Value Unit (RVU) based on the amount of work required by the physician, the overhead costs of providing the service, and -- to a very limited degree -- the malpractice insurance cost associated with the procedure.

Dr. Jay Larson and Dr. Kurt Kubicka pointed out to the committee that the RVUs assigned to the typical diagnostic, treatment, and care management services provided by a primary care doctor are much lower than those assigned to services provided by a specialist, who usually performs

procedures rather than evaluation and management activities and whose practice may have higher overhead costs because of specialized equipment.

Yet a primary care provider's management of a patient's medical condition may well prevent the need for more intensive -- and costlier -- medical interventions, usually provided by a specialist.

This reimbursement model is used by Montana and many other states when they set their Medicaid reimbursement levels. Private insurers also base their rates off this model and the RVUs assigned to medical procedures.

Drs. Larson and Kubicka strongly believe that the lower RVUs assigned to primary care services keep many medical students from entering primary care practice, because their earnings potential is far lower than it would be for a specialty practice. And the average medical student starts his or her career with a debt of $160,000, making a higher-paying practice more attractive to many. These two doctors and others also believe the system is discouraging to doctors already in practice and is causing many of them to leave primary care practice. Some Montana communities have experienced rapid and noticeable decreases in the number of primary care doctors available to the general patient population.

Our committee voted on September 21 to urge you and the other members of our congressional delegation to take steps to:

- increase the value assigned to primary care services in the RBRVS system as part of a realignment of RVUs for all medical procedures that would better reflect their relative values while keeping changes to the system cost-neutral; and
- increase support for community health centers to improve low-cost access to primary health care services.

We know that Congress must piece together numerous elements as you work on expanding health insurance coverage and curbing health care costs. As I mentioned earlier, the committee has not taken a position on any of the pending health care reform bills. However, we believe that for any health care reform efforts to work well in Montana, we need to maintain and, if possible, expand our primary care workforce. We believe that an increase in the RVUs for primary care and increased support for community health centers will make a big difference in Montana. These issues are important enough to stand on their own merits and should be acted on concurrently with -- but not necessarily as a part of – the health care reform legislation now under consideration.

Thank you for your consideration of this request.

Sincerely,

Representative Diane Sands
Presiding Officer

Cl0425 9274soxa.

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

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LISA JACKSON, Staff Attorney
FONG HOM, Secretary

February 9, 2010

The Honorable Max Baucus
United States Senate
511 Hart Senate Office Building
Washington, D.C. 20510-2602

Dear Senator Baucus:

Our interim legislative committee has spent the past several months reviewing issues involving the health care workforce in Montana, as part of a study of health care in the state. As you are aware, Montana lacks a sufficient number of primary care providers to serve our rural and far-flung population. This shortage would be exacerbated if federal health care legislation extends insurance coverage to more people, who would then seek care from a primary care provider.

At a committee meeting last month, we learned more about the Montana Family Residency Program headquartered in Billings. This program gives medical school graduates an opportunity to obtain their residency training not just in Montana but -- even more importantly -- in rural areas of Montana. The common maxim is that doctors tend to set up practice in the area where they received their residency training. This appears to be holding true for the Montana program, as 70 percent of its graduates are practicing in Montana.

Committee members also heard about how the limits on Medicare funding for residency slots make it more difficult for this program and other existing residency programs to expand, because the Medicare funds make up the bulk of the funding for the programs.

We know that the reform bills pending in Congress would address this issue to some degree, by redistributing slots that aren't in use, and we support the proposed redistributions. However, we also feel that action needs to be taken on this matter if a final reform bill isn't passed or doesn't include the provisions for re-allocating residency slots. We strongly encourage you to take whatever action is possible to lift the funding cap on residencies for underserved areas or to redistribute unused slots to states with the lowest number of residents per capita. Either step would benefit Montana. Increasing residency training here is a critical factor in ensuring that our residents have access to health care in the future, no matter where in Montana they live.

Thank you for your consideration of this request.

Sincerely,

Representative Diane Sands
Presiding Officer

Cl0425 0040soxa.

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

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FONG HOM, Secretary

June 11, 2010

Keith Kelly, Commissioner
Department of Labor and Industry
PO Box 1728
Helena, MT 59624-1728

Dear Commissioner Kelly:

During the past year, our committee has been conducting a study of health care as authorized by Senate Joint Resolution 35 in the 2009 session. A significant part of the study has focused on issues involving the health care workforce.

We've learned that Montana is already experiencing shortages of some types of health care providers, particularly those who provide primary care to patients. The federal health care legislation that will extend insurance coverage to thousands of Montanans over the next several years is expected to create an even greater demand for health care providers, including primary care physicians, physician assistants, and advanced practice registered nurses.

The state currently appropriates money to help a limited number of Montana students attend medical schools in other states, and it also provides incentives such as loan repayments to physicians who practice in rural areas. Committee members have heard testimony in the past year about the possible need to increase state support in these and other areas, to help alleviate current and potential shortages. At the same time, we've also heard that targeting state support most appropriately is difficult, because little specific data exists about our health care workforce.

The committee believes the Legislature, the Montana University System, and state agencies could better plan for and support health care workforce programs if the licensing boards within the Department of Labor and Industry collected certain data as they issue or renew licenses in the health care professions. The information could be provided to other state entities to analyze and use in developing programs that will meet the state's workforce needs. The committee believes collection of the following types of information would help in this planning process:

- whether a licensee is currently practicing and if so, whether the person is working full time or part time;
- the city or town in which the licensee is employed and whether the person is employed primarily in a hospital, private practice, community health center, or other setting;
- whether the licensee is accepting new patients;
- whether the licensee accepts Medicaid and Medicare patients; and
- when the licensee is planning to retire.

This information would be useful for many types of health care professions and is particularly important for those primary care professions that are likely to be impacted most significantly by health care reform, including dentistry.

Committee members recognize that collecting this data may place additional administrative costs on the licensing boards. However, we believe the boards have the ability to address this by adjusting the licensing fees through administrative rule, if necessary.

Thus on behalf of the Children, Families, Health, and Human Services Interim Committee, I would like to ask you to consider making this data collection a routine part of the professional licensing and renewal process. If you would like to discuss this matter in more depth with the Committee at a future meeting, I'd be happy to schedule time on the agenda. The committee will meet on June 28 and on Aug. 23-24. Please contact our committee staff, Sue O'Connell, at 444-3597 if you would like to discuss this further.

Thank you for your consideration.

Sincerely,

Rep. Diane Sands
Presiding Officer

c: Mike Cooney
Jeannie Worsech
Maggie Connor

Cl0425 0162soxa.

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

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FONG HOM, Secretary

June 16, 2010

Steve Meloy, Executive Secretary
Board of Public Education
PO Box 200601
Helena, MT 59620

Dear Mr. Meloy:

As part of an ongoing study of issues related to health care, the Children, Families, Health, and Human Services Interim Committee has spent part of the past year reviewing efforts related to promoting good public health. Members have been particularly interested in childhood health promotion. Young people who adopt healthy lifestyles early on are much more likely to avoid the health care problems — and costs — that can occur later in life if they have chosen sedentary lifestyles and poor diets.

The committee strongly believes that schools provide one of the best forums for teaching lifelong skills in making wise and healthy choices about food and exercise. Health, physical education, and consumer science classes all offer opportunities for students to learn about the importance of healthy lifestyles and gain the lifetime skills they'll need to maintain good health.

The presentations we've heard as part of our Senate Joint Resolution 35 study of health care have included discussion of the need for schools to:

- increase opportunities for students to make healthy choices, through such means as improving the nutritional value of school-provided meals, providing ongoing education in nutrition, setting nutritional standards for items sold in vending machines, and creating school wellness and health committees that could direct a coordinated approach to nutrition, health, and physical activity issues for schools;

- include physical activity as part of the school day and maintain physical education classes from kindergarten through high school; and

- include school nurses on staff to provide important screening and prevention services.

Our committee recognizes the importance of local control for Montana school districts. However, because the Board of Public Education exercises general supervision over Montana schools and sets accreditation standards, we wanted the Board members to be aware of our interest in this issue. We hope the Board will take steps to encourage — through accreditation standards or other measures — the types of activities that will promote good health and nutrition as a way to improve the overall health of this and future generations of schoolchildren.

Our members also recognize that many school districts must balance numerous competing needs as they work within budgets that often cannot meet all the requests they face. However, we believe an investment in promoting a healthy lifestyle for children is likely to reap substantial long-term benefits for both the students themselves and society as a whole.

Thank you for your consideration.

Sincerely,

Rep. Diane Sands
Presiding Officer

Cl0425 0167soxe.

Appendix E
Committee Correspondence Related to DPHHS Administrative Rules

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

PO BOX 201706
Helena, MT 59620-1706
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FAX (406) 444-3036

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ROY BROWN
CHRISTINE KAUFMANN
TRUDI SCHMIDT

HOUSE MEMBERS
DIANE SANDS--Chair
MARY CAFERRO
GARY MACLAREN
PENNY MORGAN

COMMITTEE STAFF
SUE O'CONNELL, Research Analyst
LISA JACKSON, Staff Attorney
FONG HOM, Secretary

November 23, 2009

Office of Legal Affairs
Department of Public Health and Human Services
111 N. Sanders St.
Helena, MT 59620

Dear DPHHS Office of Legal Affairs:

Please consider the following as comments on behalf of the Children, Families, Health, and Human Services Interim Committee (CFHHS) to the department's proposed rule notice (MAR Notice 37-491) regarding state matching grants to counties for crisis intervention, jail diversion, involuntary precommitment, and short-term inpatient treatment. These comments are based on discussion during the CFHHS meeting on November 16, 2009. The CFHHS Interim Committee is not asking for a formal delay in adopting rule notice 37-491 but would like the department's response and a chance to comment on that response prior to the rules being adopted. Present at the November 16 meeting, DPHHS Director Anna Whiting Sorrell assured the committee this would be possible. The committee is also asking that the department not delay sending out grant funds for counties that have submitted satisfactory applications.

COMMENT 1: It is unclear what categories of commitments will be reimbursed by the department under the proposed rules. It is only involuntary commitments, emergency and court ordered detentions or also voluntary commitments? Are voluntary commitments being reimbursed to counties? Please clarify.

COMMENT 2: Why can't the department use the matching grant formula established in HB 130?

County population		Commitments per county
State population	AND	Total commitments in state

Compare these two figures and a high-use county (commitments higher than population) will receive a lower percentage of matching funds. Please state why the department's proposed formula is preferable.

COMMENT 3: The department's proposed method of fund disbursement in Rule IV (when the amount requested exceeds legislative appropriation) calling for distribution of available funding on a pro rata basis by county population conflicts with the HB 130 language requiring a two-part sliding scale (based on population and commitments together). Why couldn't the department complete its calculation using the elements of the formula established in HB 130, then distribute on a pro rata basis, rather than just distributing off the top using population?

COMMENT 4: The committee discussed using "admissions" for the funding formula versus "commitments." DPHHS clarified it was using "admissions" for its calculations. HB 130 uses the word "commitments." The department's rule is contrary to the statute. Please comment.

COMMENT 5: Several legislators expressed concern over whether the department's planned reimbursement scheme is accurately reflecting the Legislature's intent on reimbursement. Clarify whether grant amounts will be distributed across the state or directed towards specific areas that may already have programs in place. Please address the concern voiced by several legislators that the money was intended to go towards counties with models that are already working, not be spread across the state.

COMMENT 6: The department has stated crisis intervention team training and crisis response team expenditures will be eligible for match under the proposed rules. Please state your basis for this.

COMMENT 7: The CFHHS Interim Committee would like to know which counties have responded with a letter of intent to seek state matching grants and the department's proposed funding numbers accordingly.

COMMENT 8: Will the department commit half of the biennial appropriation for this program in the FY 2010 base budget year? If not, please comment as to ongoing funding to implement the matching grants program. Is it sustainable?

COMMENT 9: The department's preliminary state matching grant award figures indicate that some counties are slated to receive a larger grant amount than was asked for. Please explain.

COMMENT 10: HB 130 directed the department to adopt rules for implementation by August 1, 2009 and fully implement the grant program by September 1, 2009. Please address the delay in both these areas.

If you have any questions regarding the above comments or if any clarification is needed, please do not hesitate to contact me. The CFHHS Interim Committee looks forward to hearing from you regarding these comments and potentially scheduling a conference call if needed.. Thank you very much.

Sincerely,
Lisa Mecklenberg Jackson
CFHHS Staff Attorney

cc Anna Whiting Sorrell
Lou Thompson
Sue O'Connell
Lois Steinbeck

Cl0070 9327ljha.

Children, Families, Health, and Human Services Interim Committee

61st Montana Legislature

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GARY MACLAREN
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COMMITTEE STAFF
SUE O'CONNELL, Research Analyst
LISA JACKSON, Staff Attorney
FONG HOM, Secretary

July 9, 2010

Ms. Anna Whiting Sorrell, Director
Department of Public Health and Human Services
111 North Sanders, Room 301
Helena, MT 59620

Dear Director Whiting Sorrell:

Pursuant to the Children, Families, Health and Human Services Interim Committee's (CFHHS) statutory authority as the appropriate administrative rule review committee under 5-5-225, MCA, and the provisions of Title 2, chapter 4, parts 3 and 4, this letter constitutes notice to the Department of Public Health and Human Services that the members of the CFHHS Interim Committee have notified the committee's chair that they object to the adoption of rulemaking promulgated by MAR Notice 37-509 relating to resource based relative value scale (RBRVS) for physician reimbursement of services under Medicaid. Montana Medicaid uses the RBRVS rate system to calculate the fee Montana Medicaid pays to 20 types of health care professionals. The department annually proposes to amend ARM 37.85.212, in this case, via MAR Notice 37-509, to adopt current relative value units (RVUs). The fee paid for a procedure by a health plan is calculated by multiplying that procedure's RVU by the health plan's conversion factor. The conversion factor for licensed physicians is set by 53-6-124 through 53-6-127, MCA. Because of the general fund budget deficit, in MAR Notice 37-509, the department is proposing to set conversion factors and fees for Medicaid reimbursement for physicians for SFY 2011 at the SFY 2010 level.

Specifically, as discussed during the administrative rule review portion of their June 28, 2010 meeting, the CFHHS Interim Committee is objecting to the rule adoption notice for MAR Notice 37-509 for the following reason:

CFHHS disagrees with the department's authority to set the physician's reimbursement rate at SFY 2010 levels. In 2007, the Montana Legislature enacted 53-6-125, MCA, pertaining to physician's reimbursement rates and provides that for fiscal year 2011, the 2010 percentage of the conversion factor (and accordingly, physician rate increases) will be increased by a minimum of 6%. In the opinion of CFHHS, there is nothing in 17-7-140, MCA, giving the governor limited authority to reduce certain expenditures during a projected fund budget deficit, which explicitly or implicitly gives the executive branch the authority to change statutorily prescribed payments or duties. Such a practice would be seen as a violation of the separation of powers. Furthermore, the department's assertion that because physician provider rates are not listed in 17-7-140(2), MCA, as being exempt from a reduction in spending, it is therefore allowable to make cuts to those statutorily mandated rates doesn't hold merit either. Only six exemptions are listed in 17-7-140(2). Using the department's reasoning, hundreds of state statutes should be specifically exempted in order to be free from reductions by the executive branch.

Legal staff for the CFHHS Interim Committee had asked the department to respond to these concerns precipitated by the proposal notice of MAR Notice 37-509 prior to adopting the rule. The department chose to respond in the rule adoption notice in which the department continued to state it had the authority to make the cuts to physician reimbursement rates under 17-7-140, MCA. Although the department has broad authority under 53-6-101(8) and 53-6-113 (3), MCA, to set Medicaid provider reimbursement rates generally, it cannot ignore or change other statutes. That is the role of the legislature.

Pursuant to the authority granted to CFHHS as the rulemaking review authority for DPHHS and pursuant to 2-4-406, MCA, the CFHHS Interim Committee is submitting this letter in written objection to the department's adoption of MAR Notice 37-509. Under 2-4-406, MCA, the CFHHS Interim Committee does not consider the rule adoption contained in MAR Notice 37-509 to have been done in substantial compliance with 2-4-305, MCA, which specifically states that rules may not be adopted when they are in conflict with statute, which is clearly the case here.

Pursuant to 2-4-406, MCA, the department is required to respond to this letter within 14 days. After receipt of the response, the committee may withdraw or modify its objection. Section 2-4-406, MCA, further states:

> (3) If the committee fails to withdraw or substantially modify its objection to a rule, it may vote to send the objection to the secretary of state, who shall, upon receipt of the objection, publish the objection in the register adjacent to any notice of adoption of the rule and in the ARM adjacent to the rule, provided an agency response must also be published if requested by the agency. Costs of publication of the objection and the agency response must be paid by the committee.
>
> (4) If an objection to all or a portion of a rule has been published pursuant to subsection (3), the agency bears the burden, in any action challenging the legality of the rule or portion of a rule objected to by the committee, of proving that the rule or portion of the rule objected to was adopted in substantial compliance with 2-4-302, 2-4-303, and 2-4-305. If a rule is invalidated by court judgment because the agency failed to meet its burden of proof imposed by this subsection and the court finds that the rule was adopted in arbitrary and capricious disregard for the purposes of the authorizing statute, the court may award costs and reasonable attorney fees against the agency.

Furthermore, if an administrative rule is not implemented in accordance with the requirements of Title 2, chapter 4, parts 3 and 4 of the Montana Administrative Procedure Act, it is not considered to be effective. Such would be the case here as the department is attempting to adopt a rule in direct conflict with statute.

Thank you for your consideration of this matter.

Sincerely,

Rep. Diane Sands
CFHHS Chairperson

cc: Bernie Jacobs, DPHHS Chief Legal
Geralynn Driscoll, DPHHS Legal staff
CFHHS Interim Committee
Montana Secretary of State Linda McCollough

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