MONTANA MEDICAL ASSOCIATION

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March 17, 2008
Monday

MEMORANDUM

TO: SENATOR DAN WEINBERG
AND
REPRESENTATIVE ERNIE DUTTON
COCHAIRMEN
SJR - 15 INTERIM SUBCOMMITTEE

FROM: KURT T. KUBICKA, M.D.
CHAIRMAN
MONTANA MEDICAL ASSOCIATION
COMMITTEE ON LEGISLATION

Dear Legislators:

The physician members of the Montana Medical Association thank the committee for its tireless diligence and applaud the marked progress in successive draft legislation to date. In general we are quite pleased with current drafts LC0038 and LC8888. We respectfully offer the following suggestions.

LC0038-new March 10, 2008, 4:01 PM:

1.Page 1, NEW SECTION 1, STRIKE in its entirety. Failing that, limit disclosure requirements to instances of a proven abusive referral pattern and/or limit disclosure specifically to non-urgent, elective referrals.

COMMENTS: While we recognize the inherent merits in disclosure and the very even handed language of section 1, MMA is concerned about the feasibility of implementation, particularly as pertains to our hospital employed members. Independent physicians seldom have investment interest in free standing ancillary providers such as imaging centers, physical therapists, durable medical equipment suppliers and the like. Consequently no disclosure statement will be required in making referrals for such services. In the instance of ambulatory surgical centers, disclosure is already largely covered under federal rule and statute. However, our hospital employed members will find the proposed disclosure requirements particularly onerous as their employers, hospitals, often face substantial competition from such free standing ancillary providers and owing to the physician's employment relationship with their community hospital disclosure will be required. Nonetheless, the MMA sees virtue in disclosure and can abide by this provision, particularly in the instance of a proven abusive referral pattern. We feel that the rational for limiting disclosure to non-urgent, elective referrals is self evident.

2.Page 3, NEW SECTION 3, STRIKE in its entirety and
INSERT NEW SECTION Section 3. Disciplinary action for abusive referral pattern. (1) An abusive referral pattern by a health care provider is unprofessional conduct under 37-1-410 and subjects that health care provider to disciplinary action by the appropriate licensing board under Title 37. (2) An abusive referral pattern by a health care provider employed by a health care facility is grounds for disciplinary action against the health care facility's license under 50-5-207.

COMMENTS: MMA is concerned about the substantial costs and duration of arbitration in adjudicating a purported abusive referral pattern. We certainly agree that an abusive referral pattern, predicated on payer source or ability to

pay, gets to the heart of the matter before the SJR committee. We absolutely agree that such practices must be policed and if not abolished certainly discouraged with real and certain repercussions. MMA proposes that the respective licensing boards allow for a less costly yet equally suitable means of adjudication.

3.Page 8, Section 5: 50-5-117(2)(c):
Following: "due process of law" in the first line of subsection (c) STRIKE "and arbitration"

COMMENTS: MMA is quite satisfied with the intent in the current draft definition of an abusive referral pattern. We feel that our proposed amendment simply lends clarity. As discussed above we feel state licensure boards are the appropriate venue for determining whether an abusive referral pattern exists.

4.Page 8, Section 5: 50-5-117(3)(a), definition of abusive referral pattern:
STRIKE: Subsection (a) in its entirety.
INSERT: (a) "abusive (economic?) referral pattern" means a referral pattern by a health care provider or a health care facility through an employed health care provider that demonstrates consistent referrals based on a patient's health insurance coverage or ability to pay. Consider substitution of 'economic' for 'abusive'.

5.Pages 8 and 9, Section 5: 50-5-117(3)(b), definition of conflict of interest:
STRIKE: Subsection (b) in its entirety
INSERT: (b) "Conflict of Interest" means an ownership interest by a health care provider of 5% or more in a health care facility licensed under Title 50.

COMMENTS: MMA believes it is imperative that the definition of "conflict of interest" be clear and concise and that the implications of a "conflict of interest" as distinct from an abusive referral pattern be clearly delineated as occurs earlier in the draft (page 7, section 2a). We suggest that our proposed definition of a conflict of interest represents a first tier conflict with an abusive referral pattern representing an egregious second tier conflict.

6.Page 11, Section 6, Section 50-5-207(l)
FOLLOWING: subsection (g)
INSERT: "There is an abusive referral pattern as defined in 50-5-117 by a health care provider employed by the facility."

COMMENTS: MMA believes this simply codifies the consequences of all of the above.

7.Page 13, NEW SECTION. Section 7:
STRIKE: New Section 7 in its entirety.
INSERT: "complaint of a abusive referral pattern by a health care provider or health care facility."

COMMENTS: MMA believes respective licensure boards provide for sufficient enforcement and repercussions for abusive referral patterns. We likewise are concerned that the current language under section 7 invites new additional and unnecessary liability in medical liability actions. Liability premiums will increase and health care costs will rise. Further, federal code and enforcement is already in place.

LC8888b March 10, 2008, 6:10 PM:

1.Page 15, Section 2: 50-5-245(1)(c):
FOLLOWING: "scope of services" on the last line of 50-5-245(1)(c)
INSERT: ". A nonprofit community hospital shall negotiate a transfer agreement with an applicant for a specialty hospital license in good faith and in the best interests of patient access to care and choice. A nonprofit community hospital may not decline to enter into a reasonable transfer agreement that meets recognized standards of care."

2.Pages 15 and 16, Section 2: Section 50-5-245(d)
STRIKE: Subsection (1)(d) in its entirety.

COMMENTS: MMA believes that this will all be dealt with at the federal level and need not be codified at the state level, and certainly should not be codified at the state level until federal debate is concluded.

3.Page 16, Section 2: Section 50-5-245(4)
STRIKE: Subsection (4) in its entirety.

COMMENTS: It is quite possible and wholly reasonable that an existing ambulatory surgery center may seek to expand its capabilities and consequently licensure to allow length of stay of greater than 24 hours. An existing and licensed ambulatory surgery center should be allowed to apply for a specialty hospital license according to the same criteria which a new venture must satisfy. The current draft precludes this.

The ability of a currently licensed hospital to apply for specialty hospital licensure to better serve the needs of a community must be distinctly preserved and protected.

We thank you for consideration of our comments and again applaud the work of the committee and the wisdom of its members.