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To: SJR 15 Subcommittee Members, Pat Murdo
From: Mona Jamison, Lobbyist-Attorney for Great Falls Clinic
Date: May 30 , 2008
RE: LC 38 - Proposed Changes to April 29, 2008 Draft (only sections with comments are set forth below)

Proposed Section 1. This section must apply to patients admitted as an inpatient of a hospital or this section (and its related ones) should be deleted entirely from the bill. Hospital employed physicians serve their employer's interests and are encouraged either directly or indirectly to steer (refer) their patients to hospital based or owned services. (See comment in section 2 from Bozeman Deaconess Physicians admitting steerage). As a matter of equity, hospitals should not be exempt from the "disclosure" provisions of this section when referring patients; nor should hospital patients be denied the same benefits of "choice" as those provided to patients of independent physicians under this section. If there are certain situations where disclosure of economic interest in referrals by hospital employed physicians would be exceedingly impractical, those situations should be carved out as exceptions in the bill. It is patently unfair for the MHA to argue that the disclosure provisions apply to physician clinics but not to hospitals especially when the trend is towards hospitals employing more physicians in and out of the hospital. Furthermore, the legislators on the subcommittee felt strongly about these disclosure requirements applying to hospital employed physician, and for this reason alone, hospitals should not be exempt.

Proposed Section 2. Do not delete subsections (1) or (2)(a) of the current text from the proposed section. Subsection (2)(a) from the current text should be retained as it reiterates that as a matter of public policy a health care provider may enter into contracts and acquire ownership interests in health care facilities, products or equipment. The disclosure section of the bill (Section 1) remedies conflict of interest situations if they exist. And, while subsection 2(2)(b) may single out hospital employed docs, the letters from the Bozeman Deaconess physicians underscore why hospital employed physicians must be included. The Bozeman Deaconess physicians comment as follow: **"We have no problem if our employment contracts direct us to use the hospital for services, if those services are provided in a quality manner."**

Proposed Section 3 (current section 4): Keep as proposed. This section is absolutely necessary in order to provide the enforcement mechanism against a health care facility licensed under Title 50 for causing its employed physician to act in ways that create a "conflict of interest" and result in a determination of unprofessional conduct for that physician by their

licensing board. Without this provision the licensed health care facility remains unaccountable for its illegal behavior and just the physician licensee suffers for the violation.

Proposed Section 5 (current section 6): If this section (and its related ones) are not deleted in their entirety, **keep Section 5 as proposed**. The proposed section 5 is a vast improvement over the current section 6 (§37-1-302(2). The current section is faulty in many ways.

For example: The Federal Stark Law (42 U.S.C. §1395nn) already addresses the content of §37-1-302(2)(a) for Medicare patients. Yet, §37-1-302(2)(a) does not provide any of the exceptions provided under the Stark Law. While Stark prohibits physicians from referring patients for designated health services from entities in which the physician has a financial relationship, it excepts “in-office ancillary services” such as radiology, radiation therapy services, occupational therapy services, along with numerous others. Further, §8.03 of the American Medical Association Code of Medical Ethics makes it clear that “Under no circumstances may physicians place their own financial interests above the welfare of their patients. ...” The federal statute addresses these situations more fully and provides adequate protections. Current section 37-1-302(2) is not needed and creates many unintended consequences.

Also, current section 6, §37-1-302(2)(c), is already more fully addressed by the federal Anti-Kickback Statute (AKS), (42 U.S.C. §1320a-7b(b)) which makes it a felony to accept a fee in exchange for patient referrals. Again, current section 6 provides none of the “safe-harbors” provided by the AKS for providers who are in compliance with various provisions of the AKS. The federal statute addresses these situations more than adequately. Further, as written, the current section 6 does not make it clear that it applies to situations where the remuneration comes from an independent health care provider not in the employ or under contract with the referring provider. As drafted, the current section raises more questions and confusion than it solves problems.

Finally, current section 6 (§37-1-302(2)(e)) is already addressed by the Federal Social Security Act (42 U.S.C. §1320a-7a; 42 C.F.R. §1003.102) and the Federal False Claims Act (31 U.S.C. §§3801 et seq.), as well as the Montana False Claims Act (§§17-8-401 et seq.), which impose civil monetary penalties against any person who knowingly, in summary, submits false or fraudulent claims. If current subsection (2)(e) is interpreted to prohibit billing for services of other licensed providers who are excepted under the Stark Law, the consequences would be disastrous for both physicians, clinics, and hospitals.

**Fortunately, the proposed new section 5 eliminates the concerns summarized above and should be kept as proposed. The proposed new definition of “conflict of interest” succinctly addresses the concerns regarding economically driven referrals.**

Current Section 7 and Current Section 8: Keep the current language and reject the proposed language which deletes the term “detrimental.” The term “detrimental” sets a threshold standard for a finding of “conflict of interest”. The conflict of interest standing alone is not the issue; its when the conflict has a negative impact on the safety and welfare of the patient.

Current Section 10 (proposed section 9): Keep as proposed except in the following two areas:
-the reference to “equitable” call issues, as listed in current text section (3)(c)(ii)(B), should be reinserted into the proposed language in order to prevent a hospital from punishing a “competing” physician and his or her patient in this oppressive manner.

-Also, in the proposed language add the words “an in-patient” before the words “service traditionally offered by a hospital” in proposed section 9(3)(b). This insertion makes it clear that as hospitals continue to encroach into traditional primary care services, a physician’s conflict of interest with a hospital does not exist unless the competition in a traditional area of hospital patient care.