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March 4, 2008

Senator Dan Weinberg
Representative Ernie Dutton
SJR Committee on Economic Credentialing, Specialty Hospitals

Dear Sirs:

Pat Murdo, the Legislative Services staff person assigned to your subcommittee has sent out to interested parties some bill drafts and comments thereon covering issues which have been discussed in previous meetings. It was our understanding that comments concerning the bill drafts and other pertinent matters are expected from undersigned representing our clients as well as from others.

We respect the time and effort that has been put into the two bill drafts that have been presented. We understand the concerns of the committee and its desire to protect the interests of health care recipients in the state. However over-regulating by statutory fiat may very well have the effect of removing flexibilities that are necessary to develop and maintain adequate and responsive health care facilities. In that regard please consider the following:

1. In reviewing bill draft LC 8888 covering specialty hospitals on p. 13 line 4 the phrase "through self attestation" appears. We fail to see the need for that term and suggest that the use of it creates an additional requirement that is vague and unnecessary.

   Further down the same page under Subsection 55(i)(D)(ii) – (iii) language sets up two exclusive types of allowable ownership mixes. One requires participation of a hospital on a joint venture basis with physicians or other investors and the other allows a facility owned solely by physicians but no physician may have more than a 5 percent ownership position. What about private ownership exclusive of either a hospital of a physician? What about a mix of private ownership with either or both hospitals and/or physicians?

   We suggest that no restrictions be placed on ownership. Simply let the parties determine for themselves the source of investment and the levels of ownership. We did say that we would be willing to discuss with others the question of the right of first refusal being given to the hospitals. This was for the purpose of negotiating. We have approached the Hospital's Association through its

representatives and have been informed that they do not care to negotiate—at least at this time. We suggest to you that Montana's statute should stay the same on this issue and not specify or put limitations on investor ownership.

The same comments then apply to Section 2 of the bill draft which would amend Section 50-5-245, MCA to provide for a right of first refusal for hospitals with certain conditions attached that must be met. Again we believe that this should be left out of the statute.

The proposal in Section 2(1) (b) on page 15 of the specialty hospital bill draft contains a requirement that if the facility is a joint venture with a non-profit community hospital the required charity case guidelines provided by the specialty hospital must use the same ratio and mix of payers for patients as used by the hospital. If reference to ownership is not included this section would be superfluous. If this section remains in the bill we suggest that trying to maintain the same mix in two diverse institutions seems almost impossible to accomplish. The mix will vary depending upon the type of applications for admission from time to time. Conversely if the specialty hospital is not a joint venture the facility must provide an explanation of its charity care policy, a requirement which the community hospital does not have to meet. This seems to be a requirement that is again unnecessary. Why the requirement for one entity and not the other?

2. As to Bill Draft #LC0038 covering economic credentialing we believe that various parts of the suggested language are contradictory one with the other. For instance while language on pages 6 and 7 provides that a hospital may generally not deny privileges to a physician for criteria other than the training, current competence, experience, personal character and judgment of that individual, other provisions of the proposal regarding a "conflict of interest" collide head-on with the provisions that protect against economic credentialing. The provisions contradict one another.

Also in Section 1 (5) language appears providing that under certain circumstances a conflict of interest may be considered detrimental to a patient. This raises the specter of a possible new cause of action for mal-practice. This in turn will at the least cause an increase in malpractice insurance costs.

A similar problem is raised with regard to the requirement for patient notification. We fail to understand how patient notification can be adequately accomplished under circumstances where the patient's cognitive capacity may be diminished or nullified by sedation or the extent of the patient's illness. This again develops a new cause of action for malpractice and a resultant increase in the cost of malpractice insurance.

Many of the requirements in this bill draft have unintended consequences. There are other problems with the drafts but we assume these will be addressed by other parties.

We respectfully suggest that the subcommittee and full committee recommend legislation that follows the form set forth in our letter of February 8, 2008 which is attached.

If the committee does not care to follow our suggestion with respect to economic credentialing and specialty hospitals then perhaps the committees could adopt a proposal for economic credentialing and let the full 2009 session deal with the question of specialty hospitals.

Respectfully Submitted,

Jerome Anderson and Cory Swanson
Representatives for Yellowstone Physicians Alliance
and Montana Orthopaedic Society

FREQUENTLY ASKED QUESTIONS ABOUT SPECIALTY HOSPITALS

I. What is a specialty hospital?

A specialty hospital is a hospital facility that is primarily or exclusively engaged in the care and treatment of specific health conditions. Typical of the kinds of treatment covered are to patients with orthopedic conditions, those with cardiac conditions, patients receiving surgical procedures and patients receiving treatment for cancer related diseases and receiving oncology services. They are facilities that provide for inpatient stays of up to and more than 24 hours.

The present Montana statute, 50-5-101 (55) MCA 2007, defines a specialty hospital as one that provides the above services. The facility must be exclusively engaged in the diagnosis, care, or treatment of one or more of the named categories. In Montana the facility may provide other specific services so long as the additional services encompass 35 percent or less of the hospital services.

The term "specialty hospitals" does not include psychiatric, rehabilitation, or children's hospitals, or long term care or critical access hospitals.

Thus it is clear that specialty hospital facilities are designed, constructed and operated and hold themselves out to treat specific named and identified health conditions and/or requirements. These facilities are adequately defined in Section 50-5-101 MCA 2007 and there is no need to change or augment these definitive provisions.

II. What is the difference between a specialty hospital and a non-profit community hospital?

A specialty hospital is typically privately financed owned and operated while a non-profit community hospital is a publicly financed, supported and subsidized facility. The community hospital pays no taxes while the specialty hospital pays all taxes that are paid by those engaged in private business operations. Specialty hospitals may be owned and operated by physicians, private individuals with physician control and management, a mix of physician and private ownership or a mix of private or community hospital and physician ownership.

III. What benefits are provided by specialty hospitals?

Obviously one prime benefit is the standard of care for the specific conditions for which the facility provides care. The physicians providing services at these facilities are generally specialists in the treatment categories offered by these hospitals. Specialists are in short supply in some areas of health care in Montana (see accompanying news reports). Today many patients travel out of state seeking specialized care for specific conditions. Specialty care facilities can reduce the need to go elsewhere.

The facilities provide additional surgical opportunities for patients thus reducing the need for patients to wait extended periods for surgical opportunities in community hospitals whose surgical facilities are over-extended.

Specialty hospitals attract physicians who are specifically trained and uniquely qualified to treat particular diseases and physical conditions. Conversely the lack of opportunity to participate in specialized facilities not only discourages specialists from coming to Montana but encourages those who are here to go elsewhere.

Specialists associated with these special facilities can travel periodically to surrounding communities to offer care. Doctors associated with ambulatory surgical centers now operating in Montana now travel to smaller communities to perform such health care.

The facilities provide choices for patients for health care and treatment. An urban area dominated by a community hospital with an integrated health care system does not provide freedom of choice for physicians services. Specialty hospitals fill that void.

IV. Will specialty hospitals harm Montana community hospitals?

Experience has shown that ambulatory surgical centers in Montana have not harmed community hospitals in the same communities. They have augmented hospital services for the community and the competition they have provided has resulted in improvement in the over-all operations of the community facility. The same would be true for specialty hospitals which are facilities that provide extensions and enlargements of care now available in the ambulatory surgical centers and would provide additional choice options for those seeking health care.

In other states specialty hospitals have driven community hospitals to become more competitive in the delivery of health care. Past federal studies done between the period of 2003-2005 found that in areas where specialty hospitals are located, community hospitals demonstrate financial performance comparable to other community hospitals. In addition, a February 2005 study done by Health Economics Consulting Group found that community hospitals in areas with at least one specialty hospital actually have higher profit margins than those that don't have specialty hospitals.

Montana communities are entitled to have available to them the best possible health facilities and these should include specialized care opportunities.

V. Will the cost of treatment at a specialty hospital exceed costs at a community hospital?

Dr. Elliott from Billings who is associated with the Yellowstone Surgery Center and is a representative for the Montana Orthopaedic Society previously has testified before legislative committees during the 2007 session and before this subcommittee. His testimony made it clear that costs to patients for procedures performed in that ambulatory surgical center were on average less than in either of the two community hospitals in Billings. It was his testimony that the differentiation in cost factors would be expected to

continue at a specialty hospital facility. There has been no contrary evidence presented to either the Legislature or this subcommittee on this issue.

VI. How do other states treat specialty hospitals?

Our research indicates that Montana is the only state which has a statute providing for a moratorium. No state has legislated a ban on specialty hospitals. No state provides for a right of first refusal.

Efforts were unsuccessful in Wyoming and Idaho to ban physician self referral.

No state has any statutory provision that requires a physician to maintain privileges and on call participation at a second or another hospital. Our sources generally believe that such a requirement would be unconstitutional.

An effort in the state of Washington to ban specialty hospitals was rejected by that legislature.

Montana should not be out of step with the rest of the country. It should allow competition to advance patient's interests.

VII. Will physicians investment in and referral to specialty hospitals conflict with the best interest of patients?

Findings from a 2005 HHS study revealed no evidence that physicians who have an investment in a specialty hospital inappropriately referred patients. In fact, the study showed no difference in referral patterns between physician investors and non-investor physicians regarding referrals to both community hospitals and specialty hospitals.

Another federal study (Med Pac) found that overall utilization rates in communities with specialty hospitals were similar to rates in other communities.

Physicians have been referring patients to ambulatory surgery centers in the U.S. for decades with no evidence of abuses.

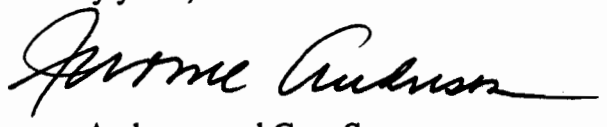
Physicians have an ethical and legal responsibility to refer patients to the facility that best meets the needs of the individual patient.

The bottom line in any health care debate should be—how can we provide the best health care to patients. We believe that specialty hospitals provide that standard of care because of their focus on the patient and that patient's specialized needs. Every one should favor the elements of fair competition, freedom of choice, innovation and specialization that makes U.S. health care the best in the world.

specialty hospital shall first offer the non-profit community hospital in the community an opportunity to participate in the establishment and ownership of the specialty facility. The negotiations will encompass the maximum amount of participation that would be required to be offered to the hospital, the management of the specialty facility if joint ownership occurs, the time period within which the hospital would be required to respond to the offer, and other pertinent matters. We also would include the need for retention of call at the community hospital.

We are disappointed that negotiations could not have been conducted prior to this time but are ready, willing and able to go forward with such negotiations.

Sincerely yours,



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Mark A. Baker

February 8, 2008

Senator Dan Weinberg
Representative Ernie Dutton
SJR Subcommittee on Economic Credentialing, Specialty Hospitals

Dear Sirs:

We understand that your subcommittee at its last meeting requested interested parties to present to you their suggestions with respect to any amendments or additions of new language to the provisions of §50-5-101 (55) MCA, 2007 (the definition of specialty hospitals) and §50-5-117 MCA, 2007, (the statute providing for prohibition of economic credentialing by any hospital). We also understand that some parties may also desire to change other relevant portions of the law governing specialty hospitals and relationships between hospitals and physicians.

The undersigned suggests the following amendment to §50-5-117 MCA—that subsection (2) of the statute be amended by striking language as follows:

> (2) Notwithstanding the prohibitions in subsection (1), a hospital may refuse to appoint a physician to the governing body of the hospital ~~or to the position of president of the medical staff or presiding officer of a medical staff committee~~ if the physician or a partner or employee of the physician ~~provides medical or health care services at,~~ has an ownership interest in~~, or occupies a leadership position on the medical staff of~~ a different hospital, hospital system, or health care facility.

The subsection of the statute would then read:

> (2) Notwithstanding the prohibitions in Subsection (1), a hospital may refuse to appoint a physician to the governing body of the hospital if the physician or a partner or employer of the physician has an ownership interest in a different hospital, hospital system, or health care facility.

As to §50-5-102 (55) MCA, 2007, the existing statutory definition of specialty hospitals, we recommend that the language of that subsection of the statute remain unchanged.

With respect to this definition and the issues surrounding it, we are willing to negotiate with interested parties statutory language requiring that those who desire to establish a

Closures concern doctors

St. Peter's

Two specialists are closing their Helena offices, and dozens of other medical professionals have expressed their concern to the board of directors of St. Peter's Hospital over a rash of specialists leaving town.

Letter sent | Medical workers upset with board over loss of specialists

By JOHN HARRINGTON
Independent Record

Announcements that two medical specialists are closing their Helena practices has led dozens of medical professionals to write a letter to the St. Peter's Hospital board over the direction of specialty practice here.

Gastroenterologist Jonathan Riegler and urologist Tim Grossman will both close their offices next month.

The closures will leave the Helena region with just one full-time urologist and one part-time gastroenterologist.

Riegler could not be reached for comment Tuesday, while Grossman said he had nothing to add to an advertisement that ran in the newspaper announcing the

More DOCTORS, *page 10A*

Doctors

continued from 1A

shuttering of his local practice.

Hospital spokeswoman Peggy Stebbins said the hospital will bring in "locum tenens," or doctors on short-term contracts that can last several months or more, to fill the void until new permanent specialists can be found.

"The community has been short a (gastroenterologist) for quite a while," she said. "It's a hard position to fill." She added that the hospital began advertising for a new urologist upon learning of Grossman's pending departure.

Stebbins said 120 doctors are credentialed to practice at the hospital, of whom 36 are St. Peter's employees. Riegler is a hospital employee, while Grossman is independent.

Both closures were referenced in a letter to the hospital's board of directors late last month — a letter discussing the "recent serious losses of specialty services at St. Peter's."

A source close to the situation said the letter was signed by at least 70 physicians and others in the medical community.

The letter requested a meeting with the board and hospital president and CEO John Solheim to address the loss of specialists.

Acknowledging that a decision to close a practice is a complex one, the letter nonetheless said "we feel that the bullying and antagonistic attitude of the administration is significantly to blame" for the specialists' departures.

Board president Rick Hays confirmed a meeting was to take place Tuesday but declined to discuss the agenda or who would attend.

"I think there's obviously another side to the story. It's not what it looks like," Hays said, but he didn't elaborate.

Stebbins said ongoing meetings between board officers, hospital administrators and doctors have involved an outside voice.

"The health care industry is dynamic and Helena is not unique in dealing with the complex issues," she said. "To help with the process, the hospital engaged a consultant in September 2007 to help facilitate the dialogue with the medical staff on the best way to proceed with the right mix and process for recruiting and retaining physicians in the community."

The letter also indicated that the hospital's rheumatologist "has been looking to locate elsewhere because of the problematic nature of dealing with the hospital."

An attempt on Tuesday to reach rheumatologist Carolyn Coyle was referred to Stebbins, who said she was unaware of any plans of Coyle to leave Helena. Coyle, at Maria Dean Medical Specialists, is the lone rheumatologist affiliated with the hospital, according to its Web site.

Reporter John Harrington: *447-4080 or john.harrington@helenair.com.*

HELENA INDEPENDENT FEB. 20, 2008