MINUTES OF THE HUMAN SERVICES COMMITTEE HEARING
FEBRUARY 2, 1981

The meeting of the Human Service Committee convened on February 2, 1981, in Room 103 of the Capitol at 12:30 p.m. with CHAIRMAN BUDD GOULD presiding. All members were present except REPS. BRAND and SEIFERT, who were excused.

HB 517

REP. BARDANOUVE opened the hearing on HB 517. He stated that the purpose of the bill was to repeal a law which was originally passed to provide for eugenical sterilizations and a board of eugenics. Now that the mental level of the patients at Boulder River School is much lower (than at the time the law was passed) patients cannot appear at hearings, therefore rendering the law obsolete. Also, REP. BARDANOUVE stated that the state might be in violation of civil rights having this law on the books; therefore, he recommends repealing it.

PROPONENTS:

NICK ROETERING, attorney for the department of SRS, stated that at present the patients at Boulder are so profoundly retarded that this law doesn't apply, as patients would not be able to request a sterilization.

OPPONENTS: There were none.

REP. BARDANOUVE closed the hearing on the bill.

HB 513

REP. MENAHAN opened the hearing on the bill, which relates to licensing and certificates of need of health care facilities.

PROPONENTS:

GEORGE FENNER, administrator of the hospital and medical facilities division, spoke as a proponent of HB 513 (EXHIBIT I). He also presented charts which more clearly explained his position.

RALPH GILDROY of the Montana Health Systems Agency, read printed material in favor of the bill (EXHIBIT II).

JUDY OLSON of the Montana Nurses' Association gave testimony in favor of the bill. (EXHIBIT III)

JUDITH CARLSON of the SRS said she felt that Montana had to comply with the federal law in order to retain federal funding.

DAVID LACKMAN, lobbyist for the Public Health Association, stated that, in his opinion, Montana must comply with the federal statutes. He said that he had seen funds taken away by the federal government, because of failure to comply with federal statutes. PAT PETAJA, appearing for SHARON DIEZIGER of the Montana Health Systems Agency, urged support of the bill. BEN BUSHYHEAD, representing the Montana United Indian Association, felt there could be a loss of dollars and services to Montanans (EXHIBIT V).
ROSE SKOOG, executive director of the Montana Nursing Home Association supported the bill, also, but did, suggest amendments. (EXHIBIT VI)

OPPONENTS:

KEN RUTLEDGE, vice president of the Montana Hospital Association, testified in opposition to HB 513. (EXHIBIT VII) He also presented testimony (EXHIBIT VII, attachment 1) proposing changes in Montana laws relating to health care facilities, licensing and certificate of need. DR. JACK MC MAHAN, representing the Montana Medical Association, asked the committee to oppose the bill. He stated that the Certificate of Need (CON) doesn't work in his opinion. He related a hospital's experience in getting a "scanner" telling that several hearings and great expense were required because of the CON.
He said that tax dollars were used on attorney's fees. He also said that a higher than necessary percentage of grant money was used in administering the grants, rather than on patient care.
FRANK STEWART, the administrator of Columbus Hospital in Great Falls, said that the necessity of a CON in expanding facilities and equipment often caused delays.

QUESTIONS FROM THE COMMITTEE:

REP. KEYSER asked George Fenner if a public hearing was an option in applying for a CON. FENNER said that for "good cause" a hearing could be granted. REP. KEYSER asked about "batching" of applications, not dealing with one at a time, but rather waiting until several had been received by the DHES. FENNER said that certain types of applications were heard twice a year as a result of governmental rule. REP. KEYSER asked for opinions about the cutting off of funds if Montana did not comply. RUTHLEDGE, of the MHA, felt that the situation is a bit unclear, at the present. He said that office of Management Budget director David Stockman has proposed zero funding for the health programs as of October 1, 1981, in referring to the Health Planning and Resources Development Act of 1979. CHAIRMAN GOULD asked who

would enforce the cuts in funding and was told the DWHEW. REP. WINSLOW asked if all the provisions of the bill were necessary. FENNER felt that some were not, but that they were included to comply with federal regulations. REP. BARDANOUVE asked about federal funding in Louisiana, a state which has no CON law. FENNER said that Louisiana came "under different provisions" and the DWHEW chose not to remove the funds; however, the funds could be removed now, he said. REP. BARDANOUVE asked about the CON in other states. RUTLEDGE, of the MHA, said a survey had been taken on 14 states that did not meet the CON standards (see EXHIBIT VII). REP. BARDANOUVE asked if there was any relationship to our not having CON and our relatively low hospital costs. FENNER said "yes" in some instances, but has made costs higher in other cases he felt. STEWART felt hospital costs could be even lower, if it were not for CON requirements. He said scanners and other pieces of equipment were being bought because hospital administrations felt they had to "buy now" or lose the opportunity. REP. BENNETT asked if CON had contributed to lower health costs. DR. MC MAHAN said that the total health care costs must be considered. He felt that X-raying was one of the best diagnostic methods, yet his hospital's board of directors wouldn't allow the purchase of a CT scanner. Through CON, you can get any equipment or facilities, if you are willing to spend enough on attorneys' fees, he said. REP. WINSLOW asked if there were any figures on money spent to receive CONS. RUTLEGE said the only figures were from a study made 2 years ago. He said small hospitals had had projects turned down because they didn't have enough money to spend for attorneys. He said the budget for the State Health Planning and other agency cost nearly $1,000,000 to administer CON. REP. BARDANOUVE asked if any large hospitals were turned down for projects. FENNER said that Billings Deaconess had their plans modified though they weren't turned down. He said that Plains Hospital was turned down. REP. KEYSER asked why the nurses were in favor of the bill. JUDY OLSON said the threat of the loss of funds was the reason. REP. BARDANOUVE asked how this bill affected the Nursing Homes. REP. DEVLIN asked if the CON could be called "blackmail". FENNER said the threat was real, whether or not it was intended.

REP. SIVERTSEN asked what had been done to alert the Legislature to this "blackmail". FENNER said that reports had been issued by the DHEW that the state must conform. Statements have been placed in individual boxes for each legislator, he said.

REP. MENAHAN temporarily closed the hearing on HB 513.

EXECUTIVE SESSION

HB 517

REP. DEVLIN moved for a DO PASS. It was seconded and PASSED UNANIMOUSLY.

HB 445
REP. KEYSER moved for a DO PASS. The committee held discussion on possible amendment to the bill, regarding variances and hearings. RUSS JOSEPHSON suggested an amendment on page 1, line 20 and on page 2, line 4. Also discussed was the county commissioners part in granting variances, hauling garbage great distances and fees for hauling garbage.

REP. METCALF moved that the committee accept the amendments as drawn up by RUSS JOSEPHSON, the committee's legal counsel.

The DO PASS AS AMENDED motion was seconded and PASSED UNANIMOUSLY.

CHAIRMAN GOULD announced that four bills has been assigned to sub-committees, and asked them to progress as quickly as possible.

The meeting was adjourned at 2:35 p. m.

BUD GOULD, CHAIRMAN

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VISITORS' REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL HB 513 Date Feb. 2, 1981

SPONSOR REP. MENAHAN

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
RALPH GILDROY	HELENA	MT HEALTH SYSTEMS AGENCY	✓	
Cindy Olsen		Mt. Nurses' Assoc.	✓	
KEN RUTLEDGE	Helena	MT Hospital Assoc		✓
JIM T LIEN	"	MT MEDICAL ASSN		✓
Patty Emmelander	Helena	Montana United Indian Assoc	✓	
Susan Gust	Helena	MT Home Ed. Assoc.		
Pat Sweet	Helena	MSEA	✓	
Ben Bushyhead	Helena	MUIH	✓	
Leroy Bingham	Helena	M.U.I.A.	✓	
Jennifer Jones	Helena	Helena Indian Alliance	✓	
[illegible]	Helena	DHES	✓	
[illegible]	Helena	DHES	✓	
Margaret Johnson	Helena	MUIHA	✓	
Pat Roberts	Helena	MHSA	✓	
[illegible]	Helena	MMA		✓
[illegible]	Helena	MUIHA		✓
Beverly Gibson	Helena	MACO	✓	
JUDITH H CARLSON		SRS	✓	
Merle Adler	Helena	MHSA	✓	
David B. Lackman	Helena	MT Public Health Assn.	✓	
Norman E. Bass	HELENA	DEPT. OF HEALTH	✓	
Frank Stewart	Great Falls	Columbus Hosp		✓
Brad Robinson	Great Falls	Columbus Hosp		✓
ROSE SKOOG	HELENA	MT. NURSING HOME ASSN	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL HB 517 Date Feb. 2, 1981

SPONSOR REP. BARDANOUVE

NAME	RESIDENCE	REPRESENTING	SUPPORT	OPPOSE
[illegible] Reading	Helena	Dept of Institutions	✓	
Gye Skoog	Helena	MNHA		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

EX. I

NAME George M. Fenner Bill No. HB 513

ADDRESS Cogswell Building DATE 2-2-81

WHOM DO YOU REPRESENT Department of Health & Environmental Sciences

SUPPORT X OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: See Attachment

Mr. Chairman, members of the Committee, for the record, my name is George Fenner. I am Administrator of the Hospital and Medical Facilities Division of the Department of Health and Environmental Sciences. House Bill 513 is a Department bill. For the past six sessions, I have appeared before committee members of the Legislature, discussing Certificate of Need in one form or another. The Montana Certificate of Need Law was passed in the 1975 Legislative Session, was amended in the 1977 Session, again in the 1979 Session, and here we are once again requesting more amendments.

These amendments for the most part are to meet the mandates of Public Law 96-79, plus a few changes perceived as needs by the State Health Planning and Development Agency.

In a letter from the Federal Department of Health and Human Services dated December 2, 1980, we were informed and I quote, "As you know, P.L. 96-79 revised and further clarified the penalty for failure of a state to have a fully designated SHPDA by the effective date established in the law." The effective date for Montana is January, 1982. "In order for the SHPDA to continue to be fully designated, it must have a Certificate of Need program which meets the minimum requirements as specified in the October 21, 1980, Federal Regulations. Failure of the SHPDA to have a satisfactory Certificate of Need program by this effective date will result in the reversion of the agency to conditional designation and will subject the agency to the penalty clause provided in Section 1521(d). Section 1521(d) provides authority for a reduction of Federal funds which are awarded under the Public Health Service Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act and the Drug Abuse Act by 25%

in the first year, 50% in the second year, 75% in the third year and total elimination of funds thereafter." In Montana, we are presently receiving approximately fifteen million dollars per annum through these funding mechanisms. Over a four year period this would mean a thirty-seven million, five hundred thousand dollar loss in essential health funding for the State of Montana. I have furnished the Chairman and the Secretary a manual entitled Public Health Service Grants Affected by Certificate of Need which contains specifics on these grants as to where they are located, total amount of grant, name of project director and other related information which may be of interest to you. (Use maps)

The testimony I have presented to this point has been all about the threat of loss of Federal funding. I will now change the thrust of my testimony.

The reexamination of Certificate of Need statutes, regulations, and procedures that has recently occurred as many states have attempted to bring their CON programs into compliance with P.L. 93-641 and P.L. 96-79, has given providers, and particularly hospitals, an opportunity to air their frustrations with Certificate of Need. Across a broad range of states and types of institutions, a common set of criticisms continally emerges:

- The process is too lengthy and cumbersome and does not sufficiently differentiate between projects with major cost and service implications and proposals to meet more mundane replacement needs.

- The costs associated with application development and justification, and attendant to delays in construction or purchase of equipment, often exceed the savings achieved through project denial or reduction in scale.

- The criteria and standards applied in determining "need" are arbitrary, insensitive to local conditions, and ever changing.

The complaints over process length are widely acknowledged to be legitimate, at least in part. A number of states are now developing expedited review procedures to handle noncontroversial projects that have only limited capital and operating costs, will therefore have only limited effects on patient charges, and do not involve clinical or therapeutic services that could have substantial systemwide impacts. Several recent studies on the cost and service implications of various types of projects subject to Certificate of Need are beginning to provide a basis for identifying projects appropriate for such expedited review. As a recent report pointed out, however, it is important to realize that given the state's concern for cost containment and an institution's concern for its own well-being, an adversarial CON process is inevitable at least in the case of large projects involving bed and service expansion and renovation. The attendant desire on the part of both the state and the institution to retain all possible influence in the course of review is therefore likely to produce a lengthy review period on controversial applications.

Except when applied to projects that should be handled through expedited review, the arguments that have been raised over cost increases attributable to the CON process are not valid because they usually exclude one major category of cost savings that can be achieved through project review. Most studies that attempt to demonstrate the cost-increasing nature of CON, such as a recent one performed by Ernst and Whinney for the Federation of American Hospitals, compare the cost of application preparation and inflation with the savings in capital costs achieved through project denial or modification. It is essential to remember, however, that the actual capital costs of a project often represent only a small fraction of the total operating costs generated over the 20-or-more year useful life of the asset created. The construction of a major new facility and

the introduction of new services, often the most controversial projects and therefore the ones that experience the longest CON review periods, represent the necessary first steps in the addition of new personnel and increase in the "intensity" of hospital care to which most cost increases associated with capital investment are attributable. Only by including estimates of savings in operating costs achieved through CON can a valid comparison of the costs versus the benefits of CON review be made.

Finally, on the question of standards and criteria for review, the points raised by the critics of CON do have some legitimacy. Particularly in states that enacted Certificate of Need regulation prior to the passage of P.L. 93-641, little objective information was often available upon which to base an assessment of "need" and the development of defensible guidelines and standards progressed slowly. Even with the establishment of a Federal planning structure and the creation of national guidelines, the information base from which to derive standards is still often less than ideal and can be expected to change over time. However, it must also be appreciated that hard and fast criteria of "need" do not and never will exist. The issue of how many resources of what types should be devoted to the care of various kinds of patients is essentially a social policy judgment. Prior to the establishment of CON, the preferences of individual institutions alone determined the nature of services provided, even though the larger community often bore the costs of those decisions. The presence of CON now assures that a larger set of preferences is brought to bear on these questions. At the most fundamental level, much of the criticism of the standards applied to determine "need" simply reflects institutional frustration with the fact that the state, not the individual provider, now makes the final decision on what is desirable.

Even many of the most ardent critics of CON still view health planning as a valuable asset in identifying community health needs. But it is important to remember that many of the planning objectives now embodied within the framework of the National Health Planning and Resource Development Act were also present in its predecessor, Comprehensive Health Planning (CHP). What CHP lacked, however, was any mechanism to ensure the implementation of its plans. Hence, the development of those plans rarely was taken seriously by the providers they were intended to influence. Only the availability and use of a regulatory tool with authority over specific investment projects has created the opportunity to bring larger community concerns to bear on the decision-making of individual institutions. Were changes to occur in the reimbursement system that would make providers more aware of and sensitive to the "consumer" perspective, perhaps the planning arena would no longer be needed to serve this function. But until such change is accomplished, a strong and effective planning system will be essential, and one critical component of this system will continue to be Certificate of Need regulation.

I wish to thank the Committee for this opportunity to testify in support of House Bill 513. I urge a "do pass" recommendation from this Committee.

State	Federal	Numeral	Significance	Addition	Change in Wording
	X	1	definition; re: affected persons		X
	X	2	definition; re: capital expenditure	X	
	X	3	definition; re: CFR - Code of Federal Regulations	X	
	X	4	definition: re: facility	X	
	X	5	definition; re: health services	X	
	X	6	definition: re: Health Systems Agency	X	
	X	7*	definition; re: long term care facility		X
	X	8	definition; re: skilled nursing		X
	X	9	definition; re: intermediate mentally retarded care	X	
	X	10*	deletion; re: hotels, motels, boarding homes		
	X	11	definition; re: major medical equipment		X
	X	12*	definition; re: transfer trauma	X	
X		13*	definition; re: confidentiality	X	
	X	14*	license requirements		X
	X	15*	licensure; re: discontinuance and transfer of licensure		X
	X	16 *	licensure; re: annual licensure - license fee		X
	X	17*	licensure application; re: officers		X
	X	18*	care; re: residents	X	
	X	19*	provisional licensure; re: time period		X
	X	20	provisional licensure; re: appeal process revocation of provisional license		X
X		21	receivership	X	

* Licensing

State	Federal	Numeral	Significance	Addition	Change in Wording
X		22	definition; re: review requirements, acquisition of major medical equipment not in health care facility		X
X		23	letter of intent		X
X		24	request for additional information; re: incomplete application		X
X		25	notification; re: time schedule for review		X
X		26	removal of criteria (will be adopted as rules)		
X		27	population; re: need and accessibility	X	
X		28	term of application		X
X		29	appeal process procedure		X
X		30	special circumstances; re: removal of life safety deficits : consistent with State Health Planning		X

Final Draft

LC0885/01

47th Legislature

House BILL NO. 513

Introduced by

By request of the Department of Health and Environmental Sciences

A BILL FOR AN ACT ENTITLED: AN ACT TO GENERALLY REVISE AND CLARIFY THE LAWS RELATING TO HEALTH CARE FACILITIES, LICENSING, AND CERTIFICATES OF NEED, AMENDING SECTIONS 50-5-101, 50-5-201, 50-5-203, 50-5-204, 50-5-208, 50-5-301, 50-5-302, 50-5-304, 50-5-305, 50-5-306, AND 50-5-308, MCA, and providing for confidentiality of complaints and, authorizing receivers to be appointed for long-term care facilities.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 50-5-101, MCA, is amended to read:

"50-5-101. Definitions. As used in parts 1 through 4 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Adult day-care center" means a facility, free-standing or connected to another health care facility, which provides adults, on an intermittent basis, with the care necessary to meet the needs of daily living.

(2) "Affected persons" means includes the applicant, ~~members-of-the-public-who-are-to-be-served-by-the-proposal,-health-care-facilities-located-in-the-geographic-area-affected-by-the-application,-agencies-which-establish-rates-for-health-care-facilities,-and-agencies-which-plan-or-assist-in-planning-for-such-facilities,-including-any-agency-qualifying-as-a-health-systems-agency-pursuant-to-Title-XV-of-the-Public-Health-Service-Act.~~ the health systems agency for the service area in which the project is proposed to be located; health systems agencies serving contiguous health service areas; any person residing within the geographic area served or to be served by the applicant; any person who regularly uses health care facilities and health maintenance organizations located in the health service area in which the project is proposed to be located which provide services similar to the services of the facility under review; health care facilities and health maintenance organizations which,

1. prior to receipt by the department of the proposal being reviewed, have formally indicated an intention to provide similar services in the future; third party payers who reimburse health care facilities for services in the health service area in which the project is proposed to be located; and any agency which establishes rates for health care facilities or health maintenance organizations located in the health service area in which the project is proposed to be located.

(3) "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery from surgery or other treatment.

(4) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

2. (5) "Capital expenditure" means an expenditure made by or on behalf of a health care facility which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance.

~~(5)~~ (6) "Certificate of need" means a written authorization by the department for a person to proceed with a proposal subject to 50-5-301.

3. (7) "CFR" means the Code of Federal Regulations published by the U.S. Government Printing Office, Washington, D.C.

~~(6)~~ (8) "Construction" means the physical erection of a health care facility and any stage thereof, including ground breaking; or the remodeling or renovation of an existing health care facility.

~~(7)~~ (9) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

~~(8)~~ (10) "Federal acts" means federal statutes for the construction of health care facilities.

~~(9)~~ (11) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

~~(10)~~ (12) "Health care facility" or "facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term

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does not include offices of private physicians or dentists. The term includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospitals, infirmaries, kidney treatment centers, long-term care facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, and adult day-care centers.

5. {11} (13) "Health maintenance organization" means a public or private organization organized as defined in 42 U.S.C. 300e, as amended.

(14) "Health services" means clinically related (i.e., diagnostic, treatment, or rehabilitative) services, and includes alcohol, drug abuse, and mental health services.

6. (15) "Health systems agency" means an entity which is organized and operated in the manner described in 42 U.S.C. 300l-2 and which is capable, as determined by the Secretary of the United States Department of Health and Human Services, of performing each of the functions described in 42 U.S.C. 300l-2.

{12} (16) "Home health agency" means a public agency or private organization or subdivision thereof which is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

{13} (17) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff which is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

{14} (18) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

~~(15)~~ (19) "Kidney treatment center" means a facility which specializes in treatment of kidney diseases, including freestanding hemodialysis units.

~~(16) (a) "Long-term care facility" means a facility or part thereof which provides skilled nursing care or intermediate nursing care to a total of two or more persons or personal care to more than three persons who are not related to the owner or administrator by blood or marriage, with these degrees of care defined as follows:~~

~~(i) "Skilled nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis.~~

~~(ii) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.~~

~~(iii) "Personal care" means the provision of services and care which do not require nursing skills to residents needing some assistance in performing the activities of daily living.~~

~~(b) Hotels, motels, boarding homes, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care are not long-term care facilities.~~

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~~(16)(a)~~ (20) "Long-term care facility" means a facility or part thereof which provides: skilled nursing care, ~~or~~ intermediate nursing care, or intermediate mental retardation care to a total of ~~two~~ 2 or more persons; or personal care to more than ~~three~~ 3 persons who are not related to the owner or administrator by blood or marriage; ~~with these degrees of care defined as follows:~~ . The term does not include hotels, motels; boarding homes, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care.

8.

~~(i)~~ (a) "Skilled nursing care" means the provision of ~~nursing care services, health-related services, and social services under the supervision of a licensed registered nurse on a 24-hour basis,~~ furnished pursuant to physician order which require the skills of technical or professional personnel 24 hours per day, and which are provided either directly by or under the supervision of such personnel.

~~(ii)~~ (b) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse on a 24-hour basis.

21. established principles of law for receivers of real property. Such duties and responsibilities shall be determined by the court following a hearing, at which time the parties may appear and be heard. The court shall specify the duties and responsibilities of the receiver in the order of appointment. No security interest in any real or personal property comprising said facility or contained within the facility nor any fixture of the facility shall be impaired or diminished by the receiver, but the receiver shall comply with the rules of the department in providing health care to patients.

(7) Nothing in this section shall prevent the court from altering or amending the terms and conditions of the receivership or the receiver's responsibilities and duties following a hearing at which time the parties may appear and be heard; and nothing in this section shall prohibit the parties from stipulating to the terms and conditions of the receivership and the responsibilities and duties of the receiver, including the duration thereof, and such stipulation shall be submitted to the court for approval.

(8) A receivership established pursuant to this section may be terminated by the court upon application therefor by the licensee of a long-term care facility, the department, or the receiver. The receivership may be terminated upon a finding by the court that the receivership is no longer necessary, but in no case shall the receivership continue for longer than 180 days from the date of

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(4) Prior to ordering the appointment of a receiver for the operation of a long-term care facility, the district court must find:

(a) That grounds for the appointment of a receiver exist as provided in subsection (1) of this section; and

(b) that proper notice as required by subsection (2) of this section has been served; and

(c) that there is a necessity to continue care on a temporary basis at the facility to avoid potential transfer trauma which would serve the best interests of the residents of the facility pending arrangements for the lease, sale, or closure of the facility.

(5) The department *may* grant the receiver a license pursuant to section 50-5-204 and the department of social and rehabilitative services shall reimburse the receiver for the long-term care facility's medicaid residents pursuant to section 53-2-201(1)(a) and Title 53, Chapter 6.

(6) The appointment of the receiver shall be in accordance with and governed by the provisions of rule 66 of the Montana rules of civil procedure. The court *may* enter an order of appointment and fix the fees and expenses of the receiver. The receiver shall be a licensed nursing home administrator and shall post a bond with adequate sureties as determined by the court, and the receiver may be sued upon the same in the name of the state of Montana at the instance and for the use of any party injured. The receiver shall perform duties, assume responsibilities, and preserve the long-term care facility property in accordance with

(2) Application for the appointment of a receiver pursuant to this section shall be to the district court for the county where the long-term care facility is located. No hearing on such application shall be held sooner than seventy-two hours after the licensee of such facility has been served with notice thereof, as provided in the Montana rules of civil procedure; except that when the department exercises its summary powers, an emergency receiver may be appointed upon agreement in writing between the department and licensee, with the approval of the owner, until a hearing for appointment of a receiver is held as provided in this section. Notice shall also be served upon any owner and any lessee of the long-term care facility and any holder of a security interest of record in said facility. An application for appointment of a receiver pursuant to this section shall have precedence and priority over any civil or criminal case pending in the district court wherein the application is filed.

(3) For the purpose of this section the action of the department exercised pursuant to subsection (1) of this section shall become effective upon appointment of the receiver of the court.

NEW SECTION Section 7. There is a new MCA section numbered 50-5-210 that reads:

"50-5-210 Receivership.

21. (1) The department, the licensee or owner of a long-term care facility, or the lessee of such facility with the approval of the owner, may apply to the district court for the appointment of a receiver to operate the long-term care facility when:

(a) The department has refused to issue a new license, a renewal license or has revoked the license of such facility; or

(b) the department has taken summary action to suspend the license of any such facility in accordance with the provisions of section 2-4-631(3).

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Section 6. Section 50-5-208, MCA, is amended to read:

"50-5-208. Hearing required. ~~(1) A license may not be denied, suspended, or revoked without notice and an opportunity for a hearing before the board.~~

~~(2) Notice shall be given the applicant or licensee of a date, not less than 15 days after mailing or service, for a hearing before the board.~~

~~(3) The decision of the board is final 30 days after it is mailed or served unless the applicant or licensee commences an action in the district court to appeal the decision. An appeal shall be in the district court where the facility is located or will be located.~~

~~History: En. Sec. 168, Ch. 197, L. 1967; amd. Sec. 73, Ch. 349, L. 1974; R.C.M. 1947, 69-5210.~~

(1) A decision of the department to deny, suspend, revoke, or reduce to provisional status a health care facility license is final unless, within 30 days after notice is given of the department's decision, the applicant or licensee files an appeal to the board.

(2) If a decision of the department is appealed to the board pursuant to this section, a hearing will be held pursuant to the contested case provisions of the Montana Administrative Procedure Act.

(3) The decision of the board is final 30 days after notice is given unless the applicant, licensee, or department files an appeal in the district court. Such an appeal shall be in the district court where the facility is located or will be located.

(4) Service for purposes of this chapter may be made by certified mail."

Section 4. Section 50-5-203, MCA, is amended to read:

"50-5-203. Application for license. The procedure to apply for a license is as follows:

16. (1) At least 30 days prior to ~~the opening~~ commencing operation of a facility and annually thereafter a person shall submit an application is made to the department accompanied by the license fee.

17. (2) The application ~~shall~~ must contain:

(a) the name and address of the applicant if an individual, the name and address of each member if a firm, partnership, or association, or the name and address of each officer if a corporation;

(b) the location of the facility;

(c) the name of the person or persons who will manage or supervise the facility;

(d) the number and type of patients or residents for which care is

18. to be provided;

(e) any information which the department may require pertaining to the number, experience, and training of employees;

(f) information on ownership, contract, or lease agreement if operated by a person other than the owner."

Section 5. Section 50-5-204, MCA, is amended to read:

"50-5-204. Issuance and renewal of licenses. (1) On receipt of a new or renewal application, the department or its authorized agent shall inspect the facility. If minimum standards are met and the proposed staff is qualified, the department shall issue a license for 1 year. If minimum standards are not met, the department may issue a provisional license with conditions for continued operation for ~~less than~~ a period not to exceed 1 year if operation will not result in undue hazard to patients or residents or if the demand for accommodations offered is not met in the community. The minimum standards which home health agencies must meet in order to be licensed shall be as outlined in 42 U.S.C. 1395x(o), as amended, and in rules implementing it which add minimum standards.

19.

(2) Licensed premises shall be open to inspection, and access to all records shall be granted to the department at all reasonable times."

Section 3. Section 50-5-201, MCA, is amended to read:

"14. 50-5-201. License requirements. (1) A licensee who contemplates construction of or alteration or addition to a health care facility shall submit plans and specifications to the department ~~for preliminary inspection and approval prior to commencing construction~~ which must be approved by the department in writing prior to the licensee's commencing the construction, alteration or addition.

(2) No person may operate a health care facility unless the facility is licensed by the department. Licenses shall be for 1 year unless issued for a shorter period. A license is valid only for the person and premises for which it was issued. A license may not be sold, assigned, or transferred.

(3) ~~Upon discontinuance of the operation or upon transfer of ownership of a facility, the license must be returned to the department.~~

15. A health care facility must surrender its license to the department within 10 days after:

(a) discontinuance of the facility's operation; or

(b) the transfer of the facility's ownership or controlling interest, or the transfer of its lessees.

(4) Licenses shall be displayed in a conspicuous place near the admitting office of the facility."

12. (32) "Transfer trauma" means the physical, psychic or emotional shock that a patient or resident in a long-term care facility may suffer as the result of an unexpected move to another facility.

(33) "U.S.C." means the United States Code."

Section 2. There is a new MCA section numbered 50-5-110 which reads:

13. " 50-5-110. Confidential information. (1) A written complaint or charge made to the department alleging a violation of this chapter or a rule adopted pursuant thereto against a health care facility licensee or applicant shall be kept confidential unless and until the department has taken formal action pursuant to 50-5-207, 50-5-221, or 50-5-307.

(2) This statute may not be construed to prohibit the department from sharing confidential information it possesses alleging violations of health care laws and rules with agencies charged under state or federal law with the administration of health care laws and rules."

11.

(39)(17) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients or the rehabilitation of such persons, or any combination of these services.

~~(18) "New institutional health services" means:~~

~~(a) the construction, development, or other establishment of a health care facility which did not previously exist;~~

~~(b) any expenditure by or on behalf of a health care facility within a 12-month period in excess of $150,000, which, under generally accepted accounting principles consistently applied, is a capital expenditure. Whenever a health care facility or a person on behalf of a health care facility makes an acquisition under lease or comparable arrangement or through donation, which would have required review if the acquisition had been by purchase, such acquisition shall be considered a capital expenditure subject to review.~~

~~(c) a change in bed capacity of a health care facility which increases or decreases the total number of beds, redistributes beds among various service categories, or relocates such beds from one physical facility or site to another over a 2-year period by more than 10 beds or 10% of the total licensed bed capacity, whichever is less;~~

~~(d) health services which are offered in or through a health care facility and which were not offered on a regular basis in or through such health care facility within the 12-month period prior to the time such services would be offered or the deletion by a health care facility of a service previously offered;~~

~~(e) the expansion of a geographic service area of a home health agency.~~

(23) (19) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

(24) (20) "Observation bed" means a bed occupied for not more than 6 hours by a patient recovering from surgery or other treatment.

(25) (21) "Offer" means the holding out by a health care facility that it can provide specific health services.

(26) (22) "Outpatient facility" means a facility, located in or apart from a hospital, providing, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients in need of medical, surgical, or mental care. An outpatient facility may have observation beds.

(27) (23) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

(28) (24) "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

(29) (25) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices.

(30) (26) "Rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

(31) (27) "Resident" means a person who is in a long-term care facility for intermediate or personal care.

(28) ~~(28) "State plan" means the state medical facility plan provided for in part 4.~~

History: (1)En. Sec. 2, Ch. 197, L. 1967; amd. Sec. 28, Ch. 349, L. 1974; Sec. 69-4102, R.C.M. 1947; (2) thru (18)En. Sec. 159, Ch. 197, L. 1967; amd. Sec. 1, Ch. 290, L. 1969; amd. Sec. 1, Ch. 197, L. 1971; amd. Sec. 1, Ch. 448, L. 1973; amd. Sec. 1, Ch. 150, L. 1974; amd. Sec. 1, Ch. 447, L. 1975; amd. Sec. 22, Ch. 187, L. 1977; R.C.M. 1947, 69-4102(1), 69-5201; amd. Sec. 1, Ch. 347, L. 1979.

9 (c) "Intermediate mental retardation care" means the provision of nursing care services, health-related services, and social services for mentally retarded or persons with related problems as may be defined by rules adopted by the department.

~~(iii)~~ (d) "Personal care" means the provision of services and care which do not require nursing skills to residents needing some assistance in performing the activities of daily living.

~~(b)--Hotels,-motels,-boarding-homes,-rooming-houses,-or-similar accommodations-providing-for-transients,-students,-or-persons-not-requiring institutional-health-care-are-not-long-term-care-facilities.~~

10 (21) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used to provide medical and other health services and which costs more than $150,000. This term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of the Act. In determining whether medical equipment costs more than $150,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to acquiring the equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

21.

the initial appointment of the receiver unless extended by written agreement of the parties as provided in subsection (7) of this section.

(9) Upon termination of the receivership, the court shall order a final accounting and finally fix the fees and expenses of the receiver following a hearing, at which time the parties may appear and be heard."

Section 22. Section 50-5-301, MCA, is amended to read:

22.

"50-5-301. ~~When application is required. Unless an application has been submitted to and a certificate of need granted by the department, no person may initiate any of the following:~~

~~(1) a new institutional health service as defined in 50-5-101;~~

~~(2) any expenditure by or on behalf of a health care facility in excess of $150,000 made in preparation for the offering or development of a new institutional health service and any arrangement or commitment made for financing the offering or development of the new institutional health service. Expenditures made in the preparation for the offering of a new institutional health service shall include expenditures for architectural designs, preliminary plans, working drawings, specifications, studies, and surveys.~~

History: En. Sec. 170, Ch. 197, L. 1967; amd. Sec. 21, Ch. 366, L. 1969; amd. Sec. 2, Ch. 447, L. 1975; R.C.M. 1947, 69-5212(1); amd. Sec. 3, Ch. 37, L. 1979; amd. Sec. 12, Ch. 347, L. 1979.

22. (1) When certificate of need is required. Unless a person has submitted an application for and is the holder of a certificate of need granted by the department, he may not undertake any of the following projects:

(a) the incurring of an obligation by or on behalf of a health care facility for any capital expenditure (other than to acquire an existing health care facility) that exceeds $150,000. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, (including staff effort and consulting and other services) essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds $150,000.

(b) the incurring of an obligation for any capital expenditure by or on behalf of a health care facility which changes the bed capacity of a health care facility by 10 beds or 10% , whichever is less, in any 2-year period, through:

(i) increases or decreases in the total number of beds;

(ii) redistributions of beds among various categories; or

(iii) relocations of beds from one physical facility or site to another.

(c) the incurring of an obligation for any capital expenditure by or on behalf of a health care facility which is associated with the addition of a health service which was not offered by or on behalf of the facility within the previous 12 months, or the termination of a health service which was offered in or through the facility; or

(d) the addition of a health service which is offered by or on behalf of the health care facility which was not offered by or on behalf of the facility within the 12 -month period before the month in which the service would be offered, and which entails annual operating costs of at least $75,000.

(e) the acquisition by any person of major medical equipment that will be owned by or located in a health care facility.

22.

(f) the acquisition by any person of major medical equipment not owned by or located in a health care facility, if:

(i) the person has failed to submit the notice of intent required by 50-5-302(2); or

(ii) the department finds within 30 days after it receives the notice of intent required by 50-5-302(2) that the equipment will be used to provide services for inpatients of a hospital.

(g) the incurring of an obligation for a capital expenditure by any person to acquire an existing health care facility if:

(i) the person has failed to submit the notice of intent required by 50-5-302(3); or

(ii) the department finds within 30 days after it receives the notice of intent required by 50-5-302(3) that the services or bed capacity of the facility will be changed in being acquired.

(2) For purposes of this section:

(a) an obligation for a capital expenditure is considered to be incurred:

(i) when an enforceable contract is entered into by or on behalf of a health care facility for the construction, acquisition, lease, or financing of a capital asset;

(ii) when the governing board of a health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or

(iii) in the case of donated property, on the date on which the gift is completed under Montana law.

(b) An acquisition by donation, lease, transfer, or comparable arrangement shall require a certificate of need if the acquisition would be subject to certificate of need review under subsection (1) of this section if made by purchase.

(c) An acquisition for less than fair market value shall require a certificate of need if the acquisition at fair market value would be subject to review under subsection (1) of this section.

(d) A health maintenance organization is to be considered a health care facility except to the extent exempted from certificate of need requirements as prescribed in rules adopted by the department.

22.

(e) The acquisition of major medical equipment does not require a certificate of need if it will be used to provide services to inpatients of hospitals only on a temporary basis in the case of a natural disaster, a major accident, or equipment failure.

(3) A proposed change in a project associated with a capital expenditure under subsections (1)(a), (1)(b), or (1)(c), for which the department has previously issued a certificate of need will require subsequent certificate of need review if the change is proposed within one year after the date the activity for which the capital expenditure was granted a certificate of need is undertaken. As used in this subsection, a "change in project", shall include but not be limited to any change in the bed capacity of a health care facility as described in subsection (1)(b), and the addition or termination of a health service.

(4) If a person acquires major medical equipment not located in a health care facility without a certificate of need and proposes at any time to use that equipment to serve inpatients of a hospital the proposed new use requires a certificate of need unless the service is confined to the circumstances specified in subsection (1)(g).

(5) If a person acquires an existing health care facility without a certificate of need and proposes to change, within one year after the acquisition, the services or bed capacity of the health care facility, the proposed change shall require a certificate of need if one would have originally been required under subsection (1)(h)."

Section 9. Section 50-5-302, MCA, is amended to read:

22. "50-5-302. Notice of intent, application and review process. (1) The department may adopt rules including but not limited to those for:

(a) the forms and content of notices of intent and applications.

(b) the scheduling of reviews of similar proposals.

(c) the abbreviated review of a proposal which: does not significantly affect the cost or utilization of health care; is necessary to eliminate or prevent immenent safety hazards; or is to comply with licensure or certification standards.

(d) the format of public informational hearings.

(2) At least 30 days before any person enters into a contract to acquire major medical equipment which will not be owned by or located in a health care facility, the person shall submit to the department and the appropriate health systems agency a notice of his intent to acquire the equipment and of the use that will be made of the equipment.

(3) At least 30 days before any person acquires or enters into a contract to acquire an existing health care facility, the person shall submit to the department and the appropriate health systems agency a notice of his intent to acquire the facility and of the services to be offered in the facility and its bed capacity.

23. ~~(1)~~ (4) Any person intending to initiate an activity for which a certificate of need is required shall submit a letter of intent to the department. After its receipt, the department shall send the ~~applicant~~ person an application form requiring the submission of information considered necessary by the department. ~~to determine if the proposed activity meets the standards in 50-5-304. The form and content of the notification of intent and applications for certificates of need shall be prescribed by rule by the department.~~

24. ~~(2)~~ (5) Within 15 calendar days after receipt of the application, the department shall determine whether if it ~~contains sufficient information to determine if the proposed activity meets the standards in 50-5-304;~~ is complete. If the application is found incomplete, the department shall request the necessary additional information. If the applicant fails to submit the necessary additional information requested by the department by the deadline as prescribed by department rules for considering such reviews, a new letter of intent and application must be submitted.

25.

(3) (6) After the application has been designated complete, notification must be sent to the applicant and all other affected persons regarding the department's projected time schedule for review of the application. and ~~the review period time schedule.~~ The review period for the application may be no longer than 90 calendar days ~~after the notice is sent unless a longer period is agreed to by the applicant~~. All completed applications pertaining to similar types of services, facilities, or equipment affecting the same health service area may be considered in relation to each other. During the review period a public hearing may be held if requested by an one or more affected persons, or when determined necessary by the department.

(4) (7) The department shall, after considering the application, the transcript of a public hearing if one was held and the all comments received during the review period, issue a certificate of need, with or without conditions, or ~~reject~~ deny the application. The department shall notify the applicant and affected persons of its decision."

Section 10. Section 50-5-304, MCA, is amended to read:

"50-5-304. Review criteria, required findings, and standards. The department shall by rule promulgate and utilize, as appropriate, specific criteria for reviewing certificate of need applications under this chapter, which, ~~including but not limited to the following considerations and required findings:~~

~~(1) the relationship of the health services being reviewed to the applicable health systems plan and annual implementation plan developed pursuant to Title XV of the Public Health Service Act, as amended;~~

~~(2) the relationship of services reviewed to the long-range development plan, if any, of the person providing or proposing the services;~~

~~(3) the need that the population served or to be served by the services has for the services;~~

~~(4) the availability of less costly quality equivalent or more effective alternative methods of providing such services;~~

~~(5) the immediate and long-term financial feasibility of the proposal as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the health service;~~

~~(6) the relationship and financial impact of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided;~~

~~(7) the availability of resources, including health manpower, management personnel, and funds for capital and operating needs for the provision of services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services;~~

~~(8) the relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services;~~

~~(9) the special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health profession schools, multidisciplinary clinics, and specialty centers.~~

~~(10) the special needs and circumstances of health maintenance organizations for which assistance may be provided under Title XIII of the Public Health Service Act. Such needs and circumstances include the needs of and costs to members and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services.~~

~~(11) the special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages;~~

~~(12) in the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project;~~

~~(13) the distance, convenience, cost of transportation, and accessibility of health services for persons who live outside urban areas in relation to the proposal; and~~

~~(14) any other criteria, required findings, or requirements for reviewing certificate of need applications cited in the federal regulations found in Title 42, CFR, Part 123, as amended.~~

27. (a) address the need of the population to be served by the proposed project and the extent to which this population has access to the proposed project; and

(b) consistent with the requirements of . . 42 U.S.C. 300n, et seq., and with the federal regulations found in 42 CFR, part 123."

Section 11. Section 50-5-305, MCA, is amended to read:

"50-5-305. Period of validity of approved application. ~~A certificate of need shall terminate 1 year after the date of issuance unless:~~

~~(1) the application has commenced construction if the project provides for construction or has incurred an enforceable capital expenditure commitment for projects not involving construction; or~~

~~(2) the certificate of need validity period is extended by the department for one additional period of 6 months, upon showing good cause by the applicant for the extension.~~

(1) A certificate of need shall expire unless an extension is granted pursuant to subsection (2):

(a) 1 year after its issuance if the applicant has not commenced construction on a project requiring construction or has not incurred an enforceable capital expenditure commitment for a project not requiring construction;

(b) 12 months from the estimated time for completion as shown in the application if the approved project is not complete; or

(c) when the department withdraws a certificate of need for good cause as specified in rules adopted by the department.

(2) The holder of an unexpired certificate of need may apply to the department to extend the term of the certificate of need for one additional period not to exceed 6 months. The department may grant such an extension upon the applicant's demonstrating good cause as defined by department rule.

(3) The holder of an unexpired certificate of need shall report to the department in writing on the status of his project at the end of each 90 day period after being granted a certificate of need and thereafter until completion of the project for which the certificate of need was issued."

28.

Section 12 . Section 50-5-306, MCA, is amended to read:

29.

" 50-5-306. ~~Right to hearing and appeal.~~ ~~(1) The applicant or a health systems agency designated pursuant to Title XV of the Public Health Service Act may request and shall be granted a public hearing before the department to reconsider its decision, if the request is received by the department within 30 calendar days after the decision is announced. Any other affected person may, for good cause, request the department to reconsider its decision at such a hearing. The department shall grant the request if the affected person submits the request in writing showing good cause as defined in rules adopted by the department and if the request is received by the department within 30 calendar days after the decision is announced. The public hearing to reconsider shall be held, if warranted or required, within 30 calendar days after its request. The department shall make its final decision and written findings of fact and conclusions of law in support thereof within 45 days after the conclusion of the reconsideration hearing. The hearing shall be conducted in accordance with 2-4-601 through 2-4-625.~~

~~(2) An aggrieved applicant or a health systems agency designated pursuant to Title XV of the Public Health Service Act may appeal the department's final decision to the board by filing a written notice of appeal stating the specific findings of fact and conclusions of law being appealed and the grounds. The notice of appeal must be received by the board within 30 calendar days after formal notice of the department's final decision was issued. The board shall give public notice of the appeal within 10 days, and the hearing shall be held within 30 days after receipt of the notice of appeal.~~

~~(3) The scope of the hearing before the board is limited to a review of the record upon which the department made its decision. The board, upon request of any party to an appeal before the board, shall hear oral arguments and receive written briefs. Within 45 calendar days after the conclusion of the public hearing, the board shall make and issue its decision, supported by written findings of fact and conclusions of law. The board may affirm the department's decision or remand it for further proceedings. The board may reverse or modify the department's decision if the appellant's rights have been prejudiced for any of the reasons found in 2-4-704.~~

~~(4) The final decision of the board shall be considered the decision of the department for purposes of an appeal to district court. Any affected person may appeal this decision to the district court as provided in Title 2, chapter 4, part 7.~~ (2)-(4) remain see next page

(5) The department may by rule prescribe in greater detail the hearing and appellate procedures.

History: En. Sec. 170, Ch. 197, L. 1967; amd. Sec. 21, Ch. 366, L. 1969; amd. Sec. 2, Ch. 447, L. 1975; R.C.M. 1947, 69-5212(6); amd. Sec. 16, Ch. 347, L. 1979.

Appeal of certificate of need decisions.

29. (1) Within 15 days after formal notice of the department's decision is issued, an affected person may, for good cause shown as defined in rules adopted by the department, request a hearing before the department to reconsider its decision. A hearing to reconsider the decision, if warranted, shall commence within 30 days after the request is received, and a final decision shall be issued within 45 days after conclusion of the hearing.

(2) An affected person does not have to request the department to hold a reconsideration hearing prior to filing an administrative appeal to the board. An affected person may appeal the department's final decision to the board by filing a written notice of appeal stating the specific findings of fact and conclusions of law being appealed and the grounds therefore. The notice of appeal must be received by the board within 30 days after formal notice of the department's final decision was issued. The board shall give public notice of the appeal and the hearing shall commence within 30 days after receipt of the notice of appeal.

(3) The hearing before the board shall be a hearing de novo conducted pursuant to the contested case provisions of the Montana Administrative Procedure Act. Within 45 days after the conclusion of the hearing, the board shall make and issue its decision, supported by written findings of fact and conclusions of law. The board may affirm, reverse, or modify the department's decision.

(4) Any affected person or the department may appeal the decision of the board to the district court as provided in Title 2, Chapter 4, part 7.

(5) The department may by rule prescribe in greater detail the hearing and appellate procedures. "

Section 13. Section 50-5-308, MCA, is amended to read:

"50-5-308. Special circumstances. ~~In the event of destruction of any part of a health care facility as a result of fire, storm, civil disturbance, or any act of God, the department may issue a certificate of need for only the replacement of the previously existing facility or portion thereof.~~

The department shall issue a certificate of need for a proposed capital expenditure if:

(1) the capital expenditure is required to eliminate or prevent immenent safety hazards as defined by federal, state or local fire, building or life safety codes or regulations, to comply with state licensure, certification, or accreditation standards; and

(2) the department has determined that the facility or service for which the capital expenditure is proposed is needed and the obligation of the capital expenditure is consistent with the state health plan."

Section 14. Codification instruction. Section 7 is intended to be codified as an integral part of Title 50, chapter 5, part 2, and the provisions of Title 50, chapter 5, part 2, apply to section 7.

Section 15. Codification instruction. Section 2 is intended to be codified as an integral part of Title 50, Chapter 5, Part 1, and the provisions of Title 50, Chapter 5, Part 1, apply to section 2.

Section 16. Saving Clause. This act does not affect rights and duties that matured, penalties that matured, penalties that were incurred, or proceddings that were begun before the effective date of this act.

Section 17. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

HOUSE BILL 513

1981 Legislative Session

House Public Health, Welfare and Safety Committee

February 2, 1981

Proposed amendments of the Department of Health and Environmental Sciences:

1. Page 8, line 3
   Following "of"
   Strike: "the act."
   Insert: "that Act."

2. Page 16, line 17
   Strike: "of"
   Insert: "by"

3. Page 23, line 13
   Following "in"
   Insert: "a"

4. Page 23, line 22
   Strike: "(1)(f)"
   Insert: "(2)(e)"

5. Page 31, line 4
   Following subsection (3)
   Insert: New subsection (4)

   "(4) If an appeal is filed challenging the granting of a certificate of need, the period of validity of the certificate of need shall be stayed until a final decision has been issued."

Exhibit II

NAME RALPH GILDROY BILL No. 513

ADDRESS 324 FULLER AVE HELENA DATE 2/2/81

WHOM DO YOU REPRESENT MONTANA HEALTH SYSTEMS AGENCY

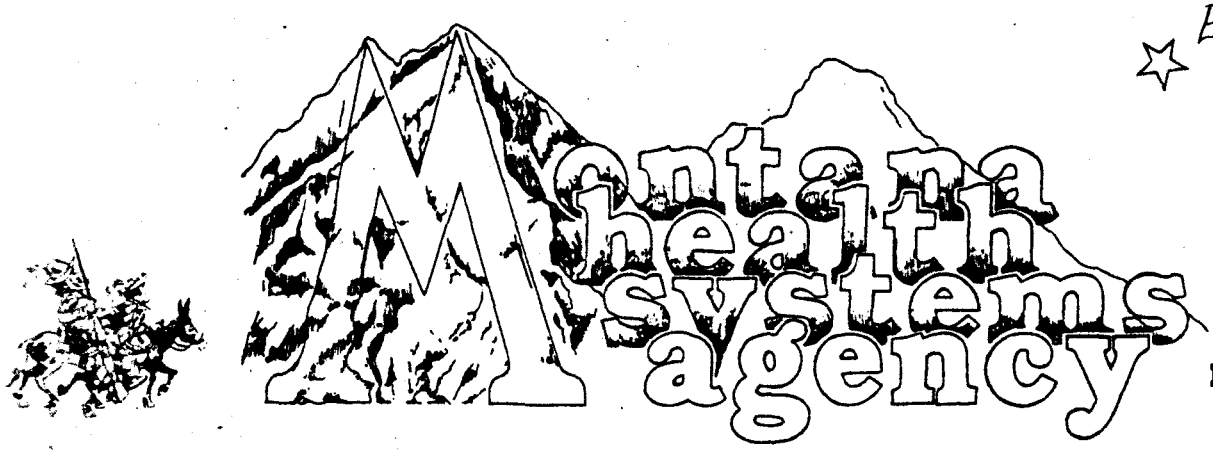
SUPPORT ✓ OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: ATTACHED

FORM CS-34
1-81

Exhibit II



Ralph Gildroy
Executive Director

324 Fuller Avenue • Helena, Montana 59601 • (406) 443-5965

FEBRUARY 2, 1981

IN SUPPORT OF HOUSE BILL 513

Mr. Chairman and members of the committee, for the record, my name is Ralph Gildroy. I am the Executive Director of the Montana Health Systems Agency, Inc. I am here for the purpose of conveying to you the Montana Health Systems Agency's resolution of support for House Bill 513.

The Health Systems Agency performs its mandated functions and responsibilities under Public Law 93-641, the National Health Planning and Resources Development Act of 1974, and as amended in Public Law 96-79. The Health Systems Agency works very closely with the Hospital and Medical Facilities Division of the Montana Department of Health and Environmental Sciences. In the testimony presented by the administrator of the Hospital and Medical Facilities Division you have been informed of the necessity for amending the Montana Certificate of Need Law. You have been alerted as to the probable reductions of Federal funds in accordance with Section 1521(d) of Public Law 96-79. You have been made aware of some providers' criticisms of Certificate of Need.

Over the past several years the Health Systems Agency has worked very diligently and very closely with the State Agency to mitigate both the applicant's work load and any added cost which may be attributed to the Certificate of Need review process. Considerable progress has been made. The review process is a positive and a supportive process. Every effort is made by both Agencies to assist and advise the applicant in meeting those standards and criteria which seek to balance cost containment with accessibility of health care.

The principle role of the Montana Health Systems Agency in the Certificate of Need process is the provision of consumer input and expertise for review decisions. As in all other pies, the health pie is shrinking. There are fewer and fewer dollars to go around. It is extremely important that consumers have a voice in any actions which add to health care costs. It is important that consumers have the opportunity to express their value judgments as to the degree and the amount of accessible health care. For these express purposes the Montana Health Systems Agency has in place five Subarea Advisory Councils comprised of 104 volunteers donating their time and money to improve the health systems of Montana. It also has a Governing Board of forty two and approximately 100 on various task forces. These volunteers are well trained and knowledgeable about both plan development

OVER

and plan implementation.

Last year Montana volunteers contributed over 20,000 hours in attending monthly meetings for the purpose of developing health standards and criteria and applying them to the review processes. Many additional hours are spent by these volunteers in the study and analyses of applications and plan components. This degree of voluntarism is without peer in Montana and it is a tribute to the need for sound planning and review including certificate of need.

Both the State Agency and the Health Systems Agency are continuing to cooperate to the fullest in eliminating duplication, simplifying the formats, providing technical expertise, sharing expenses and accomplishing the best possible balance between the accessibility and cost containment of health care.

The Montana Health Systems Agency supports House Bill 513 and urges this committee to give a "do pass" recommendation.

Ralph Gildroy

RALPH GILDROY, EXECUTIVE DIRECTOR

Exhibit III

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59601

TESTIMONY ON HOUSE BILL 513:

My name is Judy Olson, and I represent the Montana Nurses' Association. I wish to speak in support of HB 513.

Health care and the entire health care delivery system have surely become a controversial issue in the past few years, and rightly so -- controversial in respect to poor planning, fragmentation, duplication of services, and constantly rising costs.

Certificate of need has not been uncontroversial by any means. New laws are not without problems, and it takes time to develop their effectiveness. We believe that is now just happening in Montana, and wonder if that is why it is becoming so unpopular with the opponents.

Consumers in our state and nationwide are no longer willing to sit back and quietly accept what has happened to them in an unorganized health care system. Consumers in every county in our state are participating in the certificate of need law in their subarea advisory councils. Nurses all over the state are working as consumer advocates through this law.

We all are consumers and believe that all people have a right to help determine what is appropriate in our own communities related to our own health care services. Through certificate of need there is an opportunity for maximum community and grass roots input.

The federal government has mandated that Montana's certificate of need law be brought into compliance with federal standards -- or Montana will lose its federal funding. To try to second guess the federal government and the new Reagan administration by ignoring this mandate may place this state in serious jeopardy. Certainly we all know that President Reagan is determined to cut the cost of federal government; and we certainly agree that this needs to be done. We do not agree that we can afford to test fate and have the life lines cut from our health care programs in Montana. By ignoring federal mandate as it relates to certificate of need, we are blatently encouraging, if not inviting, the federal government to enforce withholding public service funds from this state and any state that does not comply with certificate of need.

We respectfully request that you give an unanimous "do pass" to HB 513, and thank you for this opportunity to present testimony on this vital issue that concerns the health care of every Montana citizen.

Exhibit IV

NAME Pat Petaja BILL No. HB 513

ADDRESS 309 No HORACK DATE Feb 2, 1981

WHOM DO YOU REPRESENT Montana Health Systems Agency

SUPPORT ✓ OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

Read Statement by Sharon Duerger, Chairman Governing Board Montana Health Systems Agency

FORM CS-34
1-81

Exhibit IV

Montana health systems agency

Ralph Gildroy
Executive Director

324 Fuller Avenue • Helena, Montana 59601 • (406) 443-5965

February 2, 1981

Budd Gould, Chairman
Public Health - Human Services
House Committee
Capitol Building
Helena, MT 59620

Dear Mr. Gould:

On behalf of the 104 members of the Montana Health Systems Agency Sub-area Advisory Councils and the 42 members of the Governing Board, I urge your support of House Bill 513.

Our council and board are comprised of a majority of consumers. In view of the rural nature of Montana, both Providers and Consumers are concerned about a balance between accessibility and cost containment.

Recognizing that there are increasingly limited Health Care Dollars available, it is important that the people at a community level have the opportunity to voice their input. For this reason, Certificate of Need Review is necessary.

We would appreciate your support and a "do pass" vote on House Bill 513.

Sincerely,

Sharon Dieziger (sjp)

Sharon Dieziger, R.N., Chairman

SD/sjp

Exhibit V

NAME Ben Bushyhead BILL No. HB 513

ADDRESS 846 Front St. DATE 2-2-81

WHOM DO YOU REPRESENT MONT. UNITED INDIAN ASSOCIATION

SUPPORT X OPPOSE AMEND

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

Exhibit V

Montana United Indian Association

P.O. Box 5988
Helena, MT
59601

M U I A

February 02, 1981

PUBLIC HEALTH COMMITTEE
STATE CAPITOL
HELENA, MT 59601

DEAR COMMITEE MEMBERS,

FOR THE RECORD MY NAME IS BEN BUSHYHEAD, EXECUTIVE DIRECTOR OF THE MONTANA UNITED INDIAN ASSOCIATION LOCATED IN HELENA, MONTANA.

THE MONTANA UNITED INDIAN ASSOCIATION WISHES TO THANK THE COMMITTEE FOR PROVIDING US THE OPPORTUNITY TO PRESENT OUR TESTIMONY REGARDING HB513.

ON BEHALF OF THE MONTANA UNITED INDIAN ASSOCIATION AND THE MONTANA INTER-TRIBAL POLICY BOARD, JOINTLY REPRESENTING A CONSTITUENCY OF 50,000 INDIAN PEOPLE OF MONTANA, WE STRONGLY URGE THE PASSAGE OF HB513.

THE POSSIBLE RAMIFICATIONS WHICH THIS BILL WILL HAVE, IF NOT PASSED, CAN BE MEASURED IN THE LOSS OF DOLLARS BUT MORE IMPORTANTLY CAN BE MEASURED IN THE LOSS OF SERVICES TO ALL MONTANANS.

MORE SPECIFICALLY, THE EFFECTS ON THE INDIAN POPULATION COULD PROVE DEVASTATING. ALCOHOLISM IS THE NUMBER ONE HEALTH PROBLEM OF MONTANA'S INDIAN POPULATION WITH A RATE AS HIGH AS 70%.

DRUG ABUSE IS ON THE RISE ESPECIALLY AMONG INDIAN YOUTH WHERE GASOLINE, PAINT AND GLUE SNIFFING ARE REPLACING THE MORE CONVENTIONAL AND SOPHISTICATED DRUGS.

WE ARE MAKING STRIDES TOWARD THE SOLVING OF THESE PROBLEMS UTILIZING THE PREMISE THAT INDIANS KNOW THEIR PROBLEMS AND CAN DEVELOP THE SOLUTIONS TO THOSE PROBLEMS.

WITHOUT THE PASSAGE OF THIS BILL THE POSSIBLE LOSS OF REVENUE TO THE INDIAN PROGRAMS WOULD PERMIT THE EPIDEMIC OF ALCOHOLISM TO RUN RAMPANT AND UNCHECKED. ALL AVAILABLE RESOURCES INCLUDING MENTAL HEALTH AND FAMILY PLANNING ARE NEEDED TO COMBAT THE PROBLEMS OF ALCOHOLISM AND DRUG ABUSE WITH MANY ADDITIONAL RESOURCES NEEDED RATHER THAN BEING DIMINISHED AS COULD BE THE CASE WITH HB513's FAILURE TO PASS.

Exhibit VI

mnha
MONTANA NURSING
HOME ASSOCIATION

34 So. Last Chance Mall, No. 1
Helena, Montana 59601
Telephone: 406-443-2876

HOUSE BILL 513

Testimony before House Public Health Committee - February 2, 1981

For the record, my name is Rose Skoog. I am the executive director of the Montana Nursing Home Association and make this statement on behalf of that association.

We wish to go on record as supporting HB 513. While we oppose the federal mandate to amend the certificate of need statutes we support the Department of Health and Environmental Sciences in its efforts to bring Montana's law into compliance with the federal regulations in order to safeguard health planning funds flowing into the state and to safeguard the health planning process itself.

We do, however, wish to offer some amendments to the proposed legislation and ask your consideration of the following:

1. Amend page 1, line 25 and page 2, line 1, by re-inserting the following words: "health care facilities located in the geographic area affected by the application".

Purpose: to insure that health care facilities are included as interested parties and receive notice of various activities affecting them.

2. Amend page 6, lines 18-24 as follows:

Delete: All of lines 18 through 24.
Insert: ~~(i)~~ (b) "Skilled nursing care" means the provision of nursing care services, health related services, and social services furnished pursuant to physician order under the supervision of a licensed registered nurse on a 24 hour basis.

Purpose: To conform to requirement that skilled nursing facility employ registered nurse on 24 hour basis.

It is my understanding that the Department has no objections to these amendments.

One additional area of major concern to us is Section 7, a new section dealing with receivership. This section runs from page 15 through 19. This section is not required by federal mandate.

Our association has serious reservations about this entire section. As written, it appears to be constitutionally deficient. It provides for the taking of property with no real safeguards built in for the person whose property is being taken. It also mandates that its provisions take priority over any civil or criminal case pending in the district court wherein an application for receivership is filed. This, too, seems constitutionally suspect.

We ask that the entire section be deleted.

However, if the Department demonstrates a real need for this type of legislation and you feel you want to enact this type of provision, we ask consideration of the following amendments, aimed at tightening up the requirements and providing some protection to those owning and operating long term care facilities:

1. Amend page 15, line 18, as follows:

Delete: the word "or"
Insert: the words "and such action by the Department has not been appealed by the licensee, owner or lessee; or, if the department's action has been appealed, all remedies have been exhausted and the department's action has been upheld; or"

2. Amend page 15, line 21, as follows:

Delete: the period
Insert: "; and such action by the department has not been appealed by the licensee, owenr or lessee; or, if the department's action has been appealed, all remedies have been exhausted and the department's action has been upheld."

3. Page 16, lines 14-17

Delete: All of subsection 3; renumber following subsections.

4. Amend page 16, line 25 and page 17, lines 1 through 4:

Delete: page 16, line 25 and page 17, lines 1 through 4
Insert: "(c) that there is a reasonable likelihood of transfer trauma or other serious harmful effects to patients if care is not continued on a temporary basis pending arrangements for the lease, sale, or closure of the facility; and"

"(d) that all other alternatives have been examined and receivership is the only viable alternative for the protection of patients pending arrangements for the lease, sale or closure of the facility."

5. Amend page 18, line 22

Delete: the term "180"
Insert: "90"

We urge your positive consideration of our amendments, and of HB 513 as amended.

Exhibit VII

NAME Ken Rutledge BILL No. HB 513

ADDRESS P. O. Box 5119 DATE Feb 2, 1981

WHOM DO YOU REPRESENT Montana Hospital Association

SUPPORT _____ OPPOSE ✓ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments:

FORM CS-34
1-81

Exhibit VII

TESTIMONY ON HB 513
by
Ken Rutledge, Vice President, Montana Hospital Association

At its October 27, 1980 meeting, the Board of Trustees of the Montana Hospital Association (MHA) unanimously adopted a position to oppose any legislation aimed at bringing the Montana Certificate of Need law into compliance with the federal regulations for state certificate of need laws as published in the Federal Register on October 21, 1980. This position was reaffirmed at our December 18 meeting of the Board. Our position of opposition to passage of House Bill 513 is based on a number of considerations, but the primary factor upon which our opposition is based is the fact that this bill has nothing to do with the needs of Montana, but rather reflects the dictates of the federal bureaucracy in Washington, D.C. and the former Carter Administration.

We feel there are a number of questions this committee must address with respect to HB 513, including the following:

1. Is this legislation needed in Montana?
2. What is the potential impact on Montana's health care delivery system if this bill is passed?
3. How real is the threat of the withholding of federal funds if this bill is not passed?

I will begin by addressing the question of whether this certificate of need legislation is needed in Montana. The purpose of certificate of need laws, put very simply, is to help restrain the increase in health care costs, particularly those attributable to hospital services. Whether or not such laws actually do have a restraining influence on hospital costs is a question which will be addressed when this committee takes testimony on HB 458, a bill to repeal Montana's CON statute.

I am certain that every member of this committee has heard or read about hospitals costs being "out of control" or that they are increasing at a "tremendous

rate". Most of these claims were originated by the same federal bureaucracy which is now trying to force the contents of HB 513 upon Montana. For the most part it has simply been assumed that these claims are also applicable to Montana.

Attached to the written text of our testimony are a number of tables which give an indication of how well Montana hospitals have managed to control their expenditures as compared with the rest of the nation.

On Table I we have listed the 1967 hospital expenditures of each state, their 1979 expenditures and the cumulative percentage increase over that 12 year period. 1967 is used as the base year because it was that year the Medicare and Medicaid programs became fully operational and government started to become concerned about the cost of health care. The states are ranked in order of their percentage increase in hospital expenditures from highest to lowest. As you can see, Montana ranks 50th in the nation, more than 130 percentage points below the national average. The average yearly increase in hospital expenditures for Montana was about 12.7% compared with a U.S. average of 15.6% per year.

Tables 2, 3 and 4 show how Montana hospital expenditures have fallen behind the rest of the nation over the 12 year period from 1967 to 1979. Looking at those three tables you can see that in 1967 Montana ranked 26th in the nation in hospital expenditures per capita, $6.00 less than the national average. By 1976, Montana had fallen to 40th place in terms of per capita hospital expenditures, some $63 less than the national average. In 1979, the most recent year for which data on all the states is available, Montana had gone to 46th place in the nation with per capita hospital expenditures which were $97 less than the national average. In terms of its percentage of increase in per capita expenditures, Montana ranked 49th in the nation, trailed only by Wyoming and Vermont.

The final indicator of hospital expenditures which should be mentioned is the average cost per admission or per case. In 1967 Montana's average expenditures

per hospital admission ranked 43rd in the nation, $131 below the national average; by 1976 we had fallen to 47th place in the nation, $496 less than the national average and finally, in 1979 Montana ranked 48th in the nation, with an average cost per admission which was $555 less than the national average.

The significance of these statistics is very clear; Montana is not experiencing "run away" hospital costs. In fact, there might be some cause for alarm based on our fall from 26th in the nation in hospital expenditures per capita in 1967 to 48th place in 1979, that Montanan's are falling behind the nation in terms of the level of hospital services offered to them. In 1979 the Washington, D.C. bureaucrats who are forcing this new law upon us had an average of $741 in hospital costs compared with $203 for the average Montanan.

Do we then need a more stringent certificate of need law in Montana? I believe that the answer to that question is very clearly, No, we do not.

The next question I would like to address is what potential impact this bill would have on Montana's health care delivery system.

If you turn to attachment #1 you will see a list of the 15 significant changes in our state CON law which would result if HB 513 is passed. Because of time limitations I will very briefly address just 5 of those provisions:

Number 2, which would expand the definition of construction. As a result of this change, the plans and specifications of <u>any</u> remodeling must be approved by the Department of Health before they can be undertaken. The result of this change will be more paperwork, more delays and higher costs.

Number 4, which requires CON coverage of a new service, even if no capital expenditure takes place. This could result in hospitals being forced to apply for a certificate of need each time they succeeded in recruiting a physician with a new specialty or when they contracted with another organization to provide services to the hospital if the annual direct and indirect costs exceeded $75,000. The result, more paperwork, more delays, more cost.

Number 9, requires that similar projects be reviewed together, thus increasing the pressure on hospitals to pursue the addition of new services whenever another hospital makes a proposal.

Number 11, which eliminates specific certificate of need review criteria for Montana, and adopts all federal criteria. One such federal criterion as listed in the October 21, 1980, Federal Register would require that a hospital address in writing the extent to which low income persons, racial and ethnic minorities, women and handicapped persons, use the hospital services in comparison to the percentage of the population in the hospital service area which fit those characteristics, and also to what degree such persons are expected to use the service which the hospital has applied for under the CON law. The federal regulations list 21 separate criteria which must be addressed, many which have detailed instructions on how they must be applied to certificate of need applications.

Finally, Number 13 would require reports every 90 days on the status of projects approved under CON.

These five proposed changes in the Montana CON law together with others listed on attachment #1 will not improve our health care delivery system, nor will they restrain costs. What they will do is increase paperwork, delay needed improvements in our hospitals and add to the already exhorbitant cost of regulations which must be borne by hospitals and ultimately by their patients.

Finally we turn to the question of how real is the threat that federal health funds will be withheld if HB 513 is not passed.

Prior to the introduction of HB 513 we informed officials at the State Department of Health that it is difficult to believe that the new Reagan Administration, with its call for a reduction in federal interference and increased state control, will carry out a policy of withholding federal health funds from states which refuse to carry out dictates developed by the former Carter Administration.

Despite the logic of our arguments, the Department of Health has introduced HB 513, not because it is needed in Montana, but because they fear the blackmail threat of a former Congress and a former Administration.

While we understand the Department's concern about the loss of federal funds, we do not believe the new Administration in Washington, D.C. will carry out an action which is so totally in conflict with its philosophy on the role of the federal government versus the role of state and local government. Apparently we are not the only state hospital association which has this belief. On December 5, the Montana Hospital Association sent a CON survey to all state hospital associations in the nation so we could better evaluate the number of states which might be out of compliance with federal requirements. Attached you will find a summary of the results of that survey (attachment #2) with a list of the 17 states which very likely will be out of compliance. I would like to also point out that with the exception of Louisiana which does not have a certificate of need law, the state hospital associations listed all supported the certificate of need laws which are currently in effect in those states. I would also like to draw your attention to attachment #3, the California Hospital Association's January 23 newsletter, wherein they report that on January 21 the director of the California office of Statewide Health Planning and Development informed the California Senate Health and Welfare Committee that his office does not plan to sponsor conforming legislation because the new Reagan Administration is unlikely to cut off funds should California fail to comply. The amount of federal health dollars which could be affected in California is $600 million.

In closing I would like to inform you that the Montana Hospital Association is currently working with other state hospital associations and the American Hospital Association to eliminate any threat of the withholding of federal health dollars. We are at this time pursuing three possible courses of action to insure that this federal blackmail threat is eliminated. The Executive Committee of the

Montana Hospital Association is currently in Washington, D.C. to take part in a strategy session which the American Hospital Association is holding as a part of its annual meeting and tomorrow will be meeting with our congressional delegation to gain their support in eliminating federal sanctions against states like Montana. I would urge you to vote Do Not Pass on HB 513.

DHES' Proposed Changes in Montana Laws Relating to Health Care Facilities, Licensing and Certificate of Need

1. Redefines "affected persons" under CON to include, in effect, any person living in Montana. As a result anyone in the state can demand a public hearing on a CON application.

2. Expands the definition of "construction" to include any remodeling or renovation of an existing health care facility. While this definition change does not appear to affect the scope of coverage under CON, it will result in a requirement that plans and specifications for any remodeling or renovation must be approved, in writing, by DHES before it is undertaken by a health care facility.

3. Creates a new section of the law whereby a long-term care facility may be placed in receivership when DHES has refused to issue a new license, a renewal license, has revoked a license, or when the department has taken action to suspend the license of any such facility.

4. Expands CON coverage to the addition of a new service, even if no capital expenditure takes place if the annual operating expenses of the service are $75,000 or greater.

5. Expands CON coverage to the acquisition by any person of major medical equipment (costing more than $150,000) if:

   a. The equipment will be used on hospital inpatients on anything other than a temporary basis in the case of a natural disaster, a major accident or equipment failure.

   b. The person fails to submit a letter of intent at least 30 days prior to the purchase of major medical equipment.

6. Expands coverage to purchases of health care facilities if the purchaser fails to submit a letter of intent to the department and the HSA 30 days prior to the effective purchase date.

7. Requires the submission of a letter of intent to the department and the HSA 30 days prior to any purchase of major medical equipment by any person.

8. Requires the submission of a letter of intent to the department and the HSA 30 days prior to a change in ownership of a health care facility.

9. Requires "batching" of applications for similar proposals so that such proposals can be reviewed in relationship to each other.

10. Provides that if an applicant for a CON fails to submit requested additional information by the deadline prescribed by the department that a new letter of intent and CON application must be submitted.

11. Eliminates specific CON review criteria and replaces such criteria with a reference to all federal requirements.

12. Adds a provision whereby the department can withdraw a CON for "good cause".

(over)

13. Requires written reports every 90 days on the status of projects approved under CON. (The current law requires reports every six months.)

14. Requires "good cause" be shown prior to the granting of a reconsideration hearing

15. Provides that CON appeals before the Board of Health will be "de novo" hearings (not based on an already existing official record).

SUMMARY OF MHA SURVEY RESULTS ON STATE HOSPITAL ASSOCIATION POSITIONS ON COMPLYING CERTIFICATE OF NEED LEGISLATION

State hospital associations opposed to complying certificate of need legislation:

1. Arizona
2. Colorado
3. Georgia
4. Idaho
5. Indiana
6. Louisiana (Does not currently have a CON law.)
7. Minnesota (With qualifications)
8. Missouri
9. Montana
10. Nevada
11. Oregon
12. Pennsylvania (Limited to only one aspect of compliance.)
13. Virginia
14. Wyoming

Additional state hospital association positions of interest:

Washington has a complying CON law, but intends to introduce legislation to take its law out of compliance.

Vermont and Iowa did not indicate opposition to a complying CON law, but did not feel their state CON laws would be brought into compliance by the federal deadline.

cha NEWS

Myers Reports A Potential Deficit Of $102 Million This Year In The Medi-Cal Program

Director of Health Services Beverlee Myers said Wednesday that Medi-Cal expenditures are exceeding projections, and by the end of the fiscal year, June 30, the Medi-Cal program faces a potential deficit of $102 million. Myers discussed the deficit Wednesday at a Los Angeles meeting of the Advisory Committee on Health and Medical Care Services, and she suggested three possible solutions: (1) reduce reimbursement to providers, other than hospital inpatient and skilled nursing facilities, by up to 10 percent and postpone elective services; (2) introduce legislation for a deficiency appropriation; or (3) continue business as usual, but not pay the last two checkwrites in June. The last alternative would have the heaviest impact on hospitals and nursing homes. Myers said she is seeking input from providers about the most feasible and palatable alternative.

"At This Point," Zaretsky Won't Sponsor A Major Health Planning Conformity Bill

The Office of Statewide Health Planning and Development does not plan to sponsor major health planning conformity legislation this year, director Henry Zaretsky told the Senate Health and Welfare Committee Wednesday. Zaretsky last year pushed a bill which failed, arguing then that it was needed to avert the cutoff of $600 million in federal funds. The deadline was extended to December of this year, but Zaretsky said in an interview yesterday that the new Reagan Administration is unlikely to cut off funds should California fail to comply. And with the current federal planning law due to expire in 1982, Zaretsky said a conformity measure "at this point" would be "counter-productive." OSHPD does intend to sponsor some "minor" clean-up planning legislation this year, Zaretsky said, and would like to work with the health care industry on a more comprehensive bill next year.

But there is nonetheless a law on the books which calls for compliance this year, and even if Zaretsky doesn't change his mind later, someone else could introduce a conformity bill. CHA and other health care providers are consequently moving ahead on preparation of a conformity bill for introduction this spring.

CHA Creates A Separate Corporation To Handle Four Insurance Programs

The CHA Board of Trustees yesterday voted to create a separate corporation to run four insurance programs. The major reason for the changeover is to protect CHA's status as a non-profit corporation, but the move is also expected to enhance management and control of the four insurance programs: professional liability, worker's compensation, group life, and tax sheltered annuity. The unemployment insurance program will remain under CHA.

The new corporation will have only one shareholder, CHA, and will be governed by a 21-member board of directors appointed by the CHA Board of Trustees at its annual meeting each year. The President of CHA will automatically be a member of the new corporation and will each year nominate the new corporation's President (its chief executive). Two of the directors must be physicians, two must be members of governing boards of hospitals, and 16 must be chief executive officers or designated representatives of CHA member hospitals.

CHA NEWS, published weekly at 925 L St., Suite 1250, Sacramento, California 95814, (916) 443-7401. Subscription price $10.00 per year for members of the California Hospital Association, $15.00 per year for non-members. Second-class postage paid at Sacramento, California. USPS (099-180)

TABLE 1

AGGREGATE HOSPITAL EXPENDITURES
(numerical list)
(in millions)

	State	1967	1979	Percentage Increase
1.	Alaska	8.3	98.1	1081.9
2.	Nevada	28.3	229.5	711.0
3.	Florida	346.0	2771.9	701.1
4.	Arizona	96.6	683.4	607.5
5.	Georgia	179.7	1241.7	591.0
6.	Mississippi	82.4	536.0	550.5
7.	Louisiana	171.7	1091.2	535.5
8.	Arkansas	75.1	474.6	532.0
9.	Tennessee	201.1	1267.7	530.4
10.	Oklahoma	113.3	710.2	526.8
11.	New Mexico	39.5	246.3	523.5
12.	Maine	50.3	312.9	522.1
13.	Alabama	163.2	1009.5	518.6
14.	Virginia	196.2	1209.6	516.5
15.	Texas	555.7	3384.6	509.1
16.	South Carolina	96.9	567.8	486.0
17.	Indiana	249.6	1449.7	480.8
18.	Utah	47.7	274.6	475.7
19.	Maryland	202.2	1160.4	473.9
20.	North Carolina	213.9	1226.5	473.4
21.	Idaho	29.6	168.5	469.3
22.	Michigan	558.7	3163.9	466.3
23.	Oregon	111.6	624.8	459.9
24.	Missouri	288.5	1608.8	457.6
25.	Illinois	757.1	4193.9	453.9
26.	California	1363.9	7535.0	452.5
27.	Ohio	619.1	3419.0	452.3
28.	Colorado	133.0	727.1	446.7
	U.S. Total	12081.5	66003.7	446.3
29.	Kansas	127.7	692.4	442.2
30.	Hawaii	35.3	191.3	441.9
31.	Delaware	29.3	158.3	440.3
32.	Kentucky	144.3	775.6	437.5
33.	Pennsylvania	725.9	3885.9	435.3
34.	Nebraska	82.3	438.5	432.8
35.	New Jersey	373.9	1961.6	424.6
36.	West Virginia	102.9	536.5	421.4
37.	Iowa	158.1	811.8	413.5
38.	Wisconsin	261.9	1329.5	407.6
39.	New Hampshire	39.0	194.7	399.2
40.	North Dakota	38.8	191.9	394.6
41.	Washington	173.5	844.9	387.0
42.	Massachusetts	488.3	2369.3	385.2
43.	Wyoming	15.8	76.6	384.8
44.	South Dakota	30.6	144.8	373.2
45.	Connecticut	197.2	918.8	365.9
46.	Rhode Island	63.9	295.8	362.9
47.	District of Columbia	106.4	485.9	356.7
48.	Minnesota	268.0	1206.9	350.3
49.	New York	1572.2	6821.2	333.9
50.	MONTANA *	38.7	159.4	311.9
51.	Vermont	28.3	112.9	298.9

HOSPITAL EXPENDITURES PER CAPITA - 1967

	1967 ($)	
1.	D.C.	$135.
2.	New York	88.
3.	Massachusetts	87.
4.	Minnesota	73.
5.	California	71.
6.	Rhode Island	70.
7.	Illinois	69.
8.	Connecticut	67.
8.	Vermont	67.
10.	Colorado	65.
10.	Michigan	65.
12.	Missouri	64.
13.	Nevada	63.
14.	North Dakota	62.
14.	Pennsylvania	62.
16.	Wisconsin	61.
*	U.S. AVERAGE	61.
17.	Arizona	59.
17.	Ohio	59.
19.	Kansas	58.
19.	West Virginia	58.
21.	Iowa	57.
22.	Delaware	56.
22.	Nebraska	56.
22.	New Hampshire	56.
22.	Oregon	56.
26.	Florida	55.
**26.	MONTANA	55.
26.	Washington	55.
29.	Maryland	54.
29.	New Jersey	54.
31.	Tennessee	52.
31.	Texas	52.
33.	Maine	50.
34.	Hawaii	49.
34.	Indiana	49.
34.	Wyoming	49.
37.	Louisiana	48.
38.	Alabama	47.
38.	Utah	47.
40.	Oklahoma	46.
40.	South Dakota	46.
42.	Kentucky	45.
43.	Virginia	44.
44.	Idaho	43.
44.	North Carolina	43.
46.	Georgia	41.
47.	Arkansas	40.
47.	New Mexico	40.
49.	South Carolina	38.
50.	Mississippi	37.
51.	Alaska	30.

TABLE 3

HOSPITAL EXPENDITURES PER CAPITA - 1976

	1976 ($)	
1.	D.C.	$482.
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3.	New York	301.
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*	U.S. AVERAGE	211.
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18.	New Jersey	196.
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21.	Delaware	193.
23.	Maine	191.
23.	Iowa	191.
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26.	Tennessee	188.
26.	Kansas	188.
28.	Vermont	186.
29.	Indiana	183.
30.	Oregon	177.
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8.	Illinois	$1,916
9.	Michigan	$1,892
10.	Connecticut	$1,831
11.	Nevada	$1,806
12.	Delaware	$1,781
13.	Arizona	$1,736
14.	Pennsylvania	$1,723
15.	Ohio	$1,674
16.	New Jersey	$1,672
17.	Hawaii	$1,663
	U.S. Average	$1,641
18.	Missouri	$1,629
19.	Minnesota	$1,601
20.	Florida	$1,597
21.	Wisconsin	$1,568
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29.	Washington	$1,354
30.	North Dakota	$1,348
30.	Oklahoma	$1,348
32.	Louisiana	$1,323
33.	Texas	$1,315
34.	Iowa	$1,313
35.	New Mexico	$1,297
35.	Vermont	$1,297
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8. Michigan	1567.
9. Delaware	1545.
10. Illinois	1493.
11. Arizona	1448.
12. New Jersey	1419.
13. Alaska	1391.
14. Nevada	1387.
15. Pennsylvania	1382.
* U.S. AVERAGE	1331.
16. Ohio	1317.
17. Hawaii	1285.
18. Florida	1273.
19. Wisconsin	1257.
20. Missouri	1227.
21. Minnesota	1215.
22. Vermont	1197.
23. Oregon	1187.
24. Maine	1181.
25. Colorado	1178.
26. Indiana	1161.
27. Virginia	1142.
28. Washington	1119.
29. Nebraska	1068.
30. New Mexico	1053.
31. New Hampshire	1040.
32. Texas	1016.
33. Oklahoma	1014.
34. Kansas	1012.
35. Georgia	1003.
36. Iowa	995.
36. North Dakota	995.
38. Louisiana	987.
39. North Carolina	982.
40. Tennessee	980.
41. Alabama	956.
42. West Virginia	955.
43. Utah	954.
44. South Carolina	934.
45. Kentucky	907.
46. Idaho	868.
**47. MONTANA	835.
48. Mississippi	811.
49. South Dakota	806.
50. Wyoming	787.
51. Arkansas	769.

HOSPITAL EXPENDITURES PER CAPITA - 1979

	State	Per Capita
1.	District of Columbia	741
2.	Massachussets	411
3.	New York	387
4.	Illinois	373
5.	Michigan	344
6.	California	332
7.	Missouri	331
7.	Pennsylvania	331
9.	Nevada	327
10.	Ohio	319
11.	Rhode Island	318
12.	Florida	313
	U.S. Total	300
13.	Minnesota	297
14.	Connecticut	295
15.	Kansas	292
15.	North Dakota	292
17.	Tennessee	289
18.	West Virginia	286
19.	Maine	285
20.	Wisconsin	282
21.	Iowa	280
21.	Maryland	280
23.	Arizona	279
23.	Nebraska	279
25.	Delaware	272
25.	Louisiana	272
27.	Alabama	268
27.	Indiana	268
27.	New Jersey	268
30.	Colorado	262
31.	Texas	253
32.	Oregon	247
33.	Oklahoma	246
34.	Georgia	243
35.	Alaska	242
36.	Virginia	233
37.	Vermont	229
38.	Mississippi	221
39.	Kentucky	220
39.	New Hampshire	220
41.	North Carolina	219
42.	Arkansas	218
43.	Washington	215
44.	South Dakota	210
45.	Hawaii	209
46.	MONTANA *	203
47.	Utah	201
48.	New Mexico	198
49.	South Carolina	194
50.	Idaho	186
51.	Wyoming	170

DHES' Proposed Changes in Montana Laws Relating to Health Care Facilities, Licensing and Certificate of Need

1. Redefines "affected persons" under CON to include, in effect, any person living in Montana. As a result anyone in the state can demand a public hearing on a CON application.

2. Expands the definition of "construction" to include any remodeling or renovation of an existing health care facility. While this definition change does not appear to affect the scope of coverage under CON, it will result in a requirement that plans and specifications for any remodeling or renovation must be approved, in writing, by DHES before it is undertaken by a health care facility.

3. Creates a new section of the law whereby a long-term care facility may be placed in receivership when DHES has refused to issue a new license, a renewal license, has revoked a license, or when the department has taken action to suspend the license of any such facility.

4. Expands CON coverage to the addition of a new service, even if no capital expenditure takes place if the annual operating expenses of the service are $75,000 or greater.

5. Expands CON coverage to the acquisition by any person of major medical equipment (costing more than $150,000) if:

   a. The equipment will be used on hospital inpatients on anything other than a temporary basis in the case of a natural disaster, a major accident or equipment failure.

   b. The person fails to submit a letter of intent at least 30 days prior to the purchase of major medical equipment.

6. Expands coverage to purchases of health care facilities if the purchaser fails to submit a letter of intent to the department and the HSA 30 days prior to the effective purchase date.

7. Requires the submission of a letter of intent to the department and the HSA 30 days prior to any purchase of major medical equipment by any person.

8. Requires the submission of a letter of intent to the department and the HSA 30 days prior to a change in ownership of a health care facility.

9. Requires "batching" of applications for similar proposals so that such proposals can be reviewed in relationship to each other.

10. Provides that if an applicant for a CON fails to submit requested additional information by the deadline prescribed by the department that a new letter of intent and CON application must be submitted.

11. Eliminates specific CON review criteria and replaces such criteria with a reference to all federal requirements.

12. Adds a provision whereby the department can withdraw a CON for "good cause".

(over)

13. Requires written reports every 90 days on the status of projects approved under CON. (The current law requires reports every six months.)

14. Requires "good cause" be shown prior to the granting of a reconsideration hearing.

15. Provides that CON appeals before the Board of Health will be "de novo" hearings (not based on an already existing official record).

SUMMARY OF MHA SURVEY RESULTS ON STATE HOSPITAL ASSOCIATION POSITIONS ON COMPLYING CERTIFICATE OF NEED LEGISLATION

State hospital associations opposed to complying certificate of need legislation:

1. Arizona
2. Colorado
3. Georgia
4. Idaho
5. Indiana
6. Louisiana (Does not currently have a CON law.)
7. Minnesota (With qualifications)
8. Missouri
9. Montana
10. Nevada
11. Oregon
12. Pennsylvania (Limited to only one aspect of compliance.)
13. Virginia
14. Wyoming

Additional state hospital association positions of interest:

Washington has a complying CON law, but intends to introduce legislation to take its law out of compliance.

Vermont and Iowa did not indicate opposition to a complying CON law, but did not feel their state CON laws would be brought into compliance by the federal deadline.

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Volume 12 Number 39 January 23, 1981

Myers Reports A Potential Deficit Of $102 Million This Year In The Medi-Cal Program

Director of Health Services Beverlee Myers said Wednesday that Medi-Cal expenditures are exceeding projections, and by the end of the fiscal year, June 30, the Medi-Cal program faces a potential deficit of $102 million. Myers discussed the deficit Wednesday at a Los Angeles meeting of the Advisory Committee on Health and Medical Care Services, and she suggested three possible solutions: (1) reduce reimbursement to providers, other than hospital inpatient and skilled nursing facilities, by up to 10 percent and postpone elective services; (2) introduce legislation for a deficiency appropriation; or (3) continue business as usual, but not pay the last two checkwrites in June. The last alternative would have the heaviest impact on hospitals and nursing homes. Myers said she is seeking input from providers about the most feasible and palatable alternative.

"At This Point," Zaretsky Won't Sponsor A Major Health Planning Conformity Bill

The Office of Statewide Health Planning and Development does not plan to sponsor major health planning conformity legislation this year, director Henry Zaretsky told the Senate Health and Welfare Committee Wednesday. Zaretsky last year pushed a bill which failed, arguing then that it was needed to avert the cutoff of $600 million in federal funds. The deadline was extended to December of this year, but Zaretsky said in an interview yesterday that the new Reagan Administration is unlikely to cut off funds should California fail to comply. And with the current federal planning law due to expire in 1982, Zaretsky said a conformity measure "at this point" would be "counter-productive." OSHPD does intend to sponsor some "minor" clean-up planning legislation this year, Zaretsky said, and would like to work with the health care industry on a more comprehensive bill next year.

But there is nonetheless a law on the books which calls for compliance this year, and even if Zaretsky doesn't change his mind later, someone else could introduce a conformity bill. CHA and other health care providers are consequently moving ahead on preparation of a conformity bill for introduction this spring.

CHA Creates A Separate Corporation To Handle Four Insurance Programs

The CHA Board of Trustees yesterday voted to create a separate corporation to run four insurance programs. The major reason for the changeover is to protect CHA's status as a non-profit corporation, but the move is also expected to enhance management and control of the four insurance programs: professional liability, worker's compensation, group life, and tax sheltered annuity. The unemployment insurance program will remain under CHA.

The new corporation will have only one shareholder, CHA, and will be governed by a 21-member board of directors appointed by the CHA Board of Trustees at its annual meeting each year. The President of CHA will automatically be a member of the new corporation and will each year nominate the new corporation's President (its chief executive). Two of the directors must be physicians, two must be members of governing boards of hospitals, and 16 must be chief executive officers or designated representatives of CHA member hospitals.

CHA NEWS, published weekly at 925 L St., Suite 1250, Sacramento, California 95814, (916) 443-7401. Subscription price $10.00 per year for members of the California Hospital Association, $15.00 per year for non-members. Second-class postage paid at Sacramento, California. USPS (099-180)

TABLE 1

AGGREGATE HOSPITAL EXPENDITURES
(numerical list)
(in millions)

	State	1967	1979	Percentage Increase
1.	Alaska	8.3	98.1	1081.9
.	Nevada	28.3	229.5	711.0
.	Florida	346.0	2771.9	701.1
4.	Arizona	96.6	683.4	607.5
.	Georgia	179.7	1241.7	591.0
.	Mississippi	82.4	536.0	550.5
7.	Louisiana	171.7	1091.2	535.5
8.	Arkansas	75.1	474.6	532.0
.	Tennessee	201.1	1267.7	530.4
10.	Oklahoma	113.3	710.2	526.8
11.	New Mexico	39.5	246.3	523.5
1 .	Maine	50.3	312.9	522.1
1	Alabama	163.2	1009.5	518.6
14.	Virginia	196.2	1209.6	516.5
1 .	Texas	555.7	3384.6	509.1
1 .	South Carolina	96.9	567.8	486.0
17.	Indiana	249.6	1449.7	480.8
18.	Utah	47.7	274.6	475.7
1 .	Maryland	202.2	1160.4	473.9
20.	North Carolina	213.9	1226.5	473.4
21.	Idaho	29.6	168.5	469.3
2	Michigan	558.7	3163.9	466.3
2	Oregon	111.6	624.8	459.9
24.	Missouri	288.5	1608.8	457.6
2 .	Illinois	757.1	4193.9	453.9
2	California	1363.9	7535.0	452.5
27.	Ohio	619.1	3419.0	452.3
28.	Colorado	133.0	727.1	446.7
	U.S. Total	12081.5	66003.7	446.3
29.	Kansas	127.7	692.4	442.2
30.	Hawaii	35.3	191.3	441.9
3 .	Delaware	29.3	158.3	440.3
3	Kentucky	144.3	775.6	437.5
33.	Pennsylvania	725.9	3885.9	435.3
3 .	Nebraska	82.3	438.5	432.8
3	New Jersey	373.9	1961.6	424.6
36.	West Virginia	102.9	536.5	421.4
3 .	Iowa	158.1	811.8	413.5
3 .	Wisconsin	261.9	1329.5	407.6
39.	New Hampshire	39.0	194.7	399.2
40.	North Dakota	38.8	191.9	394.6
4 .	Washington	173.5	844.9	387.0
4	Massachusetts	488.3	2369.3	385.2
43.	Wyoming	15.8	76.6	384.8
4 .	South Dakota	30.6	144.8	373.2
4	Connecticut	197.2	918.8	365.9
46	Rhode Island	63.9	295.8	362.9
47.	District of Columbia	106.4	485.9	356.7
4 .	Minnesota	268.0	1206.9	350.3
49.	New York	1572.2	6821.2	333.9
50.	MONTANA *	38.7	159.4	311.9
5 .	Vermont	28.3	112.9	298.9

HOSPITAL EXPENDITURES PER CAPITA - 1967

	1967 ($)	
1.	D.C.	$135.
2.	New York	88.
3.	Massachusetts	87.
4.	Minnesota	73.
5.	California	71.
6.	Rhode Island	70.
7.	Illinois	69.
8.	Connecticut	67.
8.	Vermont	67.
10.	Colorado	65.
10.	Michigan	65.
12.	Missouri	64.
13.	Nevada	63.
14.	North Dakota	62.
14.	Pennsylvania	62.
16.	Wisconsin	61.
*	U.S. AVERAGE	61.
17.	Arizona	59.
17.	Ohio	59.
19.	Kansas	58.
19.	West Virginia	58.
21.	Iowa	57.
22.	Delaware	56.
22.	Nebraska	56.
22.	New Hampshire	56.
22.	Oregon	56.
26.	Florida	55.
**26.	MONTANA	55.
26.	Washington	55.
29.	Maryland	54.
29.	New Jersey	54.
31.	Tennessee	52.
31.	Texas	52.
33.	Maine	50.
34.	Hawaii	49.
34.	Indiana	49.
34.	Wyoming	49.
37.	Louisiana	48.
38.	Alabama	47.
38.	Utah	47.
40.	Oklahoma	46.
40.	South Dakota	46.
42.	Kentucky	45.
43.	Virginia	44.
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9.	Delaware	1545.
10.	Illinois	1493.
11.	Arizona	1448.
12.	New Jersey	1419.
13.	Alaska	1391.
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18.	Florida	1273.
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21.	Minnesota	1215.
22.	Vermont	1197.
23.	Oregon	1187.
24.	Maine	1181.
25.	Colorado	1178.
26.	Indiana	1161.
27.	Virginia	1142.
28.	Washington	1119.
29.	Nebraska	1068.
30.	New Mexico	1053.
31.	New Hampshire	1040.
32.	Texas	1016.
33.	Oklahoma	1014.
34.	Kansas	1012.
35.	Georgia	1003.
36.	Iowa	995.
36.	North Dakota	995.
38.	Louisiana	987.
39.	North Carolina	982.
40.	Tennessee	980.
41.	Alabama	956.
42.	West Virginia	955.
43.	Utah	954.
44.	South Carolina	934.
45.	Kentucky	907.
46.	Idaho	868.
**47.	MONTANA	835.
48.	Mississippi	811.
49.	South Dakota	806.
50.	Wyoming	787.
51.	Arkansas	769.

TABLE 7

HOSPITAL EXPENDITURES PER ADMISSION - 1979

	State	Per Capita
1.	District of Columbia	741
2.	Massachussets	411
3.	New York	387
4.	Illinois	373
5.	Michigan	344
6.	California	332
7.	Missouri	331
	Pennsylvania	331
8.	Nevada	327
9.	Ohio	319
10.	Rhode Island	318
11.	Florida	313
	U.S. Total	300
12.	Minnesota	297
13.	Connecticut	295
14.	Kansas	292
	North Dakota	292
15.	Tennessee	289
16.	West Virginia	286
17.	Maine	285
18.	Wisconsin	282
19.	Iowa	280
	Maryland	280
20.	Arizona	279
	Nebraska	279
21.	Delaware	272
	Louisiana	272
22.	Alabama	268
	Indiana	268
	New Jersey	268
23.	Colorado	262
24.	Texas	253
25.	Oregon	247
26.	Oklahoma	246
27.	Georgia	243
28.	Alaska	242
29.	Virginia	233
30.	Vermont	229
31.	Mississippi	221
32.	Kentucky	220
	New Hampshire	220
33.	North Carolina	219
34.	Arkansas	218
35.	Washington	215
36.	South Dakota	210
37.	Hawaii	209
38.	MONTANA *	203
39.	Utah	201
40.	New Mexico	198
41.	South Carolina	194
42.	Idaho	186
43.	Wyoming	170

Lackman VIII 8

NAME David B. LACKMAN BILL No. HB 513

ADDRESS 1400 Winne Ave. Helena DATE Feb. 2 1981

WHOM DO YOU REPRESENT Lobbyist; MT Public Health Assn.

SUPPORT X OPPOSE _____ AMEND _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Comments: Prepared Statement - Copies attached.

FORM CS-34
1-81

Exhibit VIII

House Bill No. 513 (Menahan) An act to generally revise and clarify the laws relating to licensing and certificates of need of health care facilities ; .....

Hearing Mon. Feb. 2 12:30 Room 103 Committee Public HHs.

I am David Lackman, Ph. D. in the Medical Sciences , Lobbyist for the Montana Public Health Association ; and I am testifying in support of House Bill 513.

Certificate of Need legislation provides for the maintenance of the quality of health care while containing its cost. The prevention of duplication of expensive equipment and facilities is one method of doing this. U.S. health care expenditures in 1979 totaled $212.2 billion or $943. per person. Forty-three percent or $91.2 billion represented public expenditures - your tax dollars. These are truly staggering sums (over 10% of GNP).

House Bill 513 seeks to revise the codes to bring them into compliance with federal codes. Failure to do this could result in a loss ~~in federal grant~~ of $15,000,000. in federal grants to Montana over three years.

Mr. King has shown you the programs which would be affected. Collectively , they touch all of us. Not only do these threatened cuts involve activities in the Dept. of Health & Env. Sci.. ; but they include alcohol, drug abuse & mental health programs in the Dept. of Institutions. The Health Systems Agency would also be "docked".

The remark has been made that the Feds wouldn't dare to do this to us. My experience has been to the contrary. Title VI of the Social Security Act provided grants to the States for training public health workers. At the Univ. of Pennsylvania we had one of the original grants. However , as a condition for participation in the program , the Feds required states to establish a merit system in their health departments. The state of Pennsylvania wasn't about to give up the political spoils system. The Feds went along for three years with trying to change Pennsylvania's ways , but in 1941 they gave up and turned off the spigot & I fled to Montana ! Let this be a warning to you !

We recommend your support of House Bill 513 .

David B. Lackman

David B. Lackman , Ph.D. ,
Chairman , Legislative Committee & Lobbyist ,
Montana Public Health Association
February 1 , 1981

Exhibit IX

SUMMARY

Mr. Chairman and members of the Committee. I am Representative Red Menahan, sponsor of House Bill 513. This is a Department of Health and Environmental Sciences bill.

House Bill 513 proposes to amend what is commonly known as the Montana Certificate of Need law. Certificate of Need legislation is not a newcomer to this body, having been in a process of evolution since about 1972. Admittedly, a part of this evolutionary process has been a direct reaction to Federal statute and regulation. Whatever your feelings about that may be, we have still been able to develop a Certificate of Need program that considers the problems and issues of Montanans.

There are two primary issues to deal with in considering this bill. The first is the concept of Certificate of Need, which is basically a review process through which a health facility must go before making a capital expenditure in excess of $150,000 or before initiating a new service. The years' experience we have had with this process shows that it works to help contain health care costs and helps reduce duplication of services. The amendments proposed would improve on this success.

The second issue has to do with the consequences of not having a Certificate of Need law that is in compliance with the Federal statutes. The Federal leverage is that we must have a complying Certificate of Need law by January 1, 1982, or we will face the loss of certain Public Health Service monies. These Public Health Service monies reach to every corner of the State and are the financial heart of public health programs in many counties.

I urge a "do pass" recommendation from this Committee.