MINUTES OF THE MEETING
HUMAN SERVICES AND AGING COMMITTEE
50TH LEGISLATIVE SESSION
HOUSE OF REPRESENTATIVES

The meeting of the Human Services and Aging Committee was called to order by Chairman R. Budd Gould at 4:45 p.m. on Thursday, March 12, 1987 in Room 312-D of the State Capitol.

ROLL CALL: All members were present except Rep. Duane Compton who was excused.

REP. NELSON, requested permission to read Exhibits on SB170 because of the lack of time during the hearing. Chairman Gould granted him permission. (See Exhibit 1-4)

EXECUTIVE SESSION ON SENATE BILL 370:

REP. SIMON mentioned the statement of intent was not necessary to be written in the bill. He said that was written when they were anticipating that qualified dentists which was changed to oral surgeon which narrows the scope. The Board of Dentistry would not have authority to recognize other specialists qualified to take patient histories.

REP. NELSON pointed out that in Kalispell there was a dentist anesthesiologist being trained. He said that although he was a dentist he would be qualified to do anesthesiology. He felt the language in the bill would cover these types of people and should remain in the bill.

REP. MCCORMICK moved TO CONCUR on SB370. The question was called. The motion TO CONCUR SENATE BILL 370 passed unanimously.

EXECUTIVE SESSION ON SENATE BILL 185:

REP. HANSON moved TO CONCUR on SB185. Rep. Sands mentioned that there were certain private care homes that were not subject to the ombudsman and to review. Rep. Hanson replied that the health facilities had to be federally funded in some part in order for this to apply.

REP. SIMON discussed the problem on development and coordination of legal services for the elderly. He felt that legal services should not be offered unless these services were better defined. Rep. McCormick pointed out that the state paid for legal aid and SRS had a contract already.

REP. SQUIRES pointed out that the legal service was usually requested by the individual who was incapacitated and could not make the contact. The ombudsman could coordinate the services rather than actually doing them.

REP. SIMON agreed that coordinating legal services was permissible but that developing legal services was not. He moved to strike the first two words "develop and" and make it "coordinate legal services for elderly citizens".

REP. HANSON pointed out that section 3, page 2 said "office of legal and long term care, ombudsman service" that was provided under the Older Americans Act and was already in place.

ROSE SKOOG, Montana Health Care, clarified the terms that were used in the Older Americans Act. She said the position was called Legal Services Developer. The office does not do direct services to individuals in nursing homes or elsewhere. They do contact the state bar association and arrange for consultations. They write legal opinions for the area agencies on aging or other organizations involved with elderly people.

REP. SIMON WITHDREW the motion. He said that the understanding of the committee was that it was not the intention of this legislation that this office be actively engaged in providing direct legal services but that it be coordinating legal services through other agencies.

REP. CORNE' said that testimony by Doug Olson showed concern that the bill did not adequately define the term "long term care facility". Rep. Hanson replied that the term "long term care facility" was defined in statute.

GREG PETESCH commented that "adult foster care homes" could be amended to that bill.

REP. RUSSELL said that the bill did not meet federal regulations because it excludes the board and care homes.

REP. GILBERT said that other concern in testimony was that if board and care homes were included they would not be federally funded.

REP. CODY pointed out that the codes only describe facilities that are regulated by the Department of Health and Environmental Sciences and does not address adult foster care homes which are licensed by the Department of Social and Rehabilitative Services. Adult foster care homes are board and care homes subject to regulation under Section 16-16E of the Social Security Act. His concern is that the Social Security Act does not cover that.

GREG PETESCH said the provision of the code was Title 53-Chapter 5, part 3, on Adult Foster Care. The purpose of

that was to implement the provisions of Title 20 of the Social Security Act.

REP. BROWN questioned Rose Skoog about the amendment. She said the amendment was not necessary.

ROSE SKOOG clarified the issue. She said the federal act seems to intend that if there is SSI money going into any kind of home including a boarding home that ombudsman services be available to people in those facilities.

REP. CODY asked Rose Skoog about the Kees Amendment to the Social Security Act, the federal administration on aging, requires states to regulate any category of institutions, foster homes, or group living arrangements in which a significant number of recipients of supplemental security income benefits is residing or is likely to reside, is part of the aging. She said that board and care homes should be put in the bill.

ROSE SKOOG said the state has the assurance that the Department of Social and Rehabilitative Services have given to the federal government indicating compliance. Those facilities are regulated by state government including the boarding homes that do have a licence from the Health Department.

The question was called. The motion TO CONCUR on Senate Bill 185 PASSED unanimously.

EXECUTIVE SESSION ON SENATE JOINT RESOLUTION 8:

REP. HANSON moved TO CONCUR Senate Joint Resolution 8.

REP. CODY commented that lines 21-23 made the bill hypocritical. Recognizing the need of Montana's citizens underserved disabilities, guidelines with no money was inappropriate.

REP. SIMON discussed the technical terms. He said the SRS budget had increased tremendously. He pointed out that the courts may have differing interpretations and he does not support the bill.

CHAIRMAN GOULD asked Rep. Strizich about the possibility of tabling the bill and working in another bill that deals with the same subject.

REP. STRIZICH moved to TABLE Senate Joint Resolution 8. The motion TO TABLE SJR8 PASSED with 6 members voting NO.

EXECUTIVE SESSION ON SENATE BILL 176:

REP. STRATFORD moved the amendment Senate Bill 176 to DO PASS. She explained that the amendment moves the provision of nursing specialists from the mandated medicaid assistance to the optional provision and is what SRS requested. The nurse specialists should be able to bill directly. Nurse specialists are not a mandated item for coverage under federal law. This would allow the utilization of services where there is cost savings and not mandate that in all cases.

REP. CODY asked whether the option was already available. Rep. Stratford replied that the services had to be billed through a doctor with the exception of nurse anesthetics. The amendment would allow them to bill directly.

REP. CODY commented that by taking SRS out of the bill and inserting the Health Services Organization would they say it was optional and they would not have to pay. Rep. Stratford replied that the amendment affects only the Medicaid portion of the bill. She said that Section 2 was the part dealing with the Health Services and that the amendment did not pertain to that.

The question was called for. The motion PASSED with one NO vote by Rep. Cody.

REP. STRATFORD moved to CONCUR AS AMENDED on Senate Bill 176. The question was called. The motion PASSED with one NO vote by Rep. Gilbert.

EXECUTIVE SESSION ON SENATE BILL 252:

REP. SIMON said this was dealing with subrogation rights and should be referred to Judiciary Committee. Rep. Simon moved that SB252 be referred to the Judiciary Committee.

The question was called. The motion to refer SB252 to the Judiciary Committee PASSED unanimously.

EXECUTIVE SESSION ON SENATE BILL 246:

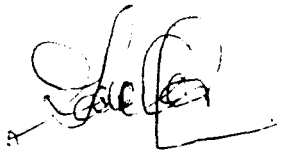
REP. PATTERSON moved TO CONCUR on SB246. Rep. Simon pointed out that the bill was lengthy, 39 pages, with many changes. He said there was too many conflicting views on the certificate of need issue. Rep. Patterson said that this would eliminate duplication of services in the communities.

REP. HANSON commented on the amendments. She said this was an important bill for her area because there were applications for 600 new extended care beds in Missoula and there should be a way to control that.

REP. SANDS commented that the bill was complicated and the certificate of need was an anti-competitive process. He said however, that it was probably needed. He said more time was needed to review the amendments.

REP. PATTERSON WITHDREW the motion. Chairman Gould recommended review of the amendments before further action.

ADJOURNMENT: There being no further business the meeting was adjourned at 5:45 p.m.



R. BUDD GOULD, CHAIRMAN

3-12ahs

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date MAR 12 1987

EX SESSION -

NAME	PRESENT	ABSENT	EXCUSED
REP. BUDD GOULD, CHAIRMAN	✓		
REP. BOB GILBERT, VICE CHAIRMAN	✓		
REP. JAN BROWN	✓		
REP DUANE COMPTON		✓	✓
REP. DOROTHY CODY	✓		
REP. DICK CORNE'	✓		
REP. LARRY GRINDE	✓		
REP. STELLA JEAN HANSEN	✓		
REP. LES KITSELMAN	✓		
REP. LLOYD MC CORMICK	✓		
REP. RICHARD NELSON	✓		
REP. JOHN PATTERSON	✓	✓	
REP. ANGELA RUSSELL	✓		
REP. JACK SANDS	✓	✓	
REP. BRUCE SIMON	✓		
REP. CAROLYN SQUIRES	✓		
REP. TONIA STRATFORD	✓		
REP. BILL STRIZICH	✓		

EXHIBIT #1
DATE 3-12-87
HB # 170 - Exhibits

"For all your Pharmacy needs"

Medical Arts Pharmacy

210 SUNNYVIEW LANE
KALISPELL, MONTANA 59901

NANCY MANNING
BOB GRADY
OWNERS - PHARMACISTS

PHONE (406) 755-4414

March 9, 1987

Mr. Richard Nelson
Legislative Council
Capital Station
Helena, MT 59601

Dear Representative Nelson:

It has been said that it is IMPOSSIBLE to define what Quality is but we all know what it is not.

As a Pharmacist and a consumer of eye care, we are emphatically against Senate Bill 170 OPTOMETRIC THERAPY BILL for the following reasons.

As Pharmacists, we would not like to be placed in the position to fill prescriptions written by optometrists. Their formal education and, more importantly, their practical experience does not qualify them for prescribing "today's" very potent medications that have very harmful side effects if not prescribed correctly.

Filling these prescriptions could place Pharmacists in a more precarious liability position and more importantly filling prescriptions from a non-qualified practioner may be ethically improper.

We see people in our pharmacy who complain of various eye problems who do want help but because of fear and expense are trying to put off going to a physician. Many eye conditions, whether chronic or acute, reach a point where they are irreversible. We suggest to these people that they see their ophthamologist for a proper diagnosis. Senate Bill 170 OPTOMETRIC THERAPY BILL would in some ways interfere with the patient receiving a proper diagnosis and solution within the time frame which may be extremely important.

If we Pharmacists recommend over-the-counter eye medicine to these patients over a period of time, rather than try to get them to see an ophthamologist, we are doing that person a disservice. Senate Bill 170 OPTOMETRIC THERAPY BILL would increase the responsibilities of optometrists to a point where the patient who truly needs the expertise of an ophthamologist quickly will not receive it until it's too late. The lesser-qualified optometrist by improper diagnosing or prescribing incorrect medication could also do a disservice. Both of us legally are within our rights, but morally and ethically we have not provided quality health care. Sadly, in our desire to help someone we are taking actions that could harm a person's most important sense of the five senses -- SIGHT.

All involvement in the health care systems entails a RISK/BENEFIT ratio. Your goal should be to vote for legislation which decreases this ratio, not increases it.

Thank you for your consideration,

Nancy Manning — Bob Grady

NANCY MANNING, R.Ph — BOB GRADY, R.Ph.

NM,BG/jg

EXHIBIT #2
DATE 3-12-87
HB #176 - Ex Sec

MEDICAL ARTS OPTICIANS

210 Sunny View Lane • Kalispell, Montana 59901 • Phone: 755-5044

3-10-87

Representative Richard Nelson
House Human Services Council
Helena, Mt. 59601

Dear Representative Nelson,

Senate Bill 170 is now being considered by your Committee. This Bill if passed would allow Optometrists to use Therapeutic drugs. My personal opinion, which comes from Thirty five years of working with Ophthalmologists and Optometrists, is tha t Optometrists are not qualified to use Therapuetic drugs, and that the use of such drugs should be left in the hands of skilled Medical Doctors.

I sincerely hope you will consider my imput when reaching your decision on Senate Bill 170.

Sincerely yours,

James P. Steenson
Certified Optician

EXHIBIT #3
DATE 3-12-87
HB MC - Ex. Sess.

Kalispell, Montana
Feb. 20, 1987

Dear Legislator,

I am writing in regard to S. B. 170. I only recently became aware of this Bill and its contents.

N - Y
24-26

I am apalled at the ease with which it passed the Senate and strongly urge you to vote " NO " to this potentially dangerous piece of legislation. CLOSE VOTE

Common sense should tell even uninformed people that only qualified and licensed Ophthalmologists should be able to diagnose and treat disease and especially dispense medications.

I am sure there are many able and concientious Optometrists in Montana, but they have their area of knowledge and ability and should be kept within it by law.

I have a personal reason for wanting to see S. B. 170 defeated. My father went to three or four Optometrists in Great Falls, Montana. They kept giving him stronger glasses with each visit. By the time he finally went to an Ophthalmologist and was properly diagnosed as having glaucoma, the optic nerve was damaged to the point where medication did not help. He has been blind for several years.

Please use your vote to prevent this Bill from becoming a law.

Thank you,

Joan A. Paliga
184 Caroline Rd.
Kalispell, MT 59901

EXHIBIT #A
DATE 3-12-87
HB #170-Ex Sec

AARP CHAPTER

#859

The undersigned persons wish to register their opposition to Senate Bill Number 170, the optometric therapy bill.

Optometrists have had no medical school, and no medical training.

As Senior Citizens who value their remaining eyesight, we do most sincerely believe that the use of critical medication for treatment of malignant melanoma of the eye and other such serious conditions should be limited to those who are duly acredited in the skill and general practice of Ophthamology.

SIGNATURES	ADDRESS
Lydia M. Sateberg D.C.	1005-2nd Ave E. Kalispell
Dora Greer	1398 Riverside Rd Bigfork Mt. 59911
Doris R. Yenne	6010 Mont 35 Bigfork 59911
Edith E. Larson, 836 E. Washington Apt. J, Kalispell, Mont. 59901	
Margaret Nash	2575 Mission Trail Kal. 59901
Lillian Whitehouse	545 Sec. Ave. W.
Ly Jean Stingem	123 Wedgewood Lane Kalispell Mt. 59901
Venita Nelson	195 Wilson Hts. Kalispell, Mt 59901
Harriet Johnston	415 E. Center Kalispell MT 59901
Marie Evans	1086 Trumble Cr. Rd. Mt 59901
Malinda Jessup	234-9th St E. Kalispell, Mont.
Dorothy Yoder	931-4th Ave. E #2 Kalispell
Myrtle White	211-4th Ave West Kalispell
Sigurd J. Dahlquist	1717 S. Woodland Dr. Kalispell, MT
Ruth J. Gunderson	812 8th Ave East
Leslie Gunderson — Dorothy Garvin	4 Ave. W. Kalispell 59901
Sam Yenne	6010 Mt 35 Bigfork Mt
Janet Crowe — Edna Rexford, Walter Rexford	1480 Wedgewood Lane Kal. — Kalispell Mt.
Ellis Drewry	2310 Witty Lane Columbia Falls Mt.
Jean Klein	125 Klein Lane, Columbia Falls, Mt. 59912
Magdalen M. Hatho	182 Valleyview Dr. Kalispell
Lovetta Gilleard	Box 625 Columbia Falls
Ethel Thomas	821 7th St W. Columbia Falls
Helen Heher	1711 Bison Dr.
[illegible] Kal. 194 V. View	836 E. Washington Ernest J. [illegible]
[illegible]	Col. Falls
Noel W. Furlong	520-6th Ave. W. Kalispell, Mt.
Jim Ludwig	174 Many Lakes Dr., Kalispell

SEE ALSO SIGNATURES ON BACK OF PAGE. Thank you!

EXHIBIT 5
DATE 2-28-97
HB

Amend Senate Bill 176 Third Reading Copy (blue)
Rep. Sands

1. Page 1, lines 20 through 22.
Strike: "; and" on line 20 through "37-8-202(5)" on line 22.

2. Page 2.
Following: line 17
Insert: "(k) nursing services provided by nurse practioners, nurse-midwives, and nurse-anesthetists as permitted by federal and state law;"
Renumber: subsequent subsection

XT01
\wp\lee\amdsb176

EXHIBIT 4
DATE 3-12-87
HB 24 - Ex Session

Montana Hospital Association

(406) 442-1911 • P.O. BOX 5119 • HELENA, MONTANA 59604

March 11, 1987

Chairman Gould and Members of House Human Services and Aging Committee:

I am enclosing a copy of the Montana Hospital Association revised certificate of need testimony. Since our presentation was very rushed, due to time limitations, I would appreciate it if you would take a couple of minutes to review the reasoning behind our proposed amendments.

In the revised testimony I have eliminated all references to extending the law to cover physician and dentist offices. At the hearing I officially withdrew our amendment which would have included these entities. I am also enclosing for your use additional reference documents which support some of the positions we have taken.

If you have any questions about the proposed amendments or the Montana Hospital Association's views on the certificate of need issue, please feel free to contact me or any member of the staff.

Sincerely,

James F. Ahrens
President

Enclosures

DATE
HB

March 10, 1987

TESTIMONY ON SENATE BILL 246 BEFORE HOUSE HUMAN SERVICES AND AGING COMMITTEE.

Testimony presented by Montana Hospital Association

CHAIRMAN GOULD, MEMBERS OF THE COMMITTEE, FOR THE RECORD, I AM JAMES AHRENS, PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. OUR ORGANIZATION OPPOSED THIS BILL IN THE SENATE. WE BELIEVED MANY OF THE CIRCUMSTANCES THAT MADE CON A DESIRABLE PUBLIC POLICY OPTION IN THE 70'S DO NOT EXIST TODAY. THE FEDERAL GOVERNMENT HAS REALIZED THAT THE HEALTH CARE ECONOMY HAS CHANGED DRAMATICALLY IN THE PAST FEW YEARS. IT WITHDREW ITS FINANCIAL SUPPORT FROM STATE CON PROJECTS ON OCTOBER 1, 1986. THE FEDERAL MATCH WAS ABOUT 60 PERCENT. YOUR COLLEAGUES IN OTHER STATES HAVE ALSO WITHDRAWN THEIR SUPPORT FROM CON. ELEVEN STATES DO NOT HAVE CON LAWS. THEY ARE ARIZONA, IDAHO, UTAH, MINNESOTA, NEW MEXICO, TEXAS, KANSAS, LOUISIANA, AND MISSISSIPPI. CALIFORNIA'S LAW SUNSET JANUARY 1, 1987 AND WYOMING REPEALED ITS CON LAW JUST LAST WEEK. IN COLORADO A CON REAUTHORIZATION BILL THAT COVERS LONG-TERM CARE BEDS ONLY WILL BE HEARD BEFORE A LEGISLATIVE COMMITTEE THIS WEEK. THE CURRENT COLORADO LAW WILL SUNSET JUNE 30, 1987. CLEARLY, THE TREND IS AWAY FROM REGULATION BY CERTIFICATE OF NEED.

THE MONTANA HOSPITAL ASSOCIATION, FRANKLY, WOULD RATHER NOT HAVE A CON LAW IN MONTANA. WE REALIZE, HOWEVER THAT MANY PEOPLE HAVE A LEGITIMATE CONCERN ABOUT THE COST OF HEALTH CARE, PARTICULARLY AS IT EFFECTS STATE FUNDING THROUGH THE MEDICAID BUDGET. IN AN EFFORT TO RECOGNIZE THOSE CONCERNS AND AT THE SAME TIME LIMIT SOME OF THE MORE BURDENSOME ASPECTS OF CON, I WOULD LIKE TO PROPOSE THE FOLLOWING AMENDMENTS, ON BEHALF OF THE 55 MEMBERS OF THE MONTANA HOSPITAL ASSOCIATION.

FIRST, THE MHA PROPOSES THAT THE REVIEW THRESHOLDS BE AMENDED UPWARDS. IN THE BILL THE THRESHOLDS ARE $100,000 FOR OPERATING EXPENSES ON NEW SERVICES, $750,000 FOR EQUIPMENT AND $1,500,000 FOR CONSTRUCTION. HOW WERE THESE NUMBERS

SELECTED? THEY WERE PULLED OUT OF THE AIR. THEY WERE ARBITRARILY CHOSEN. WHO IS TO SAY THAT OTHER NUMBERS WOULD NOT DO AS WELL? MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, IF CON IS TO ACHIEVE ITS END OF REDUCING HEALTH CARE COSTS BY LIMITING CAPITAL INVESTMENT, IT MUST FOCUS ON MATERIAL EXPENDITURES. CON SHOULD ONLY BE CONCERNED WITH "BIG TICKET" PURCHASES. THE COMPETITIVE MARKETPLACE SHOULD BE ALLOWED TO DISTRIBUTE CAPITAL EXPENDITURES FOR SMALLER TICKET ITEMS. RAISING THRESHOLDS WOULD PROVIDE THE CITIZENS THE PROTECTION THEY DESIRE FROM THE CONSTRUCTION OF NEW LONG-TERM CARE FACILITIES OR PSYCHIATRIC HOSPITALS. YET IT WOULD ALLOW THE MARKET TO FUNCTION FOR CAPITAL INVESTMENTS OF LESS MAGNITUDE. WE PROPOSE AMENDING THE NEW SERVICE THRESHOLD TO $1,000,000, THE EQUIPMENT THRESHOLD TO $3,000,000 AND THE CONSTRUCTION THRESHOLD TO $3,000,000.

SECOND, MHA PROPOSES THAT THE APPLICATION FEES BE ELIMINATED. IF YOU ACCEPT THE AMENDMENTS TO THE CAPITAL THRESHOLDS AND LEAVE IN THE APPLICATION FEES, THE LOWEST FEE TO FILE A CON WILL BE $9,000. THE APPLICATION FEE UNNECESSARILY ADDS TO THE COST OF THE PROJECT. HEALTH CARE PROVIDERS, WHETHER HOSPITALS, NURSING HOMES OR AMBULATORY SURGERY CENTERS, WILL FINANCE THESE COSTS FROM PATIENT REVENUES. IT IS, IN THE FINAL ANALYSIS, PATIENTS AND NURSING HOME RESIDENTS WHO PAY THE CON APPLICATION FEES. THE DEPARTMENT OF HEALTH PUT THE FEES IN THIS BILL TO HELP DEFRAY THE LOSS OF FEDERAL FUNDING. IF YOU BELIEVE THAT THE CERTIFICATE OF NEED PROCESS IS A LEGITIMATE BENEFIT TO THE PEOPLE OF MONTANA, THEN ITS COSTS SHOULD BE BORNE BY ALL OF THE PEOPLE OF MONTANA. WHY SHOULD HEALTH CARE CONSUMERS PAY MORE THROUGH A HIDDEN TAX, FOR A PUBLIC GOOD THAT IS CLAIMED TO BENEFIT NOT ONLY TODAY'S CONSUMERS BUT TOMORROW'S AS WELL?

THIRD, MHA PROPOSES THAT ALL REFERENCES TO BATCHING BE REMOVED FROM THE BILL. BATCHING IS A PROCEDURAL PROBLEM. THIS IS THE WAY IT WORKS. A HEALTH FACILITY DEVELOPS A PLAN, A BUSINESS PLAN, IF YOU WILL. IT PERFORMS MARKET STUDIES TO DETERMINE THE NEED FOR A PARTICULAR SERVICE. IT PERFORMS FINANCIAL FEASIBILITY STUDIES TO MAKE CERTAIN THAT IT AND THE COMMUNITY CAN AFFORD THE

SERVICE. WHEN ALL OF THE STUDIES ARE COMPLETED AND THE DECISION BY THE BOARD AND ADMINISTRATION IS TO PROCEED WITH THE PROJECT, THE FACILITY SENDS A LETTER OF INTENT TO THE DEPARTMENT OF HEALTH. THE DEPARTMENT THEN ANNOUNCES TO THE FACILITY'S COMPETITORS THE INTENT OF THE APPLICANT AND ALLOWS, IF NOT ENCOURAGES, THEM TO SUBMIT COMPETING APPLICATIONS FOR REVIEW. THE ORIGINAL FACILITY HAS ALREADY DETERMINED THE NEED FOR THE SERVICE. PART OF THAT DETERMINATION IS MADE ON THE BASIS OF THE STATE HEALTH PLAN. SO EVERYBODY, (THE FACILITY, ITS COMPETITORS AND THE DEPARTMENT) KNOWS THAT A NEED MOST LIKELY EXISTS, BUT THAT ONLY ONE PROJECT WILL BE APPROVED. THE FIGHT IS ON FOR WHO WILL WIN THE PRIZE. THE PROCEDURE IS ADVERSARIAL, ACRIMONIOUS, ANTICOMPETITIVE AND INCREASINGLY LITIGIOUS.

MHA BELIEVES THAT CON APPLICATIONS SHOULD BE MEASURED AGAINST THE STATE HEALTH PLAN, NOT AGAINST OTHER COMPETING APPLICATIONS. IF COMPETITION IS DESIRED THEN ONE MAKES THE CASE FOR ELIMINATING THE CON PROCESS ITSELF. CONs SHOULD BE AWARDED TO THE FACILITY THAT SHOWS ENTERPRISE AND VISION, THE FACILITY THAT PERFORMS THE INITIAL GROUND-UP PLANNING, NOT TO THE FACILITY THAT FILLS OUT THE BEST APPLICATION. HEALTH PLANNING AFTER ALL IS NOT ABOUT FILLING OUT APPLICATIONS TO THE DEPARTMENT'S SATISFACTION. IT IS ABOUT KNOWING AND BEING IN TOUCH WITH YOUR COMMUNITY AND RESPONDING IN A TIMELY FASHION TO ITS WANTS AND NEEDS.

FOURTH, WE RECOMMEND THAT THE DEPARTMENT OF HEALTH BE INSTRUCTED BY LAW TO PHASE-OUT ITS OPERATION BY JUNE 30, 1989. WE PROPOSE THAT THE DEPARTMENT CANDIDLY ASSESS ITS PERFORMANCE, STIPULATE A PHASE-OUT PLAN AND PROJECT THE CONSEQUENCES OF LETTING CON SUNSET IN 1989. A REPORT WOULD BE DUE TO THE NEXT LEGISLATURE IN JANUARY 1989. THIS REPORT WILL HELP THE 51ST LEGISLATURE JUDGE WHETHER OR NOT TO REAUTHORIZE THE CON IN 1989.

FINALLY, WE ARE INTERESTED IN SHORTENING THE PROCESS. TIME REALLY IS

MONEY. THE DEPARTMENT HAS IN SEVERAL AREAS AMENDED THE BILL TO LENGTHEN THE TIME FRAME OF REVIEW. WE WOULD STRIKE THOSE AMENDMENTS TO MAKE THE PROCESS MORE TIMELY AND LESS COSTLY TO THE APPLICANT.

IN SUMMARY LET ME REITERATE THAT THE MONTANA HOSPITAL ASSOCIATION FEELS THAT THE COMPETITIVE NATURE OF HEALTH CARE IN 1987 NO LONGER WARRANTS A REGULATORY DEVICE LIKE CERTIFICATE OF NEED. HOWEVER, IF THERE IS TO BE A CON LAW IN THIS STATE IT SHOULD NOT CONTAIN UNNECESSARY REGULATIONS. EVENTS IN HEALTH CARE HAVE TRANSPIRED VERY QUICKLY. EVEN THOUGH WE ARE IN A DIFFERENT ENVIRONMENT, THERE ARE THOSE WHO DO NOT RECOGNIZE IT, THOSE WHO ARE UNWILLING TO BELIEVE IT, AND THOSE, WHO FOR SELFISH GAIN, DENY IT. IN THE SENATE, SENATOR JACOBSON SAID, "I AM NOT CONVINCED THAT CON CONTROLS COSTS, BUT IT IS DYING TWO YEARS TOO SOON." PERHAPS SHE IS RIGHT. MAYBE IT IS TWO YEARS TOO SOON. IF THE LEGISLATURE AND THE PUBLIC ARE NOT CONVINCED THAT IT IS TIME TO ALLOW THE LAW TO SUNSET, IT IS TOO SOON.

THEREFORE, MHA SUPPORTS THE REAUTHORIZATION OF CON, IF THE BILL IS AMENDED TO REMOVE BURDENSOME PROCEDURAL FLAWS LIKE BATCHING AND TO EASE MONTANA INTO THE TIME WHEN CON WILL SUNSET. CHAIRMAN GOULD, MEMBERS OF THE COMMITTEE, I STRONGLY URGE YOU TO ACCEPT THESE AMENDMENTS:

1. INCREASE THE THRESHOLDS
2. ELIMINATE THE APPLICATION FEES
3. ELIMINATE BATCHING
4. REQUIRE A PHASE-OUT PLAN
5. MAKE THE PROCESS MORE TIMELY.

THESE AMENDMENTS PROTECT THE PUBLIC AND YET REMOVE UNNECESSARY REGULATIONS. THEY WILL MAKE A MUCH BETTER LAW. THANK YOU.

CON AMENDMENTS

A. Eliminate batching and competitive reviews. In order to eliminate batching, the following amendments must be made:

1. Page 2, lines 16 through 25, strike in their entirety.

2. Page 3, lines 1 and 2, strike in their entirety.

3. Page 3, lines 16 through 20, strike in their entirety.

4. Page 4, lines 16 through 21, strike in their entirety.

5. Page 24, line 17, strike "and consolidation".

6. Page 25, lines 13 through 18, strike in their entirety.

7. Page 26, lines 14 through 21, strike in their entirety.

8. Page 27, lines 24 and 25, strike in their entirety.

9. Page 28, lines 1 through 4, strike in their entirety.

10. Page 28, lines 16 through 20, strike in their entirety.

11. Page 29, lines 7 through 10, strike in their entirety.

B. Increase new service operating expense threshold. Amend:

1. Page 20, line 20, strike "$100,000" and insert "$1,000,000" in lieu thereof.

C. Increase equipment threshold. Amend:

1. Page 24, line 4, strike "$750,000" and insert "$3,000,000" in lieu thereof.

D. Increase construction threshold. Amend:

1. Page 24, line 6, strike "$1,500,000" and insert "$3,000,000" in lieu thereof.

E. Improve the timeliness of the process. Amend:

1. Page 28, line 13, strike "90" and insert "60" in lieu thereof.

2. Page 28, line 14, insert a period (.) after "sent".

3. Page 29, line 5, insert a period (.) after "person".

4. Page 29, lines 5 and 6, strike "or when considered appropriate by the department."

5. Page 35, line 6, strike "30" and insert "20" in lieu thereof.

F. Create a phase out plan for 1989 sunsetting of CON. Amend:

1. Insert "New section. Phase out plan. The department will begin a planning process no later than July 1, 1988 that documents the effectiveness of certificate of need, details how certificate of need will be phased out, and documents the effect on the health system of the elimination of certificate of need. The department will provide a report to the legislature no later than the fifth day of the 1989 legislative session."

G. Eliminate application fees. Amend:

1. Page 37, lines 4 through 14, strike in their entirety.

H. Create a "level playing field" for all competitors (improve definition of "person" and "health care facility"). Amend:

1. Page 10, line 13, strike "health maintenance organization" and insert "alternative delivery system" in lieu thereof.

2. Page 17, line 21 insert "alternative delivery system" between "estate," and "or".

3. Page 21, line 24 insert "alternative delivery system" before "or".

EXHIBIT # 8
DATE 3-12-87
HB #216 - Ex Sess.

THE ARIZONA CASE

The Montana Health Care Association and others have used the state of Arizona as an example of what will happen in Montana if Certificate of Need is allowed to sunset or if construction thresholds are too high to protect the nursing home franchise. First, it is difficult to draw an analogy between Arizona and Montana. The circumstances of the two states are vastly different. According to the U.S. Bureau of Census the 1980-1985 population increase in Arizona was 17.3 percent. In Montana it was 5.0 percent. Much of the population growth in Arizona is attributable to retirees emigrating to the sun belt in search of warmth and leisure. Relatively few "new elderly" immigrate to Montana, on the other hand.

Second, we must ask ourselves, what indeed was the Arizona experience? You have heard that since 1982, when CON was repealed in Arizona for nursing home beds, that beds increased by 4,246. The source of this information claims that the number of nursing home beds in 1982 was 8,313. This number is at significant variance with those published by the U.S. Department of Health and Human Services, Division of Health Care Statistics (attached). The Division states that there were some 1,575 more beds in 1982 (or 9,888) than the number reported. If we are to believe the HHS numbers, the rate of increase in beds was 27 percent between 1982 and 1985 and not the alleged 51.1 percent.

As significant as that increase is, it should be pointed out that the increase in nursing home beds between 1976 and 1982 was 69.5 percent. The period 1976 to 1982 was one that was covered by CON in Arizona.

Counting nursing home beds, however, does not get to the real question of need. In 1976 the Arizona nursing home bed rate (number of beds per 1,000 population 65 years and over) was 24.6. The national bed rate was 56.4 and Montana's was 61.4. Arizona was significantly underbedded. It had less than one-half the nursing home beds it should have had. By 1982, despite an increase in beds of almost 70 percent, the Arizona bed rate was only 29.0. The national bed rate was 54.8 and Montana's was 56.9. Arizona's rate was still only 53 percent of the national rate. In 1985, using figures supplied by the Montana Health Care Association, the Arizona bed rate was 31.3, an increase of only 1.3 beds per 1,000 over the 1982 rate, still well below the national average despite the new construction.

In Arizona, nursing home construction is merely chasing need. It has not yet caught up. The building activity, in terms of nursing home beds, was no different in Arizona before or after CON.

Similar trends may also be seen in hospital beds. Attached are several pages from the Arizona Hospital Association charting the growth of hospital beds in Arizona over the past six years. Bed construction has once again chased population. Hospital beds per 1,000 population falls below the national rate by almost 30 percent. Moreover, since 1980 in Arizona, the bed rate for hospitals has actually dropped from 4.27 to 4.14 in 1985.

All building is based upon need. If there is no need for a service, it will not be used. If it is not used, the health facility cannot afford to pay for it. Montana's nursing home bed rate is already above the national average. The

(over)

demand for new services is too low to justify the risk of investing in a nursing home. Investors could make more money by keeping their funds in a money market account. Hospital bed rates in Montana are almost 9 percent above the national rate. In 1985 over one-half of all hospital beds in Montana were empty. There will be no acute care beds built in Montana in the foreseeable future.

Montana is not Arizona. Even Arizona, as painted for you by those interested in protecting their franchise, is not Arizona. Arizona is a medically underserved growth state that is trying frantically to catch up.

Table 75. Nursing homes with 25 or more beds, beds, and bed rates, according to geographic division and State: United States, 1976 and 1982--Continued

(Data are based on reporting by facilities)

Geographic division and State	Nursing homes		Beds		Bed rate[2]	
	1976[1]	1982	1976[1]	1982	1976[1]	1982
West South Central.....	1,742	1,789	157,347	177,237	72.6	68.9
Arkansas.....	208	200	19,322	19,327	69.5	59.7
Louisiana.....	200	224	18,969	24,836	53.4	59.3
Oklahoma.....	341	359	25,990	28,902	76.2	74.3
Texas.....	993	1,006	93,066	104,172	78.0	72.3
Mountain.....	493	529	41,874	47,857	47.4	41.4
Montana.....	69	59	4,725	5,120	61.4	56.9
Idaho.....	53	47	4,215	4,102	52.0	40.6
Wyoming.....	22	25	1,753	2,060	51.6	52.8
Colorado.....	173	157	17,833	16,848	81.8	64.1
New Mexico.....	30	31	2,489	2,351	26.5	18.7
Arizona.....	67	109	5,832	9,888	24.6	29.0
Utah.....	63	76	3,707	5,025	39.0	42.6
Nevada.....	16	25	1,320	2,463	28.1	32.0
Pacific.....	1,920	1,667	165,818	153,955	58.5	44.8
Washington.....	318	309	29,415	30,017	78.4	65.0
Oregon.....	202	177	15,758	15,711	59.0	48.5
California.....	1,369	1,148	118,144	105,325	55.7	41.2
Alaska.....	8	10	738	1,031	82.0	79.3
Hawaii.....	23	23	1,763	1,871	29.4	22.0

[1]The 1982 National Master Facility Inventory (NMFI) excluded certain types of nursing homes that the 1976 NMFI included (nursing home units of hospitals, nursing homes for the blind, etc.). To make the data comparable, these types of homes and their beds were subtracted from the 1976 figures.
[2]Number of beds per 1,000 population 65 years of age and over.

SOURCE: Division of Health Care Statistics, National Center for Health Statistics: Data from the National Master Facility Inventory.

Note: The pages on this table have been reversed to show the Mountain Region of the U.S. first.

Source: Health United States, 1985, US Department of Health and Human Services, Public Health Service.

Table 75. Nursing homes with 25 or more beds, beds, and bed rates, according to geographic division and State: United States, 1976 and 1982

(Data are based on reporting by facilities)

Geographic division and State	Nursing homes		Beds		Bed rate[2]	
	1976[1]	1982	1976[1]	1982	1976[1]	1982
United States.....	14,129	14,565	1,295,067	1,469,357	56.4	54.8
New England.....	1,213	1,246	92,189	105,293	66.0	66.3
Maine.....	121	155	7,027	9,717	54.9	66.1
New Hampshire.....	68	70	5,633	6,729	61.9	61.7
Vermont.....	53	51	3,477	3,196	65.6	52.4
Massachusetts.....	645	620	47,169	50,366	69.5	67.0
Rhode Island.....	85	95	6,766	8,885	58.3	67.3
Connecticut.	241	255	22,117	26,400	66.8	68.2
Middle Atlantic.....	1,567	1,587	187,435	210,010	44.1	44.6
New York.....	708	732	97,489	108,898	47.3	49.4
New Jersey.....	313	332	31,147	36,638	39.5	40.6
Pennsylvania.....	546	523	58,799	64,474	41.8	40.2
East North Central.....	2,899	2,966	284,035	326,171	68.2	69.4
Ohio.....	750	830	60,680	74,276	55.7	60.6
Indiana.....	420	449	35,799	47,196	65.9	77.0
Illinois.....	808	809	84,343	99,777	71.8	76.1
Michigan.....	505	471	54,442	55,349	65.3	57.5
Wisconsin.....	416	407	48,771	49,573	93.1	84.0
West North Central.....	1,964	2,171	156,992	185,774	75.7	81.8
Minnesota.....	385	390	38,177	42,500	85.4	85.0
Iowa.....	440	475	31,785	38,150	86.1	95.4
Missouri.....	408	530	32,539	46,403	53.3	69.7
North Dakota.....	81	80	6,357	6,402	84.8	76.2
South Dakota.....	117	116	8,047	7,938	93.6	84.4
Nebraska.....	210	225	18,399	18,516	93.4	87.8
Kansas.....	323	355	21,688	25,865	75.0	82.1
South Atlantic.....	1,475	1,745	142,383	177,495	38.4	38.1
Delaware.....	22	27	2,123	2,194	40.8	34.8
Maryland.....	165	179	18,559	21,164	53.0	50.2
District of Columbia.....	17	16	2,742	2,556	38.6	34.5
Virginia.....	208	267	23,816	29,251	54.1	54.4
West Virginia.....	73	95	4,858	7,505	22.6	30.4
North Carolina.....	276	346	20,903	28,156	40.8	43.5
South Carolina.....	102	130	8,311	11,560	34.8	37.3
Georgia.....	304	306	28,732	32,194	64.9	58.6
Florida.....	308	379	32,339	42,915	23.3	23.7
East South Central.....	856	865	66,994	85,565	45.5	49.5
Kentucky.....	267	276	19,929	25,837	53.3	60.8
Tennessee.....	258	251	19,448	26,111	42.9	48.1
Alabama.....	209	190	19,207	20,490	49.6	44.4
Mississippi.....	122	148	8,410	13,127	32.5	43.9

See footnotes at end of table.

ARIZONA HOSPITAL ASSOCIATION
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ARIZONA HOSPITAL CONSTRUCTION

BACKGROUND

In 1984, Arizona hospital construction was deregulated through certificate of need expiration. As is the case with deregulation of any industry, the final story on deregulation of hospitals will no doubt take many years to unfold. To date the Arizona Hospital Association cannot confidently identify absolute trends; it is just too soon after CON expiration to make definitive judgments of any kind. We can only make the following observations, with the assurance that we will update at least annually all statistics relevant to this issue as additional hospital capacity is put into service and as further changes in population materialize.

- With only 4.14 staffed beds per thousand population, total hospital capacity in Arizona is among the lowest in the country --ranking 44th out of 50 states. (see enclosures)

- Between 1980 and 1985, Arizona experienced a 17.3% population growth (U.S. Census Bureau figures) and a 13.7% bed growth (American Hospital Association figures). Since 1984, the year of deregulation, Arizona's population has grown by more than 115,000 people; the number of acute care hospital beds put into service has grown by 592 (AHA figures), the majority of which are psychiatric beds (Arizona's Department of Health Services information.)

- Adjusted for population growth, total hospital capacity in Arizona has actually declined slightly since 1980.

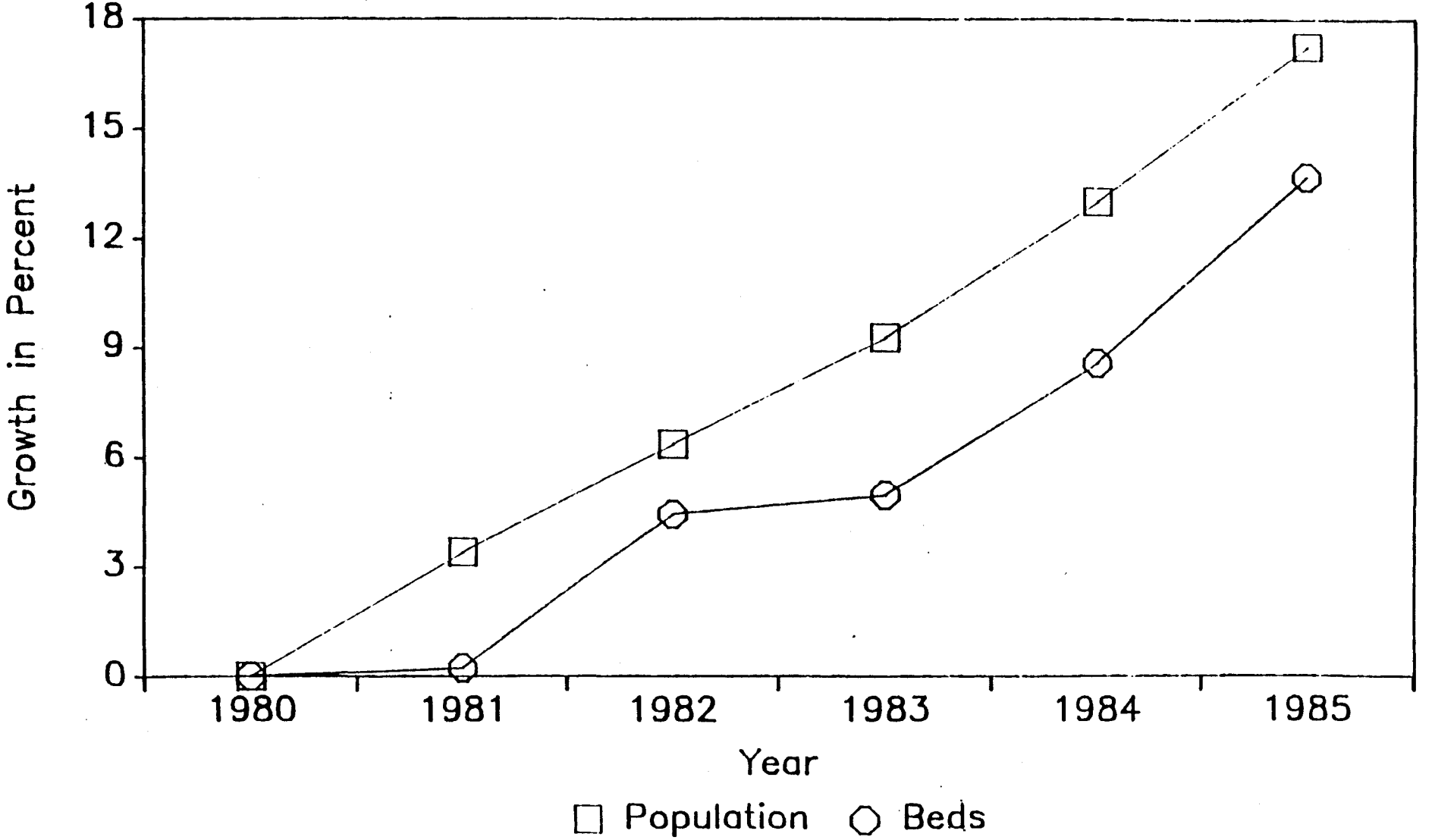
- Virtually all new construction of acute care facilities has occurred in areas of burgeoning population. In Maricopa County, which contains approximately half the state's population, nearly 50,000 new housing units are constructed each year.

Ours is a growing and dynamic state. Hospitals, like most other vital sectors of the economy, are also growing and dynamic. Such growth is to be expected in a state that traditionally has encouraged risk-taking and innovation across the economic spectrum. Arizona hospitals are proud to take part in this tradition, for it helps us provide our communities with health care services that are among the finest in the nation.

slw

Bed Growth Trends

Arizona 1980–1985

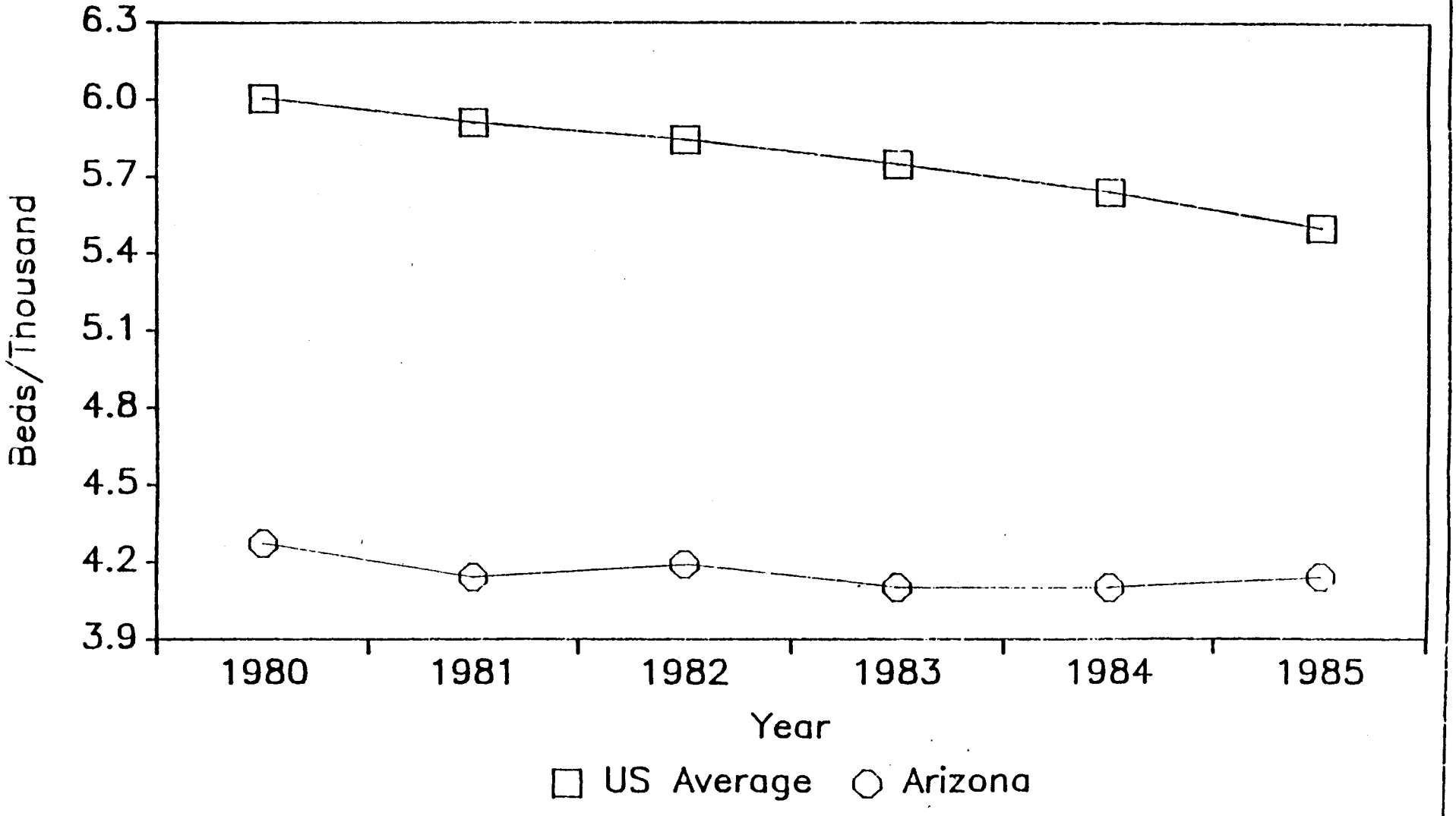


Calculations use 1980 as Base Year

Prepared by ADHS 1986

Beds/Thousand Trends

Arizona vs U. S.
1980–1985



Revised by AHA 1986
14 States are higher than Arizona
5 States are lower than Arizona

State List
by
Beds/Thousand Population

October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1985	6102	685000	8.91
SOUTH DAKOTA		5775	708000	8.16
NEBRASKA		11784	1606000	7.34
MASSACHUSETTS		41062	5822000	7.05
KANSAS		17176	2450000	7.01
TENNESSEE		31356	4762000	6.58
MINNESOTA		27421	4193000	6.54
MISSISSIPPI		17070	2613000	6.53
NEW YORK		115845	17783000	6.51
IOWA		18753	2884000	6.50
PENNSYLVANIA		76395	11853000	6.45
MISSOURI		32206	5029000	6.40
ALABAMA		24771	4021000	6.16
WYOMING		3106	509000	6.10
DELAWARE		3788	622000	6.09
WEST VIRGINIA		11764	1936000	6.08
LOUISIANA		27093	4481000	6.05
MONTANA		4972	826000	6.02
ILLINOIS		67208	11535000	5.83
WISCONSIN		27655	4775000	5.79
GEORGIA		33951	5976000	5.68
ARKANSAS		13403	2359000	5.68
RHODE ISLAND		5459	968000	5.64
OHIO		60490	10744000	5.63
NEW JERSEY		42390	7562000	5.61
MAINE		6411	1164000	5.51
INDIANA		30198	5499000	5.49
FLORIDA		61508	11366000	5.41
VERMONT		2872	535000	5.37
VIRGINIA		30355	5706000	5.32
OKLAHOMA		17554	3301000	5.32
TEXAS		86350	16370000	5.27
MARYLAND		22881	4392000	5.21
KENTUCKY		19317	3726000	5.18
CONNECTICUT		16226	3174000	5.11
NORTH CAROLINA		31398	6255000	5.02
MICHIGAN		45617	9088000	5.02
SOUTH CAROLINA		15418	3347000	4.61
NEW MEXICO		6573	1450000	4.53
COLORADO		14564	3231000	4.51
NEW HAMPSHIRE		4488	998000	4.50
CALIFORNIA		110488	26365000	4.19
NEVADA		3918	936000	4.19
ARIZONA		13199	3187000	4.14
OREGON		11108	2687000	4.13
IDAHO		4132	1005000	4.11
HAWAII		4128	1054000	3.92
WASHINGTON		16642	4409000	3.77
ALASKA		1871	521000	3.59
UTAH		5101	1645000	3.10
	Total	1309312	238113000	5.54

Sources:

State List
by
Beds/Thousand Population October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1984	6303	687000	9.17
SOUTH DAKOTA		5813	705000	8.25
NEBRASKA		11864	1605000	7.39
KANSAS		17606	2440000	7.22
MASSACHUSETTS		41273	5798000	7.12
MINNESOTA		28088	4163000	6.75
TENNESSEE		31880	4726000	6.75
MISSISSIPPI		17424	2598000	6.71
IOWA		19449	2903000	6.70
MISSOURI		33477	5001000	6.69
NEW YORK		118635	17746000	6.69
PENNSYLVANIA		78302	11887000	6.59
ALABAMA		26273	3989000	6.59
MONTANA		5353	823000	6.50
WEST VIRGINIA		12546	1951000	6.43
DELAWARE		3773	614000	6.14
ILLINOIS		69403	11522000	6.02
LOUISIANA		26703	4461000	5.99
WISCONSIN		28188	4762000	5.92
GEORGIA		33801	5842000	5.79
RHODE ISLAND		5574	962000	5.79
ARKANSAS		13497	2346000	5.75
NEW JERSEY		43039	7517000	5.73
OHIO		61399	10740000	5.72
INDIANA		31373	5492000	5.71
VERMONT		3009	530000	5.68
WYOMING		2868	513000	5.59
MAINE		6425	1156000	5.56
FLORIDA		60809	11050000	5.50
OKLAHOMA		18081	3310000	5.46
VIRGINIA		30671	5636000	5.44
MARYLAND		23496	4349000	5.40
TEXAS		86365	16083000	5.37
CONNECTICUT		16616	3155000	5.27
NORTH CAROLINA		32257	6166000	5.23
MICHIGAN		47104	9058000	5.20
KENTUCKY		19237	3720000	5.17
SOUTH CAROLINA		16503	3302000	5.00
COLORADO		15329	3190000	4.81
NEW HAMPSHIRE		4539	978000	4.64
NEW MEXICO		6481	1426000	4.54
CALIFORNIA		110089	25795000	4.27
OREGON		11396	2676000	4.26
IDAHO		4094	999000	4.10
ARIZONA **********		12607	3072000	4.10
NEVADA		3696	917000	4.03
HAWAII		4129	1037000	3.98
WASHINGTON		16509	4349000	3.80
ALASKA		1782	505000	3.53
UTAH		5129	1623000	3.16
	Total	1330257	235875000	5.66

Sources:

State List
by
Beds/Thousand Population October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1983	6014	681000	8.83
SOUTH DAKOTA		5730	699000	8.20
NEBRASKA		12037	1596000	7.54
KANSAS		18280	2426000	7.54
MASSACHUSETTS		41208	5763000	7.15
MINNESOTA		29128	4144000	7.03
NEW YORK		122150	17663000	6.92
TENNESSEE		32080	4676000	6.86
IOWA		19778	2904000	6.81
MISSOURI		33730	4963000	6.80
MISSISSIPPI		17356	2581000	6.72
PENNSYLVANIA		79946	11889000	6.72
WEST VIRGINIA		12983	1962000	6.62
ALABAMA		26001	3961000	6.56
MONTANA		5345	815000	6.56
DELAWARE		3906	606000	6.45
WISCONSIN		29357	4746000	6.19
ILLINOIS		70612	11474000	6.15
RHODE ISLAND		5829	956000	6.10
LOUISIANA		26430	4440000	5.95
ARKANSAS		13772	2325000	5.92
INDIANA		32018	5472000	5.85
GEORGIA		33468	5732000	5.84
OHIO		62405	10736000	5.81
CONNECTICUT		18153	3139000	5.78
VERMONT		3020	525000	5.75
NEW JERSEY		42581	7464000	5.70
VIRGINIA		31289	5556000	5.63
FLORIDA		59704	10742000	5.56
MAINE		6359	1145000	5.55
MARYLAND		23759	4299000	5.53
OKLAHOMA		17833	3310000	5.39
TEXAS		84935	15779000	5.38
NORTH CAROLINA		32605	6076000	5.37
WYOMING		2762	516000	5.35
MICHIGAN		47812	9050000	5.28
KENTUCKY		19085	3713000	5.14
SOUTH CAROLINA		16713	3256000	5.13
COLORADO		15267	3148000	4.85
NEW HAMPSHIRE		4578	958000	4.78
NEW MEXICO		6283	1399000	4.49
OREGON		11747	2658000	4.42
CALIFORNIA		110329	25186000	4.38
IDAHO		4088	987000	4.14
ARIZONA		12187	2970000	4.10
NEVADA		3629	897000	4.05
HAWAII		4106	1018000	4.03
WASHINGTON		16174	4302000	3.76
ALASKA		1754	481000	3.65
UTAH		5390	1618000	3.33
	Total	1341705	233402000	5.75

Sources:
Population - Bureau of Census

State List
by
Beds/Thousand Population October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1982	6039	672000	8.99
SOUTH DAKOTA		5674	694000	8.18
KANSAS		18512	2407000	7.69
NEBRASKA		11841	1589000	7.45
MASSACHUSETTS		41444	5745000	7.21
NEW YORK		125884	17569000	7.17
MINNESOTA		29349	4132000	7.10
IOWA		20481	2907000	7.05
PENNSYLVANIA		82941	11879000	6.98
MISSOURI		34249	4942000	6.93
TENNESSEE		31751	4659000	6.81
MISSISSIPPI		17457	2567000	6.80
DELAWARE		3975	600000	6.62
WEST VIRGINIA		12906	1961000	6.58
ALABAMA		25904	3942000	6.57
MONTANA		5242	805000	6.51
RHODE ISLAND		5924	953000	6.22
ILLINOIS		71211	11466000	6.21
WISCONSIN		28967	4745000	6.10
LOUISIANA		26010	4382000	5.94
ARKANSAS		13635	2307000	5.91
GEORGIA		33016	5651000	5.84
MARYLAND		24881	4272000	5.82
OHIO		62683	10773000	5.82
INDIANA		31898	5482000	5.82
CONNECTICUT		18171	3126000	5.81
MAINE		6588	1136000	5.80
VIRGINIA		31550	5486000	5.75
FLORIDA		59644	10470000	5.70
NEW JERSEY		42362	7428000	5.70
VERMONT		2907	520000	5.59
TEXAS		84599	15349000	5.51
OKLAHOMA		17697	3231000	5.48
NORTH CAROLINA		32548	6015000	5.41
WYOMING		2733	510000	5.36
SOUTH CAROLINA		17133	3226000	5.31
MICHIGAN		48328	9115000	5.30
KENTUCKY		18794	3694000	5.09
NEW HAMPSHIRE		4695	948000	4.95
COLORADO		15127	3070000	4.93
NEW MEXICO		6310	1367000	4.62
CALIFORNIA		111541	24698000	4.52
OREGON		11901	2666000	4.46
ARIZONA **********		12125	2891000	4.19
IDAHO		4047	977000	4.14
HAWAII		4108	997000	4.12
NEVADA		3503	878000	3.99
ALASKA		1718	444000	3.87
WASHINGTON		15689	4276000	3.67
UTAH		5279	1571000	3.36
	Total	1350971	231190000	5.82

Sources:
Population - Bureau of Census

State List
by
Beds/Thousand Population

October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1981	5959	661000	9.02
SOUTH DAKOTA		5874	692000	8.49
KANSAS		18283	2388000	7.66
NEBRASKA		11928	1583000	7.54
MASSACHUSETTS		42252	5754000	7.34
MINNESOTA		30015	4112000	7.30
NEW YORK		126029	17558000	7.18
IOWA		20673	2918000	7.08
PENNSYLVANIA		83600	11878000	7.04
MISSOURI		34599	4939000	7.01
DELAWARE		4160	596000	6.98
MISSISSIPPI		17703	2547000	6.95
TENNESSEE		31513	4632000	6.80
ALABAMA		25838	3927000	6.58
WEST VIRGINIA		12887	1960000	6.58
MONTANA		5204	796000	6.54
RHODE ISLAND		5999	953000	6.29
ILLINOIS		71498	11468000	6.23
LOUISIANA		26546	4300000	6.17
WISCONSIN		28773	4735000	6.08
MAINE		6818	1133000	6.02
OHIO		64019	10799000	5.93
MARYLAND		24969	4256000	5.87
INDIANA		32160	5489000	5.86
ARKANSAS		13379	2300000	5.82
CONNECTICUT		18129	3122000	5.81
GEORGIA		32353	5569000	5.81
FLORIDA		58870	10184000	5.78
VIRGINIA		31357	5441000	5.76
NEW JERSEY		42193	7407000	5.70
VERMONT		2918	516000	5.66
TEXAS		83147	14753000	5.64
WYOMING		2741	494000	5.55
OKLAHOMA		16995	3107000	5.47
NORTH CAROLINA		32465	5956000	5.45
SOUTH CAROLINA		17274	3187000	5.42
MICHIGAN		48963	9210000	5.32
KENTUCKY		18948	3676000	5.15
NEW HAMPSHIRE		4742	937000	5.06
COLORADO		14956	2983000	5.01
CALIFORNIA		111774	24216000	4.62
NEW MEXICO		6011	1334000	4.51
OREGON		11948	2669000	4.48
HAWAII		4121	981000	4.20
ALASKA		1729	416000	4.16
ARIZONA		11636	2810000	4.14
IDAHO		3977	964000	4.13
NEVADA		3447	846000	4.07
WASHINGTON		16023	4236000	3.78
UTAH		5390	1524000	3.54
	Total	1352785	228912000	5.89

Sources:

State List
by
Beds/Thousand Population October 31, 1986

STATE	YEAR	BEDS	POPULATION	BEDS/ THOU.
NORTH DAKOTA	1980	5942	653000	9.10
SOUTH DAKOTA		5518	691000	7.99
MASSACHUSETTS		43048	5737000	7.50
KANSAS		17736	2364000	7.50
NEBRASKA		11652	1570000	7.42
MINNESOTA		30057	4076000	7.37
NEW YORK		127561	17558000	7.27
PENNSYLVANIA		85459	11864000	7.20
WEST VIRGINIA		13979	1950000	7.17
MISSOURI		35277	4917000	7.17
IOWA		20581	2914000	7.06
DELAWARE		4179	594000	7.04
MISSISSIPPI		17205	2521000	6.82
TENNESSEE		30905	4591000	6.73
MONTANA		5268	787000	6.69
ALABAMA		25214	3894000	6.48
ILLINOIS		72887	11427000	6.38
RHODE ISLAND		6036	947000	6.37
LOUISIANA		26650	4206000	6.34
WISCONSIN		28687	4706000	6.10
MAINE		6817	1125000	6.06
FLORIDA		59056	9746000	6.06
NEW JERSEY		43925	7365000	5.96
MARYLAND		25113	4217000	5.96
OHIO		63573	10798000	5.89
INDIANA		32094	5490000	5.85
CONNECTICUT		18162	3108000	5.84
VIRGINIA		31187	5347000	5.83
TEXAS		81844	14229000	5.75
VERMONT		2924	511000	5.72
GEORGIA		31159	5463000	5.70
OKLAHOMA		17186	3025000	5.68
ARKANSAS		12949	2286000	5.66
NORTH CAROLINA		32804	5882000	5.58
SOUTH CAROLINA		16985	3122000	5.44
WYOMING		2511	470000	5.34
MICHIGAN		49369	9262000	5.33
COLORADO		15262	2890000	5.28
KENTUCKY		18771	3661000	5.13
NEW HAMPSHIRE		4579	921000	4.97
CALIFORNIA		112478	23668000	4.75
NEW MEXICO		6074	1303000	4.66
OREGON		11901	2633000	4.52
ARIZONA		11610	2718000	4.27
NEVADA		3417	800000	4.27
ALASKA		1682	402000	4.18
HAWAII		3964	965000	4.11
IDAHO		3779	944000	4.00
WASHINGTON		15716	4132000	3.80
UTAH		5279	1461000	3.61
	Total	1356011	225911000	5.94

Sources:

EXHIBIT # 9
DATE 3-12-87
HB # 241

CON AND OTHER STATES

Your legislative colleagues in other states are also considering what to do with CON this year. Just two weeks ago, the Wyoming legislature repealed its CON law effective May 22, 1987. There has been no discussion to date of signing a Section 1122 agreement. In Colorado this week, a CON bill that covers long-term care beds only will be heard before committee. The California legislature voted to allow its CON law to sunset January 1, 1987. There is no Section 1122.

Attached is some pertinent pages from a January 1987 report by the National Conference of State Legislatures. It describes what the various states plan to do with CON this year. Seventeen proposals would expand thresholds or exempt certain providers, ten proposals would abolish CON outright and ten proposals would strengthen the program. Because some states have more than one proposal, Table 3, which lists the action each state plans, is included.

According to the most recent information available and augmented by a Montana Hospital Association telephone poll March 4, 1987, the following is a count of states without CON:

No CON or 1122

California	(sunset 1/1/87)
Wyoming	(repealed as of 5/22/87)
Utah	
Arizona	
Texas	
Kansas	

No CON

Idaho
Minnesota
New Mexico
Louisiana
Mississippi

On July 1, 1986 the Oklahoma legislature increased the CON thresholds from $400,000 on equipment to $3,000,000, and from $600,000 on buildings to $3,000,000 in FY 1987, $4,000,000 in FY 1988, and $5,000,000 in FY 1989 and beyond.

STATE ISSUES 1987

A REVIEW OF THE MAJOR ISSUES CONFRONTING STATE LEGISLATURES

National Conference of State Legislatures

Foundation for State Legislatures

1050 Seventeenth Street, Suite 2100
Denver, Colorado 80265

444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001

January 1987

HEALTH CARE ISSUES IN 1987

HEALTH CARE AND THE STATES: A PREVIEW OF LEGISLATIVE ISSUES

By David Landes, Program Manager, Health Care Project

Health care will continue to occupy a prominent place in state legislative deliberations, as indicated by NCSL's 1987 State Issues Survey. The survey asked what actions would be considered in a number of health issue areas:

- health care for the medically indigent
- Medicaid and medical assistance programs
- long-term care and Alzheimer's Disease
- hospitals
- certificate of need and health planning
- medical malpractice
- professional licensure
- organ transplantation and donation
- AIDS
- health insurance
- state employee health plans

The five most frequently mentioned issues, according to the survey results, were: care for the medically indigent, medical malpractice, certificate of need and health planning, long-term care and Alzheimer's Disease, and Medicaid and medical assistance programs. Each of these issues is discussed in more detail below.

HEALTH CARE FOR THE MEDICALLY INDIGENT

Funding for health expenses for those who cannot afford to pay themselves has been an important issue in past years and will continue to be in 1987. The medically indigent are the group of people who are not poor enough to qualify for Medicaid or medical assistance but who do not have insurance or personal assets sufficient to pay medical bills. Studies have shown that many of these people are working but uninsured for for medical care. Much of the care they receive is for accidents, common medical problems, or childbirth. In the past, hospitals and other health care providers subsidized the cost of care for this population by charging higher prices to other payers. However, health care cost containment pressures from both the public and private sectors have made it more difficult for providers to continue this subsidy. As a result, providers have limited the amount of charity care they will provide, placing larger burdens on public facilities and on those providers unwilling to limit charity care. Both providers and advocates for the poor have actively sought legislative action in this area.

Three possible options for dealing with the medical indigency problem were mentioned frequently by respondents (Table 1):

- Expand eligibility for Medicaid or medical assistance (19 states)

  The Medicaid program is the primary vehicle for paying for medical care for the poor, and extension of this program to the medically indigent is a logical proposal. An additional advantage of Medicaid expansion is the possible availability of federal matching funds, which may reduce the states' funding contribution.

- Provide funding for prenatal care (17 states)

  Prenatal care is one of the types of health care most often provided to the medically indigent. Prenatal care is often considered especially important because small investments of funds can prevent massive lifetime expenses due to birth defects and other birth-related problems.

- Risk pools for uninsurable persons (14 states)

  Some persons cannot get health insurance because they are in high-risk medical or occupational categories and are not part of a large insurance-purchasing group. Some states have established special insurance pools for these individuals, offering low premiums subsidized by a tax on insurers or by state general funds.

Other options frequently identified by respondents were:

- Creation of a medically indigent fund, not with general revenue, but by assessing such entities as hospitals, third-party payors, employers, long-term care facilities, or counties (12 states);
- Increase in access to emergency medical care for the indigent (12 states);
- Redistribution of uncompensated care costs more equitably among hospitals (11 states);
- Establishment of pharmaceutical assistance program for the elderly (10 states).

MEDICAL MALPRACTICE

In 1986, 16 states passed legislation related to medical malpractice. Indications are that medical malpractice will continue to be an important issue in 1987. Insurers claim that skyrocketing claim settlements and court awards threaten their financial solvency, necessitating large premium increases or complete withdrawal from the market. Providers faced with premium hikes or insurance cancellation have urged legislatures to limit the financial pressures on insurers. On the other hand, trial lawyers and public advocates have accused insurers of creating a phoney crisis as a way of getting legislatures to limit the legitimate claims of policyholders.

A number of possible actions were identified by survey respondents (Table 2):

- o Limits on insurers' financial burden (lo states)

  These limits include caps on total awards or on awards for specific types of damages, and payment of awards over time rather than in a lump sum. Another common change is elimination of the collateral source rule, which makes all other defendants liable for payment of damages awards against those who cannot afford to pay.

- o Limits on attorneys' fees (14 states)

  Because most malpractice attorneys' fees are based on a percentage of the damage awards, limits on attorneys' fees are proposed as a way of reducing attorneys' incentives to file malpractice suits.

- o Reducing the statute of limitations (lU states)

  Reducing the period of time within which malpractice suits must be filed is also seen as a way of reducing the number of suits filed.

- o Medical malpractice insurance data collection (lU states)

  Many policymakers have commented on the lack of reliable data on which to evaluate the insurance industry's claims of financial losses. Reporting of claims information to state regulators is seen as one way of assuring that such information will be available for future legislative consideration.

Other possible legislative actions identified by respondents were:

- o Improvement of discipline of negligent providers (9 states);
- o Encouragment of claims resolution without trial through such reforms as arbitration or pretrial screening panels (7 states);
- o Assistance to physicians in obtaining medical malpractice insurance coverage (7 states).

CERTIFICATE OF NEED (CON) AND HEALTH PLANNING

Abolition of federal health planning requirements and withdrawl of federal funds will motivate states to reexamine the scope of health planning and certificate of need programs. Aimed at reducing health care costs, these programs attempt to control the number and type of health care facilities through state-mandated review and approval procedures. They have been criticized as ineffective, inconsistent, and inappropriate in today's climate of deregulation.

The possible actions described by survey respondents indicate a divergence of opinion. Some states will consider both weakening and strengthening these programs. Options identified include (Table 3):

- Reduce the powers of CON programs (17 states)

  The trend nationwide has been to deregulate certain types of facilities and providers such as ambulatory surgical centers and home health agencies. Also, the capital expenditure "thresholds" that determine which projects will be subject to state review have been increased, reducing the number of projects reviewed.

- Abolition of the CON program (10 states)

  Outright abolition of CON would create a largely unregulated health care system.

- Strengthen the CON program (10 states)

  Actions to strengthen the CON program are the opposite of those described above.

In addition to these actions, four states will consider imposing moratoriums on construction of certain types of health facilities.

LONG-TERM CARE AND ALZHEIMER'S DISEASE

Long-term care has figured prominently in legislative actions because of the growth in the elderly population and the large portion of the Medicaid budget devoted to long-term care. Recent long-term care issues have been improvements in the nursing home system, increasing the efficiency and effectiveness of the Medicaid system, and development of a range of noninstitutional long-term care services. Alzheimer's Disease, which causes progressive mental and physical deterioration in its victims, has had high visibility in the media.

The most frequently mentioned legislative options in this area were (Table 4):

- Expanded Alzheimer's Disease activities (22 states)

  Possible state activities include: establishing or expanding services to Alzheimer's victims and their families, funding research into the illness, and broadening eligibility for existing services to include individuals impacted by Alzheimer's Disease.

- Long-term care insurance (16 states)

  Long-term care insurance for nursing home and home health care is experiencing increasing interest and acceptance among the elderly. States have become interested in long-term care insurance because widespread insurance could reduce Medicaid long-term care expenditures. State actions might be regulation to protect consumers or incentives to encourage purchase.

- Case management systems for long-term care (14 states)

  Case management means placing responsibility for coordination and approval of long-term care services for each individual in the hands

TABLE 4: LONG-TERM CARE AND ALZHEIMER'S DISEASE

States*	Services for Alzheimer's Disease	Long-Term Care Insurance	Enhance Quality of Care	Implement Case Management
ALABAMA	o			
ARIZONA				
ARKANSAS	o		o	o
CALIFORNIA	o	o	o	o
COLORADO			o	
CONNECTICUT	o			
DELAWARE	o	o	o	
FLORIDA	o	o		o
HAWAII	o			o
IDAHO				
ILLINOIS		o	o	
INDIANA	o	o		o
IOWA	o			
KANSAS	o	o		o
LOUISIANA		o		o
MAINE				
MARYLAND	o			
MINNESOTA	o			
MISSISSIPPI				
MONTANA	o	o		
NEBRASKA		o		o
NEVADA		o	o	o
NEW HAMPSHIRE	o			
NEW JERSEY	o		o	o
NEW YORK	o	o	o	o
NORTH CAROLINA		o		
NORTH DAKOTA	o			
OHIO				
OKLAHOMA		o	o	o
OREGON	o	o	o	
RHODE ISLAND	o			o
SOUTH DAKOTA	o			
TENNESSEE	o	o	o	o
TEXAS				
UTAH				
VERMONT				
VIRGINIA	o			
WEST VIRGINIA			o	
WISCONSIN		o		
WYOMING				

* States not responding to the survey are not listed in the table.

TABLE 3: CERTIFICATE OF NEED AND HEALTH PLANNING

States*	Reduce CON Powers	Abolish CON	Strengthen CON
ALABAMA			o
ARIZONA			
ARKANSAS		o	
CALIFORNIA			
COLORADO		o	
CONNECTICUT			
DELAWARE			
FLORIDA	o	o	
HAWAII	o		
IDAHO			
ILLINOIS		o	o
INDIANA	o	o	o
IOWA			
KANSAS			
LOUISIANA	o		o
MAINE	o		
MARYLAND			o
MINNESOTA			
MISSISSIPPI			
MONTANA			
NEBRASKA	o		
NEVADA	o		
NEW HAMPSHIRE	o		
NEW JERSEY	o		
NEW YORK			o
NORTH CAROLINA	o		
NORTH DAKOTA			
OHIO	o	o	
OKLAHOMA			
OREGON	o	o	o
RHODE ISLAND			o
SOUTH DAKOTA	o	o	o
TENNESSEE			
TEXAS			
UTAH			o
VERMONT			
VIRGINIA	o	o	
WEST VIRGINIA	o		
WISCONSIN	o	o	
WYOMING	o		

* States not responding to the survey are not listed in the table.

EXHIBIT #15
DATE 3-12-91
HB #246 Ex Session

REVIEW OF CON ACTIVITY

The Montana Health Care Association claims that CON has been an effective break on investment because it approves only 53.3 percent of all projects. This number is based upon a report prepared by the Office of Planning and Budget Development, Arizona Department of Health Services for 1984. The Montana Hospital Association believes a better source of information is the seven-year report (1980-1986) prepared by the Montana Health Planning Bureau, Department of Health and Environmental Sciences. A copy of the one-page report is attached.

According to this report, the approval rate (approvals ÷ [approvals + denials]) for the seven years was 91.6 percent. MHA contends that the approval rate would even be higher, if it were not for batching. The denials in the report are also somewhat problematic. For example, although the report shows that $10 million were denied in 1982, $9 million was approved by the Board of Health in the next year. In 1986, although there were eight denials, there were as many as three reversals.

To point out how acrimonious the CON process has to become, compare the number of appeals to denials. According to the report there is a 76 percent appeal rate (appeals ÷ denials). Less than one in four claimants is willing to accept the verdict of the Department.

Finally, over the seven years of the report 952 nursing home beds were proposed and 479 were built. These uninterpreted statistics are misleading. Notice, if you will, the large number of beds proposed since the introduction of batching, (July 1983) compared to those proposed before batching. There was never any intention to build the 952 beds proposed. The real intent was to build the 479 beds that were approved. Under batching, if a provider declares his intention to build 100 beds, his competitors can also submit applications to build 100 beds each. If there are four competing applications for 100 beds each, the total proposed nursing home beds is 400. However, there is clearly not a desire to build 400 beds. In reality, there are four claimants for the same 100 beds. The uninterpreted data appears to indicate that there is a much greater desire to build nursing home beds than there are permits being issued. This, in fact, is not the case.

In summary, the number of batched proposals is no indication of the amount of investment that would have been made if CON were to sunset or if thresholds were higher. A better indicator of the investments that would be made without CON is to look at those made under CON.

SUMMARY OF MONTANA CON ACTIVITY 1980-1986*

	1980	1981	1982	1983	1984	1985	1986
Letters of Intent	60	41	58	92	85	89	79
Applications Completed	40	27	44	31	62	44	51
Proposals # Reviewed	39	27	45	31	61	46	65
Proposals ($1,000,000)	33	28	93	35	35	13	60
Approvals (#)	39	27	40	30	48	40	47
Approvals ($)	33	28	80	35	16	9	49
Denials (#)	0	0	2	1	12	2	8
Denials ($1,000,000)	0	0	10	0	19	3	8
Appeals	0	2	2	1	7	2	5
Nursing Home Beds Proposed	0	0	30	65	466	74	317
Nursing Home Beds Approved	0	0	30	5	243	56	145

*Prepared by Health Planning Bureau, Department of Health and Environmental Sciences, January, 1987.