MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 12, 1993, at 1:00 p.m.

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing:	SB 266, SB 312, SB 313
Executive Action:	SB 267, SB 118, SB 120, SB 166, SB 312, SB 313

EXECUTIVE ACTION ON SB 267

Discussion:

Sen. Bill Yellowtail said he has been assessing the prospects of passing health care reform legislation through the legislature. He and Sen. Franklin share the commitment that Montana move forward with meaningful health care reform. It is not rational that two competing bills should pass through the legislature, so Sen. Yellowtail proposed that the Committee adopt SB 285 as the vehicle for moving health care reform through the legislature. The reason for this is that SB 267 is a "direct to single-payor" bill, and he remains dedicated to that principle. However, SB 285 has the potential for both single-payor and multi-payor

systems to be developed for the consideration of the next legislative session. Sen. Yellowtail proposed that the "integrity" of SB 267 be incorporated into SB 285, as well as other common interest items. Sen. Yellowtail said he didn't want the people of Montanans for Universal Care (MUC) to try and stop SB 285.

Chairman Eck said the Committee would not act on SB 285 today unless there were a motion to Table SB 267 and accept amendments to SB 285.

Sen. Klampe asked for Sen. Franklin's response. Sen. Franklin thanked Sen. Yellowtail for appearing before Committee and "helping us find a direction" to move forward. Sen. Franklin said there must be clear language in SB 285 that will commit us to significant reform.

Sen. Christiaens asked Chairman Eck how the Committee would proceed, with a subcommittee or through an amendment process. Chairman Eck said a subcommittee would not be necessary. She suggested that if anyone had amendments to submit, they should be taken to Susan Fox, Legislative Council, first. Executive Action will be taken on Monday, February 15th, and on Wednesday, February 17. If it appears that the Committee is getting "bogged down," certain sections could be assigned to a subcommittee, but she would rather see the Committee work on it all together.

Sen. Christiaens said he wanted to inform the Committee that in the Business and Industry Committee a bill from Sen. Lynch was heard which addresses preferred provider organizations. In addition, Sen. Harp has worker's compensation legislation which specifically addresses preferred providers. Sen. Christiaens said this is an issue with "far reaching ends."

Chairman Eck said she requested that Sen. Lynch's bill come to the Public Health Committee, but Sen. Lynch wanted it heard in Business and Industry. Chairman Eck asked Sen. Christiaens to make the Business and Industry Committee aware that bill is in direct opposition to the notion of cost containment.

Chairman Eck asked if the Committee wanted to Table SB 267. Sen. Towe said it would be better to wait.

Sen. Christiaens announced that Tom Gomez, Legislative Council, was back in the hospital, and the Committee might want to do something to recognize his absence. Chairman Eck said she would send a card on behalf of the Committee.

EXECUTIVE ACTION ON SB 120

Discussion:

Susan Fox went over the amendments suggested by Sen. Towe. (Exhibit #1)

Motion:

Sen. Towe moved the amendments.

Discussion:

Sen. Christiaens asked Sen. Towe if multi-disciplinary teams were covered by the amendments. Sen. Towe said amendment #6 addressed that, stating that the treatment team must contain a person who is not part of the treatment plan.

Vote:

The motion carried unanimously.

Motion/Vote:

Sen. Christiaens moved SB 120 as amended DO PASS. The motion carried unanimously.

EXECUTIVE ACTION ON SB 118

Discussion:

Chairman Eck went over the amendment. (Exhibit #2)

Sen. Towe said he had concerns about the amendment, that it doesn't go farther. He said he was going to change Chairman Eck's amendment.

Chairman Eck said the Committee would first discuss the amendments which take "adult foster care" out of the bill.

Motion/Vote:

Sen. Towe moved the amendments. The motion carried unanimously.

Discussion:

Sen. Towe said he and Sen. Franklin had concerns that just getting a signed statement from a physician agreeing to a patient's admission were not completely satisfactory. If a patient is there for a long time, there needs to be an update. And, perhaps someone other than the physician should look at the facility to see if it were appropriate. Sen. Towe said Chairman Eck's amendment addresses the first part, but not the second part.

Sen. Franklin said the language should contain something about a patient's health status.

Sen. Towe said there should be something stating the facility being appropriate and continuing to be appropriate.

Sen. Franklin said a physician or a registered nurse could do this.

Chairman Eck said she had "... and on a regular basis as determined by rule, a physician or registered nurse shall..."

Sen. Franklin continued with "determine appropriateness of placement based on a patient's health status."

Sen. Towe suggested "... on a regular basis as determined by rule, a signed statement by a physician or a registered nurse is obtained that the particular needs of the patient are being met."

Chairman Eck said that because the language may need to be addressed in the statement of intent, Susan Fox should review it for the meeting on Monday, February 15th.

Sen. Towe said he wasn't going to be able to attend that hearing, and suggested that there be specific language completed before the end of today's hearing.

EXECUTIVE ACTION ON SB 166

Discussion:

Susan Fox said the amendments were agreed to by the Physical Therapists Association and the Occupational Therapist Association. The Rose Hughes amendments were never accepted.

Greg Duncan said he and Mona Jamison are in total agreement on the amendments already taken care of by Sen. Towe.

Motion/Vote:

Sen. Towe moved the amendments. The motion carried unanimously.

Motion/Vote:

Sen. Franklin moved SB 166 DO PASS as amended. The motion carried unanimously.

HEARING ON SB 266

Opening Statement by Sponsor:

Sen. Bruce Crippen, Senate District 45, said SB 266 amends section 37-13-104 and 303 dealing with the Acupuncture Act, which states who can practice the art of acupuncture, and the requirements for acupuncture licenses. SB 266 eliminates the requirement that a physician or an osteopath adhere to the rules of the Act, and that they could be licenses under their respective chapters in order to practice acupuncture. Sen. Crippen said one of his constituents is an anesthesiologist, but with his medical background and study of acupuncture at UCLA, he was still not qualified to expand his practice of pain management to acupuncture. Montana has a law requiring 1000 hours of study of acupuncture before a license can be obtained.

Proponents' Testimony:

Dr. Dave Healow, Billings, handed out an article concerning the requirements as a medical acupuncturists. (Exhibit #3) Dr. Healow said he took an acupuncture course at UCLA, and currently has about 400 hours of training which he cannot utilize. For him, acupuncture is both an in-hospital and out-of-hospital practice. Dr. Healow called the Committee's attention to Page 11 of the article showing the requirements of training to practice acupuncture in the different states. Dr. Healow said it is simply a therapeutic technique. He said none of the lay acupuncturists in Billings he refers his patients to have taken the NCCA exam or completed the 1000 hours of training. These acupuncturists can't practice in hospitals so his in-hospital patients cannot benefit from it. Also, patients who won't see a non-physician are deprived of it, and the acupuncturists in Billings will not see Medicaid patients. Physicians go to post-graduate continuing education courses to learn about new procedures, and receive credits approved by the American Medical Association (AMA). The current law acts as if the practice of acupuncture is "owned" by the lay acupuncturists in the state. The American Osteopathic Association has endorsed it as an effective technique, and the AMA soon will. Dr. Healow said there is not a lot of scientific literature support the use of acupuncture, but this is increasing. The Board of Medical Examiners has an excessive training requirements, which would require Dr. Healow to take a lay acupuncture exam, but this does not have the accreditation of the medical associations. Also, this exam only covers traditional Chinese medicine which is a very narrow part of acupuncture. Essentially, the public is protected by the Medical Practice Act, but this is a "turf battle," and he would like it to be included as part of medical practice, and SB 266 does that.

Jerry Loendorf, Montana Medical Association, said in 1974 when the Acupuncture Act was passed, the testimony was that physicians were not delivering acupuncture. It was passed to expand the delivery of acupuncture. The Board of Medical Examiners has

always regulated the practice of acupuncture, and there has never been a complaint that medical doctors do not have adequate training. The general education that many health care providers have, including physicians, includes good basic background to the practice of acupuncture.

Opponents' Testimony:

Dr. Nancy Aagenes, licensed primary care naturopathic physician and a licensed acupuncturist, said her licensing act does not allow her to distribute antibiotics. The changes proposed require no training or credentials for a physician to practice acupuncture. Dr. Aagenes said the training requirements for a physician and a non-physician should be the same. Regarding the licensing exam, the requirements for Montana were the lowest in the United States, and the requirement for a standardized National Acupuncture exam are a good idea.

Donald Beans, Registered Nurse, said he has been practicing acupuncture since 1980. In 1974, an act was passed regulating acupuncture, and the legislature decided that no one should have a license without education and an exam. The requirements have been changed to require more hours of education. The law requires everyone to be licensed in the same way. The basic training requirement for acupuncture is 2000 hours inside of 3 years of training, or a 4000 hour apprenticeship. Mr. Beans said that acupuncture is much more of a complete system than it was in the 1970's, and the national requirements are well established. The Board of Medical Examiners can change the rules in the Acupuncture Practice Act, and they have a good working relationship with the Board of Medical Examiners. Mr. Beans said it is not fair or prudent to allow a physician or osteopath to practice acupuncture without any training or education requirements. He asked that the Committee give SB 266 a do not pass recommendation.

Bridgette Mazurek, licensed acupuncturist in Helena, said she currently serves as Secretary to the Montana Acupuncture Association. Ms. Mazurek said she opposes SB 266 because she sees no need to make exceptions to the requirements for practicing acupuncture. There are currently 70 licensed acupuncturists in Montana, and students coming out of acupuncture school look to Montana as a model state. At this time acupuncture is relative inexpensive as provided by lay acupuncturists, and including medical doctors could drive up costs. Acupuncture is currently covered by many insurance companies, and it is included in the Freedom of Choice of Health Care Practitioners Act, and the Workers Compensation Act.

Dan Shea, Montana Low Income Coalition, said the Coalition opposes SB 266 because it is special interest legislation. Mr. Shea said that there will be no assurances that physicians or osteopaths have had training if SB 266 passes.

Thomas Bump, licensed acupuncturist, said he has been practicing for five years in Helena. Mr. Bump asked the Committee what they would say if he came before the Committee after having taken some classes in pharmacology, and wanted to prescribe medications for his patients. He urged the Committee give SB 266 a do not pass recommendation.

Questions From Committee Members and Responses:

Sen. Christiaens said he would like to know how many of the acupuncturists now licensed in Montana have completed the full 1000 hours of training, and were not grandfathered in. Donald Beans said the law was changed, and the 1000 hour requirement was implemented in 1987. From that time, everyone has been required to meet these requirements, and that is when the bulk of acupuncturists came to Montana. Those licensed before 1987 were not required to meet the 1000 hour requirement.

Sen. Christiaens asked Mr. Beans how many of the 70 licensed acupuncturists in Montana did not complete the 1000 hour requirement and were grandfathered in. Mr. Beans said more than half have completed the 1000 hour requirement.

Sen. Rye asked how many acupuncturists at the hearing today accept Medicaid patients. Mr. Beans said that Medicaid does not accept acupuncturists. Last legislative session, acupuncturists were added to the Freedom of Choice in Health Care Act, and they were added as primary care providers under the Workman's Compensation Act. There are some instances where they can accept insurance payments and others where they cannot.

Sen. Rye asked Mr. Beans if Dr. Healow accepts Medicaid payments because he's a medical doctor. Mr. Beans said that is because Medicaid accepts medical doctors as primary care providers.

Sen. Towe asked Dr. Healow how he responded to the concerns that there would be no requirements before a medical doctor would be allowed to practice acupuncture. Dr. Healow said the Medical Practice Act states that without training, a physician is guilty of unprofessional conduct. Acupuncture is a therapeutic technique, and he has no problem with a 200-300 training requirement. There are lots of acupuncturists who say that is adequate to begin treatment. The 1000 hour training course is such a high fence, it would require him 10 years to get it.

Sen. Franklin asked Dr. Healow how much overlap there is between his medical knowledge and the acupuncture course. Dr. Healow said there was a significant amount of overlap. Acupuncture is an applied tool and one discipline should not "own it."

Sen. Franklin said she was wondering what was transferable from the medical background which would allow medical doctors to arrive at training at a different level.

Thomas Bump said the only course that medical school gives which are taken at acupuncture school is anatomy.

Sen. Klampe asked Dr. Healow why he had left out dentistry from SB 266. Dr. Healow said he would have no objection to it, but he would not presume to do dentists' political work.

Sen. Towe asked Mr. Beans how he responded to Dr. Healow's statement that 37 states allow medical doctors to practice acupuncture without any restrictions. Sen. Towe asked Mr. Beans why that was not sufficient for medical doctors not to misrepresent themselves or mislead the public. Mr. Beans said in other states, physicians can decide that they are as qualified as those individuals taking the national examination. It is not like adding a separate technique, it is a separate profession.

Sen. Towe asked Mr. Beans if the other states were not concerned about it. Mr. Beans said the states do license acupuncture, and the licensing of acupuncture is just getting started because it is a new profession.

Sen. Mesaros asked why Montana required 1000 hours of training when other states seemed to require 100-300 hours of training. Thomas Bump said 27 states do license acupuncturists, and 2/3 of those states use the national exam. Montana is not the most restrictive state.

Sen. Franklin asked Dr. Healow if he could pass the current acupuncture exam if he took it today. Dr. Healow said he could easily pass the exam, but one cannot take it until 1000 hours of training have been completed.

Chairman Eck asked Mr. Beans what he did with the State Board of Medical Examiners. Mr. Beans said they were rewriting the rules to the Acupuncture Practice Act.

Chairman Eck asked Mr. Beans who was doing that with him. Mr. Beans said Patricia England, and the entire board.

Sen. Towe asked Mr. Beans if he would be satisfied with a 200-300 hour requirement for medical doctors only. Mr. Beans said he would be satisfied with any requirement so long as they would take the exam.

Sen. Towe asked Dr. Healow if that were an acceptable compromise. Dr. Healow said it wasn't because the exam does not represent medical acupuncture, and medical doctors have had no input into it. Dr. Healow said it was not a valid exam for medical doctors.

Chairman Eck asked Dr. Healow if there were a nationally given exam that is adequate. Dr. Healow said there was not one for physicians.

Closing by Sponsor:

Sen. Crippen said that many good points had been made on both sides of the issue. Montana has requirements that are entirely too high for medical doctors. But, a middle ground can be reached. Sen. Crippen said it is not fair to demand the same requirements of a medical doctor as for someone who has had no previous training.

HEARING ON SB 312

Opening Statement by Sponsor:

Sen. Tom Beck, Senate District 4, Deer Lodge, said that currently physicians who receive training in Montana are restricted to only two months in one area. SB 312 establishes something to allow those physicians to stay.

Proponents' Testimony:

Frank Michels, M.D., said he is a family physician in Billings. Dr. Michels said Montana is facing a shortage of family physicians, and they are in great demand. Montana has taken a responsible step by purchasing 20 slots per year at the University of Washington School of Medicine, the WAMI program. Each year, medical students must go through a residency program before they can begin to practice medicine. Most doctors practice within 150 miles of where they did their residency. Montana has no residency programs and the best solution is to start a residency program in family practice to be placed in an underserved area. The residency could also have rural rotations. Currently, a feasibility study is underway, and Dr. Michels is chairman of the steering committee. He submitted written testimony in behalf of the legislation to delete barriers for SB 312. (Exhibit #4) The merits of the funding and the program will be discussed in greater detail in testimony to other committees.

Verner Bertlesen, Montana Legacy Legislature, said SB 312 is necessary to make a rural residency program possible because it eliminates the two month restriction. The Legacy Legislature feels that SB 312 is one of their "priority" pieces of legislation. Alaska and Montana are the only states without such a program, and both states suffer from a shortage of physicians. Mr. Bertlesen encourages the Committee's support for the appropriation which is in the Governor's budget.

Jim Ahrens, President of the Montana Hospital Association, said the Association supports the deletion of the two month restriction to make it possible to extend the training programs over a three year period.

Jerry Loendorf, Montana Medical Association, said the Association very strongly supports SB 312.

Paulette Kohman, Executive Director of the Montana Council for Maternal and Child Health, said SB 312 and the funding for it is on the Council's agenda. Ms. Kohman said that if Montana adopts a universal health care system, there will not be enough providers in Montana, and physicians will have to be actively recruited. SB 312 is one of the key measures to assuring that Montana has primary care providers.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

Sen. Christiaens asked Verner Bertlesen how much money from the Governor's budget would go towards this bill. Mr. Bertlesen said it would be heard March 18th in the Health and Human Services and Aging Subcommittee. This was a fund originally planned for in the Governor's budget, but somehow it wasn't included. It is $200,000 per year.

Chairman Eck asked if this were in Rep. Cobb's bill, HB 145. Paulette Kohman said in HB 145 there was mention of this program, but there was not a line item appropriation for it. That bill is the best probable appropriation funding for the project.

Dr. Michels said this program was part of the Montanans for Health Care proposal, $200,000 per year for it. The costs are close to $2 million per year, but this program, with accreditation and affiliation with the University of Washington, the federal government, patient revenue and hospital sponsors would make up part of the funding. This program was dropped from the Governor's budget in December, but it was an oversight, and it is now back in the appropriation.

Closing by Sponsor:

Sen. Beck said SB 312 is a good bill, and he supports it. He said he knows that "times are tough," but it makes sense to get resident physicians to Montana.

HEARING ON SB 313

Opening Statement by Sponsor:

Sen. Tom Towe, Senate District 46, said SB 313 is a request from the Department of Family Services which deals with adult foster care family homes. Currently a juvenile who is in a foster home may have to leave that home when he turns 18. SB 313 states that that individual may stay in that home if he has been there the

year prior to his 18th birthday. Sen. Towe went through SB 313, noting reporting elderly abuse, and the confidentiality of those abuse records except in certain conditions included in the bill.

Proponents' Testimony:

Don Sekora, Program Officer with the Department of Family Services, provided written testimony. (Exhibit #5)

Sue Jackson, Development Disabilities Division of SRS, said they support SB 313. It is important that an individual be able to remain in the foster home they have been in throughout their youth. Ms. Jackson said it was an oversight in Section 2 that "developmentally disabled" were not addressed. She also said it was important to provide information to those who need it, for example, those working with the developmentally disabled need information to correct or avoid certain situations.

Opponents' Testimony:

None.

Questions From Committee Members and Responses:

Chairman Eck asked Don Sekora if a youth foster home would also be licensed as an adult foster home. Mr. Sekora said that was the intent.

Chairman Eck asked Mr. Sekora if that home would then be licensed in two ways. Mr. Sekora said there was no prohibitions against licensing a home as both a child foster care home and an adult foster care home. A dual license is a possibility.

Chairman Eck asked Mr. Sekora how often the homes were evaluated. Mr. Sekora said there was an annual evaluation.

Sen. Christiaens asked Mr. Sekora if these homes would accept an adult disabled ex-offender. Sue Jackson said they would.

Sen. Christiaens asked Mr. Sekora if he was aware of any that have or do. Mr. Sekora said the Foster Care Act is geared to serve those who are aged or defined as disabled. Therefore, individuals must qualify as disabled to qualify for the home.

Sen. Christiaens said this was a concern of his because at Montana State Prison there are growing numbers of this population who have had difficulties with the law. In his community, it is almost impossible to get those individuals services, and they are going to need service. Because they are ex-offenders, they cannot receive services under the mental health program.

Sen. Towe asked Sen. Christiaens if those individuals were disabled. Sen. Christiaens said they were disabled.

Mr. Sekora said that homes could be developed specifically geared for those individuals. If an individual came into a community in need of protective services, they would provide them. However, there are no such homes now. There are mental health group homes that have discussed possibly taking those individuals.

Sen. Mesaros asked Mr. Sekora, once a home has received dual licensing, if who they can accept would be dramatically expanded. Mr. Sekora said there are requirements in the licensing rules that limit the number of people in a home. Adult foster care homes can only have four residents, and child foster care homes can only have six residents. There would have to be limits for homes with dual licenses.

Chairman Eck asked Mr. Sekora if the adult foster care homes took any day care patients. Mr. Sekora said the rules so far prohibit day care patients. There are concerns that there would be too many patients for that home's care capacity.

Closing by Sponsor:

Sen. Towe closed.

EXECUTIVE ACTION ON SB 118

Motion: Sen. Towe moved that, "Additionally a resident must have a signed statement from a physician or a registered nurse who has actually visited the facility and has certified that the particular needs of the resident can be adequately met in the facility, and that there has been no significant change in the health care status that would require another level of care," be added to Page 14, Line 7 of SB 118.

Discussion:

Sen. Franklin said Mike Craig had some preferences about home health agencies.

Mike Craig, Department of Health, said their preference was to include a nurse practitioner or a physician assistant. They do have some apprehensions about just including a nurse.

Sen. Towe asked Mr. Craig what his suggestion was. Mr. Craig said it was a nurse practitioner or a physician assistant.

Sen. Towe said that was fine with him.

Mr. Craig said the Department has a greater level of comfort as

long as a nurse can be disassociated from the facility in every manner, because it creates safeguards for adult services.

Sen. Franklin said there is trouble with trying to identify an individual by discipline. The issue is not the discipline of the person, but the point is that someone who is unconnected with the direct care of an individual doing the evaluations.

Mr. Craig said that doctors and nurses rarely agree.

Sen. Towe suggested the language read, "Additionally a resident must have a signed statement from a nurse practitioner or a physician's assistant unrelated to the operation of the facility who has actually visited the facility and has certified that the particular needs of the resident can be adequately met in the facility and that there has been no significant change in health care status that would require another level of care. Both statements must be renewed at least once each year."

Motion:

Sen. Towe moved that language.

Discussion:

Sen. Christiaens said he would like to have the language printed and executive action be taken at the next hearing.

Sen. Franklin said she had concerns with the bill, and she feels like she is not 100% clear about the regulations.

Sen. Towe said this bill provides homes from illegally operating for providing "something that is terribly critical."

Sen. Franklin said the Departments need some direction to develop policy. Sen. Towe said that is included in the statement of intent.

Sen. Franklin said there should be some reevaluation, possibly a Sunset because the Committee is not entirely sure about the direction of SB 118.

Chairman Eck said that in the past the county health professionals have been concerned about existing personal care homes being lax in procedures. Chairman Eck said the Sunsetting would be a good way to look at the bill.

EXECUTIVE ACTION ON SB 312

Motion/Vote:

Sen. Towe moved that SB 312 DO PASS. The motion carried unanimously.

EXECUTIVE ACTION ON SB 313

Motion/Vote:

Sen. Towe moved SB 313 DO PASS. The motion carried unanimously.

ADJOURNMENT

Adjournment: Chairman Eck announced that Sen. Towe would be absent the following week, and adjourned the hearing.

Dorothy Eck
SENATOR DOROTHY ECK, Chair

Laura Turman
LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-12-93

NAME	PRESENT	ABSENT	EXCUSED
Eck	✓		
Franklin	✓		
Klampe	✓		
Hager	✓		
Towe	✓		
Mesaros	✓		
Rye	✓		
Christiaens	✓		

FC8

Attach to each day's minutes

SENATE STANDING COMMITTEE REPORT

February 13, 1993

MR. PRESIDENT:
We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 120 (first reading copy -- white), respectfully report that Senate Bill No. 120 be amended as follows and as so amended do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Title, line 11.
Following: ";"
Insert: "AND"

2. Title, lines 12 and 13.
Following: "MCA"
Strike: the remainder of line 12 through "MCA" on line 13

3. Page 2, line 17.
Strike: "and"

4. Page 2, line 20.
Following: "(f)"
Insert: "criteria for release to less restrictive treatment conditions; and
(g)"

5. Page 4, line 5.
Following: ";"
Strike: "and"

6. Page 4, line 6.
Following: "days"
Insert: "; and
(f) by a treatment team that includes at least one professional person who is not primarily responsible for the patient's treatment plan"

7. Page 7, line 23.
Following: line 22
Insert: "(10) a summary of each significant contact by a professional person with the patient;"
Renumber: subsequent subsections

M- Amd. Coord.
___ Sec. of Senate

8. Page 8, line 9.
Strike: "and"

9. Page 8, line 16.
Following: "~~; and~~"
Insert: "."

10. Page 8, line 19.
Following: "~~53-21-163~~"
Insert: "(18) a summary by the professional person in charge of the facility or by an appointed agent of the findings after the 30-day review provided for in 53-21-163"

11. Page 9, line 1.
Following: page 8, line 25
Insert: "(2) criteria for discharge;"
Renumber: subsequent subsections

12. Page 9, lines 8 and 9.
Strike: Section 4 in its entirety
Renumber: subsequent section

-END-

SENATE STANDING COMMITTEE REPORT

February 13, 1993

MR. PRESIDENT:
We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 166 (first reading copy -- white), respectfully report that Senate Bill No. 166 be amended as follows and as so amended do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Page 3, lines 10 through 13.
Strike: "rehabilitative" on line 10 through "devices" on line 13.
Insert: "splints or selective adaptive equipment and training in the use of upper extremity prosthetics or upper extremity orthotic devices"

2. Page 4, line 3.
Strike: "functional"
Insert: "work"

3. Page 4, lines 4 and 5.
Following: "through"
Strike: "exercise"on line 4 through "principles" on line 5
Insert: "occupational therapy intervention, including education and instruction, activities to increase and improve general work behavior and skill, job site evaluation, on-the-job training and evaluation, development of work-related activities, and supported employment placement"

4. Page 7, lines 18 through 21.
Strike: "rehabilitative" on line 18 through "devices" on line 21.
Insert: "splints or selective adaptive equipment and training in the use of upper extremity prosthetics or upper extremity orthotic devices"

5. Page 7, line 24.
Following: "cognitive,"
Insert: "psychosocial,"

6. Page 8, line 11.
Strike: "functional"
Insert: "work"

m- Amd. Coord.
Sec. of Senate

7. Page 8, lines 12 and 13.
Following: "through" on line 12
Strike: "exercise" on line 12 through "principles" on line 13
Insert: "occupational therapy intervention, including education and instruction, activities to increase and improve general work behavior and skill, job site evaluation, on-the-job training and evaluation, development of work-related activities, and supported employment placement"

8. Page 10, line 20.
Following: "and"
Strike: "in"

9. Page 11, line 5.
Strike: "or modality"
Insert: "of selected modalities"

10. Page 11, line 23.
Following: "of"
Strike: "an"
Insert: "a qualified"

11. Page 12, line 8.
Following: "hand"
Insert: "to restore and enhance hand function"

12. Page 12, line 13.
Following: "and"
Strike: "in"

13. Page 12, line 14.
Page 12, line 18.
Following: "section"
Strike: "2(2)"
Insert: "2(1)(c)"

-END-

SENATE STANDING COMMITTEE REPORT

February 12, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 312 (first reading copy -- white), respectfully report that Senate Bill No. 312 do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

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Sec. of Senate

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SENATE STANDING COMMITTEE REPORT

February 12, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 313 (first reading copy -- white), respectfully report that Senate Bill No. 313 do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

Amd. Coord.
Sec. of Senate

351739SC.Sma

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-12-93
BILL NO. SB 120

Amendments to Senate Bill No. 120
First Reading Copy

Requested by Sen. Towe
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan B. Fox
February 1, 1993

1. Title, line 11.
Following: ";"
Insert: "AND"

2. Title, lines 12 and 13.
Following: "MCA"
Strike: the remainder of line 12 through "MCA" on line 13

3. Page 2, line 17.
Strike: "and"

4. Page 2, line 20.
Following: "(f)"
Insert: "criteria for release to less restrictive treatment conditions; and
(g)"

5. Page 4, line 5.
Following: ";"
Strike: "and"

6. Page 4, line 6.
Following: "days"
Insert: "; and
(f) by a treatment team that includes at least one professional person who is not primarily responsible for the patient's treatment plan"

7. Page 7, line 23.
Following: line 22
Insert: "(10) a summary of each significant contact by a professional person with the patient;"
Renumber: subsequent subsections

8. Page 8, line 9.
Strike: "and"

9. Page 8, line 16.
Following: "~~; and~~"
Insert: "."

10. Page 8, line 19.
Following: "~~53-21-163~~"
Insert: "(18) a summary by the professional person in charge of the facility or by an appointed agent of the findings after the 30-day review provided for in 53-21-163"

11. Page 9, line 1.
Insert: "(2) criteria for discharge;"
Renumber: subsequent subsections

12. Page 9, lines 8 and 9.
Strike: Section 4 in its entirety
Renumber: subsequent section

Amendments to Senate Bill No. 118
First Reading Copy

Requested by Sen. Eck
For the Committee on Public Health, Welfare, and Safety

Prepared by Susan B. Fox
February 1, 1993

1. Page 13, line 25.
Following: "facility"
Insert: "and, on an annual basis, a signed statement from a physician agreeing to continued placement"

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THE STATUS OF ACUPUNCTURE LEGISLATION IN THE UNITED STATES: A COMPREHENSIVE REVIEW

GARY KAPLAN, D.O.

INTRODUCTION

Haphazard regulation of acupuncture threatens to fragment the United States health care system. Acupuncture theory and practice have been extremely controversial since first introduced in the United States in the 1820's. When China reopened to the West in the 1970's, the American medical establishment became briefly infatuated with acupuncture's therapeutic promises. This affair soon ended as initial investigations proved disappointing and Chinese medical theory appeared unyielding to the prevalent reductionist scientific methodology. Acupuncture was officially termed an "experimental medical practice", though not considered worthy of serious investigation or funding. The medical community sought to prohibit non-physician practice of acupuncture by labeling it as medical practice. Acupuncture thus became an underground phenomenon in this country, thriving in the Oriental communities of the United States (1).

While the conventional medical establishment lost interest in acupuncture, others did not. Many Americans attended training schools in England, Austria, France and China. These people then returned to the U.S. and became part of an underground acupuncture network, since most of them were not licensed to practice medicine in this country. Schools of acupuncture began to emerge out of this network, under the academic leadership of these practitioners. Initially, the schools were modeled after a single individual's teaching style and material. Later, they paralleled foreign training schools attended by some of the teaching acupuncturists.

In the late 1970's and early 1980's, three factors set the stage for the incipient standardization of acupuncture education in the United States: 1) two basic textbooks of Traditional Chinese medicine (TCM) became available in English for the first time; 2) prominent influential acupuncturists began organizing their schools around TCM theory; 3) these schools organized and founded the National Council of Schools and Colleges of Acupuncture and Oriental Medicine. This organization then created the National Commission for the Certification of Acupuncture (NCCA). The NCCA has formulated a national examination and, together with National Council, they have been directly influencing the evolution of lay acupuncture curricula (2).

Thus an entirely new class of non-physician health professionals emerged in the brief 20-year period since China re-opened to the West. The profession has grown virtually outside of the conventional medical establishment and now demands the right to practice medicine - albeit Chinese medicine- in this country. There are at present approximately 6,000-7,000 non-physician acupuncturists in the United States (3). They have lobbied successfully for practice rights in 23 states and the District of Columbia (Table 4). Enacted legislation enables non-physicians to practice acupuncture with some form of limited medical supervision, but essentially as independent medical providers. Five states have not passed any specific regulations regarding non-physician acupuncturists. These states do provide for limited practice under direct medi-

cal supervision (Table 5). Twenty one states allow only physicians to practice acupuncture (table 6).

Until recently, the response of the conventional medical establishment to the growth of this new profession has been one of indifference. The American Medical Association still regards acupuncture as experimental (4). The Food and Drug Administration requires acupuncture equipment to be labeled as investigational devices (5). On the other hand, in 1988, the American Osteopathic Association (AOA) endorsed acupuncture as a therapeutic modality (6). The AOA, however, has not yet initiated any recommendations for training or licensing physicians in medical acupuncture.

A comprehensive training program in medical acupuncture for physicians has been in existence since 1983 through the Division of Continuing Education in Health Sciences, UCLA School of Medicine Extension. This rigorously academic course is accredited for 200 hours of category I, AMA Continuing Medical Education credits (7). The American Society of Acupuncture in New York has also established a series of training programs for physicians, which also offer CME I credits through the New York University School of Medicine and Dentistry.

In 1987, the American Academy of Medical Acupuncture (AAMA) was founded as the first physician-only acupuncture organization in the United States. AAMA established minimum training requirements for membership consistent with the World Federation of Acupuncture-Moxibustion Society's guidelines. AAMA's present membership is approximately 500 physicians (8). The estimated total of physicians currently practicing some form of acupuncture in the United States is 2,000-3,000 (3). At present, 14 states have established separate regulations governing the practice of acupuncture by physicians (Table 2).

The medical community and state legislators have been increasingly at odds regarding the practice of acupuncture. The medical establishment has consistently regarded acupuncture as a form of practice of medicine. Acupuncture's scope of efficacy is still controversial. State medical regulatory bodies have been divided as to whether to allow licensure of non-physician acupuncturists. They are united, however, in their position to require non-physician acupuncturists to have proper medical supervision.

State legislators have not been entirely consistent. Different standards have been applied to issues such as eligibility to practice acupuncture, training requirements, scope of techniques included under the practice of acupuncture, and integration of acupuncture into the health care system.

The result of these inconsistencies has been the extreme individualization of acupuncture rules, regulations and legislation from state to state. For example, Alabama allows only physicians to practice acupuncture within the context of approved experimental protocol (9). New York licenses both physicians and non-physicians to practice acupuncture, and has separate training requirements for each group (10). New Mexico has established a completely separate acupuncture board which licenses both physicians and non-physicians in that state. Training requirements for all acupuncture practitioners (lay or with a medical degree) are identical (11). New Jersey allows physicians to practice acupuncture within the scope of their medical practice without additional training requirements. Non-physician acupuncturists are licensed separately (12).

Legislation on the training requirements for non-physicians to practice acupuncture, also lacks uniformity. Some states require only two years of training (12, 13, 14). Others require three years of acupuncture training (11, 15). All states that regulate non-physician acupuncturists require that they pass either a state examination or the NCCA examination. Provisions are also made in many states for licensing following apprenticeship and for experience prior to formal training [Colorado(16), District of Columbia(17) and California(18)]. Physicians are permitted to practice acupuncture without any specific training requirements in 37 states (Table 1). In the 14 states that do regulate physicians (Table 2), requirements vary from 100 hours of training in Georgia (19), to a three-year program in New Mexico (11).

DISCUSSION

If acupuncture is considered as the practice of medicine, as virtually every state has declared, shouldn't the practice of acupuncture exist only under physician supervision? Should physicians then have specific training requirements to practice and supervise the practice of acupuncture and, if so, what kind of training? Should non-physician acupuncturists be able to practice acupuncture and, if so, under what circumstances?

At present, there are no clear and consistent answers to any of these questions. In addition to the regulatory cacophony prevalent in the practice of acupuncture, there are inconsistencies over the definition of what constitutes the practice of acupuncture. To perform acupuncture in the state of Maryland means, "to stimulate a certain point or points on or near the surface of the human body by the insertion of needles..." (20). New Mexico expands this definition to include, "the use of all allied techniques of oriental medicine, both traditional and modern, for the diagnosis, prevention ... or correction of any disease or pain... Techniques of oriental medicine include but are not limited to moxibustion, herbology, dietary and nutritional counseling, body work and breathing exercise techniques" (11). In California, the definition of the practice of acupuncture is equally as expansive (18). What then, is the practice of acupuncture? What does it encompass?

Legislators are also at odds with the medical establishment regarding what conditions should be treated with acupuncture. The position of the American Medical Association is that acupuncture is experimental. Only three state medical boards explicitly support this position, however (9, 21, 22). The legislative response to this question has been to define acupuncture applications broadly and in the most general terms. In Florida, for example, acupuncture is seen as useful "for the promotion, maintenance, and restoration of health and the prevention of disease" (13).

Is this a legitimate definition of acupuncture's capabilities or a perception of its potential promise? While acupuncture's role in the treatment of pain and drug and alcohol abuse is gaining acceptance, other applications remain controversial, often due to insufficient information or inconclusive clinical research outcomes (23, 24, 25). Certain definitions of acupuncture's efficacy suggest it can be applied in any and all circumstances and is always helpful even if the person is in a state of health. How accurate is this claim? Such definition sets the stage for the evolution of acupuncture as an autonomous medical system. Is this a direction in which the U.S. health care system should proceed?

The present and proposed legislation defining acupuncture's place in the health care system reveals two extreme view points. The first one advocates the integration of acupuncture into the existing health care system. In this model, physician and non-physician acupuncturists can practice acupuncture side-by-side as a team. This model defines the non-physician acupuncturists' role as being similar to that of a physical therapist or physician's assistant. Legislation in Virginia (26), Pennsylvania (14), Maryland (20), and the District of Columbia (17), are examples of this type of legislation.

The second legislation model seeks to establish acupuncture as a fully autonomous health care profession. Under this model, patients are diagnosed and treated by, and prescribed for by acupuncturists licensed by an independent board of acupuncture, sometimes referred to as board of Oriental medicine, generally composed by a majority of lay acupuncturists. Legislation of this type was introduced (not enacted) in New Mexico. It defined the scope of oriental medicine as the "diagnosis, prescription or treatment for the prevention, cure or correction of any pain, injury, disease or other condition... Oriental medicine includes all techniques of traditional and modern oriental medicine including but not limited to acupuncture, moxibustion, herbal and homeopathic medicine, body work, including but not limited to acupressure, "Tui Na", manipulation and massage, physical medicine procedures and modalities, breathing and exercise techniques, dietary and nutritional and lifestyle counseling; and any necessary diagnostic techniques" (27).

Maryland's non-physician acupuncturists recently attempted to introduce legislation that would have expanded the scope of practice of acupuncture and eliminated the requirement of direct physician supervision (28).

This model is similar to that developed by the chiropractors. If legislators are going to create a separate profession of acupuncture they must be able to assure the public that they have done so in a responsible manner. What is the probability that a patient with a serious illness be misdiagnosed or not receive proper care from a non-physician acupuncturist?

Substantial credible data must be obtained from the states to determine what conditions are being treated with acupuncture, how often are acupuncture treatments administered, and what is the outcome of these treatments. Quality assurance guidelines must be developed to detect if serious medical diagnoses are being delayed or missed entirely when patients are treated independently by non-physician acupuncturists. The content of acupuncture training programs, especially at schools run by lay acupuncturists, must be analyzed. Are the standards of training and examinations for non-physician acupuncturists comparable to any other health care professionals (e.g., physicians, nurses, physical therapists and physician assistants)?

This paper highlights and raises areas of concern regarding the place of the practice of acupuncture in the American health care system, and its proper regulation. It also notes that legislative efforts may have gotten ahead of the available data necessary to make well informed decisions on the proper role of acupuncture in the medical system. The question that must ultimately be addressed is how the public will be best served, and how the quality of U.S. medical care can be preserved and enhanced by proper licensing and supervision of all health care practitioners.

TABLE 1

States which regard the practice of acupuncture as within the scope of a physician's medical/osteopathic license and impose NO restrictions on licensed physicians who wish to practice acupuncture:

Alaska	Kansas	North Dakota
Arizona	Kentucky	Oklahoma
Arkansas	Maine	Oregon
California	Massachusetts	Rhode Island
Colorado	Michigan	South Carolina
Connecticut	Minnesota	South Dakota
Delaware	Mississippi	Tennessee
Florida	Missouri	Texas
Idaho	Nevada	Utah
Illinois	New Hampshire	Vermont
Indiana	New Jersey	Washington
Iowa	North Carolina	Wisconsin
		Wyoming

TABLE 2

States that regulate or restrict the practice of acupuncture by licensed physicians.

Alabama	Maryland	Ohio
Dist. of Columbia	Montana	Pennsylvania
Georgia	Nebraska	Virginia
Hawaii	New Mexico	West Virginia
Louisiana	New York	

TABLE 3

REGULATIONS APPLIED TO LICENSED PHYSICIANS PRACTICING ACUPUNCTURE

STATE	CERTIF.	EXPERIMENTAL	HOURS	EXAMINATION	CONSENT
Alabama	No	Yes			Yes
D.C.	Yes		250	Yes	
Georgia	Yes	Yes	100		Yes
Hawaii	Yes	(1)	(1)	(1)	
Louisiana	Yes		6 mos.		
Maryland	Yes		540		
Montana	Yes		1000		
Nebraska	(2)	Yes	(3)		
New Mexico	Yes		3 yrs.	Yes	
New York	Yes	Yes	300		Yes
Ohio	Yes	Yes	(4)		Yes
Pennsylvania	Yes		200		
Virginia	Yes		200		
W. Virginia	Yes		(4)		

(1) Standard to be defined and implemented by 12/31/91
(2) Permission of State Board of Medical Examiners
(3) Policy under review
(4) Acceptable course of study

TABLE 4

States which license, certify or register non-physician acupuncturists:

Alaska	Maryland	Pennsylvania
California	Massachusetts	Rhode Island
Colorado	Montana	Texas
District of Columbia	Nevada	Utah
Florida	New Jersey	Vermont
Hawaii	New Mexico	Virginia
Louisiana	New York	Washington
Maine	Oregon	Wisconsin

Note: Most states require some degree of medical supervision though the form and extent of that supervision is highly variable from state to state.

TABLE 5

States which do not separately regulate non-physician acupuncturists but have provisions for non-physicians to practice acupuncture under medical supervision:

Arizona
Connecticut
Delaware
Minnesota
South Carolina

TABLE 6

States in which only physicians are allowed to practice acupuncture:

Alabama	Kentucky	North Carolina
Arkansas	Illinois	North Dakota
Georgia	Michigan	Ohio
Idaho	Mississippi	Oklahoma
Indiana	Missouri	South Dakota
Iowa	Nebraska	Tennessee
Kansas	New Hampshire	West Virginia
	Wyoming	

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2. Flaws, B. Viewpoint. American Acupuncture Education: Has a Wrong Turn Been Taken? American Journal of Acupuncture. 1991, 19 (1):63-71.

3. Data: National Acupuncture Office, Washington, D.C.. Estimate is based on an extrapolation which assumes that California, which certifies approximately 2,700 active acupuncturists, represents one third to one half of all non-physician acupuncturists in the country. The American Association of Acupuncture and Oriental Medicine in Washington, D.C. estimates that the 2,500 NCCA certified acupuncturists represent about one third to one half of all practicing acupuncturists (California Acupuncture Board and personal communication with Hana Bradford of AAAOM). Physician acupuncturists are estimated to number 2,000- 3,000 (personal communication with Dr. J.M. Helms, president AAMA, 1991).

4. Council on Scientific Affairs of the American Medical Association, position paper on acupuncture. 1981.

5. Federal Register. Vol. 36, No. 44. March 9, 1973.

6. In 1988, the American Osteopathic Association went on record "recognizing that acupuncture may be a part of the armamentarium of qualified and licensed physicians."

7. Medical Acupuncture for Physicians. Health Sciences. UCLA Medical School Extension. P.O. Box 24901, Los Angeles, CA 90024-0901.

8. American Academy of Medical Acupuncture. 5820 Wilshire Blvd. Suite 500, Los Angeles, CA 90036.

9. Alabama State Board of Medical Examiners, Rule 545-x-4-.05, of the Rules and Regulations of Medical Licensure Commission of Alabama.

10. Article 160, Education Law of the State of New York.

11. New Mexico Acupuncture Practice Act, Section 61-14A, as amended by Senate bill 88, approved March 17, 1989.

12. New Jersey Statutes, annotated. 45:2C-1 et seg.

13. Florida Statutes. 45-7 and Rules 21AA, Board of Acupuncture, 457.102.

14. Commonwealth of Pennsylvania. Acupuncture Registration Act No 1986.2 Section 3 (c).

15. Nevada Revised Statutes, 1973. Chapter 634A.

16. Colorado Revised Statutes 12-29.5-110 (1) (a) CRS (1989), 24-4-103 (4) (1982), and 24-4-105 (11) CRS (1988), Office of Acupuncturists Registration. Permanent rules effective May 30, 1990.

17. District of Columbia Register. Chapter 47 (Acupuncture) Title 17 D.C.M.R. Department of Consumer and Regulatory Affairs.

18. State of California Department of Consumer Affairs. Laws and Regulations relating to the practice of Acupuncture, Chapter 12, article 2, 4937.1.

19. Rules of the Composite Board of Medical Examiners. Chapter 360-6, amended. Acupuncture as interpreted by the board in a memorandum to Physicians applying to practice acupuncture in Georgia, from the Executive Director.

20. Commonwealth of MAryland Acupuncture Regulation. 10.32.05.02 B.

21. Nebraska Board of Examiners in Medicine and Surgery. Policy adopted in 1973 and revised 1986.

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26. Personal communication Charlene L. Naninau, Executive Secretary, Board of Acupuncture, Professional and Vocational Licensing Division. Department of Commerce and Consumer Affairs, Hawaii, 1991.

27. Acupuncture Practice Act of Louisiana. Revised Statutes 37:1356 through 37:1360.

28. State of Montana Acupuncture Practice Act. Chapter 13 37-13-302.

29. Regulations of the Practice of Acupuncture. Virginia Board of Medicine. Chapter 4.2.

30. West Virginia Board of Medicine. Guidelines for the Practice of Acupuncture. July 14, 1986.

Exhibit 3
2-12-93
SB-266

DIFFERENCES IN THE TRAINING BACKGROUNDS OF PHYSICIAN ACUPUNCTURISTS AND LICENSED ACUPUNCTURISTS

ALLEN McDANIELS, M.D.

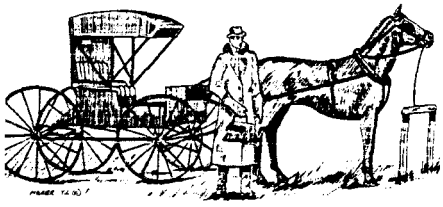
ABSTRACT — Acupuncture is used as a treatment modality by practitioners with various backgrounds and training. This article reviews the training of Licensed Acupuncturists in the state of California and that of physicians who are members of the American Academy of Medical Acupuncture.

INTRODUCTION

In the Western world, acupuncture has evolved as an effective therapeutic modality in medical practice. In recent years, a growing and substantial bibliography in the medical literature is beginning to provide the scientific basis for many of acupuncture's clinical effects. There is a growing number of practitioners using acupuncture in a clinical setting, who have a variety of backgrounds, training and experience. The purpose of this article is to review and compare the acupuncture training between physician and non-physician acupuncturists in the state of California. Such comparison is made with the intention of highlighting strengths and weaknesses in each one of these groups, thus clarifying common misconceptions and often blurred boundaries between the two, and therefore opening the doors to better assessment of educational needs and practice regulations in the field of acupuncture. This discussion is a timely one, given the state of confusion among consumer groups and largely uninformed medical professionals who are often hesitant to refer patients for acupuncture treatment.

In this presentation, the term "Licensed Acupuncturist" (L.Ac.) shall mean someone who has completed acupuncture training from a California-approved acupuncture school, including supervised clinical work, and has received the state license to practice acupuncture by passing the required examination (1). The term "Physician Acupuncturist" shall mean a practitioner who has completed medical school, at least a first year of residency training, and has fulfilled the requirements for full membership in the American Academy of Medical Acupuncture (AAMA) (2). The AAMA's basic requirement is that all applicants possess a valid and updated U.S. or Canadian medical license. In California, as well as in many other states, a physician can practice acupuncture under the mandate of his medical license.

The scope of this paper does not allow for an extensive discussion of premedical education or post-graduate education of physicians beyond their first year of residency, which varies between three and seven years of clinical training depending on the specialty. Discussion of undergraduate education of Licensed Acupuncturists is not pertinent since most acupuncture training programs do not require an undergraduate college degree, although some may recommend or require a certain number of college course credits.



MONTANA FAMILY PRACTICE RESIDENCY

A tradition of caring...

...receiving the call

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 2-12-93
BILL NO. SB 312

To: Public Health, Welfare, and Safety
Senate Standing Committee
Dorothy Eck, Chairwoman
Rm 410
1:00 pm
Friday, February 12, 1993

From: Montana Family Practice Residency
Frank C. Michels, M.D.
Acting Program Director

Legislation to be considered:

To delete the following:
DHES TITLE 50, CHAPTER 5, PART 603, PARAGRAPH 3

"No resident physician may train more than 2 months in any one community in any 12-month period."

Argument FOR Deletion:

The Montana Family Practice Residency is currently in the feasibility stage. To become an accredited full 3 year residency, regulations must be adhered to by the accrediting agency for residencies (Residency Review Commission).

RRC guidelines are quite specific about lengths of rotations. Some would be only 2 months, but some would be longer.

This bill was first introduced with the intention to allow for 2 month rotations to be done in Montana as a portion of an out of state residency (1985). The funding for this type of training has diminished and fewer resident physicians are rotating through Montana under this program. Even if this language is deleted resident physicians from other programs may still rotate in Montana.

Montana is now on the threshold of a full three year residency. By deleting the above language, barriers to the establishment of a true Montana Family Practice Residency will be removed.

Argument AGAINST Deletion:

none

Frank C. Michels, M.D.
Program Director (Acting)

P.O. Box 35500-554
Billings, Montana 59107

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-12-93
BILL NO. SB 313

DEPARTMENT OF FAMILY SERVICES

MARC RACICOT, GOVERNOR

STATE OF MONTANA

(406) 444-5900
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HANK HUDSON, DIRECTOR
JESSE MUNRO, DEPUTY DIRECTOR

PO BOX 8005
HELENA, MONTANA 59604-8005

February 12, 1993

DEPARTMENT OF FAMILY SERVICES **TESTIMONY IN SUPPORT OF SB 313**

Submitted by Don Sekora, Program Officer

The Department of Family Services requested SB 313 to correct an oversight contained in Section 52-3-305 of the Adult Foster Family Care Act. The Act was amended last session, making the licensing of adult foster care homes mandatory. The Act allows adult foster care homes to provide only light personal care, but does not take into consideration disabled youth requiring more than light personal care residing in youth foster care homes who turn 18 years old. Because these people require more than light personal care, the youth foster home they were residing in as a minor cannot be licensed as an adult foster care home to continue to provide for their care after their 18th birthday. Section 1 will allow a person with disabilities to remain in, and be cared for in the homes in which they have been residing without disrupting their lives with a move to a different type of home. The requirement for a physician's approval (page 2, lines 9-11) is included to assure that the home can meet the specific health needs of the person.

The remaining Sections of SB 313 amend the "Montana Elder and Developmentally Disabled Abuse Prevention Act". Section 2 of the bill amends 52-3-805 of the Act and will allow adult protective service (APS) teams to review cases of persons with developmental disabilities in addition to cases involving the aged. This too is presumed to be an oversight when the original language of this statute was drafted.

Section 2 also allows the county attorney or DFS to include additional members on an APS team, other than those specifically listed, as deemed appropriate. The department investigated 1,469 alleged incidents of abuse, neglect, and/or exploitation of the elderly and persons with developmental disabilities this past year, in which 596 cases were opened to provide protective services. Cases have become more complex and serious. Due to the complexity and serious nature of these cases, the department needs authority to involve more community professionals in assisting its staff to meet the protective service needs of the victims of abuse, neglect, and/or exploitation.

Section 3 amends 52-3-811. This amendment (page 5, lines 7-9) will make it mandatory for persons who provide services under a federal or state contract to aged persons or persons with a developmental disability to report alleged incidents of abuse, neglect, and/or exploitation to the Department of Family Services. This group of people have a great deal of contact with aged and disabled persons and therefore are in a good position to observe or become aware of possible abuse, neglect, and/or exploitation situations. The department must receive referrals to trigger an investigation and to prevent or stop abuse. Past experience shows that the sooner the department receives a report, the less intensive the services that are required to assist an alleged victim.

Section 4 of SB 313 amends 52-3-813 to allow the department to share information contained in its adult protective services records with service providers, Department of Social and Rehabilitation Services' staff, and guardianship programs when the best interest of the alleged victim will be served.

Sharing information with service providers, under certain conditions, becomes important when the provider's license may be in jeopardy because of substantiated abuse by their staff, and the provider needs to know enough information regarding the alleged abuse to make a knowledgeable decision regarding disciplinary action.

Sharing information with SRS is to aid in the provision of services to a client.

Lastly, being allowed to share information with a guardianship program is necessary to allow a program established to match guardians with incapacitated persons, access to enough information to make an informed decision regarding the appointment of a specific guardian for a specific client.

Thank you for consideration of SB 313.

Senate Public Health, Welfare,
and Safety Committee
February 12, 1993

Minutes from the February 12, 1993 meeting also contained a letter from Lois Menzies, Director, Department of Administration that expressed the Department's concerns on Senate Bill No. 267.

DEPARTMENT OF ADMINISTRATION
DIRECTOR'S OFFICE

MARC RACICOT, GOVERNOR

MITCHELL BUILDING

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PO BOX 200101
HELENA, MONTANA 59620-0101

TO: Senator Dorothy Eck, Chair
Senate Committee on Public Health, Welfare, and Safety
Capitol Station

FROM: Lois Menzies, Director

DATE: February 10, 1993

SUBJECT: SB267, Universal Health Care Act (Section 16)

Health care reform is generally a subject the Department of Administration leaves to the Department of Health and Environmental Sciences and the Department of Social and Rehabilitation Services. Our concerns on SB267 are narrowly focused on Section 16. Section 16 establishes a purchasing pool that includes the State Employee Health Plan administered by the Department of Administration, along with the University Employee Plan, portions of the Medicaid case load and, at their discretion, local government health plans.

While the concept of "bulk purchasing" to reduce costs has some merit, and is a cost control approach we are trying, we have the following concerns with this particular provision:

1. With all the other responsibilities and ambitious time frames of the Health Care Authority, it seems unlikely that sufficient staff resources could be devoted to the purchasing pool to make it effective, and we have no available staff resources to contribute.

2. We project few, if any, significant short term (FY94 and FY95) savings in claims costs to any of the groups involved. The purchasing/implementation process takes a full year for a single plan. Purchasing for diverse groups with diverse needs, diverse benefit structures, differing insurers or self-insurance arrangements, differing planning and implementation cycles, differing fiduciaries, and differing administrative requirements will take a couple of years to plan and implement.

The purchasing process includes: developing specifications, issuing a "Request for Proposal," providing a pre-proposal question-and-answer period, allowing vendors adequate proposal preparation time, scoring proposals, providing a "Last and Final Offer" process (as needed), developing a contract (including legal review), developing and distributing communication materials to Plan members and instituting administrative changes required for implementation.

3. While long term savings in claims costs from group purchasing may be possible (see limitation in 4 below); by the time they can be achieved, other more effective cost control mechanisms contained in the bill will be in place making group purchasing obsolete. Also, proponents appear to favor this approach as a way to draw self-insured plans (which are currently exempted by ERISA from State statute) into a single payor system. If ERISA exemption is removed by federal reform, this would no longer be necessary.

4. The success of the bulk purchasing approach to cost containment is limited by 33-22-1740 (2), MCA—the "any willing provider" clause. It is not possible to effectively bulk purchase, unless the bulk of business can be delivered to the low bidders; and this statute allows other providers (high bidders or non bidders) to join the contract and syphon off part of the business. The various groups may, consequently, have more success with other approaches that could be preempted by this one.

5. To the extent the various groups have common purchasing needs that would benefit from "bulk purchasing," they can collectively purchase now.

6. It is very unlikely that any of the proposed administrative consolidation and savings would be possible, given the diversity of benefit structures, insurance arrangements, funding arrangements, accounting requirements, computer/administrative systems, etc., already in place. Attempted consolidation could increase short-term administration costs.

7. The biggest problem appears to be the intent to look at risk-pooling at a later date. Establishing a risk pool for groups to <u>voluntarily</u> join, assures that only those who cannot do better elsewhere (the high risk

groups) will join. This could greatly increase the pool's and the State Employee Benefit Plan's costs.

We encourage you to delete Section 16 from the bill. It requires investment of resources in a cost containment approach that we expect to have limited short term success; potentially preempts other more effective cost containment approaches; can already be implemented by affected groups; will likely become obsolete under either federal or proposed State reform legislation; and, if risk pooling is implemented, could increase State health care costs.

Please call Joyce Brown, Chief of the Employee Benefits Bureau at 444-2552 if you need clarification or additional information.

LM/JFB/mms

DATE 2-12-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 266, SB 312, SB 313

Name Please Print	Representing	Bill No.	Check One: Support	Oppose
Don Sekora	Dept of Family Services	SB313	X	
Verner Bertelsen	Legacy Legislators	SB312	X	
Bridgette Mazurek	Montana Acupuncture Assoc.	SB266		X
[illegible]	MT. ASSOC. of [illegible]	SB266		X
Thomas Bump	MT. Ass. of Acupuncture & Oriental Medicine	SB266		X
Nancy Aagenes, ND	self	SB266		X
David Healow MD	AAMA	SB266	X	
[illegible]	MMA	SB266	X	
[illegible]	SRS	313	✓	
[illegible]	MOTA (exact)	166	/	
[illegible]	MLIC	[illegible]		X
[illegible]	mt. med assn	312	X	
[illegible]		[illegible]		X

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

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