MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN SCOTT ORR**, on January 3, 1995, at 3:10 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Betty Lou Kasten (R)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Susan Fox, Legislative Council
Vivian Reeves, Committee Secretary

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

CHAIRMAN ORR welcomed members of the Select Health Care Committee, and announced that **GOVERNOR MARC RACICOT** and **Sam Hubbard, Executive Director Health Care Authority** will be the guest speakers today to provide an update on health care.

The Members of the Committee introduced themselves and explained what experience they have in the health care field.

The guest speaker for January 5, 1995, will be **Dr. Larry. Bartlett, Health Care Authority Consultant** from the east coast. The guest speakers for January 10, 1995, will be **Dr. Paul Gorsuch, PHD, HEAL Montana/Project '94,** and **Mr. Ed. Grogan, Montana Medical Benefits Plan.**

The guest speakers for January 12, 1995, will be **Ms. Claudia**

Clifford, Auditor's Office who will speak on small group reform, and **Mr. Chuck Butler and Ms. Tanya Ask, Blue Cross Blue Shield.**

CHAIRMAN ORR announced that his intentions are to hear bills, but delay executive action until bills can be considered as a group.

CHAIRMAN ORR announced that they will be taking a collection for coffee, tea and cocoa.

CHAIRMAN ORR invited input on how to handle the tabling of bills. He said he would not like to cut off any discussion on bills and recommended a full discussion before anybody makes a tabling motion.

REP. JOHN JOHNSON said he has a strong belief that a tabling motion is a nondebatable motion. **REP. JOHNSON** asked if that was the way **CHAIRMAN ORR** perceived it, and that he would ask that a motion not be made until every member has had their opportunity to comment.

CHAIRMAN ORR answered that is correct.

REP. RICHARD SIMPKINS announced that if **CHAIRMAN ORR** determines that there is still lively discussion on a bill and you want to continue that, then **CHAIRMAN ORR** has the right to not recognize a tabling motion. This gives more control to make sure that there is full discussion on each bill.

CHAIRMAN ORR agreed.

CHAIRMAN ORR recognized that health care will be a topic that many people will want to give input on and will be traveling long distances to do that and requested input on time frames to let everyone speak, but at the same time to prevent meetings from lasting until midnight.

REP. LIZ SMITH suggested taking a count on how many people wished to testify in two hours and then divide the time frame by the number of people testifying.

CHAIRMAN ORR recognized **REP. SMITH'S** suggestion.

REP. SIMPKINS noted that many times, local people from Helena will be the first ones to speak, and the people who drove from out of town do not get a chance to speak. **REP. SIMPKINS** suggested that since people will be driving many miles to testify, that **CHAIRMAN ORR** be sure that these people driving from out of town be given an opportunity to testify.

CHAIRMAN ORR recognized **REP. SIMPKINS** suggestion and asked if there were any other comments.

REP. BEVERLY BARNHART wanted to know where the Select Health Care Committee bills go after they have passed.

CHAIRMAN ORR responded that they would go to the floor, but if they involve money they will go to appropriations.

REP. BRUCE SIMON noted that this is a Select Committee because it is important to the people of Montana. **REP. SIMON** announced that he is disturbed that we would impose an artificial time limit to hear a bill. People feel very strongly and passionately about health care and some will travel many miles to speak, and they should be allowed to speak. **REP. SIMON** does not feel comfortable about restricting the time limit to hear bills. "That does not mean that we cannot ask people to be succinct and try to move the process along in a business-like and prompt fashion."

REP. SIMPKINS noted that when he made that comment **CHAIRMAN ORR** "was talking midnight. After midnight, we should put some time limits in there."

REP. CAROLYN SQUIRES wanted to know when they would be taking executive action.

CHAIRMAN ORR requested input on the proper procedure for taking executive action.

REP. BARNHART noted that is sometimes difficult if there is a lot of new information.

REP. SIMPKINS suggested checking into the possibility of "declaring this bill, other than a regular bill, to make sure that we're not up against the first time limit, and possibly carry it into a different time zone, at least the taxation type approach." **REP. SIMPKINS** agreed with **REP. BARNHART** that it would be best to give a one-week notice prior to taking executive action on a bill, so that people can reschedule their time. **REP. SIMPKINS** suggested addressing the leadership to see about getting these things classified to give them more time.

CHAIRMAN ORR responded that they would look into that.

An announcement was made that in appropriations it is listed on the Committee Notice, and that usually works well.

CHAIRMAN ORR introduced **GOVERNOR MARC RACICOT.**

GOVERNOR RACICOT acknowledged that **CHAIRMAN ORR** was hoping for an informal discussion about the present status of the authority through our eyes. In 1993, there were urges from a variety of different centers of interest and energy to do something about the issue of health care in Montana and in our nation. At that particular time, there was a wide variety of possibilities that were being presented to the legislature. At that point in time, "all agreed that prior to making those kind of decisions, that it would be wise for all of us to understand precisely all of the dynamics of our health care system, so that we can make careful and thoughtful judgements about which direction to proceed." The

"federal administrations had guaranteed states that demonstrated the initiative the opportunity to act in their own best interest and design their own systems in a way that meets their own unique characteristics. We seized that opportunity to study and carefully think, between legislative sessions, precisely how we ought to proceed." Montana has been in the fore in terms of leading the nation with that kind of analysis.

In 1993, the Health Care Authority was formed. The membership was initially selected by the legislature. **GOVERNOR RACICOT** selected five names from the ten names recommended to him. This was a challenge because by law they were supposed to reflect the geographic diversity of Montana as well as the, gender diversity, ethnic diversity, and disciplinary diversity.

The recommendations that the Health Care Authority reviewed were a government-run health care system, a single payer system, and the multi-payer system. (Exhibit 1, Parts A - J) "This Authority has been associated with the executive branch of government, but it is an organ of the legislature, as much as it is anything, because it was crafted" and is to report back to the legislature. The Health Care Authority "ought to be the vehicle for the expression of the joint concerns of all Montanans."

GOVERNOR RACICOT noted that the Health Care Authority has been the topic of some especially controversial conversations. This is largely because of misconceptions of its mission and the performance of that mission. "That has been unfortunate, because I do believe that the work that they have done is going to serve this state for a long time in the future."

In 1993, a contract was made to do a variety of different things and set forth an ambitious agenda. "The design of a data base, the purchasing pool certification process, the update of resource management plans, the evaluation of progress and impact of enacted reforms, the management of cooperative agreement processes, the monitoring and analyzing of health care system cost trends, providing support for state and regional boards and the assumption that the Comprehensive Health Plan are still duties that were assigned to that authority were given timelines in the legislation for completion in 1996 and '97 and had not yet been completed." It is recommended that the Montana Legislature continue on with its support of the Montana Health Care Authority as it performs those functions.

GOVERNOR RACICOT noted that there are a number of concerns about the Small Business Insurance Availability Act, and concerns about whether or not the certificate of need is a process that ought to be maintained in Montana and should it be located within the Department of Health or in the Montana Health Care Authority. Should the Authority be administratively attached to the Department of Health and Environmental Sciences, or should it be an "on-line agency within that particular department?"

GOVERNOR RACICOT said that if he could leave the committee with any impressions at all, it'd be to say that: "1) we had a contract we entered into all jointly, freely, voluntarily, and 2) that contract is being performed. The Authority is living up to the expectations that were placed upon it. Its business is, as yet, unfinished. It has accomplished a great deal. It has made recommendations to this panel and will to the legislature for the enactment of incremental reforms that are designed to hold down cost."

GOVERNOR RACICOT said, "I think that Montana has made a tremendous amount of progress in comparison to the rest of the nation in terms of wrapping its arms around this problem, defining its focus in terms of solutions, and moving forward on reforms that will provide the opportunity for Montanans to be taken care of with reasonable access to quality medical care in the state of Montana without the creation of an extraordinary amount of government expense."

GOVERNOR RACICOT stated that "it will be a constantly changing process that allows for us as technology and demographics change to demand and we'd be able to provide the kinds of services to the people we live with in a way that ultimately make sense to them, and respects the kind of diversity and different ways of life that we have in the state of Montana."

CHAIRMAN ORR thanked **GOVERNOR RACICOT** for speaking before the Select Health Care Committee and acknowledged that "we're not going to know all that there is to know about health care during the next four months."

CHAIRMAN ORR introduced **Mr. Hubbard,** who turned the panel over to their **Chair, Dorothy Bradley.**

Ms. Bradley stated that she owed **GOVERNOR RACICOT** for giving her "the opportunity to serve with the five members of this board, and a special debt of gratitude to the other members who stuck with me as Chairman."

Ms. Bradley introduced the members of the Health Care Authority board.

Ms. Bradley spoke about the members of the board and stated that "this may well be the biggest task, the shortest timeline, and the best team" that she has had the opportunity to work with. She said they are satisfied that the work (Exhibit 1, Parts A-J) "respects and reflects Montana values, reflects Montanan's concerns for their fellow citizens, and reflects Montanan's extreme caution about spending other people's money. That is what health care reform is all about. It's about people, and it's about people's money."

Ms. Bradley stated that they worked to put forward a third alternative, called the Market-Based Sequential Reform. (Exhibit 1, Part H) This proposal suggests that reform is taken just several steps at a time, and then look back on those steps and examine the progress.

Ms. Bradley pointed out the following pages from the Market-Based Sequential Reform (Exhibit 1, Part H):

Page 9	The steps to expand access.
Page 15	Market-based Cost Containment
Page 27	Health Care Delivery System and different ideas

Ms. Bradley announced that Thursday, January 5, 1995, the guest speakers will be **Larry Bartlett, Health Systems Research, Consultant** from Washington, D.C., and **Sam Hubbard, Executive Director of the Montana Health Care Authority, and the rest of the HCA staff.**

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CHAIRMAN ORR introduced **Dr. John T. Molloy, M.D, Northwest Medical Center, Great Falls, MT.**

Dr. Molloy thanked the legislature for allowing him to participate in this endeavor as a HCA board member. **Dr. Molloy** stated that the cumbersome health care system that we have developed has reached a crux because of the cost. There is no easy way to solve these problems. "This has taken the country by storm and seemingly gone from a major issue that people wanted the government involved in, to an issue that they don't want the government involved in," and let the market run its course. **Dr. Molloy** stated that there were many things that were bad in 1993, but they are worse now. "It seems that the Sequential Market-Based proposal is a position that will allow the existing structure to develop in a way, without undue influence from government, to develop better control on the cost of health care and, hopefully, the quality and accessibility of health care will improve, also." **Dr. Molloy's** concern is if "we let the market do this on its own, we won't have in existence, without the Health Care Authority, or some similar body, an organization that can critically evaluate whether or not the changes that occur are accomplishing the goals of the people of Montana" set out to accomplish at the last legislative session. "Certainly we want cost control, but we want affordable insurance available to everybody." We want people to be responsible for their own health care, and "I think that it's imperative that the system we have makes people responsible, but I, also, think that as things are changing now, what we need from the standpoint of government is to see that the industry" is performing for all of the people.

Dr. Molloy said that what concerns him a great deal is the development of for-profit organizations. They perform very well. They do, at this point, deliver high quality health care, and they are able to get control of cost. "But what you won't see is the impact on the communities that they serve. You will not see the people who are left out of those systems. You won't see the statistics that relate to that." "They are profiting. The CEO of the organizations are making $20 million a year. Those are the insurance premiums for 5000 families for one individual. That can't be allowed to happen." **Dr. Molloy** stated that he would make himself available, at any time, throughout the deliberations.

Maggie Newman, National Farmer's Union Insurance Company, Ronan, Montana, said that she would be happy to make herself available on issues that she has knowledge about. "It's important that this process continues. This is an ongoing problem that won't go away." Currently, we have prosperous times in the state of Montana, so the problem of health insurance and health care inflation doesn't look quite as bad. It has doubled the rate of the rest of the inflation of our economy. It is 1/7 of our economy.

CHAIRMAN ORR introduced **Mr. Hubbard** who stated that he and the Health Care Authority staff would be happy to provide the legislators with whatever help they can as they move through their deliberations. **Mr. Hubbard** stated that "we've been very much indebted to the assistance on the board of their four exofficio members: Peter Blouke, Director of SRS; Robert Robinson, Health and Environmental Sciences; Mark O'Keefe, Insurance Commissioner State Auditor; Joseph Mazurek, Attorney General, and Beth Baker; Assistant Chief Deputy Attorney General.

REP. RICHARD SIMPKINS wanted to know if the Health Care Authority study include thoughts on how the county health departments throughout the state of Montana could provide health care to people.

Mr. Hubbard responded that they relied on the committee that consisted of county health officers and representatives of the Department of Health and Environmental Sciences who "came up with a very good initial step in trying to get the county health departments more involved in the core public health functions and the Health Care Authority supported their recommendations." These recommendations will be brought to the legislators under a different form than our report.

REP. SIMPKINS responded that he knows the HCA has another plan on the county health department level that will be made available. **REP. SIMPKINS** wanted to know if HCA took into consideration the, proposed requirement by Heritage Foundation to make every person buy health insurance. This proposal means mandating individuals to take responsibility for their own health insurance, and then work with those people who cannot afford health insurance.

Mr. Hubbard responded yes. That was dealt with as a part of regulated multiple payer option, "and, in fact, the Authority did opt for an individual mandate under that approach, rather than an employer mandate, as has been done elsewhere."

REP. SIMPKINS noted that a recent publication in the Hospital Rate Review Board suggested making it a mandate to belong to that organization, and asked if the HCA looked at that organization to determine whether it is an efficient organization "in order to carry out this great review and hold the cost down."

Mr. Hubbard responded that the HCA "looked quite long and hard at the Rate Review System and the authority believes it is an excellent tool. It is already in place for both dealing with data needs, as well as cost containment kinds of issues for hospitals." It is currently voluntary. The HCA would encourage those hospitals that are not currently members of the Rate Review System to enroll.

REP. JOHN JOHNSON stated that he attended a meeting where the budget request was going to be about $1.2 million. He wanted to know if that budget request has been reduced.

Mr. Hubbard responded that the Authority board asked the staff to develop a list of responsibilities and activities that the Authority was mandated to carry on, and try to attach a cost figure to each of those activities. This was done, and that number totalled about $1.2 million. The Authority went through those activities and brought them down considerably, and finalized that process. The budget request that we have forwarded to **GOVERNOR RACICOT** to handle about eight fundamental activities would be just under $400,000 a year.

REP. J. JOHNSON wanted to know what the eight fundamental activities were.

Mr. Hubbard responded that the eight activities are:

1. to complete the design of the health information data system,
2. to provide certification procedures for voluntary purchasing pools,
3. to update the regional and state health care resource management plans on a biennial basis (SB 285 mandated that those be done annually),
4. to evaluate the progress and impact of any sequential market-based reforms that are enacted by this session,
5. to manage the cooperative agreements process,
6. to monitor and analyze on an on-going basis health system cost trends,
7. to provide support for the state board and the regional planning boards, and
8. to assume responsibility for the state conference health plan.

Mr. Hubbard stated that the HCA recommends that these eight items be focused on during the next biennium.

REP. J. JOHNSON wanted to know how this all integrates with the current health care delivery system and "the changes that they're talking about currently, of merging departments into HCA, if that happens, the managed care system the SRS is currently suggesting we contract for, and the resources management system that is in place at this time."

Mr. Hubbard responded that this has been designed to fit neatly with all of those possible developments. A recommendation in the "Market-Based Plan is to encourage the on-going development of managed care organizations, not only in the Medicaid area, but in the private insurance sector." Primarily the HCA is recommending with this approach is much more of a catalyst and a coordinator of reforms.

REP. BRUCE SIMON responded that the HCA has reached the 1995 goal of bringing these reports to the legislature, and acknowledged and congratulated all of the Health Care Authority members and volunteer members that served on the board, for their hard work and dedication over the last 1 1/2 years.

REP. SIMON in the Sequential Market-Based Plan access area, **Mr. Hubbard** spoke about supporting the Family Residency Program. **REP. SIMON** noted that there is nothing "in there about Physician's Assistance or Advanced Trained Nurses," which are, also, an important component in a rural setting. **REP. SIMON** wanted to know if that was discussed, and if the Authority had any input for strengthening or improving those programs which are an important component of health care in Montana.

Mr. Hubbard responded that the Authority discussed "the importance of mid-level practitioners in improving access to health care services to rural areas."

Mr. Hubbard stated that having more primary care physicians in family practice positions, particularly in rural areas, will tend to automatically make better use of mid-level practitioners as a matter of course. **Mr. Hubbard** deferred to **Dr. Molloy.**

Dr. Molloy stated that they did have this discussion. In the state of Montana they are developing a Family Practice Residency Program, but the Montana State University in Bozeman, Montana, Nursing Program is a little further along. There is no Physician's Assistant Program in the state of Montana. The concern of the HCA "is that we're developing these things and there is no dialogue between those entities, which is just a reflection of the problem overall, that there are solutions that are occurring separate from dialogue with each other, and we would like to see all of that come together."

REP. SIMON noted that on the Sequential Market-Based Reform, that there are a lot of items mentioned in skeletal form.

Mr. Hubbard agreed and responded that this was done by design. The HCA felt that after sending the five volumes of the main report, we thought that we should have sent the skeletal issue, as well. The HCA can work with the legislatures on the Sequential Report and direct the legislators to the information that is needed.

REP. SIMON stated that there are a lot of concepts that the legislators may want to use, but they won't be in bill form; however, there are bill draft requests in for those items. **REP. SIMON** wanted to know if **CHAIRMAN ORR** anticipates taking a number of items and making committee bills based on concepts brought up the Select Health Care Committee.

CHAIRMAN ORR responded that there was a strong possibility for making a committee bill or bills.

REP. TOM NELSON stated that the mandate in SB 285 directed the Authority to look at two types of health insurance reform plans. Much of the focus of the Authority was on insurance reform. **REP. NELSON** noted that the rate of inflation is double the rest of the economy in the health care sector, and stated that "we can do a lot of work in this committee for health insurance reform, much of which is needed. But I question whether that will even begin to solve the problem that we're after, and that's to slow down the rate of inflation." **REP. NELSON** wanted to know if in the HCA's work, there was much focus on how to do cost containment. **REP. NELSON** stated for that to be effective, it would have to be in market reform.

Mr. Hubbard noted that while the Authority itself was responsible for developing the two alternative financing systems - the single payer and the multi-payer, a significant part of SB 285 was the Small Employer Health Insurance Availability Act, and the responsibility of the development and implementation of that, which is known as Small Group Reform.

Mr. Hubbard stated that HCA "looked at a number of approaches to cost containment, certainly how insurance and how services are purchased." What the HCA attempted to do in the Sequential Market-Based Approach was to present the legislators with a variety of mechanisms that are being used and have been used in other states that appear to have promise for success in cost containment. The Purchasing Pool is one; this approach pools a number of purchasers mainly from small employer groups and then the pool acting on behalf of those purchasers negotiates the best deal they can possibly get with insurance providers. Managed Care, if done right, has shown in other states significant promise in cost containment from the provider standpoint.

REP. SIMPKINS stated that one thing in the insurance industry that they failed to do was to increase the deductible portion of a policy to match the rate of inflation, which would cause the insurance premium to accelerate at a higher rate. **REP. SIMPKINS** asked that if the comparisons of the deductible portions had increased at the inflation rate, it would have contained the cost.

Mr. Hubbard stated that the HCA saw nothing on either side of that issue, so he cannot comment on that.

REP. SIMPKINS stated that there has been a lot of discussion on the three elements of health care. The elements are quality, affordability, and timely delivery. He went on to say that "if you want high quality, at the least expense, delivered on a timely basis, you can have two but not three."
REP. SIMPKINS asked if it is possible to achieve availability of all three elements.

Mr. Hubbard responded that "all three are goals to be strived for, but I'm not sure that you can achieve all three goals without having to either redistribute some of the burden for who pays for the achievement of those three goals, or simply having to invest more money in order to achieve those three goals." This is why the Authority chose to suggest that the legislature take a "Sequential Approach" where you try a few things, see how they work, and then see if you need to take any other steps to gradually pursue the attainment of those three goals. **Mr. Hubbard** stated that everyone is responsible for the problems confronted with health care. It is the insurer, the provider and the consumer.

REP. SIMPKINS said "I think what you're saying" is that in order to maintain high quality on a timely basis, we have to put more money into it.

Mr. Hubbard responded that if you want to expand access, that is probably true.

REP. SIMON stated that the government is also responsible for some of the problems with health care. **REP. SIMON** wanted to know if **Mr. Hubbard** had any suggestions on how to address the governmental intervention which has greatly added to the health care problem.

Mr. Hubbard responded that "it's pretty hard look at health care reform, particularly cost containment, without looking at the purchasing practices of both the Medicaid and Medicare programs. Clearly they are largely responsible for a significant portion of the cost shifting" on the part of providers which are having to make up the difference between what Medicare and Medicaid will pay providers, and what their actual costs are by shifting the burden of those costs to those who are more willing to pay. "It does create a fundamental imbalance or inequity in the way that

works, and certainly contributes to a cost containment problem." The HCA did include in both the Universal Access Plan report and the final report recommending that regulatory reform be studied seriously and implemented wherever possible.

Mr. Hubbard noted that the government is "a major purchaser of health care services, so clearly how government behaves in the marketplace is going to have a major effect, for good or bad, on how the marketplace conforms."

REP. SIMON asked **Mr. Hubbard** if regulatory reform and review is part of the work plan that he would outline for the health care program for the next two years.

Mr. Hubbard responded that it is not.

REP. SIMPKINS noted that the government is a major health care purchaser and stated that "there has been a significant increase in this over the period of years," and that now "42 per cent of third-party carrier payments are made by the federal government," which include CHAMPUS, Medicare, and Medicaid. "At the same time, the rate of increase of health care had risen almost in direct proportion to this. As the government became more involved the rate of increase also went up. **REP. SIMPKINS** asked if the HCA found "any correlation that shows that because of government, health care costs have risen on just their third-party payment basis.

Mr. Hubbard responded that those increases tended to come in the earlier years than more recently, when Medicare and Medicaid started to implement their GRG payment approaches, and the like, designed to hold their costs down. This has tended to shift the burden, particularly to the states, and this is probably a lot of the reason for the substantial increases in the Medicaid budget over the last four to six years. Probably other purchasers do cost shifting, in terms of their ability to handle that. It is something that can be looked at more carefully, "but we probably don't have as good a fix on it as what you suggested."

REP. SIMPKINS was shocked when he received his CHAMPUS bill for $9000 for a hospital stay. "CHAMPUS recognized about 50 per cent of it, is what they allowed. I've never seen this great disparity between a government program and the actual allowed amount." They work on 80 per cent of the national average, versus 80 per cent of the state average. "I cannot believe that 80 per cent of the state average would be only 50 per cent of the allowable amount. I see that this is a way that the government is cost containing themselves," by not changing the rates to determine higher averages. **REP. SIMPKINS** asked if **Mr. Hubbard** had seen any evidence of this.

Mr. Hubbard responded that this is the basis of cost shifting and that cost shifting is a problem.

CHAIRMAN ORR added that "the citizens of Montana are truly indebted to the task that you've taken on for the last 1 1/2 years, and the taxpayers are certainly thankful that you stayed within your budget, and I'd like to compliment you on that. It's a monumental job that you've done."

CHAIRMAN ORR announced that the next meeting is Thursday, January 5, 1995 at 3:00 P.M. The guest speaker will be Dr. Larry Bartlett, Health Care Authority Consultant from Washington, D.C.

ADJOURNMENT

Adjournment: 4:43 P.M.

SCOTT ORR, Chairman

Vivian Reeves, Secretary

SO/vr

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL DATE Jan. 3-95

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten	✓		
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		

MONTANA HEALTH CARE AUTHORITY

EXHIBIT 1
DATE 1-3-95

MEMORANDUM

TO: Governor Marc Racicot

FROM: Dorothy Bradley, Chair
Montana Health Care Authority

DATE: January 3, 1995

SUBJECT: Proposed Health Care Authority Work Plan and Budget for the 1995-1997 Biennium

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Pursuant to my letter of December 15th, I would like to expand a bit on those activities which the Health Care Authority members believe the Authority should be responsible for during the 1995-1997 biennium. These include, in order of priority:

1. Complete the design of a health information data base. The Authority has found itself repeatedly suffering from the lack of a comprehensive and unified source of information about health care in the state. Thus we, like our counterparts in several other states, consider the ongoing development of such a data base to be of the highest priority. We have provided for an FTE and contract funding adequate to complete the design phase of this project in our most recent budget recommendation.

2. Provide for certification of voluntary purchasing pools. The development of a process for encouraging the formation of at least one private voluntary purchasing pool for Montana is also a high priority of the Authority. We have provided funding adequate to allow the Authority to play a certification role in the development of one or more pools during the upcoming biennium.

3. Update the regional and state health care resource management plans. This effort, initiated in 1994 in accordance with SB 285, currently provides the only comprehensive source of information on the existence and availability of health care resources throughout the state. The Authority believes that this will prove to be a valuable tool for both public policy makers and private businesses in providing for and allocating health care resources in the future. SB 285 provides for an annual update of these plans; we would propose that for the foreseeable future, they be updated biennially and we have provided adequate funding in our budget proposal for that purpose.

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4. Evaluate the progress and impact of sequential reforms. By definition, a sequential approach to health care reform implies that additional steps will be necessary in the future. The key to such steps will be the evaluation of those reforms already enacted and the analysis of additional modifications that may result in the accomplishment of the fundamental goals of health care reform. We have provided for funding in our proposed budget to carry out such a monitoring and evaluation process.

5. Manage the cooperative agreements process. Again, SB 285 provided for the development and operation of this process, designed to provide for state action immunity for collaborative ventures among health care providers when cost savings will result. We are in the process of promulgating administrative rules for this process and have provided for funding adequate to manage the process during the next biennium.

6. Monitor and analyze health system cost trends. Since continuing cost increases at a rate substantially greater than the overall rate of inflation in our economy are a major source of problems affecting the health care system in Montana, the Authority believes that continuing to monitor and analyze health care system cost trends is especially important. Accordingly, we have provided for this activity in our most recent budget proposal.

7. Provide support for state and regional Authority boards. If these boards are to continue to function, both financial and staff support is necessary to enable them to hold periodic meetings and carry out their statutory responsibilities. We have provided *minimal* funding for this purpose in our budget request.

8. Assume responsibility for state comprehensive health plan. SB 285 transferred authority for this activity from DHES to the Authority. We believe that this can best be accomplished by consolidating the process with the health care resource management planning process (see #3, above). This effort is also closely tied to the certificate of need process, which you have already provided funding for in your executive budget request.

We believe that these activities can be accomplished with an annual budget of 4 FTEs and approximately $400,000, a substantial reduction from the Authority's budget for the current biennium. For your information and consideration, I am including a copy of a detailed budget projection for the next two years.

This is the budget we would like to submit to the Joint Appropriations Subcommittee for its consideration. It is a relatively Spartan request, but will enable the state to continue to make significant progress in the area of health care reform.

Thank you for your consideration.

Attachment

MONTANA HEALTH CARE AUTHORITY
PROPOSED BUDGET -- 1995-97 BIENNIUM

ITEM	FY 96	FY 97
PERSONAL SERVICES		
Salaries	145,276	145,276
Employee Benefits	31,961	31,961
Board Per Diem	13,000	13,000
Personal Services Total	190,237	190,237
OPERATING EXPENSES		
Consulting/Professional Services (data base)	65,000	65,000
Other Services	4,100	4,100
Supplies & Materials	3,000	3,000
Communications	4,500	4,500
Travel		
Board Members	23,000	23,000
Regional Board Members	16,800	16,800
Staff	4,500	4,500
Travel Total	44,300	44,300
Rent	11,844	11,844
Other Expenses	40,586	40,586
Operating Expenses Total	173,330	173,330
EQUIPMENT & INTANGIBLE ASSETS	0	0
Equip. & Intan. Assets Total	0	0
TOTALS - BUDGETED EXPENSES	363,567	363,567

EXHIBIT 1
DATE 1-3-95

MONTANA HEALTH CARE AUTHORITY

MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN
SUMMARY OF RECOMMENDATIONS

1. Expanded Access to Health Care Coverage and Services

1.1 Expand Medicaid eligibility to cover low income pregnant mothers and children ages 0 to 6 up to 200 percent of the federal poverty level; provide matching funds to the Caring Program for Children ages 7 through 18

1.2 Provide support for the Family Practice Residency Program as a method of increasing access to primary care physicians, especially in rural areas

1.3 Allow tax deductibility for health insurance premiums for self-employed individuals, sole-proprietorships, subchapter s corporations, and partnerships on the same basis as that of other businesses

1.4 Provide for mandatory employer insurance offering to employees

2. Health Insurance Market Reforms

2.1 Retain Small Employer Health Insurance Availability Act incorporating the following provisions:

- guaranteed issue and renewability
- portability
- limitations on pre-existing condition exclusions
- set premiums on modified community rating basis
- provide for two standardized benefit plans offering basic and standard levels of coverage

2.2 Extend small group reform to apply to groups of 1 to 100, with individuals included on a risk-adjusted basis

3. Market-Based Cost Containment

3.1 Provide for the formation of at least one statewide private voluntary health insurance purchasing pool

3.2 Promote managed care and utilization review for both private insurance and Medicaid

3.3 Support federal and state income tax deduction for Medical Savings Accounts

3.4 Support aggressive medical insurance fraud prosecution effort

3.5 Implement integrated and coordinated health care resource allocation planning process, including the merger of state health plan and statewide health resources management plan

3.6 Retain the current certificate of need process; support transfer of CON from DHES to Health Care Authority

3.7 Develop consumer education mechanisms designed to produce more efficient and effective use of health care system

3.8 Encourage all hospitals to obtain independent rate review by joining the voluntary Montana Hospital Rate Review System

3.9 Implement simplified billing approach

4. Health Care System Infrastructure Improvements

4.1 Implement unified health care data base (especially important to produce cost containment data); include data from all medical providers and medical malpractice claims

4.2 Support health care regulatory reform

4.3 Upgrade public health system

EXHIBIT 1
DATE 1-3-95

MONTANA HEALTH CARE AUTHORITY

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EXHIBIT 1
DATE 1-3-95

Designing a Health Purchasing Pool for Montana

A Report on the Merits and Possible Design Features of a Collective Arrangement for Purchasing Health Coverage for Smaller Employers and Individuals

(booklet)

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EXHIBIT 1
DATE 1-3-95

AN ASSESSMENT OF

MONTANA'S

CERTIFICATE OF NEED PROGRAM

(booklet)

STATE OF MONTANA
HEALTH CARE AUTHORITY
REPORT TO THE LEGISLATURE
DECEMBER 1, 1994

MONTANA HEALTH CARE AUTHORITY

December 1, 1994

Members of the Montana Legislature
Capitol Station
Helena, Montana 59620

Dear Legislators:

Senate Bill 285, enacted during the 1993 legislative session, required the Montana Health Care Authority to conduct a study of the state's certificate of need process and submit the results to the legislature on or before December 1, 1994. This report is the Authority's response to that charge.

As such, it attempts to determine whether changes to the CON program are necessary in light of other health care system reforms recommended by the MHCA. The study, in accordance with the statutory mandate, considers "the role, effect, and desirability of maintaining the exemptions from the certificate of need process for hospitals and for offices of private physicians, dentists, and other physical and mental health care professionals; and maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities." In order to determine what (if any) changes need to be made to the program, the Authority and its consultant, Health Systems Research, Inc., utilized an assessment strategy which included a review of the effectiveness of CON programs in general, as well as an in–depth examination of the CON review process in Montana.

On behalf of the other members of the Health Care Authority, I would like to express our appreciation to the many individuals and groups who participated in various aspects of this study process.

Sincerely,

Dorothy Bradley

Dorothy Bradley
Chair

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EXHIBIT 1 - Part A
DATE Jan. 3, 1995
HB

MONTANA HEALTH CARE AUTHORITY
1995 BIENNIUM ACCOMPLISHMENTS (PERFORMANCE INDICATORS)

1. STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLANS (REPORTS)

- VOLUME I (50-4-101, 301, 302, 303, 305, 306, 601 MCA)

  Single Payer Alternative
  Regulated Multiple Payer Alternative

- VOLUME II

  Supporting and reference materials for the single and multiple payer plans, including financing strategies, cost assumptions, demographic information, and small group health insurance reform

- VOLUME III (50-4-304, 402)

  Regional and Statewide Health Resource Management Plans

- VOLUME IV (50-4-101, 304, 307, 402 MCA)

  Public Participation Activities, including reports on electronic citizens forums, town meetings, public hearings on the statewide universal access plans, public hearings on the regional and statewide health care resource management plans, and a telephone survey of public opinion on health care reform

- VOLUME V (50-4-503 MCA)

  Health Insurer Cost Management Plans

2. DESIGN OF A HEALTH PURCHASING POOL FOR MONTANA (50-4-308 MCA) (REPORT)

3. AN ASSESSMENT OF MONTANA'S CERTIFICATE OF NEED PROGRAM (50-4-311 MCA) (REPORT)

4. A MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN FOR MONTANA (REPORT)

5. ADMINISTRATIVE RULES

- Selection of regional health planning board members

- Cooperative Agreements Process

Vol. 1

SB 285

EXHIBIT 1 - Part B
DATE Jan. 3, 1995
HB

Statewide Universal Health Care Access Plans

State of Montana
Health Care Authority
Report to the Legislature
October 1, 1994

(comb-bound)

EXHIBIT 1 - Part C
DATE Jan. 3, 1995
HB

Statewide Universal Health Care Access Plans

Volume II

Supporting Materials

Montana Health Care Authority
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(comb-bound)

EXHIBIT 1 - Part D
DATE Jan. 3, 1995
HB

Statewide Universal Health Care Access Plans

Volume III

Montana Health Care Resource Management Plans

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(comb-bound)

EXHIBIT 1 - Part E
DATE Jan. 3, 1995
HB

Statewide Universal Health Care Access Plans

Volume IV

Public Participation Activities

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(comb-bound)

EXHIBIT 1 - Part F
DATE Jan. 3, 1995
HB

Statewide Universal Health Care Access Plans

Volume V

Health Insurer Cost Management Plans

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(comb-bound)

EXHIBIT 1- Part G
DATE Jan. 3, 1995
HB

Designing a Health Purchasing Pool for Montana

A Report on the Merits and Possible Design Features of a Collective Arrangement for Purchasing Health Coverage for Smaller Employers and Individuals

Montana Health Care Authority
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(booklet)

EXHIBIT 1- Part H
DATE Jan. 3, 1995
HB

A MARKET-BASED SEQUENTIAL HEALTH CARE REFORM PLAN FOR MONTANA

State of Montana
Health Care Authority
Report to the Governor
and Legislature

December 16, 1995

(booklet)

EXHIBIT 1 - Part I
DATE Jan. 3, 1995
HB

CHAPTER 48

MONTANA HEALTH CARE AUTHORITY

Sub-Chapter 1

Organizational Rule

Rule 16.48.101 Creation of the Regional Health Care Planning Board

16.48.102 Composition of the Regional Health Care Planning Board

16.48.103 Selection of Board Members

Sub-Chapter 1

Organizational Rule

16.48.101 CREATION OF THE REGIONAL HEALTH CARE PLANNING BOARD (1) There are five regional health care planning boards, or "board" as used throughout these rules, each representing the regions established pursuant to 50-4-401(1), MCA. (History: Sec. 50-4-401, MCA; IMP, Sec. 50-4-401, MCA; NEW, 1993 MAR p. 2416, Eff. 10/15/93.)

16.48.102 COMPOSITION OF THE REGIONAL HEALTH CARE PLANNING BOARD (1) The membership of each board shall include at least one member from each county within each region according to 50-4-401(1) and (3).

(2) The size of membership of each board may be expanded upon application of the board to the health care authority and approval by the health care authority. (History: Sec. 50-4-401, MCA; IMP, Sec. 50-4-401, MCA; NEW, 1993 MAR p. 2416, Eff. 10/15/93.)

16.48.103 SELECTION OF BOARD MEMBERS (1) Board members shall be selected by the health care authority from a list of nominees submitted by the board of county commissioners of each county as provided in (2)-(4) below.

(2) The board of county commissioners of each county within each region, as defined in 50-4-401, MCA, shall submit to the health care authority four nominees from the commissioners' own county for the position representing their county on the regional health care planning board.

(3) The commissioners' submission of the four nominees must list nominees in order of preference with the most preferred nominee being first. A short description of how this rating was conducted is encouraged.

(4) The board of county commissioners must solicit applications for membership on forms supplied by the health care authority.

(5) The health care authority shall make its selection:

(a) giving consideration to a balance between rural and urban interests, and

(b) involving a balance of individuals according to 50-4-401(3), MCA, by gender and consumer or health care provider status. (History: Sec. 50-4-401, MCA; IMP, Sec. 50-4-401, MCA; NEW, 1993 MAR p. 2416, Eff. 10/15/93.)

EXHIBIT 1 - Part J
DATE Jan. 3, 1995
HB

BEFORE THE MONTANA HEALTH CARE AUTHORITY

In the matter of the adoption of rules specifying the procedure for review, approval, supervision and revocation of cooperative agreements between health care facilities and the issuance and revocation of certificates of public advantage.	))))))))	NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED

DRAFT

TO: All Interested Persons.

1. On [date of March MHCA meeting], the Montana Health Care Authority proposes to adopt rules specifying the procedure for review, approval, supervision and revocation of cooperative agreements between health care facilities and the issuance and revocation of certificates of public advantage.

2. The proposed rules provide as follows:

RULE I DEFINITIONS (1) "Authority" means the Montana Health Care Authority created by 50-4-201, MCA.

(2) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

(3) "Health care facility" has the meaning specified in 50-4-102(7), MCA.

(4) "Certificate of public advantage" has the meaning specified in 50-4-102(3), MCA.

(5) "Cooperative agreement" or "agreement" has the meaning specified in 50-4-102(4), MCA.

(6) "Costs" or "health care costs" means the amount paid by consumers or third party payers for health care services or products.

(7) "Person" means an individual or entity.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE II APPLICATION PROCEDURE (1) Health care facilities seeking a certificate of public advantage must apply to the Montana Health Care Authority and must include the following information in the application:

(a) a descriptive title;

(b) a table of contents;

(c) the names of each party to the application and the address of the principal business office of each party;

(d) the name, address, and telephone number of the persons authorized to receive notices and communications with respect to the application;

(e) a verified statement by a responsible officer of each party to the application attesting to the accuracy and completeness of the enclosed information;

(f) information relating to the proposed cooperative agreement, including, if applicable:

(i) a description of the proposed agreement, including a list of any services or products that are the subject of the proposed agreement;

(ii) a description of any consideration passing to any person under the agreement, including the amount, nature, source, and recipient;

(iii) a description of each party's contribution of capital, equipment, or other value to the transaction, as well as each party's nonmonetary involvement in the arrangement, if any;

(iv) identification of any tangential services or products associated with the services or products that are the subject of the proposed agreement;

(v) a description of the geographic territory involved in the proposed agreement;

(vi) if the geographic territory described in item e. is different from the territory in which the applicants have engaged in the type of business at issue over the last five years, a description of how and why the geographic territory differs;

(vii) identification of all products or services that a substantial share of consumers would consider substitutes for any service or product that is the subject of the proposed agreement;

(viii) identification of whether any services or products of the proposed agreement are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item e.;

(ix) identification of the steps necessary, under current market and regulatory conditions, for other parties to enter the territory described in item e. and compete with the applicants;

(x) a description of the previous history of dealings between the parties to the application;

(xi) a detailed explanation of the projected effects, including expected volume, change in price, and increased revenue, of the agreement on each party's current businesses, both generally as well as the aspects of the business directly involved in the proposed agreement;

(xii) the parties' estimate of their respective present market shares and that of others affected by the proposed agreement, and projected market shares after implementation of the proposed agreement.

(xiii) a description of:

a. how the proposed agreement will enhance the quality of or access to health care in Montana;

b. whether the proposed agreement is likely to result in lower health care costs and, if so, how and to whom;

(xiv) a statement of whether competition among health care providers or health care facilities will be reduced as a result of

the proposed agreement; whether there will be adverse impact on quality, availability, or cost of health care; whether the projected levels of cost, access, or quality could be achieved in the existing market without the proposed agreement; and, for each of the above, an explanation of why or why not; and

(xv) if information is not supplied under any of the above items, an explanation of why the item is not applicable to the transaction or to the parties.

(g) A copy of the proposed cooperative agreement must be attached to the application.

(2) The application and cooperative agreement are public documents, except for any trade secrets, as defined by 30-14-402(4), MCA, or information otherwise required by law to be kept confidential. If the applicants believe the application contains any information which must be kept confidential, such information must be clearly identified and duplicate applications must be submitted, one application with full information for the Authority's use and one redacted application available for release to the public. A written statement must accompany the application, explaining the legal basis for protection of any information as confidential.

(3) The time for action by the Authority as prescribed in 50-4-603(3), MCA, does not begin to run until the application is determined by the Authority to be complete.

(4) Once the application is complete, the Authority shall cause notice of the application to be published in the Special Notices section of the Montana Administrative Register and sent to the regional health care planning board for each region that includes all or part of the territory covered by the proposed agreement, and to any person who has requested to be placed on a list to receive notice of applications. All costs associated with publication of notice shall be borne by the applicants.

(5) Written comments with respect to the application will be accepted by the Authority within 30 days after the notice is published. Persons submitting comments must provide a copy of the comments to the applicants. The applicants may respond in writing to the comments within ten days after the deadline for submitting comments. The applicants must send a copy of their response to the person submitting the comment.

(6) The provisions of these rules do not apply to, and certificates of public advantage may not be issued for, a merger or consolidation of two or more health care facilities, including but not limited to any agreement among health care facilities by which ownership or control over substantially all of the stock, assets or activities of one or more health care facilities is placed under the control of another health care facility.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE III PROCEDURE FOR REVIEW OF APPLICATIONS (1) Following the close of the comment period, the Authority shall schedule a public hearing on the application. If written comments have been submitted in opposition to the agreement, the hearing must be held within the geographic territory covered by the proposed agreement. The Authority may appoint any one of its voting members to conduct the public hearing. The hearing must be held no later than 60 days after the completed application is received. Notice of the hearing shall be mailed to the applicant and to all persons who have submitted written comments on the application. Notice also shall be published by the Authority in the same manner as notice of its regular meetings [or in the form prescribed by the Authority], but in any event no later than 10 days before the hearing. The hearing shall be recorded in a manner suitable for transcription, but need not be transcribed unless the Authority's decision is appealed pursuant to 50-4-610, MCA. Costs associated with preparation of the transcript shall be paid by the party appealing the Authority's decision, unless otherwise ordered by the court.

(2) In its review of the application, the Authority shall consider: the application and any supporting documents submitted by the applicants; the agreement; any written comments submitted by any person, and any written response by the applicants; and any comments, written or oral, submitted at the public hearing. The Authority may consider any other material submitted to or requested by the Authority bearing on whether the cooperative agreement is likely to result in lower health care costs or in greater access to or quality of health care.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE IV STANDARDS FOR CERTIFICATION (1) The Authority may not issue a certificate of public advantage unless it finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement.

(a) In evaluating the potential benefits of a cooperative agreement, the Authority shall consider whether one or more of the following benefits may result from the cooperative agreement:

(i) Enhancement of the quality of health care provided to residents of Montana;

(ii) Preservation of health care facilities in geographical proximity to the communities traditionally served by those facilities;

(iii) Gains in the cost efficiency of services provided by the health care facilities involved;

(iv) Improvements in the utilization of health services and equipment;

(v) Provision of services that would not otherwise be available;

(vi) Avoidance of duplication of health care resources; or

(vii) Any other manifestation of lower health care costs or of greater access to or quality of health care as a result of the agreement.

(b) In evaluating any disadvantages likely to result from the agreement, the Authority may consider the following factors:

(i) Adverse impact on quality, availability, or cost of health care services to consumers;

(ii) Adverse impact on the ability of health care payers to negotiate optimal payment and service arrangements with health care providers;

(iii) Reduction in competition among health care providers or other persons furnishing goods or services to, or in competition with, health care facilities that is likely to result directly or indirectly from the cooperative agreement; and

(iv) The availability of arrangements less restrictive to competition that achieve the same benefits.

(c) In making determinations as to availability of or access to health care services, the Authority may consider:

(i) The extent to which the utilization of needed health care services or products by the population to be served by the agreement is likely to increase or decrease;

(ii) The extent to which the proposed agreement is likely to make available a new and needed service or product to a certain geographic area; and

(iii) The extent to which the proposed agreement is likely to otherwise make health care services or products more financially or geographically available to persons who need them.

(d) In making determinations as to quality, the Authority may consider the extent to which the proposed agreement is likely to:

(i) Decrease morbidity and mortality;

(ii) Result in faster convalescence;

(iii) Result in fewer hospital days;

(iv) Permit providers to attain needed experience or frequency of treatment, likely to lead to better outcomes;

(v) Increase consumer satisfaction; and

(vi) Have any other features likely to improve or reduce the quality of health care.

(2) Within 90 days of receiving a completed application, the Authority must issue a written decision approving or disapproving the application and stating the reasons for its decision. If the application is approved, a certificate of public advantage must be issued. The Authority may condition approval on a modification of all or part of the proposed agreement to eliminate any restriction on competition that is not reasonably related to the goals of reducing costs or improving access or quality. The Authority may also establish conditions for approval that are reasonably necessary to protect against abuses of private economic power or to ensure that the agreement is appropriately supervised and regulated by the State.

(3) The Authority shall maintain on file all cooperative agreements for which a certificate of public advantage remains in effect. Any party to a cooperative agreement who terminates the

agreement shall file a notice of termination with the Authority within 30 days after termination.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE V RECONSIDERATION (1) A request for reconsideration by a party whose application for a certificate of public advantage has been denied by the Authority must be filed in writing within 30 calendar days of the Authority's decision and must include a statement of grounds upon which reconsideration is sought.

(2) Upon timely submittal of a request for reconsideration, the Authority shall publish notice of the request in the Montana Administrative Register. The Authority shall schedule a public hearing no later than 30 days after receipt of the request for reconsideration, unless the requesting party agrees to a later date. The hearing must be held within the geographic territory covered by the proposed agreement. The Authority may appoint any one of its voting members to conduct the public hearing. Notice of the hearing shall be given by the Authority in the same manner as notice of its regular meetings, but in any event no later than 10 days before the hearing. The hearing shall be recorded stenographically or electronically, and shall be conducted in accordance with 2-4-604(4), MCA.

(3) In ruling on a request for reconsideration, the Authority shall consider all written or oral evidence submitted to the Authority or presented at the public hearing and any other material required by 2-4-604, MCA, to be considered.

(4) The Authority must act on the request for reconsideration within 30 days of the public hearing, and must enter its decision in the form of findings of fact and conclusions of law. The decision must be served upon the party requesting reconsideration.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE VI ACTIVE SUPERVISION (1) Parties to an approved cooperative agreement must submit, in accordance with the provisions of this rule, progress reports that provide information to enable the Authority to evaluate the impact of the agreement on the availability, cost effectiveness, quality, and delivery of health care services and to determine whether the parties to the agreement have complied with its terms and with the order of the Authority approving the agreement.

(a) The progress reports must be submitted within six months after issuance of the certificate of public advantage, and each six months thereafter.

(b) Each progress report must contain the following information:

(i) A narrative providing a qualitative and quantitative assessment of progress in meeting the objectives of lower costs or

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greater access to or quality of care identified as the basis for approval of the cooperative agreement;

(ii) If the objective(s) of the certificate of public advantage is (are) not being met or progress cannot be demonstrated, a narrative explanation as to why the objective(s) is (are) not being met or there is no progress, together with the planned corrective actions and a proposed timetable for meeting the objective(s) of the certificate of public advantage;

(iii) A narrative analysis of the benefits and disadvantages resulting from the implementation of the cooperative agreement, including benefits or disadvantages not previously identified; and

(iv) A copy of minutes or a comparable substitute report of all meetings held in order to implement and conduct the activity under the cooperative agreement.

(2) The Authority may require specific data relating to cost, access, and quality, or any other information it determines to be reasonably necessary to its inquiry, and may conduct such audits of the books, records, and other documents pertaining to the agreement and of the operations under the agreement as the Authority determines to be reasonably necessary. Any such audit shall be for the purpose of determining whether grounds exist for revocation under 50-4-609, MCA. The expense of the audit must be borne by the parties to the cooperative agreement.

(3) The Authority may solicit and consider public comment on any progress report required by this rule, and shall send a copy of the annual report to the regional board or boards in the geographic area affected by the agreement. The Authority may request additional oral or written information from the parties to the agreement or from any other source.

(4) The Authority may request additional information from the parties to a cooperative agreement at any time during the implementation of the cooperative agreement. The parties shall respond within 30 days to any additional requests for information requested by the Authority.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE VII REVOCATION OF CERTIFICATES (1) Proceedings for revocation of a certificate of public advantage are governed by 50-4-609, MCA. Proceedings may be initiated by the Authority if it finds reasonable cause to believe the agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in the absence of the agreement.

(2) The Authority may revoke a certificate of public advantage if it determines that:

(a) Its approval of the agreement was procured by material fraud or misrepresentation;

(b) The parties have failed, in a material respect, to comply with the terms of the agreement as approved by the Authority or with the terms of the Authority's decision approving the agreement

and have failed, to the reasonable satisfaction of the Authority, to cure their noncompliance;

(c) The agreement is not resulting in lower health care costs or greater access to or quality of health care;

(d) The agreement has not and is not likely to substantially achieve the improvements in cost, access, or quality identified in the Authority's decision as the basis for its approval of the agreement; or

(e) The conditions in the marketplace have changed to such an extent that competition would promote reductions in cost and improvements in access and quality better than does the cooperative agreement at issue. In order to revoke on the basis that conditions in the marketplace have changed, the Authority's order must identify specific changes in the marketplace and articulate why those changes warrant revocation.

(3) The Authority shall not revoke a certificate of public advantage pursuant to paragraph [VII.B.3.] if it is reasonably possible for the parties to modify the agreement to accommodate the effect of any changed circumstances and achieve lower costs or greater access to or quality of health care.

(4) If proceedings are commenced to revoke a certificate of public advantage, the parties to the cooperative agreement bear the burden of proving by a preponderance of the evidence that the agreement is resulting in lower health care costs or greater access to or quality of health care.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

RULE VIII APPEALS (1) A party to a cooperative agreement may appeal a final decision by the Authority to deny an application for a certificate or to revoke a certificate.

(2) Appeal of the Authority's decision to deny or revoke a certificate of public advantage under these rules is governed by 50-4-610, MCA, and Title 2, chapter 4, part 7, MCA.

AUTH Sec. 50-4-612 MCA. IMP Sec. 50-4-601 through 50-4-612 MCA.

3. The rules are necessary to provide state action immunity from the antitrust laws of the United States and the State of Montana to health care facilities that enter into cooperative agreements that will result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. The rules implement 50-4-601 through -612, MCA, which express the Montana Legislature's intent that supervision and control over the implementation of cooperative agreements substitution state regulation of health care facilities for competition between the facilities. These rules will provide the supervision and control required by the Legislature.

EXHIBIT 1 - Part J
DATE 1-3-95

4. Interested parties may submit their data, views or arguments concerning the proposed rule in writing to Sam Hubbard, Executive Director, Montana Health Care Authority, 28 North Last Chance Gulch, P.O. Box 200901, Helena, MT 59620-0901, to be received no later than March 13, 1995.

5. If a person who is directly affected by the proposed adoption wishes to express his or her data, views and arguments orally or in writing at a public hearing, s/he must make written request for a hearing and submit this request along with any written comments s/he has to Sam Hubbard, Executive Director, Montana Health Care Authority, 28 North Last Chance Gulch, P.O. Box 200901, Helena, MT 59620-0901. The comments must be received no later than March 13, 1995.

6. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the administrative code committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 45 persons based on the fact that there are 450 licensed health care facilities in Montana.

By: _____
Dorothy Bradley, Chair
Montana Health Care Authority

_____
(Rule Reviewer)

Certified to the Secretary of State January 30, 1995.

DRAFT