MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Stella Jean Hansen, Chairman, on March 3, 1989 at 3:00 p.m.

ROLL CALL

Members Present: All
Members Excused: None
Members Absent: None
Staff Present: Mary McCue, Legislative Council
Announcements/Discussion: None

HEARING ON SB 340

Presentation and Opening Statement by Sponsor:

Senator Williams stated that this bill was an act to revise and continue the certificate of need laws; to exempt hospitals from certificate of need requirements in certain circumstances; and providing an effective date.

Testifying Proponents and Who They Represent:

Rep. Bob Marks
Jim Aherns, Montana Hospital Association
Rep. Dave Brown
Richard Brown, Liberty County Hospital
Hollis LeFever, M.D.
Jerry E. Jurena, Trinity Hospital
Sandra Erickson, Montana Associated Physicians
Grant Winn, Missoula Community Hospital
Jerry Beaudette, Sheridan Memorial Hospital
Ed Sheehy, National Association of Retired Persons
Lawrence McGovern, Montana Associated of Physicians
James T. Paquette, St. Vincent Hospital and Health Center
Jerry Loendorf, Montana Medical Association
John Guy, St. Peter's Hospital
Jack Casey, Shodair Hospital

Proponent Testimony:

Rep. Bob Marks stated that health care costs are high. The federal government gave up on certificate of need in 1986. The National Health Planning Act was scheduled to be re-authorized as early as 1981 but it never was. Congress merely funded it with the
continuing resolution year after year until 1986 when it said enough is enough. Each year the federal participation in certificate of need activities grew smaller and smaller until it finally faded away. In Montana the agency with certificate of need once employed over 16 FTE's and now that the federal government has ceased, it is budgeted at less than 5 FTE's and it is staffed even less than that. It is time to have the competitive market to reduce health care costs. If health care facilities engage in unwise, unneeded, overly expensive procedures which their communities cannot support with utilization, let them pay the consequences. Rep. Marks stated that it is his belief that not many health care facilities would be willing to take that risk. Self regulation will prevail. This bill removes hospitals from the certificate of need and hospitals are less in need of capital regulation than are other providers. If hospitals are taken from certificate of need this year, and extend the certificate of need for the other health care facilities, and watch very carefully to see if the doom and gloom results which proponents of certificate of need say will result, the next session can come back in and place hospitals in under the certificate of need law. If costs go down in two years the legislature should start thinking about reducing the scope of certificate of need even further.

Jim Ahrens stated that the Montana Hospital Association represents 54 hospitals and 31 attached nursing homes throughout the state. It has been characterized as a compromise bill and it is just that. It is the compromise between those who want no certificate of need for anyone and those who want certificate of need forever for all providers. This bill extends certificate of need for two years and exempts hospitals for certain services. Exhibit 1.

Rep. Dave Brown stated that he was convinced that after visiting with the hospitals in his area, that this legislation is imperative. Certificate of need does nothing but drain dollars from hospitals operating budgets. Quality of care is not the issue, trying to regulate competition amongst a sector. Rep. Brown also stated that he wondered why there is such a push in the other areas to retain certificate of need. Is there some intent to maintain a monopoly situation and prevent private competition in the certificate of need area. That is a very real question that the committee should consider. If just hospitals are out of this bill, then this bill should die.

Richard Brown stated that as an administrator of a small rural hospital, it does not allow him to make unwise business decisions regarding programs and
business and capital investments. When the decision is made to pursue new programs to consider equipment purchases or building projects, hospitals go through very methodical processes of their own to determine the need and feasibility. Hospitals must make decisions on capital investments and programs in a very business-like manner. Exhibit 2.

Hollis LeFever, M.D. stated that the certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. Exhibit 3.

Jerry E. Jurena stated that if the intent of certificate of need is to assure quality, it has missed the boat. If it is to restrict the access of health care and limit the technologies associated with building or remodeling, then it is working, if certificate of need is an asset, why haven't other industries introduced this type of restrictive legislation? Exhibit 4.

Sandra Erickson stated that certificate of need process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth in neighboring states and they have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles. Exhibit 5.

Grant Winn stated that in Missoula there was a hospital that received a certificate of need that was not needed and ultimately was absorbed by another hospital. A certificate of need was submitted last year for an expansion of the hospital with absolutely no opposition and the application itself was $28,000.00. Certificate of need for hospitals has been a waste.

Jerry Beaudette stated that this bill is a step towards total elimination of the certificate of need process. Mr. Beaudette also said that within a year of the completion of the facility his community had under way, all 20 beds were full and have been so ever since. This is a step closer towards total elimination of the certificate of need process.

Ed Sheehy said that he supported this bill.

Lawrence McGovern stated that he supported this bill.

Jim Pacquette stated that there is no proof that certificate of need law reduces costs to the consumer;
there is supporting documentation that certificate of need legislation raises costs of operation to hospitals and that certificate of need law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace. Exhibit 6.

Jerry Loendorf stated his support of this bill.

John Guy stated that he supported this bill.

Jack Casey stated his support of this bill.

Testifying Opponents and Who They Represent:

Rose Hughes, Montana Health Care Association
Chuck Butler, Blue Cross and Blue Shield
Wilbur Rehman, Montana Nurses Association
Mona Jamison, Rocky Mountain Dependency Center
Fred Patton, American Association of Retired Persons
Joan Ashley, Cooney Convalescent Hospital
Steve Waldron, Mental Health Center
Mike Cahill, Granite County Hospital

Opponent Testimony:

Rose Hughes stated that it was with reluctance that she spoke in opposition against this bill because the association would not be thrilled if it failed. Ms. Hughes then proposed some amendments to the bill. A packet was also presented which contained information on the high cost of deregulation; the move at the federal level to reinstate certificate of need; excess capacity and high costs and the unconstitutionality to exempt hospitals. Exhibit 7.

Chuck Butler stated that Blue Cross and Blue Shield supports the continuation of certificate of need with the amendments. The hospital community should be included in the certificate of need process. As Montana's largest insurer of health care, it is known first hand the effect of these rising costs on the people of Montana. Health care costs are one of the fastest if not the fastest growing expenses for employers and employees in our state and country. Mr. Butler stated that the health care insurers have lost money because they could not charge enough in the last three years to cover the actual costs that have been paid out.

Wilbur Raymond stated his support of the certificate of need process. If the bill were amended to include hospitals it would be a good bill. If certificate of need were done away with we would have a brighter future for the cost of health care. That is not true. The issue is really the issue of public involvement and public trust.
Mona Jamison stated that she supports this bill however, the issue of compromise was discussed. How can we compromise among ourselves and not have everyone mad in terms of the bill as presented. The amendments were supported as proposed. The amendments make clear that if hospitals do get into providing the other services, that it is the legislature's intent that the initial provision of those services or expansion that they do comply with certificate of need.

Fred Patton stated that this would not slow the rate of health care costs there would be duplication of expensive equipment and facilities. There would be no longer any rational planning of health care facilities.

Joan Ashley supports the amendments of this bill.

Steve Waldron stated his support of the amendments.

Mike Cahill stated his opposition of the bill.

Questions From Committee Members: Rep. Gould asked Ms. Erickson why she was afraid of competition and Ms. Erickson stated that there would be a need for affordable chemical dependency treatment and that there is an increase every year of people being admitted for the first time.

Rep. Good asked Mr. Robinson about the Wyoming situation regarding certificate of need and also questioned the constitutionality.

Rep. Simon asked Mr. Aherns about swing beds and long term care. and Mr. Aherns said that if a hospital did in fact want to expand to a swing bed facility they would be required to complete a certificate of need. Rep. Simon then again asked where this was read in the bill and Mr. Aherns said it was contained on page 4, section h. Rep. Simon then stated that this bill excludes the exemption of hospitals in section (1) (i).

Rep. Russell asked Mr. Aherns about health care facilities.

DISPOSITION OF SB 340

Motion: Rep. Simon made a Motion to BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. Simon made a Motion to move the Statement of Intent. A vote was taken on the Statement of Intent and all voted in favor. Motion carries.

Recommendation and Vote: A vote was taken TO BE CONCURRED IN WITH A STATEMENT OF INTENT. All voted in favor. Motion carries.
Closing by Sponsor: Senator Williams closed on the bill.

HEARING ON SB 124

Presentation and Opening Statement by Sponsor:

Senator Hager stated that bill was an act prohibiting a long term health care facility from refusing to admit a person to the facility solely because that person has aids or any other HIV-related condition.

Testifying Proponents and Who They Represent:

Bob Johnson, Montana Public Health Association
Mary Beth Frideres, Montana Aids Coalition
Sandy Hale, Montana Women's Lobby
Ann McIntyre, Human Rights Division
Wilbur Rehman, Montana Nurses Association

Proponent Testimony:

Bob Johnson stated that every hospital and nursing home in the state in coming years in Montana will be faced with the responsibility for admitting people with Aids. The staffs of these institutions have been trained in universal procedures that will allow them to treat Aids effectively and to protect the staffs of those institutions. There is virtually no health reason why any institution should be allowed to refuse to admit somebody who has Aids based upon health reasons.

Mary Beth Frideres supports this bill. There is no medical or scientific reason why we cannot take care of people with this infection. Technology has advanced and is appropriate and available to take care of people. There are procedures to be put in place to take care of individuals and there is no reason to discriminate on the basis of HIV infection for providing health care.

Sandy Hale stated that they endorse measures to prevent the human and economic loss relating to Aids. They support the adoption of a strong and comprehensive state level Aids policy including provision for the adequate resources and funding for prevention, education and direct care; opposition for mandatory testing; provisions for informed consent, adequate counselling and confidentiality in conjunction to HIV antibody testing. Exhibit 8.

Anne McIntyre stated that she had amendments to supply for the committee. The Human Rights Division has taken the position that these laws prohibit discrimination against someone who has an HIV related condition. This interpretation is similar to the position taken by
the federal courts and agencies in interpreting federal handicap laws. Exhibit 9.

Wilbur Rehman stated that he supports this legislation.

Testifying Opponents and Who They Represent:

None

Opponent Testimony:

None

Questions From Committee Members: Rep. Squires asked Mr. Johnson if there will be many to care for in Montana with Aids and Mr. Johnson stated that there would not.

Rep. Good asked Ms. McIntyre about the amendments, the impact of the bill and the public accommodations for these patients.

Rep. Russell asked Ms. McIntyre about the president in this kind of language in other kinds of statutes in other states and Ms. McIntyre stated that the laws of other states have been interpreted in the courts and by agency interpretation to include HIV related conditions.

Rep. Simon asked Ms. McIntyre regarding the amendment, would this broaden this act so that it would also pertain to employment and Ms. McIntyre stated that it would indeed pertain to employment.


DISPOSITION OF SB 124

Motion: Rep. Brown made a Motion to BE CONCURRED IN.

Amendments, Discussion, and Votes: Rep. McCormick made a Motion to move the amendments. Rep. Simon spoke against the amendments. A vote was taken on the amendments and all voted against the amendments with the exception of Reps. Russell and McCormick. Motion fails.

Recommendation and Vote: A vote was then taken to BE CONCURRED IN. All voted in favor. Motion carries.

HEARING ON SB 129

Presentation and Opening Statement by Sponsor:

Senator Manning state that this bill was an act to ensure that parents fulfill the duty to support their children by providing for a presumptive obligation of support in certain
legal proceedings; to require consideration to Uniform Guidelines to establish a minimum support level; to require paternity child support orders to include a provision covering health insurance in certain cases; to provide for child support collection through automatic income withholding; to grant the Department of Revenue the authority to charge fees in cases in which an obligor's failure or refusal to pay support requires the Department to act and providing an applicability date. Senator Manning also supplied amendments. Exhibit 10.

Testifying Proponents and Who They Represent:

Jim Smith, Human Resource Development Council
Mignon Waterman, Montana Association of Churches
Judith Carlson, Montana Association of Social Workers
Christine Deveny, League of Women Voters
Rep. John Cobb
Brenda Nordlund, Montana Women's Lobby
Marsha Dias

Proponent Testimony:

Jim Smith stated that sends a message that if you make a baby, baby you will be responsible for the financial well being until that child reaches adulthood. No maybe baby, you are responsible.

Mignon Waterman stated that parents, mother and father alike, should assume financial responsibility for their children. It is only through strict child support decrees and enforcement that adequate child support can be ensured. Exhibit 11.

Judith Carlson stated that this includes not only married fathers who are divorced or mothers but also there is the cases of paternity action is taken. Most people may not be aware but when a young woman applies for AFDC she must name the father of her child so no matter what the legal status is, an action will be taken in court requiring that support be made.

Christine Deveny stated that only one third of all single mothers receive the full amount of their court awarded child support. Exhibit 12.


Brenda Nordlund presented the committee with the guide for determination of child support obligations which was prepared by the Montana Child Support Advisory Council. Exhibit 14.

Marsha Dias stated her support of this bill.
Testifying Opponents and Who They Represent:

None

Opponent Testimony:

None

Questions From Committee Members: Rep. Brown asked Mr. McCray about the obligor notice and how employers will be informed and Mr. McCray said that booklets will be sent out to every employer in the state.

Rep. Blotkamp asked Mr. McCray about out of state fathers and the acquisition of health insurance.

Rep. Whalen asked Ms. Nordlund about the number of divorces and the number of children and Ms. Nordlund stated that if one out of four parents are self employed and the number of children that are involved in divorces in 1988 then approximately 3/4 of the children who affected by divorce will benefit by this bill because their parents are employed rather than self employed.

Rep. Squires asked Mr. Smith about the amendments.

Rep. Boharski asked Mr. McCray about withholding sanctions and Mr. McCray stated that the original language came from was an add in during the last session. If for some reason the attorneys who drafted the papers, they did not want the process to stop.

Rep. Simon asked Mr. McCray about the acceptance of an application and how there might be a time frame and how the Department would need to adopt immediate withholding and put money into a trust account. Mr. McCray stated that the provision originated from the Minnesota statutes. The reason is for timeliness. Get the support obligation being paid as soon as possible as soon as the order is entered. It requires the clerk of courts to provide copies of the decree. With that the custodial parent submits the application. Meanwhile the money for the child is coming in automatically.

Closing by Sponsor: Senator Manning closes on the bill.

HEARING ON HB 741

Presentation and Opening Statement by Sponsor:

Rep. Harper stated that this bill was an act entitled: "The Montana hospital cost containment commission act; creating a
Montana hospital cost containment commission; empowering the commission to set and regulate the rates of Montana hospitals and to require annual reports from those hospitals; providing for the appointment of commission members; empowering the commission to fund all of its costs by making assessments against hospitals subject to its jurisdiction and providing an immediate effective date.

Testifying Proponents and Who They Represent:

Gardner Cromwell, American Association of Retired Persons
Wilbur Rahmer, Montana Nurses Association

Proponent Testimony:

Gardner Cromwell stated that from 1976-83, hospital costs in Montana had risen 195% and that in that period the ranking of expense per adjusted admission had arisen from 41st in the nation to 1st.

Wilbur Rahmer supports this bill and says it is the public's right to know and the public's involvement in health care planning and costs.

Testifying Opponents and Who They Represent:

Jim Aherns, Montana Hospital Association
Jerry Levitt, Montana Hospital Rate Review System
Shane Roberts, St. Luke's Hospital
Ed Sheehy, National Association of Retired Persons
Earl Laury, Missoula Community Hospital
Dale Jessup, North Valley Hospital
Leonard Brewer, M.D.
John Bartos,

Opponent Testimony:

Jim Aherns said that bill was by far the most troubling bill to be introduced this session. It is troubling for hospitals because it places tremendous new burdens on them at a time when many are struggling to remain open another day. It should be troubling to all Montanans because it produces a threat to the future viability of the health care delivery system in the state. Exhibit 15.

Jerry Levitt stated that the rates charged patients are both equitable to the patient and hospital. Montana's hospital rates are among the lowest in the nation.

Shane Roberts stated that 65-85% of the hospital business is prospectively set through medicare, medicaid, worker's compensation and in some cases Indian health services. The rates are already set. This commission would have not say over that.
Ed Sheehy stated his opposition of this bill.

Earl Laury stated that rates are now set by 600 trustees of the hospitals in the state of Montana. Those are representative citizens of the cities in which those hospitals occur.

Dale Jessup stated that the commission may cost more to run per year than the budget set forth by the hospitals it is going to regulate.

Leonard Brewer, M.D. stated that he was in opposition to this bill.

John Bartos stated his opposition to this bill.

Questions From Committee Members: Rep. Gould asked Mr. Grant if the Board meeting were open to the public and Mr. Grant stated that they were.


ADJOURNMENT

Adjournment At: 7:20 p.m.

REP. STELLA JEAN HANSEN, Chairman
### Daily Roll Call

**Human Services and Aging Committee**

**51st Legislative Session -- 1989**

Date: 3/3/89

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CS-30
Mr. Speaker: We, the committee on Human Services and Aging report that SENATE BILL 124 (blue reading copy) be concurred in.

Signed: __________________________

Stella Jean Hansen, Chairman

[REP. SQUIRES WILL CARRY THIS BILL ON THE HOUSE FLOOR]
Mr. Speaker: We, the committee on Human Services and Aging report that SENATE BILL 340 (blue reading copy), with statement of intent included, be concurred in as amended.

Signed:
Stella Jean Hansen, Chairman

[REP. MARKS WILL CARRY THIS BILL ON THE HOUSE FLOOR]

And, that such amendment read:

1. Page 1.
Following: line 16
Insert:
"STATEMENT OF INTENT

It is the legislature's intent to exclude acute care hospitals from certificate of need requirements, except in certain limited circumstances that are enumerated in subsections 50-5-301 (1) (h) and 50-5-301 (1) (i). The provision by a hospital of services under either of those subsections is intended to include construction, conversion, or expansion of bed capacity."
MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JAMES AHRENS; I AM THE PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. THE ASSOCIATION REPRESENTS 54 HOSPITALS AND 31 ATTACHED NURSING HOMES THROUGHOUT THE STATE. THE MONTANA HOSPITAL ASSOCIATION SUPPORTS SENATE BILL 340. IT HAS BEEN CHARACTERIZED AS A COMPROMISE BILL, AND IT IS JUST THAT. IT IS THE COMPROMISE BETWEEN THOSE WHO WANT NO CON FOR ANYONE, AND THOSE WHO WANT CON FOREVER FOR ALL PROVIDERS. THIS BILL EXTENDS CON FOR TWO YEARS AND EXEMPTS HOSPITALS FOR CERTAIN SERVICES.

THE ASSOCIATION I REPRESENT DOES NOT FAVOR CON. WERE IT POLITICALLY ACHIEVABLE, WE WOULD PREFER TO SEE CON SUNSET IN ITS ENTIRETY. HOWEVER, WE RECOGNIZE THAT OTHER PROVIDERS MAY NOT SHARE OUR DISTASTE FOR CON. RATHER THAN PROVOKE A CONFLICT, WE DECIDED TO RESPECT THE WISHES OF THOSE PROVIDERS AND SUPPORT A BILL THAT WOULD CONTINUE CON FOR THEM, BUT SIMPLY EXEMPT HOSPITALS. THE CON PROTECTION, THE CON FRANCHISE, WOULD STILL BE EXTENDED TO NURSING HOMES, INPATIENT CHEMICAL DEPENDENCY AND INPATIENT PSYCHIATRIC TREATMENT FACILITIES AS WELL AS TO HOME HEALTH AGENCIES, HOSPICES, PERSONAL CARE SERVICES AND INPATIENT REHABILITATION SERVICES. MORE THAN THAT, IF A HOSPITAL WANTED TO ENGAGE IN ANY OF THESE PROTECTED SERVICES, IT WOULD HAVE TO OBTAIN A CON.
YOU HAVE NO DOUBT HEARD A LOT ABOUT CON IN THE LAST FEW WEEKS. THE WITNESSES THAT FOLLOW ME WILL TELL YOU MORE OF THE REASONS WHY CON IS NOT NECESSARY FOR HOSPITALS. THEY HAVE TRAVELED TOO FAR FOR ME TO GIVE THEIR TESTIMONY, SO I WILL MAKE MY REMARKS BRIEF AND CONFINE THEM TO THE REASONS WHY THIS IS THE CON BILL YOU SHOULD VOTE FOR--WITH NO AMENDMENTS. THIS IS A GOOD BILL AND IT NEEDS NO AMENDMENT.

THERE WERE TWO CON BILLS INTRODUCED IN THE SENATE. THE FIRST ONE, SENATE BILL 217, SIMPLY REMOVED THE SUNSET PROVISION OF EXISTING LAW, SO THAT CON WOULD CONTINUE INTO PERPETUITY. HOSPITALS WERE NOT INVITED TO PARTICIPATE IN THE CRAFTING OF THAT BILL. WE WERE SIMPLY TOLD, "YOU WILL BE IN CON...FOREVER."

SENATE BILL 217 NEVER MADE IT OUT OF COMMITTEE, BECAUSE THE SENATE PUBLIC HEALTH COMMITTEE SAW THE WISDOM OF 1) REMOVING HOSPITALS FROM CON AND 2) ESTABLISHING A SUNSET PROVISION.

THE COMMITTEE BELIEVED THAT IT WAS NO LONGER NECESSARY FOR HOSPITALS TO BE SUBJECT TO CON. THEY BELIEVED THAT THE COMPETITIVE MARKET USHERED IN BY THE MEDICARE PROSPECTIVE PAYMENT SYSTEM PROVIDED MORE EFFECTIVE COST CONTROL THAN CON EVER DID. THEY BELIEVED THE FEDERAL TRADE COMMISSION REPORT THAT STATED CON, BECAUSE IT INHIBITED COMPETITION, ACTUALLY DROVE UP HEALTH CARE COSTS, AND THEY BELIEVED THE REPORT FROM THE LEGISLATIVE AUDITOR OF MONTANA WHO, AFTER STUDYING CON FOR TWO YEARS AT THE DIRECTION OF THE LEGISLATURE, CAME TO THE CONCLUSION THAT "IT IS DIFFICULT TO ASCERTAIN WHETHER MONTANA'S CON PROGRAM HAS BEEN EFFECTIVE ENOUGH TO CONTINUE BEYOND JUNE 30, 1989." THE COMMITTEE FELT IT WAS NECESSARY TO RETAIN A SUNSET PROVISION BECAUSE A SUNSET DATE PROVIDES FOR A PROGRAMMED REVIEW OF CON. A
PROGRAMMED REVIEW OF CON IS NECESSARY BECAUSE 1) THE EFFECTIVENESS OF THE PROGRAM IS STRONGLY QUESTIONED AND 2) THE RELATIONSHIP BETWEEN REGULATORS (THE CON AGENCY) AND THE REGULATED (THE NURSING HOME AND CHEMICAL DEPENDENCY INDUSTRIES) DESERVES LEGISLATIVE OVERSIGHT TO PROTECT THE PUBLIC INTEREST. THE LEGISLATIVE AUDITOR COULD NOT SAY THAT CON WAS EFFECTIVE. ALL OF THE ROCKY MOUNTAIN STATES HAVE TERMINATED THEIR CON PROGRAMS AND THEY HAVE BEEN JOINED BY A NUMBER OF OTHERS. WE HOPE IN TWO MORE YEARS THERE WILL BE STUDIES THAT ENABLE US TO SAY DEFINITIVELY THAT CON DOES NOT WORK, THAT IT IS AN EXPENSIVE AND BURDENSOME PROGRAM WHOSE SOLE PURPOSE IS TO DOLE OUT FRANCHISES TO PROVIDERS WHO DO NOT WANT TO COMPETE.

THE SENATE PUBLIC HEALTH COMMITTEE KILLED SENATE BILL 217 AND FOUGHT BACK AN ATTEMPT TO AMEND SENATE BILL 340 BY REMOVING THE SUNSET AND PUTTING HOSPITALS BACK IN. ON THE SENATE FLOOR, THE PROONENTS OF SENATE BILL 217, ATTEMPTED TO OVERTURN THE ADVERSE COMMITTEE REPORT. THEY FAILED. ON SECOND READING OF SENATE BILL 340, THE PROONENTS OF SENATE BILL 217 ATTEMPTED TO AMEND THIS BILL BY REMOVING THE SUNSET AND BY WIDENING THE NUMBER OF SERVICES FOR WHICH A HOSPITAL MUST OBTAIN A CON. BOTH AMENDMENTS FAILED AND THE BILL PASSED SECOND READING 48-0. IT PASSED THIRD READING 49-1, THE ONE SENATOR VOTING AGAINST IT, VOTING SO BECAUSE HE WANTED CON TO SUNSET IN ITS ENTIRETY.

YOU MAY HEAR SOME PEOPLE TESTIFY TODAY THAT TAKING HOSPITALS OUT OF CON WILL HAVE A HARMFUL EFFECT ON THE MEDICAID BUDGET. THOSE WHO MAKE THAT CLAIM DO NOT UNDERSTAND THE REIMBURSEMENT SYSTEM FOR MEDICAID. MEDICAID REIMBURSES HOSPITALS FOR INPATIENT SERVICES ON THE BASIS OF DIAGNOSTIC RELATED GROUPS
(DRGs). This is a fixed rate payment system by which every hospital in the state receives the same payment from Medicaid for providing care. SRS sets the weights for DRGs. That is, SRS determines if, say gall bladder surgery should be paid at a rate twice that of a tonsillectomy. The legislature is responsible for granting annual increases to the DRG price, but it cannot exceed the amount set by the federal Congress according to its authority in the Tax Equity and Fiscal Responsibility Act of 1982.

These prices are set without reference to actual hospital costs. So, Medicaid payments are set by SRS and the legislature. Increases in cost are due to an increase in utilization and case complexity. Both of these factors are beyond our control.

Furthermore, SRS has never shown its concern for capital regulation during the actual CON process. Not once in the last four years has SRS testified on a hospital CON application. The contention that taking hospitals out of CON will raise the roof on the Medicaid budget is simply based on misinformation.

This is a good bill. It is the compromise bill. We urge you to accept it as is. I would be happy to speak to any suggestions for amendment, if any are made. Hospitals do not want to be under certificate of need. If others do, let them.
This report provides information regarding the Certificate of Need program and identifies areas for legislative consideration.
Chairman Hanson and Committee Members:

I am Richard Brown, Administrator of Liberty County Hospital and Nursing Home, an 11-bed acute care and 40-bed skilled nursing facility located in Chester. I have been the administrator of that facility for eleven years. Currently I am serving as Chairman of the Montana Hospital Association.

I am here today to speak in support of Senate Bill 340 (Williams) which would continue Certificate of Need (C.O.N.) and exempt hospitals from most services, all equipment and all construction. This bill would still require C.O.N. for swing beds, long term care beds, psyche, rehab and chemical dependency services. The bill in its present form addresses the concerns of most health care provider organizations.

As the Administrator of a small, rural hospital I am in a position that does not allow me to make unwise business decisions regarding capital investments. When the decision is made to pursue a new program, consider an equipment purchase or building project, hospitals go through a very methodical process of their own to determine need and feasibility. Hospitals must make decisions on capital investments and programs in a very business like manner. The questions asked by hospital administrators as they determine the need for these projects or programs, are the same questions asked in the C.O.N. application. This duplication only adds to the rising cost of health care and creates another obstacle in the efforts of hospitals to run an efficient operation.

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EXHIBIT 2
DATE 3-3-89
HB 340
I don't deny that health planning is beneficial but the needs within our individual communities and around the state will determine whether or not additional health care facilities should be constructed or whether additional equipment should be purchased for providing services. I have had occasion to go through the C.O.N. process for program change and equipment purchases. Those incidents were time consuming, and expensive use of resources, and in my opinion a duplication of process. In addition these programs were delayed for implementation until the application could go through a lengthy, unnecessary cycle. In essence the entire process is very ineffective.

Our decision to pursue these projects was driven by the needs of the residents we were serving. Nothing was done frivolously or without thought. That type of approach would only lead to the eventual demise of our hospital.

The Certificate of Need process is no longer effective for Montana's hospitals. Ideally the sunset of the C.O.N. law would be in the best interest of health care organizations throughout the state. I do however support Senate Bill 340 in its' current form and urge the passing of this Bill. Any amendment to the Bill would only dilute the intent of the Legislation.

Thank you for your consideration.
I speak in favor of SB 340. The certificate of need law does not certify need, it certifies legal and political power to serve sociopolitical pressures. It does not limit cost to patients and taxpayers. It only limits availability; availability of needed services. I have spent 31 years trying to bring patients and services together in Montana.

The certificate of need law 50-5-301, part 3, may be referred to as the State Franchise Bill, it was initially conceived to prevent unnecessary duplication of health care facilities, equipment and services that would result in extra cost to the health care recipients or the public through the expenditures of tax funds. The law has failed miserably to accomplish these goals and is no longer a necessary obstacle in the provision of health care in Montana. Indeed, the bill has never proved cost saving measure and has cost the health care industry in Montana literally millions of dollars as well as the tax payers of Montana who are spending over a quarter of a million dollars annually just to keep the State Department funded to oversee the certificate of need law. Only a third of the expense for the operation of the State Department responsible for the enforcement of this law is paid by health care providers. Even so, the amount paid by health care providers is a considerable burden to each health care facility attempting to improve it's ability to provide current state-of-the-art health care. The bill has been demonstrated to invite bias, excessive socioeconomic & political pressures, and to not only hamper the effort at facilities to provide needed services but to saddle the patients in our facilities with tremendous extra cost involved in funding the certificate of need process. Indeed, Montana is remiss in not having repealed this law much sooner. We are the only Rocky Mountain State to still have such a law in the books. Our neighbors Arizona, Colorado, Idaho, New Mexico, Utah, and Wyoming do not have such a law. California, Texas, Kansas, and Minnesota have rejected this type of legislation. The law includes, among other undesirable elements, a restraint of trade. The Federal Trade Commission reported that CON grants a franchise and inhibits competition and thereby increases health care costs. In September of 1986, Congress suspended all funding for CON and CON related agencies because it did not reduce cost. The Federal Government, through the Medicare Program does not pay hospitals according to the money they spend. Hospitals are reimbursed according to the diagnoses of the diseases they care for. Excessive expenditures to care for those diseases would only jeopardize the hospitals financial stability. No additional federal reimbursement would be received because the hospital expended unnecessary funds to provide facilities, services, or equipment. The DRG law ended that. Indeed the only rational way to justify expenditures in the 1989 scene of health care and all the demands that are made for cost containment and quality.
care, is to allow individual facilities to make capital investment decisions based upon community needs, availability of the service in the area, the volume of the potential demand for the service, and the ability of the health care consumer to pay for the service so that the facility will be able financially to continue to provide the service with the reimbursement it can obtain for it. Having considered these factors and made an intelligent decision, health care facilities administrations and boards should not be hampered by second guessing at a State level, particularly when that second guess, namely the CON review process, is so costly and time consuming & comparatively uniformed about local needs.

What are these costs? First of all, there is a major cost simply to file the application with the State to obtain a certificate of need. Second, there are large costs in obtaining legal and financial feasibility studies to accompany the application, and third, there are great costs in time and services of institutional personnel to gather all of the data and information needed to submit a CON application. And, let's don't forget that while all of this is going on (a process which has been proven to take months and even years in Montana) that service is being denied to the patient's in the area and the revenue from that service is being denied the facility which is trying to survive in this age of economic realities in the health care field. Twelve States have eliminated this type of legislation so that the health care industry was deregulated. Those areas have not seen excessive growth in the provision of services for acute care.

I have been watching the needs and the attempts to meet these needs in Montana since 1958. I have been in the private practice of medicine. I have tried to deal with these problems as a physician admitting patient's to acute care hospitals in Glendive and in Lewistown. I have tried to provide services while serving as President of the Medical Staff and Boards of these hospitals, I have watched the health care needs in the State as past president of the Montana Medical Association, and I have heard the certificate of need presentations as I served on the area health council. I have watched the frustration and humiliation of hospital administrators presenting applications where the cost of the applications far exceeded the cost of providing the service. I have watched patients in communities do without needed services either because of denial under the certificate of need law, or the fear of denial, or the fear of the expense in attempting to obtain a franchise to provide a much needed facility, service or equipment. The small hospitals in which I work and the smaller hospitals than that, don't have tens of thousands and hundreds of thousands of dollars to spend on legal fees, surveys and application fees. They have a hard enough time scraping together the dollars to buy a piece of X-ray equipment or to set up a surgery suite or to create a certain type of acute care bed that is critically needed. I well remember our committee hearing the applications of a facility where
twice as much money was spent obtaining a certificate need as was needed to move an X-ray unit from a Physician's office into the hospital. This was not only absurd, it was unconscionable in this day and age of limited funds and almost unlimited health care needs for our citizens. Now that the certificate of need is determined by the State Department of Health & Environmental Science, some of the steps have been eliminated but it has not reduced the cost, uncertainty, and erroneous decisions that could be avoided if the CON law were simply allowed to die at this time. We have seen the State approve CON's for facilities when those of us in the health care industry watched with dismay and could not believe that they could have been approved, and at the same time we have watched the State deny CON's only to have them overturned in court. How long will you, our respected Legislators, perpetuate this folly? If indeed you feel that long term care facilities and psychiatric and drug abuse services would proliferate without the law, then accept Senator William's compromise bill, Senate Bill 340. But, please remove the hobbles from the feet of those of us who are trying to provide health care services to the acutely ill in Montana. Eliminate certificate of need restrictions for acute care facilities and providers in our State.

Hollis K. Leftever, M.D.

Signatures of Concurrence:

Administrator, Central Montana Hospital

Medical Staff - Central Montana Hospital

EXHIBIT 3
DATE 3.3.89
HB 340
During the 1989 session, you will be dealing with legislation concerning Certificate of Need (CON). The legislation concerning CON will range from maintaining its current structure to letting it sunset. It is my belief as a rural hospital administrator, who has been involved with three (3) building projects since 1976, to let it sunset. It is my belief that the current legislation regarding CON is time consuming, costly and can be restrictive. It is my intent to share with you my thoughts about the CON.

First, let me review the process we, as healthcare administrators, must go through for a building project or major remodeling process.

1) Internal Planning
   a) list problems and ideas
   b) develop solutions

2) Hire professional planners or architects

3) Present plans and ideas to local community

4) Secure funding and local support

5) Hire professionals to develop CON application

6) Submit to CON Board and request hearing date

7) Present application to CON Board

8) If there is no contention - start project.

If there is contention or questions, this can be for a variety of reasons, i.e., local study differs from state plan which uses averages, or there may be political roadblocks. The CON application process starts over.

1) Application is redone or revised

2) Re-submitted to CON Board

3) Re-schedule hearing with CON Board

4) Present application to CON Board

5) If no contention - start project.
In my experiences, the CON application has been an unnecessary burden which does not assure quality as an outcome. I would like to recap each briefly.

1) Nebraska. Project to decrease hospital bed size, increase emergency room facilities and remodel obstetrics, surgery and physical therapy.

Questions were raised if we had done sufficient planning and did the community support the project.

RESULT - delayed project by six (6) months and created additional cost. On second hearing, four hundred (400) people traveled to hearing to demonstrate their support, community of 3,000 people. Project had also been approved prior to first CON hearing by a vote of 78%.

2) Wyoming. Project to increase number of nursing home beds and downsize hospital by six (6) beds.

Questions were raised regarding local statistics, did not coincide with state averages.

RESULT - project delayed, statistics had to be re-verified and re-submitted. Again, we had additional cost added to project. Problem was local statistics for elderly over 65 were higher than state averages and there was disbelief on the waiting list submitted. Project was approved on second hearing.

3) Wyoming. Project to joint venture with medical staff.

Question was raised if the hospital and physicians could work together in this arrangement, and if the project was really necessary to provide healthcare in a rural setting.

RESULT - project delayed, additional costs were added to project. Project approved on second hearing.

Prior to both Wyoming projects, hospital and physicians held open forums in the community (prior to hearings). Projects were voted on through the 1% sales tax levied to complete the projects. Vote was 70 plus percent in favor of the projects.
In each case, we had approval by the local community to support and fund projects and there was no outside contention with our projects; however, each project experienced a delay due to the CON process.

The problem that I have experienced with CON are:

1) It is costly - as a result the costs associated with this process are shifted to the consumer in the end.

2) It creates delays - the delays in effect are costly and in some cases the quality (suffers).

3) There are political problems that arise from the process.

4) I believe free enterprise is restricted.

5) Monopolies are created by legislation.

6) If CON is the answer to controlling healthcare, why are so many states battling the issue and sunsetting the law.

When one becomes involved in a building process, the CON process becomes another obstacle to cross. It is not spoken of favorably unless it is restricting a competitor.

If the intent of CON is to assure quality, it has missed the boat. If it is to restrict the access of healthcare and limit the technologies associated with building or remodeling, then it is working. One last point, if CON is an asset, why haven't other industries introduced this type of restrictive legislation?

In conclusion, I support Senate Bill 340 (The Williams Compromise) and I am opposed to Senate Bill 217.

Jerry E. Jurena
Administrator/CEO
Trinity Hospital
Wolf Point, Montana
March 3, 1989

Proponent for SB340 with amendments

I am here today representing Providence, a family counseling center specializing in chemical abuse and dependency, located in Great Falls. We are a private, nonprofit agency and have been in existence for over twenty years. We have facilities in three counties: Pondera, Glacier, and Cascade.

I am also testifying for Chemical Dependency Programs of Montana, an association of 23 member programs from throughout the state.

I, as an individual program and CDPM are proponents of SB340 because it is the only certificate of need legislation left alive.

Inpatient chemical dependency treatment facilities are required to function within the regulations of CON to maintain an orderly growth in our rapidly expanding industry, there is a reason. Nationwide an inpatient chemical dependency treatment center opens every three weeks, primarily in hospitals to offset losses in acute care services. Montana, however has wisely charged the Department of Institutions to assess each county's needs every four years to carefully prepare a comprehensive chemical dependency plan. That comprehensive chemical dependency plan has three objectives:
1) To assist the citizens of Montana in understanding the problems of chemical dependency and efforts currently employed to deal with this problem.

2) To provide a policy document that promotes efficiency, cost effectiveness, and availability of chemical dependency services within the state.

3) To provide information to service providers, other agencies involved with chemical dependency services, state and local government agencies, and the Montana Legislature about the current status and future requirements of chemical dependency programming.

Please note that last sentence: future requirements of chemical dependency programming. This comprehensive planning document and the CON process guide Montana in development and growth based on the documented need of those services. Montana treatment facilities have witnessed unbridled growth in neighboring states, Utah and Minnesota immediately come to mind, that have ultimately resulted in reduced quality of care, reduced occupancy rates, reduced treatment options and left the field of chemical dependency treatment in shambles.

Thankyou and I urge you to pass SB340

I am concerned with the expansion of existing services as well as expansion of new services.
1. Montana Associated Physicians, Inc. is an 87 member physician organization based in Billings. (Our practices employ approximately 350 people in addition to our physicians.)

2. Eliminating this expensive, time-consuming and counterproductive Certificate of Need process for hospitals would improve access to medical technology for all physicians, including those in rural areas.

3. Referring physicians from the entire region, as well as their respective patients, should have a choice of services (hospitals).

4. The Federal Trade Commission actively promotes competition in health care. Certificate of Need law can hold the level of services below what the public needs, create a demand for these services and increase prices well beyond what they would have been in a competitive situation. Competition ensures that services will be offered at the lowest possible price, regardless of where the procedure is done.

5. The time has come to let hospitals control their own destiny. Hospital boards and administrators are in a much better position to determine what their communities need and what they can and cannot afford than some governing agency almost 400 miles away.

6. Health care is surely the dominant industry in the state, and considering the state of our economy, I think that we have no choice but to let this component of our economy grow and develop in any way that we can.

7. Because the health care industry, particularly the reimbursement systems, is in such a state of flux, the need for regulatory processes, such as Certificate of Need law, has to be re-evaluated on a regular basis.

8. In summary, Montana Associated Physicians, Inc. supports Senate Bill 340 without amendments.
Chairman Hansen and respected members of this Committee, my name is James T. Paquette and I serve as President and Chief Executive Officer of Saint Vincent Hospital and Health Center, a 280-bed general acute care hospital in Billings, Montana. We have consistently taken a position against Certificate of Need law for hospitals since the changes in Medicare and Medicaid reimbursement went into effect in the mid 80's.

We support the elimination of Certificate of Need law as it relates to hospitals and as it is embodied in Senate Bill 340, without amendments. The Senate showed tremendous support for Senate Bill 340 through a vote of 49 to one, and we ask that the House concur.

Decades ago, Certificate of Need legislation was intended to function as a cost-containment device. When it was first enacted during the early 70's, there was little incentive for hospitals to control their costs. Medicare and Medicaid reimbursed on a cost plus basis, so the more they spent, the more they were reimbursed. With the introduction of the DRG (Diagnostic Related Group) system in the mid 80's, the situation changed dramatically. In this new era, decisions to enter into new services or purchase capital are based upon: 1) demand; 2) ability to command a price in the market sufficient to cover costs and provide margin for capital; 3) ability to deliver quality care. Certificate of Need law is no longer necessary to control costs or excess building.

Proponents suggest that eliminating CON for hospitals will increase Medicaid costs. They claim that hospital service costs are growing faster than any other segment of the Medicaid budget. This growth is not the result of hospitals' increasing their charges, as some proponents of the Certificate of Need process would like you to believe. Hospitals in Montana have been paid a fixed fee per Medicaid admission for inpatient services since October 1, 1987. No matter how much is charged, we are still reimbursed the same amount.

There is no evidence that the absence of Certificate of Need law contributes to higher cost to the patient. Montana ranks 47th out of 51 states (including the District of Columbia) in cost/admission according to data supplied by the Montana Hospital Association. We submit that this is not a result of any regulatory process. A more probable explanation is that hospitals representing 85% of the beds in this state open their rates to a voluntary review process. Last year average rate increases approved through this process were approximately 7%.

Post Office Box 35200
Billings, Montana 59107-5200
406-657-7000

We touch your life.

EXHIBIT 6
DATE 3-3-89
HB 340
Contrary to some of the stories you have heard, deregulation does not promote unwarranted growth. For example, Wyoming deregulated in May, 1987. At that time, 600 long-term care beds had already been approved under CON law. Since then, approximately 400 of those beds have either been completed or are still under construction. No other capital activity is anticipated for several years. Granted, Wyoming's economy doesn't allow for much activity. But, Wyoming's economy more closely parallels Montana than does Arizona and Utah. It is not valid to compare states with total populations of less than a million with large metropolitan areas of more than 3 million people. The growth rate in Arizona two years ago was almost four times the growth rate of the entire United States. These two states, of course, are cited by proponents of Certificate of Need law as examples where deregulation only fuels unnecessary construction.

The Federal Trade Commission (FTC) actively promotes competition in health care. The Commission has cited the entry barrier created by CON law as a factor significantly contributing to the potential for anti-trust violations.

Proponents of CON law suggest that joint ventures would not occur without a CON process. In Billings, Saint Vincent Hospital has entered into a number of cooperative ventures with Deaconess Medical Center and will continue to evaluate other opportunities. The two hospitals operate a jointly-owned hospice, cancer center, MRI unit and laundry services. These joint ventures were sound business decisions based on months of research and planning. They were not a compromise for a contested CON application.

Senate Bill 340 is a compromise bill. It recognizes the needs of nursing homes, psych hospitals, rehab hospitals, mental health and chemical dependency programs and allows these types of services to remain under the protection of Certificate of Need law.

In summary, we support Senate Bill 340 and ask that the House concur for the following reasons:

1. There is no proof that CON law reduces costs to the consumer.
2. There is supporting documentation that CON legislation raises costs of operation to hospitals.
3. CON law is a clear restraint of trade and hinders the ability of hospitals to function in the free marketplace.
Senate Bill No. 340 - Certificate of Need

PROPOSED AMENDMENT

Amend Senate Bill 340 as follows:

1. Page 4, following line 15, add a new section (3):

   "(3) For purposes of subsection (1) (i), the provision by a hospital of services for ambulatory surgical care, home health care, long term care, inpatient mental health care, inpatient chemical dependency treatment, inpatient rehabilitation, or personal care, includes all activities described in subsections (1) (a) through (1) (h) related to the provision of the enumerated services."

2. Renumber subsequent sections.

Explanation:

This amendment is required to clarify that any activity undertaken by a hospital related to providing long term care and the other services enumerated in section (1) (i) such as adding new beds by construction, expansion or conversion, will require a certificate of need. If another provider, such as a nursing home or chemical dependency treatment facility, would be required to obtain a CON in order to engage in the activity, then a hospital would be treated similarly.
SENATE BILL 340

PROPOSED AMENDMENT TO INCLUDE HOSPITALS IN CERTIFICATE OF NEED PROCESS

Amend Senate Bill 340, as follows:

1. Page 3, line 25, following "or"
   Insert: "or"

2. Page 4, line 5, following "50-5-101"
   Strike: "; or"
   Insert: ";"

3. Page 4, lines 6 through 9,
   Strike: in their entirety.

4. Page 4, line 20, following "hospital."
   Insert: "hospital,"

5. Pages 4, lines 24 and 25, and page 5, line 1,
   Strike: in their entirety.

Explanation:

The amendments remove the hospital exemption and make hospitals and all health care providers currently covered by certificate of need a part of the CON process.

The legislation continues to include a two-year sunset for review of the process.

The amendments are necessary to avoid an unconstitutional distinction between hospitals and other health care providers and to maintain some method of controlling hospital costs and duplication of services and equipment.

An Affiliate of
American Health Care Association
SENATE BILL 340 - Exempting hospitals from Certificate of Need

THE HIGH COST OF Deregulation...

The Montana Hospital Association's "green sheet" indicates that no study has been released that claims that certificate of need reduces health care costs.

The fact is that studies are available with respect to the states of Arizona and Utah--which have been without CON longer than other states--which indicate that unnecessary services--both hospital and nursing home--have proliferated; that occupancy rates have gone down; and that total health care expenditures have gone up, when CON has been abandoned.

Common sense should tell us all, including the Hospital Association, that when services are duplicated and occupancy goes down, costs go up...and the consumers and taxpayers pay the bill.

The attached newspaper articles should be of interest in that regard.

The "free enterprise" system you're being asked to experiment with is funded with state and federal taxpayer dollars coming from the Medicaid and Medicare programs.

PLEASE SUPPORT SENATE BILL 340 WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.
Keep hospital costs low

The state Senate recently passed Senate Bill 340 with an overwhelming 49-to-1 vote. The bill is now resting comfortably in the House Human Services Committee awaiting a hearing. The measure would allow the expiration of a law requiring hospitals to obtain a “certificate of need” from the state before hospitals could proceed with new services or an expansion of existing services. Essentially, the certificate-of-need law is intended to eliminate duplication of services and presumably keep health-care costs down.

In Billings, Deaconess Medical Center officials took one look at the Senate vote, considered the odds and withdrew from administrative hearings reconsidering St. Vincent Hospital’s proposal to add cardiac surgery to its services.

If indeed SB 340 is a fait accompli, then we can safely assume that not only will St. Vincent add cardiac surgery to its list of services, but those hospitals in the state that are in direct competition with each other will — to one degree or another — engage in games of one-upmanship with programs, services and equipment.

Health care in America today is a very expensive business. Monday’s Wall Street Journal reports that hospitals in some parts of the country are paying kickbacks to doctors who refer patients to them. Any way you look at it, that unethical practice is just another hidden cost that must be borne by the health-care consumer.

The certificate-of-need law served as a check and balance against costs. Without it, both Deaconess and St. Vincent have an obligation to keep the high cost of medicine down and the quality of care up. Patients must insist on that.

Applause due

The Yellowstone County Commission held its brainstorming session last week and opened it to the public. That was after Commission Chairman Dwight MacKay’s uncertainty over inviting the public.

MacKay and the other commissioners deserve an A-plus not only for allowing the public in but also for developing a mission statement and outlining goals.

The statement is clear and uncomplicated, and the goals intelligent and necessary. We now know how much the commissioners are dedicated toward improving government, and that helps all of us.
Laissez faire sends nursing homes to public
Warm Bodies
Hospitals That Need Patients Pay Bounties For Doctors' Referrals
The Practice Is Questionable, But It Spreads as Profit From Care Is Threatened
Lack of Enough Sick People

BY WALT ROSENBAUM
And Michael Waldholz
Staff Reporters of The Wall Street Journal

The hottest commodities in the patient-care business these days are patients. Hospitals with empty beds and testing centers with idle equipment are buying doctors' referrals.

Patients are rarely aware of the under-the-counter market in their bodies. Many physicians are rarely aware of it; some are not.

Physicians have become more vulnerable to financial inducements offered by hospitals and testing centers because the physicians' income is under pressure.

"Doctors no longer have a blank check to essentially set whatever price they want, and make as much money as they think is reasonable," says Barry Moore, of Hamilton/KSA, a medical consulting group in Atlanta.

Paying for patients helps keep healthcare costs up and encourages unnecessary medical services. A Rhode Island physician, Felix M. Balasco, sent 28 people to the hospital for pacemaker implants they didn't need; for taking kickbacks he was convicted in federal court in Providence of Medicare fraud in 1986.

The practice sometimes deceives patients. Higher-quality care that they might have received at another hospital, one hospital accused in a physician kickback scheme in Medical Center of North Hollywood, in California, operated by the American Medical International chain. U.S. Health Care Financing Agency reports show that in 1986, this hospital was one of only 24% in the nation whose Medicare patients died at a higher-than-predicted rate. The hospital, however, in a letter to federal health officials, says it provides excellent care. The hospital also says its patients are sicker than those in other hospitals.

Of even broader concern, many healthcare specialists say, is the new willingness of reputable hospitals—large and small, for-profit and nonprofit—to push ethical boundaries in their search for patients.

There is little doubt that the practice of selling patients is worsening.

Last year, the U.S. attorney in Philadelphia charged nearly 400 area physicians with taking kickbacks to send patients to a medical testing laboratory. It is believed to be the largest single enforcement action ever brought against physicians. This incident prompted Richard Kaslenow, inspector general for the Department of Health and Human Services, to warn of a "nationwide proliferation" of kickback allegations in medical testing.

Donald S. Winstun, a Houston physician, says kickbacks have been so common at times that American Medical International, the hospital chain, once mistakenly sent him a $30,000 check intended for another physician. The check was delivered some years ago by a bank officer. "I grabbed it out of her hand, locked her in the waiting room, copied both sides, and returned it," Dr. Winstun says.

Angry over seeing that check, Dr. Winstun filed suit against American Medical International's Twelve Oaks Hospital in federal court in Houston. The suit alleges that American Medical secretly paid $1 million to subsidize a physician's group in return for their patients. Twelve Oaks used the money to persuade physicians to refer patients to "higher cost hospital services" rather than lower cost outpatient services, according to briefs Dr. Winstun filed in court in 1987.

Officials of American Medical declined to be interviewed because the case is pending. In court papers, American Medical doesn't deny making payments to physicians, including Dr. Winstun, but says it was doing so on behalf of "third parties."
Warm Bodies: Hospitals That Need Patients Pay Bounties to Physicians in Return for Referring Them

Continued From First Page

TiltWall

15 was likely following.

The lawlibrary

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was 15

The Fall Guy

Rick Robinson, a Washington lawyer for

and Precious General, says: "The company's view was that

they didn't approve of any agreement to

pay physicians for referrals. And such an

agreement, had it existed, violated company policy." But

Randy Schaffer, a lawyer who represented Mr.

Furth, blames American Healthcare for his

client's problems.

"He went out and recruited in the manner

they suggested, and when it all hit the fan, they told him to take the hit," Mr.

Schaffer says. "They couldn't single out

him out of all the people in the country and

make him a front, because that's the way

the industry operated."

Mr. Furth's prosecutor, Linda Lattin

agrees that Mr. Furth "was just doing

what was common in the trade. That's

my gut feeling, reality."

That's certainly what Mr. Furth thought.

"Let's say something should happen to me," said Mr. Furth in one of

McShane's tape recordings. "You also

want to know that the next person coming in is going to be doing the same
damn thing I'm doing."

Just days before Mr. Furth spoke of

patient buying in front of Dr. McShane's hidden

disc microphone in Texas in 1986, a similar

conversation was taking place more than

1,200 miles away, in a quiet Midwestern
town just off the Lake Erie shore.

On a July evening, board members of

the nonprofit, tax exempt Northern

Ohio General Hospital were meeting in the

hospital's community room to act on a

gamble to bring in more patients. The plan

was for the small, revenue-poor hospital to

lend $15,000 to a group of six physicians,

the core members of the independent

Medicaid Clinic.

This was to be a special loan: It didn't have to be repaid. All the physicians had
to do to get it was promise to admit "not less than 75% of their patients."

One reason for the generosity: In the previous four months Bill Sorensen, a Medal-

lion Clinic physician, had referred less than half the number of patients than he had re-

ferred during the comparable months the year before. The hospital couldn't afford
such patient losses.

At a board meeting several months ear-

lier, Dr. Sorensen, representing the clinic, had

warned the hospital to talk money quickly if it wishes to compete with other

hospitals for patients from the clinic. Conscience and Cash; ·

"Dr. Sorensen stated that he had walked

the halls for a lot of years and it serves as

though to get someone outside financial help makes one feel better that the Board is standing

behind you," according to hospital board

minutes.
Two Houstonian pathologists, Drs. Spinks and Jerry McGown, were central figures in the feud. Their in-laws, the Spinks and the McGowns, were bitter enemies. Drs. Spinks and McGown had been vying for the same position—one for a while, Dr. Spinks had an advantage. The administrator of Pasadena General finally decided to award the position to Dr. Spinks, who had been recommended by the old board. The decision was unanimous, and both doctors were pleased with the outcome.

Unfortunately, this feud was not over. The doctors continued to feud, and the hospital's reputation suffered as a result. The hospital was known for its high-quality care, but the feud had taken a toll on the staff and patients. The doctors were not working together, and this had a negative impact on the hospital's reputation.

In 1985, the feud came to a head when the administrators of the two hospitals were hospitalized with a mysterious illness. It was later discovered that the doctors had been poisoning each other with a toxic substance. The doctors were arrested and charged with attempted murder.

The case received national attention, and the hospital's reputation was seriously damaged. The hospital was forced to close, and the doctors were sentenced to life in prison. The feud had cost the hospital and the doctors dearly, and it was a sad end to an otherwise promising career.
House bill would restrict hospital construction

By Merit C. Kimball

HealthWeek Washington Bureau

WASHINGTON—Rep. Fortney "Pete" Stark, D-Calif., introduced a bill Sept. 7 that would force states to crack down on inefficient hospital spending for new buildings, expansions and purchases of expensive medical equipment.

Hospitals that don’t get approval for such expenditures would forfeit Medicare payments to cover these capital costs.

In attempting to revitalize the states’ certificate-of-need efforts, the bill also would require states to identify hospitals that should close because of low occupancy rates. However, the measure contains no penalty to force hospital closures.

A trial balloon

Although the bill is a trial balloon that won’t be considered until next year at the earliest, its intent is to rein in Medicare’s capital payments for major hospital purchases. These payments have risen 76 percent during the past five years, compared with a 17 percent increase in general inflation, according to Stark, chairman of the House Ways and Means Health Subcommittee.

Stark said Medicare’s capital payments are projected to rise an average of 11 percent annually through 1993.

“These increases will occur while use of hospital facilities reaches ever-higher levels of inefficiency,” he said in a statement. “Over one-third of the hospital beds in the nation which are staffed are standing idle every single day.”

Stark added that each empty bed, by conservative estimates, costs $40,000 a year, for a total $14 billion in “wasted resources.”

“It certainly does not cost the amount of money Stark is talking about,” said

Continued on page 33

Bill restricts some spending by hospitals

Continued from page 9

one health industry observer. The empty beds are "not staffed, not operated. No one is spending any money on them. They are stand-by capacity."

‘A step back’

"This represents a step back into a certificate-of-need program that did nothing to eliminate excess capacity," said Jack Owen, head of the American Hospital Association’s (AHA) office here. "We need to let economics dictate capital expenditures."

Stark said the "normal rules of economics do not appear to apply in any meaningful way to hospitals."

He said when Texas relaxed its capital-expenditure review law in 1985, nine new hospitals opened in Houston at a time when the city was in a recession due to falling oil prices. He added that $1.5 billion currently is being spent on hospital construction, even though occupancy rates have declined to less than 60 percent.

Specifically, Stark’s bill would:

• Require each state with an urban-hospital occupancy rate below 85 percent and a rural occupancy rate below 75 percent to set up a review system to approve any capital expenditure of more than $1 million or which creates new beds or services.

If the state does not set up this system, Medicare would withhold capital reimbursement.

According to AHA data, every state is below those occupancy rates.

• Limit the amount of new capital spending allowed per year in each state but still allow cost-based reimbursement within that limit.

• Exempt rural hospitals from the limits if the state develops a separate health plan to stabilize those hospitals.

Stark’s bill has no chance of consideration this year before Congress adjourns in October. But next year, as one congressional aide put it, "Whatever saves money is a viable option—no matter how wild and crazy it may seem."
SENATE BILL 340 - exempting hospitals from Certificate of Need

DEREGULATION - THE ARIZONA EXPERIENCE....

The following information is excerpted from a report on Arizona deregulation entitled, "A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes, and Health Services in Arizona."

Nursing Homes:

<table>
<thead>
<tr>
<th></th>
<th>1982</th>
<th>1985</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds</td>
<td>8,313</td>
<td>12,559</td>
<td>+51.1%</td>
</tr>
<tr>
<td>(Growth of 51.1% for 3 years, compared to 55.8% for preceding 9 years.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupancy</td>
<td>92.55</td>
<td>82.8</td>
<td>-10.5%</td>
</tr>
<tr>
<td>Gross patient revenues</td>
<td>$124.2M</td>
<td>$224.7M</td>
<td>+81%</td>
</tr>
<tr>
<td>Per capita expenditures</td>
<td>$370.76</td>
<td>$553.81</td>
<td>+53.5%</td>
</tr>
</tbody>
</table>

"In Arizona, nursing home care is provided by the counties. Increasing costs are placing a heavy cost burden on county funds."

Hospitals:

- New hospitals: 3
- Psychiatric hospitals: 1
- Open Heart Surgery: 5
- Cardiac Catheterization Labs: 3
- MRI systems: Arizona has 9 MRI systems. (Comparison: California with 10 times Arizona's population, has only 18 units)

The state estimated in the report that "consumers are currently expending in excess of $225 million per year for excess hospital capacity."
A STUDY OF
THE IMPACT OF HEALTH CARE DEREGULATION
ON
HOSPITALS, NURSING HOMES AND HEALTH SERVICES
IN ARIZONA

November 15, 1985

Gloria Heller, Associate Director
Mary Chase, Planner

Office of Planning and Budget Development
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007
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NOTE

The data for this study were provided by the Office of Health Facilities and Economic Review, Arizona Department of Health Services. Within this Office grateful acknowledgement is extended to Fred Bodendorf, Ph.D., Manager, and to Cal Lockhart, Hal Webb, and Doris Evans of his staff.
I. HISTORY AND DEREGULATION TIME FRAME

A. Enactment - 1971: Arizona was one of the first few states to enact legislation authorizing Certificate of Need and Rate Review programs and Uniform Accounting and Reporting for Health Care Institutions. The Department of Health Services, established in 1974, received responsibility for the administration of these regulatory programs.

B. Deregulation: The Arizona Legislature terminated Certificate of Need review for:
   - Nursing Homes: July 15, 1982 (a 41-month period).
   - Hospitals: March 15, 1985 (an 8-month period). Deregulation included major capital construction projects, new services and high-cost specialty services affected by CON review criteria.

C. Continued Regulation: Arizona's RR and UAR programs are still in place. The RR program requires mandatory participation of health care facilities and provides for voluntary compliance of the applicant with the State's review recommendations. Under RR and UAR programs, all health facility rates and charges are maintained by ADHS for public information and disclosure upon request.

D. Current Status of Post-deregulation System Activity: Very dynamic, with activity in hospital and nursing home construction, bed expansion, freestanding and hospital-based outpatient facilities, tertiary services and rate increases.
II. NURSING HOMES

A. 1982 Status

1. **Nursing Home Facilities:** 79 Facilities
2. **Beds (All Levels):** 8,313 Beds
3. **Average Occupancy Rate:** 92.5% Occupancy
4. **Beds/1,000 Population:** 24.1 Beds/1,000 Pop. 65 + Years
5. **Gross Patient Revenues:** $124.2 million
6. **Per Capita Expenditures:** $360.76 - Pop. 65 + Years

B. Changes in Status: 1982 - Present

1. **Permit Applications:** A total of 169 nursing home applications have been received since deregulation in July, 1982:
   - 26 in the last 6 months of 1982;
   - 47 in 1983;
   - 55 in 1984;
   - 41 in 1985 to date

2. **Number of Facilities:** increased from 79 to 118 nursing home facilities, an increase of over 50% statewide in 3 years, with an average of 11 new facilities per year.

3. **Number of Beds:** increased from 8,313 beds in 1982 to 12,559 in 1985, an increase of 4,246 beds as of November, 1985. This is a 51.1% increase overall in 3 years, compared to a 55.8% growth in the preceding 9-year period 1974 through 1982.

4. **Occupancy Rates:** fell from 92.5% in 1982 to 82.8% in 1985, a decrease of 10.5% for the 3-year period.

5. **Beds/1,000 Population 65 + Years:** increased from 24.5 beds/1,000 to 31.3/1,000, an increase of 27.8% in the 3-year period.

When all proposed construction is completed, Arizona will increase to about 45 beds/1,000 elderly, an 84% increase over 1982. This ratio is approaching the national average of 50 beds/1,000 population; however,
75.3% of Arizona's beds are skilled nursing, compared to 20.3% nationally. Therefore Arizona's costs run significantly higher than other states for an equivalent number of beds.

6. **Gross Patient Revenues**: increased from $124.2 million in 1982 to $224.7 million in 1985, an increase of $100.5 million (GPR) over 3 years an overall increase of 81%.

7. **Per Capita Expenditures**: The State's population 65+ years increased by about 17% from 1982-1985. During the same period, per capita nursing home expenditures increased by 53.5%, from $360.76 (1982) to $553.81 (1985).

8. **Average Revenue Growth**: increased by 22.0% per facility, compared with a 8.4% increase in the National Nursing Home CPI for the same period.

9. **Average Arizona Rate Increase**: stands at 5.6% for the 3-year period. This indicator is down from the 9-year average of 8.7% for the period 1974-1982 due to various market factors, including the surplus of beds and the fact that new facilities are establishing higher initial charges to support current building costs that average between $25,000 and $30,000 per bed.

C. **1985 Permit Activity (Year to Date)**

1. **Number of existing facilities**: 118 Nursing Homes

2. **Permit Applications Received**: 41 applications

3. **Permits Issued to Date**: 7 permits

4. **Profile of Proposed Construction/Expansion**

   - **New Facilities**: 1,878 beds, $49.1 Million
   - **Expansion of Existing Facilities**: 308 beds, $9.2 Million

   **TOTAL**: 2,186 beds, $58.3 Million
5. **Bed Redesignations:** 355 beds were redesignated to a higher level of care:
   
a. 147 Personal Care to Intermediate  
b. 208 Intermediate to Skilled Care

6. **Nursing Home Care for Indigent Patients:** In Arizona, nursing home care is provided by the counties. Increasing costs are placing a heavy cost burden on county funds. Although long-term care is not included under AHCCCS, the counties are increasingly using the AHCCCS model by employing a bid process which results in "below-market" cost levels for county patients. The industry's acceptance of this process is in part fostered by the existing surplus of beds and falling occupancy rates.
III. HOSPITALS

A. 1982 - 1985 Permit Activity

1. Hospital Facilities: 69 facilities in 1982 and 1983, 73 in 1984, and 72 hospitals in 1985. In the past two years, 4 mining hospitals closed and 6 new general hospitals opened, 3 of which were replacement facilities.

2. Permit Applications: A total of 366 permits received for the 4-year period; 86 in 1982, 106 in 1983, 78 in 1984 and 96 in 1985 to date.

3. CON Applications: A total of 39 permit applications were received for the 3-year period; 6 in 1982, 22 in 1983 and 11 in 1984. No CON applications were submitted to the State in 1985 in anticipation of the termination of CON on March 15.

B. 1985 System Performance Status (State Health Plan)

1. Hospitals by Type: Total 88 Facilities
   - 72 General Acute Nonfederal 10,762 Beds
   - 16 Federal Hospitals 1,927 Beds

2. Growth in Nonfederal Bed Capacity: The statewide bed supply increased in the past 2 years by 833 beds, a 10% increase since 1983.


4. Average Daily Census: remained steady from 1980 (6,337 average inpatient census) to 1983 (6,367 average inpatient census). In 1984, the ADC decreased to an average ADC of 5,934, a decline of nearly 7%.

5. Total Patient Days: remained relatively steady from 1980 (2.36 million patient days) to 1980 (2.33 million patient days). In 1984, there were 2.17 million patient days, a decrease of 10% for the 12-month period.
6. **Average Length of Stay**: remained steady, averaging 6.4 days from 1980 through 1983, then decreased to 5.8 days for 1984.

7. **Average Occupancy Rate**: decreasing statewide. The 1984 rates are 60.1% in Maricopa County, 55.2% in Pima County, and 47.1% for all rural counties combined. The statewide occupancy rate for 1984 was 56.8%.

   Only four acute care hospitals achieved the state standard of 80% occupancy for urban hospitals in the 3-year period 1982-1984. Overall occupancy in the existing hospital system has experienced a recent rapid decline.

8. **Beds/1,000 Population**: The State standard is 3.2 beds/1,000 population. The 1985 bed ratio currently is 3.7 beds/1,000.

9. **Projected Bed Need**: The 1985-1990 State Health Plan projects a statewide bed need of 7,827 acute care beds in 1990. Assuming there is no further expansion of the existing system, there will be a projected statewide excess capacity of 2,935 beds in 1990.

10. **Estimated Cost of Excess Capacity**: Based on the 5-year Consumer-Price Index for Hospital and Other Medical Services, 1979-1983, the State estimates that consumers are currently expending in excess of $225 million per year for excess hospital capacity.

11. **Impact of DRG System**: The Federal Prospective Payment System is clearly having an impact on hospital utilization in Arizona, but we do not yet have definitive data except for year-to-year measurements of system performance. Cost and revenue data and special analyses will be provided when a new computerized system is implemented.

C. **1985 Permit Status (8 Months)**

1. **Existing System**: 72 Facilities, 10,762 Beds

2. **Permit Applications**: 96 total; 24 prior to termination of CON and 72 after termination.
3. Total Permit Value: All projects - $255,971,000.

4. Proposed New Facilities: 11 new hospitals

5. Permits Issued to Date: 1 permit (203 beds)

6. Profile of Proposed Hospital Construction:
   
   New Facilities: 1,312 Beds $196.2 million
   Existing Bed Expansion: 328 Beds 54.8 million
   
   TOTAL 1,640 Beds $251.0 million

7. Change in Permit Status: 4 proposed new hospital construction projects totaling $90 million were filed with the State immediately following termination of CON. These projects were withdrawn by the applicant several months later. The 4 projects included 3 new general acute care hospitals (500 beds), costing $85 million, and 1 new psychiatric hospital (68 beds), costing $5 million, all in the greater Phoenix area. These four projects were recently reinstated by the applicant.

8. Number of Projects Previously Subject to CON: If CON had remained in place, 38 (53%) of the 72 proposed projects filed after March 15, 1985 would have been subject to CON review. The total cost of these projects is $164.75 million.

9. Bed Redesignations: A total of 90 beds have been redesignated as to use:

   Med/Surg to SNF 30
   SNF to Med/Surg 10
   Detox to Med/Surg 8
   Substance Abuse to Psych 30
   Med/Surg to Pediatric 12

10. Other Activity:
   
   a. There is a great deal of interest in Arizona by consultants nationwide for all kinds of health care projects.

Page 7
b. Hospitals are starting to compete in alternative health care settings by purchasing or establishing nursing homes, emergency/urgent care, home health, ambulatory surgery, outpatient clinics. There is evidence these facilities are increasingly used as "feeders" for referral of patients to inpatient hospital care. Some freestanding services competing with hospital-based programs (e.g., 25 home health agencies) have gone out of business in the past two years because they cannot maintain utilization.

c. Some hospitals have purchased land in the outer peripheries of the greater Phoenix metropolitan area, as evidenced by zoning permits and HSA contacts.

d. There is substantial interest by national health care chains in moving into the Arizona market, particularly Phoenix. However, there is interest in both hospitals and nursing homes in all areas of the State.
IV. HEALTH SERVICES

A. Open Heart Surgery: 5 Permit Applications received, 4 Permits issued to date. The CONs for these projects were either previously denied, withdrawn or deferred until termination of CON. One project is costed at $504,000; the remaining 4 applications indicate no cost since heart-lung machines were previously purchased and the project represents a new service not requiring construction. The addition of 5 new programs has reversed declining utilization: in 1984, HSA I had a 17.9% decline (117 surgeries/100,000 population). In 1985, surgeries increased by 18.2%, to 138.6/100,000. All of the increases came from units not approved under CON.

B. Cardiac Catherization Laboratories: 3 Permit Applications received, 2 Permits issued to date. All CONs for this service had been denied in the past 2 years. In 1983, the statewide use rate was 239.5/100,000 population, and the national use rate was 218.8 procedures/100,000. In HSA I the use rate was 363.4/100,000, increasing by only 2.7% to 373.1 in 1984. After termination of CON, HSA I's rate rose to 421.8, a 13.1% increase. All increased were in units not approved under CON; procedures declined in some existing units which had received CON approval.

C. Physical Plant Expansion: 9 Permit Applications received, 4 Permits issued to date for major expansion or renovation projects. Approximate cost: $31.3 million.

D. Nuclear Magnetic Resonance Imaging Systems: Arizona has 8 operating MRI units in both hospitals and freestanding settings. A 9th system is to be installed in the University of Arizona. Total cost exceeds $14 million.

Comparison - Utah has about 2/3 of Arizona's population, but only 3 units. California has 10 times Arizona's population, and had only 18 as of last summer.

E. Lithotripsy Services: The lithotripsy service unit located in a Phoenix medical center serves as a statewide referral center. Two additional units are reported to be in the planning stages.
V. COST IMPACTS

A. Hospital Rate Increase Proposals: As of October, 1985, 52 Rate Increase Applications were filed by Arizona hospitals since March, 1985, following a rate freeze in effect for 9 months. In addition, 4 hospitals that applied for rate increases in 1984 implemented the new rates during or after the freeze ending March, 1985.

B. Hospital Revenues/Existing Rates: Prior to implementing these rate increases, existing rates for the 56 applicant hospitals generated annualized gross patient revenues of over $1.82 billion. Total State gross patient revenues for all nonfederal hospitals exceeded $2.02 billion in 1984. Total 1984 gross patient revenues for both hospitals and nursing homes in Arizona exceeded $2.25 billion.

C. Hospital Revenue Increases/Proposed Rates: The implementation of the proposed rate increases by the 56 applicant hospitals increased gross patient revenues for 1985 by $109.4 million to a total of $1.93 billion. This represented a statewide revenue increase of over 6%, as of October, 1985.

D. Repeated Hospital Rate Requests in 12-Month Period: 2 private psychiatric hospitals implemented 2 rate increases in 1985 (both hospitals have the same ownership). The compound effect of the 2 rate increases raised revenues for these hospitals by $1.02 million and $990,000, increases of 13.0% and 11.4%, respectively, within a 10-month period.

The State Department has received applications for more than one rate increase within the year from several hospitals. In the last month, 6 hospitals within the State filed for a second rate increase in approximately 7 months. The compounding effect of double rate increases by these hospitals will result in the following revenue increases on an annualized basis:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>18.2%</td>
</tr>
<tr>
<td>B</td>
<td>21.3%</td>
</tr>
<tr>
<td>C</td>
<td>25.1%</td>
</tr>
<tr>
<td>D</td>
<td>30.9%</td>
</tr>
<tr>
<td>E</td>
<td>46.3%</td>
</tr>
</tbody>
</table>

The Department expects additional duplicate filings within the calendar year.
SENATE BILL 340 - IS IT UNCONSTITUTIONAL TO EXEMPT HOSPITALS?

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. No reasons why hospitals should be treated differently from other health care facilities have been put forth. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons that hospitals should be exempted.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.

Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose.

If enacted into law, SB 340 would be reviewed by the courts under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to the discriminatory classification.

There is no identifiable governmental objective in including all health care facilities in CON except hospitals. There is considerable question whether Senate Bill 340, if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (Section 5). However, if Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which must meet CON requirements while hospitals are exempt. If this challenge is successful, there will be no CON in Montana. This of course would not bother the proponents as their stated purpose is to eventually eliminate CON completely. Senate Bill 340 is simply a first, and maybe last step. By exempting hospitals, even though it may be an unconstitutional denial of equal protection to other health care facilities, the end of CON may be ensured.

We urge your support of Senate Bill 340 WITH AMENDMENTS to include hospitals in the process.
MEMORANDUM

To: File
From: Patrick E. Melby
Re: SB 340
Date: February 14, 1989

Certificate of need is an exercise of a state government's inherent "police power" to protect public health, safety, and welfare. It is a regulatory program in which a state administrative agency is delegated quasi-legislative and quasi-judicial powers by the legislature to grant or deny a certificate, similar to a permit or license, which is a legal prerequisite to constructing or modifying a health care facility. The rational underlying CON is that for a number of reasons - e.g., the non-profit status of most hospitals, a financing system and patterns of consumer behavior which stifle price competition, some elements of the monopoly behavior, the inability to define and measure "health care" - ordinary market forces will not operate to prevent the duplication of institutional services or the use of resources in an inefficient, uncoordinated, and wasteful manner. The Guide to Health Planning Law (1987) page XX.

Montana’s CON law generally applies to all health care facilities as defined in 50-5-101 (19) MCA. A health care facility may not build new beds, add a new health service or make capital expenditures for equipment over $750,000 or for construction over $1,500,000 without a CON.

Senate Bill 340 would continue CON regulation to July 1, 1991. However, hospitals would be excluded from the CON requirements while all other health care facilities would be included. There was absolutely no testimony at the Senate Public Health and Welfare Committee Hearing on Senate Bill 340 to establish a reason why hospitals should be treated differently from all other health care facilities. In fact, the proponents of SB 340 stated that all health care facilities should be exempted from CON for the same reasons as hospitals.

SB 340 raises a serious constitutional question regarding the denial of equal protection of the laws.
The right to carry on a lawful business is a property right and due process requires that it not be unreasonably or unnecessarily restricted. However, the regulation of the lawful business by the state is a valid exercise of its police power. Equal protection of the laws requires that all persons be treated alike under like circumstances. Classification of persons is allowed as long as it has a permissible purpose and the classifying statute has a reasonable relationship to that purpose. Billings Associated Plumbing, Heating and Cooling Contractors v. State Board of Plumbers, Mont. 602 P.2d 597, 600 (1979).

There is no fundamental right or invidious discrimination involved in Senate Bill 340, therefore, the bill is not subject to the "strict scrutiny" test of equal protection. For this reason, the bill, if enacted into law would be reviewed under the "rational relationship" test - i.e., does a legitimate governmental objective bear some identifiable rational relationship to a discriminatory classification. Cottrill v. Cottrill Sodding Service, Mont. 744 P.2d 895, 897 (1987).

The Supreme Court has stated it succinctly thus:

A classification that is patently arbitrary and bares no rational relationship to a legitimate governmental interest offends equal protection of the laws. (cites omitted). As we have previously held equal protection of the laws requires that all persons be treated alike under like circumstances.


The court in trying to determine the governmental interest in making a classification will generally (1) attempt to ascertain the governmental objective from the face of the statute; (2) review the legislative history; or (3) consider other evidence of what objective the legislature may have had in mind at the time of passing the legislation. See Cottrill v. Cottrill Sodding Service, Supra at 897.

Using the rational relationship test, the Montana Supreme Court has several times found state statutes or city ordinances unconstitutional as a violation of equal protection. In Cottrill v. Cottrill Sodding Service, Supra, the court found that a state statute which excluded from workers' compensation coverage an employer's family member who resided in the employer's household unless the employer
specifically elected to include the employee, unconstitutional as a denial of equal protection.

In Tipco Corp., Inc. v. City of Billings, Supra, the Supreme Court found an ordinance by the City of Billings which declared uninvited door-to-door solicitation a nuisance punishable as a misdemeanor but exempted local merchants with regular established places of business from its operation as unconstitutional. The City of Billings had argued that the ordinance had a rational relationship to the city's objectives because it could exercise control over local merchants and their uninvited door-to-door solicitations but could not exercise such control over out-of-state firms and their solicitors. The state rejected this rational and found the ordinance unconstitutional.

In Godfrey v. Montana State Fish and Game Commission, ___ Mont. ___ 631 P.2d 1265 (1981) the Supreme Court found a state statute which required a person to be a resident of Montana to qualify for an outfitter license to be unconstitutional. The state argued at page 1268 of 631 P.2d, that the discrimination was justified because:

The statutes were enacted pursuant to the power to control the activities of outfitters to ensure the safety of persons utilizing their services within the borders of Montana, to protect private property rights, and to ensure reasonable law enforcement ability in preserving and protecting the wildlife of Montana.

The court found that none of the reasons offered to justify the discrimination were persuasive. 631 P.2d 1268.

And the court found a statute which required a non-resident hunter to be accompanied by a licensed outfitter unconstitutional in the case of State v. Jack, ___, Mont. ___, 539 P.2d 726 (1975). The court found the statute unconstitutional even though it was allegedly designed to promote safety for hunters, to foster better protection for private land owners and to provide more effective law enforcement. The court found that the relationship between the statutory classification and its legitimate objectives was tenuous and remote and was, therefore, insufficient to justify the inequities it engendered. See 539 P.2d at page 730.

There is considerable question whether Senate Bill 340,
if enacted into law, would withstand a constitutional challenge based on equal protection.

The constitutional infirmity of Senate Bill 340 has obviously been recognized by its proponents as they have included a severability provision in the bill (See Section 5). Severability clauses are not included in legislation unless there is a question of constitutionality of part of the bill. The inclusion of a severability clause only provides a presumption that the legislature intended that if the invalid part of the statute is severable from the rest, the portion which is constitutional may stand while that which is unconstitutional is stricken. If, when an unconstitutional portion of an act is eliminated, the remainder is complete in itself and capable of being executed in accordance with the apparent legislative intent, it must be sustained. Montana Automobile Association v. Grely, at page 311 of 632 P.2d.

However, the inclusion of a severability section is no guarantee that the entire act will not be found invalid if a portion of it is constitutional. If a portion of an act is found unconstitutional and the remainder is not complete in itself or is incapable of being executed in accordance with legislative intent, the whole act will be found invalid. North Central Services, Inc. v. Hafdahl, ___ Mont. ___, 625 P.2d 56, 59 (1981).

If Senate Bill 340, assuming it becomes law, is challenged, it will be because it is applied to a health care facility which is not a hospital which must meet CON requirements while hospitals are exempt. It is hard to contemplate a situation where a successful challenge would not invalidate the entire CON procedure. This of course would not bother the large metropolitan hospitals as their primary purpose is to eventually eliminate certificate of need completely anyway. Senate Bill 340 is simply a first, and maybe a last step. By exempting hospitals even though the bill may raise a question of an unconstitutional denial of equal protection to other health care facilities, hospitals ensure the end of certificate of need.
SENATE BILL 340 - to remove hospitals from certificate of need process

Hospitals should not be removed from health planning because of their impact on the Medicaid budget. Hospital service costs are growing faster than any other part of the Medicaid budget.

MEDICAID PAID CLAIMS STATISTICS FY87 thru 1/31/89:
(from SRS print out)

<table>
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<tr>
<th>Service</th>
<th>FY87</th>
<th>FY88</th>
<th>89 YTD</th>
</tr>
</thead>
<tbody>
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<tr>
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<tr>
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<tr>
<td>Cost per service</td>
<td>$ 7.53</td>
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<td>INCREASE COST PER SERVICE</td>
<td>-12.8%</td>
<td>+5.5%</td>
<td></td>
</tr>
</tbody>
</table>

An Affiliate of
American Health Care Association

EXHIBIT 7
DATE 3-3-89
HB 340
## Service

### Nursing home costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>FY87</th>
<th>FY88</th>
<th>FY89YTD</th>
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<tr>
<td>Cost per day</td>
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**INCREASE COST PER DAY**

- **FY87 - FY88:** +1.8%
- **FY88 - 89YTD:** +2.3%

---

### SUMMARY

<table>
<thead>
<tr>
<th>Service</th>
<th>Increase or Decrease in Cost Per Service:</th>
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</thead>
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<tr>
<td></td>
<td>FY87 - FY 88</td>
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<tr>
<td>Inpatient Hospital</td>
<td>+8.1%</td>
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<tr>
<td>Outpatient Hospital</td>
<td>+42.0%</td>
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<tr>
<td>Physicians</td>
<td>- 2.7%</td>
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<tr>
<td>Other primary care</td>
<td>-12.8%</td>
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<tr>
<td>Nursing homes</td>
<td>+ 1.8%</td>
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</table>

|                                | FY88 - 89YTD                           |
| Inpatient Hospital             | +15.0%                                 |
| Outpatient Hospital            | +19.0%                                 |
| Physicians                     | -.8%                                   |
| Other primary care             | + 5.5%                                 |
| Nursing homes                  | + 2.3%                                 |

It is clear that hospital services, both inpatient and outpatient, are the services responsible for the fastest growth rate. The cost per service is growing at a rate that far exceeds inflation, while other health service costs are growing at rates that are less than general inflation.

SUPPORT CERTIFICATE OF NEED FOR ALL HEALTH CARE PROVIDERS, INCLUDING HOSPITALS.
MEDICAID BUDGET

Effect of each 1% increase in utilization of various health care services:

<table>
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<tr>
<th>Health Care Service</th>
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<td>Nursing homes</td>
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<tr>
<td>Outpatient Hospital</td>
<td>65,942</td>
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</tbody>
</table>
February 13, 1989

Montana State Legislators
State Capitol
Helena, Montana 59620

Dear Senators and Representatives:

Please be advised that I strongly support the continuation of the Certificate of Need process and believe that it should cover the entire health care field, including hospitals.

I am the Administrator of Granite County Memorial Hospital and Nursing Home in Philipsburg, as well as a member of the Board of Directors of the Montana Health Care Association, so I am very familiar with the Certificate of Need process.

The process eliminates duplication of services and helps hold down health care costs for everyone. Your vote to continue Certificate of Need would be very much appreciated.

Sincerely yours,

GRANITE COUNTY MEMORIAL HOSPITAL AND NURSING HOME

Mike Kahoe, Administrator

MK/me
Dear Honored Senators and Representatives:

RE: SB 340

I would like to make known my opposition to Senate Bill 340, regarding the exclusion of hospitals from the Certificate of Need (CON) process.

The CON process was developed to apply to all healthcare facilities and to effectively control their growth in a positive manner. As you are well aware, health care financing is an important and complicated issue. In order for the CON process to have the desired effect on health care spending, it must apply not only to nursing homes but also to hospitals. I would be disappointed to think that short term personal interests are being substituted for long term planning and benefits.

As an administrator of both a hospital and nursing home, I urge you to study this issue and consider opposing Senate Bill 340.

Thank You,

Sincerely,

Nancy A. Berry
Administrator

cc: Cecil Weeding
Dahl Memorial Hospital Association

P.O. Box 46

Ekalaka, Montana 59324

February 28, 1989

Rose Hughes
Executive Director
Mt. Health Care Assn.
36 S. Last Chance Gulch, Suite A
Helena, Montana 59601

Dear Rose:

Certificate of Need legislation has plagued health care providers in all the states in which I have been an administrator, mainly Montana and North Dakota.

I have always felt that the CON law has accomplished most of what it was designed to do. I'm only for the CON law when it effects all providers in the same manner. It now appears there are certain forces that think the large hospitals should be exempt from the CON law.

It is the feeling of myself and the Board of Directors, Dahl Memorial Healthcare Association that there should be a CON law and that providers should be subjected to it in the same manner.

Thank you.

Sincerely,

[Signature]

Paul A. Langden,
Administrator
TO: All Montana Senators and House Representatives

We support the Certificate of Need process. All health care facilities should have the same requirements.

Sincerely,

MACK N. SIMPSON
Administrator
February 13, 1989

Bill Good
Montana Health Care Association
Last Chance Gulch
Helena, Montana 59601

Dear Mr. Good:

In reference to Senate Bill # 340 entitled "An Act to Revise and Continue the Certificate of Need Laws", we feel that hospitals should be included in the certificate of need process along with other health care facilities.

Sincerely,

James R. Mantz
Administrator
TO: Members of the Montana Legislature

FROM: Paul Hanson, Administrator

DATE: February 24, 1989

RE: SB 340

As the Administrator at Roosevelt Memorial Hospital and Nursing Home I would ask that you support Senate Bill 340.

I have conferred with Rose Hughes, President of the Montana Health Care Association and I concur with her understanding of that Bill and give her my full support.
CERTIFICATE OF NEED IS THE ONLY PROTECTION THE STATE OF MONTANA HAS IN PLACE TO PROTECT CONSUMERS FROM THE HIGH COSTS ASSOCIATED WITH UNNECESSARY INVESTMENT IN HEALTH CARE FACILITIES AND DUPLICATION OF SERVICES.

DEREGULATION LEADS TO EXCESS CAPACITY AND HIGHER COSTS.

Let's look at the "Utah experience."

The following are all excerpts from a report on Utah deregulation entitled "An Examination of the Long Term Care Industry in Utah", released in September, 1988.

"There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need."

1,445 new beds were added and occupancy dropped from 90% to 75%.

"The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding."

"A lower occupancy rate increases the per patient cost of care."

"Where the influx of providers and new beds are most prominent is in the area of new free-standing psychiatric hospitals. Since January 1, 1985, eight new free-standing psychiatric hospitals have been built in the state for a total of 550 new licensed beds. Although one or two psychiatric hospitals may actually have been needed, it is generally thought that there is now a substantial excess of such beds..."

"The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding."

"Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. As occupancy declines, these costs must be spread over a smaller number of patients."

"If Medicaid expenditures on long term care are not controlled, the
number of individuals served or the number of services provided by the Medicaid program will have to be reduced."

"An even more serious concern lies in the realm of quality of care. ...The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits..."

"In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys adjustments or relationships the patient has made..."

"In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care."

You are being asked to abandon your concern for patients, consumers, and taxpayers, and to risk major increases in the Medicaid budget, to satisfy a few hospitals which find certificate of need inconvenient. PLEASE SUPPORT SENATE BILL 340, WITH AMENDMENTS TO INCLUDE HOSPITALS IN THE PROCESS.
AN EXAMINATION OF THE LONG TERM CARE INDUSTRY IN UTAH AND THE FUTURE IMPLICATIONS TO CERTIFICATE OF NEED

by

Heidi M. Brich
Graduate Student
Arizona State University

Presented to

Suzanne Dandoy, M.D., M.P.H.
Executive Director
Utah Department of Health

Rod L. Betit
Director
Division of Health Care Financing

September 1, 1988
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1 - Net Change in Geriatric Beds
2 - Projected Number of Beds Required for Those 65 and Over
I. EXECUTIVE SUMMARY

This paper examines the current condition of skilled and intermediate care facilities in Utah. It traces the Certificate of Need program, repealed in 1984, and evaluates the future implications for the long term care industry in the State. The report also assesses how other states are meeting the challenges posed by a projected increase in the number of people requiring long term care services within the context of limited resources. It is recommended that the State move to limit construction while fostering the growth of competitive forces.

Information for this report was collected from a variety of resources. A computer search and a review of the professional literature was completed, a telephone survey of every state was made, and interviews were conducted with a number of people in Utah on all sides of the long term care and Certificate of Need issues.

The Utah Certificate of Need program was an outgrowth of the federal health planning movement. Section 1122 and Certificate of Need were designed to control health care expenditures by discouraging or preventing "unnecessary" investment in health facilities. This was justified because it was argued that the market was unable to control health care costs.

Utah had a program to review capital expenditures from 1974 through 1984. During this ten year period the supply of beds in hospitals and nursing homes was tightly controlled. Emphasis later shifted from a "health planning" approach to an "open market" strategy for controlling rising costs. Implementation of free market forces and price competition was seen as an innovative way to control the growth of health care costs. The Certificate of Need law was repealed as a component of this policy.

There has been rapid growth in the number of long term care beds in Utah since the repeal of Certificate of Need. While Certificate of Need was in place, only 99 additional long term care beds were approved. Following the repeal of the program there was a net increase of 216 beds in 1985, 644 beds in 1986, and 585 beds in 1987. The large increase in beds has caused the average nursing home industry occupancy rate to plummet from almost 90 percent to 75 percent. The increase in beds demonstrates that the market was not successful at guarding against excess capacity and overbuilding.

A lower occupancy rate increases the per patient cost of care. At the same time other factors, including the nursing shortage, past and future changes in staffing requirements, and patients with heavier care needs, have increased operating costs for nursing homes. During this period there have been only small increases in the Medicaid flat rate paid to nursing homes. The financial situation of the industry as a whole has deteriorated. If the growth continues this condition will worsen.
If the current trend is allowed to run its course, it will bring about the closure of a number of nursing homes, relocation of patients, and diminished quality of patient care due to cuts in expenditures for food, activities and staffing. There may also be a negative impact on the Medicaid budget. A worsening of the financial situation in nursing homes will increase the pressure on the preadmission screening program to allow more patients into facilities and on Medicaid to increase the rate paid for care. This money may have to come from programs designed to provide care to other indigent and ill people.

Other states are also working to control Medicaid expenditures for long term care. In some states, controlling the supply of long term care beds is viewed as an effective means of controlling expenditures. States with strong regulatory agencies have high average nursing home industry occupancy rates. States with little or no regulation tend to have a lower average census. There are difficulties associated with both very high and very low nursing home occupancy rates.

The Certificate of Need programs vary widely from state to state. The programs are effective and more readily accepted where there is a longstanding interest in government regulation. This attitude is not present in Utah.

A Certificate of Need program would be very expensive and difficult to reinstate. There are additional concerns about the program such as its cost, the length of the appeals process, and the impact of political influence. At this time, reinstating a capital expenditure review program is unlikely to be politically successful or desirable.

The most effective strategy to handle the situation in the long term care industry is a plan to provide relief from incessant construction while assessing the feasibility of price competition. Prohibiting new construction will halt the sharp decline of occupancy rates, allowing facilities to better cover costs. A pilot project will allow nursing homes in a small area to compete for new Medicaid admissions on the basis of quality and price of care. At present, competitive forces are not at work in the long term care market. This pilot project will lay the foundation for future competition. Such a move addresses the current situation while adhering to the policy of promoting competition as a way of controlling cost.

Other recommendations in the report include collecting more relevant demographic and utilization data, increasing funding to nursing schools to increase enrollment, encouraging the development of private long term care insurance, and investigating other innovative ways to finance long term care.
II. INTRODUCTION

Since the repeal of Certificate of Need in Utah in 1984 there have been a number of changes in the long term care industry. The number of nursing home beds has increased rapidly. Operating costs of nursing homes have risen. A serious shortage of nursing personnel has developed. If conditions continue to worsen, there may be a serious impact on the quality of care in nursing homes and on the overall Medicaid budget. The purpose of this paper is to examine the prevailing conditions in the long term care industry in the state of Utah, the Certificate of Need program, and the experience in other states, and to evaluate possible solutions.

Section three reviews the background of the Certificate of Need program. It outlines the political roots of the program, evaluates its success, and describes Utah's innovative approach to control health care costs. Section four traces the developments since the repeal of Certificate of Need. Areas where there has, and has not, been a flurry of construction are examined. It also looks at possible explanations for the rapid growth in long term care beds for the elderly in Utah. Section five describes the factors present in the long term care market. It notes those elements distinguishing long term care from a competitive market. In section six the long term care industry is investigated. The factors increasing operating costs for nursing homes are examined, and the reasons why this is of concern to State Government and the Medicaid program are highlighted. Strategies other states use in an attempt to balance the competing goals of assuring access while providing low cost and high quality care are described in section seven. Every strategy has accompanying difficulties. Section eight notes the difficulties in reinstating a Certificate of Need program at this time in the state of Utah. Although it did control bed supply and many states still have such a program, reintroducing such a program at this point in time would be likely to encounter a great deal of political opposition and also be expensive. Since it is not an appropriate time to revive a capital expenditure review program, other strategies to deal with the problems posed in long term care are examined in section nine. The options are outlined and a solution consistent with the concern over the current situation and consistent with Departmental policy is proposed. Section ten covers the need for information in order to make decisions in the future, and section eleven specifies some issues which should be investigated further. Section twelve cites the resources used in completing this research.
III. BACKGROUND OF CERTIFICATE OF NEED

The Certificate of Need program had its roots in the health planning movement. One of the first moves toward comprehensive health planning was the Hospital Survey and Construction Act of 1946, commonly referred to as the Hill-Burton Act. It provided funds for construction of health care facilities. Initially, a bed/population formula was used to identify underserved areas. In 1966, the "Comprehensive Health Planning Act" was passed, which was intended to assess health service needs and make changes. The program was given little authority to actually bring about these changes, however.

Under Section 1122 of the 1972 Social Security Act Amendments, a state-optimal program could be adopted to review capital expenditures proposed by health care facilities. If states gave a negative recommendation, reimbursement for capital costs associated with the project were withheld under Medicare and Medicaid. This was not always an effective deterrent, since the amount of Medicare and Medicaid funding received by institutions varied, as did the size of the penalty. In some cases there were only very weak penalties if an institution went ahead with the project without approval. States also began to define their own certificate of need programs to review the provision of new services and the construction or major renovation of health care facilities. Certificate of need programs generally had broader coverage than 1122 programs and also carried more substantial penalties for noncompliance.

The first certificate of need (CON) program was begun in New York in 1964. The "National Health Planning and Resource Development Act of 1974" was passed in 1975. It made funding available for state planning activities, and authorized the creation of State Health Planning and Development Agencies (SHPDAs) and Health System Agencies (HSAs). These agencies were put in place to prepare comprehensive health plans which were then to be used in the CON review process. This Act effectively required states to implement CON programs according to federal standards. If they did not, states lost federal funding for state health planning and health resource development. "By January 1975, 46 states and the District of Columbia had certificate of need, Section 1122, or both."[1]

CON programs were designed to discourage or prevent what was deemed by the planning agencies as "unnecessary" investment in health facilities. Health facility construction and capital expenditures were reviewed on the basis of community need, not demand. The need for such a review was supported by citing areas of "market failure" in health care. Market failure occurred because: there was little or no information available to consumers about price or quality, third party

reimbursement shielded consumers from the cost of health services, and the physician (not the patient) often determined when care was necessary and where the care would be given. CON programs were also used to control health expenditures by controlling bed supply, capital investments in new equipment, and new services. The rationale for controlling supply to control costs was supported by research that indicated there was supply induced demand for hospital beds. 2 (Roemer's law: A built bed is a filled bed). CON programs included provisions for public hearings and administrative and judicial appeals.

Utah agreed to review capital expenditures in 1974. In 1976, the Utah Health Planning and Resource Development Act was passed. The Act created a local Health Systems Agency, and a State Health Planning and Development Agency. By 1979 a CON program complying with federal standards, the "Utah Pro-Competitive Certificate of Need Act," was enacted. This replaced 1122 review. The Act was amended and reenacted in 1981 and 1983.

The Certificate of Need program in Utah did a good job of controlling bed supply. It was much less successful in controlling major capital equipment purchases or the provision of new services. The focus of the program on controlling beds forced hospitals to diversify in areas not as tightly controlled. See Appendix 1.

After the Reagan Administration came into office in 1980, emphasis was shifted from health planning to market forces. The "National Health Planning and Resources Development Act" expired in 1982.

In February, 1983, the Utah Department of Health published a statement of health policy entitled, A Prescription for Health Care Costs in Utah. The report noted that health care costs in Utah were lower than in the rest of the nation, but that the rate of increase was greater. The strategy recommended dealing with rising health care costs by establishing "price competition as the controlling factor in the health care market" and allowing market forces to take over. It recommended discontinuing the CON program. The report also noted, "most health economists believe that the establishment of price competition in any given area will take between six and eleven years. Because of this fact there has always been concern that the strategy will be dropped before it has a chance to develop." The Certificate of Need program was terminated by the State Legislature on December 31, 1984.

IV. IMPACT OF Deregulation

The repeal of Certificate of Need legislation was based on the premise that the free market could more efficiently control health care costs than could regulation. Some argued that free market forces were not in place in areas of the health care market. In order to establish price competition, several important changes in the environment were proposed in A Prescription for Health Care Costs in Utah. These included establishing health insurance plans with "a financial incentive to consider costs at the time health care is purchased," and making information about the cost and quality of health care available to consumers.

It was hoped that the free market forces already in place would be sufficient to deter overinvestment once the control of certificate of need was lifted. Establishing price competition was expected not only to control health care costs but also to increase efficiency in the market. Copayments and deductibles were to be introduced into third party reimbursement to make consumers more aware of the cost of care. As consumers became more conscious of the cost of their health care, they were expected to want to become more informed before making choices. The Utah Health Cost Management Foundation (a coalition of business and industry) and the Utah Department of Health were directed to publish information on health care cost trends in the early years, and information about the relative quality of health care sold by individual and institutional providers in the later years.

Since the termination of CON, overbuilding has not been a problem in the area of intermediate care facilities for the mentally retarded, where there have been additions of only a few beds; or for general acute care hospitals. No new acute care hospitals have been built since the repeal of CON. Where the influx of providers and new beds are most prominent is in the area of free-standing psychiatric hospitals. Since January 1, 1983, eight new free-standing psychiatric hospitals have been built in the State for a total of 550 new licensed beds. The majority of these beds were built along the Wasatch Front. Although one or two psychiatric hospitals may have actually been needed, it is generally thought that there is now a substantial excess of such beds. Occupancy rates are low for most of these facilities. At the time of this report, Medicaid was not reimbursing for psychiatric care provided in free-standing facilities. However, the pressure for Medicaid to cover care in this setting was mounting.

Prior to the demise of CON in 1984, few new nursing home beds had been approved by the review agency. Virtually no beds were approved between 1979 and 1983. From January, 1983 through December 31, 1984, 99 additional beds were approved. In 1985 there were 159 new geriatric nursing home beds built. There were also 129 beds converted to geriatric use, but 27 beds were lost for a net increase of 261 beds. The growth escalated in 1986. In that year, 635 new beds were built, and 31 hospital beds were converted to "transitional" care, although 22 beds
were lost or converted, for a net increase of 644 beds. The year 1987 showed similar growth with 615 new licensed geriatric beds, although 30 beds were lost for a net increase of 585 beds. The expansion may be slowing now. In the first six months of 1988 were additions of 19 new beds, and the conversion of 14 hospital beds to transitional care. In 1988, 42 beds that were geriatric care beds were converted to other use, and 53 beds are no longer licensed, for a net decrease of 62 beds. However, plans have been submitted to the Bureau of Facility Licensure for 324 new beds, 120 of which are currently under construction. As of May 1, 1988, there were 1,721 empty SNF or ICF beds in the State.

Utah has a lower long term care bed to population ratio than most other states. It also has a smaller proportion of the elderly population residing in institutions. Nationally, 5 percent of the elderly over age 65 reside in nursing homes, while in Utah the figure is only 3.5 percent. If potential investors look only at the absolute number of beds instead of historical utilization and current occupancy rates, Utah may still be perceived as an attractive market. There is the danger of an explosion of long term care beds in the next several years if there are no steps taken to restrict growth. An indication that there are more beds than needed is the declining occupancy rate of the nursing homes as a whole. Statewide average occupancy rates, which were running around 90 percent in 1983, were 75 percent in June, 1988.

The increase in beds in the above areas demonstrate that the market was not successful at guarding against excess capacity and overbuilding. The long term care area of the health care market has several features which distinguish it from a competitive market.
V. MARKET CONDITIONS OF THE LONG TERM CARE INDUSTRY

In Utah the market for long-term care is not a competitive market, but a monopsony. The Medicaid program is the principal buyer. In May, 1988, Medicaid supported 67 percent of the ICF/SNF and 97 percent of ICF/MR patients in the State. As the principal buyer, Medicaid does not have free access to the competitive market. Medicaid pays all certified providers according to a predetermined formula based on historical property costs and levels of care. Providers currently do not bid for the provision of services and Medicaid does not contract for only the number of needed beds. In addition, there is an almost complete lack of price sensitivity in the market.

Medicaid reimburses nursing homes on a flat rate schedule. Since the introduction of the flat rate in 1982, there has been only a 4.2 percent average annual increase in the reimbursement rate. Included in the schedule are differentials for historical property costs, return on equity (frozen at the 1981 level), and varying levels of care. Otherwise, all facilities receive the same reimbursement for Medicaid patients. There is no leeway for nursing homes to raise the price for Medicaid patients and no incentive to charge less than what Medicaid pays. Medicare will cover some skilled nursing care, but only makes up 2 percent of nursing home reimbursement nationally. Private insurance accounts for less than 1 percent of national nursing home expenditures. Out-of-pocket payment from individuals and their families comprises the balance of nursing home reimbursement. Most nursing homes do charge private patients higher rates than Medicaid patients.

Medicaid in Utah does not charge patients copayments or otherwise have them share the cost of care once they are eligible for coverage. Therefore, patients are not sensitive to the cost of care, and price does nothing to deter unnecessary utilization. A preadmission screening program is in place to make certain that individuals receiving care truly need it. There are no incentives for patients to shop for care on the basis of cost, nor is there objective information published on the quality of care provided in any given institution. The Federal Health Care Financing Administration (HCFA) will soon publish results from Medicare/Medicaid nursing facility survey reports, listing deficiencies for individual nursing facilities. The seriousness of the deficiencies may not be clear to the average reader, however. In addition, the nursing home industry maintains that the survey results are subjective and inconsistent.

Private pay patients are more sensitive to price, yet they represent only a small segment of the market. In addition, private pay patients may become Medicaid patients when their assets are diminished. Once they begin spending down their assets, it makes little difference what the facility costs, because the patient's share will be the same regardless of cost. Thus, there are no rewards built into the system for cost conscious behavior on the part of the consumer. The principal buyer pays a flat rate to all facilities, and long term care facilities must accept the rate Medicaid pays, or choose not to accept Medicaid patients at all.
VI. INSTITUTIONAL FACTORS

Several factors are increasing the operating costs for nursing homes: demands for higher wages caused by the nurse shortage, past and future increases in staffing requirements, and patients with heavier care needs. Since the repeal of Certificate of Need, the average census has declined from 89.8 percent in 1983, to 75.21 percent in May, 1988. Excluding the State Training School, the average ICF/MR census was 88.78 percent in 1988. Per unit costs increase with declining occupancy. Fixed costs, such as housekeeping, mortgage payments, and equipment, remain constant regardless of occupancy. Semifixed costs such as nursing salaries will remain constant within a certain operating range due to staffing requirements. As occupancy declines, these costs must be spread over a smaller number of patients.

The number of people entering nursing homes in Utah has been growing at a steady rate of one to two percent per year, limited in part by a very effective preadmission screening program. All Medicaid patients, and all patients who are expected to apply for Medicaid eligibility within 90 days, are required to undergo the Patient Assessment Evaluation.

Historically, only 3.5 percent of the population over age 65 in Utah live in nursing homes compared with 5 percent nationally. Factors associated with nursing home placement include extreme old age, living alone, lack of informal support from relatives or friends, the availability of community services, and difficulty with the activities of daily living. The lower percentage of Utah elderly in institutions could be due to a number of these factors or other influences.

Utah also has a lower number of beds per 1,000 population than the national average. This low bed to population ratio is appealing to investors, and may be an important factor attracting individuals and corporations to this area to build new nursing homes. There is a potential explosion of long term care beds from investors who view this as a lucrative potential market. As more beds are built, industry wide occupancy declines, there is pressure to fill the empty beds. This strains the preadmission screening program which is working to make sure only appropriate placements are made. Based on the national average of 5 percent, Utah seems to have a shortage of long term care beds. However, if the Utah average is used, a different picture emerges. Using the historical average of 3.5 percent of the population over age 65 in Utah in nursing homes, 1980 census data projected forward, and a target occupancy rate of 90%, it is projected that 6,060 SNF and ICF beds are needed in 1988. This will increase to 6,488 in 1990 and 7,337 in 1995. In June, 1988, there were 6,784 total licensed geriatric nursing care beds in the State—an excess of 724 beds. There were 324 additional beds in planning stages. If these beds are the only additional beds built, and the others remain, a surplus of beds will exist until 1994. See Appendix 2.
Looming on the horizon is another potential threat of bed expansion. Its source is the significant number of free-standing psychiatric hospitals built following the repeal of Certificate of Need here. All but one of these hospitals have a very low patient census and are experiencing financial difficulties. They were all built to nursing home specifications, so there is a potential for 496 beds in psychiatric hospitals to be converted quickly to provide long term care. Hospitals are also exploring the possibility of converting areas to long-term care to ease their occupancy problems. Two hospitals have already converted wings to "transitional care." Hospitals can more easily channel patients with subacute needs into their own wings rather than into nursing homes for skilled nursing care. Hospitals would then be creaming off the more lucrative Medicare patients, leaving nursing homes less revenue to cover operating costs.

Another issue affecting the long term care industry is the nurse shortage. In an effort to attract more nurses, "hospitals, nursing homes, and other employers have increased starting salaries and initiated incentives to attract nurses." The situation has a more severe impact on nursing homes than on hospitals because nurses typically are not trained to provide long term care and lack experience in the long term care setting. In addition, the wages and benefits long term care institutions are able to offer are lower than those paid by hospitals. "Registered nurses (RNs) earn an average of 35 percent less in nursing homes than in hospitals."4

Preliminary results from the 1987-88 Utah Registered Nurses' Licensure survey of 2,000 RNs who were eligible for relicensure but chose not to retain their Utah license, approximately 200 chose to work in a field other than nursing and 900 worked as RNs, but not in Utah. It is estimated that 78 percent of licensed Utah nurses are working as nurses in the State. Few nurses are inactive in the work force. The national unemployment rate for nursing is below one percent.

The nurse shortage causes concern about the care an institution is able to provide. According to the American Health Care Association, "The nurse shortage is clearly handicapping our ability to provide quality care."5 By October 1, 1990, facilities will be required by the federal government to have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty 24 hours per day, 7 days per week. These requirements passed by Congress will further exacerbate the nurse shortage.

3Diane Blake, "Nurse Shortage Has Broad Implications," Pro Re Nata, 10 No. 2. (March/April 1988).

4American Health Care Association, Issue Paper, "Eliminate Restrictions on Labor Costs for Nursing Staff"

5Ibid.
Because of high turnover, there is no longer a stable, constant work force providing care to the elderly and chronically ill individuals in nursing facilities. Especially when the patient is confused or disoriented, familiar faces and a set routine can be comforting. Stability of the staff is a necessary component to high quality care, which declines sharply with excessive turnover. In addition, nurses are leaving positions just when they have completed the training process. "High turnover among workers and growing use of temporary employees have affected patients, too." This disrupts the continuity of care patients receive.

According to some Utah nursing home administrators, there is also a shortage of qualified nurses' aides. This is a view shared by Congress which included in 1987 legislation a provision that nurses' aides must be certified and a registry established. This is likely to make it more difficult for facilities to locate and hire aides, even though Medicaid will be required to cover the cost of implementing this policy. If Congress raises the minimum wage, this will have an even stronger impact on long term care institutions. Not only will it be expensive to pay aides more, but there is a ripple effect. Wages for other staff members will also have to be increased. This may exert extreme financial pressure on nursing homes. This problem is further exacerbated by the decline in the population age group (17-25) which typically fills these positions.

The characteristics of the patients are also changing. The typical nursing home resident is becoming older and needs more care. In the past, nurses had only a few patients with heavy care needs and could concentrate their time with these patients. Today, heavier care needs, in both hospitals and nursing homes, cause nurses to spread their care more thinly among a group of very elderly or ill patients.

The new beds built in Utah since 1983 have surpassed the current demand for care, resulting in declining occupancy rates. This increases the per patient per day cost of care. Nursing homes are competing with each other to staff facilities with nurses and nurses aides. This competition will intensify as the new federal staffing requirements are implemented.

A 1986 report on the profitability of nursing homes showed that on average reported revenue was in excess of costs. Exact data on nursing home profitability since then is not available. However, according to Dennis McFall, President of the Utah Health Care Association, 12 facilities have filed for Chapter 11 bankruptcies in 1988.

The declining financial viability of nursing homes and the increasing number of empty beds put financial pressure on the Medicaid

program. There will be a greater push by the homes to increase the
reimbursement rate paid and to allow more people to enter nursing homes
to fill the empty beds.

However, the Medicaid budget and the State budget are limited. Unless more funding becomes available, increasing expenditures in one area force cutbacks to be made in other areas. If Medicaid expenditures on long term care are not controlled, the number of individuals served or the number of services provided by the Medicaid program will have to be reduced.

An even more serious concern lies in the realm of quality of care. The elderly, chronically, and mentally retarded persons in nursing facilities often do not have the ability to defend themselves or to safeguard their rights. The care a facility provides just before it goes under is likely to be of dubious quality. Even before reaching that point, facilities may be cutting corners in the areas of food, staffing, wages, and benefits. These changes may be difficult to detect from the outside, but may make an enormous difference to the individual eating the food or relying on a staff member.

In addition, there is the problem of relocating patients when a facility closes. This is very traumatic and destroys any adjustments or relationships the patient has made. In smaller communities, the nursing home that closes may be the only one within 100 miles, so the patient is removed from friends and family.

The Nursing Home Profitability report noted that "a typical operation should maintain a floor of 80 percent occupancy" and recommended that "in order to maintain a healthy industry, the State should monitor this status and, perhaps, take action to discourage new facilities from entering the marketplace until levels are stabilized."7

VII. STATE STRATEGIES

The Medicaid program is administered differently by each state. Consequently, there is wide variation across programs. The percent of the Medicaid budget devoted to long term care ranges from 26 to 65 percent in the states. In Utah, 31 percent of the Medicaid budget goes to long term care. Medicaid is the principal source of financing for institutional long term care, and long term care makes up the largest single component of the Utah Medicaid budget. Each state's program has evolved within a specific regulatory environment and has its own unique challenges, but every state is faced with the dilemma of striking an appropriate balance between cost, quality and access.

States have approached the challenge of controlling the rate of growth of long term care expenditures in a number of different ways. One strategy is to restrict the number of beds available. This is based on the assumption that as the supply of beds increases there is increasing pressure to fill them (Roemer's law). Certificate of Need programs and moratoriums on construction are the primary methods used to restrict bed growth. States may also try to signal the industry to limit expansion by limiting the number of beds Medicaid will certify. If construction of facilities intended only for privately paying patients is still permitted, there is the potential that there will then be pressure on the state to allow the beds to later become Medicaid certified after they are built.

States which have strong CON programs and have been successful in controlling bed supply, tend to have high average occupancy rates and concern about access to care. When the average industry occupancy rate is at or above 95 percent, finding appropriate beds for patients can be difficult. Medicaid patients and patients with heavy care needs may suffer discrimination. In some states there are large backlogs of patients in hospitals awaiting nursing home placement. It costs a great deal more to pay for hospital stays than to finance the more appropriate nursing home care. In such a "seller's market" the facility can essentially choose which patients to admit because beds are in short supply. Private pay patients and patients with lighter care needs may be preferred.

To tackle this problem, some states have implemented a case mix reimbursement system for Medicaid patients. Such a system provides higher reimbursement rates for patients with heavier care needs so there is an incentive to accept these patients. Other states enact laws designed to prevent Medicaid or heavy care patients from discrimination. In some states separate waiting lists for private pay patients and Medicaid patients are outlawed. In two states there is an "equalization law." If a facility is certified for Medicaid, it cannot charge private patients more than it charges Medicaid patients. This slows down the "spend down" process. Facilities may, however, take only private pay patients and charge higher rates.
In many states where Certificate of Need has been repealed without employing a moratorium or other restrictive mechanism, there has been considerable growth in the long term care bed supply and a corresponding decrease in occupancy. Low occupancy rates increase the per patient cost of providing care. An exception is New Mexico where low reimbursement for capital expenditures and an imputed occupancy have kept overbuilding in check. Freezing the property reimbursement rate at the 1981 level in Utah, however, has not seemed to discourage growth. The result of overbuilding is increased pressure to fill beds and to raise Medicaid rates. Just as in Utah, market forces have not come into play quickly following the repeal of CON in other states.

In Arizona there was rapid long term care facility growth immediately following the repeal of CON. According to Hazel Chandler, Arizona Department of Health Services, recently there have been four total bankruptcies in nursing homes, four facilities have closed due to financial difficulties, and another four have been closed due to licensure difficulties (which she believes had their roots in financial difficulties). Occupancy rates in Arizona have now increased. They were 68 to 70 percent a year ago, and are now 80 to 82 percent. Ms. Chandler believes the rate will reach 90 percent by this time next year and that the industry will stabilize.

At the opposite extreme, New York has a very formal, effective, CON program. The program was so effective, in fact, that some argue there is now an overall shortage of long term care beds. The long term care occupancy rate is over 95 percent. There is a backlog of hospitalized patients waiting for nursing home placement and 2,000 people are placed out-of-state. Similarly, Nevada, which has retained CON, has an occupancy rate of 96 to 98 percent, and has some patients placed in Utah.

A moratorium may be aimed at controlling the growth of Medicaid expenditures. In some states such a move is used to restrict institutional growth while more emphasis is put on home and community based care. For example, in Wisconsin when a facility closes, funding goes to individuals being cared for in the community.

A moratorium on construction or licensure is more effective than a Medicaid moratorium. In Minnesota, a Medicaid moratorium went into effect in 1983. Between 1983 and 1985, 1,000 new beds were built. In 1985, a moratorium on licensed beds was put into place; since then virtually no new beds have been built. In Wisconsin there was a moratorium on construction from 1981-83. Now there is an absolute cap on the number of long term care beds available. (The absolute number cannot increase beyond the 1983 level.) Wisconsin has seen a gradual reduction in the number of beds.

Texas has a moratorium on Medicaid contracted beds. Issuing the moratorium seemed to create a panic mentality. There were several conditions under which facilities could be granted an exception to the
moratorium: 1) adding ten new beds or ten percent of the total beds, 2) facilities granted CONs prior to September 1, 1985, 3) facilities with capacity of less than 60 licensed beds, 4) if the applicant had a previous Medicaid contract, or 5) if an applicant had demonstrated "substantial commitment" which included expenditures of $25,000. The number of net approved beds under all of these exceptions totaled 17,432! There were so many exceptions granted, the moratorium was of little immediate use. Texas will not experience a "real" Medicaid moratorium until the loopholes are closed in 1989. Since the moratorium does not affect licensing, additional beds for private pay patients are still being built. The Texas experience demonstrates that is important to limit the number of exceptions to as few as possible.
VIII. DIFFICULTIES WITH REINSTATING CON

While in place, the Certificate of Need program in Utah was successful in restricting the long term care bed supply. Between 1979 and 1983, there was a net increase of only 20 acute care beds along the Wasatch Front, and virtually no new long term care beds were approved. In 1983 and 1984, 99 new long term care beds were constructed. These were allowed due to the adoption of a "modified flat rate" reimbursement system for nursing homes.

CON programs that exist today vary widely by state and have differing goals and objectives as well as differing levels of power to make and enforce decisions. "Even after minimum Federal standards were enacted, there continued to be substantial variation among States in the scope of coverage, thresholds, review procedures, due process requirements and sanctions incorporated in their individual certificate of need programs." An major policy goal for such a review program is controlling health care costs. Other goals include "preserving quality of medical care and preventing geographic and income related maldistribution of institutional health services," and to "reward and protect facilities that internally subsidize socially desirable but unprofitable lines of business such as indigent care."

Since CON is a regulatory measure, it tends to have more support and be more successful in areas where the philosophy of government intervention has a strong foundation. This has not traditionally been the case in the state of Utah.

There are concerns with CON programs. Existing providers who already have a substantial market share may be able to sway the decisions of the planning agencies and use the process to protect their own investments. When major investments or new services require review, the health facility or provider that is awarded the certificate of need is virtually guaranteed a franchise. This may cause companies to submit "defensive proposals" for expansions or new services just to keep up with, or to hinder, potential competitors. "Applications may be filed as a means for preempting applications by competing institutions when, in fact, the applicant is not seriously interested in following through with the project." Such moves increase the cost to the system and lengthen the review process.


9Simpson, p. 1225.

10Simpson, p. 1225.

Another difficulty is that regulatory agencies may not be able to review thoroughly all projects, due to staffing and financial constraints. The program can be expensive and cumbersome for the state and for the applicant. Large, wealthy health care corporations can spend a considerable amount of money to prepare and defend requests. "A large and politically strong institution may easily convince an understaffed and underfinanced CON agency not to incur costs required to develop a compelling refutation. Accordingly, the agency will adopt the path of least resistance, that is approval." Even if denied, those with the resources are able to zealously pursue the appeal process. In the case of competing applications, or batched proposals, the appeal process may drag on for years. This leaves smaller health care institutions, without the financial and time resources to wage a major legal battle, or groups lacking political clout at a disadvantage.

At this time, memories of the earlier difficulties with the CON system are still fresh in Utah. The process was becoming longer and more complex. It was generally perceived as effective in controlling bed supply but less effective in other areas. The term "Certificate of Need" still engenders the memory of a program disliked by many, making it difficult to reestablish such a program.

If a capital expenditure review program is to be reinstated in Utah in the future, it would have to be less cumbersome and expensive than the previous CON system. The criteria used to determine the number and location of beds would need to be explicit and fair. Once a decision, based on the bed need criteria, is made, there should be no provision for appeal of the decision, only appeals based on the procedures followed in the course of review. It would also have to be simplified so that it would not be too expensive for the state or for the applicant.

Currently there are 12 states with no capital review program in place: Arizona, California, Colorado, Idaho, Kansas, Louisiana, Minnesota, New Mexico, South Dakota, Texas, Utah and Wyoming. Indiana dropped CON review for hospitals but retained the program for nursing homes. Texas currently has a moratorium on new Medicaid certified long term care. South Dakota implemented a moratorium on licensing new nursing home beds which coincided with the July 1, 1988, sunset date of CON. Louisiana had never had a CON program, but at the time of this writing a CON program had passed the House and Senate in Louisiana and was awaiting the Governor's signature. The program would apply only to nursing homes.

Beginning in 1983, the Utah Department of Health set forth a policy to promote price competition to control the health care market. It was estimated by most economists that 6 to 11 years would be needed to

establish the necessary market conditions. Before a capital expenditure review program is reinstated, this new policy should be given time to work and its effectiveness in controlling the market should be evaluated. Once this has been done, it may be appropriate to reinstate capital review statewide, or in the areas where the market is not effective. The competitive policy should not be abandoned, however, until it has been given a fair chance to develop.
IX. STRATEGIES TO BE EXAMINED

Any strategy to influence current conditions should have the objective of controlling cost while assuring access and high quality care for Medicaid patients.

The first option is simply to do nothing. If the current pattern is extended into the future, a likely scenario is as follows: the number of long term care beds will continue to grow, average occupancy rates will continue to decline, per unit costs will continue to rise, some nursing homes will be forced out of business, patients will have to be relocated, and the quality of care will decline. Access to care for patients will probably continue to be very good because nursing homes will need to fill empty beds. Empty beds may also allow Medicaid to provide only minimal increases in the flat rate.

A second course is to inject competitive forces into the market to foster price competition. Medicaid could contract only for the number of beds needed and allow nursing homes to submit their best bids. If such a strategy were to be followed, it would be extremely important to specify the minimum standards of care required. This strategy should serve as a signal to the industry that Medicaid will not support continued growth.

The third direction is to return to a regulatory measure, such as CON or a moratorium, to check the unrestrained growth. This would allow time for the demand for beds to catch up to the supply. There are difficulties in reinstating a capital review program like CON. The Health Systems Agencies have been dismantled. Policy makers in Utah do not favor government regulation, and past experiences with CON have left negative perceptions of this program.

The most effective strategy to handle the situation in the long term care industry is to give the industry relief from the incessant construction while assessing the feasibility of price competition. The market, as suggested by the Peat Marwick study, may need some time to stabilize. The first step is to place a Departmental moratorium on new construction or conversion of beds until the next legislative session. During this period the Department could design a competitive bidding experiment. The experiment will take place in a limited area and only involve Medicaid patients newly admitted to nursing homes. It would be designed to see if price competition in the long term care market can control cost while assuring access and high quality care for Medicaid patients.

During the legislative session a moratorium on the construction of, or conversion to, skilled and intermediate care beds could be passed. A legislative moratorium on construction and the competitive bidding project would go into effect at the same time. The moratorium would restrict new facilities from entering the market to halt the decline of occupancy rates.
Under the moratorium, only projects which had approved architectural plans and evidence that they had funded construction contracts prior to the date of the Department-initiated moratorium would be allowed to complete their projects under an exception to the moratorium. Nursing home beds proposed, built, or converted after that date would not be approved, licensed, or certified to care for long term care patients. This is to prevent corporations or individuals from "slipping in under the wire."

The rural swing bed program, which originally allowed hospitals with 50 or fewer beds to temporarily convert a few beds to provide long term care under Medicare, should be exempt from the moratorium. The program will be extended to include hospitals with up to 100 beds. Further easing of the requirements for "swing beds" should be carefully watched, however. It is important to assess whether the program is extending to the point where "swing beds" are substituting for nursing homes. If this happens, swing beds also should be included under the moratorium. Conversion of beds in general acute care hospitals, psychiatric hospitals, and other specialty hospitals to provide long term care should be included under the moratorium.

An integral portion of the plan is the implementation of a pilot project in competitive bidding. It may be necessary to apply to the federal government for a waiver of the freedom of choice requirement. This should be done as soon as possible.

The Department of Health also needs to begin collecting data on new admissions to nursing homes, to determine how many beds for which to contract initially. The Department will want to contract with the top ranked bids based on quality of care and price. The department will contract only for the number of beds needed in the area for the pilot project, so that the contracting providers will be assured of high occupancy rates. Currently the Department does not maintain records on the origin of new admissions. Patients may be readmitted for a number of reasons, including excessive leave of absence, hospital stays, change of ownership of the facility, and roll over to Medicaid coverage. There is currently no distinction made between admissions which are actually readmissions, and admissions of patients who are new to the system. These data will be needed before the actual number of contract beds can be determined. A conservative estimate of the number of new admissions by county should be made, based on the data collected. This information will then be available in time to send out the requests for proposals.

The number of patients involved in the project should be large enough to assure high occupancy rates for the facilities which successfully bid for the beds but not so large that the facilities not participating in the project are affected dramatically. The fall in occupancy in nonparticipating homes should be halted by the effect of the moratorium and by allowing some new Medicaid patients to be admitted. Nonparticipating facilities will be able to maintain current patients and also accept private patients, patients supported by Medicare, and patients not assigned to the demonstration project.
The pilot project also needs to take place in an area with a reasonable number of facilities. If the project were restricted to an area with only a handful of nursing homes, certain homes would be singled out for failure if their bids are not successful. A large enough number of nursing homes needs to be included so that the impact of the project will be to allow the nonparticipating facilities in the area of the project to retain current occupancy rates and to allow for occupancy to increase slowly over the next few years. A slow increase in occupancy should also occur in areas outside the pilot study. Facilities participating in the pilot study will increase their occupancy rates more quickly. A possible location for the pilot project would be Davis and Weber counties. Patients with a legal residence in these counties should be randomly assigned to either the demonstration project or a control group. A percentage of patients large enough to increase occupancy in the number of top bidding facilities would then be assigned to the pilot project. Those not assigned could enter a facility of their choice.

The freedom of choice waiver may not be needed if facilities which either do not bid or are not awarded a contract are allowed to participate at the awardee rate if they can assure the same level of quality. If this approach is chosen, it may be possible to include a greater percentage of new admissions in the project.

Before the project and the legislative moratorium go into effect, the Department of Health would issue Requests for Proposals, based on the Maricopa County, Arizona, model, with modifications for the structure of the present system in Utah. Facilities which provide intermediate and skilled nursing care would be allowed to bid. Intermediate care facilities for the mentally retarded (providing care levels of IMR-1, IMR-2, and IMR-3) will be excluded from the pilot project. The levels of care to be bid on will be: SNF-2, ICF-1, and ICF-2. Facilities participating in the project may also provide SNF-1 level care, but it will be excluded from the demonstration and the payment will be individually negotiated as it has been in the past.

Proposals should not be accepted from facilities where there is a history of major and substantiated violations of patient care standards, if this history can be verified, nor from those institutions with very poor facility survey track records. The type and maximum number of deficiencies allowed in the last two surveys will be specified to assure a level of high quality care. For example, if a skilled facility has had deficiencies in two conditions of participation in the last two surveys, a decertification action or an intermediate sanction reported in the last two surveys, it will not be allowed to participate. Complaints should also be investigated, and an excessive number of substantiated complaints should also exclude providers from participating in the project. It is important to keep in mind that the project must be designed to encourage price competition at an acceptable level of quality. Bids received which are below what is reasonable to provide acceptable care should be rejected.
Separate from the Department, a Ceiling Rate Committee should be established. This committee will be independent of the Department of Health, so that it is clear that the Department is not setting rates for the project. The Committee members should include individuals with expertise on nursing home costs and accounting, but should not be affiliated with any nursing home. The committee will establish ceilings for reasonable charges for care. Facilities bidding below the ceilings should be given preference.

The evaluation and selection of facilities by the Department should be final and not subject to review. The Department may reject any and all proposals submitted in response to the Request for Proposal. Contracts for those facilities successful in the bid will be finalized to coincide with the legislative moratorium.

If the number of new patient admissions (not included in the exceptions) exceeds the number of beds available in contracting facilities, the Department will then complete contracts with a facility or facilities ranked next according to the quality and price guaranteed in their bids.

The Department of Health will monitor each facility's compliance with and performance under the contract. Either party may terminate the contract with 90 days prior written notice. The Department will have the right to terminate the contract upon 24 hours notice if it deems that the health or welfare of a patient is endangered.

When the project begins, all new admissions will be screened to see if the patients should be included in the project. Several categories of patients will be excluded: patients who had previously financed their care privately but now qualify for Medicaid, patients who were Medicaid supported in a facility but had to be readmitted due to a hospital stay or an excessive leave of absence, and patients transferring from one nursing facility into the demonstration site. If the patient is to be included in the pilot project, she or he would be randomly assigned to the control or the experimental group. If a patient is assigned to the experimental group, she or he will be given the choice of any of the facilities which were successful in their bids and have completed contracts with the Department. If assigned to the control group, the patient will be able to choose any facility certified by Medicaid.

The preadmission screening process and continued stay review currently required for all Medicaid patients will also be required for all patients in the project. Facilities outside the geographic area of the project and those which either did not bid or were not chosen to participate in the project will continue to be reimbursed under the Medicaid flat rate.

The pilot project and the moratorium should be evaluated annually. The effect of the moratorium, its success in preventing construction, and its impact on access to care should be reviewed. If necessary,
amendments or revisions should be proposed. The pilot project should be examined to determine if it is cost effective for Medicaid, if high quality care standards are being maintained, and if access to care for Medicaid patients has been safeguarded. Patients, families of patients, and advocates of patients in both the experimental and control groups should be surveyed about their perception of care, and the results should be compared. Evaluations of care standards should be conducted by the Department. If necessary, changes in policies or procedures should be recommended. The impact of both moves on the Medicaid budget should also be assessed.

After two years, both the demonstration and the moratorium should be examined to determine if market forces are in place. If so, the moratorium should be discontinued. The moratorium should remain in place if market forces are not yet present. Evidence that competitive forces are in place include: (1) the extension of competitive bidding to the entire Medicaid system, or (2) use of selective contracting or competitive bidding by another payor such as a carrier of private long term care insurance.

If, at any time, average industry occupancy rates are at or above 92 percent for three consecutive months, the moratorium should be removed. If the competitive forces fail to take root, the moratorium would have a sunset date in six years regardless of the prevailing market conditions. If the moratorium has successfully prevented building, by this time the projected demand for beds should have caught up with supply.

If it is determined that the moratorium and competitive bidding project are to continue, the Department will again submit Requests for Proposals. If a facility which participated in the first part of the project does not participate in the continuation, patients in the facility will be given the choice to remain in that facility or to be relocated. If a patient chooses to remain in the facility, reimbursement will be made consistent with that for Medicaid patients not participating in the project. Periodically, patients in noncontracting facilities should be canvassed to determine if they would be interested in moving to a lower cost facility. The project should not be discontinued without also lifting the moratorium. Lifting of the moratorium, however, should not necessarily end the competitive bidding project.

This demonstration will foster the development of competitive forces. It includes a small experimental group of facilities which receive contracts for new admissions, while retaining the traditional Medicaid payment mechanism for the control group. It also allows the projected need for long term care beds to catch up to the current supply through a moratorium on new construction.
X. NEEDED FOR ADDITIONAL INFORMATION

No matter what strategy the Department follows, there is an increasing need for accurate information about the long term care environment to be collected, analyzed and made public. It is important to gather, maintain, and analyze demographic data. Projections of the number of long term care beds needed in the future should be made, based on historical utilization of specific groups. These projections should take into account the growing proportion of the population over age 85, the number of elderly living alone, the changing social environment (more women in the work force which makes them less available to care for elderly relatives). The main factors which lead to institutionalization including a high level of functional disability and the loss or absence of informal support in the community such as spouses and children.13 The projections should be made available to the public and to potential developers after a moratorium is lifted.

The Department must also collect information on admissions to nursing homes, including patient origin and destination, previous nursing home and Medicaid utilization, and level of care.

The Department of Health already collects information on occupancy rates of nursing homes. This information, too, should be made available to potential developers. After the moratorium is lifted, the State should require any developer who wants to build a new nursing home, increase or decrease bed capacity, or convert beds from or to any long term care use, to give written notice. Included should be a very brief description of the project (number of beds) and a cost estimate. This information should also be made available to the public.

XI. ADDITIONAL RECOMMENDATIONS

An area of serious concern is the nursing shortage. It is increasing the cost of providing care, raising concerns about quality of care, and increasing the stress on already overworked nurses. Such stress multiplies the burnout rate and makes the profession less attractive to potential nurses, further exacerbating the shortage. In confronting this issue, there are several areas where improvements are needed: the image of the nursing profession, opportunities for advancement, working conditions, recognition for achievement, and relationships with administrators and physicians. Overcoming these difficulties goes beyond the scope of this paper. However, encouraging projects between nursing schools and nursing homes may help to ease the difficulty of long term care facilities in attracting nurses. In addition, Utah is the only state in the nation where the applicants to nursing school exceed the number of slots available. Increasing funding to nursing schools and providing incentives to increase enrollment are important first steps toward a long range solution.

Even though the Medicaid program is likely to remain the dominant buyer of long term care services in the future, the State should still support the development of private financing alternatives. Nationally, approximately 20 percent of all elderly will be in nursing homes for some period of time. Since the risk of needing long term care is spread evenly over the population, it is logical to pool the risks of needing such care through the use of long term care insurance.

Private long term care insurance would allow individuals to contribute a small amount over time to protect themselves against the eventuality of needing long term care. Availability of such insurance could slow the rate of increase in spending on long term care by Medicaid. In order to make purchasing long term care insurance attractive, the state must first educate residents of Utah about the potential need for long term care. Many people still believe that Medicare, Medigap, or private insurance will cover the costs of a long term nursing home stay. In reality, these sources account for less than three percent of the payment for long term care! People must also be encouraged to purchase policies at a young age, so the policies will be affordable. Objective consumer information about available long term care policies must then be made public. Some long term care policies now available are fixed in both premiums and pay out. Although a pay out rate of $35 a day may help to cover the cost of a nursing home stay in 1988, when the typical individual would need the coverage in the year 2010, when the daily charge could have increased to $450.14 Such a benefit does little to cover the future cost of care. The State should

sponsor an educational campaign highlighting the potential need for long term care, the lack of financing by other payors, and the factors to consider in purchasing long term care insurance policies.

Innovative ways to provide and finance long term care will be needed for the State to cope with the challenges of an aging population. New ideas and demonstration programs should be investigated. Currently there are demonstration projects underway to test the innovative idea of a Social Health Maintenance Organization (S/HMO). It is worthwhile to investigate developing such a program in the state of Utah. All aged, blind, and disabled Medicaid recipients could be enrolled in such a program. S/HMOs would take responsibility for acute, home health, nursing home, and other social and medical services. The S/HMO would be paid on a capitation basis. As an HMO it may be able to establish contracts with hospitals and nursing homes to purchase care at a discount. The success or failure of the demonstration projects in other states should be monitored. There are several obstacles to be overcome in establishing such a program which makes it a long range solution.


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Net Change in Geriatric Beds

Figures for 1989 are based on June facility construction survey report
• Includes transitional care beds in McKay Dee hospital
  Does not include the beds in Wasatch-Hatch (156) and South Davis (80)

Medicaid flat rate introduced 07/01/82
Certificate of Need repealed 12/31/84
Projected Number of Beds Required for those 65 and Older

Based on historical utilization rates and 90% occupancy.
We, the undersigned, do hereby support the passage of SB 694 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<td>3307 Spokane St, Billings, MT 59101</td>
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<td>Ann D. Enders</td>
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<td>Marjorie H. Crick</td>
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DJT 1-30-89
We, the undersigned, do hereby support the passage of SB 3410 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<td>409 Carson Ave</td>
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<td>J. Kevin Suyk</td>
<td>3849 Midland Dr</td>
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<td>Rick Sifford</td>
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<td>3251 Maple Ave E 4th</td>
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<td>Janis Harvey</td>
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<td>112 Governors Blvd</td>
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<td>Clarence M. Zent</td>
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<tr>
<td>Karen A. Johnson</td>
<td>Karen A. Johnson</td>
<td>620 Maple Ave E 4th</td>
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<td>Evelyn Zent</td>
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<td>Dee Ann Anderson</td>
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<td>Mary Allen</td>
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<td>3933 3rd Ave S. Big E</td>
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<td>Barbara J. Hamer</td>
<td>Barbara J. Hamer</td>
<td>1639 Clark Ave Big E</td>
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<tr>
<td>Bobbi J. David</td>
<td>Bobbi J. David</td>
<td>5650 Hwy 87 N.</td>
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<td>Daniel A. Tatum</td>
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<td>Laurie J. Burd</td>
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<td>Connie M. White</td>
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<td>808 Frederick Ln</td>
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<td>Nancy Gray</td>
<td>Nancy Gray</td>
<td>903 Princeton Billings</td>
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<tr>
<td>Jack W. Chapman</td>
<td>Jack W. Chapman</td>
<td>1412 Ave E 8th Big E 8th</td>
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</table>
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

Petition

<table>
<thead>
<tr>
<th>Signature</th>
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<tr>
<td>Mr. John S. Lincoln</td>
<td>Lady of Good Works</td>
<td>525 29th St. S.</td>
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<tr>
<td>George Halak</td>
<td>Ray H. Walsch</td>
<td>5220 Ave B 3400 N.E.</td>
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<td>Agnes Miskolci</td>
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<td>Pauline Beaudet</td>
<td>Pauline Beaudet</td>
<td>803 South F. Wolf Drive 7700 S.</td>
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<td>Mary Chillington</td>
<td>Mary Chillington</td>
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<td>Yvonne Tuffin</td>
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<td>8233 2000 L Ave 500 12th St.</td>
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<td>Carol Atkinson</td>
<td>Carol Atkinson</td>
<td>8 Dillman Rd. Roundup 3401 MT</td>
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DJT 1-30-89
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<th>SIGNATURE</th>
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<td>Pat Ellison</td>
<td>165 Sky Ranch</td>
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<td>David Healong</td>
<td>Drum 6 Healong</td>
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<td>Dan E. Staley</td>
<td>Copy E. Staley</td>
<td>1607 215 St West</td>
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<td>RITA TURLEY</td>
<td>114 White Circle</td>
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<td>Reagan Litzinger</td>
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<td>833 Northen Bldgs 5910</td>
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<td>William J. Pliny</td>
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<td>Jill Penwell</td>
<td>Jill Penwell</td>
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</table>

D/JT 1-30-89
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<tr>
<td>M. Wolf</td>
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<td>Jan Christensen</td>
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<td>Mildred Woods</td>
<td>5515 Havil</td>
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<td>Judy Perciv</td>
<td>6111 Pay with lip</td>
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<td>James E. Elam</td>
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<td>Sharon Tripp</td>
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<td>Kathy Myers</td>
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<td>Phyllis LeDeseau</td>
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<td>Deborah Smoot</td>
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<td>A. Fisher</td>
<td>Arlette Fisher</td>
<td>517 Riverside</td>
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<tr>
<td>C. Larson</td>
<td>Candie Larson</td>
<td>332 Phillip</td>
</tr>
</tbody>
</table>
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE   PRINTED NAME   ADDRESS
Dan Vinkeli   Dan Boehler   2411 Howard Billings
David Pearl   David Parke   40113 N. 11th St. Billings, MT
Janet Wagner   Janet Wagner   2794 Phyllis Circle, Sa
Joan Ganthier   Joan Ganthier   2701 Animas Pass, MT
Holly Green   Nancy McDaniel   1161 Lander, 59341
Holly Green   Nancy McDaniel   1161 Lander, 59341
Jerry L. Bower   Jerry L. Bower   720 Humid Ave.
Patty Fuchs   Patricia Fuchs   304 Pah. 1189, MT
David Huntley   David Huntley   3015 West, Billings
Wanda Gallentine   Wanda P. Gallentine   2311 Oldham, 59323
Wilma Peterson   Wilma Peterson   2720 Beechwood, MT
Doug Stoddard   Doug Stoddard   2924 45 Ave So.
Leah Billinger   Fern Billinger   373 Underwood
Dan Rogers   Dan Rogers   231 Hiller
Kurt Mcaulay   Kurt Mcaulay   1107 1/2 north 9th St.
Rob Fanning   Rob Fanning   1731 Yellowstone Ave
Michael Hewitt   Michael Hewitt   4803 Hazelwood Ave
Rudy A. Moortz   Rudy A. Moortz   593 Cedar
Pete Orman   Pete Orman   1241 North 34th
Spencer Smith   Spencer Smith   1600 Lakeshore Drive
Virginia A. Kern   Virginia A. Kern   4304 S. Frontage
Sister Marian Berry   Sister Marian Berry   1333 N. 30th St.
Sister Valerie McGough   Sister Valerie McGough   402 Wythe Ave, Billings
Lynn Massey   Lynn Massey   3800 St. Leon,
Dara May Abbe   Dara May Abbe   3301 Stone Blvd. Billings
Helein M. McPhee   Helen M. McPhee   2721 Glenwood Ln
Phil Tilley   Phil Tilley   721 Cross Billings
Evelina Chinen   Evelina Johnson   286 Wester
Lee Bradshaw   Sue Bradshaw   80 Plateau Ave.
Gene Mccall   Gene Mccall   301 Colfax Ave.
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<td>Janet L. Olson</td>
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<td>Margaret M. Fiedler</td>
<td>Margaret Fiedler</td>
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<td>Dolly Homme</td>
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<td>MARY M. MAPP</td>
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<td>Vonni L. Fletcher</td>
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<td>Marilyn M. Reid</td>
<td>DONNA M. REID</td>
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<td>MARY J. MUNSELL</td>
<td>69 Bannock Circle, Miles City</td>
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<td>Marilyn Dunne</td>
<td>MARY L. DUNNE</td>
<td>54 Shadow Glen</td>
</tr>
<tr>
<td>Kathleen James</td>
<td>KATHLEEN L. JAMES</td>
<td>Box 21557 BILLINGS</td>
</tr>
<tr>
<td>Connie M. Tipton</td>
<td>CONNIE M. TIPTON</td>
<td>517 Berry Hill Blvd. BILLINGS</td>
</tr>
<tr>
<td>Wanda L. Hartman</td>
<td>WANDA L. HARTMAN</td>
<td>4323 Cloverhill Ave. BILLINGS</td>
</tr>
<tr>
<td>Lesley L. Green</td>
<td>LESLEY L. GREEN</td>
<td>543 W. HOMESTEAD LAKE</td>
</tr>
<tr>
<td>Patricia Fiedler</td>
<td>PATRICIA FIEDLER</td>
<td>1455 South 54th Ave. BILLINGS</td>
</tr>
<tr>
<td>Donna L. Fiedler</td>
<td>DONNA L. FIEDLER</td>
<td>3827 37th Ave. BILLINGS</td>
</tr>
<tr>
<td>Martha L. Schulz</td>
<td>MARTHA L. SCHULZ</td>
<td>511 Acadia Place. BILLINGS, MT 59101</td>
</tr>
<tr>
<td>Paul Hartman</td>
<td>PAUL HARTMAN</td>
<td>BILLINGS MT 59102</td>
</tr>
<tr>
<td>Reba Speckman</td>
<td>REBA SPECKMAN</td>
<td>1425 Broad Ave. BILLINGS</td>
</tr>
<tr>
<td>Deborah I. Tierney</td>
<td>DEBORAH I. TIERNEY</td>
<td>2304 32nd St. W. BILLINGS</td>
</tr>
</tbody>
</table>

Dated 1-30-89
I, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Eileen E. Heisinghaus</td>
<td>Eileen E. Heisinghaus</td>
<td>420 W. 2nd St. Missoula, MT 59801</td>
</tr>
<tr>
<td>Edith P. Allen</td>
<td>Edith P. Allen</td>
<td>1106 Locust Missoula, MT 59801</td>
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<tr>
<td>Ellen J. Black</td>
<td>Ellen G. Gibb</td>
<td>5040 E. 29th Street Missoula, MT 59801</td>
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<tr>
<td>Catherine B. Beene</td>
<td>Catherine R. Beene</td>
<td>521 E. 4th St. Missoula, MT 59801</td>
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<tr>
<td>Karen A. Sauter</td>
<td>Karen A. Sauter</td>
<td>432 E. 4th St. Missoula, MT 59801</td>
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<tr>
<td>Kathy Boucher</td>
<td>Kathy Boucher</td>
<td>311 Broadway Missoula, MT 59801</td>
</tr>
<tr>
<td>Marie Freid</td>
<td>Marie Freid</td>
<td>509 W. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Madde Dodge</td>
<td>Madde Dodge</td>
<td>4444 E. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Sylvia Duncan</td>
<td>Sylvia Duncan</td>
<td>615 S. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Joyce Fletcher</td>
<td>Joyce Fletcher</td>
<td>723 S. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>ROSE S. G.</td>
<td>ROSE S. G.</td>
<td>941 16th Avenue Missoula, MT 59801</td>
</tr>
<tr>
<td>Alice Kober</td>
<td>Alice Kober</td>
<td>1039 N. 30th Street Missoula, MT 59801</td>
</tr>
<tr>
<td>Donald O'Neill</td>
<td>Donald O'Neill</td>
<td>2009 Austin Street Missoula, MT 59801</td>
</tr>
<tr>
<td>Marija O'Neill</td>
<td>Marija O'Neill</td>
<td>900 W. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Marie Sullivan</td>
<td>Marie Sullivan</td>
<td>308 W. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Mary Co. Miller</td>
<td>Mary Co. Miller</td>
<td>3724 Hannah Drive Missoula, MT 59801</td>
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<tr>
<td>Marie Bergman</td>
<td>Marie Bergman</td>
<td>344 Whitefish Rd. Missoula, MT 59801</td>
</tr>
<tr>
<td>Ersa D. French</td>
<td>Ersa D. French</td>
<td>444 E. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Betty L. Erickson</td>
<td>Betty L. Erickson</td>
<td>5229 Bayard St. Missoula, MT 59801</td>
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<tr>
<td>Ethel Ellis</td>
<td>Ethel Ellis</td>
<td>150 Broadway Missoula, MT 59801</td>
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<tr>
<td>Betty Brown</td>
<td>Betty Brown</td>
<td>315 North 2nd Missoula, MT 59801</td>
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<tr>
<td>Ann Leischner</td>
<td>Ann Leischner</td>
<td>411 W. 2nd St. Missoula, MT 59801</td>
</tr>
<tr>
<td>Kim Han</td>
<td>Kim Han</td>
<td>1200 W. 2nd St. Missoula, MT 59801</td>
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<tr>
<td>Audrey Hansieck</td>
<td>Audrey Hansieck</td>
<td>3081 Burlington Rd. Missoula, MT 59801</td>
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<tr>
<td>Marie Roll</td>
<td>Marie Roll</td>
<td>7 W. Haagen St. Bigfork, MT 59911</td>
</tr>
<tr>
<td>Mary Andrea</td>
<td>Mary Andrea</td>
<td>1130 W. 2nd St. Missoula, MT 59801</td>
</tr>
<tr>
<td>Doris Hamilton</td>
<td>Doris Hamilton</td>
<td>334 E. 2nd St. Missoula, MT 59801</td>
</tr>
</tbody>
</table>

DJT 1-30-89
We, the undersigned, do hereby support the passage of SD 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE   PRINTED NAME   ADDRESS

Bill Lavel  Bill Land  Box 71  Lame Deer Mt.
Ed Ryan  Ed Ryan  918 Constitution Ave  Billing
Thomas Patterson  Thomas Patterson  1339 Lynne Ave  Bill
Timothy Stiver  Timothy Stiver  4020 Redbud  Bill
Dorothy Braun  Dorothy Braun  3960 Johnson Bl
Dorothy Fleet  Dorothy Fleet  3015 South Bill
Mary Maggard  Mary Maggard  119 Thomas St  Bill
Donnie Miller  Donnie Miller  4522 Greely
Sue Anne Kems  Shirley McNeil  845 Park Place
Susan Hart  Suzanne Hart  1303 N  30 St
Ida Heaven  Ida Heaven  945 N  3rd
Bobbi Jobb  Bobbi Jobb  #6 Headtown
Mary Welch  Mary Welch  305 Manchester Dr
John R Butler  John R Butler  525 8th publicity
Julie June Donnel  Julie June Donnel  1017 8th
Raymond H Lewis  Raymond H Lewis  Box 85  Rome
Evelyn Shields  Evelyn Shields  845 Terry Ave
Evelyn Shields  Evelyn Shields  3295 Craney Ave E
John Trelin  John Trelin  24th St  840 Kelly
Eva M Speck  Eva M Speck  3849 Mallard
John Trelin  John Trelin  909 Wicks Dr
Deann Downs  Deann Downs  560 Brown
Glenn Hardy  Glenn Hardy  Billing MT
Mary A Ballard  Mary A Ballard  Shepherd MT
Angela Biebracht  Angela Biebracht  1741 Lord St  Bill
Bonnie Price  Bonnie Price  130 Wyoming
Dawn M Stewart  Dawn M Stewart  331 Fairfield
Connie L Dyke  Connie L Dyke  971 Oxford
Evelyn D  Owen  Evelyn D Owen  Box 16  South
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

<table>
<thead>
<tr>
<th>Signature</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Mary Jane Riley</td>
<td>Marilyn Louis</td>
<td>2333 Higher Heights</td>
</tr>
<tr>
<td>Elmer Nelson</td>
<td>Paul F. Nelson</td>
<td>1202 Crawford St.</td>
</tr>
<tr>
<td>Jane B. Kennedy</td>
<td>Gemma E. Kennedy</td>
<td>2380 Heilman Ct.</td>
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<tr>
<td>Joanne Evans Jorgenson</td>
<td>Paul J. Jorgenson</td>
<td>3210 Montana Blvd.</td>
</tr>
<tr>
<td>Timothy D. Foster</td>
<td>Edward J. Foster</td>
<td>3020 Fitts Rd.</td>
</tr>
<tr>
<td>Benjamin R. Sheard</td>
<td>Barbara Coddington</td>
<td>2218 Coddington St.</td>
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<tr>
<td>Kathleen R. Zachert</td>
<td>Katherine Zachert</td>
<td>2333 Green Rd.</td>
</tr>
<tr>
<td>Chrystal Ball</td>
<td>Terry Ball</td>
<td>4601 Aniest Blvd</td>
</tr>
<tr>
<td>Robert Slaven</td>
<td>Sheilah Slaven</td>
<td>1021 Montana Blvd.</td>
</tr>
<tr>
<td>Ken McQ</td>
<td>Helen McQ</td>
<td>1216 Montana Blvd.</td>
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<tr>
<td>Helen J. Fuller</td>
<td>Theifsa Fuller</td>
<td>3221 11th Ave.</td>
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<tr>
<td>Wilma Jean Richardson</td>
<td>Helen F. Richardson</td>
<td>2384 West Blvd.</td>
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<tr>
<td>Julie Janssen</td>
<td>Julie Janssen</td>
<td>283 Nubia St.</td>
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<tr>
<td>James D. Penny</td>
<td>2012 11th Ave. Bridge, MT 59101</td>
<td></td>
</tr>
<tr>
<td>R. Dew Lynn</td>
<td>R. Dew Lynn</td>
<td>3334 California Dr.</td>
</tr>
<tr>
<td>Steve McQ</td>
<td>Steve McQ</td>
<td>7266 Elm.</td>
</tr>
<tr>
<td>Linda Baugh</td>
<td>Linda Baugh</td>
<td>2441 Teton Ave. 59102</td>
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<tr>
<td>Margaret L. English</td>
<td>Margaret S. English</td>
<td>583 Green St.</td>
</tr>
<tr>
<td>Dorothy M. Hare</td>
<td>Dorothy E. Hare</td>
<td>312 Kootenay, Boz Mt</td>
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<tr>
<td>Michelle A. Byer</td>
<td>Michelle A. Byer</td>
<td>1034 Kansas Ave. 59101</td>
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<tr>
<td>Christine O'Leary</td>
<td>Christine O'Leary</td>
<td>1029 Kansas Ave.</td>
</tr>
<tr>
<td>Laura B. Hendricks</td>
<td>Laura B. Hendricks</td>
<td>1340 Lawrence Ave.</td>
</tr>
<tr>
<td>Beverly Tieszen</td>
<td>Beverly Tieszen</td>
<td>1637 Yellowstone Cir</td>
</tr>
<tr>
<td>Nancy E. Harrison</td>
<td>Nancy E. Harrison</td>
<td>385 Wyoming Ave.</td>
</tr>
<tr>
<td>George F. F.</td>
<td>George F. F.</td>
<td>3023 Montana Blvd.</td>
</tr>
<tr>
<td>Donald J. Y.</td>
<td>Donald J. Y.</td>
<td>3215 5th Ave.</td>
</tr>
<tr>
<td>Ethel H. N.</td>
<td>Ethel H. N.</td>
<td>2132 Trails End</td>
</tr>
</tbody>
</table>
We, the undersigned, do hereby support the passage of SB 598 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

MARY P. SCHNEIDER, 919 E. Mt.
9th Scheidlin
NI. Schneider 919 E. Billings 59
Herman Scheidlin 911 E. Billings 59
Herman Scheidlin 911 E. Billings 59
Herman Scheidlin 911 E. Billings 59
Herman Scheidlin 911 E. Billings 59
Herman Scheidlin 911 E. Billings 59
Herman Scheidlin 911 E. Billings 59
SHIRLEY McFARLAND, 1912 E. Billings 59
JIM BECKER 1838 Lincoln 64
SUE WINTHALL 1620 W. Hill Ave.
LIVINGSTON McCAULIFFE 1626 W. Hill Ave.
ELIZABETH GRACE 237 Main St.
LISA RUFFIN 1117 Dean St.
Melinda Allphin 326 E. Billings 59
Mary E. Ellis 696 E. Billings 59
SUSAN TELFORD 1893 E. Billings 59
MRS. NELSON 1312 W. Highland 59
MIKE ELLIOTT 1639 W. Highland 59
MARGARET BURTON 1709 Oakes St.
KENNETH KALONDA 2410 S. Park Dr. 59106
MALISSA ROBYN 2938 S. Iowa 59102
TAMMY LET BEAVERS 1331 S. Park Dr. 59106
CHARLOTTE FANNIN 1731 Yellowstone 59101
PAMELA C. ROSS 3836 Oakland 59102
CINDY HALL 2413 Grand Ave. 59102
ELON KALIN 1236 REESE DR. 59105
CAROL PETROWITZ 619 Ave. B. Billings
MARGARET MARTIN 1440 Palisades Park
MICHAEL G. LESTER 3912 Tarrant Ave.
BRENT HUFF 110 W. Hickman St.
PAUL SCHUNK 8412 Shepherd Pk.
WILL MRS. GREEN 934 E. Billings 59
We, the undersigned, do hereby support the passage of SB 452 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

We, the undersigned, do hereby support the passage of SB 452 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE                        PRINTED NAME                        ADDRESS

Pete Sondreal                  Liz Butz                36 W. Fairview
Vivian Frank                  Vivian Frank             Main Street 139 C
Norah E. Smith                 Danene Lukin              1807 Belvedere Dr
Franzene Vancourt              Frances Vancourt          234 Cherry St.
Charles Wilson                 Liz Myers                30-36 1st St.
Sister Eilene                   Linda E. Myers           31-36 1st St.
Vivien M. Stotensteig         Vivien M. Stotensteig      1700 Harvard
Sister Dorothy                 Sister Dorothy            134 N. 31

ADAM L. SCHWARTZ                 ANNA M. SO.              124 W. 5th Lane Bldg.

James Miller                   Leslie Miller            117 W. Main St.

Dorothy Edel                 David Hareton             5th Roosevelt

Velma Fielder                   Mary Kalbey              Argyle State Home


delina J. Durley                Geraldine Holley           Miscon

Laura Wilcox                   Laura Weber               201 North St.

Ed Knights                     Ed Krafter               243 Nebraska

Annie Bunn                    522 2nd Avenue

Sandra Almond                  Sandra Almond            3206 Avenue A

James Almond                   James Almond            3206 Avenue A

J. Campbell                   Kelly Campbell            1022 Antwerps

William Walker                Billie O. Walker          35 Prince Albert

Gene Brand                    Gene Harn                428 Custer

Frances Hecker                Frances Hecker           Melbourne, NY

Victoria Winn                   Victoria Winn            910 14th St. W. #226

Valerie Geist                   Valerie Geist           274 Suburban Drive

Althea Dicke                   Althea Dicke            1423 5th Ave. E

Diana Pearson                  Diana Pearson            2514 Coe Ave

Penny Barrand                  Penny Barrand            4114 Larimer

James E. Buns                James A. Buns            409-18th W. Parks


**SIGNATURE**  | **PRINTED NAME**  | **ADDRESS**  
--- | --- | ---  
Colette I. McCauley | Elizabeth Lockner | 3003 Blackbird  
Jill P. Bell | Julie Bell |  
James L. Johnson | Joseph C. Brinkley | 1200 North  
Darwin L. Smith | William A. Shery |  
Thomas J. Anderson | Forrest J. Wallin |  
K. Hunt | Maxine Higgin |  
Marilyn Bell | Mary Beth Bel  
John C. Culver | Alex C. Seef | Broadwater  
John F. Condit | Richard G. Baker |  
D. L. Cooney | W. A. Moore |  
P. S. McCutcheon | Rosemary Matlock | mc-3073738  
Haroldine Jones | Geraldine Cross | 16 Mountain Lynn  
Ingrid M. Dool | Linda Brower |  
Fred Backus | Fred Lehman |  
William E. Ford | Timothy Birkle |  
Barbara J. Day | Barbara Willey | Billings MT 59102  
Juneteenth Blass | Joan Bumgarner |  
Zade Lining | Zeda Lining |  
Kent T. Swift | Kent T. Swift |  
James O. Tabor | James O. Palmer |  
Dona M. Trace | Donna M. Trace |  
E. W. Miller | Stan McElhinney |  
Lorraine Prudhomme | 8222 Rendisburg Dr  
Eloise Reed | Eloise Y. Reed | 907 Howard Ave  
Ila White | Ila White | 1638 Howard AVE.
We, the undersigned, do hereby support the passage of SB 340, the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.
PETITION

We, the undersigned, do hereby support the passage of SB 346 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE          PRINTED NAME      ADDRESS
Mary Jane East      Mary Jane East      2225 Willowbrook
Ron Fischer         Ron Fischer         Billings, MT 59102
Audra Miller        Sandra Miller       931 Lark, #201
Phyllis Farmer      Doris Winder       970 E. 3rd Ave
Crystal Deutchler   Cindy S. Neuscher  418 S. Hibb
Don Buckley         Don Buckley         4220 King Ave. East
Lynne Kennedy       Janie W. Jones     106 W. Third Ave
Barbara Tyrell      Barbara Tyrell     20 R. H. Nelson
J. Sawka            J. Sawka            2405 7th Ave
Ray Marsh           Ray Marsh           2320 Cascade
Jim Hews            Jim Hews           438 Recher Hill Blvd
Connie Martin       Gary Hoffman       3759 Lakeview Ave
Janice Jaramouchy   Janice Jaramouchy  30095 Kingsridge Dr
We, the undersigned, do hereby support the passage of SB 325 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
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<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise Anderson</td>
<td>Mary Eggum</td>
<td>6713 Winding Rose Ranch</td>
</tr>
<tr>
<td>Leslie Croy</td>
<td>Mary Eggum</td>
<td>6713 Winding Rose Ranch</td>
</tr>
<tr>
<td>Mildred Warren</td>
<td>Mildred Warren</td>
<td>213 Central Ave.</td>
</tr>
<tr>
<td>Joan Fitfield</td>
<td>Joan Fitfield</td>
<td>1538 Howard</td>
</tr>
</tbody>
</table>

EXHIBIT 7
DATE 3-3-89
HB 340
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<th>SIGNATURE</th>
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<tbody>
<tr>
<td>Ken Burt</td>
<td>Judy Burt</td>
<td>1516 Cook</td>
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<tr>
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<td>1516 Cook</td>
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<tr>
<th>SIGNATURE</th>
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<tbody>
<tr>
<td>John J. McPhail</td>
<td>Elmer E. Kobold</td>
<td>1004 Emerson Rd</td>
</tr>
<tr>
<td>Elmer E. Kobold</td>
<td>John D. Middleton</td>
<td>500 30th St</td>
</tr>
<tr>
<td>John H. Cook</td>
<td></td>
<td>1831 Madison</td>
</tr>
<tr>
<td>Dennis L. Engen</td>
<td></td>
<td>526 Montana Ave</td>
</tr>
<tr>
<td>Doris L. Madison</td>
<td>Bennie L. Whitman</td>
<td>3637 Jay St</td>
</tr>
<tr>
<td>George E. Erickson</td>
<td>George L. Erickson</td>
<td>201 Golden Field</td>
</tr>
<tr>
<td>Evonne Heflin</td>
<td>Julian J. McPhail</td>
<td>2112 Woodland Drive</td>
</tr>
<tr>
<td>Julian J. McPhail</td>
<td></td>
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EXHIBIT ______
DATE ______
HB ______
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PETITION

We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE  PRINTED NAME  ADDRESS

[Signatures and printed names filled in]

EXHIBIT

DATE

HB
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

[Signatures]

Signature: Jane McCall
Printed Name: Jane Brusseau
Address: 2119 Broadway
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON legislation for hospitals only.

SIGNATURE
Richard Anderson

PRINTED NAME
Richard Anderson

ADDRESS
1234 Main St, Bozeman, MT 59718
We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

SIGNATURE  PRINTED NAME  ADDRESS
Paula Ludlum  MEAL B. SCHAFFER  1220 4th St
Lee Bergman  CELIZ BENNET  1230 3rd Billing
Pamela J. Sheld  Pamela J. Sheld  1230 N 3rd Pl Pk
Phyllis Whitescull  PHYLLIS WHITESCULL 133 Ave F
J. Patrick Byrne  J. PATRICK BYRNE  1230 N 3rd Pl Pk
Shirley Dyce  SHIRLEY DYCE  1230 1st Ave S
Laurene Faught  LAURENCE FAUGHT  2522 CLARK

DATE
HB
We, the undersigned, do hereby support the passage of SB 376 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

**SIGNATURE**

**PRINTED NAME**

**ADDRESS**

---

[Signature: Yvonne Nagele]

[Printed Name: Neil L. Meyer]

[Address: 3101 Fairview]

---

[Signature: Dona I. Schumacher]

[Printed Name: Ginnie L. Kenney]

[Address: 100 Airport Road]

---

[Signature: Kim Woodman]

[Printed Name: Kim Woodman]

[Address: 1701 Coon Road]
We, the undersigned, do hereby support the passage of SB 240 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>N. O. LeRoi</td>
<td>Kenneth O. LeRoi</td>
<td>2234 Magnolia Ave.</td>
</tr>
<tr>
<td>Lillian H. Warren</td>
<td>Richard E. Warren</td>
<td>3212 South Highland</td>
</tr>
<tr>
<td>Kathryn J. Warren</td>
<td>Kathy J. Warren</td>
<td>203 Josephine A. Pl.</td>
</tr>
<tr>
<td>Emma E. LeRoi</td>
<td>Emma E. LeRoi</td>
<td>2222 Millen Dr.</td>
</tr>
<tr>
<td>David More</td>
<td>David More</td>
<td>1801 Montana</td>
</tr>
<tr>
<td>Fred Schneider</td>
<td>Fred Schneider</td>
<td>3221 Country Club</td>
</tr>
<tr>
<td>Frank M. McDade</td>
<td>Frank M. McDade</td>
<td>1225 5th St.</td>
</tr>
<tr>
<td>Susan E. Davis</td>
<td>Susan E. Davis</td>
<td>1235 2nd St.</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Jenny Jackson</td>
<td>AT Sherard</td>
<td>1575 Community</td>
</tr>
<tr>
<td>Karen Novosic</td>
<td>Brenda S.</td>
<td>1600 Clark</td>
</tr>
<tr>
<td>Linda King</td>
<td>Linda K.</td>
<td>1547 Kendall</td>
</tr>
<tr>
<td>Brenda Mead</td>
<td>Brenda A.</td>
<td>718 N 2nd St</td>
</tr>
<tr>
<td>Charlene Spear</td>
<td>Charlene S.</td>
<td>1506 Thompson Blvd</td>
</tr>
<tr>
<td>Carol J. Allen</td>
<td>Carol J.</td>
<td>3329 Bumrock Rd</td>
</tr>
<tr>
<td>Linda G. Rand</td>
<td>Linda G.</td>
<td>3329 Bumrock Rd</td>
</tr>
<tr>
<td>Edward H. Barnes</td>
<td>Edward H.</td>
<td>505 5th St</td>
</tr>
<tr>
<td>Mary J. Kramer</td>
<td>Mary J.</td>
<td>7185 Chicago 5th Floor</td>
</tr>
<tr>
<td>Carol H.</td>
<td>Carla H.</td>
<td>4916 Caravan Blvd 59</td>
</tr>
<tr>
<td>Rosemary Olver</td>
<td>Rosemary O.</td>
<td>4903 Havens Park Blvd 59</td>
</tr>
<tr>
<td>Becky Turner</td>
<td>Becky L.</td>
<td>2515 Montana Blvd 59</td>
</tr>
<tr>
<td>Kathy Bennett</td>
<td>Kathy B.</td>
<td>283 Ashland Blvd 59</td>
</tr>
<tr>
<td>Vicki Mckee</td>
<td>Vicki M.</td>
<td>2400 Howard Blvd 59</td>
</tr>
<tr>
<td>Anne Lintz</td>
<td>Anne L.</td>
<td>285 Wyoming Blvd 59</td>
</tr>
<tr>
<td>Annie Jones</td>
<td>Annie J.</td>
<td>3101 7th Ave Blvd 59</td>
</tr>
</tbody>
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SIGNATURE                         PRINTED NAME                        ADDRESS

Jean Clark                       Jean Clark                       132 Clark Blvd.

John A. Lindsey                   John A. Lindsey                   1121 E. 2nd St.

Mary Jones                        Montana Teacher                   2001-2003 1st Ave.

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<tbody>
<tr>
<td></td>
<td>L. J. Brentford</td>
<td>2920 Rowndale Blvd</td>
</tr>
<tr>
<td></td>
<td>Dee Daniel</td>
<td>1409 Thomas Dr</td>
</tr>
<tr>
<td></td>
<td>Wildlife Hospital</td>
<td>WYoming, 715 S. 39th</td>
</tr>
<tr>
<td></td>
<td>Gary Holle</td>
<td>10460 W. Loma, BLS</td>
</tr>
<tr>
<td></td>
<td>Mary J. MacIntyre</td>
<td>5254 Francis Ave</td>
</tr>
<tr>
<td></td>
<td>Elsie Heideman</td>
<td>3009 Bluebird</td>
</tr>
<tr>
<td></td>
<td>Frances C. Allen</td>
<td>12957 Fellowship</td>
</tr>
<tr>
<td></td>
<td>Patricia M. Biski</td>
<td>43 W. Lake Rd</td>
</tr>
<tr>
<td></td>
<td>R. W. Calkin</td>
<td>1205 Bench Blvd</td>
</tr>
<tr>
<td></td>
<td>Gertrude M. Calkin</td>
<td>1205 Bench Blvd</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Kathy Berscheid</td>
<td>Kathy Berscheid</td>
<td>311 Hickory Blgs</td>
</tr>
<tr>
<td>Frederick Kahn</td>
<td>Frederick Kahn</td>
<td>3003 W. McDonald</td>
</tr>
<tr>
<td>Karla Brunan</td>
<td>Karla Brunan</td>
<td>5506 Billy Casper</td>
</tr>
<tr>
<td>Judith A. Burns</td>
<td>Judith A. Burns</td>
<td>5506 Billy Casper</td>
</tr>
<tr>
<td>Lianne M. Moyer</td>
<td>Lianne M. Moyer</td>
<td>3501 Lindahl Cir</td>
</tr>
<tr>
<td>Marilyn Whitley</td>
<td>Marilyn Whitley</td>
<td>1230 Chief Rd.</td>
</tr>
<tr>
<td>Arlene E. Ferrar</td>
<td>Arlene E. Ferrar</td>
<td>1111 Beach Rd.</td>
</tr>
<tr>
<td>Kelly Castro</td>
<td>Kelly Castro</td>
<td>4644 Route 240</td>
</tr>
<tr>
<td>Lucie Martin</td>
<td>Lucie Martin</td>
<td>3533 St. Johns</td>
</tr>
<tr>
<td>Lori Hedges</td>
<td>Lori Hedges</td>
<td>3541 Granger Dr.</td>
</tr>
<tr>
<td>Sherry L. Hamilton</td>
<td>Sherry L. Hamilton</td>
<td>1145 N. 29th St.</td>
</tr>
<tr>
<td>William S. Smith</td>
<td>William S. Smith</td>
<td>1145 N. 29th St.</td>
</tr>
<tr>
<td>Terry A. Bower</td>
<td>Terry A. Bower</td>
<td>1123 N. 1st St.</td>
</tr>
<tr>
<td>Thomas C. Thompson</td>
<td>Thomas C. Thompson</td>
<td>2504 Wildwood Rd.</td>
</tr>
</tbody>
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<tr>
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</thead>
<tbody>
<tr>
<td>J. Walter</td>
<td>L. F. C. Grimm</td>
<td>Twin Falls</td>
</tr>
<tr>
<td>Don Rights</td>
<td>Don Rights</td>
<td>Billings</td>
</tr>
<tr>
<td>Marilyn Meyer</td>
<td>Marilyn Meyer</td>
<td>Billings</td>
</tr>
<tr>
<td>Maxine Schmidt</td>
<td>Maxine Schmidt</td>
<td>Billings</td>
</tr>
<tr>
<td>Karen Wilson</td>
<td>Karen Wilson</td>
<td>Billings</td>
</tr>
<tr>
<td>Walter Tuley</td>
<td>Walter Tuley</td>
<td>Billings</td>
</tr>
<tr>
<td>Brenda King</td>
<td>Brenda King</td>
<td>Billings</td>
</tr>
<tr>
<td>Patrick Crumley</td>
<td>Patrick Crumley</td>
<td>Billings</td>
</tr>
<tr>
<td>Tom J. Hill</td>
<td>Tom J. Hill</td>
<td>Billings</td>
</tr>
<tr>
<td>Mitch Gallagher</td>
<td>Mitch Gallagher</td>
<td>Billings</td>
</tr>
</tbody>
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<tbody>
<tr>
<td></td>
<td>N. W. Kolpin</td>
<td>501 4th Street, Ennis, MT 59729</td>
</tr>
<tr>
<td></td>
<td>M. N. Callen</td>
<td>1000 Main Street, Helena, MT 59622</td>
</tr>
<tr>
<td></td>
<td>J. L. Knight</td>
<td>105 Missoula Ave, Butte, MT 59701</td>
</tr>
<tr>
<td></td>
<td>W. G. Shepard</td>
<td>106 19th St, Bozeman, MT 59715</td>
</tr>
</tbody>
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Harold B. Mueller</td>
<td>Harwell Hospital, Miles City, MT</td>
</tr>
<tr>
<td></td>
<td>Trygve Alme</td>
<td>6400 Pritchett, Glendive, MT</td>
</tr>
<tr>
<td></td>
<td>Jerry Dawson</td>
<td>3206 37th St., Billings, MT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Geneva, 5516 Broadway Blvd, Missoula, MT</td>
</tr>
<tr>
<td></td>
<td>Mariner Marine</td>
<td>苦味: STEVER. B. BIRCHER</td>
</tr>
<tr>
<td></td>
<td>W. J. Kersel</td>
<td>3714 17th St., Missoula, MT</td>
</tr>
<tr>
<td></td>
<td>Donald Powers</td>
<td>4537 Toya de Oles, Billings, MT</td>
</tr>
</tbody>
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We, the undersigned, do hereby support the passage of SB 340 - the Certificate of Need (CON) compromise bill introduced by Senator Williams at the request of the Montana Hospital Association. This bill recommends the elimination of CON regulation for hospitals only.

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<tbody>
<tr>
<td>William B. Lyons</td>
<td>William B. Lyons</td>
<td>234 Fair Park Dr</td>
</tr>
<tr>
<td>Gerald J. Murphy</td>
<td>Gerald J. Murphy</td>
<td>420 Nelson Ave</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Cheryl Oliver</td>
<td>Kasley Jones</td>
<td>4029 Robbin Lane</td>
</tr>
<tr>
<td>George Anglea</td>
<td>George Anglea</td>
<td>2000 Northside Billings MT</td>
</tr>
<tr>
<td>Bernice Larson</td>
<td>Bernice Larson</td>
<td>2014 Silver Sage Trail Billings MT</td>
</tr>
<tr>
<td>Mary McPhail</td>
<td>Marg McPhail</td>
<td>4139 Audubon Way Billings MT</td>
</tr>
<tr>
<td>Sue Zook</td>
<td>Sue Zook</td>
<td>484 Lemoujon</td>
</tr>
<tr>
<td>Otto Houchen</td>
<td>Otto Houchen</td>
<td>1824 Calumet</td>
</tr>
<tr>
<td>Martin Fisher</td>
<td>Martin Fisher</td>
<td>116 N 36th St. Biggs</td>
</tr>
<tr>
<td>Sue K. Knie</td>
<td>Sue K. Knie</td>
<td>1351 Hardrock Lane</td>
</tr>
<tr>
<td>Vic Brown</td>
<td>Vic Brown</td>
<td>111 Stillwater</td>
</tr>
<tr>
<td>Eric D. Jensen</td>
<td>Eric D. Jensen</td>
<td>165 Windermere Cutoff</td>
</tr>
<tr>
<td>Tray Scrivner</td>
<td>Tray Scrivner</td>
<td>2040 Buerstead #300</td>
</tr>
<tr>
<td>Jeanne Krule</td>
<td>Jeanne Krule</td>
<td>3023 36th West Billings MT</td>
</tr>
<tr>
<td>Jo Olenburger</td>
<td>Jo Olenburger</td>
<td>7105 Rockwood</td>
</tr>
<tr>
<td>Ardella Mack</td>
<td>Ardella Mack</td>
<td>1218 Rolling St.</td>
</tr>
<tr>
<td>Joanne Card</td>
<td>Joanne Card</td>
<td>2207 Pueblo Dr.</td>
</tr>
<tr>
<td>Eugene Fletcher</td>
<td>Eugene Fletcher</td>
<td>1119 Princess Billings MT</td>
</tr>
</tbody>
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SIGNATURE

W. Jewett

PRINTED NAME

W. Tom Orr

ADDRESS

800 Cline Ave

Montana, MT 59047

William D. Riffe

LEWISTON, MT 59047

Stevens Central

LEWIS & CLARK, MT 59042

L. Stewart Stewart

LEWISTON, MT 59042

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<tbody>
<tr>
<td>Kirk Hodson</td>
<td>KIRK HODSON</td>
<td>3040 BURNSTOWN CT.</td>
</tr>
<tr>
<td>James C. Young</td>
<td>JAMES C. YOUNG</td>
<td>158 AVE B BILDS</td>
</tr>
<tr>
<td>Kathy Vuitont</td>
<td>KATHY VUITONT</td>
<td>115 M#, HILL</td>
</tr>
</tbody>
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SIGNATURE          PRINTED NAME        ADDRESS

Diane J. Taylor    DIANE TAYLOR         3221 Aevin, Bel.

Linda Smith        BEl. (Wen.)

Theresa Backsted    2931 Mickle.

Ben Jones           4629 Peeble

Debra McKeen Smiths 3345 Morris.

ABEL BREWER         3135 E. Black.

Vivian Norgato      3016 18th. St.

Ellen Arnot         1057 Rainier

Margaret A. Bayne   3308 E. 10th

Louise Nichols      Box 42023

Deborah D. McFarlin 3133 18th St.

Ruth D. Harvey      2307 Service 8315

Anne Hill           1930 Forest Pl. Dr.

Kay Wilson          Kathleen Wilson 1101 Delphian Dr.

Mary T. Hagen       Margaret Thomas 2303 Lawrence

Jean John Allen     3106 3rd..tsv. 34A

Louise Murray       105 Ald. E.

Kate Jordan         KACL DORSEY 210 50 W.


Evelyn Funk         3309 Helena 44

Donald Brown        Donald Brown 10435 Terry

Evelyn C. Armstrong Evelyn C. Sweeney 2730 Downer In

Bruce A. Abbott     Bruce A. Abbott 2264.5nd. 50.

Hazel Henry         906 1st. Ave. Lame

Page 46 of
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SIGNATURE	PRINTED NAME	ADDRESS

Lorrie S. Engen	Robert A. Engel

Barry J. Robinson	521 Celisrum Billings

Arthur J. Freake	588 Ave C. Butte

David A. Schopp	406 West 8th, Laurel MT

Lakisha L. Wells	Latisha D. Wells 3285 Canyon Dr #73

Claudia A. Smith

Joanne K. ceilings

Joanne K. Bailey	Victoria J. Bailey 529 West G Rd, Huntley

Linda Waska	Sister Anita Sullivan 608 Wyoming Blgs 5

Sister Linda Dean	Sister Linda Dean 216 N 31st Blgs

Sister Mary Ann Theisen	Sister Mary Ann Theisen 608 Wyoming Blg 50

Irene Auce	Irene Auce 629 Hillview

Barbara Thomas	Barbara Husby 2001 Dollar Rd

Kathleen Allmon	Kathleen A. Warren 916 15th St. W, Billings

Laura D. Robinson	Louella Roberts 517 Kallen Blvd

Helen Uffelman	Helen Uffelman Box 2380, Hardin

Debbie Greenfield	Debbie Greenfield 364 Aristocrat Billings

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<tr>
<td></td>
<td>KAVNE MELIKH</td>
<td>Kinesey, Miles City</td>
</tr>
<tr>
<td></td>
<td>BENITO MIRANDA</td>
<td>LUVI, CAVITE</td>
</tr>
<tr>
<td>Mickey C. Butler</td>
<td>MARY Q. BUTLER</td>
<td>52500</td>
</tr>
<tr>
<td></td>
<td>VIRGINIA TENGE</td>
<td>GOREN</td>
</tr>
<tr>
<td></td>
<td>JOHN E. TENGE</td>
<td></td>
</tr>
<tr>
<td>Ross Lemire</td>
<td>Ross Lemire</td>
<td>3697</td>
</tr>
<tr>
<td>Syms Nursing</td>
<td>SYMS NURSING</td>
<td>2212-24TH</td>
</tr>
<tr>
<td>Peter C. Ferraro</td>
<td>RITA E. LEMIRE</td>
<td>3616 BROAD</td>
</tr>
</tbody>
</table>
Madame Chairwomen and members of the committee,

My name is Sandy Hale and I appear on behalf of the Montana Women's Lobby in support of SB 124.

Montana Women's Lobby endorses measures to prevent the human and economic loss relating to AIDS. We support the adoption of a strong and comprehensive state-level AIDS policy including:

1. Provision for adequate resources and funding for prevention, education and direct care;
2. Opposition to mandatory testing;
3. Provisions for informed consent, adequate counseling and confidentiality in conjunction with HIV antibody testing; and
4. Protection for infected and high risk individuals from discrimination.

By prohibiting HIV-related condition discrimination in health care facilities, we are taking one step to assure that those who desperately need care, will not be shut out, because of fear, ignorance or a misguided sense of invulnerability.

Like it or not, the people that will be protected by this bill are not strangers, but our sons and daughters, our uncles and aunts, our brothers and sisters. They are the people who need to be close to caring families and support systems as they struggle to survive in the face of a momentarily insurmountable disease. We must voice our intolerance of discriminatory practices against AIDS victims, whether in workplace, our schools or the admissions office of a health care facility.

Montana Women's Lobby applauds Senator Hager's sponsorship of SB 124 and urges a "do pass" recommendation from this committee.
I support Senate Bill 124 but would like to propose some amendments.

Title 49 of the Montana Code already has provisions which prohibit discrimination on the basis of handicap in employment, housing, public accommodations, education, financing and credit transactions, and government services. The Human Rights Division has taken the position that these laws prohibit discrimination against someone who has an HIV-related condition. This interpretation is similar to the position taken by the federal courts and agencies in interpreting federal handicap laws. I am concerned that if the legislature carves out one area, such as health care facilities, to say that providers cannot discriminate on the basis of an HIV-related condition, it could open the door to an argument that the existing discrimination laws do not protect persons with HIV-related conditions.

The amendments I have prepared would clarify that any HIV-related condition is considered to be a handicap for purposes of the Human Rights Act (Title 49, chapter 2, MCA), which is the most comprehensive state law prohibiting employment discrimination. This would provide for a consistent approach between state and federal law. The amendments also have the advantage of making sure an enforcement mechanism exists so that persons with HIV-related conditions are protected.
related conditions can file complaints with the Human Rights Commission if they are denied admittance to a health care facility. This would be the case because a health care facility would be considered a "public accommodation" for purposes of §49-2-101(17), MCA. Under the bill as it presently exists, the only enforcement mechanism would be for the Health Department to seek an injunction.
1. Page 1, line 7.
   Following: "HIV-RELATED CONDITION;"
   Insert: "ESTABLISHING THAT AIDS AND OTHER HIV-RELATED CONDITIONS ARE CONSIDERED TO BE PHYSICAL HANDICAPS FOR PURPOSES OF DISCRIMINATION LAW;"

2. Page 1, line 12.
   Following: "facility"
   Insert: ", including admissions,"

3. Page 1, lines 16 through 18.
   Strike: Subsection (a) in its entirety
   Insert: "(a) For the purposes of subsection (1) and the laws prohibiting discrimination set forth in Title 49, an HIV-related condition is considered to be a physical handicap."
Amendments to Senate Bill No. 129
Third Reading Copy

For the Committee on

Prepared by Greg Petesch
February 21, 1989

   Following: line 3
   Insert: "NEW SECTION. Section 18. Coordination. If [this act]
   and SB 70 are both passed and approved, the amendment to 40-
   4-204, MCA in SB 70 is void."

   Renumber: subsequent sections
March 3, 1989

CHAIRWOMAN HANSEN AND THE HOUSE HUMAN SERVICES COMMITTEE:

I am Mignon Waterman of Helena and I represent the Montana Association of Churches.

We support the concept embodied in SB129 that parents, mother and father alike, should assume financial responsibility for their children. It is only through strict child support decrees and enforcement that adequate child support can be ensured.

Once again, we believe recommendations like this will help reduce public assistance costs in Montana while not adversely hurting Montana's low income individuals.

We support the concept of SB129.
Madam Chair, members of the committee, my name is Christine Deveny, here today representing the League of Women Voters of Montana, and here to support Senate Bill 129.

In keeping with its historic involvement with the issue of child welfare, the National League of Women Voters recently completed an extensive study of the unmet needs of our nation. The study draws attention to the fact that only one-third of all single mothers receive the full amount of their court-awarded child support. In many cases that child support payment could be the major financial resource that keeps households headed by single parents from needing AFDC payments to meet basic living needs. Those households with limited financial resources are the ones who most need dependable, regular child support payments to enable them to be self-sufficient without relying on AFDC payments.

The provision of Senate Bill 129 requiring automatic withholding of child support payments is a positive step toward ensuring that non-custodial parents meet their financial responsibilities toward the support of their dependant children. Assurances that adequate child support payments will be made on a regular schedule should reduce the number of households that need AFDC assistance.

The League strongly supports the changes in Section 1 subsection 2 that call for the courts to consider the child's medical needs and day care costs when setting child support payment amounts. The cost of quality child care and medical expenses can be a significant proportion of the overall amount needed to provide for a child, and must be considered when setting child support payments.

The League of Women Voters urges the committee to give a "do pass" recommendation to Senate Bill 129. Thank you.
SECTION 1. Section 40-4-204, MCA, is amended to read:

40-4-204. Child support - orders to address health insurance - warning of withholding procedures. (1) In a proceeding for dissolution of marriage, legal separation, maintenance, or child support, the court may order either or both parents owing a duty of support to a child to pay an amount reasonable or necessary for his support without regard to marital misconduct, after considering all relevant factors including:

(a) the financial resources of the child;
(b) the financial resources of the custodial parent;
(c) the standard of living the child would have enjoyed had the marriage not been dissolved;
(d) the physical and emotional condition of the child and his educational needs;
(e) the financial resources and needs of the noncustodial parent; and
(f) the medical or health insurance needs of the child as required under subsection (3) and the financial ability of the parent to provide such insurance; and

(g) for the purposes of determining a minimum amount for support, the amount received by children under the AFDC program, as defined in 53-2-702.

(2) If the court does not order a parent owing a duty of support to a child to pay any amount for the child's support, the court shall state the reasons for not ordering child support.

(3) Each district court judgment, decree, or order establishing a final child support obligation under this title and each modification of a final order for child support must include a provision addressing health insurance coverage in the following cases:

(a) If either party has available through an employer or other organization health insurance coverage for the child or children for which the premium is partially or entirely paid by the employer or organization, the judgment, decree, or order may contain a provision requiring that coverage for the child or
children be continued or obtained.

(b) In the event that health insurance required in a child support judgment, decree, or order becomes unavailable to the party who is to provide it through loss or change of employment or otherwise, that party must, in the absence of an agreement to the contrary, obtain comparable insurance or request that the court modify the requirement.

(c) All temporary child support orders must contain a provision requiring the party who has health insurance in effect for the child or children of the parties to continue the insurance coverage pending final disposition of the case.

(d) The parties may by written agreement provide for the health care coverage required by this section, subject to the approval of the court.

(e) Unless otherwise provided in the decree, the health care coverage required by this section is in addition to and not in substitution, in whole or in part, for the child support obligation.

(f) If the department of revenue is enforcing a support order for a child pursuant to Title IV-D of the Social Security Act, upon notice by the department, the, non-custodial parent shall obtain and maintain health insurance coverage as provided in this subsection. Such insurance must be provided even though it may reduce the amount of the child support obligation determinable under this section, or have the effect of reducing the non-custodial parent's ability to pay the child support as ordered. Unless the noncustodial parent is already required to provide insurance coverage by court order, this insurance is in addition to:

(i) Any order requiring a parent to maintain insurance;
(ii) Any agreement that the other parent will maintain insurance; or
(iii) Any failure of the decree, order or modification to require insurance coverage.

The non-custodial parent shall provide to the department the name of the insurance carrier, the policy identification
names(s) and number(s), the name(s) of the person(s) covered, and any other pertinent information regarding coverage.

(4) Each district court judgment or order establishing a child-support obligation under this title, whether temporary or final, and each modification of an existing order for child support entered after October 1, 1985, must include a warning statement that if the obligor is delinquent in the payment of support, the obligor's income may be subject to income withholding procedures under Title 49, chapter 5, part 3 or 4.

Failure to include a warning statement in a judgment or order does not preclude the use of withholding procedures.

(4) Each district court judgment or order establishing either a child support obligation or an insurance obligation as provided under this section, whether temporary or final and each modification of an existing order for child support or insurance coverage must include:

(a) in the case of a child support order or modification entered after October 1, 1985, a warning statement that if the obligor is delinquent in the payment of support, the obligor's income may be subject to income withholding procedures under Title 40, chapter 5, part 3 or 4;

(b) in the case of an order for insurance or modification of an order for insurance entered after October 1, 1989, a statement that if the child is or becomes a recipient of public assistance, and the insurance coverage is being enforced by the department of revenue, then failure to maintain insurance coverage or failure to provide information to the department regarding the insurance coverage may result in the imposition of sanctions under 40-5-208.

(c) The failure to include either statement in a judgment or order does not preclude the use of withholding procedures or sanctions.

/ / 

EXHIBIT 12
DATE 3-3-89
HB 129
SECTION 2. Section 40-5-208, MCA, is amended to read:

40-5-208. Medical support obligation enforcement. (1)(a) In all proceedings initiated pursuant to this part, the department must require parents obligated to pay child support to secure and maintain health insurance coverage for each dependent child, at-a-cost-not-to-exceed--5%--of--net-income, whenever such health insurance is available through their employment, or other group health insurance plan. However, if a court of competent jurisdiction has entered an order establishing a current support obligation and has ordered the obligated parent to secure and maintain health insurance coverage for each dependent child, the department shall enforce the obligation as ordered by the court.

(b) The obligor shall provide to the department the name of the insurance carrier, the policy identification names(s) and number(s), the names(s) of the person(s) covered, and any other pertinent information regarding coverage.

(c) Such insurance must be provided even though it may reduce the amount of the child support obligation which may be established under this part.

(d) Every order for child support established under this part shall contain a statement to the effect that failure to obtain and maintain health insurance coverage, or failure to provide information to the department regarding the insurance coverage may result in the imposition of sanctions under this section. Failure to include the warning does not preclude the imposition of sanctions.

(2) If the department determines that an obligated parent has failed to maintain health insurance coverage required by the order of a court of competent jurisdiction or an administrative agency empowered to enter such order:

(a) that an obligor has failed to obtain or maintain health insurance coverage required under 40-4-204;

(b) that an obligor has failed to obtain or maintain health insurance coverage under this section; or
(c) that an obligor has failed to provide information required under either this section or 40-4-204, the department may issue a notice commanding the parent to appear at a hearing held by the department and show cause why a sum of not more than $100 should not be assessed for each month health insurance coverage is not secured or maintained, or for each month information is not provided.

(3) If the department finds, after hearing or failure to appear, that health insurance coverage has not been secured or maintained in accordance with the court or administrative order, or the obligor has failed to provide the information as required, the department may assess against the obligated-parent obligor not more than $100 for each month health insurance coverage has not been secured or maintained, or for each month information has not been provided. Such amount may be enforced by any administrative remedy available to the department for the enforcement of child support obligations including warrant for distraint provided for in 40-5-241, and income withholding, provided for at Title 40, chapter 4, part 4.

(3) Whenever an obligated-parent who has been served with notice under this section appears before the department and shows that health insurance coverage in accordance with the court or administrative order:

(a) has been secured and maintained continuously since the date of the order; the department shall dismiss the pending action; or

(b) has not been secured or continuously maintained but such coverage is presently in effect; the department shall suspend the pending action for a period of 12 months.

(4) At the end of the suspension period, the department may schedule a hearing. If at this hearing the department finds that during the suspension period health insurance coverage:

(a) has been continuously maintained, the department shall dismiss the pending action and the obligated-parent will not be assessed under this section; or

(b) has not been continuously maintained, the department...
may-enter-a-final-order-requiring-the-obligated-parent-to-pay-the
sum—as-assessed—in—accordance—with—this—section—for-each-month
coverage—was—not—maintained.

(4)(5) Any amounts collected pursuant to this section
must be returned to the general fund to help offset expenditures
for medicaid.
GUIDE FOR DETERMINATION OF CHILD SUPPORT OBLIGATIONS

Prepared by
Montana Child Support Advisory Council
October 1, 1985

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I

Introduction

The statutory standards for determining child support obligations in Montana are contained in M.C.A. Sections 40-4-204 and 40-6-116 for dissolution of marriage proceedings and paternity actions. Although these standards offer broad guidance to persons involved in the establishment of child support obligations, the standards do not explain how to apply the standards to specific child support actions. The major purpose of this guide is to produce a uniform and equitable approach to applying the standard that is predictable, reasonable, simple to calculate, and which reflects the duty of both parents to support their children commensurate with their ability.

The economic principles underlying this guide are founded upon a formula developed by the Institute for Court Management of the National Center for State Courts. In concept, the formula is based on economic evidence that the costs of a child can be accurately depicted as a proportion of family income consumption. This proportion remains relatively consistent but does change predictably with changes in the level of household income and with the number and ages of the children. The formula, in turn, converts this data into percentages of net family income which are computed into a child support obligation.

This guideline calculates child support as a share of each parent’s income estimated to have been spent on the child if the parents and child were living in an intact household. If one parent has custody, the amount calculated for that parent is presumed to be spent directly on the child. For the non-custodial parent, the calculated amount establishes the level of child support. For cases with split custody, or extensive sharing of physical custody, each parent’s share of child support becomes the basis for determining his or her legal child support obligations.

II

Use Of The Guideline

The guideline is designed for proper application to a broad range of cases and therefore is intended only to create a rebuttable presumption of the reasonableness of the child support obligations. As is true with any system, the application of this guide may not produce a child support payment that is fair or adequate in every instance. In applying the guide as a baseline from which to proceed, the parties or the court may make adjustments either upward or downward to reflect a particular inconsistent circumstance. The burden of showing why such deviation from the guide should be made, will be on its proponent. Any departure from the guide should be accompanied by a written statement which gives the reasons for deviation from the guide’s direct application.

III

Determination of Child Support Amount

Part 1. Determination of gross income for each obligor parent.

In the determination of child support obligations the explicit policy of this guideline is to make available for the benefit of the child(ren) sufficient funds to provide the standard of living the child would have enjoyed had the marriage not been dissolved. Accordingly, all income, from whatever sources, including business expense account payments for meals and automobiles to the extent that they provide the parent with something he or she would otherwise have to provide, will constitute gross income. Also to be included are such income as pensions, dividends, interest, trust income, proceeds from contracts, and so forth.

AFDC and other welfare benefits being received by an obligor parent are not to be included as income. In those cases where obligor parents are receiving Veterans Administration Disability, Supplemental Security Income, or other private disability benefits, they should be required as part of any court ordered support obligation to apply for those program benefits their children are entitled to receive. Depending on case-by-case circumstances, these benefits may replace in whole or in part any child support obligation.

All income should be annualized and copies of the last two years’ tax returns should accompany financial statements as well as current wage stubs. Such annualization and examination of a two year period will provide a normalized pattern of income-producing abilities. Without such examination a temporary period of present unemployment or underemployment may indicate an unwarranted low amount of income available for support.

Part 2. Imputed or attributed income.

A particular problem exists for obligor parents who are voluntarily unemployed or underemployed. It is the policy of this guide that a parent will be excused from making a financial contribution only if he or she is physically or mentally incapacitated.

In cases where the obligor parent is not working or is not working at full earning capacity, the reasons for such a limitation on earnings should be examined. If the reason is a matter of choice, the local job market should be reviewed to determine what a person with the obligor parent’s trade skills and capabilities could earn. Those typical earnings can then be imputed to the obligor parent for use in this guide. This approach is most useful when the obligor parent has a relatively stable and recent work history. The approach can also be used when the obligor parent has minimal skills and no work history by ascribing earnings based on a minimum wage for a full work week.

Alternatively, when the obligor parent is remarried to a person who is fully employed, and the obligor parent elects to stay at home as homemaker for the new spouse, a dollar value may be set which shall be considered as that obligor’s parent’s income. The value for homemaker services should be assessed at no less than the federal minimum wage level for a forty hour week.

Part 3. Income of current spouses.

Stepparents and other adult household members are not generally responsible for the support of children of prior marriages or relationships. Consequently, these guidelines do not take into account income from other adults who may reside with either of the separated obligor parents. However, for subsequent modifications of initial support awards, due consideration may be given the effect of shared expenses. That is, current spouse’s income might be counted as reducing the obligor parent’s living expenses and might, therefore, increase on a case-by-case basis the amount of income available for child support.

Part 4. Assets as income.

Actual or imputed income may not be by itself an adequate measure of the obligor parent’s ability to pay child support. The obligor parent, for example, may have savings, life insurance, vehicles, real estate (other than permanent home), collections, and other assets in amounts unrelated to income. Unless account is taken of these holdings, preferential treatment will be given the obligor parent and the child(ren) will correspondingly be denied a share. This is not to imply that there must be a forced sale of these assets but that their dollar value be counted in determining funds available for support. Consequently, an amount equal to two (2)

1For a detailed explanation of the economic evidence see Robert G. Williams, Development of Guidelines for Establishing and Updating Child Support Orders (National Center for State Courts, Denver, June 1985).
percent of the total value of the obligor parent's assets is to be added each month to that parent's total monthly income. The obligor parent can later decide whether, in fact, to liquidate assets or to make other expenditure adjustments to compensate.

The assessment of assets should exclude from consideration such non-income and non-depreciable producing assets of "reasonable" value such as a permanent home, farm land, furnishings, and one automobile. Also excluded should be income producing assets such as real property in the form of a farm or business, vehicles, tools, or instruments used to produce a primary source of income.

Part 5. Determining net income available for support.

The implementation of the policy of keeping primary focus on the needs of the child(ren) requires that from each obligor parent's income only a minimum of exclusions be allowed. Therefore, from gross income only the following are subtracted as deductions: federal and state income taxes; FICA; union dues, retirement contributions, uniforms, etc., which are required as a condition of employment and are not reimbursed by the employer; legitimate business expenses; and health insurance if the benefits are maintained for the obligor parent's dependents, including the child(ren) of the action at hand.

Child support payments owed for children of the obligor parent not of the union between the parents in this case which are actually being paid are being withheld from the obligor parent's wages by involuntary wage assignment or other similar legal process, may be excluded from gross income to the extent that such withholding actually occurs.

Deductions made by an employer from the obligor parent's wages for credit unions or merely for the convenience of the obligor parent will not be recognized.

Where income has been imputed to a stay-at-home homemaker, the permissible deductions will not be permitted since none are being made.

Part 6. Application of the formula.

For ease of use, the formula is manifested by a table which has a series of percentages differing by income level, number of children, and age of children. To determine child support from this table, the net income of the two parents is added together. This sum is then compared to the income level column, and the line showing the number and age of the children to arrive at a percentage figure. This percentage is then applied separately to each parent's income to establish in dollar amounts the support obligation for each parent.

For example, father and mother are divorced. Neither has remarried. Father nets $7,849 annually; mother nets $6,600. The combined income is $14,448. Their only child, age 2, lives with mother. Referring to the table, child support is calculated as 19.7%, a support obligation of $2,858 results for father and $108.35 for mother. Since mother is the custodial parent, the $108.35 is retained by her. It represents the amount that is presumably spent directly on the child in the custodial household. The obligation of $2,858 per month incurred by the father is payable as child support to the mother.


Under these guidelines a child support obligation is calculated separately for each parent without initial regard to custody. Subsequent to such determination, in sole custody arrangements the custodial parent for all the children will retain his or her share of the support obligation and the non-custodial parent pays his or her share to the custodial parent. If there is split custody of the children, each parent shall retain the share of the total child support owed to the child in his or her custody and pay the difference, if any, to the other parent for the children in the other parent's custody.

When the obligor parents share joint physical custody (both parents have custody of the children more than 30% of a 365 day period), to avoid unnecessary transfers of funds, the "pay over" of each parent for the year should be determined by multiplying the monthly support obligation times the number of months the parent has custody. If one parent's yearly obligation is greater than that owed by the other, the excess amount shall be divided by 12 and paid monthly over the year.

For example, Parent A's support obligation is $300 per month and Parent B's obligation is $100. Parent A has custody for 4 months of the year and Parent B has the child for the remainder. Thus, over a year, Parent A would pay to Parent B $300 times 8 months or $2,400; and Parent B would pay Parent A $100 times 4 months or $400. Accordingly, Parent A owes $2,000 per year more than Parent B owes to Parent A. To meet this obligation, Parent A should pay to Parent B $166.66 per month ($2,000 divided by 12 months).

For cases involving joint physical custody, the table presumes that direct expenses are incurred in approximate proportion to the duration of physical custody. This presumption should be reviewed carefully in the application of the table since some expenses may not be borne proportionately. For example, the parent having custody of the child during the major part of a school term may incur additional expenses for clothing, books, recreation, and so forth. Adjustments may be made in the amounts calculated from the table to reflect any such disparity.

Part 8. Age adjustments.

Studies of household expenditure patterns have found that spending levels for children are related to their age. The table makes provisions for only two age brackets: 0-11 and 12-17. This is based on a general consensus that expenditures increase markedly for children in the twelve to seventeen range. The table thus has an advantage of concentrating higher child support awards during the teen years when the need for augmentation or "teenage premium" is greatest.

When the ages of the children require use of more than one line from the table, locate the per-child percentage from the correct age grouping and then divide the percentage by the number of children to get the percentage of the obligor parent's income allocated to that child.

For example, the combined net income of the parents of a 7 year old child and a 14 year old is $20,000. The percentage for two children age 7 is 27.1% which is divided by two to arrive at a figure of 13.55% of net income for the 7 year old child. Likewise, the percentage for two 14 year olds is 33.5% which yields an obligation of 16.75% of net income for the other child thus the total obligation would be 30.3% of the parent's net income.

Part 9. Low income parents.

Regardless of the presumptive level derived from the table, an obligor should not be held to his or her full application of the table percentage if to do so would reduce the parent's standard of living below the poverty line. Where this will occur, child support should be established on a case-by-case basis. Except in unusual adverse circumstances, a minimum order of no less than $50.00 should be set in all cases to establish the principle of payment and to lay the foundation for increased orders when the parent's income increases.


Under state law, every decree, judgment or order establishing a child support obligation and every modification of an existing order must include a provision requiring the parents to obtain medical insurance on the child in addition to the child support obligation.
tion. If health insurance on behalf of the child is carried by a parent, the parent’s net cost of the child’s share of the premium is allowed as a deduction from gross income.

Insurance deductibles, medical, dental, and optical expenses which are not covered by insurance should be pro-rated between the parents based on the net income of each.


Any extraordinary medical expenses which are likely to be reoccurring during the minority of the child should be pro-rated between the parents and added to the basic child support obligation. Extraordinary medical expenses include physical therapy, special education, mental disorders, and any other uninsured chronic health problems which are likely to occur on a periodic basis.

The amount to be paid each month for extraordinary medical expenses may be determined by adding a monthly average of past costs if future costs are expected to be comparable, or by adding extraordinary medical expenses to the child support obligation on a monthly as-incurred basis with the custodial parent billing the non-custodial parent accordingly.


Work or training related child care expenses are a mutual responsibility of both parents and are to be apportioned between them based on their respective levels of net income. Because child care expenses may be of indeterminate duration, such expenses are to be considered as a supplement to the child support established by the table and are to be paid only during those times when child care expenses are actually being incurred. For this reason, orders establishing the dollar contribution of a parent toward child care costs should set this amount as a separate item in the order.

Determination of a monthly child care obligation for the purpose of this guide should be heard either upon annualized, average costs of receipted expenses, or, when the history of such expenses are not available, upon estimates based on the average necessary monthly costs of such services.

Part 13. Other dependents.

As regards the treatment of other dependents, this guide uses a “first mortgage” approach in which children of prior marriages or relationships are given priority over subsequent children. This policy is based on reason and economic theory. Both suggest that the problems of inadequate support for children of multiple relationships would be alleviated if parents were discouraged from having more children unless they were capable of contributing adequately to the needs of all their offspring. Consequently, if support is sought for children of a subsequent relationship when there is a preexisting order for a child born from a previous relationship, priority would be given to the earlier children born by subtracting the amount actually paid from the parent’s net income base. (See Part 5). This diminishes the amount of parental resources available to support children from the subsequent relationship.

Likewise, when this guide is being used to reevaluate a prior child support order for modification, the position is taken that the parent’s prior child support obligations have absolute precedence over the needs of a new family. A parent’s plea that his or her new responsibilities are a change in circumstances justifying a reduction in a prior child support award will not serve as a basis for a reduction of support. Creation of the new family is a voluntary act and that parent should decide whether he or she can meet existing support responsibilities and provide for new ones before taking that step.


Even if a support order accurately reflects the needs of the child and the resources of a parent when it is initially set, changes in circumstances that inevitably occur with the passage of time can seriously erode its value and reduce the equity for the parties. As a result, these guidelines recommend that all support orders and support agreements contain a provision for biannual review on instance of either party of the support obligation. The review should be made by reapplication of this guideline. Doing so will take into account changes in all factors considered by the guidelines rather than focusing on only one or two variables.

SUPPORT GUIDELINES TABLE

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<td>0-11</td>
<td>55.7</td>
<td>55.7</td>
<td>54.6</td>
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<td>12-17</td>
<td>68.9</td>
<td>68.9</td>
<td>67.5</td>
<td>62.4</td>
<td>57.1</td>
<td>55.0</td>
<td>51.4</td>
<td>43.1</td>
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For children in different age categories, pro-rate based or total number of children. Example: for one child age 7, one age 14, annual income of $18,000, use percentages for two children, divided by two — $(28.0/2) + (34.6/2) = 31.3.$
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<th>Combined</th>
<th>Father</th>
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<tr>
<td>c. percent of asset value</td>
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<tr>
<td>e. TOTAL</td>
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<td>2. Deductions (annualized)</td>
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<td>b. FICA</td>
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<td></td>
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<tr>
<td>c. union dues</td>
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<td>d. mandatory retirement</td>
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<tr>
<td>e. mandatory health insurance</td>
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<tr>
<td>f. child support preexisting</td>
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<tr>
<td>g. medical insurance paid in behalf of child(ren)</td>
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</tr>
<tr>
<td>h. other</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>i. TOTAL</td>
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<td></td>
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<tr>
<td>3. Net Available Resources</td>
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<td></td>
<td></td>
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<tr>
<td>(line 1e minus line 2i)</td>
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<tr>
<td>4. Combined Total Net Income</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| 5. Percentage from Table | | % |%
| 6. Each Parent’s Obligation | | | |
| (line 3 x line 5) | | | |
| 7. Monthly Support Obligation | | | |
| (line 6 divided by 12 months) | | | |

**WORK SHEET #2**

FOR

CHILD CARE COSTS

<table>
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<th>Combined</th>
<th>Father</th>
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<td>2. Net Available Income</td>
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<tr>
<td>3. Combined Net Income</td>
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</tbody>
</table>
| 4. Pro-rata share | | % |%
| (line 2 divided by line 3) | | | |
| 5. Parent’s Share of Costs | | | |
| (line 4 times line 1) | | | |
| 6. Monthly Child Support Obligation | | | |
| (line 7, Worksheet #1) | | | |
| 7. Child Support With Child Care Costs (line 5 plus line 6) | | | |
MADAM CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS JAMES AHRENS, PRESIDENT OF THE MONTANA HOSPITAL ASSOCIATION. I REPRESENT AN ASSOCIATION OF 54 HOSPITALS THAT IS UNITED AS NEVER BEFORE IN ITS THEIR OPPOSITION TO HOUSE BILL 741. THIS IS BY FAR THE MOST TROUBLING BILL TO BE INTRODUCED THIS SESSION. IT IS TROUBLING FOR HOSPITALS BECAUSE IT PLACES TREMENDOUS NEW BURDENS ON THEM AT A TIME WHEN MANY ARE STRUGGLING TO REMAIN OPEN ANOTHER DAY. IT SHOULD BE TROUBLING TO ALL MONTANANS BECAUSE IT PRODUCES A THREAT TO THE FUTURE VIABILITY OF THE HEALTH CARE DELIVERY SYSTEM IN THE STATE. IN THE LAST EIGHT (8) YEARS, 621 HOSPITALS HAVE CLOSED IN THE UNITED STATES. WE HAVE LEARNED THAT WHEN A HOSPITAL IN A ONE-HOSPITAL TOWN CLOSES, THE DOCTOR GENERALLY LEAVES TOWN NOT LONG AFTER. WHEN THE DOCTOR LEAVES, THE NURSING HOME CLOSES. NOT ONLY DOES THE TOWN SUFFER FROM THE LOSS OF PRIMARY AND LONG-TERM CARE SERVICES, BUT IT LOSES THE JOBS ASSOCIATED WITH THE HOSPITAL AND THE NURSING HOME. IT LOSES THE ABILITY TO ATTRACT NEW BUSINESSES AND NEW PEOPLE TO THE COMMUNITY. THIS BILL, IF PASSED, WILL CLOSE HOSPITALS IN MONTANA. I BELIEVE IT WILL CLOSE ENOUGH HOSPITALS TO CREATE AN ACCESS CRISIS IN THE STATE. IT WILL DAMAGE THE HEALTH STATUS OF
THE POPULATION AND ADVERSELY EFFECT THE ECONOMIC DEVELOPMENT OF THE STATE.

FIRST I WILL TELL YOU WHY I BELIEVE THIS BILL WOULD CLOSE HOSPITALS, AND THEN I WILL EXPLAIN WHY I THINK IT IS NOT NECESSARY.

IN 1987, THE MOST CURRENT YEAR FOR WHICH WE HAVE STATISTICS, AVERAGE PATIENT MARGIN AT ALL MONTANA HOSPITALS WAS 1.7%. PATIENT MARGIN IS CALCULATED BY DIVIDING REVENUE LESS EXPENSE BY GROSS PATIENT REVENUE. A PATIENT MARGIN OF 1.7% MEANS THAT, ON THE AVERAGE, MONTANA HOSPITALS MADE 17 CENTS ON EVERY 10 DOLLARS OF REVENUE. BUT AVERAGES ARE DECEIVING. HOSPITALS WITH FEWER THAN 30 BEDS HAD NET PATIENT MARGINS OF NEGATIVE 15.2%. IN OTHER WORDS, THESE HOSPITALS LOST $1.52 ON EVERY 10 DOLLARS OF REVENUE. TWENTY-FOUR OF 32 HOSPITALS UNDER 30 BEDS LOST MONEY ON OPERATIONS IN 1987. THE COST OF COMPLIANCE WITH THIS BILL COULD PUSH SOME OF THESE HOSPITALS OVER THE BRINK.

LOOK AT WHAT IS REQUIRED OF THESE HOSPITALS BY THE BILL. FIRST THEY HAVE TO PAY A HOSPITAL TAX FOR THE PRIVILEGE OF BEING REGULATED. THEN THEY HAVE TO SUBMIT TO BUDGET REVIEW, UNIFORM REPORTING, AND SPECIAL AUDIT REQUIREMENTS. THEY ARE SUBJECT TO MONEY PENALTIES FOR LATE OR NONCOMPLIANCE. ONE OF THE PROVISIONS OF THE BILL IS THAT IF THE COMMISSION QUESTIONS OR WANTS TO VERIFY HOSPITAL DATA, IT HAS THE POWER TO ORDER FULL OR PARTIAL AUDITS "OF ALL RECORDS AND ACCOUNTS" TO CLARIFY OR VERIFY INFORMATION. THESE AUDITS WILL BE PAID FOR BY HOSPITALS.
AND WHAT KIND OF RATES WILL THIS SYSTEM PRODUCE? THIS IS A RATE SYSTEM KNOWN AS AN ALL PAYER SYSTEM. UNDER IT, ALL PAYERS ARE TREATED EQUALLY, THAT IS EVERYBODY PAYS THE SAME RATES. A PROVISION OF THE BILL IS THAT MEDICARE WILL PAY NO MORE THAN IT WOULD HAVE PAID HAD IT REMAINED UNDER ITS OWN PAYMENT SYSTEM. IF YOU THINK ABOUT IT FOR A MINUTE, YOU CAN SEE WHAT THIS MEANS. IT MEANS ALL PAYERS WILL PAY AT RATES NO MORE THAN MEDICARE RATES. THE SINGLE MOST IMPORTANT FACTOR IN DRIVING SMALL RURAL HOSPITALS TO THE BRINK OF INSOLVENCY HAS BEEN THE MEDICARE PAYMENT SYSTEM, AND THIS BILL SUGGESTS THAT ALL PAYERS PAY ON THIS SAME BASIS. IN THE LAST SIX YEARS, THE MEDICARE MARKETBASKET, THE GOVERNMENT CREATED INDEX OF HOSPITAL GOODS AND SERVICES, HAS GONE UP 28%. MEDICARE RATE INCREASES HAVE GONE UP ONLY 14.9%. THERE IS A 13.1% SHORTFALL BETWEEN COSTS AND REIMBURSEMENT. WHAT ARE THE CONSEQUENCES OF THE SHORTFALL? IN 1986 ALL MONTANA HOSPITALS WROTE OFF $30.6 MILLION IN MEDICARE AND MEDICAID DISCOUNTS. IN A SINGLE YEAR, THAT AMOUNT JUMPED 38% TO $42.1 MILLION IN WRITE-OFFS. IN 1987, MEDICARE AND MEDICAID REPRESENTED 46.5% OF ALL HOSPITAL UTILIZATION. IF ALL PATIENTS HAD TO PAY ON THE BASIS OF MEDICARE RATES, THE WRITE-OFF IN MONTANA WOULD HAVE BEEN $90.5 MILLION IN 1987. ADJUSTING FOR THE CONTINUED SHORTFALL IN MEDICARE PAYMENT RATES THROUGH 1989, I ESTIMATE THAT THE WRITE-OFF WOULD BE $125 MILLION. THAT IS MORE THAN 4 TIMES THE SURPLUS RETAINED BY HOSPITALS IN 1987. MEMBERS OF THE COMMITTEE, AN ALL PAYER SYSTEM THAT PEGS PAYMENT RATES TO MEDICARE COULD CLOSE ALL OF THE HOSPITALS IN THE STATE.
THERE WERE FOUR ALL PAYER RATE REVIEW STATES. EACH OBTAINED A WAIVER FROM HEALTH AND HUMAN SERVICES TO CONDUCT THEIR PROGRAMS. ONLY ONE STATE, MARYLAND, STILL MAINTAINS THE WAIVER. IN THE THREE STATES THAT CANCELLED THEIR WAIVERS (NEW YORK, NEW JERSEY, AND MASSACHUSETTS) 68 HOSPITALS CLOSED. THIS BILL SAYS THE COMMISSION WILL ATTEMPT TO OBTAIN A WAIVER FROM HEALTH AND HUMAN SERVICES, BUT EVEN IF IT DOESN'T RECEIVE ONE, IT WILL SET RATES AS THOUGH IT HAD ONE.

IS THIS BILL EVEN NECESSARY? EVERYONE AGREES THAT HEALTH CARE IS EXPENSIVE, BUT IN MONTANA WE ARE DOING OUR BEST TO KEEP COSTS LOW. THE PROONENTS SAY THAT BETWEEN 1976 AND 1983 HOSPITAL COSTS ROSE BY 195%. THAT MAY BE TRUE. DURING THAT PERIOD WE WERE ALL LOOKING AT AN OIL EMBARGO, THE IRANIAN REVOLUTION, AND CPI INCREASES OF DOUBLE DIGITS. THE COST OF EVERYTHING GREW AT RATES NEVER BEFORE WITNESSED. BUT SINCE THEN, BEGINNING IN 1984, HOSPITAL COSTS BEGAN TO MODERATE. HOSPITAL COSTS HAVE INCREASED AT AN AVERAGE RATE OF 6.3% AND GROSS PATIENT REVENUE HAS INCREASED AT AN AVERAGE RATE OF 5.5% SINCE 1984. WE SHOULD NOT BE PUNISHED NOW FOR RAPID INCREASES IN RATES SIX YEARS AGO.

FURTHERMORE, THE RATES WE DO CHARGE IN MONTANA ARE, BY COMPARISON, QUITE LOW. MONTANA RANKS 47TH IN THE COUNTRY IN TERMS OF COST PER STAY (EQUICOR). ACCORDING TO THE AMERICAN HOSPITAL ASSOCIATION, MONTANA RANKS 42ND IN MARK-UP RATIOS, A MEASURE OF PROFITABILITY.
FINALLY, MADAM CHAIRMAN AND MEMBERS OF THE COMMITTEE, I CAN TELL YOU THAT I DON'T LIKE OPPOSING AARP. SENIOR CITIZENS AND HOSPITALS ARE A NATURAL CONSTITUENCY GROUP. THEY ARE OUR LARGEST CUSTOMERS, AND THEY RELY UPON US TO BE THERE WHEN THEY NEED US. THROUGHOUT THE STATE WE WORK CLOSELY WITH LOCAL SENIORS ORGANIZATIONS. THIS BILL IS NOT IN THEIR INTEREST. IF HOSPITALS CLOSE, RURAL HOSPITALS WILL BE THE FIRST TO GO. SMALL RURAL HOSPITALS SERVE A DISPROPORTIONATE SHARE OF THE ELDERLY. IF THESE HOSPITALS CLOSE, THE ELDERLY WILL HAVE TO TRAVEL TO SEEK CARE. MANY ARE NOT ABLE TO TRAVEL. THEY WILL POSTPONE RECEIVING CARE, OR FOREGO IT ALTOGETHER, IF IT IS NOT LOCALLY ACCESSIBLE.

INSTEAD OF FIGHTING AMONG OURSELVES, I SUGGEST WE SIT DOWN AFTER THE SESSION AND HOST A SERIES OF MEETINGS TO DISCUSS OUR MUTUAL CONCERNS.

THIS BILL WILL HURT HOSPITALS, BUT MORE IMPORTANTLY, IT WILL HURT THE ELDERLY AND HURT THE STATE, AND FOR THAT REASON, I URGE YOU TO VOTE DO NOT PASS ON HOUSE BILL 741. THANK YOU.
Medicare Payment Rates to Hospitals Aren't Keeping Up With the Cost of Providing Quality Care

Hospital Market Basket represents the costs hospitals must pay for goods and services, such as nursing, equipment, mortgage, utilities, etc.

Cumulative gap: 13.1%
Cumulative increase: 14.9%

Fiscal Year


DUG Rate Increase

AHA Data
Montana has sixty-five hospitals to serve its residents. The vast majority (55) of them are locally operated, not-for-profit general hospitals distributed in every corner of the state. Three of the hospitals specialize in either children, adolescent or adult psychological disorders and chemical dependency. Six are federally owned and operated exclusively for either veterans, Indians, or military personnel and their dependents. One is owned and operated by the State of Montana.

Most of Montana's hospitals serve rural populations and, due to demographics and geography, they are necessarily small. More than 78 percent of Montana's hospitals are smaller than 90 beds and almost 54 percent are smaller than 30 beds in size. More than 90 percent meet the federal designation of being rural hospitals.

### Hospital Types

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<td>190 and more beds</td>
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<td>90-189 beds</td>
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<td>30-89 beds</td>
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<td>Fewer than 30 beds</td>
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<td><strong>By Primary Service</strong></td>
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<td><strong>By Ownership</strong></td>
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### Hospital Utilization

The information in this section of the report is based upon the results of a survey of 1987 utilization and financial data for 56 general, acute care hospitals. The survey was co-sponsored by the Montana Hospital Association, the Montana Department of Health and Environmental Sciences and the American Hospital Association.

Admissions and patient days per 1,000 people is a common measure of the efficiency of a health care system. In the aggregate, hospital costs are most effectively controlled by reducing inpatient utilization. Montana's utilization per 1,000 people closely follows the national trend, however, Montana began the four-year period 6 per cent below the national admissions rate, and 37 per cent below the patient days rate.

#### Admissions per 1000 Population

![Admissions per 1000 Population Graph]

#### Patient Days Per 1000 Population

![Patient Days Per 1000 Population Graph]
An Annual Report from Equicor

Service Charges
Hospital Daily
1987

Exhibit
Date: 3-3-89
HB: 147
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**District of Columbia**

Average Charge Per Stay - State Ranks
Prognosis gloomy for many rural hospitals

Montana's rural hospitals, like this one in Conrad, are struggling to maintain their position as the keeper of the people's health.

Stories by LINDA CARICABURU  Tribune Regional editor

The financial health of many of the state's smallest facilities is reaching a critical stage, and the rural isolation intensifies the frustrations of care industry leaders. We identify the problems and attempt to isolate their causes. And finally, we take a look at some of the possible cures.

The property tax freeze mandated by Initiative 152, which suspends local property taxes paid by hospitals for future budgetary purposes. The legislation has had limited success.

Equipment costs have jumped with changes in technology. But if you don't keep up, your clients will go elsewhere for care.
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<td>Jim Fanson</td>
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<td>Chemical Dependency Programs SMT</td>
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<td>WARP</td>
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<tr>
<td>Jean C. Weeks</td>
<td>Volunteer at Perez</td>
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<td>Hope Weldon</td>
<td>Mental Health Center</td>
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If you care to write comments, ask Secretary for Witness Statement Form. Please leave prepared statement with Secretary.

Ann Scott
RUTC
Rie Bellwood
Private Citizens
Steve Browning
Nortin Hop
Lessen

For
Against

X