

I am representing the Montana Chapter of the American Physical Therapy Association [or for simplicity, the “Montana Physical Therapy Association”]. Our membership includes over 400 licensed physical therapists and physical therapist assistants in Montana. We are the only professional organization in the state representing the physical therapists. More important, we believe our positions are in the best interests of the Montana healthcare consumer.

We believe that any new legislation should provide (1) transparency, (2) an informed choice, and (3) protection for the consumer. We are concerned that many of the changes suggested on 5/28/08 fail all three tests.

There are two provisions that we consider essential to LC0038. First, the “Conflict of Interest” definition in Section 6 (2) (a-e), of the 4/29/08 draft. Second, it is essential that every out-patient referral contain a list of alternative licensed health care facilities or providers if they are available, in Section 1 (3)(ii) of the 4/29/08 draft.

I will go through each section of LC0038 to comment on changes suggested on 5/28/08.

[1] Section 1. PATIENT INFORMATION - - DISCLOSURE - - REFERRALS.

A. We like the “Whereas” format suggested on 5/28/08.

B. It is essential that disclosures of a financial conflict of interest be made at the time of the referral, and that the disclosure is combined with a list of alternative providers. If blanket financial disclosures are contained in a large stack of in-take papers, they will be overlooked. The referring provider could not know at the time of admission that they will refer. The important point is to notify consumers that they have a choice of where they want to receive any additional healthcare services.

C. Consumers must be specifically notified that “you have a choice,” and that information is far more meaningful if a list of alternative providers is given to the consumer. That list should identify at least three alternative providers (if available), and might be as simple as a photocopy of the local yellow pages. However, it will clearly demonstrate to the consumer that they have options. Currently, most consumers believe their only option is the referral’s first recommendation.

D. Consumers must also be notified they will not be treated differently if they choose their own alternative provider.

E. We support adding “When making a referral to another healthcare provider or facility, the referral source shall...” in section 1(3)(a).

[2] Section 2. PRIMARY RESPONSIBILITY - - CONTRACTS - - REFERRALS - - DEFINITIONS.

A. “A healthcare provider’s primary responsibility is the welfare and wellbeing of the patient...” must be contained somewhere in the bill. We do not care if it stays in this section, or is included as a separate section 3.

B. We support using “Kickbacks Prohibited” as a subtitle. It clearly identifies the primary issue. However, it deals only with “kickbacks” in a contractual or employment relationship. It does not address the “Conflict of Interest” issues discussed below.

C. It has been suggested that this section may make recruiting physicians more difficult, presumably, because there would be fewer financial incentives to offer physicians. We believe it is far more important to protect the interests of the consumer than it is to retain a convenient recruiting mechanism that is potentially unethical.

D. We support the following definitions:

(3) For the purposes of this section, the following definitions apply:

(a) A "health care provider" is a person licensed under Title 37, chapters 3 and 4, 6 through 17, 20 through 28, 34 through 36.

(b) A "referral" is a written or oral order from a health care provider to a patient or client for health care services, including: (i) the forwarding of a patient or client to another health care provider with a different license or to a health care facility licensed under Title 50 or operated by a health care provider

licensed under Title 37; or (ii) a request or establishment of a plan of care that includes the provision of prescribed health services or prescribed health care supplies.

[3] Section 3. PRIMARY RESPONSIBILITY

A. We believe that welfare of the patient must be the primary responsibility for all licensed healthcare providers and facilities. Again, we would like to retain this language, but do not care where this language is located.

[4] Section 4 3. ENFORCEMENT - - CONFIDENTIALITY - - DEFINITIONS.

A. This is the only enforcement provision in the bill, and it is an essential part of the bill. We strongly support leaving it in the bill.

B. Removing (2) [economic credentialing complaint] appears to be a housekeeping measure, and we support it as such.

[5] Section 5 4. LICENSING INVESTIGATION AND REVIEW...

A. No changes. We support the current section.

[6] Section 6 5. DEFINITIONS – “CONFLICT OF INTEREST”

A. Most high quality studies show a high correlation between physician ownership of medical facilities, and increased referrals to those facilities. The “high bar” or “gold standard” for avoiding conflict of interest is contained in Section 37-2-103, MCA, which prohibits physician ownership of pharmacies. The 1971 legislature, which enacted 37-2-103, MCA, apparently believed that physician ownership of pharmacies was simply an unacceptable conflict of interest. We do not support an outright ban on physician ownership of all medical facilities. The interim committee appears to be most interested in finding a realistic balance between “acceptable” conflicts of interest, and “unacceptable” conflicts of interest. We believe the definition suggested on 5/28/08 places the bar “too low,” and that the definition in the 4/29/08 draft should be the absolute minimum standard allowed in Montana.

B. We strongly support the “old” definition [shown below] of “Conflict of Interest” that is borrowed from North Dakota, and other current statutes. Subsection (c, d, & e) clearly indicate that fee-splitting, fraud, and other activities are unacceptable. We strongly support the following definition:

(2) "Conflict of interest" means a set of conditions in which a referring health care provider: (a) exercises professional judgment concerning a patient's welfare that is unduly influenced directly or indirectly by a financial or investment interest; (b) demonstrates an economically motivated referral pattern, as defined in 50-5-117; (c) accepts, pays, or promises to pay a part of a fee in exchange for patient referrals; (d) obtains any fee by fraud, deceit, or misrepresentation; or (e) pays or receives, indirectly or directly, any fee, wage, commission, rebate, or other compensation for services not actually or personally rendered."

C. We strongly oppose the 5/28/08 suggested definition that asks a hearing examiner or Board to determine whether a referring provider places their own financial interests above the patient’s welfare. This is almost impossible to do. How do you fairly “measure” the referring provider’s financial interests? How do you fairly “measure” the patient’s welfare. Then, how do you determine which measurement is greater? With this vague standard, it may be “appropriate professional conduct” for a referral source to (1) accept bribes, (2) misrepresent facts, or (3) split fees as long as it does not increase the consumer’s costs. Referrals could simply go to the highest bidder, as long as the consumer’s costs did not increase.

[7] Section 7 6. UNPROFESSIONAL CONDUCT.

A. We support the suggested changes to “(19) for health care practitioners licensed under Title 37, chapters 3 and 4, 6 through 17, 20 through 28, and 34 through 36 a determination of conflict of interest.” We believe the new version is easier to understand.

[8] Section ~~8~~ 7. UNPROFESSIONAL CONDUCT.

A. We support the suggested changes “(m) engaging in a conflict of interest, as defined in 37-1-302.”

[9] Section ~~9~~ 8. DISCRIMINATION PROHIBITED.

A. No changes.

[10] Section ~~10~~ 9. ECONOMIC CREDENTIALING OF PHYSICIANS PROHIBITED - - DEFINITIONS.

A. We support including ambulatory surgical centers.

[11] Section ~~11~~ 10-13. DENIAL...HEALTH CARE FACILITY LICENSE; REPEALER; CODIFICATION.

A. We have no comment on the last three sections.

As noted above, these recommendations are submitted on behalf of the Montana Physical Therapy Association.

Jim M. McLean
Doctor of Physical Therapy