



FALLON MEDICAL COMPLEX

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FALLON MEMORIAL HOSPITAL
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HOME CARE SERVICES
COMMUNITY CLINIC
PARKVIEW RETIREMENT CENTER

SENATE PUBLIC HEALTH, WELFARE & SAFETY

January 28, 2005

EXHIBIT NO. 9

DATE: 1-28-05

BILL NO. SB 257

Dear Senator Brent Cromley, Chairman, and Members of the Senate Public Health Committee:

I appreciate this opportunity to provide written testimony in support of SB257, introduced by Senator Duane Grimes, regarding Certificate of Need (CON) requirements for swing bed additions to Critical Access Hospitals (CAH). My name is David Espeland and I have been working for over nine years as the CEO of Fallon Medical Complex (FMC) in Baker, Montana with a county-wide population of about 3,000 people. FMC is a typical small-town medical facility with a CAH, a skilled nursing facility (SNF), a home care agency, and a physician's clinic.

In my opinion, SB257 should not affect small-town facilities such as mine. After all, FMC offers *the only* CAH services in the county as well as *the only* SNF services in the county. Given the historical trend of decreasing populations in small Montana communities, I believe it is safe to say that none of us will need to add additional medical capacity in the near future. However, some of us may be shifting capacity from SNF beds to CAH swing beds, simply because it is advantageous (as well as a survival measure) to dedicate as much of our physical square footage as possible to the CAH in order to maximize our Medicare reimbursement.

SB257 is sensitive to the need for flexibility in small-town Montana CAHs. That is, it specifically allows CAHs to swap long-term bed for long-term bed, or SNF bed for CAH swing bed. This bill does, however, present a difficulty for CAHs that do not have a SNF attached to it. Stand-alone CAHs are not typical of small town Montana medical facilities, and in those instances, the CAH is often competing with stand-alone SNFs for long-term care patients. This competition is not always a problem for those stand-alone SNFs, as long as they are operating at capacity. A difficulty arises, however, when there are excess beds in the community. And, according to the Montana Department of Public Health and Human Services (DPHHS), virtually all Montana communities have excess long term care beds.

Over the years, DPHHS has worked diligently to keep healthcare resources "right-sized" for Montana communities through the CON process. Although submitting a CON may be arduous and potentially expensive, it does require a thorough examination of a community's need to increase medical capacity or to add new medical services. SB257 is designed to ensure that the addition of new swing beds to a CAH (without the reciprocal reduction of SNF beds) is in the best interest of the community, wherein the community has a distinct and displayed need for those additional long term care beds.

Over the past nine years, FMC's CAH has increasingly become the facility's financial savior and its SNF has become the poorest performing business in its portfolio. This condition is indicative of the state of healthcare nationwide, wherein SNFs are realizing a greater struggle to stay alive than are many CAHs, primarily because CAHs are cost-based reimbursed for their Medicare volume, and skilled nursing facilities are paid a *per diem* for each bed day. This means that CAHs will always recover part of their overhead, even if they have low census, as long as they have some Medicare patients (and if they had low Medicare utilization, it wouldn't be advantageous for them to be a CAH.) However, SNFs must rely on a continuous high census in order to cover their costs, since Medicaid and insurance *per diems* (and often private pay rates) are not adequately covering the full cost of care for their residents.

Overall, in a community where new swing beds may add to the total long-term care capacity of the community, and where the addition of such capacity may not necessarily be needed, an addition of beds may simply serve to shift resident care from one provider to another -- and from the less favorably reimbursed to the most favorably reimbursed, at that. Under these conditions, any siphoning of residents away from a SNF bed and into a CAH swing bed can be financially distressing to the SNF.

There should be no doubt that there is a distinct need for both CAH and SNF services in Montana communities, and that there exists a delicate balance between the numbers of beds at both levels of service that can be supported by any given community. CON allows a thorough discovery of that level of balance, such that there is stability between the capacities of each level of service.

I believe that SB257 appropriately addresses the need to explore that balance, while not unnecessarily encumbering the flexibility of small-town CAHs to attain proper levels of SNF beds to CAH swing beds, with the final blend being appropriate for each individual community. I urge you to support this bill as it is written, for I believe it is written in the mutual best interest of both SNFs and CAHs.

Respectfully Submitted,



David Espeland, CEO