



AN ASSOCIATION OF  
HEALTH CARE  
PROVIDERS

SENATE PUBLIC HEALTH, WELFARE & SAFETY	
EXHIBIT NO.	<u>17</u>
DATE:	<u>1-28-05</u>
BILL NO.	<u>SB 257</u>

**MHA...An Association of Montana Health Care  
Providers**

**Testimony Before the Senate Public Health, Safety  
and Welfare Committee**

**Pertaining to Senate Bill 257; Imposing Certificate  
of Need on Critical Access Hospital Swing Bed  
Services**

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1720 Ninth Avenue P.O. Box 5119  
Helena, Montana 59604-5119  
tel: 406-442-1911 fax: 406-3894  
www.mha.org



For the record, my name is Bob Olsen, Vice President at MHA. MHA is the principal spokesperson for the collective interests of our member institutions. MHA represents Montana hospitals, nursing facilities, home health agencies, independent living facilities, hospices and other health providers.

We ask that this committee not approve Senate Bill 257. We do so for several reasons.

### **Montana Statute**

Montana statutes currently do not require a critical access hospital to obtain a certificate of need in order to offer swing bed care. Most of the people involved in this issue did not know this. For past few years critical access hospitals were being required to obtain a CON for their swing bed programs. Only recently did it come to light that Montana CON statutes don't apply to critical access hospitals. SB 257 aims to subject CAHs to the statute. It does so under the guise of "clarifying" current law. Actually, this bill does not clarify current law. It extends current law onto a currently exempt health care facility.

The question before the Committee is whether the CON process provides some value to the health care system in this case. We believe that CON is a program that has outlived its utility and is no longer required. Payers, including the State and federal government paid health facilities based upon their costs. Overcapacity meant higher payments.

Current fixed rate payment systems has reduced this risk, and current occupancy rates of about 70 percent make it unlikely that excess new capacity will be created.

### **The Numbers**

There are about two million days of care provided in long term care facilities each year. Swing bed services account for about 1% of that total, with fewer than 25,000 days of care per year. The average length of a stay in a traditional, hospital-based long term care facility was 103 days in SFY 04. The average length of a stay in a swing bed was 10.7 days. (Source: MHA Databank and the MHREF Performance Improvement Network)

Swing beds simply do not pose a substantial threat to the traditional long term care industry. Swing bed services may differ somewhat from the type of care in a traditional nursing facility. Even if swing bed utilization quadrupled, it would remain dwarfed by traditional nursing homes.

MHA believes the numbers just don't justify imposing CON on critical access hospitals.

### **Capacity**

One may choose to embrace CON's historical mission to avoid creation of too much treatment capacity. Never mind that the major payers are not concerned about the cost of capacity as they have developed payment schemes in place of CON and centralized health planning.

The current Montana State Health Plan seeks to encourage 85% utilization of nursing homes before allowing for new beds to be placed into service. Several years ago nursing home markets customarily operated at 90% of capacity and more. The current occupancy ranges downward at about 70%, with many small nursing facilities struggling at 50% occupancy and lower.

CON did not cause this apparent oversupply of nursing home beds. Economic conditions, health status of seniors and consumer preference have all played a role in reducing the need for nursing home beds. CON, in fact, was unable to foresee this trend, nor to react to the changing economic environment.

One need not believe that save for the CON program the hospitals may create so many swing beds as to worsen the excess capacity. To what benefit will a hospital supply empty swing beds in an already over-served market?

### **Level Playing Field**

If public policy desires a level playing field, we offer the following solutions: Repeal CON for nursing facilities together. In the alternative, MHA asks that the Committee consider an amendment to strike the term "critical access" from page 2, lines 18 and 19 of the bill.

While a licensed community hospital must obtain a CON for any swing beds beyond five beds, the bill proposes to allow CAHs to convert existing long term care beds to swing beds if the total LTC capacity is not changed. We would ask that the playing field be leveled by allowing similar treatment of other hospitals.

### **Patient Choice**

For all payers except Montana Medicaid, the patient is free to obtain their care in either a swing bed or a traditional nursing facility. Medicaid requires that a swing bed patient covered by Medicaid to be transferred to a traditional nursing home if a bed is within 25 miles of the swing bed provider and is available for admission. Medicaid policy does consider some exceptions based upon medical condition.

This is another example of an uneven playing field. However, since Medicaid pays for about 60% of nursing facility treatment days, this policy acts as a natural limiter of swing bed care.

Finally, since many swing bed patients are transferred from the hospital, the hospital is required to inform the patient of their treatment options and ensure the patient has a choice of providers. Patients with significant medical needs sometimes can't be served in a traditional nursing home. The nursing home may determine the resident care needs are beyond their treatment capacity. In these cases the swing bed is the only option for the resident. CON does not consider this problem in its review process.

**MHA believes that the CON process serves no constructive purpose for critical access hospitals. We ask you to oppose adoption of Senate Bill 257.**