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Via Federal Express

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Ms. Kathryn Olson
Chair
Illinois Health Facilities and Services Review
Board
525 West Jefferson Street, Second Floor
Springfield, IL 62761

**Re: Response to Safety Net Impact Statement
Holy Cross Hospital
Project No. 13-076**

Dear Ms. Olson:

Pursuant to Section 5.4(f) of the Illinois Health Facilities Planning Act, the Association of Safety Net Community Hospitals¹ submits the following Safety Net Impact Statement Response to Holy Cross Hospital's ("HCH") proposal to establish a 50-bed acute mental illness ("AMI") unit. This Safety Net Impact Statement Response is for consideration of the Illinois Health Facilities and Services Review Board ("State Board") in connection with its review of HCH Project Number 13-076. As discussed in greater detail below, the Association of Safety Net Community Hospitals OPPOSE the HCH proposal to begin providing inpatient behavioral health services because it will have a significant negative impact on safety net hospitals in the area. We urge you to reject this application.

Requirement for Safety Net Impact Statement

In 2009, the Illinois General Assembly substantively amended the Illinois Health Facilities Planning Act (the "Amended Planning Act") (Public Act 96-0031). To ensure the impact on safety net services would be considered as part of any application for a permit, the General Assembly added a provision in Section 2 of the Act to require the Board to "... evaluate applications, and establish mechanisms to support adequate financing of the healthcare delivery system in Illinois, for the development and preservation of safety net services . . . Cost

¹ Members include Hartgrove Hospital, Ingalls Memorial Hospital, Loretto Hospital, Mercy Hospital & Medical Center, Norwegian American Hospital, Roseland Community Hospital, Saint Anthony Hospital, St. Bernard Hospital and Health Care Center, South Shore Hospital, and Swedish Covenant Hospital.

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containment and support for safety net services must continue to be central tenets of the Certificate of Need process.” The amendments further added a requirement that an applicant evaluate: (1) the project’s material impact on essential safety net services in the community and (2) the impact the project would have on other providers’ ability to cross-subsidize safety net services to the community. (2009 Ill. Health Facilities Planning Act Amendments, Pub. Act 096-0031 (codified as amended at 20 ILCS 3960/2 and 5.4)).

Importantly, not only did HCH not address the State Board’s criteria regarding impact on safety net services or the ability of other providers to cross-subsidize those services, but it did not consult with other safety net hospitals about the proposed AMI unit and its potential impact on the community or other hospitals prior to submitting its CON application. While more resources need to be devoted to providing better access to mental health services in the City of Chicago, these scarce resources should focus on greater access to community-based mental health programs, which are more cost-effective and shown to provide better outcomes and improved quality of life compared to institutional-based care. Collaboration and coordination among State agencies, providers and the community is essential to ensure successful and sustainable community-based mental health programs are accessible across the entire continuum of care. The State Board should not act on this CON application until HCH addresses the concerns of other safety net hospitals.

Information will not overcome the adverse impact the proposed AMI unit will have on other safety net providers. The proposed inpatient AMI unit does not adequately address the behavioral health needs of the community. HCH should implement a program in line with the Specialized Mental Health Rehabilitation Act of 2013. (2010 ILCS 49/1-101 et seq.) The General Assembly recognizes the inordinately high inpatient hospitalization rate for behavioral health services in the State of Illinois is not a productive or cost effective means to meet the needs of persons needing behavioral health services. A variety of services and settings are necessary to both improve outcomes and reduce costs. Rather than focusing on inpatient hospitalization designed to stabilize patients in crisis, the General Assembly advocates for the establishment of residential treatment facilities that are available when necessary to provide high quality rehabilitation and recovery care. These facilities should coordinate care to help individuals achieve and maintain their highest level of independent functioning and prepare them to live in permanent supportive housing and other community-integrated settings. HCH should work collaboratively with other mental health providers in the community to achieve the General Assembly’s objective of providing behavioral health services in the most community-integrated settings possible.

Impact on Essential Safety Net Services in the Community

As defined in the Amended Planning Act, “safety net services” are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation.” (20 ILCS 3960/5.4(b)). Safety net hospitals in the City of Chicago are located in some of the poorest neighborhoods and serve the neediest members of society. They are often a stop-gap medical system for the poor, who frequently lack health insurance or cannot afford to pay for care. As discussed in the Chicago Tribune article attached hereto as Attachment – 1, safety net providers are frequently the site for initial treatment of trauma patients and care for the sickest patients. In many cases reimbursement from government-subsidized health programs, such as Medicare and Medicaid, do not cover the costs of providing care. Due to the limited number of patients with commercial/private insurance, safety net hospitals have fewer opportunities to cross subsidize essential safety net services. Further, they have limited resources, when compared to non-safety net hospitals, to provide charity care, improve aging infrastructure and invest in new technology.

Within the City of Chicago, there are twenty safety net hospitals. In 2012, these hospitals treated a disproportionate number of Medicaid and charity care patients. In fact, 60.1% of all Medicaid patients were treated at safety net hospitals. Medicaid remains the primary payor for most Safety Net Hospitals, averaging approximately 30.5% of the net revenue for safety net hospitals, compared to 22.8% for non-safety net hospitals. For some safety net hospitals, Medicaid can account for more than 60% of total net revenue. Further, despite limited financial resources, 22.8% of all charity care in 2012 was provided by safety net hospitals. For many safety net hospitals, charity care was over 7% of net revenue (compared to 5.5% of net revenue among all Chicago hospitals).

Among the Chicago safety net hospitals, fourteen provide adult inpatient behavioral health services. AMI units at the safety net hospitals are underutilized with average utilization in 2012 of 66.9%, which is significantly below the State Board’s 85% utilization standard. Based on the State Board’s target utilization of 85% for AMI services, there are 158 available AMI beds among safety net hospitals. Most notably, Loretto Hospital (20 available AMI beds) Jackson Park Hospital (23 available AMI beds), Mercy Hospital and Medical Center (17 available AMI beds), Roseland Community Hospital (15 available AMI beds), and South Shore Hospital (13 available AMI beds) have overlapping service areas with HCH and can easily accommodate the projected HCH AMI referrals.

Importantly, the vast majority of the patients receiving AMI services who will be diverted to HCH if this proposal moves forward, are receiving services from the current safety net

providers of inpatient mental health services. As documented in the referral letters, 1,183 (or 44%) of the projected referrals will come from safety net hospitals. This will not only result in further underutilization of safety net hospitals, but the loss of vital revenue that could be used to expand safety net services to the community. For example, St. Bernard Hospital anticipates the loss of 5 to 10 AMI patients per day and approximately \$1.5 million in revenue annually.

The proposed AMI unit will further weaken already financially fragile safety net hospitals within the GSA. Importantly, HCH, in its application, does not cite increasing trends in inpatient AMI admissions to support the need for 50 additional AMI beds in the GSA. To the contrary, the need for AMI beds will likely decrease in the future as the health care system shifts from inpatient programs to community-based treatment programs particularly since community mental health services funding that was eliminated in 2009 has now been restored. Community-based care is not only shown to improve health outcomes and promote recovery and wellness, but it is also significantly less costly to the state and federal government over time than institutional care. In fact, Governor Pat Quinn's proposal, "The Path to Transformation" seeks to expand community mental health services to allow individuals with mental health challenges to receive the care they need in their own homes and communities instead of institutions. See Attachment 2. If federal approval is granted, "The Path to Transformation" will lower inpatient AMI admissions further lowering utilization of existing AMI providers. The proposed HCH AMI unit will shift AMI admissions and corresponding revenue from existing safety net AMI providers to HCH. As a result, safety net hospitals will face even more daunting financial challenges as they seek to expand their community-based health programs with limited financial resources.

Impact on Other Provider's Ability to Cross-Subsidize Safety net Services

Safety net hospitals provide high levels of Medicaid and uncompensated care to low-income individuals. To assist in covering the cost of providing this care, safety net hospitals are eligible for supplemental Medicaid payments, which are based, in part, on the hospitals' Medicaid inpatient utilization rates. Therefore, not only will the proposed HCH AMI unit divert AMI revenue from the safety net hospitals, but it will lower AMI admissions, thereby decreasing supplemental Medicaid payments, which are vital to the survival of safety net hospitals.

Safety net hospitals serve the most vulnerable members of society who are often uninsured and underinsured. Due to the lack of access to primary care, many medically indigent patients are sicker with more chronic conditions and higher treatment needs, which results in higher health care costs. Due to low commercial payor mix, safety net hospitals cannot cost shift as other hospitals with better payor mixes are able to do. As a result, all revenue sources, whether it be commercial/private insurance, Medicare, Medicaid or supplemental payments, are

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vital to the ongoing survival of safety net hospitals. The shift of AMI patients to HCH will reduce revenue and adversely impact the ability of safety net hospitals to provide essential safety net services to their communities. Existing safety net services would likely be curtailed and implementation of new/innovative community-based health programs will be limited. For these reasons, the Association of Community Safety Net Hospitals opposes Holy Cross Hospital's proposal to add an AMI unit and requests the State Board to deny this application.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Newton".

Mark Newton
Chairman
Association of Community Safety Net Hospitals

Attachments

cc: Michael Constantino

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Section: News

Many **safety-net** hospitals need help of their own
Peter Frost, Tribune reporter

Correction Data

The graphic accompanying this story contains corrected material, published June 20, 2013.

The 63-year-old woman, a Mexican citizen, arrived at St. Anthony Hospital by ambulance, complaining of dizziness, nausea and vomiting:

She had no insurance. No matter.

Dr. Kaleem Malik immediately gave her a round of anti-nausea drugs, had her blood drawn for analysis and ordered images to see if she had any bleeding on her brain.

Sixteen minutes after her arrival, the tests were completed. The scans revealed no bleeding but signs of a possible stroke. Doctors decided to hold her overnight for observation, despite more than \$10,000 in costs that the hospital has little hope of collecting.

"Yes, this kind of care costs a lot of money," said Malik, the chairman of St. Anthony's emergency department, which logs about 36,000 patient visits each year. "But we don't think patients here deserve anything less. People get so hung up on costs, but not everyone realizes the dire need in these communities."

In Lawndale, one of Chicago's most poverty-stricken neighborhoods, St. Anthony often is the site for initial treatment of trauma victims, as well as where the sickest patients come who don't have health insurance or cannot afford to pay for care.

Like many of the Chicago area's 20 **safety-net** hospitals, which act as a stop-gap medical system for the poor,

St. Anthony is facing unprecedented pressure to adjust its business model amid the most sweeping changes to the health care system in decades.

While their larger and better-financed counterparts are investing millions in new facilities, equipment and physicians, many of Chicago's **safety nets** live day-to-day, week-to-week, much like their patients. Some, like St. Anthony, are adapting and thriving. Others, like Roseland Community Hospital, are financially imperiled.

Plagued by declining reimbursement from government-subsidized Medicare and Medicaid programs, which in many cases don't cover the cost of providing care, and other pressures associated with the health care overhaul law, many of the city's **safety nets** are teetering on the brink of insolvency.

Closure of such hospitals, often the largest employers in their neighborhoods, would have major implications on local economies but also could create health care deserts where major swaths of the city would be left without immediate access to health care.

Across the city, at St. Bernard Hospital in Englewood, the emergency room staff sees many patients so often they know their medical histories, their living situations and their family members' names.

On a recent morning, one patient had suffered a heart attack earlier in the day. Another man was sleeping off an apparent alcohol binge on a bed next to the cramped nurses station. Three more people lay behind closed doors in a separate emergency mental health unit.

"Around here, it's always kind of rowing upstream," said Dr. George Dengler, the longtime medical director of St. Bernard's emergency department. "It's sort of demoralizing."

Nonetheless, he said, he's proud of his hospital's commitment to the community and its enduring mission to treat all patients, regardless of their ability to pay.

St. Bernard has a long-tenured management team and a reputation for financial discipline, but it has weathered increasing financial pressures, and its struggles are apparent.

Most patients share rooms. The ER is typically over capacity. And while the facility is spotless, much of its equipment and infrastructure is out of date.

Plans to build a modern, steel-and-glass replacement facility were scuttled in 2009, after money tightened in the recession's aftermath. A 3-D cardboard model of the future hospital now collects dust on a table in St. Bernard's marble-floored chapel, a daily reminder of what could have been.

What if St. Bernard were forced to close?

"It would be a public health disaster," Dengler said. "There would be nowhere for people to go. It would be devastation."

So the little hospital presses on, hoping it can avoid the fate of 18 other hospitals in the state that have been forced to shutter since 2000; seven were urban **safety nets**, serving a disproportionate share of patients who cannot pay or are covered by Medicaid.

Now on the critical list is Roseland Community Hospital on Chicago's Far South Side.

Despite receiving a one-time, \$350,000 infusion from the state this month to meet payroll, the lone acute-care facility in a 5-mile radius is burdened with more than \$7 million in past-due debt.

Closures are inevitable, hospital executives and state officials say, because Chicago has more acute-care hospital beds than it needs, particularly as fewer patients require hospital stays because of a shift toward outpatient treatment.

Julie Hamos, director of the state's Department of Healthcare and Family Services, said she doesn't want to see any **safety nets** go under, but she acknowledged the changes afoot will put pressure on smaller, distressed hospitals that already "are struggling."

Once the Affordable Care Act kicks in, it's expected to provide a reprieve for some of these hospitals by providing a new stream of paying customers.

Through an expansion of the state Medicaid program and a federal income tax credit that aims to help offset the cost of purchasing health insurance, Illinois officials expect nearly 1 million new patients to sign up for health insurance in 2014.

In theory those patients will start paying for the care they previously could not afford.

But for many **safety nets**, it's no panacea.

The reason: There's uncertainty about the future of a hundreds of millions of dollars of supplemental payments hospitals receive each year from the state and federal government in exchange for treating a large percentage of uninsured and Medicaid patients. Also unknown is whether newly insured patients will continue to use **safety-net** hospitals when their health coverage will allow them to use any hospital in the region.

Illinois hospitals also stand to lose a combined \$11.1 billion over the next 10 years through cuts to Medicare, the federal health insurance plan primarily for those age 65 and older, according to the Illinois Hospital Association.

Any gain in insured patients would not come close to offsetting those losses, **safety-net** hospitals say, because they expect to shoulder a disproportionate load in caring for people who will remain without insurance even after the law is implemented.

Because the law does not extend coverage to undocumented immigrants, who tend to use the small community hospitals nearest their homes, many hospitals will continue to provide a significant percentage of free care.

That means Norwegian American Hospital, a 200-bed **safety net** in Humboldt Park, could remain vulnerable. About 20 percent of the 119-year-old hospital's patients don't have insurance and many are undocumented.

"Our patients come to us with some of the worst preventable diseases: prostate cancer, breast cancer, obesity and advanced diabetes," said Jose Sanchez, its president and CEO. "We do not turn away anyone."

In the last two years, the hospital managed to turn a small operating profit, but through April, Norwegian is running a \$2.7 million deficit, Sanchez said.

In response, he's laid off workers, renegotiated contracts and scaled back certain services. Sanchez fears he may have to cut even deeper with changes on the way.

One reason is that many people eligible for free or subsidized insurance won't bother getting coverage. About 470,000 Illinoisans eligible for subsidies to help offset the cost of purchasing health insurance are expected to decline coverage and instead pay a penalty, according to state estimates. That means they'll continue to use hospitals like Norwegian without paying.

And even if a large percentage of a hospital's uninsured patients gain coverage under the state's Medicaid program, reimbursement rates are far below what commercial insurers and even Medicare pay.

For example, Medicaid would pay about \$1,350 to a hospital for performing an outpatient surgery to fix a patient's torn knee ligament. For the same procedure, Medicare would pay around \$2,340. A commercial insurer could pay more than six times that amount, or around \$9,000, according to data compiled by a local hospital.

Norwegian, where 62.9 percent of billings are covered by Medicaid, loses money each time a patient with that coverage walks in the door.

For those reasons, the supplemental payments are a crucial source of revenue that helps keep nearly all of Illinois' **safety nets** afloat.

Combined with state money and subsidies derived from a hospital assessment tax, the 20 **safety nets** in the Chicago area took in \$366 million in supplemental payments in 2011, the last full year for which data is

available.

At Norwegian, supplemental payments accounted for about \$25 million of its \$111.6 million revenue for its fiscal year ended Sept. 30, 2011.

"We really depend on funding from the state to support the gap in money based on the population we serve," Sanchez said. "Right now those supplementals are up in the air. Without that money, we would have to close our doors."

While Sanchez expects many of Norwegian's patients will remain without insurance in 2014, he is optimistic that his team will engineer ways to keep the hospital open. Ideally, he said, the hospital would partner with another facility or health system.

With distressed balance sheets and a poverty-stricken patient base, **safety-net** hospitals are finding few suitors, despite a prevailing trend of industry consolidation.

There are exceptions.

The region's largest acute-care **safety-net**, Mount Sinai Hospital, completed its acquisition in January of fellow **safety-net** Holy Cross Hospital, which nearly closed in the late 2000s amid deteriorating finances.

Although the newly combined health system has struggled -- it posted a \$7.9 million operating loss in the nine months ended March 31 -- Sinai President and CEO Alan Channing said the marriage eventually will create cost savings and provide an opportunity to better coordinate care among patients on Chicago's West, South and Southwest sides.

Such combinations are becoming more common as Medicare, Medicaid and commercial insurers move toward models that pay hospitals and physicians to take care of groups of patients instead of for each procedure.

Under these alignments, provider groups that are able to reduce waste and duplication while improving quality are rewarded by sharing in any savings they produce.

"We are putting Sinai in a position to expand into the community as we move into more of a managed care environment. When you consider those things, it starts to make sense for us to come together," Channing said.

Still, there have been bumps, Channing acknowledged. "I feel like I've got one foot on the dock and another in a boat, and the boat's not tied to anything."

Sinai's Lawndale neighbor, St. Anthony, has taken an opposite approach, eschewing an affiliation to go it

alone.

When now-CEO Guy Medaglia arrived as a consultant in 2007, the 151-bed hospital was losing millions of dollars annually. Medaglia was tasked by its then owner, Ascension Health, with closing or selling it.

Instead, he emboldened the hospital's board to break away from the chain in 2009 and become independent.

Despite that commercial insurance covers fewer than 1 percent of its patients, St. Anthony has posted operating income nearly every year since.

St. Anthony embarked on its turnaround after assessing the needs of its community and tailoring its services to match. It now functions as a de facto community hub, teaching language classes and hosting courses for people studying to take high-school equivalency tests. It also added health services like dialysis and occupational health and expanded its infusion, pediatric and maternal centers.

"If you're doing what the community needs, you become very valuable to them," Medaglia said. "And to continue to serve them, you really have to think out of the box. You have to think: What can we do that's different, that can service this community at a lower cost and higher quality?"

St. Anthony is pushing forward with plans to build a 1 million-square-foot commercial development at 31st Street and Kedzie Avenue anchored by a 100-bed replacement hospital.

The \$430 million Focal Point development is slated to be built on 11 acres acquired from the city for \$1 by a nonprofit affiliated with St. Anthony. The complex is set to include two schools, retail stores, a child-care center, an indoor recreation facility and an athletic field.

Working with Jones Lang LaSalle, which is serving as a leasing agent and project manager, Medaglia hopes to finish construction in mid-2017.

"It's going to be up to each CEO to figure out a way to make new revenue while still taking care of its community, or they're going to close," Medaglia said. "That's really what it comes down to."

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Video: Administrators at St. Bernard discuss hospital's **safety-net** duty. chicagotribune.com/safetynet

Photo: The Chicago area has 20 **safety-net** hospitals, including St. Anthony in the city's Lawndale area where Dr. Kaleem Malik, left, works. ANTHONY SOUFFLE/TRIBUNE PHOTO

Photo: Dr. Kaleem Malik gets a high five after examining a 1-year-old boy brought by his father to the emergency room at St. Anthony Hospital in Chicago's Lawndale neighborhood. ANTHONY SOUFFLE/TRIBUNE PHOTO

Photo: Patient Christopher Beard said he doesn't have insurance to pay for his sports injury care at Chicago's St. Anthony Hospital, one of 20 **safety-net** hospitals in the Chicago area. ANTHONY SOUFFLE/TRIBUNE PHOTO

Photo: Dr. George Dengler, medical director of St. Bernard Hospital's emergency department, said he's proud of his hospital's mission to treat everyone, regardless of ability to pay. TERRENCE ANTONIO JAMES/TRIBUNE PHOTO

Graphic / map: Some **safety nets** rely heavily on Medicaid

Of the 20 hospitals in the Chicago area designated by the state as **safety nets**, four have more than 80 percent of inpatient claims come from Medicaid (this sentence as published has been corrected in this text).

CHICAGO-AREA SAFETY-NET HOSPITALS

Hospital

Beds*

* 2011 certificate of need licensed beds

Most recent reported, in millions, Revenue, Operating income

Percentage of inpatient billing involving Medicaid

Supplemental funding, In millions, 2011 fiscal year

SOURCES: Illinois Health Facilities and Services Review Board, Internal Revenue Service, Provena Health TRIBUNE

- See the microfilm for a complete version of this graphic and map.

---- INDEX REFERENCES ---

INDUSTRY: (Critical & Intensive Care (1CR27); Healthcare (1HE06); Healthcare Practice Specialties (1HE49); Healthcare Regulatory (1HE04); Healthcare Service Providers (1HE78); Healthcare Services (1HE13); Hospital (1HO39); Hospital Administration (1HO60); U.S. National Healthcare Reform (1US09))

REGION: (Americas (IAM92); Europe (1EU83); Illinois (1IL01); North America (1NO39); Northern Europe (1NO01); Norway (1NO68); Scandinavia (1SC27); U.S. Midwest Region (1MI19); USA (1US73); Western Europe (1WE41))

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Quinn proposes \$5.2 billion Medicaid overhaul

February 12, 2014 | Peter Frost and Monique Garcia | Tribune reporters

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In a bid to secure up to \$5.2 billion in federal money to help bolster the state's cash-strapped Medicaid program, Gov. Pat Quinn on Wednesday released a five-year restructuring plan that aims to position the program for long-term savings [↗](#).

The proposal, dubbed "The Path to Transformation," seeks to expand services like mental health and addiction treatment, create and expand home- and community-based care for the disabled and consolidate nine programs that serve different categories of patients.



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In order to access the federal funding, regulators must approve a waiver, which the state plans to submit next month after holding two public hearings.

"This plan will help take our healthcare system to the next level – improving the health of people and communities across Illinois while significantly lowering our long-term costs [↗](#)," Quinn said in a statement.

A spokesman for Quinn said the changes hinge on investing more money  upfront to move people out of residential treatment centers and into community-based care settings. The hope is that by shifting care, the state and the federal government will ultimately save money.

That's also what the Quinn administration will have to prove to the federal government in order to get approval for the plan.

"By restructuring and streamlining, we can bend the cost curve and spend less in the long run on community care while also provide better treatment for folks across the board," said spokesman Mike Claffey. "Ours is a very ambitious plan, but we think we can do a better job by reforming and restructuring the system."

The proposal builds on program Quinn has already put in place to move patients in state-run institutions for the developmentally disabled into more individualized small home  settings. Supporters contend smaller settings offer more personalized care, while opponents contend some people are better served in institutionalized settings with highly trained staff.

Including the federal money and revenue from health care providers, the total investment for the restructuring is expected to be about \$6 billion.

While Quinn is pushing the new five-year plan, there are no guarantees he'll be in office to see it through. The Democrat is seeking re-election to a second term in office and is trying to broadcast his priorities as the four Republican hopefuls snipe at each other heading into the March 18 primary.

The federal government typically considers granting the waivers in situations where it believes the state can save taxpayer money over the long-term by implementing experimental, pilot or demonstration projects.

Under the law, such programs must be budget-neutral, meaning that any money the federal government spends under the waiver must not exceed what it would have otherwise.

Illinois last year received a special waiver to expand Medicaid early to residents of Cook County under a program called CountyCare. The expansion allowed certain low-income people access Medicaid services in advance of the Affordable Care Act, which extended coverage  across Illinois on Jan. 1.

The administration's plan has the support of a number of advocacy groups and the powerful Illinois Hospital Association.

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