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HEALTH FACILITIES &
SERVICES REVIEW BOARD

April 1, 2014

Ms. Courtney Avery
Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson
Springfield, IL 62761

Re: Comments regarding Project No. 13-076, Holy Cross Hospital, Chicago

Dear Ms. Avery,

Pursuant to Section 5.4(f) of the Illinois Health Facilities Planning Act, Presence Saints Mary & Elizabeth Medical Center 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, with consideration by the State Board tentatively scheduled for the April 22, 2014 meeting.

We would like to share our review showing that the analytical assumptions in Holy Cross's CON application do not support CON guidelines of demonstrated need. Based on the data below, this planning area already has excess acute mental illness bed capacity. What the area does not have are enough providers able to care for dual diagnosis and unfunded patients in those beds. Nor are there adequate outpatient services to allow for timely ED/inpatient discharge to a community-based care plan.

We would like to draw your attention to the fact that the Acute Mental Illness Planning Area A-03, which is the planning area for Holy Cross Hospital, currently shows an excess of 76 beds according to the latest *Inventory Of Health Care Facilities And Services And Need Determinations*. HCH's proposal to add 50 additional beds to this planning will nearly double the number of excess beds, and will undoubtedly draw existing patients away from existing AMI providers.

According to Section 1110.730.c Acute Mental Illness – Review Criteria, Unnecessary Duplication/Maldistribution – Review Criterion:

2) The applicant shall document that the project will not result in maldistribution of services. Maldistribution exists when the identified area (within the planning area) has an excess supply of facilities, bed and services characterized by such factors as, but not limited to:

B) Historical utilization (for the latest 12-month period prior to submission of the application) for existing facilities and services that is below the occupancy standard established pursuant to 77 Ill. Adm. Code 1100;

The table below shows the CON utilization rates as calculated from the IDPH 2012 Hospital Data Profile:

Hospital in Acute Mental Illness Planning Area A-03	CON Beds	2012 Admissions	2012 Patient Days	CON Occupancy Rate %
Jackson Park Hosp. Foundation	86	4,110	18,337	58.4%
Mercy Hospital & Medical Center	39	1,082	5,996	42.1%
Roseland Community Hospital	30	352	3,763	34.4%
South Shore Hospital	15	0	0	0.0%
St. Bernard Hospital	40	1,587	11,958	81.9%
Total for Acute Mental Illness Planning Area A-03	210	7,131	40,054	52.3%

As shown in the table above, the Planning Area's utilization used in the review criteria, 52.3%, is well below the target occupancy of 85% for Acute Mental Illness category of service.

Another consideration is that declining use rates for behavioral health will result in overall market volume decreases, and in concert with payors' (primarily Medicare and Medicaid) focus on reducing 30-day readmissions has already led to decreased volumes particularly in the behavioral health service line.

We believe that the real mental health needs in this area are treating patients with co-morbidities and a lack of funding to treat these patients. In treating all beds as equal, without preferentially addressing how to fill these new beds with specific patient types, HCH's application will directly harm existing providers of AMI services by greatly diluting the small pool of funded patients amongst multiple providers and increasing excess bed capacity.

A review of data provided by the CompData inpatient database for the most recent 12-month period (October 2012-September 2013) clearly drives home that there is a sizable patient mental health population that have additional health problems. Statewide, 74% of all patients with a behavioral health (psychiatric and substance abuse) diagnosis code (ICD9 Dx codes 290-303) also were admitted with a MSDRG that was not behavioral health-related (excludes MSDRG 880-887, 894-897, 917-918).



An alternative to addressing the needs of this vulnerable population might be creating a new category of service that would allow for the development of a short-stay (psychiatric observation/non-inpatient) environment for stabilization and discharge to outpatient treatment. This would be a much more cost effective model than creating unneeded inpatient capacity.

Currently, the Section 1115 Waiver that is pending Federal approval may allow for funding of this kind of demonstration project. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs and that differ from federal program rules. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid such as supportive housing
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs

Again, we believe focus and resources should be placed on the real issues: appropriate access for difficult-to-place patient populations and the bed need for dual diagnosis/unfunded patients.

Sincerely,

A handwritten signature in cursive script that reads "Sandra Bruce".

Sandra Bruce, FACHE
President and CEO
Presence Health

SB/fdjo

cc: Michael Constantino