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HEALTH FACILITIES & SERVICES REVIEW BOARD

Ms. Kathryn Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson, 2nd Floor
Springfield, Illinois 62761

Re: Analysis of Non-compliance with Review Board Standards and Opposition to Mercy Crystal Lake Hospital – Project No. 17-002 (the "Project")

Dear Chairwoman Olson:

Mercyhealth has proposed to establish an expensive new 13-bed hospital in an affluent community that is presently well served in a county with excess hospital beds. This Project disrespects the Board's rules not only on size but on many other state standards. Approval of this hospital under these circumstances would create an extraordinary precedent for other hospital projects that could disrupt health planning and services and without any significant benefit.

As legal counsel for Advocate Health Care, I have reviewed the Mercy application for permit ("CON application) as to how the project complies with Review Board regulations. As detailed below, this Project disregards Review Board regulations and policies.

A. Summary of Arguments

This letter will go into more detail as to how the CON application fails to comply with review standards. Others have reviewed the application and submitted more detailed analysis on specific sections of the application in accordance with their expertise. It may be beneficial to first summarize this other opposition analysis relating to this Project.

- This Project is for a "Micro-Hospital", but comes with a Macro Cost. The proposed 13 bed hospital comes at a cost of almost $80 million – an unprecedented $6 million per bed (plus $18.9 million for an adjoining medical office building). While Mercy will argue that this calculation should be adjusted given how much outpatient and ancillary services are included, constructing outpatient services in a high cost hospital environment is an expensive means for providing outpatient services. While this hospital based billing for outpatient services generates higher reimbursement for the provider, it leads to higher costs for health care.

- Excess Nonclinical Space Increases Costs. This Project proposes an extraordinary amount nonclinical space—60% of the hospital is not clinical and thus "non-reviewable. The Project devotes more space to administration and conference rooms than med/surg beds. Mercy proposes almost as much non-clinical space for a 13-bed hospital as it proposed in its prior 70-bed CON application. According to an experienced architect who reviewed the Project, there appears to be enough "chassis" space to support a 60-bed hospital.

- The Purpose of the Project is not to Provide Access to Care for the Indigent as Claimed. The Application states that the first purpose of the Project is to provide care for the indigent population. A study of the demographics in the area, however, show that the community of Crystal Lake is an affluent community in an affluent county. Mercy proposes to shift services from lower income Harvard to higher income Crystal Lake where there is a lower percentage of Medicaid patients requiring inpatient services and does not offer the obstetric and delivery services often needed by Medicaid patients. Mercy history at Harvard where it provided only $40,000 in total charity care services (0.2% of revenues) further undercuts its claim that this Project is to assist the indigent.

- Patients will Not Receive the Emergency Services they Expect from Hospitals. Mercy has touted that it will be providing emergency department services, but does not commit to providing the "comprehensive" level of emergency care typical of most hospitals. This level of emergency care will not provide the life-threatening care provided by the two Level II Trauma centers located within 10 miles. Much if not most of the low acuity care provided at the proposed emergency department could be appropriately provided at a much lower cost at the two immediate care facilities located near the proposed site.

- Patient Forecast Demand is Very Optimistic. Mercy is very optimistic in projecting the number of patients that will use this micro hospital when many of those patients reside closer to existing full service hospitals, calling in to question its ability to meet target utilization.

- Excess Surgical Capacity. This Project proposes adding surgical capacity to the area by establishing two operating rooms and two procedure rooms. Just as there is excessive medical/surgical capacity, there is also excessive surgical capacity in the area by ASTCs. Area ASTCs operate at only an average of 50% of target utilization.

- Transportation Services are Presently Available to Area Hospitals. The Applicants have stated that a purpose of the project is to provide better access for patients in Crystal Lake who do not have transportation to other facilities. As other letters have documented, McHenry County, through its McRide program, provides free or low-cost transportation services from a patient's home to existing providers. Similarly,

Advocate Good Shepherd Hospital provides a free transportation service to patients to and from a patient's home and the hospital and even to the immediate care center in Crystal Lake.

B. The Mercy application Fails to Comply with Review Board Rules

1. There is a Calculated Excess of Beds in the Planning Area

c) Planning Area Need – Review Criterion
The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population, based on the following:

1) 77 Ill. Adm. Code 1100 (formula calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

77 Ill.AdminCode 1110.530(c)

There is no dispute that there is an excess of beds in the Planning Area and this Project does not comply with the Review Board requirements. There is an excess of 43 medical/surgical beds in the Planning Area and an excess of 3 Intensive Care Unit beds.

Mercy offers no justification for its lack of compliance with the bed need inventory other than to state that it will be "relocating" beds from its Mercy Harvard hospital. As the Review Board well knows, there is no provision in its regulations for "transferring" beds from one hospital to another.

Although transferring licensed beds has never been permissible, this concept has recently been rejected in a similar context. The Review Board, through its Subcommittee for Long Term Care, has studied this concept in the context of long term care beds. After years of discussion the subcommittee determined that it could not make a recommendation for a bed transfer or buy/sell program. Many of the reasons that such a program could not be recommended for long term care apply similarly in not following that program for hospital beds as Mercy proposes here.

Moreover, in that context there had been a long term study which, if implemented, would have occurred only after detailed study and would only have been implemented following a change in rules and/or legislation—not through selective application of existing rules as Mercy proposes here.

2. Mercy Application Does Not Comply with Assurances Requirement

h) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

77 Ill.Admin.Code 530(h) (emphasis added)

As stated above, Review Board requirements require that the applicant provide an assurance that the project will achieve and maintain specified occupancy standards for *each category of service involved in the proposal.* Page 111 of the CON application contains a letter with the "RE" line "Compliance with the IHFSRB's Second Year Target Utilization Rate".

This assurance letter suggesting that the application complies with the Assurance requirement is, at best, not forthcoming, and perhaps intentionally misleading. The letter states that it anticipates complying with the medical/surgical category of service but makes no mention that it anticipates failing to comply with the occupancy standards for ICU. The Board regulations, however, require that the Assurance apply to each category of service in the proposal. Page 82 of the Application concedes that the application will not achieve occupancy standards for ICU.

Consequently, the Application does not comply with the Assurances standard and there should be a negative finding on this review criterion.

3. The Physician Referral Letters do not Comply with the Review Board Requirements

B) Projected Referrals

The applicant shall provide the following:

i) Physician referral letters that attest to the physician's total number of patients (by zip code of residence) who have received care at existing facilities located in the area during the 12-month period prior to submission of the application;

ii) An estimated number of patients the physician will refer annually to the applicant's facility within a 24-month period after project completion. The

> *anticipated number of referrals cannot exceed the physician's experienced caseload. The percentage of project referrals used to justify the proposed expansion cannot exceed the historical percentage of applicant market share within a 24-month period after project completion;*

77 Ill.Admin.Code 1110.530(c)(3)

Review Board regulations cited above require that physician referral letters "cannot exceed the physician's experienced caseload". Each of the physician referral letters contained in the permit application acknowledge that "*I am not able to provide specific documentation of the total number of admissions for my patients.*" Instead, the letter simply states the number of patients the physician has and that a certain percentage of those patients are admitted for hospitalization. The purported referral letters cannot comply with the Board regulation that referrals not exceed the physician's experienced caseload when the physician does not know the number of admissions that he or she makes. The letters indicate that many times the admissions are made by a different physician, a hospital physician. Further, the referral letter methodology used which only estimates how many of a physician's patients required hospitalization ignores that many inpatient admissions are from the emergency room and not an admission controlled by the physician. Consequently, a physician cannot state that those referrals have not already been committed for other CON projects, such as the new Huntley hospital which opened only last year.

4. Proposed Hospital Meets Neither 100 Bed Rule nor 4 Bed ICU Minimum

g) Performance Requirements – Bed Capacity Minimum

1) Medical-Surgical

The minimum bed capacity for a new medical-surgical category of service within a Metropolitan Statistical Area (MSA) is 100 beds.

2) Obstetrics

A) The minimum unit size for a new obstetric unit within an MSA is 20 beds.

B) The minimum unit size for a new obstetric unit outside an MSA is 4 beds.

3) Intensive Care

The minimum unit size for an intensive care unit is 4 beds.

77 Ill.Admin.Code 1110(g)

Review Board regulations have long required that new hospitals in a MSA (such as here) establishing a medical surgical category of services must have a minimum of 100 med/surg beds and for intensive care beds a minimum of 4. This project to establish only 11 med/surg beds and only 2 ICU beds does not even come close to complying with the Board's rules.

a. To allow Micro Hospitals is a Major Policy Change that, if implemented, should be done only through formal rulemaking.

Mercy has sometimes described this Project as an "innovative model".[1] Other times, Mercy has said that "small sized hospitals are not an anomaly, but already exist in significant number throughout the State".[2] If the Board choses to allow mini-hospitals as an "innovative" new model, this major policy change should be implemented only through formal rule-making and not selective enforcement of the Board's rules. Alternatively, if Mercy intends that this hospital is meant to be like other mini-hospitals (including its existing Harvard hospital), the inefficiencies and low utilization can only be justified for rural or remote areas where there are not alternatives.

The existing 100 bed/4 ICU minimum bed requirement is a long-standing policy of the Review Board. To allow mini-hospitals in urban areas like the collar counties would be a major departure from long established hospital planning. As Vista Health System points out in its opposition to the Project, approval of the Project would create a precedent for approval of other micro hospitals. The precedential implications of approving a mini-hospital in an affluent suburb where there is no calculated need (such as here) would create considerable uncertainty and inefficiency in the health care community. This major policy shift would have significant implications for health care policy in the state that should only be undertaken after significant analysis, input, and review.

If the major policy shift to deviate from existing rules is to be implemented, the Board should do so through deliberative formal rulemaking under the Administrative Procedures Act (APA). The Review Board frequently examines its own rules and often amends its rule to implement changes. When it undergoes this rulemaking policy it follows APA procedures to publish notice and give opportunity for interested parties to provide input into these changes. The legislative Joint Committee on Administrative Rules then reviews those proposed regulations before they go into effect. If Mercy wished to significantly change policy, it could have suggested that the Review Board examine this rule and change its rules. It did not. A formal rule would also provide detail and guidance of conditions for establishing a micro-

[1] Mercy CON Application, page 66
[2] April 28, 2017 Mercy Additional Information, page 5

hospital. Instead, Mercy asks that you make a special exception just for them.

b. The Small Hospital Model should not be Replicated outside Rural Areas.

Review Board staff had requested additional information asking Mercy "*Can you provide the analysis that demonstrates how the projected average daily census of 10 patients for the 11 bed med/surg units compares to other hospitals in the State?*" Mercy responded by providing a list of hospitals with daily census of fewer than 10 days. As the attached chart shows, these hospitals have an average occupancy of only 24%. Not a single small hospital meets the Review Board's target occupancy.

That list shows 48 hospitals licensed for 25 beds or less. Every hospital licensed for 25 beds or less is a "Critical Access Hospital". Critical Access Hospital (CAH) status is a federal CMS designation that qualifies those hospitals for special reimbursement from the federal government that is generally 101% of reasonable costs (rather than on a DRG reimbursement). This very favorable reimbursement structure is allowed to recognize the cost inefficiencies of operating a small hospital. Mercy's existing small hospital in Harvard, which operates at only 30.9% occupancy, cannot serve as a successful model justifying the Crystal Lake hospital. Because this special reimbursement is generally higher than allowed for other hospitals, and thus costs the government more, federal CMS (Centers for Medicare and Medicaid Services) restricts those hospitals that can qualify. These hospitals cannot exceed 25 licensed beds. More importantly, these hospitals, unless grandfathered, must be located more than 35 miles from the nearest hospital (with special conditions for mountainous regions). Consequently, the proposed Mercy Crystal Lake hospital, which is located within approximately 12 miles of 5 hospitals, does not provide the "critical access" function provided by small hospitals that qualify as a critical access hospital. A summary of CMS qualifications is attached.

When every other small hospital in the state is a Critical Access Hospital, these other small hospitals cannot be used as a successful precedent for the proposed micro-hospital. Because the proposed Mercy Crystal Lake hospital is located with 12 miles of five full service hospitals, it clearly is not "Critical Access" and does not qualify for the CAH designation.

While focus is on the Crystal Lake hospital, it is important to note that approval of this Project would result in creating only a 6-bed hospital in Harvard after those beds were discontinued. The smallest hospital is presently a 15- bed hospital and approval of this Project would create the two smallest hospitals in Illinois at 6 beds and 13 beds. The Board should thoughtfully consider whether it is clinically appropriate to have a hospital with only 4 med/surg and 2 ICU beds. Reducing the capacity is also important to consider in light of the reporting by Mercy Harvard in the annual IDPH bed survey. For 2015, Mercy shows a peak med/surg census of 11, which exceeds the proposed capacity of only 4 med/surg beds at Mercy-Harvard and even exceeds the average daily census of 4.6. Given the distance of Mercy-Harvard to other nearby hospital this proposed situation of demand exceeding proposed reduced capacity would adversely impact the Harvard community.

5. The Project Creates Unnecessary Duplication and Misdistribution of Services

d) Unnecessary Duplication/Maldistribution – Review Criterion

. . .

4) The applicant shall document that the project will not result in maldistribution of services. Maldistribution [exists when there is]

. . .

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;

. . .

As the State Board Report will show, there are 5 hospitals located within approximately 12 miles of the proposed hospital site. Four of those hospitals operate well below the occupancy standards and the fifth hospital operates at the state standard.

Med/Surg Utilization of Area Hospitals

2015 AHQ

Hospital	Miles	Occupancy %
Advocate Good Shepherd	6.3	90.3%
Centegra McHenry	7.2	62.4%*
Centegra Woodstock	8.1	59.7%*
Centegra Huntley	8.8	(New)*
Advocate Sherman	12.6	71.4%*
Mercy Harvard	24.6	30.9%*

* Does not meet state standard for occupancy

As the chart above shows, every hospital in the area except one has historical utilization well below state standards. The one hospital operating at the state standard of 90% utilization would likely fall below the standard if this Project were approved. More importantly, these 2015 utilization numbers do not reflect that a new 128-bed hospital in Huntley opened in 2016. The proposed project fails to meet the review criterion for maldistribution.

6. The Project will Negatively Impact other Providers

3) The applicant shall document that, within 24 months after project completion, the proposed project:

A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

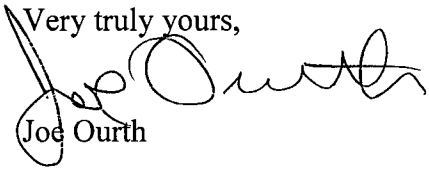
B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.

This Project will lower the utilization of other providers and negatively impact them. Mercy repeatedly argues that this Project is "relocating" licensed beds from its Harvard hospital to Crystal Lake. While proposing this paper change in the number of licensed beds at Harvard, Mercy never makes the corresponding assurance that it will be moving the actual cases from Harvard. Indeed, if it made the commitment to move actual patients from a hospital with only a 4.6 average daily census, it would need to admit that it would effectively be closing the Harvard hospital. Mercy instead concedes that to populate its new hospital it will be taking the patients from other hospitals (Application p. 107). Its only justification is to say that it will not take a lot of patients. No matter what the number of patients taking from other hospitals, the result will be that it lowers utilization of other hospitals and thus fails to comply with this review criterion.

Conclusion

The Review Board has adopted comprehensive and detailed regulations governing the state standards for establishing new hospitals, particularly the requirement that hospitals in MSA must have a minimum of 100 med surg beds. To make such a drastic departure from long standing policy should only be undertaking through the formal rulemaking process. The Applicants for this Project disrespect the Board's regulations by treating those rules as optional or not applying to them. To approve an expensive and inefficient hospital in an area without any need for a hospital would run against not only the Board's rules, but its mission. We ask that the Board deny this Project.

Very truly yours,



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Listing of All Illinois Hospitals with Med/Surg Average Daily Census of 10 or less
Source: 2015 Hospital Profiles from HFSRB website

No.	Hospital Name	CON Approved M/S Beds	Avg. Daily M/S Census	Occupancy Percentage 2015
1.	Abraham Lincoln Hospital*	22	9.2	41.8%
2.	Advocate Eureka Hospital*	25	1.6	6.4%
3.	Carlinville Area Hospital Association*	25	3.9	15.5%
4.	Clay County Hospital*	18	9.4	52.0%
5.	Community Memorial Hospital	43	2.0	4.6%
6.	Crawford Memorial Hospital*	21	9.5	45.2%
7.	Dr. John Warner Hospital*	21	2.1	9.8%
8.	Fairfield Memorial Hospital*	21	9.3	44.3%
9.	Fayette County Hospital*	23	9.1	39.5%
10.	Ferrell Hospital*	25	6.6	26.3%
11.	Franklin Hospital*	16	3.8	23.7%
12.	Genesis Medical Center Aledo*	22	2.2	10.0%
13.	Gibson Community Hospital*	17	6.6	38.9%
14.	Greenville Regional Hospital	26	6.6	25.6%
15.	Hamilton Memorial Hospital*	25	5.6	22.5%
16.	Hammond Henry Hospital*	16	8.1	50.5%
17.	Hardin County General Hospital*	25	6.5	26.2%
18.	Hillsboro Area Hospital*	25	3.9	15.7%
19.	Hoopeston Community Memorial Hospital*	24	4.6	19.2%
20.	Hopedale Hospital*	20	3.1	15.5%
21.	Illini Community Hospital*	19	3.8	20.1%
22.	Iroquois Memorial Hospital*	15	7.0	46.4%
23.	Jersey Community Hospital	61	8.2	13.4%
24.	Kirby Medical Center*	16	1.9	11.8%
25.	Lawrence County Memorial Hospital*	25	6.7	26.9%
26.	Marshall Browning Hospital*	25	5.3	21.0%
27.	Mason District Hospital*	25	2.0	7.9%
28.	Massac Memorial Hospital*	25	9.6	38.3%
29.	Memorial Hospital- Chester*	23	5.6	24.2%
30.	Memorial Hospital- Carthage*	15	3.1	20.7%
31.	Mendota Community Hospital d/b/a OSF Saint*	21	5.6	26.7%
32.	Mercy Harvard Memorial Hospital*	15	4.6	30.9%
33.	Midwest Medical Center*	25	1.2	4.9%
34.	Morrison Community Hospital*	25	8.1	32.3%
35.	OSF Holy Family Medical Center*	23	2.7	11.9%

36.	OSF Saint James John W. Albrecht Medical Center	33	8.4	25.6%
37.	OSF Saint Luke Medical Center*	22	4.3	19.7%
38.	Pana Community Hospital*	22	2.6	12.0%
39.	Paris Community Hospital*	25	4.8	19.1%
40.	Perry Memorial Hospital*	22	7.3	33.0%
41.	Pinckneyville Community Hospital*	17	4.6	27.0%
42.	Presence Holy Family Hospital	49	6.1	12.4%
43.	Provident Hospital of Cook County	79	8.9	35.7%
44.	Red Bud Regional Hospital*	25	6.0	24.0%
45.	Rochelle Community Hospital*	12	6.8	56.8%
46.	Salem Township Hospital*	22	5.1	23.1%
47.	Sarah D. Culbertson Memorial Hospital*	22	2.3	10.4%
48.	Shelby Memorial Hospital	30	4.9	16.5%
49.	Sparta Community Hospital*	25	5.8	23.1%
50.	St. Joseph Memorial Hospital*	25	5.3	21.1%
51.	SwedishAmerican Medical Center – Belvidere	34	0.1	0.4%
52.	Taylorville Memorial Hospital*	21	9.5	45.1%
53.	Thomas H. Boyd Memorial Hospital*	25	1.6	6.5%
54.	UnityPoint Health - Trinity Moline*	20	2.3	11.5%
55.	Valley West Hospital*	15	6.8	45.0%
56.	Wabash General Hospital District*	25	7.3	29.2%
57.	Washington County Hospital*	22	0.7	3.2%

Average Occupancy **24.0%**

*Critical Access Hospital

Sources: Listing of Hospitals and Average Daily Med/Surg census is from Mercy additional information provided April 28, 2017. Occupancy percentage and Critical Hospital designation is from 2015 Hospital profiles from HFSRB website.

CMS.gov
Centers for Medicare & Medicaid Services

Critical Access Hospitals

This page provides basic information about being certified as a Medicare Critical Access Hospital (CAH) provider and includes links to applicable laws, regulations, and compliance information.

CAHs represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. The CoPs for CAHs are listed in the "Code of Federal Regulations" at 42 CFR 485 subpart F.

The following providers may be eligible to become CAHs:

- Currently-participating Medicare hospitals;
- Hospitals that ceased operations on or after November 29, 1989; or
- Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

A Medicare-participating hospital must meet the following criteria to be designated by CMS as a CAH:

- Be located in a State that has established a State Medicare Rural Hospital Flexibility Program;
- Be designated by the State as a CAH;
- Be located in a rural area or an area that is treated as rural;
- Be located either more than 35-miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads; OR prior to January 1, 2006, were certified as a CAH based on State designation as a "necessary provider" of health care services to residents in the area.
- Maintain no more than 25 inpatient beds that can be used for either inpatient or swing-bed services;
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care (excluding swing-bed services and beds that are within distinct part units);
- Demonstrate compliance with the CAH CoPs found at 42 CFR Part 485 subpart F; and
- Furnish 24-hour emergency care services 7 days a week;

A CAH may also be granted "swing-bed" approval to provide post-hospital Skilled Nursing Facility-level care in its inpatient beds.

In the case of hospice care, a hospice may contract with a CAH to provide the Medicare hospice hospital benefit. Reimbursement from Medicare is made to the hospice. The CAH may dedicate beds to the hospice, but the beds must be counted toward the 25-bed maximum. However, the hospice patient is not included in the calculation of the 96-hour annual average length of stay. The hospice patient can be admitted to the CAH for any care involved in their treatment plan or for respite care. The CAH negotiates reimbursement through an agreement with the hospice.

In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.

Downloads

Chapter 2 - The Certification Process [PDF, 2MB]

Related Links

Section 1820 of the Social Security Act
Section 1861 of the Social Security Act
42 CFR Sections 485.50 - 485.74
Critical Access Hospitals
Survey & Certification - Enforcement

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