Summary of Changes to LTC App
October 2013

The work group reviewed the current application with the goal of making it applicable to long-term care and, at the same time, modernizing it.

There are several policy considerations which are beyond the scope of the work group, but which are obvious:

1. The use of 90 percent occupancy should be clarified.

   It is generally accepted in CON States, including Illinois, that 90 percent is the occupancy benchmark. Claire did the research on this and it is has been provided to subcommittee members in the form of several hand-outs. Until a facility attains 90 percent occupancy, it is not eligible for additional beds.

   Ironically, the application does not present any guidance on the 90 percent benchmark. In 1125.580, Duplication of Services, the standard of 90 percent average annual occupancy for all facilities in a service area is referenced via 1125.210 (c). The reader has to research the rules to learn this expectation.

   Does 90 pct apply to modernization projects or only to additional beds? At 1125.650 (4), the application applies the 90 pct standard to modernization, once again referencing 1125.210(c). It takes some digging to understand how the 90 pct standard is to be applied.

   The 90 pct standard is discussed in more detail in item 7, below, Duplication of Services.

2. Renovations and replacements should be encouraged.

   With Medicaid reimbursement in its current state, this encouragement may be easier said than done.

   Suppose a lower-occupancy facility has financing and wants to modernize. It believes that modernizing will allow the operation to run at 90 pct occupancy. However, since the source of the applicant's additional occupancy will be its competitors, approval of this type of modernization may cause other competitors to lose occupancy. The degree of conflict between encouraging modernization and the 90 pct standard may be so great as to be irreconcilable.

3. Financing

   Financing continues to receive a great deal of emphasis. Not all applicants can get financing even after receiving the CON. Certain types of financing involve a considerable lead time – HUD, for example. At some point, the subcommittee might wish to address financing. If financing has not been obtained after a set period, should the CON be forfeited?

4. Dead beds

   There are lots of excess beds in Illinois. Some of them are considered “dead” in that they are being used for other purposes; they remain licensed but are unlikely to be used as resident nursing beds. Should such excess beds be bought and sold as a way of reducing capacity? It remains to be seen if a buy-sell program can be effective or if it becomes the policy equivalent of shuffling cards.

   The subcommittee is well aware of this issue and its ramifications. There appears to be a decent data source that tracks the usage of resident rooms, thereby allowing for an assessment of the scope of the dead beds issue.

   Dead beds have been discussed as one factor in attaining a desired occupancy level. In practice, only actual resident days provide a true measure of facility volume. With the actual resident days in Illinois remaining in the mid- to upper- 70 pct range, it will take a lot of dead beds to “resolve” a 90 pct policy issue. If our calculations are correct, using Mike C’s 2011 data, approximately 15,000 beds will have to be eliminated in order for the State-wide occupancy to increase to 90 percent. Policy-wise, there do not appear to be enough dead beds to allow HFSRB to achieve a State-wide occupancy level of 90 percent. There may be other perfectly legitimate reasons to engage in a buy-sell program. Getting the State-wide occupancy to 90 percent does not appear to be one of them.

Items in Process - Not Requiring a Rule Change

1. Opening instructions: provide a definition of substantive and non-substantive (conf call #1, Nov 19 2012) 1130.140

2. Project Description, Section 1: Re-order so that a description of the project appears early in the application. (conf call #1, Nov 19 2012) This may already be re-located in July 2012 version of app.

3. Bed Capacity, 1125.510: Column headings would benefit from better explanation. Claire was to re-work the headers. (Conf call #1, Nov 19 2012)

4. Project Size, 1125.620: Conf call #3 Dec 20 2012. Correct references so that Appendix D becomes Appendix A. Provide the standards that guide the applicant in completing the appendices.

5. Modernization, 1125.650: The dollar limits should be presented in the application as well as a link to the Board's rules so the applicant will have the current dollar limit as an easy reference. Conf call #2 Dec 20 2012

6. Specialized LTC: 1125.720: Deleted from app as this classification of LTC is now governed by its own rules. Conf call #3 Dec 20 2012

Items Requiring a Rule Change

1. Opening Instructions, page ii: Conf Call #5, July 24-2013. Excerpt from Conf Call #5:

   > Regarding physician referral letters: There was general agreement among the staff – but not universal – that applicants are having difficulty providing the requested information. There is little that can be done to improve the situation and, more to the point, there are other ways to discern how a proposed facility is likely to be utilized. Requiring a market feasibility study was an option that was discussed and the group felt that this was worth consideration.

   As a result of this change, section 1125.540 (1 thru 4) would also be dropped.

2. Service Demand, 1125.540: The group recommended deleting item 5, rapid population growth.

   Together, items 1 and 2 result in the elimination of 1125.540.

   Discussion:

   The assigned purpose of the Application Work Group is to revise the current application to make it relevant to long-term care. Item #1, with its reference to the "…location of the recipient LTC Facility" reflects an acute care orientation of this standard. LTC facilities are on the receiving end of acute care referrals.

   Staff reports consistently that providers are having a difficult time documenting items 2, 3, and 4. Most observers, including this work group, do not believe that there is any objective or verifiable manner of providing the required referral information. As a result, the CEO certification required in Item #3 is proving difficult to get.

   Staff (Mike C) further reports that the rapid population growth exception has hardly ever been used and should be eliminated.

3. Planning Area Need, 1125.530: Conf call #1 Nov 19 2012

   a. Include a link to the bed need formula

b. Raise PSA admissions from 50 pct to 70-75 pct. (As a practical matter, special consideration will have to be given to market areas that overlap the current health service areas, which are currently the County geographic borders.)

   The rule requires that "…the primary purpose of the project will be to provide necessary LTC to the residents of the area in which the proposed project will be physically located…". Logic suggests that a minimum admission level of at least 50 percent from the PSA does not establish that the facility is serving primarily residents of the service area. If 50 percent can emanate from outside the PSA, is not the SSA equivalent to the PSA? If the intent of the rule is for the applicant to establish a PSA, the work group recommends that the application follow the usual-and-customary industry definitions of PSA, i.e., 70-75 percent.

   LTC applicants with existing facilities seeking modernization or expansion can provide historical zip code of origin for their admissions, indicating what their primary service area is. If the PSA is within the facility's assigned planning area, no further information is required. New facilities in planning areas where there is a bed need can rely on the bed need formula provided the PSA does not overlap with another planning area. For situations involving planning area overlap, for both existing and new facilities, a market demand analysis may be required to document the bed need.

c. Rule requires pt origin information while app cites pt referrals. Changes are to be made in the app to use pt origin. (Most likely new facilities should be exempted from this requirement as there is no established history.)

4. Alternatives, Section 1125.330: Conf Call #5 July 24-2013.

   After considerable discussion, the work group recommends a rule change and that the current Alternatives section be replaced with a better option.

   Staff continues to report that no negative findings are issued for failure to address alternatives. Staff supports the idea of sound strategic planning and reports that Board members appreciate learning what efforts applicants have taken to examine alternatives.

   As presented in 330, alternative options A, B, C, and D are "must" items. In the rule, A, B, and C are examples, not requirements. The current application requirements are inconsistent with the rule. Whatever the final approach is to alternatives, the current requirement to respond to four specific, mandated alternatives should be dropped and made consistent with the rule. At the same time, items 2 and 3 in the current application involve a) the preparation of forecasts that compare the requested project against the 4 required alternatives; and b) the presentation of empirical evidence "as available" that

verifies improved quality of care. The information in items 2 and 3 lends itself to subjectivity and may be difficult to prove or to disprove.

The work group recommends a rule change, dropping Alternatives as currently structured.

Discussion:

The Project Description represents a flexible option to the current mandated list of alternatives. Under Project Description, applicants can describe their process for planning the project including the assessment of demand for services and/or bed need, the rationale for making a significant investment, options considered, and the expected financial ramifications of the decision to submit an application. In other words, the applicant explains why the decision to build is the best option. This approach is consistent with the intent of the existing rule, which requires applicants to document the most effective and least costly approach to their project. Giving the reader a straight-forward account of the project early in the application is highly beneficial.

Will discussing alternatives in the Project Description make the section too lengthy? Possibly. As an option, the Alternatives section, 1125.330, could remain in the same location and be re-designed to be consistent with the rule. The important point is that alternatives are discussed in a manner consistent with the rule; where such a presentation takes place in the application is a secondary consideration.

5. Service Demand, 1125.550: Conf Call #5 July 24 2013. Mike C advised that dropping item 5, above in 540, results in item 3 being superfluous in 550. Also, item 2 in 550 calls for documentation of patient referrals, which have proven to be difficult data to obtain. Consensus: drop 2 and 3.

6. Service Accessibility, 1125.570: Conf call #5. The fourth bullet is a reference to acute care and is not applicable to LTC. Rule change required to drop; rule change recommended.

7. Duplication of Services, 1125.580: Conf call #2 Dec 5 2012. Standards such as the 30 minute drive and 90 percent occupancy are out of step with today's industry environment. According to the Springwood decision and Urso opinion, 580 can include flexible criteria, if the group so desires.

   Market studies for new facilities can be used to identify the service area for facilities that cross county boundaries.

   The application cites a minimum occupancy standard of 90 percent. Specifically, applicants must document that the project "…will not lower the utilization of other area providers below the occupancy standards specified in Section 1125.210(c)…". In the

rule, the occupancy target specifies that all facilities in the service area, not just the applicant facility, should be operating at an average annual occupancy of 90 percent.

The table and graphs below were constructed using data provided by Mike C for the years 2006 thru 2011. Based on licensed beds, the State average occupancy was:

Average Occupancy by Year
Licensed Beds, State-wide

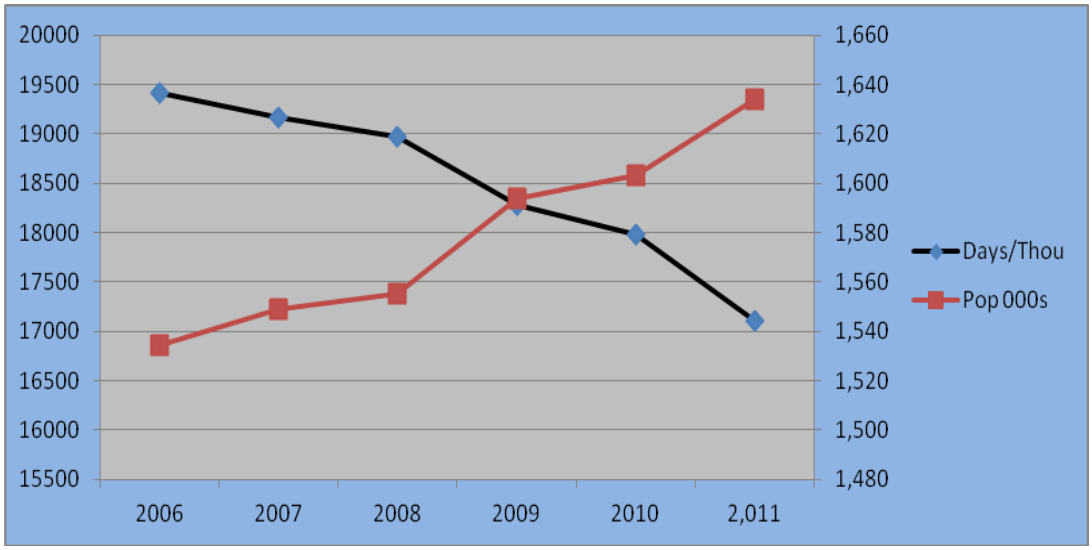
2006	78.14%
2007	78.28
2008	78.04
2009	77.84
2010	77.73
2011	76.3

Mike C also calculated occupancies using several other bases – Peak Beds, Beds Set-up, Beds In-Use. The results differ, as they should, but they reflect the same narrow fluctuation depicted above. If Beds in Use are utilized, State-wide occupancy was 98 percent in 2011, expressed as actual days measured against Beds in Use.

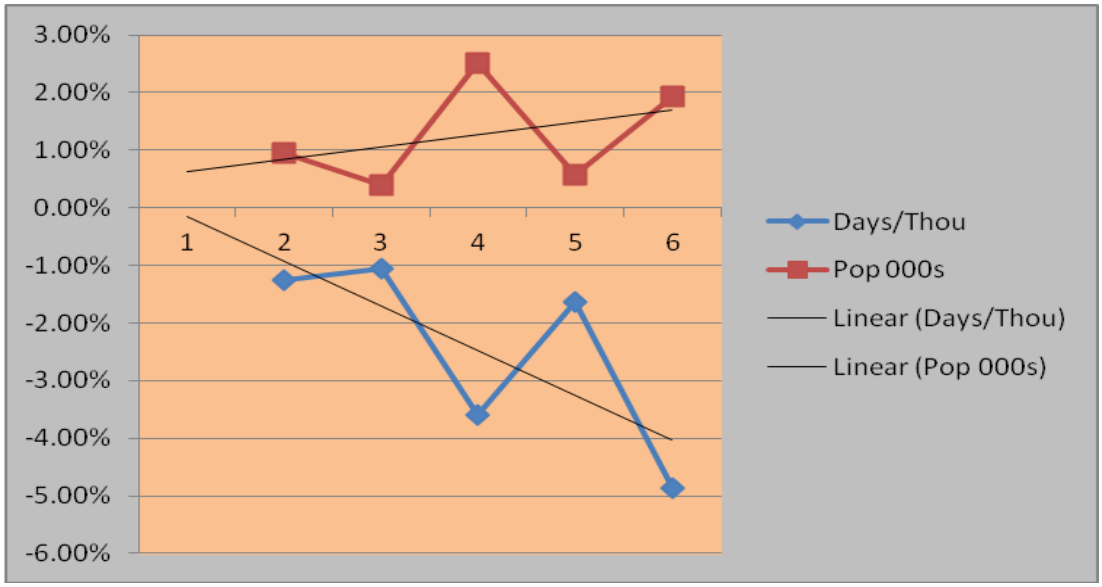
Using licensed beds, the State posted an average occupancy rate of 77 percent (above table); not as many facilities are at 90 percent as one would like.

We calculated resident days per thousand as a measure of utilization; SNF utilization is declining while population is increasing. Utilization levels are declining at a faster rate than population is increasing. Since 2006, the cumulative increase in population is 6.3 percent. Utilization for the same period is down (12.4) percent.

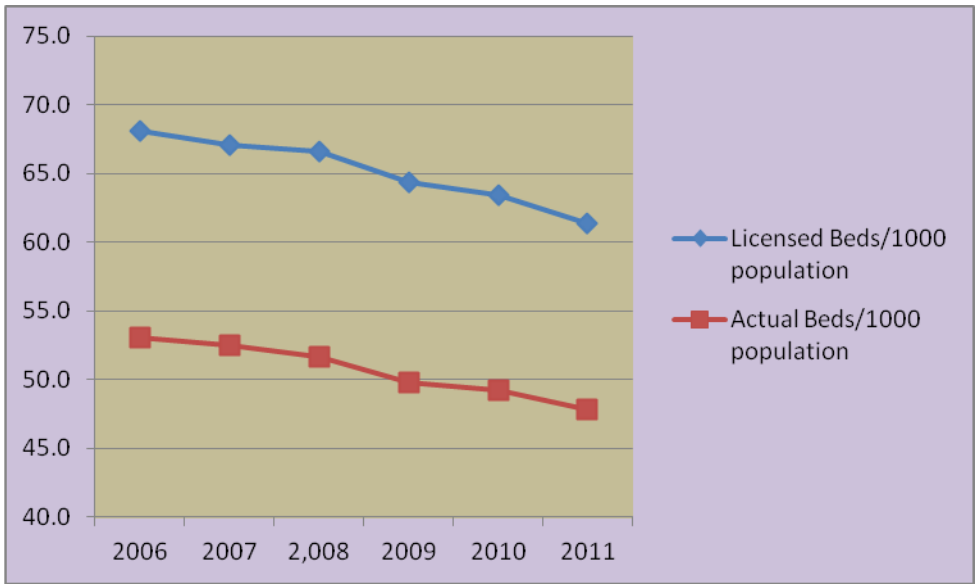
Resident Days per Thousand
versus
Population per Thousand
65+ Illinois State-Wide



Changes as Above in Percent



The disparity in utilization levels is readily apparent in the ratio of licensed beds to beds in use. (Beds in Use are higher than average daily census; ADC most closely represents the actual census in SNFs.)



Based on Mike C's data, there are roughly 22,000 surplus beds State-wide. There may be distribution issues with the number of surplus beds. Are there more empty beds downstate than in metro Chicago, for example? Illinois ranks 6th nation-wide in its tendency to institutionalize. Will the advent of managed delivery drop the falling utilization rate even lower? How will a buy/sell program redistribute the existing surplus? Current data suggests that the significant number of empty beds is unlikely to be off-set by a buy/sell program.

The 90 pct standard should receive critical evaluation. As a benchmark for additional beds, having a high figure such as 90 pct assures that all providers are likely to remain in business if a new competitor enters the market. For replacement or renovation projects, the 90 percent benchmark has less applicability. The level of Medicaid reimbursement in Illinois is far more likely to remain a deterrent to modernization efforts. However, the open question is whether financially strong applicants should be able to modernize facilities that are operating under 90 percent occupancy. Such a change in flexibility may serve to change the mix of facilities, move business to the newer facility, and place remaining operators at greater risk of closure.

As currently drafted, section 1125.580 preserves the occupancies of all facilities in the market area.

8. Staffing Availability, 1125.590: Conf call #2 Dec 5 2012. Consensus was to drop all but item (e). Item (e) is a narrative description of how the project will be staffed and provide the staffing pattern.

9. Bed Capacity, 1125.600. Conf Call #5 July 24 2013. There is no evidence supporting the inclusion of the 250-bed figure in the current application. Recommend rule change to

eliminate the reference to 250 beds. The effect of this change will be to eliminate 1125.600.

10. Community Related Functions, 1125.610. Conf Call #5, July 24 2013. Many States have dropped this requirement. However, the importance of maintaining community "linkages" is important. Recommend rule change deleting current language and substituting with language developed by Courtney regarding linkages. Letters of community support are always helpful.

11. Project Size, 1125.620: Conf call #4 Jan 28 2013. The number of square feet drives project cost, but has little impact on the State's per diem. IDPH requires minimums in its surveys. Conclusion: eliminate the upper end of the square foot range.

12. Estimated Total Project Cost, 1125.800: Conf call #4, Jan 28 2013. The over-riding staff concern was the ability of applicants to obtain financing. Conclusion: Consider a two-phased approach to CON.

    Phase 1: Provide a schematic drawing; market analysis indicating bed need and demand; and financial feasibility study.

    Phase 2: If no financing after a set number of months, permit is forfeited. If financing is secured and no progress is made after a set period of time, CON is forfeited. HUD apps can take a year or longer to approve. Establishing the time period to secure financing should take this into account.

Pending

Assurances, Section 1125.640: Conf Call #5 July 24-2013. The 90 percent occupancy representation needs resolution and awaits more data from the staff.

Follow up TC with Mike C on 8-19-13: Mike can find no data source stipulating a requirement for 90 percent occupancy. Contradiction?? – 90 pct is specified in 1125.210 (c). Also discussed using the IDPH dbase for identifying the number and types of beds in the State. Mike sent a sample via email later and it looks workable.