PRESENTATION TO THE ILLINOIS HEALTH FACILITY PLANNING BOARD

Comparative Assessment of Certificate of Need Programs

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Capital Financing: Financial and Operating Metrics Analysis

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COMPARATIVE ASSESSMENT OF CERTIFICATE OF NEED PROGRAMS

OVERVIEW

- **Selection of Four States for Comparative Assessment**

- **Three Selection Criteria**
  - States that have healthcare systems similar to Illinois
  - States that have a level of CON regulation similar to Illinois
  - States that have shown different directions for future CON reform

- **A need for an evaluation of reforms that other states have started**

- **Four Recommendations**

  - Phased-in implementation of deregulation as begun in Florida and New Jersey.
  - Batch processing as used by Michigan, Florida and New Jersey
  - Michigan's efforts to update and enforce review criteria and standards, and
  - Possible factors that may explain a significantly higher number of denials compared to the number of approvals shown in Florida

THREE SELECTION CRITERIA

1) **Comparison of supply and demand for health care (Table 1).**

Table 1. The Size of the Elderly and the Number of Beds in Medical Facilities

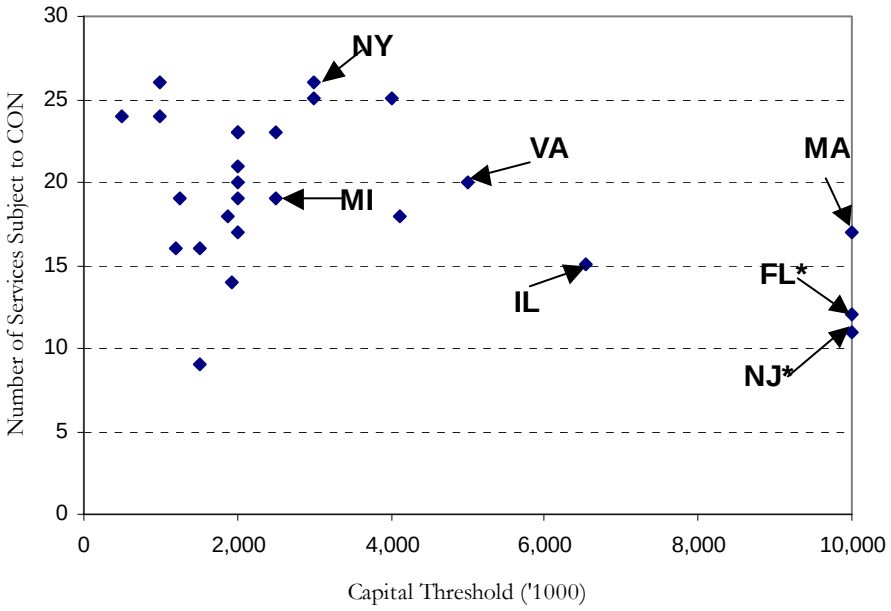
States	*Elderly*	*Number of beds in health facilities*			
		Hospital	*Nursing Home*	*Resid Care Fac*	*Psych*
Florida	2,963,204	56,286	80,448	76,828	n/a
New York	2,423,797	63,924	122,310	40,833	6099
Illinois	1,500,025	47,204	125,037	8650	4310
Ohio	1,494,482	47,347	94,925	35,551	404
Michigan	1,219,018	27,707	50,021	n/a	2445
New Jersey	1,113,136	27,317	52,544	6869	2557
North Carolina	1,011,370	20,723	43,512	40,685	4212
Massachusetts	860,162	13,458	51,625	4353	3225
Virginia	792,353	18,791	29,425	27,217	1640
Missouri	792,119	23,990	58,277	21,927	4035

Source: 2004 American Health Planning Association's National Directory

2) Level of CON regulation

- The number of services subject to CON and the capital threshold (Figure 2.1)
- New York and Michigan currently have the same level of CON scope that Illinois had prior to the 2003 Amendment Act.
- Illinois appears to be following the same path that Florida and New Jersey have been taking.

Figure 2.1
Stringency of CON Regulation



* FL and NY do not require a review solely based on capital cost

3) Review of current legislation activities reveals three broad clusters of states.

- One cluster of states that continue to cut back CON: New Jersey and Florida
  - While these states are at the same time streamlining their CON processes, they are tilted toward deregulation.
- Second cluster of states that focus on improving/streamlining their CON process without an explicit consideration of CON repeal. New York is one of those states.
- Third cluster of states that apparently need to decide on the future direction, either toward deregulation or toward improving CON processes. Categorically, Illinois and Michigan fit best in this cluster.

RECOMMENDATIONS

Recommendation 1: Examine phased-in implementation of deregulation as begun in Florida and New Jersey.

1) View of phased-in implementation of deregulation via history

Illinois

1974: *Illinois CON Statute (20 ILCS 3960).* Created the Health Facilities Planning Board.
1986: *Illinois Health Care Cost Containment Council.* Recommended the CON repeal.
1999: *IHA First Report on CON.* Illinois Hospital Association produced its 10 recommendations.
2000: *Public Act 91-0782.* Included a clause to repeal the CON on July 1, 2003 and increased the capital threshold (to $6 million) and removed non-clinical areas from CON review.
2001: *Auditor General Performance Audit.*
2001: *IHA Second Report on CON.* 9 Recommendations.
2003: *Public Act (93-0041).* Extended the sunset date to July 1, 2008. Board reduced from 15 to 9 consumer members appointed by the Governor.
2004: Further reduction of Board members.

New Jersey

1996: *CON Reform Act (*5 HLR 103*).* Created an expedited review process for 14 services that accounted for the bulk of certificate of need applications.
1998: *CON Reform Act (S. 1181).* Exempted 16 services including the 14 services above from CON requirements beginning Aug. 14, 1998, although the services still would be subject to licensure by the Health Department.
2000: CON Study *Commission Report.* The Commission recommended retaining CON for certain services. Called for changes in the need methodology and a better "call" schedule allowing institutions to apply for new services. Urged a strengthening of licensing requirements, including a hard look at volume, performance and outcome standards.

Florida

1987: *CON Reform Act of 1987.* The following statutory changes occurred: 1) Increased capital expenditure threshold from $600,000 to $1 million; capital expenditure only for inpatient services, excluding outpatient services; 2) Equipment threshold was set at $1 million; specified hospital specialty services subject to review in CON statute.
1997: *Amendment Act of 1997 to CON statute.* Started the second wave of deregulation by removing CON review from acquisition of medical equipment, regardless of cost.

2000: *Amendment Act of 2000 to CON statute.* Redefined eligibility for comparative or expedited reviews, substituting expedited review for comparative review. There is no CON review of cost overruns, and no exemption is required.

2001: *Amendment Act of 2001 to CON statute.* Continue to deregulate by exempting projects that were reviewed as expedited.

2) Comparison of Repeal Years and Services Subject to CON

Table 2. CON Regulated Services in Comparison to the State of Illinois

Review Categories Regulated by Illinois					
Categories	**Illinois**	**New York**	**Michigan**	**New Jersey**	**Florida**
Facilities					
Hospital	Y	Y	Y	Y	Y
Hospital-Based Ambulatory Surgical Center	Y	Y	Y	Y	**N**
Freestanding Ambulatory Treatment/Surgical Center	Y	Y	Y	2000	**N**
Dialysis Center	Y	Y	**N**	1998	**N**
Skilled/intermediate nursing care facility	Y	Y	Y	Y	Y
Specialized Nursing Facilities (ICF/MR)	Y	Y	Y	Y	Y
Demonstration Research Project*****	Y	Y	Y	Y	Y
Expenditure&					
Capital expenditure (only clinical area)	$6 M	$3 M	$2.5 M	**N**	**N**
Equipment expenditure	$6 M	$3 M	any	**N**	**N**
Acute Care					
Acute Care (Medical/Surgical/Pediatric)	Y	Y	Y	1998(M/S) Pediatric	Y
Intensive Care Unit (ICU)	Y	Y	Y	Pediatric	Y
Neonatal Intensive Care	Y	Y	Y	Y	Y
Obstetrics Services	Y	Y	**N**	1998	1987
Psychiatric Services	Y	Y	Y	Y	Y
Inpatient Comprehensive Rehabilitation	Y	Y		Y	Y
End-Stage Renal Dialysis (hospital-based)	Y	Y	**N**	1998	**N**
Subacute	Y	Y	**N**	2000	Y
Swing Beds	Y	Y	Y	N	N
Hospital Specialty/Surgical-Related					
Cardiac Catheterization	Y	Y	Y	Y	Y%
Open Heart Surgery	Y	Y	Y	Y	Y
Organ Transplant	Y	Y	Y	Y	Y
Review Categories Not Regulated by Illinois					
Facilities	**Illinois**	**New York**	**Michigan**	**New Jersey**	**Florida**
HMO	1995	Y	Y	**N**	**N**
Hospice	Never	Y	Never	Never	Y
Home Health	Never	Y	Never	Y	Never
Residential Care Facility	Never	Y	Never	2000	Never
Adult Care Facility	Never	Y	Never	Y	Never
Acute Care					
Air Ambulance	Never	N	Y	Y	Never
Mobile HI Tech	1987	Y	Y	Y	Never
Substance Abuse	2000	Y	Never	1998	Y
Burn Care	2003	Y	Never	Y	Y
Medical Equipment					

CT Scanners	n/a	Y	Y	1998	1997
MRI Scanners	2000	Y	Y	1998	1997
PET Scanners	2003	Y	Y	1998	1997
Therapeutic Radiology	2003	Y	Y	2000	1997
Ultra Sound	n/a	Y	N	1998	1997
Gamma Knives	2003	Y	Y	1998	1997
Extracorporeal shockwave lithotripters	1999	Y	Y	1998	1997

RECOMMENDATION 2: Examine Batch processing as used by Michigan, Florida and New Jersey

- Comparative review of CON projects where similar types of projects (in terms of the planning area, project type, or need methodology) can be batched.
    - An effective call structure to enable comparative review with the potential to minimize inconsistent decision making.

- **New Jersey**: a periodic calling schedule for 15 distinct items or categories.
- **Florida**: batches for two broad categories: (1) hospital beds and facilities and (2) other beds and programs. Thus the state offers two batch cycles biannually per category.
- **Michigan**: conducts a comparative review only for selected services for which it has established a need methodology or standard with which it is comfortable and when there is an indication of a need for new facilities and expanded clinical service capacity.
- Because Illinois is more similar to Michigan than New Jersey and Florida in the number/type/threshold subject to CON review, some process similar to Michigan's type may be a choice for Illinois.

Table 3. Call Structure

	Illinois	New York	Michigan	New Jersey	Florida
Batching Cycles	N	N	3 cycles for comparative review 1st of Feb., June, or Oct.	12 cycles for expedited; different call schedule (ranging from every year to every five years) per category (15 categories) subject to full review	Biannually per category: (1) hospital beds and facilities (2) other beds and programs
Non-batching	Any wkday	Any workday	First day of each month	First day of each month	First day of each month

RECOMMENDATION 3: Examine Michigan's efforts to update and enforce review criteria and standards

- Michigan is one of the forefront runners in revamping CON standards and criteria, a major source of criticism for CON.

- *Michigan CON Reform Act of 1988*. Due to concerns about a lack of clarity regarding both process and standards in CON, resulting in the overturning of too many CON decisions by the courts, Michigan substantially revised its program. This statute, effective October 1, 1988, established a specific process for developing and approving standards used in making CON decisions. It further created a 5-member bipartisan CON Commission

  within the Department of Public Health. The Commission's members are appointed by the Governor and are responsible for approving review standards (Table 4).

- Politics that attempt to force a revision of CON criteria and standards
- One staff reviewer is assigned to each of the 13 project types to ensure expertise in standards/criteria for the assigned project type.
- Standards/criteria were improved in a way to facilitate the formal consideration of the relative merits of similar applications in determining the best to meet the projected needs.

Table 4. CON Body By Categories of Task

Categories	Illinois	New York	Michigan	New Jersey	Florida
Review and recommendation for Full Review	State Health Planning Board	State Hospital Review and Planning Council; Regional Hospital Review and Planning Council	Staff reviewer assigned to each of 13 project type groups	Both State Health Planning Board and Department	Local Health Council
Local review board?	No	Yes	Depending on project type	No	Yes
Review and recommendation for Expedited Review	Executive Secretary/ CON staff	N/A	Same as above	Department	Agency: AHCA
Final Decision	State Health Planning Board	Commissioner of Health	Commissioner issues a final decision; if disapproved, a hearing can be requested.	Commissioner for both Full and Expedited	Agency Director
Promulgate criteria and standards	State Health Planning Board	Public Health Council	Commissioner	Commissioner	N/A
Approve criteria and standards	State Health Planning Board	Public Health Council	CON Commission	Health care administration board	N/A

RECOMMENDATION 4: Examine possible factors that may explain a significantly higher number of denials compared to the number of approvals shown in Florida

- As anti-CON critics argue, there were few denial decisions (excluding withdrawn. Overall, more applications than those denied were withdrawn.) compared to the number of approvals.
    - There were no denials during two recent years in Illinois—2002 and 2003 while there were 104 approvals during the same period. There were seven denials compared to 291 approvals.
    - Similarly, there were a small number of denials compared to approvals in New York.

- Florida appears to have an exceptionally high number of applications that were denied/withdrawn during the period, from 1998 to 2002 (**Table 5**). Except for 1999, there were more denials/withdrawn than approvals.

- Although this table reports initial decisions only and, thus, it does not reflect results of any appeals, another table shows that approximately 54.8% to 67.7% of final decisions, depending on the year, were the same as the initial decisions (**Table 6**).

Table 5. Florida: The Number of Applications Reviewed and Approved* by Facility Type and Review Type

Type		1998			1999			2000			2001			2002		
Facility	Review	Rev	App	Den	Rev	App	Den	Rev	App	Den	Rev	App	Den	Rev	App	Den
Hospital	Comp	86	37	49	67	34	33	60	17	43	78	23	55	79	31	48
	Exp	10	9	1	5	4	1	6	5	1	14	13	1	4	1	3
Nursing Home	Comp	65	23	42	46	26	20	17	10	7	10	5	5	5	5	0
	Exp	24	19	5	19	14	5	23	12	11	3	0	3	6	0	6
Other	Comp	4	3	1	5	3	2	4	3	1	4	1	3	1	1	0
	Exp	23	7	16	13	8	5	25	12	13	15	12	3	5	4	1
Total	All	212	98	114	155	89	66	135	59	76	124	54	70	100	42	58

Table 6. Florida: Litigation Activity By Type Of Review

	# Initially denied	Denial appealed (1)	% Appealed	Final Decision Complete (2)	% Complete	Final Same as Initial (3)	% Same as Initial
1998	114	65	57.0%	65	100.0%	44	67.7%
1999	66	36	54.5%	30	83.3%	19	63.3%
2000	76	46	60.5%	39	84.8%	22	56.4%
2001	70	51	72.9%	31	60.8%	17	54.8%
2002	58	30	51.7%				

CAPITAL FINANCING:
FINANCIAL AND OPERATING METRICS ANALYSIS

1. DEMAND FOR CAPITAL FINANCING INCREASING
   DUE TO:

   - NEED TO IMPROVE & UPDATE FACILITIES
   - ACQUISITION OF MEDICAL & INFORMATION TECHNOLOGY
   - DESIRE TO INCREASE CAPACITY

2. AVERAGE AGE OF FACILITIES IS INCREASING (NOW 10 YEARS)

   - INVERSE RELATIONSHIP – THE HIGHER THE OPERATING MARGIN (PROFIT), THE LOWER THE AVERAGE AGE OF THE PLANT

3. MOST COMMON CAPITAL PROJECTS:

   - PURCHASE RADIOLOGY SYSTEMS
   - PURCHASE COMPUTERIZED PHYSICIAN ORDER ENTRY/IT
   - INCREASE EMERGENCY ROOM CAPACITY
   - INCREASE OPERATING ROOM CAPACITY
   - ADD A SPECIALTY UNIT
   - CONVERT SEMI-PRIVATE ROOMS TO PRIVATE
   - INCREASE BED CAPACITY
   - INCREASE LAB SPACE
   - BUILD/EXPAND OUTPATIENT FACILITIES
   - BUILD NEW HOSPITALS

4. CAPITAL SOURCES OF FUNDS

   - 97% CASH FROM OPERATIONS
   - 81% PHILANTHROPY
   - 75% INVESTMENT INCOME
   - 65% TAX-EXEMPT BONDS
   - 63% CAPITAL LEASES
   - 38% BANK LOANS

5. ABILITY TO ACCESS CAPITAL

	Broad Access	**Limited Access**
Operating Margin	More than 2%	Less than 0.0%
Debt Service Coverage Ratio	More than 3.5x	Less than 1.25x
Days Cash on Hand (Short-term)	n/a	Less than 5 days
Current Ratio	More than 2.0x	Less than 1.0x
Debt-to-Capitalization Ratio	0 to 35%	Less than 0% or more than 70%

Source: Financing the Future, "How Are Hospitals Financing the Future?" Report 1, HFMA, 2003.

6. 2003 ACTUAL DATA (SELECTED CAPITAL METRICS)

	Broad Access	Limited Access
Median Operating Margin	4.7%	-.73%
Median Debt Service Coverage Ratio	8.3x	-0.1x
Short-term Cash on Hand	33.5 days	2.7 days
Debt-to-Capitalization Ratio	26.0%	82.0%

Source: Hospital & Health Networks, June 2004, pages 56-57.

7. DIFFICULTY IN COMPARING DATA

- COMPARING FOR-PROFIT & NON-FOR-PROFIT (INCOME & REAL ESTATE TAXES & DIVIDENDS)
- SYSTEM & STAND-ALONE FACILITIES (TRANSFER OF FUNDS)
- RURAL VS. URBAN FACILITIES (REIMBURSEMENT)
- CRITICAL ACCESS FACILITIES & DISPROPORTIONATE SHARE FACILITIES (REIMBURSEMENT/COSTS)

8. IHFPB STANDARDS VERSUS RATING AGENCY METRICS (TABLE A-2) ILLINOIS HOSPITALS

	IHFPB	AGENCIES
• DAYS CASH ON HAND	90	133.2- 176
• CUSHION RATIO	5X	9.8 - 12.5 X
• MAX. DEBT SERVICE COVERAGE	1.75X	3.1 – 3.5 X
• DEBT TO CAPITALIZATION	60%	36.1% - 41.9%

9. ILLINOIS "A" RATED FACILITIES 2002 RESULTS [TABLES A-4(2) & A-4(3)]

- SYSTEMS FACILITIES CAN HANDLE SHORT-TERM CASH MORE EFFICIENTLY
- SYSTEM FACILITIES HAVE GREATER FINANCIAL FLEXIBILITY
- TEACHING HOSPITALS HAVE LOWER OPERATING MARGINS, CURRENT RATIOS, & FINANCIAL FLEXIBILITY (DUE TO HIGHER COSTS, LENGTH OF STAYS, PAYOR MIX, & INTENSITY OF SERVICE)
- TEACHING HOSPITALS HAD A HIGHER % OF OCCUPANCY (55.23) VERSUS 40.65% AVERAGE OCCUPANCY FOR NON-TEACHING HOSPITALS
- RURAL FACILITIES HAD HIGHER OPERATING MARGINS, FINANCIAL FLEXIBILITY AND CURRENT RATIOS THAN NON-RURAL HOSPITALS (MAY BE DUE TO REIMBURSEMENT MECHANISMS)
- DAYS IN PATIENT ACCOUNTS RECEIVABLE DECREASED AS FACILITIES GREW LARGER
- AVERAGE OCCUPANCY & LENGTH OF STAY INCREASED AS FACILITIY SIZE INCREASED

10. NURSING HOMES INVESTMENT GRADE STANDARDS

- 180-220 DAYS CASH ON HAND
- 5.0 TO 8.0 X CUSHION RATIO
- 60-75% CASH TO DEBT
- 1% TO 3% OPERATING MARGIN
- 1.8 TO 2.2X MAXIMUM ANNUAL DEBT SERVICE COVERAGE

11. NURSING HOMES – IHFPB STANDARDS VS. 2003 ACTUAL RESULTS
(See TABLE B-1 on the last page)

- WITHIN INVESTMENT RANGE
- IHFPB MORE STRINGENT THAN ACTUAL FOR OPERATING MARGIN
- TWO OF THREE FOR-PROFIT CHAINS DO NOT MEET IHFPB NET MARGIN STANDARD

12. AMBULATORY SURGICAL TREATMENT CENTERS (TABLE B-2)

- ACTUAL RESULTS STRONGER THAN IHFPB STANDARD IN ALL CATEGORIES

COMPARISON OF IHFPB STANDARDS AND ACTUAL OPERATING RESULTS

RATIOS	IHFPB STANDARDS (1)	BIZMINER (2)
Cushion Ratios (x) (1)	3.0x	
Current Ratio (x) (2)	1.5x	1.8x
Net Margin (%) (3)	2.5%	5.81%
Debt/Capitalization (%) (4)	80%	81%
Debt Service Coverage (x) (5)	1.5x	
Days Cash on Hand (6)	45	
% Return on Assets (10)		4.60%
SAMPLE SIZE		537
PERIOD	2004	2003

1. Illinois Health Facilities Planning Board Standards, 2004
2. BizMiner Financial Analysis Profile, July 2003, SIC 8011.0201 Ambulatory Surgical Centers

13. END STAGE RENAL DISEASE (DIALYSIS) CENTERS (TABLE B-3)

- ACTUAL RESULTS STRONGER THAN IHFPB STANDARD IN ALL CATEGORIES

COMPARISON OF IHFPB STANDARDS AND ACTUAL OPERATING RESULTS

RATIOS	IHFPB STANDARDS (1)	FRESENIUS MED. CARE (2)	DaVITA INC. (2)	RENAL CARE GROUP INC. (2)
Ticker Symbol		FMS	DVA	RCI
Cushion Ratio (x) (1)	3.0x			
Current Ratio (x) (2)	1.5x	1.6x	1.7x	1.7x
Net Margin % (3)	2.5%	6.0%	8.7%	10.2%
Debt/Capitalization % (4)	80%	40.2%	71.4%	40%
Debt Service Coverage (x) (5)	1.5x			
Days Cash on Hand (6)	45			
Earnings/Share (8)		$1.13	$1.66	$1.37
Price/Earnings ratio (x) (9)		22.5x	15.8x	20.4x
% Return on Assets (10)		4.6%	9.4%	13.1%
% Returns on Equity (7)		11.2%	93.2%	18.3%
PERIOD	2004	2003	2003	2003

1. Illinois Health Facilities Planning Board Standards, 2004
2. Standard & Poor's Ratings Group Stock Report, 2004

14. ADDITIONAL ITEMS TO CONSIDER

- ADDITIONAL CRITERIA FOR:
  - ✓ FOR-PROFIT VS. NON-FOR-PROFIT FACILITIES
  - ✓ RURAL VS. URBAN FACILITIES
  - ✓ RURAL HOSPITALS DESIGNATED AS CRITICAL ACCESS
  - ✓ DISPROPORTIONATE SHARE FACILITIES
- SPECIALTY HOSPITAL STANDARDS
- IMPACT OF ADVANCING MEDICAL TECHNOLOGY & DELIVERY OF CARE ON NURSING HOMES & DIALYSIS CENTERS
- DON'T KNOW ACTUAL CONSTRUCTION COSTS (LACK OF AUDITED FINAL CONSTRUCTION PROJECT REPORTS)
- COMPARE MEDICARE CAPITAL PROPSECTIVE REIMBURSEMENT PAYMENT VS. PROJECTED CAPITAL EXPENSES
- REVIEW SARBANES-OXLEY ACT/JCAHO/OIG DISCLOSURES
- UPDATE DATA USED IN DEVEOPING STANDARDS:
  - ✓ BED INVENTORY
  - ✓ POPULATION
  - ✓ DETERMINATION OF NEED CRITERIA

TABLE B-1
NURSING HOMES
COMPARISON OF IHFPB AND FITCH STANDARDS AND ACTUAL 2003 OPERATING RESULTS

RATIOS	IHFPB STANDARDS 2004 (1)	FITCH INVESTMT GRADE –NP STDS (2)	BIZMINER (3)	MANOR CARE INC (HCR) (4)	BEVERLY ENTERPRISES INC. (BEV) (4)	KINDRED HLTHCARE INC (KIND) (4)
Days Cash on Hand (6)	75	180-220	37			
Cushion Ratio (x) (1)	3.0	5.0 - 8.0				
Cash to Debt (%) (11)		60% - 75%				
Net Margin (%) (3)	2.5%	1% - 3%	-.3%	3.9%	1.2%	1.5%
Excess Margin (%) (12)		3% - 6%				
Debt Service Coverage (x) (5)	1.5x	1.8 to 2.2				
MADS as % of Revenue (13)		6% to 10 %				
Earnings per Share (8)				$1.31	$.22	$1.41
Debt/Capitalization (%) (4)	80%		109.0%	37.2%	69.9%	18.9%
% Return on Assets (10)			.40%	5.0%	1.7%	3.1%
% Return on Equity (7)			2.4%	12.0%	12.0%	8%
Current Ratio (x) (2)	1.5x		1.6x	1.5x	1.2x	1.5x
Price/Earnings ratio (9)				21.5x	9.1x	NM
PERIOD		2003	2003	2003	2003	2003

1. Illinois Health Facilities Planning Board Standards, 2004
2. Fitch Rating Group: Rating Guidelines for Nonprofit Nursing Home, March 29, 2000
3. BizMiner Financial Analyses Profile July 2003, SIC 8051 Skilled Nursing Facilities
4. Standard & Poor's Ratings Group Stock Report, July 27, 2000