Constantino, Mike

From: Ourth, Joe [JOurth@arnstein.com]
Sent: Wednesday, June 08, 2011 7:09 PM
To: Constantino, Mike
Cc: Williams, Don A.
Subject: Summary of Arguments in Opposition - Mercy Crystal Lake Hospital (Project No. 10-089) [IWOV-ACTIVE.FID917959]
Attachments: 0675_001.pdf

Mike,

Please accept the attached Summary of Arguments in Opposition document filed in connection with the application for Mercy Crystal Centegra Hospital (Project No. 10-089).

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June 8, 2011

Via Electronic Mail and Overnight Carrier
Mr. Dale Galassie
Chair
Illinois Health Facilities and Services
Review Board
525 W. Jefferson
Springfield, IL 62761

Re: Summary of Arguments in Opposition
Mercy Crystal Lake Hospital Application (the "Application")
Project No. 10-089 (the "Project")

Dear Chairman Galassie:

Over the course of the last several months thousands of pages of material have been submitted by hundreds of people to the Illinois Health Facilities and Services Review Board ("Board" or "Review Board") to address why the Board should not approve either the Centegra Hospital – Huntley or the Mercy Crystal Lake Hospital projects. As the Board begins its review in earnest we would like to highlight some of the primary reasons the Board should deny the Mercy Hospital Application and then expand on that summary further in this letter. By separate letter, we similarly highlight why the Board should not approve the Centegra Hospital – Huntley project.

Key Reasons the Application Should be Denied

1. New Suburban Hospitals are Inconsistent with Health Care Reform. Although there are many views on health care reform, almost all are consistent with the premise that building an additional 128 bed community hospital in an affluent suburban area already well-served by five area hospitals goes against where health care reform is heading or should go.

2. There is No Need for the Mercy Crystal Lake Hospital. From any practical perspective as well as under the Review Board's own rules, there is no "need" for this proposed hospital.

3. The Proposed Hospital will Significantly and Seriously Harm Existing Providers and the Safety Net Services that they provide. Concerned hospitals have presented detailed and thorough analyses regarding the impact a new hospital would have on existing hospitals and the patients

they serve and have submitted that information to the Board by way of an extensive Safety Net Impact Statement Response. This Project will clearly reduce utilization below or further below the Board's standard for utilization.

4. Better Health Care Quality Outcomes generally Follow in an Environment where Higher Volumes are Performed. The reasons to avoid duplication of services go beyond bed need calculations. As discussed in other submissions and herein below, duplication of services can also negatively impact quality. A new hospital in the proposed area will dilute the number of cases already performed at existing hospitals and the experience and expertise that correspond to that volume.

5. The Application does not comply with other important Review Board rules. Board rules require that an Applicant document that the Project will not reduce utilization of existing providers to below, or further below target utilization.

6. The Board should Defer Consideration of New Hospital Projects until the Comprehensive Planning Function is Fulfilled. By separate letter dated June 7, 2011 the Board was asked to defer approval of new hospitals until the Comprehensive Planning Function of Public Act 96-0031 is fulfilled. We believe the Comprehensive Plan would provide valuable assistance to the Board in making decisions on matters of importance, such as these new hospitals. If the intent of the General Assembly in creating this new planning function is to be given any affect, it should be on these new hospital projects.

1. Additional Suburban Hospitals are Counter to Health Care Reform

A key function of the Illinois Health Facilities Planning Act is to establish a mechanism for health care planning. Ground changing events in health care delivery are occurring at an accelerating pace not only from federal and state governmental health care reform but also organically to achieve greater efficiency. By all accounts, the building of additional community hospitals in affluent suburban areas is counter to where health care reform is generally heading. As part of the public hearing on this project, the Camden Group presented detailed written and oral testimony.[1] We encourage the Board to review this material and the health care reform trend generally before approving a new community hospital.

[1] Public Hearing Record, Mercy Crystal Lake Hospital.

2. McHenry County Residents Already Well Served

The University of Illinois College of Medicine conducted a 2010 McHenry County Healthy Community Study ("Study"). A letter submitted to the Review Board,[2] summarized and highlighted the Study regarding the health needs of McHenry County. Surveyed McHenry County residents cited "access to quality health care" as one of the best aspects of living in McHenry County.[3] The comprehensive, year long study also found that McHenry County residents enjoy favorable health status: the mortality rate is low in the County, and 60% of its residents, compared to 51% of residents of the State overall, perceive their health to be excellent/good.

Notably, the Study did not report the need for an additional hospital to be among the priority of McHenry County residents. In fact, the Study concluded that the four primary priorities are: (1) an information and referral system; (2) access to dental care for the low income population; (3) access to mental health and substance abuse services; and (4) information regarding obesity and nutrition.

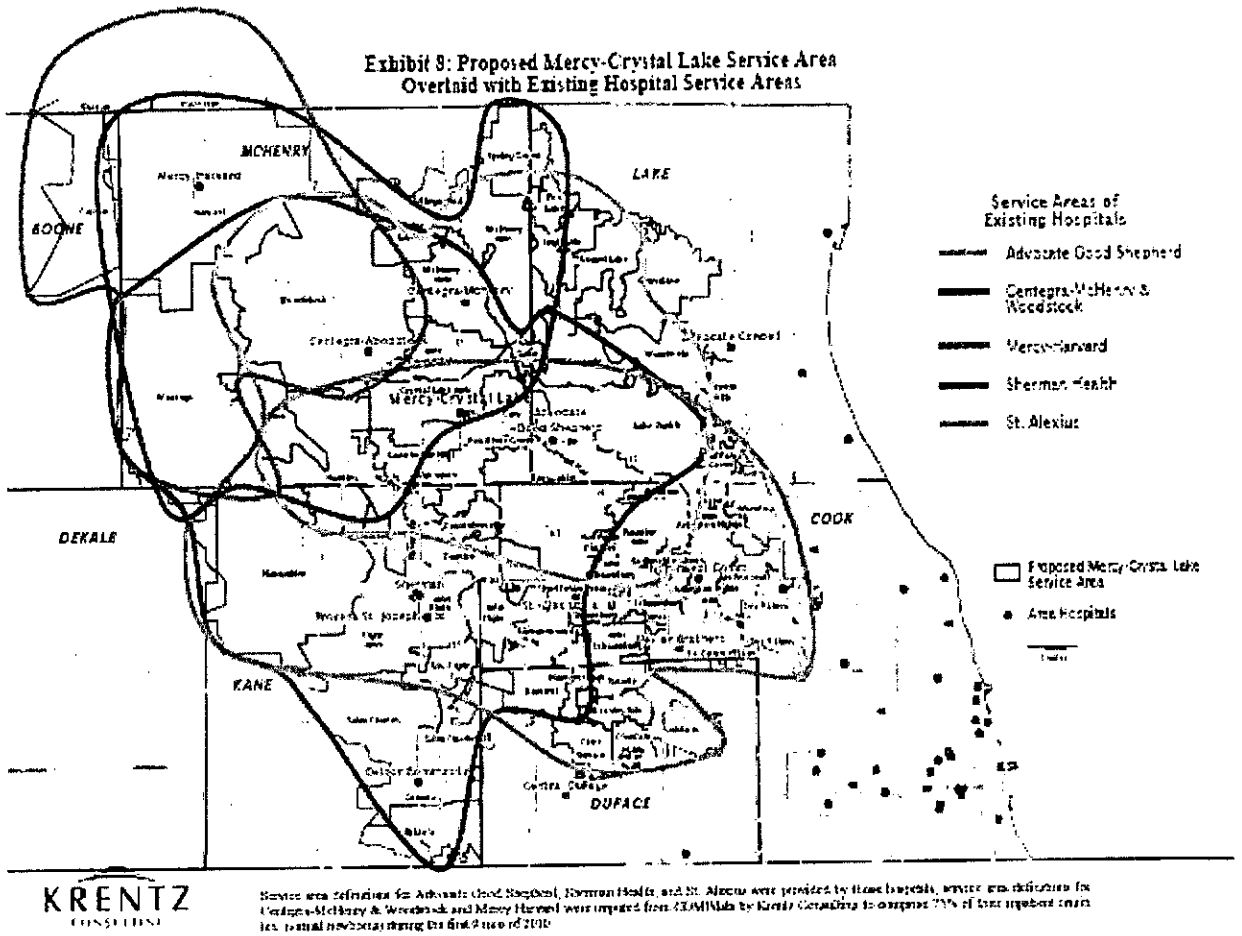
McHenry County residents have higher rates of health care insurance coverage and lower rates of poverty compared to State averages. McHenry County already enjoys very attractive health outcomes and health status. Given these benefits as well as the conclusions set forth in the Study, McHenry County residents appear well satisfied with their access to hospital care.

3. No Practical Need for Additional Hospital

The Applicants have set forth no compelling practical reason to build a new hospital. Instead, the primary arguments for a hospital appear to be that (i) by 2018 there may be a mathematical "need" for an additional hospital or (ii) residents should have a hospital closer to them. This area is already blessed with a number of high quality hospitals ready and able to accommodate residents, several with capacity to serve more patients. This is not an underserved area. 81% of the residents in the proposed Mercy service area are within 15 minutes of an existing hospital and 100% of the residents in Mercy's overall service area are within 30 minutes of an existing hospital.[4] On average, there are 295 unused licensed med/surgical beds each day available in the area for residents.[5] No one in the area is being denied hospital service for lack of an available bed. The map below shows the service areas of existing hospitals together with the

[2] Letter to Chairman Galassie from Julie Mayer and Tina Link, dated May 17, 2011.
[3] Id.
[4] Market Assessment and Impact Study, Proposed Mercy Crystal Lake Hospital (Project No. 10-089), Krentz Consulting (May 24, 2011), page 7.
[5] Id. at page 14.

proposed Mercy service area. The overlapping areas show that this area is already well served. The map does not include the Provena St. Joseph service area (likely similar to Sherman's) that would show even greater overlap. Also, the fact that existing McHenry County hospitals are operating below state standards demonstrates that patients are choosing to leave the County to receive their health care, as opposed to being forced to do so due to lack of beds.



4. Higher Volumes Can Contribute to Better Health Care Outcomes

The Review Board's rules regarding duplication of services relate not only to health care costs, but also to quality. The proposed Mercy Crystal Lake Hospital, if built, will reduce volume at existing hospitals.[6] In fact, this is one of the driving reasons that planning rules have minimum volume criteria. The dilution of volume among existing hospital services and the corresponding negative impact on patient quality and patient

[6] Krentz Consulting Financial Impact Study, Proposed Mercy Crystal Lake Hospital (Project 10-089) (May 25, 2011).

safety was analyzed by Leo Kelly, M.D. and Jan Jones, M.D. and submitted to the Review Board on June 8, 2011.[7] Drs. Kelly and Jones cite numerous studies and over 60 articles demonstrating evidence that hospitals with higher volumes of particular cases tend to have better outcomes than those hospitals with lower volumes of the same cases. The rationale is that facilities with higher volumes are able to provide not only better patient care, but are also able to provide a broader range of specialized medical and support services to its patients.

5. Safety Net / Impact on Other Provider

When the General Assembly rewrote the Planning Act in 2009, one of the key features was to implement an analysis upon Safety Net Impact Services. Applicants are required to address the impact their project will have on the ability of other providers to cross-subsidize Safety Net Services. The Mercy application completely failed to address this issue.

In response, Sherman Hospital, St. Alexius Medical Center and Advocate Good Shepherd Hospital collectively prepared a detailed response. In perhaps the first formal Safety Net Impact Statement Response submitted to the Board, the response showed the significant, and serious impact a new hospital would have on those hospitals and their ability to cross-subsidize Safety Net Services for area residents. This Response Statement showed a loss of revenue to these three hospitals of $78.2 million and a lost contribution margin of $28.6 million. For not-for-profit hospitals, if there is no margin there can be no mission.

6. Defer New Hospital Approvals Until Comprehensive Planning Function Fulfilled

Determining whether to grant a permit for a new hospital is one of the most impactful, most expensive, and often most contentious decisions, that a Review Board makes. As such, in the past 30 years, the Review Board has granted only one permit for a new hospital that has not been overturned on appeal. When the General Assembly undertook a major rewrite to the Planning Act, one of the chief components of that legislation was to integrate the Review Board function with a separate function through the Center for Comprehensive Planning to be established within the Department of Public Health. That Center is still awaiting implementation.

A letter to the Board dated June 7, 2011 formally requested that the Review Board defer consideration of new hospital applications. We refer the Board to that submission rather than repeat that information here. We note, however, that the comprehensive

[7] Letter to Courtney Avery from Leo Kelly, M.D. and Jan Jones, M.D. (June 8, 2011).

planning function was so integral to the Planning Act, that the new legislation rewrote the purpose of the Planning Act to add:

> *The Health Facilities and Services Review Board must apply the findings from the Comprehensive Health Plan to update review standards and criteria, as well as better identify needs and evaluate applications, and establish mechanisms to support adequate financing of the health care delivery system in Illinois, for the development and preservation of safety net services. The Board must provide written and consistent decisions that are based on the findings from the Comprehensive Health Plan, as well as other issue or subject specific plans, recommended by the Center for comprehensive Health Planning.*[8]

The importance of reconsidering new hospitals is also evident in the Adventist Hospital-Bolingbrook situation. Bolingbrook Hospital, which opened in 2007 and is the only new hospital in the State in the last thirty (30) years, has been challenged to build volume and reach reasonable occupancy. According to the 2009 Annual Hospital Profiles published by IDPH, Adventist Hospital-Bolingbrook is still below 40% occupancy in its third year of operation. This low occupancy highlights the challenge of a new hospital to redirect patients and physicians from previous hospital relationships. Similarly, information available from Comp Data shows that the occupancy at Bolingbrook came at the expense of existing hospitals. Since 2007 a Naperville hospital lost 15% of its volume to Bolingbrook and a Hinsdale hospital appears to have lost 20% of its volume attributable to the new Bolingbrook hospital.

The almost overwhelming introduction of a new hospital into the McHenry County community is evidenced by the fact that the proposed hospital will increase the number of medical/surgical beds in McHenry County by almost 50%. So clearly, new hospitals require particular attention by a comprehensive planning function.

7. No Need For New Hospitals Under Review Boards Rules

One of the most important issues for any Certificate of Need application, obviously, is whether the proposed project is "needed". The Board develops detailed rules for evaluating whether a project fulfills a health care "need" or whether a project is just a "want". There are various tests for whether a project is needed, including:

A. Criterion 1110.530(b) – Planning Area Need – Review Criterion

[8] 20 ILCS 3960/2

The Criterion states:

b) *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.

B) The number of beds proposed shall not exceed the number of the projected deficit, to meet the health care needs of the population served, in compliance with the occupancy standard specified in 77 Ill. Adm. Code 1100.

The Review Board has compiled an inventory for beds in the Planning Area and made a calculation of beds need, which does not show sufficient need to justify a new, 128 bed hospital. Despite the Applicant's, claims of population growth, the simple fact is that the Applicant is proposing more beds than needed and does not comply with the Board's rules.

It is important to note that the bed need is based primarily on recapturing the "outmigration" from McHenry County. This is pertinent from two perspectives. First, the state's bed need is primarily based on recapturing outmigration which is mostly to area hospitals just across the border and to academic medical centers and specialty hospitals which provide services not offered by existing area hospitals nor by the proposed facility. As there is available capacity at most area hospitals this outmigration is due to patient choice, not due to lack of beds (which is presumably the rationale for inclusion of recapture of outmigration into the bed need formula). Second, as the bed need is based on recapture of outmigration, those hospitals located outside McHenry County and serving McHenry County patients will, according to the formula, lose volume and many are operating at low occupancy levels.

B. Service Demand – Establishment of Bed Category of Service

The Board's rules specify that if an Applicant wants to establish a new hospital it must provide physician referral letters. The number of beds proposed to establish a new category of service is necessary to accommodate the service demand experienced annually by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, **or, if the applicant proposes to establish a new**

hospital, the applicant shall submit projected referrals.[9] The rule further provides that an applicant for a new hospital shall submit physician referral letters.[10]

The Section 1110.530(b) rules referenced above make clear that if the applicant proposes to establish a new hospital, the applicant must submit projected referrals. Unlike Centegra, Mercy did provide some physician referral letters from its employed physicians. These letters, however, document Mercy's intent to take 3,809 patients from existing hospitals - - clearly a significant impact on existing providers. Interestingly, the 3,809 referrals provided would be far insufficient for a new 128-bed hospital to achieve target utilization. The effect of the physician referral letters is to document insufficient need for a new hospital together with documented harm to existing providers.

8. The Mercy Application Does Not Meet Other Important Board Rules

In addition to the Applicant's failure to demonstrate "need", the Applicant fails to comply with other Board Rules including "Unnecessary Duplication and Maldistribution of Services" and "Alternatives".

A. Criterion 1110.530(c) - Unnecessary Duplication/Maldistribution – Review Criterion

This criterion provides that the applicant shall document that "the project will not result in an unnecessary duplication". Maldistribution exists when the area has an excess supply of facilities, beds and services[11].

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[9] 77 Ill. Admin. Code, Section 1110.530 (emphasis added) provides:

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;

[10] Id.

[11] The Board's Rules, 77 Ill. Admin. Code, Section 1110.530(c) (emphases added) provides:

"1) The applicant shall document that the project will not result in an unnecessary duplication. The applicant shall provide the following information":

A) A list of all zip code areas (in total or in part) that are located within 30 minutes normal travel time of the project's site;

B) The total population of the identified zip code areas (based upon the most recent population numbers available for the State of Illinois population); and

C) The names and locations of all existing or approved health care facilities located within 30 minutes normal travel time from the project site that provide categories of bed services proposed by the project.

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, beds and services characterized by such factors as, but not limited to:

A) A ratio of beds to population that exceeds one and one-half times the State average;

Maldistribution is characterized by historical utilization for existing facilities that is below the Board's occupancy standards.

Capacity of Nearest Hospitals
Serving Mercy-Crystal Lake's Proposed Service Area

Falls below targeted occupancy level

Nearest Hospitals	Adjusted Authorized CON Beds 12/31/09*	Target Occupancy Based on Bed Size 77 Ill. Adm Code 1100	2009 Occupancy	Unoccupied Beds (on average per day)
Med/Surg (adult and pediatrics)				
Centegra-McHenry	129	85%	78.6%	28
Centegra-Woodstock	60	80%	89.9%	6
Mercy-Harvard	17	80%	26.8%	12
Planning Area A-10	206		77.6%	46
Sherman Health	197	85%	47.9%	103
Advocate Good Shepherd	127	85%	80.3%	25
St. Alexius	274	90%	60.1%	109
Provena St. Joseph	99	80%	87.6%	12
TOTAL Med/Surg	903		67.3%	295

The proposed Project clearly and unequivocally creates a maldistribution of services under the Board's rules. As the Table above shows, few hospitals in the area meet the historical utilization standard for medical / surgical bed utilization. Indeed, on average there are 295 unoccupied beds in area hospitals.

B. Criterion 1110.530(c)(3) – Impact of Project on Other Area Providers

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

A) Will not lower the utilization of other GSA providers below the utilization standards specified in 77 111. 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 utilization standards.

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; or

C) Insufficient population to provide the volume or caseload necessary to utilize the services proposed by the project at or above occupancy standards."

Section 3(A)(B) of the above rule requires that the applicant document that the Project will not lower utilization of existing providers below the utilization standard (or further below the utilization standard). As shown on the table above, most area hospitals, including a Mercy hospital, operate below utilization targets.

The applicants have characterized discussion of this impact on existing providers as an attempt to maintain "market share" and that this is an inappropriate function for the Review Board. Instead, the issue of unnecessary duplication of services is at the very core of the Board's mission and planning process. The Board's rule on duplication of services is clear and the effect is clear – this project duplicates services and creates a maldistribution. The Application at hand did not even attempt to address this issue or the details of the Board's rules in its application (See Attachment to the application at pp. 130-131).

The Board's rule requiring an applicant to document effect on utilization applies not only to competing facilities within the Planning Area, but to other nearby facilities outside the Planning Area as well to the Applicant's own facilities. Mercy Hospital had utilization of only 26.8%, well below the Review Board's standard of 85%.

C. Criterion 1110.230(c) - Alternatives

The Alternatives Criterion states:

> *"The applicant must document that the proposed project is the most effective or least costly alternative.... Alternatives must include, but are not limited to: purchase of equipment, leasing or utilization (by contract or agreement) of other facilities, development of freestanding settings for service and alternate settings within the facility."*

Mercy addressed this alternative and acknowledged that this would be the lowest cost alternative.

We agree with the Applicant that the best alternative is that patients continue to use existing facilities that presently have excess capacity. Most facilities in the area have excess capacity, including one of Mercy's own hospitals. Building a new facility is more expensive, duplicates services, and is not needed. Mercy did not even raise as an alternative using other facilities in the area.

Conclusion

There is no need for this Project under the Board's rules and the Project unnecessarily duplicates existing services. This Application fails to meet the Review Boards requirements and should be denied or deferred until the Comprehensive Plan is complete.

Sincerely,

Joe Ourth

JRO/eka