BLESSING Health System

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blessinghealth.org

April 5, 2022

Ms. Debra Savage
Chairwoman
Illinois Health Facilities and Services Review Board
525 West Jefferson, Second Floor
Springfield, IL 62761

Sent via email

Dear Chairwoman Savage:

This letter is in Opposition to Project 20-044 – Quincy Medical Group Hospital.

Rural healthcare is in a crisis and the problem is getting worse. The statistics on closure of rural and small hospitals are staggering.

- According to Forbes, as of January 1, 2020, "the rural hospital closure crisis has claimed 120 facilities across the nation over the past 10 years." [i]
- 60 million Americans live in designated rural areas (approximately 20% of the population) and access to healthcare in these regions is a daily struggle. [ii]
- "Over 40% of the rural hospitals are at risk of closing in the near future…and the primary cause of closures is that payments from health insurance plans don't sustain essential services in rural communities." [iii]
- "High dependence on non-patient care services revenues that offset losses on patient services (for example state and federal subsidies, grants, funding from tax programs) can create positive total margins, but without such subsidies many hospitals' net assets would not be large enough to offset patient losses for more than two years." [iv]

As this Board considers the certificate of need ("CON") for a small format hospital filed by the physicians of Quincy Medical Group ("QMG"), serious consideration should be given to the challenges and threats to rural healthcare in Illinois. Illinois has 72 rural hospitals with 20 at risk of closing and 14 at immediate risk of closure. [v] (See the Fact Sheet, "Rural Hospitals at Risk of Closing," *Center for Healthcare Quality and Payment Reform,* attached hereto as Exhibit A.)

The plain language of the Illinois Certificate of Need statute (20 ILCS 3960/2, as excerpted with emphasis added) is as follows:

- "Cost containment and support for safety net services must continue to be central tenets of the Certificate of Need process."

- The Planning Board is required to consider and evaluate with evidence-based assessments "capacity, value, quality and equity in the delivery of healthcare services in Illinois."
- The Planning Board is responsible for "establishing an orderly and comprehensive healthcare system that "guarantees" (among other things) the "availability of quality health care to the general public; to maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent."

Stated another way, the Planning Board should consider the important issues of health disparities, health equity and social determinants of health in rural, sparsely populated, economically challenged areas of Illinois, and how the approval of a small format, low acuity hospital 1.9 miles from the region's only safety net provider will result in profound disruption to the availability of essential healthcare services in the region. According to the Illinois Health and Hospital Association ("IHA"):

"Because of their geographic location, smaller size and demographic mix, Illinois small and rural hospitals face a unique set of challenges. They are more dependent on Medicare as a government payer; financially constrained; often located in physician and mental health professional shortage areas; and are often the sole providers of health-related services in their communities." (Please see "Advancing Rural Health in Communities Across Illinois," 2018, attached hereto as Exhibit B.)

In this comprehensive IHA report on the state of healthcare in rural Illinois, certain key findings were made:

- 45.3% of small and rural hospitals operate on negative or thin operating margins.
- 50.1 % of patients in the small and rural hospitals are over the age of 65, compared to 36.8% of all other hospitals.
- Medicare and Medicaid are the primary payers for small and rural hospitals (71.5% of all admissions as compared to 57.8% for all other hospitals).
- Illinois small and rural hospitals provide a greater proportion of care on an outpatient basis than do other hospitals (in 2016 they had 23 admissions for every 1000 outpatient visits, compared to 45 admissions per 1000 visits for every other hospital).
- Many small and rural hospitals provide long term care and 56.2% of inpatient days take place in the long-term care setting compared to 18.5% of inpatient days in other hospitals.
- Workforce shortages (pre-pandemic) were critical in rural counties with rural counties having 45.5 primary care physicians per 100,000 people compared to the statewide average of 80.7 primary care physicians per 100,000 people.

Of great importance is that Blessing Hospital and Planning Area E-05 face all of the challenges that were articulated by the IHA in 2018, and those challenges have been exacerbated in the post-pandemic reality of 2022. Not only does the proposed QMG Hospital not solve any of the healthcare problems facing rural Illinois, it intensifies the problems by adding unneeded general acute care inpatient beds and operating rooms to the area, yet it fails to add any capacity to care for those with chronic or acute mental health issues, long term care needs, trauma, intensive care, or high-risk mother/baby care. QMG is providing a boutique hospital for less acute, better insured patients. If Illinois did not have the Planning Board, nor the CON process, QMG could perhaps build its micro hospital without any need for state agency oversight; however,

the legislature in Illinois has determined that establishing an "orderly and comprehensive healthcare system" that preserves safety net services is critical for Illinois residents (20 ILCS 3960/2).

The struggle of rural hospitals has been well documented, with leading causes of distress being lack of liquidity and profitability, and declining inpatient volumes. A study published in 2020 found that between 2011 and 2017 the average daily census in all rural hospitals declined 13 percent; however, the decline for sole community hospitals for the same time period was 20 percent. [vi] An assessment of the QMG physicians hospital project must consider the needs of the geographic health planning area (E-05) and the status of Blessing Hospital, as a designated "sole community hospital" by the Centers for Medicare and Medicaid Services ("CMS"). The financial benefit to the rural region of the sole community hospital status is undisputed. Not only does the enhanced reimbursement provide Blessing with the needed revenue to support its government payer mix, the additional funds provide Blessing with the capacity to offer desperately needed community services such as mental health care, support of rural health clinics, and financial support of two critical access hospitals (Illini Hospital in Pittsfield, IL and Keokuk Hospital in Keokuk, Iowa). (Please see the letter dated March 28, 2022, regarding the loss of Sole Community Hospital Status, attached hereto as Exhibit C).

Blessing Hospital has been able to successfully navigate the challenges of providing healthcare in Adams and Schuyler Counties (E-05) Illinois, its surrounding Illinois counties, and even certain bordering counties in Missouri and Iowa because it has been able to redeploy the subsidies, grants, and tax benefits it receives to support its designated rural communities, health professional shortage areas ("HPSA") and medically underserved areas/populations ("MUA/P").

Blessing is a rural health system success story, which is becoming rare in 2022. The success of Blessing cannot be overlooked, downplayed, or used against it by QMG physicians in their quest for duplicative, redundant, and unneeded expensive services. If this Board chooses to approve the QMG hospital that undermines the very existence of Blessing, the Board will be choosing to put in jeopardy the availability of medical services for an entire rural region of Illinois, as well as Eastern Missouri and Northeast Iowa.

Make no mistake, the success of both Blessing and the QMG physician group, as a hospital and a medical provider in rural Illinois, rests largely on the cooperation and collaboration of the two groups for decades. Blessing has benefitted from a stable physician group that includes both primary and specialty care. QMG has benefitted from Blessing's hospital services that are rarely available in the rural safety net hospital, including a certified Stroke Center, a certified Chest Pain Center, critical care, hospice and home care, bariatric care, trauma care, oncology and cardiology, including arrythmia care, just to name a few. Blessing has used its resources to provide and maintain state-of-the-art medical equipment. Blessing has also supported a four-year BSN nursing program, as well as multiple ancillary medical professional programs, all in an effort to provide an adequate supply of well-trained professionals for the entire community, not just for Blessing. Blessing's growth and stability has enabled QMG to recruit and retain physicians because it has maintained a well-staffed, state-of-the-art hospital for the doctors and patients of QMG.

Conclusion

The availability of adequate health and medical care in rural Illinois was in decline prior to the 2020 pandemic; post-pandemic the decline has accelerated rapidly with severe staffing shortages, extreme cost increases,

and increased patient severity and acuity, due to both Covid-19 and a two-year lack of people seeking preventive and maintenance care. The need for mental health services has surged, while the availability of providers has plummeted. The QMG physicians propose a low acuity, elective procedure-based facility that will simultaneously take insured patients from the only safety net hospital in the region, and by definition force elimination of Blessing's sole community hospital status, and the significant subsidies that result from that status. Blessing urges this Board to consider the written comments of the IHA, which suggest that you take a serious look at the need for small format hospital regulations. Finally, Blessing requests that you deny the application for the QMG small format hospital as an unnecessary duplication of services in Planning Area E-05, as well as its lack of any contribution to the alleviation of health disparities and inequities in rural Adams County.

Sincerely,

Diane Jacoby
Vice President and Chief Legal Officer
Blessing Health System
PO Box 7005
Quincy, IL 62305

Endnotes

[i] "1 in 4 Rural Hospitals Are at Risk of Closing and The Problem Is Getting Worse," *Forbes, February 24, 2020, www.Forbes.com*.
[ii] *Id.*
[iii] "The Crisis in Rural Healthcare," www.ruralhospitals.chqpr.org, April 4, 2022.
[iv] *Id.*
[v] "Rural Hospitals at Risk of Closing," *www.CHQPR.org*.
[vi] "Decline in Inpatient Volume at Rural Hospitals," *The Journal of Rural Health, vol. 37, #2, pp. 347-352.*

Exhibit A

RURAL HOSPITALS AT RISK OF CLOSING

Hundreds of Rural Hospitals Are At Immediate Risk of Closure

Over 500 rural hospitals – more than one-fourth of the rural hospitals in the country – are at **immediate risk of closure** because of continuing financial losses and lack of financial reserves to sustain operations. These hospitals have:

- **Persistent Financial Losses:** The hospitals had a cumulative negative total margin over the most recent 3-year period for which financial data were available; and
- **Low or Non-Existent Financial Reserves:** The hospitals either (a) had total liabilities exceeding all assets other than buildings and equipment, or (b) had assets greater than liabilities, but only by enough to sustain continued losses for at most 2 years.

Almost every state has at least one rural hospital at immediate risk of closure, and in 21 states, 25% or more of the rural hospitals are at immediate risk.

Hundreds More Rural Hospitals Are At High Risk of Closing In the Near Future

Over 300 additional rural hospitals are at **high risk of closure** in the near future. These hospitals fall into two categories:

- **Low Financial Reserves.** These are hospitals that have assets greater than liabilities, but the difference is only enough to cover the hospital's average annual losses for at most 5 years.
- **High Dependence on Non-Patient Service Revenues.** The second group of hospitals have had positive total margins, but only because they receive large amounts of funding from local taxes, state subsidies, or other sources of funds sufficient to offset losses on patient services. Moreover, these hospitals either have liabilities in excess of assets, or their net assets would not be large enough to offset the patient service losses for more than two years. Since it is not clear that these hospitals can continue receiving large amounts of revenue from other sources in the future, they also have to be considered at high risk of closure.

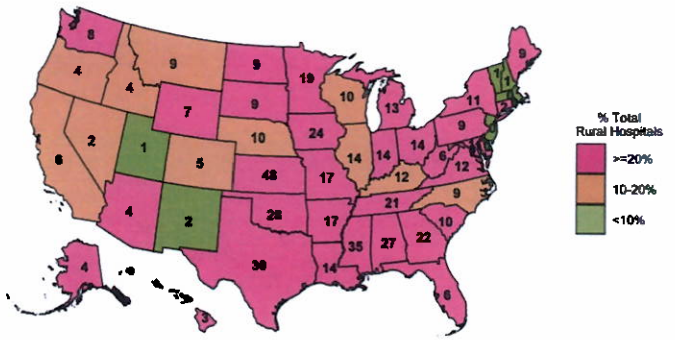
Rural Hospitals In Almost Every State Are at Risk of Closing

In total, nearly 900 rural hospitals – over 40% of all rural hospitals in the country – are either at immediate risk or high risk of closure. More than 20% of rural hospitals are at risk of closing in almost every state in the country, and in 15 states, the majority of the rural hospitals are at risk of closing. Millions of people who live in the areas served by the at-risk hospitals could be directly affected if the hospitals were to close.

Most Rural Hospitals at Risk of Closing Are In Isolated Rural Communities

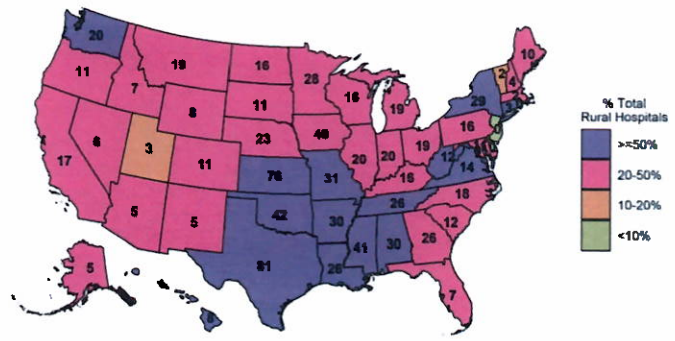
Almost all of the rural hospitals that are at immediate or high-risk of closure are in isolated rural communities. Closure of the hospital would mean the community residents have *no ability at all* to receive emergency or inpatient care without traveling long distances. In many small rural communities, the hospital is the only place where residents can get laboratory tests or imaging studies, and it may be the only or principal source of primary care in the community.

Rural Hospitals at Immediate Risk of Closing



Risk of closure is based on persistent financial losses and low financial reserves.

Rural Hospitals at Immediate or High Risk of Closing



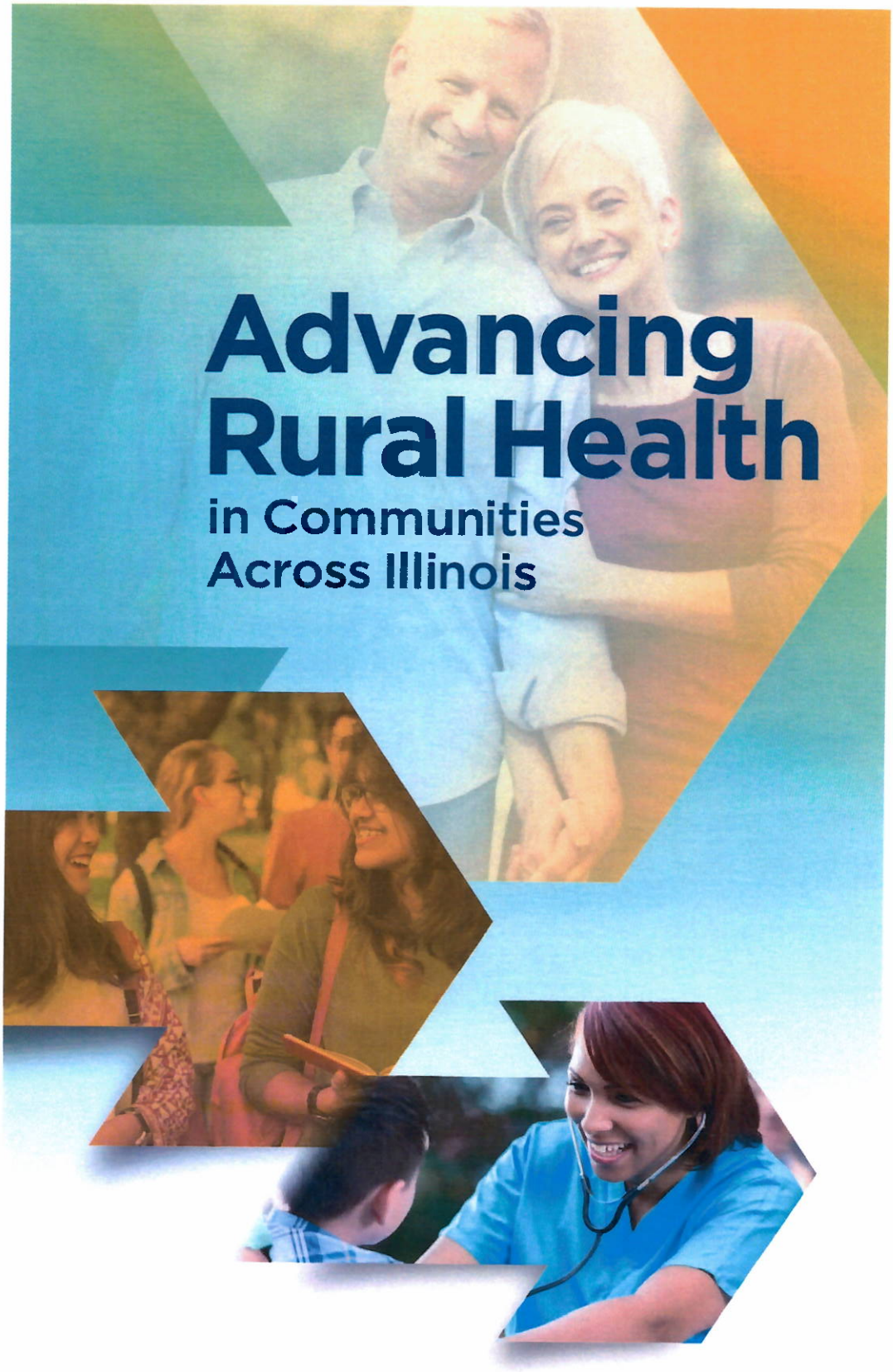
Risk of closure is based on persistent financial losses and low financial reserves, or high dependence on grants, local taxes or other revenues not derived from patient services.

RURAL HOSPITALS AT IMMEDIATE OR HIGH RISK OF CLOSING

State	Total Rural Hospitals	Number at Risk of Closing	Percent at Risk of Closing	Number at Immediate Risk of Closing	Percent at Immediate Risk	Number at High Risk of Closing
Alabama	46	30	65%	27	59%	3
Alaska	13	5	38%	4	31%	1
Arizona	18	5	28%	4	22%	1
Arkansas	49	30	61%	17	35%	13
California	52	17	33%	6	12%	11
Colorado	41	11	27%	5	12%	6
Connecticut	3	3	100%	2	67%	1
Delaware	2	0	0%	0	0%	0
Florida	20	7	35%	6	30%	1
Georgia	61	26	43%	22	36%	4
Hawaii	12	8	67%	3	25%	5
Idaho	29	7	24%	4	14%	3
Illinois	72	20	28%	14	19%	6
Indiana	53	20	38%	14	26%	6
Iowa	90	40	44%	24	27%	16
Kansas	104	76	73%	48	46%	28
Kentucky	69	16	23%	12	17%	4
Louisiana	48	26	54%	14	29%	12
Maine	25	10	40%	9	36%	1
Maryland	4	1	25%	1	25%	0
Massachusetts	5	2	40%	0	0%	2
Michigan	61	19	31%	13	21%	6
Minnesota	90	28	31%	19	21%	9
Mississippi	65	41	63%	35	54%	6
Missouri	58	31	53%	17	29%	14
Montana	51	19	37%	9	18%	10
Nebraska	71	23	32%	10	14%	13
Nevada	13	6	46%	2	15%	4
New Hampshire	17	4	24%	1	6%	3
New Jersey	1	0	0%	0	0%	0
New Mexico	23	5	22%	2	9%	3
New York	50	29	58%	11	22%	18
North Carolina	52	18	35%	9	17%	9
North Dakota	37	16	43%	9	24%	7
Ohio	70	19	27%	14	20%	5
Oklahoma	73	42	58%	28	38%	14
Oregon	32	11	34%	4	13%	7
Pennsylvania	40	16	40%	9	23%	7
Rhode Island	0	0	0%	0	0%	0
South Carolina	25	12	48%	10	40%	2
South Dakota	45	11	24%	9	20%	2
Tennessee	47	26	55%	21	45%	5
Texas	146	81	55%	30	21%	51
Utah	21	3	14%	1	5%	2
Vermont	13	2	15%	1	8%	1
Virginia	27	14	52%	12	44%	2
Washington	40	20	50%	8	20%	12
West Virginia	24	12	50%	6	25%	6
Wisconsin	73	16	22%	10	14%	6
Wyoming	24	8	33%	7	29%	1

Data current as of January 2022

Exhibit B



Advancing Rural Health

in Communities Across Illinois

Illinois Health and Hospital Association

Your trusted voice and resource

2018

Illinois has **87** small and rural hospitals that make up **39%** of our state's hospitals, have an annual economic impact of **$12.1b** and care for a greater percentage of our state's elderly citizens.

NEW THIS YEAR

This year's report looks at the growing opioid crisis impacting Illinois' small and rural communities.

Illinois Small and Rural Hospitals

Because of their geographic location, smaller size and demographic mix, Illinois small and rural hospitals face a unique set of challenges. They are:

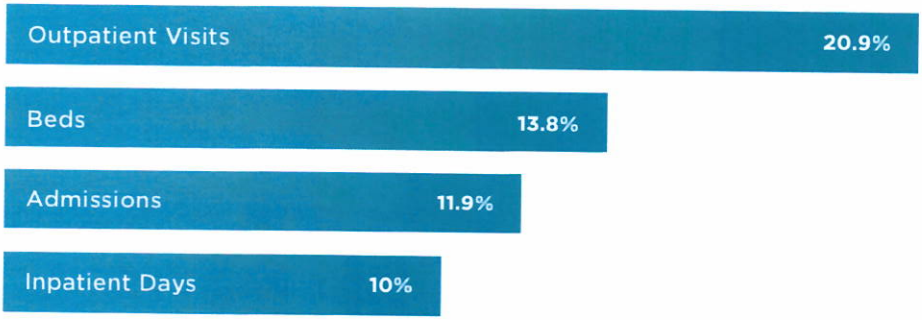
- More dependent on Medicare as a government payer;
- Financially constrained;
- Often located in physician and mental health professional shortage areas; and
- Often the sole providers of health-related services in their communities.

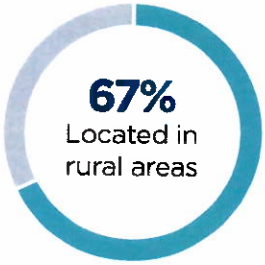
Despite these challenges, Illinois' small and rural hospitals continue to transform the delivery of healthcare and provide the highest quality care to the communities they serve.

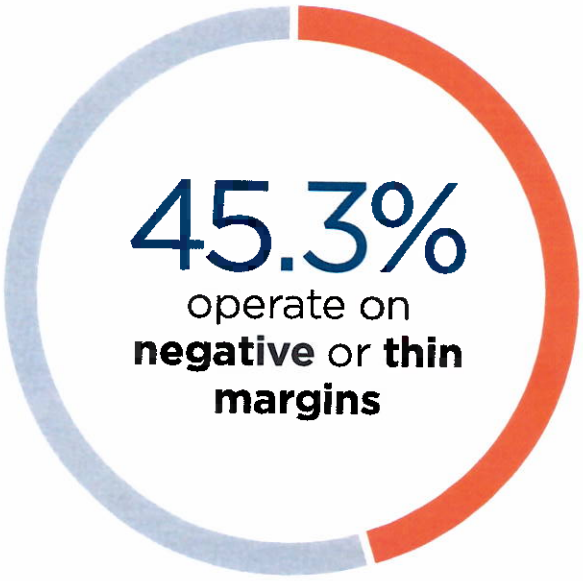
Here's their story.

Snapshot

Small and Rural Hospitals Account for 10 – 20% of Hospital Utilization in Illinois

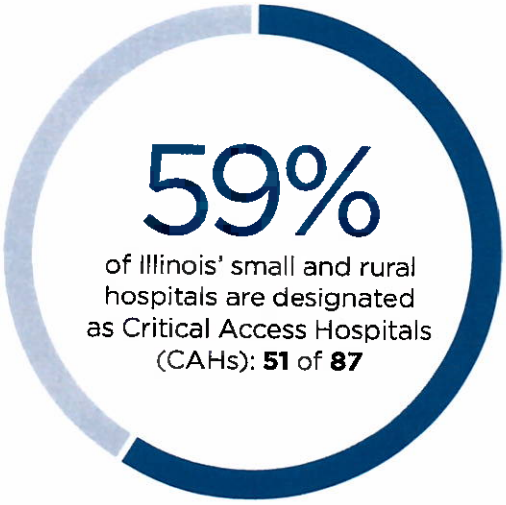






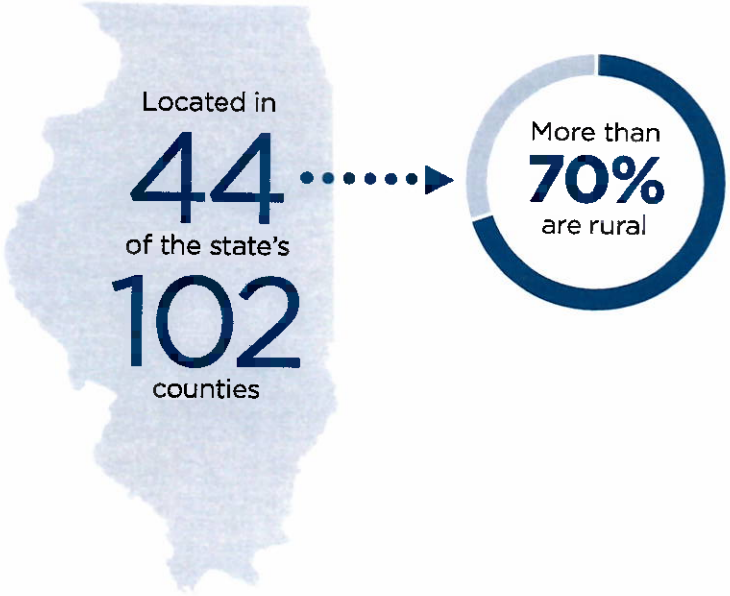
Sources: Illinois Department of Public Health Annual Hospital Questionnaire, 2016; Medicare cost reports (HCRIS), March 2018 release; IHA member database

Critical Access Hospitals—A Vital Subset



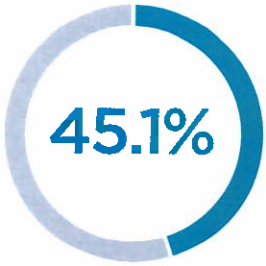
Definition of CAH

- Less than 26 acute care beds
- Average length of stay—no more than 96 hours

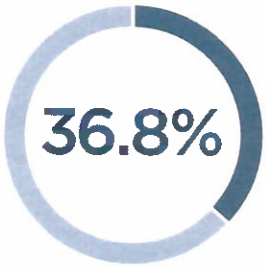


Treat a Larger Portion of Older Patients

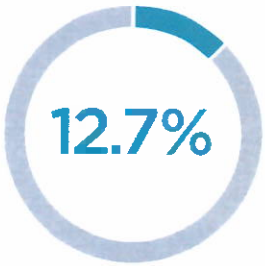
Age 65 and over:



compared to other hospitals



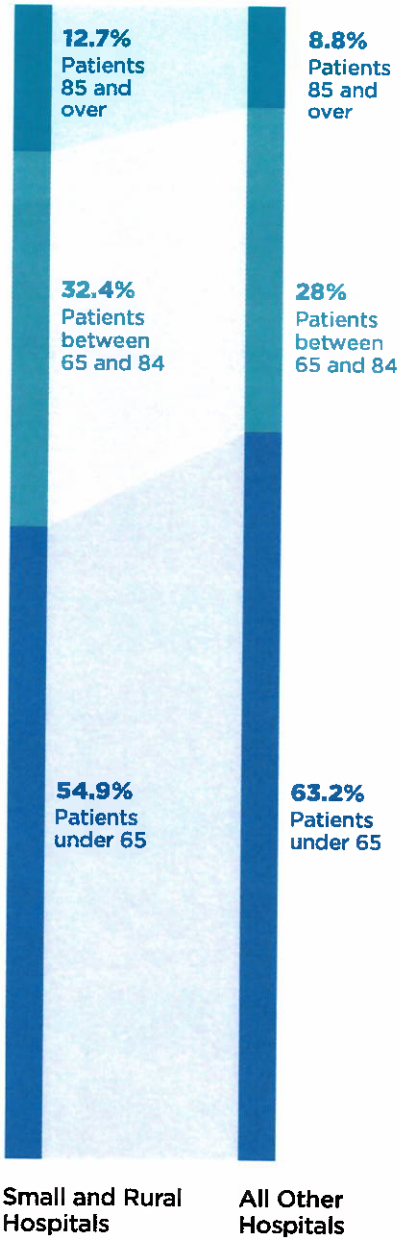
Age 85 and over:



compared to other hospitals

Small and Rural Hospitals Treat More Elderly Patients

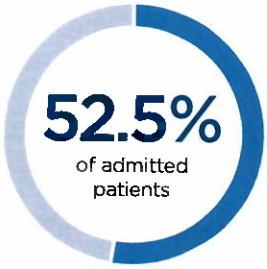
(Percent of Patients)



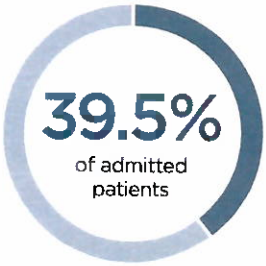
Source: IHA COMPdata, 2017 (based on inpatients only)

Rely More on Government Payers

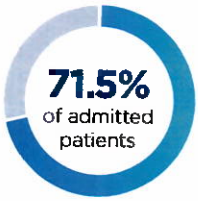
Especially Medicare:

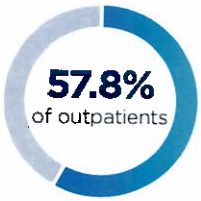


compared to other hospitals



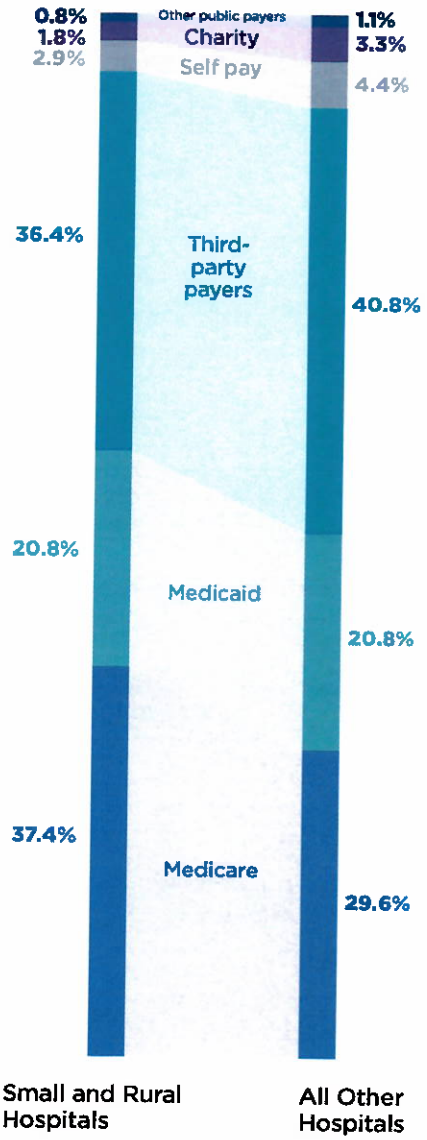
Medicare and Medicaid are the primary payers for:





Small and Rural Hospitals Rely More on Government Payers*

(Percent of Patients)



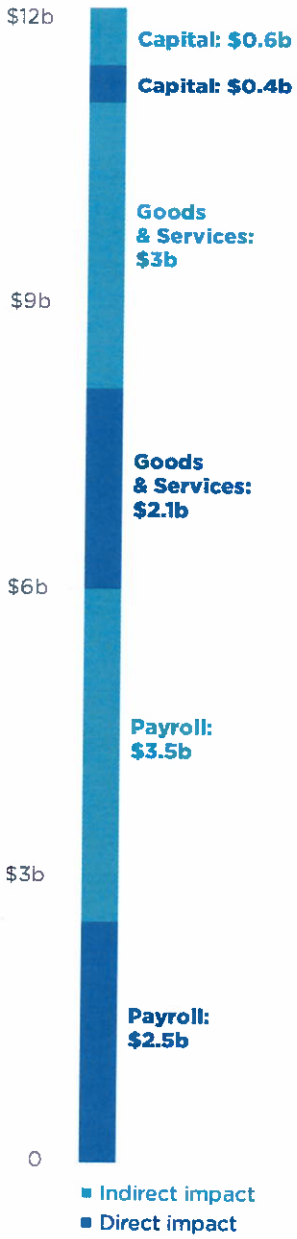
Medicare and Medicaid reimburse BELOW the cost of care.

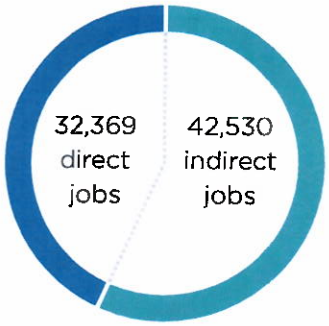
* Includes both inpatients and outpatients
Source: Illinois Department of Public Health Annual Hospital Questionnaire, 2016

Economic Engines

$12.1b
economic impact

74.9k
jobs impact





14.9%
of the state's hospital workforce

Each year Illinois' small and rural hospitals pump $2.5 billion into the state and local economies in the form of employee salaries and benefits. These salaries are then spent within their communities, generating an additional $3.5 billion in economic activity and 42,530 jobs in industries that support hospitals and their employees.

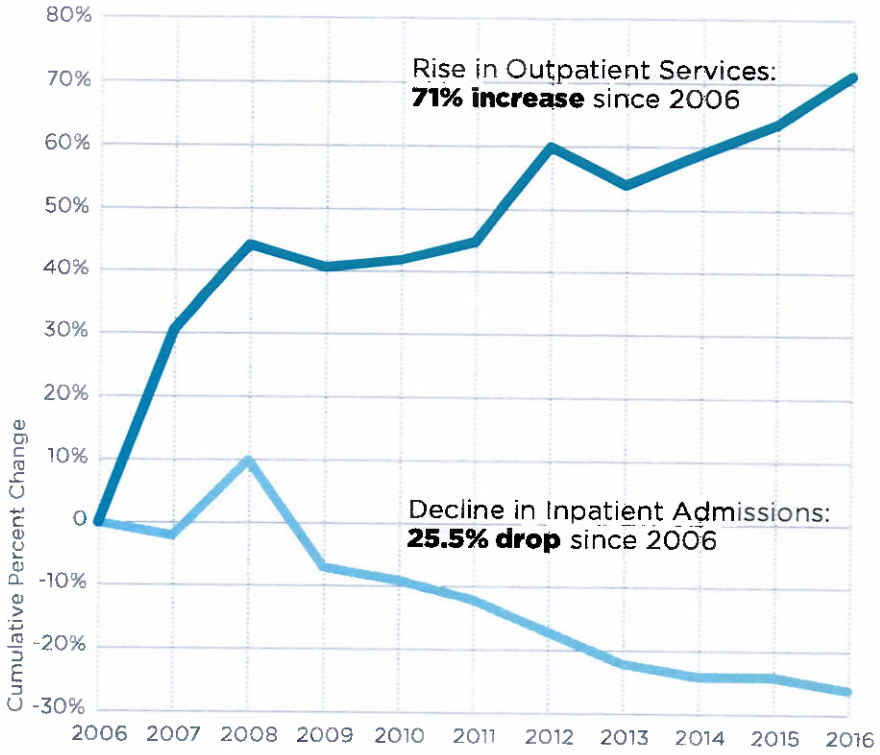
Small and rural hospitals also spent $2.1 billion on goods and services annually. This leads to more spending within the state and local economies, generating an additional $3 billion in economic activity.

Sources: IHA Economic Impact Report, 2018; AHA | Health Forum Annual Survey of Hospitals, 2016

Notes: Total economic impact includes direct spending and the ripple effect of that spending with the local economy. Indirect impacts are calculated by using a modeling system developed by the US Bureau of Economic Analysis (BEA). BEA multipliers are applied to Medicare cost report data on jobs and spending to obtain the ripple effect of jobs and spending throughout the economy.

More Outpatient Care

Inpatient Decline Compared to Outpatient Growth



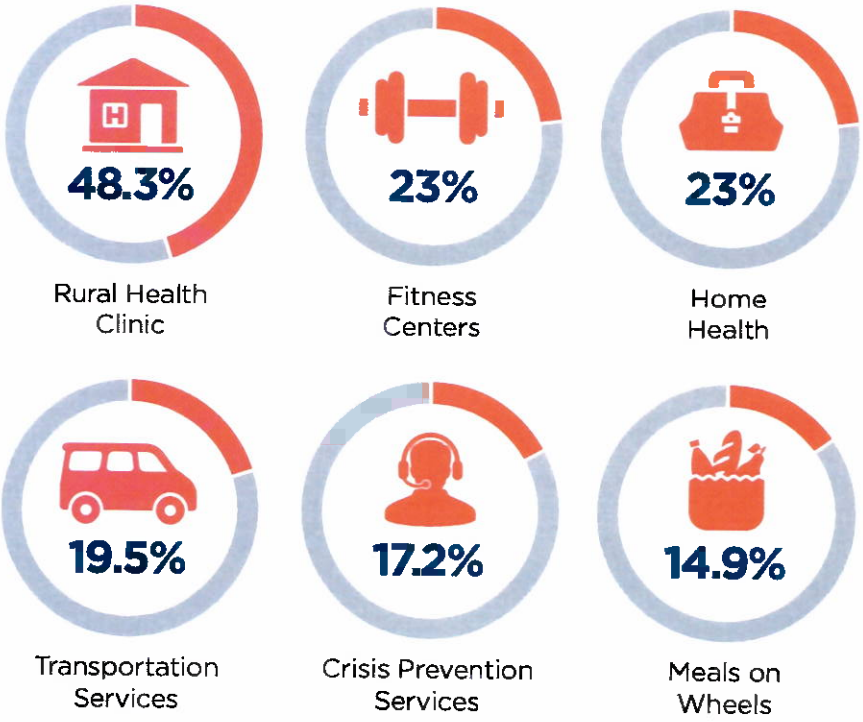
Illinois' small and rural hospitals provide a greater proportion of care on an outpatient basis than other hospitals. In 2016, they had 23 inpatient admissions for every 1,000 outpatient visits compared to 45 admissions per 1,000 outpatient visits in other hospitals.

- **76.7%** of all surgeries in small and rural hospitals were performed on an outpatient basis in 2016.
- **68.8%** of their net revenue was from outpatient services compared to **47.7%** for all other hospitals.

As more services are provided in the outpatient setting, many rural funding programs have become outdated and fail to provide the intended financial stability.

Source: IDPH Annual Hospital Questionnaire, 2006-2016

Important Providers of Community Healthcare Services

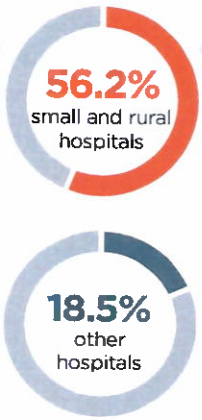


In addition, the percentage of small and rural hospitals providing community-based services has grown over the last decade (2006 - 2016). The percent providing:

- **Freestanding outpatient centers** grew by 100%
- **Indigent care clinic** grew by 66.7%
- **Retirement housing** grew by 50%
- **Crisis prevention services** grew by 15.4%
- **Ambulatory surgery center** grew by 10%
- **Fitness centers** grew by 5.3%

Inpatient Days in Long-term Care Setting

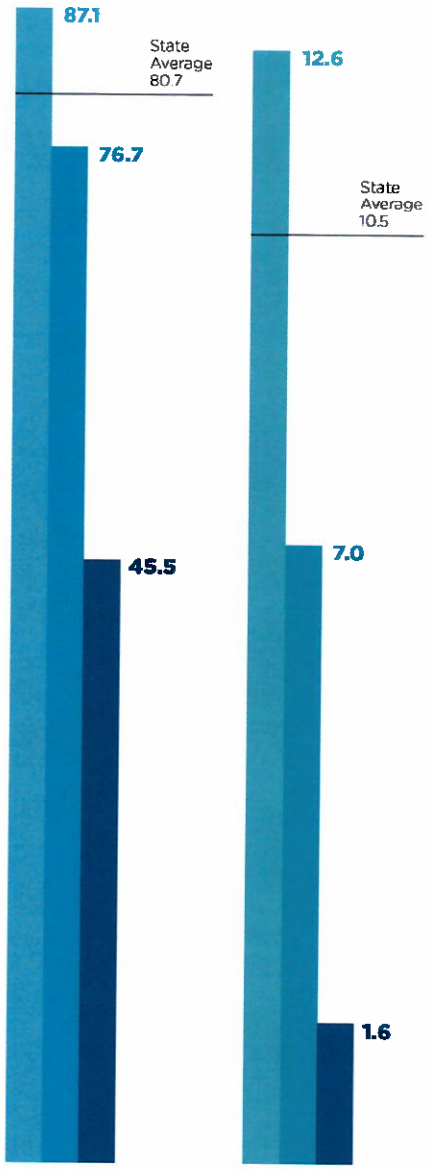
Many small and rural hospitals provide long-term care, and in the hospitals that provide this service, **56.2%** of inpatient days take place in the long-term care setting. This compares to **18.5%** of inpatient days for all other hospitals.



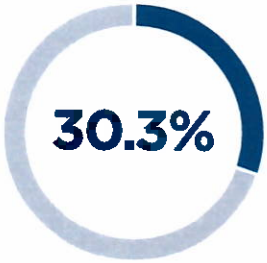
Source: AHA | Health Forum Annual Survey of Hospitals, 2006 - 2016

Face Critical Workforce Shortages

Rural Counties Face Physician Shortages



Physician and Mental Health Shortages



of small and rural hospitals are in areas designated as a Health Professional Shortage Area (HPSA) for primary care physicians

are in areas designated as a HPSA for mental health professionals

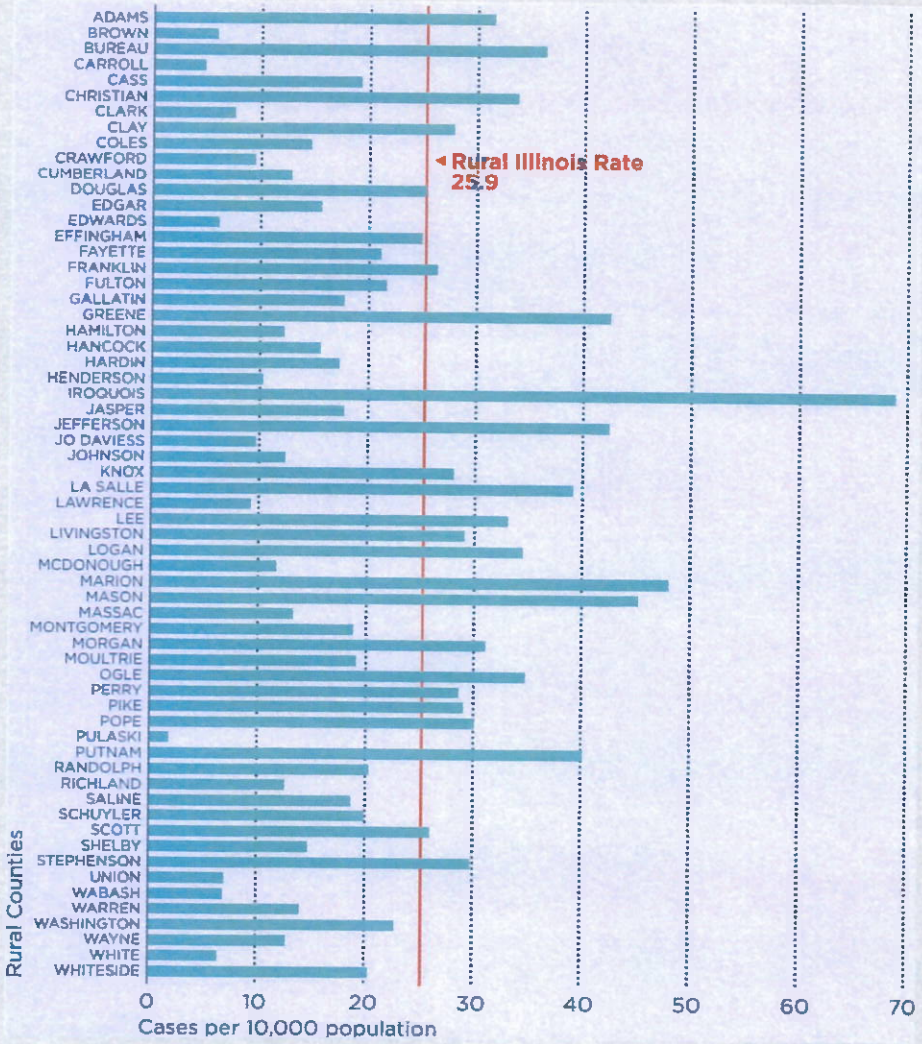
Source: Health Resources & Services Administration, Area Health Resources Files, 2017-2018

Illinois' Alarming Opioid Crisis

Impact on Small and Rural Communities

The opioid crisis is a statewide problem that shows few signs of abating. In 56.1% of rural counties, the number of heroin/opioid overdose deaths grew between 2010 and 2015. Small and rural hospitals require additional resources to combat this epidemic.

ED Cases for Opioid Use/Poisoning
Per 10,000, Rural Counties (2017)

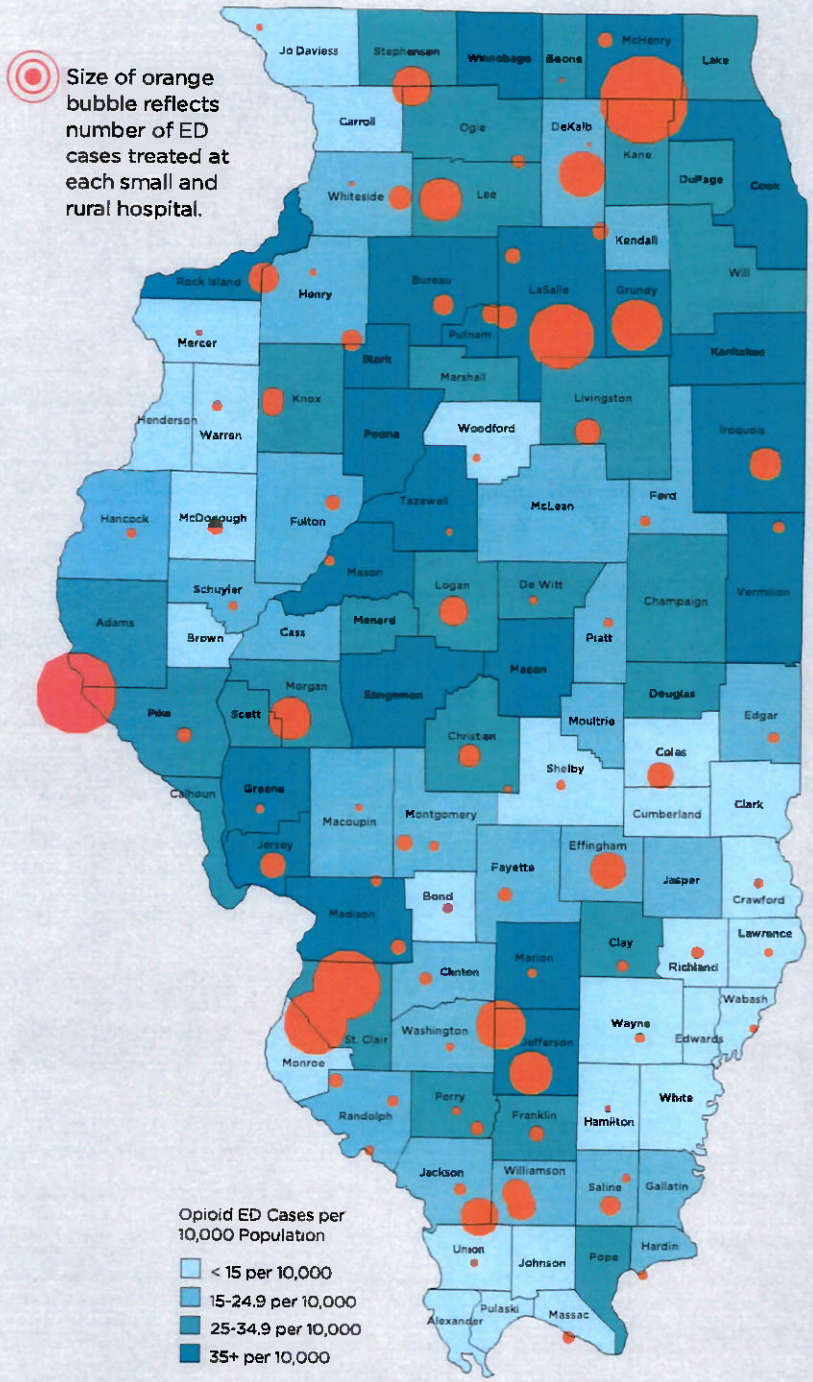


Overall rate for Illinois was 46.9 ED cases per 10,000 lives

Sources: IHA COMPdata 2017; U.S. Census Bureau;
IDPH, "County Level Percentage Change in Overdose Deaths 2010-2015"

ED Cases for Opioid Use/Poisoning

Per 10,000 Population by County and
Opioid Cases Treated in Small and Rural Hospital EDs, 2017



Sources: IHA COMPdata 2017; U.S. Census Bureau

Hospitals in Action: Improving Lives

Initiatives to improve care and patient safety are producing positive results for the patients and communities small and rural hospitals serve.

Training for Accuracy

McDonough District Hospital in Macomb implemented The Final Check toolkit to eliminate mislabeled specimens after training through IHA's Hospital Improvement Innovation Network. Hospital leaders added a final check between lab and nursing by comparing the last three digits of the patient's medical record aloud with the specimen; utilizing "just culture" principles; and creating a culture of safety, reporting, learning and transparency. That work, begun in October 2017, has enhanced patient safety.

Data and Communications Lead to Faster Recoveries

In January 2015, **OSF HealthCare Saint James – John W. Albrecht Medical Center** in Pontiac brought together physicians and nurses to decrease episiotomy rates system-wide. Using evidence-based medicine, the team implemented collaborative meetings, phone calls and emails; data presentation and transparency; feedback loops and accountability; cultural change; and optimization of electronic medical record for accurate documentation. As a result, perineal injury and post-delivery recovery time have decreased.

Improving Safety and Care

Leaders at **Illini Community Hospital** in Pittsfield revised their quality management system and identified several other initiatives to improve patient care and safety. In July 2017, leaders adopted root cause analyses of all patient or environmental safety events; team engagement in process evaluation; and department measures targeting critical quality metrics. Along with enhancing patient safety, the initiatives improve efficiency in process and patient care and increase transparency and accountability.

- **Improves patient safety**
- **Improves process and patient care efficiency**
- **Increases transparency and accountability**

Improving Workplace Safety

Wabash General Hospital in Mount Carmel initiated Vistelar's Conflict Management live training program in October 2016 and hired a security analyst for continual training to strengthen workplace safety and prevent injuries. The program helps staff avoid conflict escalation; effectively de-escalate conflict; confidently deal with verbal abuse; end the interaction in a better place than where it started; and stay safe and protect others. The initiative has reduced injuries and increased patient satisfaction.

- **Reduces injuries**
- **Improves patient and community safety**
- **Increases patient satisfaction**

Hospitals in Action: Improving Communities

To build healthy communities across Illinois, small and rural hospitals are leading and funding initiatives to improve individual and population health.

Bringing Healthcare to Life

In 2015, **Carlinville Area Hospital** in launched "High School to Healthcare," a free class for high school students in Carlinville interested in pursuing careers in healthcare. Held at the hospital, these classes bring to life the experiences of healthcare professionals by exploring a case study of a medical situation and injured or ill patient. So far, about 45 students have participated. Several of the students plan to pursue higher education in healthcare or have already done so.

Coordinating Diabetes Awareness

To tackle diabetes, **Southern Illinois Healthcare** (SIH) in Carbondale is raising awareness and dedicating resources to partnerships with six local health departments serving the state's 15 southernmost counties. The partnerships help create or expand Diabetes Today Resource Teams in the region, with SIH funding allocated for staff to implement the evidenced-based Stanford

Chronic Disease Management program. Over 1,400 people have been screened for diabetes and over 350 people have attended diabetes management classes so far.

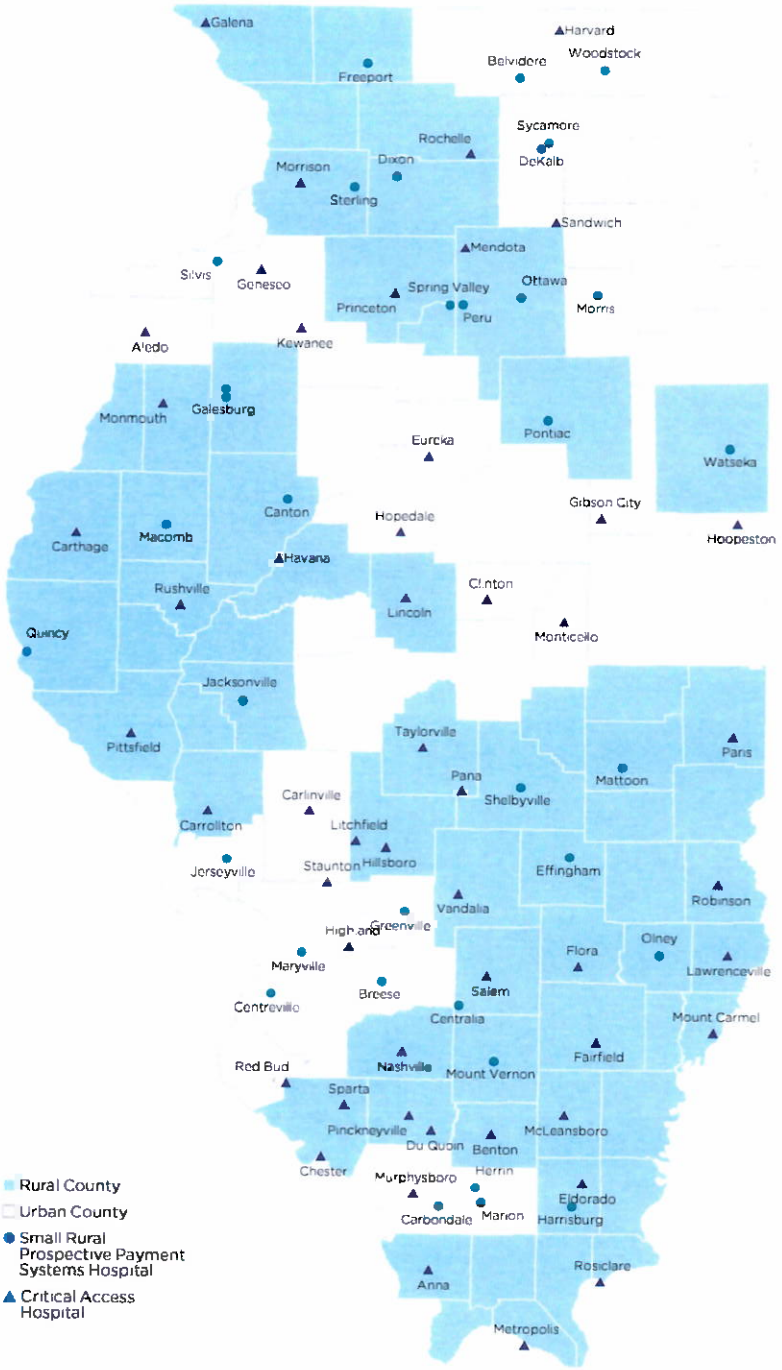
Stepping up for Screenings

HSHS St. Anthony's Memorial Hospital provided hearing and vision screenings to Effingham County schools when state budget cuts left the Effingham County Health Department without the staff to do so. Beginning with the 2015-16 school year, the hospital brought in all needed equipment and staffing to administer the screenings at no cost to schools. It also handled reporting requirements to the State. St. Anthony's efforts help improve access to healthcare services and reduce the burden on local schools.

Helping Children Cope with Grief

To help children cope with a loved one's death, **Illinois Valley Community Hospital** in Peru developed My Treasure Chest Workshop, which is run by Illinois Valley Hospice, a division of the hospital. The workshop helps children ages 6-14 preserve memories of loved ones who have recently passed away by creating their own unique treasure chests of keepsakes. It also presents other coping activities, including listening to stories, singing songs and remembering a child's loved one through writing.

Illinois' 87 Small and Rural Hospitals




Our state's small and
rural hospitals—and
the individuals and
communities they serve—
need your support.
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Exhibit C

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March 28, 2022

Illinois Health Facilities and Services Review Board
525 W. Jefferson St., Second Floor
Springfield, IL 62761

Re: Quincy Medical Group Hospital, Quincy
HFSRB No. 20-044
Blessing Hospital SCH Analysis

Dear Board Members:

This letter is to provide the Illinois Health Facilities and Services Review Board (HFSRB) with information on how the opening of a Quincy Medical Group (QMG) Hospital will adversely impact Blessing Hospital and its patients. The federal Centers for Medicare & Medicaid Services (CMS) has granted Blessing Hospital status as a Sole Community Hospital (SCH), which entitles it to favorable reimbursement terms by the Medicare program and more lenient qualification standards for participation in the federal 340B drug discount program. QMG proposes to operate a hospital in Quincy, Illinois, only 1.9 miles from Blessing Hospital. If the HFSRB approves the certificate of need (CON) for the QMG hospital, and if it operates as described in the QMG CON application to the HFSRB, Blessing Hospital will lose its SCH status, leading to significantly reduced Medicare reimbursement and potential disqualification from the 340B program.

Medicare Sole Community Hospitals

Medicare reimburses most general acute care hospitals using the inpatient prospective payment system (IPPS), which pays hospitals predetermined rates for each patient treated.[1] Congress recognized, however, that certain types of hospitals, especially in rural areas, would struggle financially under IPPS. In order to support rural health care, Congress adopted a modified IPPS payment methodology for SCHs.[2] Medicare reimburses SCHs for inpatient hospital services based on either the federal IPPS rate or the SCH's "hospital-specific" rate for either the hospital's fiscal year 1982, 1987, 1996, or 2006, whichever results in the greatest payment.[3] In very broad terms, the hospital-specific rate is the hospital's costs per inpatient discharge for the applicable fiscal year.[4]

[1] 42 U.S.C. § 1395ww(d).
[2] *Id.* § 1395ww(d)(5)(D)(i).
[3] *Id.*; 42 C.F.R. § 412.92(d).
[4] *See, e.g.*, 42 C.F.R. § 412.73.

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SCHs are also able to participate in the federal 340B drug discount program under criteria that is more lenient than the criteria for most hospitals that are not SCHs. The 340B drug discount program provides significant discounts on the purchase of outpatient drugs for qualifying hospitals.[5] Under the 340B statute, an SCH qualifies for the program if it has a Medicare disproportionate share hospital (DSH) payment percentage that is 8% or above.[6] Most other hospitals that do not have SCH designation must have a DSH percentage of above 11.75%.[7]

Medicare reimbursement for certain separately payable outpatient drugs is lower if the drug is purchased at 340B prices than non-340B prices.[8] However, rural SCHs are exempt from this lower reimbursement and receive payment at the non-340B rate.[9]

Qualification for Medicare Sole Community Hospital Status

A hospital may be designated as an SCH if it meets one of several tests that measure the distance between the SCH and "like hospitals." Specifically, a hospital is designated as an SCH if it meets one of the following tests: 1) it is located more than 35 miles from other like hospitals; 2) it is located between 25 and 35 miles from other like hospitals and meets certain requirements related to its patient population, number of beds, or accessibility; 3) it is located between 15 and 25 miles from other like hospitals but is inaccessible for at least 30 days in two of every three years; or 4) "because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes."[10] Medicare regulations define a "like hospital" as follows:

> The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care

[5] 42 U.S.C. § 256b.
[6] *Id.* § 256b(a)(4)(O). Rural referral centers also qualify with a DSH percentage of 8% or more. *Id.* Critical access hospital do not receive DSH payments and, therefore, the 340B statute does not include any criteria related to DSH payments for critical access hospitals. *Id.* at § 256b(N). The DSH payment is designed to compensate hospitals for treating a high proportion of low-income and under-insured patients. 42 U.S.C. § 1395ww(d)(5)(F)(vi); 42 C.F.R. § 412.106(b).
[7] 42 U.S.C. § 256b(a)(4)(L).
[8] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model; Request for Information on Rural Emergency Hospitals, 86 Fed. Reg. 42,018, 42,134-37 (Aug. 4, 2021).
[9] *Id.* at 42,337.
[10] 42 C.F.R. § 412.92.

> characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.[11]

The 8% test described in the regulation compares the two hospitals' inpatient days that would be payable under the IPPS if a patient is covered by Medicare or the patient were covered by Medicare. In other words, all IPPS-type days are counted, not just those attributable to Medicare beneficiaries. Inpatient days that would not be paid by Medicare are excluded from the calculation, such as days in neonatal units or days in IPPS-excluded rehabilitation, psychiatric, or long-term care units. SCH classification remains in effect "unless there is a change in the circumstances under which the classification was approved."[12]

Blessing Hospital

Blessing Hospital was formed from a merger of two hospitals in the early 1990s and has qualified as an SCH for more than twenty years. Currently, there are no other "like hospitals" within 35 miles of Blessing Hospital that would jeopardize Blessing's SCH designation. As an SCH, Blessing Hospital is paid by Medicare using the hospital specific rate based on its costs. Blessing Hospital also qualifies for the federal 340B drug discount program as an SCH. Its DSH percentage is slightly above 11.75%, so it could still qualify for the 340B program as a non-SCH, but it would be in danger of losing 340B status if its DSH percentage were to slip to 11.75% or below. Because it is a rural SCH, it receives significantly higher Medicare reimbursement for outpatient drugs purchased under the federal 340B drug discount program than it would receive as an IPPS hospital.[13]

The Proposed QMG Hospital Would Be a "Like Hospital" Leading to Loss of Blessing Hospital's SCH Status

The QMG CON application projects in year two of its operation that the QMG hospital will have 7,301 medical and surgical days and 931 obstetric days.[14] This equals 8,232 patient days that would "provide[] a level of care characteristic of the level of care payable under the"

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[11] *Id.* § 412.92(c)(2).
[12] *Id.* § 412.92(b)(3).
[13] 42 U.S.C. § 256b. The 340B statute requires pharmaceutical manufacturers to provide large discounts on covered outpatient drugs to SCHs that treat a specified percentage of low-income patients. The Medicare program reduces payments to IPPS hospitals for 340B discounted drugs but does not similarly reduce payments to rural SCHs.
[14] QMG Application for Permit #20-044, Attachment 15, https://www2.illinois.gov/sites/hfsrb/Projects/ProjectDocuments/2020/20-044/2020-12-10%2020-044%20Application%20for%20Permit.pdf.

Medicare IPPS.[15] Blessing Hospital reported on its fiscal year 2020 (FY 2020) Medicare cost report that it had 54,535 patient days that were payable under the IPPS.[16] Therefore, based on the most recent available data, the QMG hospital's IPPS eligible days will be 15.09% of Blessing Hospital's IPPS days.

Based on this data, the QMG hospital would be a "like hospital" to Blessing Hospital. Because the QMG Hospital is planned to be located only 1.9 miles from Blessing Hospital, Blessing Hospital would no longer meet any of the distance criteria from "like hospitals" for purposes of SCH status. The existence of a "like hospital" in close proximity to Blessing Hospital will constitute a change in circumstances requiring revocation of Blessing Hospital's SCH designation.[17] Blessing Hospital would, therefore, lose its SCH designation, leading to the following consequences: 1) Blessing Hospital would be paid by Medicare under the IPPS and not the more favorable hospital specific rate; 2) Blessing Hospital would receive significantly lower Medicare reimbursement for certain outpatient drugs purchased under the 340B program; and 3) Blessing Hospital would be at greater risk of losing its 340B status.

Conclusion

The proposed QMG hospital, if approved, will result in Blessing losing its SCH status, resulting in significantly lower Medicare reimbursement to Blessing Hospital and potential loss of its 340B status. This loss of SCH status would be compelled by Medicare regulations.

Sincerely,

Ronald S. Connelly
Counsel to Blessing Health System

[15] 42 C.F.R. § 412.92(b)(3).
[16] Blessing Hospital had 69,535 total days in FY 2020, but not all days are counted for the SCH 8% test. Days in nursery, psychiatric, rehabilitation, and long-term care units are not paid under the IPPS and are excluded from the 8% calculation.
[17] 42 C.F.R. § 412.92(b)(3)(i), (ii).