



**Comments of the Illinois Hospital Association
On the Illinois Health Facilities and Services Review Board's
Proposed Amendments To Its Narrative and Planning Policies
(77 ILL. ADM. CODE 1100)
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Thank you for the opportunity to comment on your proposed amendments to the Board's Narrative and Planning Policies. We support many of your proposed changes and hope you consider our suggestions for further improvement constructive. Our comments fall into three categories – suggested changes that need to be made for consistency with the Health Facilities Planning Act as amended by P.A. 96-0031, suggestions to improve some of your definitions, and suggestions relating to how authorized beds are counted and reported.

Changes Needed Due to the Enactment of P.A. 96-0031

- Change references to the Health Facilities Planning Board and replace them with references to the Health Facilities and Services Review Board or State Board as now defined under the Act.
- Eliminate the definition of the “Executive Secretary” or “Secretary” as this position no longer exists.
- Delete the definition of “Short-Term Transitional Care” since the Children’s Respite Care Center Alternative Health Care Model is no longer regulated under the Act.

Suggested Changes to the Definitions (77 Ill. Adm. Code 1100.220)

Our principal general comment regarding the definitions is that there are definitions in Part 1100 that are found either in other parts of the Board's rules or in other Department rules. The definitions are replicated, although often not exactly. It would be preferable to reference the definition rather than paraphrase or repeat it. Definitions are intended to be precise and publishing them in more than one regulation opens the door to inconsistency over time as rules are amended.

Our specific comments follow:

- “Adverse Action” - Delete the definition from this section. The proposed definition is similar to the definition for adverse action found in the Procedural Rules (77 Ill. Adm. Code 1130), but is not identical. I would suggest incorporating the proposed changes

to this definition when the Procedural Rules are amended. It makes little sense to have differing definitions for the same term in two separate sections of the Board's rules.

- “Discontinuation” - Delete this definition. A definition for discontinuation is already found in the Procedural Rules. It is unnecessary to propose a different definition in Part 1100.
- “DRG” - If a definition for is necessary, it should be clarified. The proposed definition states that DRGs are used by the Medicare program for health care reimbursement. In fact, in Illinois, Medicaid uses DRGs as well. In addition, DRGs are used for hospital reimbursement and not for all other health care providers.
- “Fertility Rate” – This definition should be made more specific. A standard definition is the number of births per 1,000 women aged 15-49 years in a given year. The definition currently in Part 1100 says that this is a determination made by IDPH. It would be helpful to define the data sources so that IDPH determinations can be replicated.
- “Health Professional Shortage Areas” – This definition should be more broadly defined to include state designated shortage areas in addition to those designated by the Health Resources and Services Administration (HRSA).
- “Home-Assisted Hemodialysis” should read “means hemodialysis done in a home and/or long term care setting...” A word was omitted in your proposed definition.
- “Index of Medically Underserved” or “IMU” - This is a HRSA index. The source should be specifically referenced.
- “Newborn Nursery Level I,” “Newborn Nursery Level II,” “Newborn Nursery Level II with Extended Neonatal Capabilities,” and “Newborn Nursery Level III” definitions should simply reference the Perinatal Health Care Code (77 Ill. Adm. Code 640) without any further definition. The verbiage that is used in your proposed definition reflects draft rules that have not even been published yet and which have generated some controversy. In addition, abbreviated definitions are also found in Subpart O of the Hospital Licensing Rules (77 Ill. Adm. Code 250). These are also in transition since work is being done to craft amendments that will bring them up to date with the changes that will be made to the Perinatal Health Care Code and current practice.
- “Observation Days” - The current definition specifies that the observation period shall not exceed 48 hours. Observation status is largely a payer construct. It is not uncommon for an observation patient to stay in this status longer than 48 hours. This is a mechanism for payers to limit their financial liability and we have seen increases

in length of stay for observation patients over the last several years. IHA would recommend eliminating the reference to a 48 hour limit in this definition.

- “Patient Days” - This definition could be improved by eliminating the language that clarifies that this metric is usually expressed as annual patient days. Hospitals analyze patient day data using other timeframes. While they report annual data to the Board, they may choose other time frames to strengthen their case about the need for beds or services.
- “Perinatal Center” – This definition of should simply reference the Developmental Disabilities Prevention Act (410 ILCS 250/2(e)). The definition included in that Act is, “*Perinatal Center*” means a referral facility intended to care for the high-risk patient before, during or after labor and delivery and characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation and other support services.” The regulations that implement this Act are the Regionalized Perinatal Health Care Code. The regulations distinguish perinatal centers from level III hospitals largely through the responsibility of the perinatal center to provide administrative support for its network. The proposed definition does not capture this. Also, since the Regional Perinatal Health Care Code is undergoing revision, the Board’s rules should simply reference the Developmental Disabilities Prevention Act.
- “Population Estimates” and “Population Projections” - Both of these definitions state that the calculation is determined by the Illinois Department of Public Health (IDPH). IHA would suggest that the calculations should be either published in these rules or referenced so that hospitals and other applicants can replicate the methodology.
- “Rapid Population Growth Rate” - This proposed definition should be rewritten for clarity and referenced if the definition was drawn from another source. If the Department developed this definition on its own, the rationale should be included either in the definition or elsewhere in the rules. This definition could have significant implications in some planning areas so transparency surrounding how the definition was arrived at is important.
- “Resource Hospital” - This definition should simply reference the Emergency Medical Services Systems Act (210 ILCS 50).
- “Transplant Hospital” – It is not clear why this definition is needed. The Board regulates the Kidney Transplantation and Selected Organ Transplantation categories of service. While definitions relating to these specific categories of service are appropriate, there does not appear to be a need for a definition that essentially says that a transplant hospital provides organ transplants and other related services. The goal

should be to simplify and streamline the rules, not encumber them with unnecessary language.

Suggested Changes Relating to Authorized Hospital Beds (77 Ill. Adm. Code 1100.440)

Our most important concern under this section is the limited number of reserve beds that small hospitals are allowed to have. Since reserve beds can only total 10 percent of the beds in each category of service, smaller hospitals can only have a very limited number of beds in reserve. For a Critical Access Hospital (CAH) that can only have 25 beds, only three reserve beds are currently allowed.

Section 1100.440(a)(2)(D) should be changed to reflect that hospitals may have 10 beds in reserve. All hospitals that are 100 beds or less could have 10 reserve beds. Larger hospitals could continue to have the number of reserve beds that are allowed under the current rules. All hospitals would continue to be required to meet the Board's other requirements for reserve beds.

This is particularly important to our CAH members. They have very little flexibility with a 3-bed reserve allowance. Allowing more reserve beds (which by definition are held in reserve) will allow CAHs to:

- Respond to a likely change in federal requirements. The Centers for Medicare and Medicaid Services (CMS) is considering a change to the CAH rules. Instead of only allowing 25 beds to be set up, CMS is considering requiring Critical Access Hospitals to have no more than an average of 20 patients per day, measured over a year. This change is intended to provide CAHs with additional flexibility to accommodate patient needs during high census periods such as flu season; and
- Rescind their CAH designation without having to go through the permit process. In some parts of the state, CAHs have had spikes in their utilization. If they are considering giving up their CAH designation due to higher utilization, they should be able to do so without a permit from the Board as long as they are not adding beds beyond what is allowed under the Act. The CAH designation is really a payment designation to qualify certain small and rural hospitals for cost based reimbursement. In addition, if a few CAHs add 10 beds to the state's bed inventory there is a very small impact on the bed count that is used for planning purposes in Illinois.

Another suggestion regarding transitional beds is to allow them to be reported for more than one reporting period. Many projects take longer than one year to complete or can overlap several reporting periods. A project to add beds can begin during one reporting period, continue through the next one, and be completed in the third reporting period while still taking less than two years to complete. IHA recommends that Section 1100.440(a)(3)(B) as follows:

“For transitional beds that are not part of a CON project, the individually identified beds can be designated transitional for no more than ~~one~~ three reporting periods.”

There are also more minor language changes that should be incorporated throughout this section to change the references to an “action plan of correction” to a “plan of correction” consistent with terminology used by the Centers for Medicare and Medicaid Services.

In addition, we have recommendations to improve the section of these rules that provides direction regarding the Annual Bed Report (77 Ill. Adm. Code 100.75). While we recognize that this section has not been included in this rulemaking, so cannot be amended now, we would hope that the Board will consider eliminating the requirement for triennial review by an architect or engineer as rules are proposed within the next year to implement changes to SB1905.

Finally, although no changes were made in this rulemaking to amend the occupancy targets found in Part 1100, we would hope that these could be reconsidered for all categories of service as soon as possible. It is important that the need criteria found in the Processing, Classification Policies, and Review Criteria (77 Ill. Adm. Code 1110) are coordinated with Part 1100, the Board’s Narrative and Planning Policies. The Board has made some progress in revising its rules, but to complete this process, the utilization standards need to be reconsidered given changes to Part 1110, the health care delivery system, design standards, and best practices for patient care.

I have only a few comments on your proposed rules for the Long-Term Acute Care Hospital Category of Service. Our members who offer this service will be providing you with input on your proposed planning areas and need determination. Our only comment on the methodology is that whatever methodology is ultimately adopted, it should be based on the need for this level of service. Our Long-Term Acute Care Hospital members care for a population of complex patients with a broad range of diagnoses and conditions in addition to caring for (and weaning of) ventilator-dependent patients. Among these are stroke, neuromuscular diseases, gastrointestinal diseases, cancer, respiratory conditions, heart disease, kidney disease, severe wounds, traumatic brain injury, and spinal cord injury. They also care for post surgical patients with medical complications. Given the relatively broad population base and the fact that Long-Term Acute Care Hospitals are not evenly distributed around the state, the rules should allow for the development of new facilities if need can be demonstrated. Ultimately, Medicare reimbursement policies will drive the growth of this category of service.

The one general comment that IHA would like to make is regarding the Long-Term Acute Care Category of Service is based on concerns related to legislation that was considered in the General Assembly two years ago. The legislation was initiated by a long term care

provider that wanted to establish a long term acute care hospital floor without having this facility meet all of the licensing requirements that hospitals must meet. Patients in long term acute care hospitals are acutely ill and should be cared for in hospitals that comply with the Medicare Conditions of Participation for hospitals as well as the Illinois Hospital Licensing Requirements. Payment to Long-Term Acute Care Hospital providers presumes that they are, in fact, hospitals.

Once again, thank you for the opportunity to comment. If you have questions, I can be reached at 630-276-5496 or via e-mail at aguild@ihastaff.org.