Fresenius Medical Care

TESTIMONY BEFORE
LEGISLATIVE TASK FORCE
ON HEALTH PLANNING REFORM

June 9, 2008

Dear Task Force Members:

We would like to thank you for this opportunity to appear before you today. We are here to speak to you about CON issues as they pertain to the dialysis industry. A person requires dialysis treatment when they enter end stage renal disease or complete kidney failure for which there is no cure. The only option for survival is a kidney transplant or, for the majority of patients, dialysis treatment. Dialysis patients typically receive dialysis treatment three times every week in 4 hour sessions, just to survive. In addition to this time consideration is the fact that they have to travel from their homes to and from treatment each of these days, many in a weakened state after their dialysis session. These patients are typically elderly, in fact 46% percent of the Illinois patients seen by Fresenius are 65 years or older and 23% are 75 and older. Many of them have significant health issues such as chronic uncontrolled diabetes and/or hypertension – the two leadings causes of end stage renal disease. African Americans and Hispanics are disproportionately affected by end stage renal disease, in part because African American's have a higher risk for hypertension and Hispanics have a higher risk for diabetes when compared to the general population.

As some of you may know, Fresenius Medical Care is the largest provider of dialysis services in Illinois, employing approximately 2,500 employees and treating nearly 7,000 patients at 95 clinics throughout the State. Our clinics are "open" meaning that any physician can be granted privileges and although we are for profit, our strategic plan is to treat all patients regardless of their payor status or their status as an undocumented alien. 71% of our patients are Medicare, 13% Medicaid and only 12% are commercial insurance patients. As evidence of this, we serve residents in Chicago communities such as Englewood, Roseland, Austin, Marquette Park, Greektown, Garfield and South Shore and in less economically challenged areas throughout the north, south and west suburbs as well as throughout the rural communities of Illinois. We have found that due to our size, we are able to reach out to communities where we sometimes sustain operating losses, because we have a sufficient number of clinics (not only in Illinois but nationally) that offset these losses. We use this advantage to strategically plan and provide care to residents in communities that many health care providers do not go into. This is particularly

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important for dialysis patients who should not have to travel long distances for access to dialysis, due to their significant health issues and the necessity of frequent treatments.

Our goal at Fresenius is to provide reasonable access to this service within the appropriate planning mechanisms established by the State of Illinois. We are in full of support of legislation, which would continue the Health Facilities Planning Act into the reasonably foreseeable future – say for five years. This would create stability for staff as well as providers. We believe this is consistent with Illinois' historical support of avoiding duplication of health care services, assuring access and focusing on cost containment. We support the firm, fair and consistent application of the Act and its rules.

Having said this, there are some statutory changes that we believe could be addressed within the Act that would reduce the amount of time that staff would have to dedicate to the review process. This would likewise move projects through the process more quickly, reduce obstacles to providing access to care within the Act's parameters, decrease costs associated with the process and hopefully increase the amount of time staff has to dedicate to other important Health Planning related issues. You may have heard some of these suggestions before via other testimony however; some are unique to dialysis providers. They include:

- First and foremost, we would very much like to present an educational offering pertaining to dialysis before the Board. Fresenius has been unable to offer this due to the concern about the ex parte rule since we submit approximately 6-10 CON applications yearly, we almost always have applications pending before the Board. However, a public presentation of information, which could include DaVita and any other ESRD provider who wished to comment – at one of the Board meetings would be a great opportunity for Staff and the Board to learn more about dialysis services and ask questions of the dialysis community. As an example, we feel generally that the Board is not educated on the specific hurdles of the dialysis patient. A dialysis patient differs from patients who utilize the other providers appearing before the Board in that these patients are chronically ill and require frequent treatments to sustain life; as well they build longstanding relationships with their nephrologists. This differs from the patients who have few, if any hospitalizations, surgeries, etc. in a lifetime or those patients who require long term care. We also feel there is a general misunderstanding by the Board on the operation of the dialysis clinic as it pertains to utilization and also how the utilization rules and travel time issues differ for rural vs. urban dialysis facilities. The vast majority of rural clinics do not operate into the evening hours due to the transportation problems and travel on long and sometimes hazardous roads, although their utilization is considered upon these hours. We would welcome the opportunity to present this education information at some up coming Board meeting, and would offer to coordinate with DaVita and other dialysis providers that might like to participate.

- Secondly, we would ask that the Board be larger and that it be made up of individuals who are familiar with a wider array of the different healthcare services that are required to seek CON approval.

- The letter of intent requirement, prior to the submittal of an application, should be abandoned – it is an unnecessary delay mechanism and takes up a good deal of staff's

time. It has added costly delays for providers when a site or applicant is changed and a new letter of intent has to be submitted and then the waiting period starts over again. Aside from this, it at times delays healthcare to an area if a letter of intent is in and a follow up application is not submitted. This discourages others from looking at establishing healthcare in the same area.

- We suggest there be dedicated project reviewers for particular application types, if possible, to promote review consistency. This is of particular concern for Fresenius which sometimes has 5 or 6 applications up at one meeting along with dialysis applications from other providers. Different reviewers, just because they are different human beings, frequently apply or look at a rule slightly differently. Also, the rules on dialysis are different than those for hospitals or long term care etc. – and it might help to expedite review generally.

- Eliminate application of the financial review criteria for projects which fall under the capital expenditure threshold. This would include almost all dialysis projects.

- Eliminate the CON review process for changes of ownership of dialysis facilities and subject this only to the exemption process, with an allowance for approval by the Chair. *(NOTE: These facilities are typically for profit facilities and larger acquisitions are subject to antitrust regulation. The acquisition of single facilities that might otherwise go out of business, etc., or a change of ownership resulting from a simple internal corporate re-structuring should not be subjected to the complicated CON review process, but rather the exemption process..)*

- Allow Chair approval of a CON to relocate an existing facility within the same HSA if it meets all the requirements, if the facility is not adding stations and if there has been no public opposition to the proposed relocation. (*NOTE: Relocation occurs when an existing facility relocates, usually due to expiration of a lease. If the relocation is within less then a few miles from the old site, and does not add stations it seems the Chair should be able to approve as opposed to the lengthy and complicated review process associated with the "establishment" of a facility (since one already exists!). The lengthy CON review process frequently causes significant issues in timing relating to the expiration of the existing lease and entering into a new one – which is bad for commerce in the areas where we do business.*)

- Dialysis providers have each application measured by the number of other existing facilities that are within 30 minutes of a proposed site for a new facility. Travel issues are at the center of a dialysis patient's world due to the frequency of treatments. While the Board has relied heavily on MapQuest for travel times in the past several years, they have recently been allowing, through its rules, for these travel times to be adjusted for more heavily congested areas. While we believe MapQuest is a handy tool and good starting point in considering drive times, we would also ask that the Board also be required by a Statutory mandate to consider independent travel studies and any other pertinent travel information relating to drive times between existing facilities as documented by the applicant. The Board's rules currently allow applicants to submit drive time studies and other relevant information, but the Board does not currently have to consider this

information nor is this information made a part of the state agency report for Board members to review. Currently the Board heavily favors MapQuest because most likely it is the most black and white and objective – but it has proven to almost always provide the fastest drive time and frequently is unreliable. For the dialysis patient who is ill and often elderly, and has treatment three times a week, the fastest drive time on a busy expressway would not be the mode of travel. (*EXAMPLE – the 16 mile drive time between Sandwich and Oswego with 25 stop lights – MapQuest said you could go 16 miles in 26 minutes.)*

- The legislation allowing comment on the State Agency Report up to 2 days before a Board meeting should be abolished. This legislation, while most likely passed in good faith, has caused frequent deferrals of many applicants, not just Fresenius – which increases cost, wastes time (of both the applicants and the Board's) and clutters the Board's agenda. One piece of the legislation which should be maintained is the ability to notify the State Agency of direct factual errors contained within State Agency Reports without concern about violating the ex parte rule.

- The ex parte rule should not pertain to staff. We have found State Agency Staff to be helpful and knowledgeable. They develop working relationships with people who appear before the Board whether these people are consultants, lawyers or applicant representatives and whether they appear regularly before the Board or not. This should be encouraged and would result in fewer delays and decreased cost to the system on both ends. If there is a concern about undue influence of Staff on the Board, the way to address this is to increase the number of Board members and to disallow any questions from staff members to applicants at the meeting (other than from legal counsel for the IHFPB). Staff members would continue to be present as a resource for Board members. This would allow for greater Board involvement and dialogue with the applicants, and would work well with a larger Board as suggested.

- We suggest at least six months notice when staff changes the interpretation of a rule. Frequently, an application is significantly delayed due to a change in a long standing interpretation of a rule. We are not arguing that Staff does not have the right to change an interpretation, but just suggesting that ramp up time should be allowed to promote firm, fair and consistent application of the rules. *(Example: MMB Dialysis project/change of ownership – re: having the current operator be an applicant – this was a deviation from prior practice that resulted in us having to file a new LOI to add the current operator as an applicant).*

- A portion of the application fee should be directed to public health initiatives. If necessary, the fees should be increased for this purpose. Perhaps there could be a fund dedicated to provide appropriate staffing for health planning from experts on the subject matter.

- The newly proposed rules, in general, are becoming more complicated versus more streamlined and we would urge that this Task Force re-emphasize legislation requiring streamlining of the rules. (*EXAMPLE: the new staffing requirements, requiring letters notifying area providers regarding staffing shortages, etc. – none of which make sense given the length of time from project initiation to when actual hiring commences. This rule also is more applicable to hospitals versus ESRDs and yet is also directed to ESRDs).*

Thank you for the opportunity to be here today.

Sincerely,

Coleen Muldoon
Regional Vice President

Lori Wright
CON Specialist