September 9, 2008

M E M O R A N D U M

TO: Members of the Task Force on Health Planning Reform

FROM: Kenneth C. Robbins, President, Illinois Hospital Association

SUBJECT: IHA Position on a Charity Care Mandate as Part of Certificate of Need

As you know, the IHA and its members strongly oppose proposals that have been presented at Task Force meetings to include a charity care requirement as part of the state's Certificate of Need process. We have developed a position paper that reflects our thinking about why Certificate of Need and charity care should not be linked. I wanted to share it with all of you in advance of our upcoming meeting.

Please feel free to call me if you would like to discuss our views in greater detail. I can be reached at 630-276-5710.

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CHARITY CARE MANDATE SHOULD NOT BE PART OF CON
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Overview

The problem of the uninsured is caused by a dysfunctional health financing system. Hospitals have done more than their share in addressing this problem. The hospital community has worked with the General Assembly on several major pieces of landmark legislation that are making measurable contributions to helping the uninsured get medically necessary care and to supporting the critical mission of safety net hospitals. Any future legislation will take considerable time and thought and will depend on a stable and predictable revenue source. Injecting the issue of charity care and redistribution of funds among hospitals into the current debate about Certificate of Need will only hamper the progress of health planning reform and jeopardize continued support for the CON program.

CON/Charity Care Mandate Proposal

The CON Task Force has been asked to consider a proposal to tax hospitals and other providers that are subject to the certificate of need law and re-distribute that money to "poor" hospitals to help them treat poor people.

Proponent's Public Policy Rationale

The rationale for this proposal can be described as follows:

1. There are "rich" hospitals and "poor" hospitals[1].

2. Rich hospitals (a) have a lot of money, (b) are located in areas with few poor people, and (c) do not take care of many poor people - as reflected by low amounts of "charity" care.

3. Poor hospitals (a) do not have a lot of money, (b) are located in areas with a lot of poor people, (c) provide a lot of charity care to poor people, and (d) are in bad financial condition because of having to take care of so many poor people.

4. It is appropriate to "tax" rich hospitals in order to subsidize poor hospitals because rich hospitals do not "do their part." (Dranove, 7/14/2008, p. 71).

[1] While the proponents of this proposal characterize hospitals as “rich” or “poor”, IHA strenuously rejects this overly simplistic view.

5. The appropriate activity to tax is hospitals applying for CONs because ...

a. Hospitals that receive CONs "tend to be prosperous organizations going into prosperous areas, and ... not providing charity care, and ... not providing Medicaid." (Dranove, 7/14/08, p.93). That is, CON is mostly helping rich hospitals get richer.

b. Those "rich" hospitals that are getting CONs to move into "rich" communities are getting protection from competition -- so called franchise protection. "So you [the state] are giving something of value every time you grant a CON, and I think it's reasonable to ask those who receive CON approval to give something back in exchange." (Dranove, 7/14/08, p. 71).

6. Forcing "rich" hospitals to "do their part" – i.e., be more "charitable" -- by forcing them to subsidize "poor" hospitals in other communities will solve the financial plight of "poor" hospitals by helping them take care of more poor people.

Factual and Policy Errors Underlying the CON/Charity Care Proposal

1. "Poor" hospitals are not "poor" because they provide more charity care to poor people than "rich" hospitals. Poor hospitals are poor because a huge portion of their patients are covered by Medicaid -- the State's insurance program for poor people -- and the State of Illinois has grossly underpaid hospitals for treating poor people for at least 25 years. The Illinois Medicaid system has pushed "poor" hospitals to the brink of bankruptcy through decades of underpayment.

2. "Rich" hospitals and "poor" hospitals provide substantially similar amounts of charity care. Based on Illinois Department of Public Health data, in 2007, the average "safety net" hospital provided 1.98% of its net patient revenue in charity care while the average non-safety net hospital provided 1.61% of its net patient revenue in charity care.

3. The difference in the financial condition of "rich" and "poor" hospitals is not the result of their nearly identical levels of charity care, but by the fact that the "patient mix" of "poor" hospitals is far heavier in Medicaid patients and far lighter in privately insured patients.

4. Most hospitals in Illinois are losing money. The proponents of this proposal have focused on a handful of "rich" hospitals and a handful of "poor" hospitals. Yet out of the state's approximately 200 hospitals, 54% are losing money on patient care.

5. Thus, the financial plight of "poor" hospitals will not be solved by transferring resources between hospitals. It requires the State of Illinois to adequately reimburse hospitals for the cost of treating Medicaid patients and the uninsured.

6. CON is <u>not</u> primarily used by "prosperous" hospitals to move into "prosperous" communities. Nearly every hospital in Illinois has applied for a CON at one time or another ... rich, poor, urban, suburban, rural, large, small. A CON or COE is required for many, many types of projects. The vast majority of CONs have nothing to do with "moving" anywhere ... but simply improving the infrastructure or facilities or services in

a hospital's existing location for its existing community. Inner city safety net hospitals apply for CONs. Small and rural hospitals apply for CONs.

7. So ... (a) almost all hospitals apply for CONs and (b) most hospitals in Illinois are either losing money or are barely in the black ... yet, this proposal would apparently tax them all and send scarce resources out of their communities in order to aid a few struggling hospitals that the State of Illinois refuses to pay adequately for treating people in the State's Medicaid program.

CON does not protect most hospitals from competition and is certainly not "franchise" protection ...

- Many CON applications have absolutely nothing to do with competition … hospitals are merely replacing or upgrading existing infrastructure or facilities. Should they pay for "franchise" protection?

- Many Illinois hospitals have little or no competition from other hospitals … for example, rural or inner city hospitals. Yet they are still required to seek CONs for certain projects. Should they pay for "franchise" protection?

- Hospitals are frequently on the losing end of the CON process – their applications are denied or applications they oppose are granted. Should they pay for "franchise" protection?

- Even when a hospital is seemingly protected from competition by the CON process, the Health Facilities Planning Act is clear that the intended and actual beneficiary of that protection is the *community* served by the hospital – not the hospital *per se*. The patients and community are protected, and thus the hospital receives a collateral benefit.

- The market for health care services – especially safety net services like hospital emergency departments – is not like the market for automobiles or other consumer goods. Unbridled competition in health care can harm patients and communities in several ways – by threatening the availability of essential services and by driving up health care costs, putting health care out of the reach of those who need care.

- If you were shopping for a car, you would be delighted to find a street with dozens of car dealers next to each other – all competing for your business. That competition would drive down the cost of cars. It might also drive some of the dealers out of business. Some dealers would survive and some would perish.

- Unlike the situation with car dealers, you do *not* want to see your community hospital surrounded by a pack of competitors. Why not? Unlike car dealers, community hospitals offer a number of unprofitable but essential safety net services – such as an emergency room. If competitors are able to move into that community – regardless of need – and siphon off profitable services (like diagnostic services) or profitable patients (like privately insured patients) that community hospital will not be able to provide those unprofitable but essential services. That hospital might not

even be able to survive. Moreover, with a shortage of health care professionals, such unbridled competition could jeopardize quality and drive up health care costs.

- So even when the CON process seems to protect a hospital from "competition" that protection is really a by-product of the State's goal of protecting communities.

- The Illinois Appellate Court recently made this very point when it ruled that the CON process is not intended or designed to protect hospitals from competition. In *Provena Health v. Illinois Health Facilities Planning Board,* 382 Ill.App.3d 34 (1st Dist. 2008), Provena argued that the Planning Board's award of a CON to Sherman Hospital to build a new facility in Elgin would cause Provena to lose $8 million annually. The Appellate Court explained: ***"It is not the Board's responsibility to protect market share of individual providers…. The Board stated on the record that it considered whether the financial impact on Provena would affect the public's access to health care, cost of health care, visibility of services, and avoidance of unnecessary duplicative services. It was not required to consider the effect on Provena's market share or profitability."***

- According to IDPH's description of the program, "CON is designed to restrain rising health care costs by preventing unnecessary construction or modification of health care facilities. The Act promotes the development of a comprehensive health care delivery system that assures the availability of quality facilities, related services, and equipment to the public, while simultaneously addressing the issues of community need, accessibility, and financing." http://www.idph.state.il.us/about/conprocess.htm

Hospitals are already "doing their part" -- both individually and collectively -- to help take care of the poor and uninsured ...

- The approximately 100 hospitals (half the hospitals in the state) required to file annual community benefit reports with the state provided overall community benefits of $4.3 billion in 2007 - ***a nearly 20 percent increase from 2005!***

- Looking at the much narrower category of charity care alone, these same hospitals have increased the level of charity care that they provide by ***more than 50 percent from 2005 to 2007***, to a total of $383 million in 2007.

- Since 2004, Illinois hospitals have been responsible for adding ***$1.7 billion*** in additional federal Medicaid funding to benefit hospitals throughout the state, including safety net hospitals, through the Hospital Assessment Program. In addition, the Hospital Assessment Program has brought the state more than ***$1 billion*** in additional funds for other Medicaid health care providers, including long term care care and developmental disability services all over the state.

CON Task Force Should Focus on Planning Reform, Not Charity Care

- The Task Force on Health Planning Reform is charged with making recommendations on reforming and streamlining the health planning process in

Illinois and should focus on that critical need. Public Act 95-5 specifically directs the Task Force to recommend ways to "expedite project approval" and to make the planning process "as efficient as possible."

- Injecting a new issue that is both unrelated to the health planning process and extremely complex – charity care and health care financing – is unnecessary, counterproductive, and contrary to the Task Force's charge under PA 95-5. In fact, the State's Adequate Health Care Task Force studied the health financing system and options for covering the uninsured for months and made detailed and specific recommendations to the General Assembly in 2007 – but those recommendations have not been enacted. The CON Task Force should stick to its primary purpose – health planning reform.

- The Illinois Health Facilities Planning Act has never been viewed and should not be viewed now as creating a process for redistributing funds among hospitals.

- It is vital that the state have a sound health planning process and that the Health Facilities Planning Board and its staff are charged with the appropriate mission.

The Planning Board Should Focus On Its Current Mission – Health Planning

- As shown by the examples below, the Planning Board has struggled in recent years to simply fulfill its current mission. It needs to master health planning rather than attempting to fix the incredibly complex problems posed by the uninsured and a dysfunctional health financing system.

- The Illinois Health Facilities Planning Act required the Department to update the IHFPB's rules by the end of December, 2004. The *first* rules revision finally took effect on September 1, 2006. While some improvements were made, the new procedural rules made the process more bureaucratic, not less, and there were unintended consequences due to their complexity.

- Significant changes to the Board's need criteria were published in the Illinois Register on February 8, 2008. Hospitals have identified serious flaws in the proposed rules. In some cases existing requirements are merely rearranged rather than actually being updated. They are also more cumbersome than necessary. Yet, staff has yet to respond to public comment. These rules need further public comment before the 2nd Notice comment period to avoid publishing an onerous set of requirements simply to complete the task.

- Rules regarding permits for freestanding emergency centers were finally published in mid-July – about a year after the authorizing legislation. Because of this delay, hospitals only have until June 30, 2009 to obtain a CON permit, to complete any necessary construction and to obtain a license from IDPH.

- The Board's financial review criteria have yet to be revised, and as a result of changes to the Procedural Rules in 2006, many facilities are being required to go through the full CON process for a change of ownership rather than being eligible

for a Certificate of Exemption, a more expedited process. The financial criteria do not adequately consider the differing financial structures of the regulated providers.

- In cases where rules were revised, often the relationship between various parts of the rules were not adequately recognized. For example, we have a new bed inventory with new bed need data. However, because the occupancy targets were not updated, the bed need may not reflect needs in the community.

- Finally, aside from the rules and the review of projects, systems need to be developed to use technology more effectively. For example, there should be an electronic application, as was recently implemented in Michigan.

- These examples demonstrate that the Planning Board and staff have a long list of significant projects relating to their core mission – health planning. The Task Force should not consider adding significant additional responsibilities regarding issues outside the domain of health planning.

Let Recent New Laws Work to Help the Uninsured

- The hospital community has worked with the General Assembly and the Attorney General's Office on several major pieces of landmark legislation that are making real contributions to the issue of charity care and helping the uninsured:
  --The Community Benefits Act (2003)
  --The Fair Patient Billing Act (2006)
  --The Hospital Uninsured Patient Discount Act (2008)

- These laws deserve the opportunity to work and policymakers deserve time to evaluate their impact before considering new legislation.

Imposing a Charity Care Mandate Is Complex and Will Distract From Health Planning

- CON stands for Certificate of *NEED*. The relevant inquiry is whether a community *NEEDS* the service or facility that an applicant wishes to provide. Additional, unrelated considerations – such as the amount of charity care provided by an applicant – should not taint that analysis.

- The health planning process will unfairly penalize a community that needs a hospital or other health care service if some arbitrary standard of charity care is imposed – by making such needed and meritorious health facility projects financially unviable.

- If a hospital wants to expand its emergency department, the decision on whether to approve the project should be based on whether the community needs the additional emergency services, and should not be derailed by an unrelated issue, such as charity care. If that hospital is required to give away millions of dollars

for some other unrelated purpose in order to gain CON approval, that project may no longer be feasible and a legitimate need of the community may go unmet.

- The current CON costs of expanding health care services to serve clear community needs are already significant. Adding an unpredictable and substantial charity care cost to the process may halt expansion and impede access to health care – to the detriment of the people who would have benefited from the expanded services.

- Developing a charity care mandate demands answers to several difficult questions:
    - How much is the charity care obligation? Is it different for different types of providers – hospitals, nursing homes, ASTCs, ESRDs? Is it different for rural or critical access hospitals?
    - Does the shortfall from Medicaid or Medicare count toward the obligation? Do any other community benefits, e.g., education and research count? For investor owned providers, are their tax payments considered?
    - If a pool of funds is created, how is it allocated among "safety net providers"? Who decides who is a "safety net provider"? Will the CON Board make these decisions? If so, based on what criteria?
    - Should suburban or downstate hospitals be required to transfer funds from their communities to subsidize Chicago hospitals?
    - Will donor hospitals find ways to satisfy their charity obligations locally, rather than paying into a state pool?

Addressing the Needs of Safety Net Hospitals

- The real causes of the financial challenges faced by safety net hospitals are the growing numbers of uninsured and poor patients they serve and the grossly inadequate levels of reimbursement by Medicaid and Medicare.

- Expecting and requiring hospitals, who are not responsible for the inadequacies of our state and nation's health care financing system, to try and make up for those inadequacies is both unworkable and unfair.

- Solutions to the problems of the poor and uninsured should be a shared responsibility, with all the key stakeholders, including government, insurance companies, employers, and others working together to develop broad-based approaches to funding and providing care for the medically underserved.

The Task Force Should Focus on Health Planning Reforms

The State Task Force's first and only order of business should be to address problems with current CON procedures as identified in PA 95-5. Infusing the complex and divisive issue of charity care will unquestionably complicate the Task Force's work and may well doom its efforts to recommend meaningful and necessary reforms. Solutions to the

problems that plague the CON program will entail dedicated resources and focused attention:

- Streamline the transactions subject to review and the review criteria
- Simplify the decision-making and administrative processes
- Improve the predictability and accountability of the process
- Reconfigure the size and composition of the Health Facilities Planning Board
- Provide a full complement of both qualified staff and Board members
- Address previous legislative directives and schedules that have not been met for rule revisions, updating of standards, and bed need methodology.

To address the concerns related to safety net services, the Task Force should also consider the use of safety net impact statements in the CON process. Current CON procedures allow for consideration of the potential impact of an applicant's service or facility on safety net services. These procedures may be enhanced by soliciting on the application form whether the applicant has conducted a community needs assessment or filed IRS form 990 Schedule H or otherwise demonstrated community benefits. An alternative approach is to allow project applicants and those members of the public who choose to submit comments to determine the format for their safety net impact statements, which would be submitted via existing application processes and mechanisms to submit public comment. The Planning Board rules should describe how staff is to use the information.

Finally, the Illinois Hospital Association is anxious to collaborate with state policy makers to reform cumbersome CON processes and also to engage in serious and constructive dialogue toward developing broad-based approaches to funding and providing care for the medically underserved.