STATE OF ILLINOIS

HEALTH FACILITIES PLANNING BOARD

REPORT FOR FISCAL YEARS 1999 & 2000

HEALTH FACILITIES PLANNING BOARD

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HEALTH FACILITIES PLANNING ACT

Background

Enacted in 1974, the Health Facilities Planning Act (the Act) created the certificate of need (CON) program. The Act's purpose is to restrain health care costs by preventing unnecessary construction or modification of health care facilities and to promote 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 community needs, accessibility, and financing.

The Act established the Health Facilities Planning Board (State Board) which is responsible for issuing permits for construction or modification projects proposed by or on behalf of health care facilities. The State Board is a 15-member commission appointed by the Governor with Senate confirmation. Eight members are consumer representatives. Seven are provider members: two representing hospitals, and one each representing nursing, physicians, commercial health insurance, ambulatory surgery, and long-term care. The Secretary of the Illinois Department of Human Services and the Directors of the Illinois Departments of Public Aid and Public Health serve as ex-officio members. The issuance of a permit requires eight affirmative votes. The Illinois Department of Public Health's Division of Facilities Development provides staff support for the State Board.

Coverage

Facilities subject to the Act include licensed and state-operated: hospitals; long-term care facilities; ambulatory surgery centers; and alternative health care models. Although not subject to licensure, dialysis centers are also included in the program. Facilities operated by the federal government are exempt. Transactions which require State Board review are listed in Chart One.

PROGRAM ACTIONS

CON Applications

During fiscal year 1999 (FY99), 134 applications were reviewed with proposed capital expenditures totaling $677 million. The State Board approved 115 applications with $630 million in capital costs. In fiscal year 2000 (FY00), the State Board reviewed 130 applications with capital expenditures totaling $853 million, approving 111 applications with $754 million in capital costs. As Chart Two shows, between FY92 and FY00 there were 1,318 applications with $7.9 billion in costs; 1,109 applications with $6.8 billion in costs were approved. Chart Three provides information on projects approved for fiscal years 1999 and 2000.

CHART 1
Transactions Reviewed by the State Board

Changing the scope or functional operation of a facility.

Establishing or discontinuing a healthcare facility.

Establishing or discontinuing a service: Acute Mental Illness, Burn Treatment, Cardiac Catheterization, High Linear Energy Transfer, Intraoperative Magnetic Resonance Imaging, Intensive Care, Kidney and Selected Organ Transplantation, Medical-Surgical/Pediatric, Neonatal Intensive Care, Obstetrics, Open Heart Surgery, Physical Rehabilitation, Positron Emission Tomographic Scanning, Renal Dialysis, Long-Term Care, and Therapeutic Radiology.

Establishing a model under the Alternative Health Care Delivery Act: Children's Respite Care Center, Community-Based Residential Rehabilitation Center, Post-surgical Recovery Care Center, and Subacute Care Hospital.

Exemptions for: acquisition of major medical equipment, addition of dialysis stations to an existing facility, change of ownership of a health care facility, combined facility licensure, temporary use of beds for demonstration programs, discontinuation of a health care facility (under certain circumstances), and equipment to be acquired by or on behalf of a health care facility.

Expenditures in excess of the established minimums (currently $6,000,000 for capital expenditures and major medical equipment; $2,709,883 for health and fitness centers).

Substantially increasing the bed capacity of a facility by more than 10 beds or 10% of a facility's total bed count, whichever is less regardless of cost over a two-year period.

CHART 2
State Board Actions on Permit Applications

Fiscal Year	Applications Reviewed	Applications Approved	Amount Reviewed	Amount Approved	Amount Not Approved	Percent Not Approved
1992	145	128	$ 653,649,049	$ 516,922,942	$ 136,726,107	21%
1993	195	176	685,127,377	638,015,714	47,111,663	7%
1994	164	133	1,384,949,276	1,219,297,173	165,652,103	12%
1995	190	155	1,600,581,731	1,310,675,525	289,906,206	18%
1996	110	74	593,283,137	524,803,694	68,479,443	12%
1997	103	88	482,889,041	425,306,004	57,583,037	12%
1998	147	129	1,022,832,533	757,911,815	264,920,718	26%
1999	134	115	677,286,058	629,939,357	47,346,701	7%
2000	130	111	852,594,564	753,723,361	98,871,203	12%
TOTALS	**1,318**	**1,109**	**$ 7,953,192,766**	**$ 6,776,595,585**	**$ 1,176,597,181**	**15%**

CHART 3
Projects Approved - Fiscal Years 1999 & 2000

Project	FY99	Amount	FY00	Amount	Total Projects	Total Amount
Ambulatory Surgery Centers	3	$ 12,893,511	7	$ 24,107,611	10	$37,001,122
Dialysis Centers	31	33,334,942	19	29,550,182	50	62,885,124
Hospitals	66	511,641,788	64	604,482,961	130	1,116,124,749
Intermediate Care Facilities *	3	0	1	0	4	0
MRI	0	0	7	16,032,857	7	16,032,857
Nursing Care Facilities	7	32,710,629	7	58,687,473	14	91,398,102
Post-Surgical Recovery Care Ctr	1	14,500	1	1,187,971	2	1,202,471
Shelter Care Facilities	4	39,343,987	5	19,674,306	9	59,018,293
TOTAL	**115**	**$ 629,939,357**	**111**	**753,723,361**	**226**	**$ 1,383,662,718**

* These projects were for discontinuation and had no costs.

Exemptions

The State Board exempts from permit the following transactions: acquisition of major medical equipment (if the equipment will not be owned by or located in a health care facility and will not be used to provide service to inpatients of a health care facility), change of ownership of a health care facility (provided no change in scope, beds, or services occurs), discontinuation of a health care facility (resulting from voluntary surrender of a suspended license or revocation or denial of a license renewal), combining two or more existing health care facilities into one license (under certain conditions); temporary use of beds for purposes other than the categories of service specified; the addition of dialysis stations to existing facilities in planning areas where the State Board's inventory identifies a need for additional stations; and, projects or transactions (i.e., corporate restructuring) that the State Board determines do not warrant review. Chart Four displays the exemptions reviewed by the State Board, while Chart Five shows change of ownership activity.

CHART 4
Exemptions Approved - Fiscal Years 1999 and 2000

Type	FY99	Acquisition Price *	FY00	Acquisition Price *	Total	Total Acquisition Price
Addition of Dialysis Stations **	0	0	1	$36,000	1	$36,000
Change of Ownership	78	$ 1,160,272,348	83	$ 1,124,300,786	161	$ 2,284,573,134
Combined Facility Licensure **	0	0	0	0	0	0
Discontinuation of a Facility **	0	0	0	0	0	0
Major Medical Equipment *	1	1,647,468	5	17,411,687	6	19,059,155
Equipment Acquired by a Facility **	0	0	0	0	0	0
Temporary Use of Beds **	0	0	0	0	0	0
TOTALS	**79**	**$ 1,161,919,816**	**89**	**$ 1,141,748,473**	**168**	**$ 2,303,668,289**

* Includes fair market value of leasing a facility or equipment.
** Exemption implemented on April 7, 2000.

CHART 5
Changes of Ownership Exemptions Approved by the State Board

Fiscal Year	Hospitals	Long-Term Care Facilities	Surgery Centers	Dialysis Facilities	TOTAL
1995	10	61	1	23	95
1996	13	63	9	4	89
1997	13	92	3	23	131
1998	15	78	9	20	122
1999	14	39	9	16	78
2000	1	76	4	2	83
TOTALS	**66**	**409**	**35**	**88**	**598**

Compliance and Monitoring

The State Board monitors permits to ensure projects are developed within approved scope and costs. These post-permit activities include reviewing: obligations, progress reports, extensions, renewals, alterations, and final cost reports. Failure to comply with post-permit requirements may result in the issuance of sanctions against a permit holder, as mandated in the Act. Compliance issues include: not obtaining permits or exemptions, incurring cost overruns, obligating a project without authorization, altering a project without approval, and completing a project without a valid permit (Chart Six). In addition, declaratory rulings are issued by the State Board on the applicability of the Act and the rules of the State Board.

CHART 6
Post-Permit Reviews and Compliance Activities - FY 94 - 98

Fiscal Year	Authorization To Obligate	Obligations	Cost Reports	Progress Reports	Obligation Extension	Permit Renewal	Permit Alteration	Declaratory Rulings	Compliance Reports	Total
94	115	156	163	475	10	25	17	10	29	1,000
95	80	92	163	426	6	20	17	2	17	823
96	81	95	148	393	10	20	16	12	32	807
97	77	54	95	253	3	12	28	0	9	531
98	55	56	93	253	1	21	19	2	18	518
99	85	67	50	202	6	18	25	4	9	466
00	87	101	101	151	0	24	18	13	4	499
TOTALS	**580**	**621**	**813**	**2,153**	**36**	**140**	**140**	**43**	**118**	**4,644**

OTHER ACTIVITIES

Legislation

In FY99, there were two legislative initiatives concerning co-operative agreements - Senate Bill 646 and House Bill 733. The legislation proposed to allow agreements between health care providers for development of services and provided an exemption from anti-trust laws if certain conditions were met. Senate Bill 646 did not pass the Illinois General Assembly. House Bill 733 passed but was vetoed.

During FY99, there was additional legislation proposed which affected the program, including:

Senate Bill 807 and House Bill 1793 both proposed repeal of the Planning Act. Neither bill passed the Illinois General Assembly.

House Bill 317 (P.A. 91-0065) - amended the Alternative Health Care Delivery Act to create the Community-Based Residential Rehabilitation Center Alternative Health Care Delivery Model. This model is used for clients who suffered severe brain trauma and require an extended stay in a rehabilitation center, but who no longer need acute care. The model gives clients the chance to recover in a facility with a homelike atmosphere while simultaneously learning independent living skills. During the fall of 1999, the State Board amended its administrative rules and established need and review criteria for this model. In July 2000, the State Board issued a CON to establish this model.

During FY00, Public Act 91-0782 was enacted and became effective June 9, 2000. This legislation significantly amended the Planning Act, including:

Increased the capital expenditure and major medical equipment thresholds from $2.7 million and $1.3 million respectively to $6,000,000;

Established an expenditure threshold for health and fitness centers ($2,709,883);

Established a definition of "non-clinical service area" which includes parking ramps, computer systems, dining areas, educational areas, etc. These transactions are no longer subject to review by the State Board;

Requires the Illinois Auditor General to conduct an audit of the State Board. The purpose of this audit is to determine the overall effectiveness of the CON program and to offer recommendations on enhancing its performance and operations; and,

Repeals the Planning Act on June 30, 2003.

Study on Consolidation and Conversion

During the 1998 legislative session, the Illinois House of Representatives passed House Resolution 555 requesting the State Board to analyze the forces for consolidation among health care facilities; the conditions likely to result from consolidation; the effect on access, quality and cost; and, the impact on contributions of an eleemosynary nature. The State Board released a report regarding these issues in May 1999. The study concluded that:

> Market forces indicate healthcare systems will continue to develop and expand and have a significant impact on the delivery of health services in Illinois.
>
> The extent to which Illinois becomes a state served by a few large healthcare systems is yet to be determined, as is the question as to whether independent and small healthcare facilities can survive in today's highly competitive health care market; and,
>
> Conversion of nonprofit facilities and the transfer of their charitable assets remain an important public policy matter that warrants further consideration.

Litigation

To keep members of the Illinois General Assembly informed of the efforts of Illinois' CON program, the State Board began submitting quarterly reports on litigation activity. The first report was prepared in July 1999. The most recent report (September 2000) indicates that since July 1992, 57 cases were filed against the State Board. Of these cases, virtually every judicial decision has affirmed the State Board's action to grant or deny a permit.

Rule Changes

During FY99 and FY00, the State Board modified various administrative rules which govern the program, including:

> Modified the requirements for an exemption for a change of ownership of a healthcare facility by including a revised definition of "control of a healthcare facility." Essentially, when the control of a healthcare facility's physical plant and related assets changes or when the governing control of a healthcare facility changes, this constitutes a change of ownership and, thus an exemption is needed from the State Board.
>
> Revised the definition of "Substantially Changes the Scope or Changes the Functional Operation of the Facility" by stating that a CON is required to add surgical capacity off the licensed premises of a healthcare facility.

Changed the need formula for dialysis service, which increased the number of stations available statewide.

Repealed the review of the Lithotripsy, Magnetic Resonance Imaging and Substance Abuse/Addiction Treatment services.

Established the review of the Intraoperative Magnetic Resonance Imaging service.

PROGRAM EFFECTIVENESS

While it is difficult to evaluate the effectiveness of the CON program, it is clear the program has a positive sentinel effect -- its very existence discourages many imprudent projects. In addition, the need assessments made by the State Board are helpful to the health care industry and consumers in identifying areas of need and channeling resources into these areas, as well as avoiding unnecessary capital investment in areas with identified excess capacity. When these facets are considered in the aggregate, many benefits can be derived. These include:

The State Board has disallowed nearly $1.2 billion in proposed capital expenditures since FY92. These savings have a tangible impact on the health care consumer and upon government and private reimbursement programs. Not only are construction costs saved, but additional expenditures that would be incurred to retire any borrowing to fund such projects are saved as well as operating costs that are not incurred. When taking these additional costs into consideration, the savings to the health care system exceeds several billion dollars.

CON aids facilities to control costs by effective planning. Facilities are required to develop plans for future operations within the overall framework of the program. This helps ensure new services and facilities are developed as needed, based on the publicly-developed measures of cost effectiveness, quality, and geographic and financial access to care.

CON controls growth in excess capacity of the health care system. One aspect is that the proliferation of services and resources within the health care system are curtailed. Many states that abolished CON programs experienced substantial development or expansion of facilities and services with no assurance or evidence that cost containment, quality of care, and access to services was maintained. It should also be noted that CON is the State's only vehicle specifically aimed at containing health care costs by reviewing capital expenditures made by health care facilities. Capital expenditures represent a substantial part of health care costs which are passed on to consumers.

Finally, CON fosters community participation and public involvement in the health planning process. One of the core aspects of CON is to allow the public a voice in the development of health care facilities, services and programs. This participation ensures the public is aware of proposed transactions that could affect their access to health care.

While the possibility of repeal looms, the State Board is committed to improving the CON process. The State Board is dedicated to finding more and better ways to streamline our process, incorporate the health care industry's shift from facility-based to service-based delivery systems, and become more proactive through effective health planning. The State Board believes government plays an important role in today's health care environment. Not only should government monitor and manage health resources in a practical framework, it also needs to encourage innovative approaches to improve access, contain costs, and increase quality for all citizens.

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