December 5, 2008

To: Senator Susan Garrett, Co-Chair
Representative Lisa Dugan, Co-Chair
Health Facilities Planning Board Task Force

From: Pat Comstock, Director

RE: Work of the Task Force on Health Planning Reform

We are in receipt of a copy of your "Proposed Blueprint" for moving forward dated October 23, 2008. We applaud the Task Force for the work that has been accomplished and again pledge our assistance in completing your report and drafting legislation as it relates to care services in Illinois. After review of the "Blueprint" we have several comments for your consideration.

First, we very much appreciate the recognition that a separate set of rules and guidelines need to be developed for long term care. The recognition that we are a separate business line with our own set of financial and practical consideration is greatly appreciated. We again pledge our assistance to the Task Force in creating these separate guidelines and regulations.

The following are our specific reactions to the "Blueprint".

First Change Requested:

58) Require the Comprehensive Health Planning Agency to conduct a special analysis regarding the availability of long term care resources throughout the state, taking into consideration data and plans developed under the Older Adult Services Act, to adjust existing bed-need criteria and standards for changes in utilization of both institutional and non-institutional care, with special consideration of the availability of least-restrictive care options, when appropriate and in accordance with the needs and preferences of the persons requiring long term care.

Recommendation 58 recognizes that the current bed need formula for long term care based solely on demographics and licensed nursing home beds is outdated and not reflective of the rapidly

changing and innovative variety of senior services that did not exist thirty years ago. However the current recommendation 58 calls for a complex “special analysis” of all “long term care resources throughout the state,” including home and community based services, and other senior residential alternatives such as Assisted Living, Supportive Living and Continuing Care Retirement Communities **that are not under the purview of the Planning Board.**

Rather than develop an impossibly complicated and ever changing bed need formula for long term care based on this complex “special analysis” that no other state remotely approaches, Recommendation 58 should recommend a simpler bed need formula from other states based on current nursing home bed occupancy levels. Additional beds in an area could only be built if the average occupancy in an area is 90% (no area in the state would currently qualify – the average occupancy in Illinois is 81%). This approach would recognize the current over-bedded situation in the state, but allow for expansion if and when consumer demand for long term care services increases in the future.

However, Illinois should also not be trapped with an increasingly aging infrastructure. Our nursing homes need to downsize and create more private rooms to reflect consumer expectations, to develop alternative community services, to modernize, and to allow for the constructive of some of the innovations in senior living architectural that have appeared in the past decade. Rather than just construct new buildings in a vacuum, Illinois, as in five other states, should allow existing facilities to sell some of their excess CON and license beds to another provider in that planning area. This would allow existing facilities to obtain capital they would not normally get to be able to modernize and create more private rooms, while at the same time allow newer innovative construction to be built, without expanding the overall existing pool of beds in an area.

Both suggestions would more simply address that rapidly changing and very fluid senior services marketplace without creating an overly convoluted formula that would likely be obsolete by the time it is published.

We recommendation that item number 58 of the Task Force Report be amended to read:

58) Change the existing bed-need formula for long term care to reflect consumer choice and need – that additional beds in a planning area would be needed once the occupancy levels in long term care facilities in a planning area reach 90%. To encourage modernization and downsizing of existing facilities, the planning act for long term care should allow existing facilities to sell excess CON and licensed capacity to another provider in that planning area. This market driven alternative would allow for more private rooms in existing facilities, modernization, development of alternative services, and newer facilities that address consumer needs and trends in senior living services without any expansion or increase in the overall existing pool of beds in an area.

Second Change Requested:

(New) Recommendation 60 – Square footage maximums and cost per square foot caps.

The current square footage maximums for long term care were mandated more than thirty years ago at a time when the institutional model was encouraged. Multiple occupancy rooms were the standard. In recent years, we have seen the benefits of single beds rooms in reducing infection rates, improving recovery times and increasing physical and emotional well-being. The average assisted living apartment already exceeds the maximum allowable space for nursing home rooms, allowing little opportunity to satisfy consumer preference for larger and more private living space.

The current planning board recognizes how these standards are outdated and is currently in the process of "updating" these figures based on projects approved in the past five years. But these new figures are historical and not reflective of what is already happening architecturally in the senior living marketplace. Even with updating of new criteria for square footage, the new criteria are already irrelevant to the future.

If the concern is cost containment, the construction and cost of long term care facilities are already circumscribed and controlled by requirements for construction by the federal government's adoption of the 2000 Edition of NFPA 101 (Life Safety Code), the Illinois Department of Public Health standards for new construction, and by Mediciad reimbursement capitation for capital construction by the Illinois Department of Healthcare and Family Services.

The concept of maximum square footage and maximum cost per square foot applies more to hospital cost-containment and is an outdated concept for long term care. The caps should not be updated; the concept, as it applies to long term care, should be eliminated. Let the sophisticated healthcare consumer in the marketplace dictate the size of their living space.

We suggest new item number 60 in the "Blueprint" read:

60) Long Term Care Facility construction, both size and cost, is driven by federal government's adoption of the 2000 Edition of NFPA 101 (Life Safety Code), monitored and reviewed by Illinois Department of Public Health licensure standards for construction and constrained by Illinois Department of Healthcare and Family Services Mediciad reimbursement caps for capital costs. An additional review by the Health Planning Agency is duplicative of already existing standards, not reflective of changing consumer expectations, and irrelevant for evaluating long term care projects.

Closing Comments:

We very much appreciate the consideration of the Task Force regarding our recommendations. Please let us know what assistance we can provide in offering our comments and suggestions and you continue your work. We would welcome the opportunity to meet with you at any time to discuss these and other long term care specific issues.