**Section 1110.250 Subacute Care Hospital Model**

a) Introduction

1) This Section contains review criteria that pertain to the subacute care hospital model category of service. Definitions pertaining to this Subpart are contained in the Act, in 77 Ill. Adm. Code 1100 and 1130, and in the Alternative Health Care Delivery Act. The subacute care hospital model category of service is a demonstration program that is authorized by the Alternative Health Care Delivery Act. These subacute care hospital model review criteria are utilized in addition to the applicable review criteria of this Subpart C and 77 Ill. Adm. Code 1120. This Subpart also contains the methodology the State Board will utilize in evaluating competing applications, if any, for the establishment of any subacute care hospital models.

2) A facility at any time may be caring for subacute patients. A permit must be obtained to establish a subacute care hospital model. Existing hospitals and long term care facilities providing subacute care are not required to obtain a permit, *provided, however, that the facilities shall not hold themselves out to the public as subacute care hospitals* (Section 15 of the Alternative Health Care Delivery Act). Establishment of a subacute care hospital model category of service occurs when a facility holds itself out to the general public as a subacute care hospital. In these instances, failure to obtain a permit will result in the application of sanctions as provided for in the Illinois Health Facilities Planning Act.

3) As the purpose of the demonstration project is to evaluate the subacute care hospital model for quality factors, access and the impact on health care costs, each applicant approved for the category of service will be required to periodically submit data necessary for evaluating the model's effectiveness.

4) Applications received for the subacute care hospital model shall be deemed complete upon receipt by HFSRB. Due to the comparative nature of the subacute care hospital model review, applicants will not be allowed to amend the application or provide additional supporting documentation during the review process. The application as submitted to HFSRB shall serve as the basis for all standard and prioritization evaluation.

b) Review Criteria

1) Distinct Unit

The applicant must document that the proposed unit or health care facility will be primarily self-contained and physically distinct and will have nursing staff dedicated to service within only that unit. Auxiliary personnel and contracted professional personnel must be available for care of unit patients but need not be dedicated to providing service to only the subacute care hospital model. Documentation shall include a physical layout of the unit detailing travel patterns to ancillary and support services and to patient and visitor access and a detailed summary of all shared services and how costs for those services will be allocated between the model and the hospital or long term care facility. Also, the applicant must provide a detailed staffing plan that includes staff qualifications, staffing patterns for the proposed subacute care hospital and the manner in which non-dedicated staff services will be provided.

2) Contractual Relationship

The applicant must document the capability to handle cases of complications, emergencies or exigent circumstances.

A) An applicant must document, for a model to be located in a currently licensed long term care facility, the capability through the existence of a contractual relationship (which includes a transfer agreement) with a general acute care hospital.

B) An applicant must document, for a model to be located on a designated site previously licensed as a hospital (see 77 Ill. Adm. Code 740(c)), capability through the existence of a contractual arrangement (transfer agreement) with a general acute care hospital.

C) An applicant must document, for a model to be located in a licensed hospital, that the emergency capability continues to exist in accordance with the requirements of hospital licensure.

3) Unit Size

The applicant must document that the number of subacute care beds proposed will equal or exceed the minimum number established for the planning area. The minimum subacute care hospital unit size is 10 beds in rural planning areas (as defined in 77 Ill. Adm. Code 1100.720(a)) and 30 beds in all other planning areas.

c) HFSRB Evaluation. HFSRB shall evaluate each application for the subacute care hospital model category of service based upon compliance with the conditions set forth in subsections (c)(1), (2) and (3).

1) HFSRB Prioritization of Hospital Applications

A) All hospital applications for each planning area shall be rank ordered based on points awarded as follows:

i) Compliance with all applicable review criteria of Subpart B – 10 Points.

ii) Compliance with all review criteria of subsection (b) – 10 Points.

iii) Compliance with all applicable review criteria of 77 Ill. Adm. Code 1120 – 10 Points.

iv) In rural areas an applicant shall be awarded 25 Points if documentation is provided that the subacute care hospital model will provide the necessary financial support for the facility to provide continued acute care services. The documentation shall consist of:

• Factors within the facility or area that will prevent the facility from complying with the minimum financial ratios established in 77 Ill. Adm. Code 1120 within the next 2 years;

• Historical documentation that the facility has failed to comply with the minimum financial ratios in each of the last 3 calendar years; and

• Projected revenue from the subacute hospital care model and the positive impact of that revenue on the financial position of the applicant facility. The applicant must explain how the revenue will impact the facility's financial position, causing the facility to comply with the financial viability ratios of 77 Ill. Adm. Code 1120. Alternatively, documentation can be provided showing that projected revenue from the subacute hospital model will be sufficient to operate the subacute care hospital care model in compliance with the financial viability ratios of 77 Ill. Adm. Code 1120, or that the applicant facility has entered into a binding agreement with another institution that guarantees the financial viability of the subacute hospital care model in accordance with the ratios established in 77 Ill. Adm. Code 1120 for a period of at least 5 years, regardless of the financial ratios of the applicant facility.

v) Location in a medically underserved area (as defined by the Department of Health and Human Services (section 332 of the Public Health Service Act (42 USC 254E)) as a health professional shortage area) – 3 Points.

vi) A multi-institutional system arrangement exists for the referral of subacute patients under which the applicant facility serves as the receiving facility for the system. A multi-institutional system consists of a network of licensed hospitals and long term care facilities located within the planning area and within 60 minutes travel time of the applicant that are interrelated by contractual agreement that provides for an exclusive best effort arrangement concerning the transfer of patients between facilities. Best effort arrangement means that the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will be transferred only to the applicant facility – 1 Point per each additional facility in the multi-institutional system, to a maximum of 10 Points.

vii) The existence of Medicare and Medicaid certification at the applicant facility and historic volume at the applicant facility. The following point allocation will be applied:

• In the last calendar or fiscal year, Medicare/ Medicaid patient days were between 10% and 25% of total facility patient days – 2 Points.

• In the last calendar or fiscal year, Medicare/ Medicaid patient days were between 26% and 50% of total facility patient days – 4 Points.

• In the last calendar or fiscal year, Medicare/ Medicaid patient days exceeded 50% of total facility patient days – 6 Points.

viii) For each of the last 5 calendar years, the applicant facility documents a case mix consisting of ventilator cases, head trauma cases, rehabilitation patients including spinal cord injuries, amputees and patients with orthopaedic problems requiring subacute care, or patients with multiple complex diagnoses that included physiological monitoring on a continual basis, of such magnitude that, if placed in the proposed subacute facility, these patients would have constituted an annual occupancy exceeding 75%. If a multi-institutional system, as defined in subsection (c)(1)(A)(vi), has an exclusive best efforts agreement, then each of the cases listed in this subsection (c)(1)(A)(viii) from such signatory facilities may be counted in computing the 75% annual occupancy threshold – 5 Points.

ix) The applicant institution has documented that, during the last calendar year, at least 25% of all patient days of the applicant facility were reimbursed through contractual relationships with PPOs or HMOs – 3 Points.

x) If the applicant institution, over the last 5 calendar year period, has been issued a notice of revocation of license from IDPH or has been decertified from the federal Title XVIII or XIX programs – Loss of 25 Points.

xi) The applicant institution is accredited by The Joint Commission – 3 Points and 1 additional Point if accreditation is "with commendation".

xii) Staff support for the subacute care hospital model:

• Full time Medical Director exclusively for the model – 1 Point.

• Physical therapist, 2 full-time equivalents (FTEs) or more – 1 Point.

• Occupational therapist, 1 FTE or more – 1 Point.

• Speech therapist, 1 FTE or more – 1 Point.

xiii) In areas where competing applications have been filed, 3 Points will be allocated to the applicant with the lowest positive mean net margin over the last 3 fiscal years. Each applicant must submit copies of the audited financial reports of the applicant facility for the latest 3 fiscal years.

B) Required Point Totals – Hospital Applications

A hospital application for the development of a subacute care hospital model must obtain a minimum of 50 Points for approval. The applicant within the planning area receiving the most points shall be granted the permit for the category of service if the minimum point total has been exceeded. In the case of tie scores, HFSRB shall base its decision on considerations relating to location, scope of service and access.

2) State Board Prioritization – Long Term Care Facilities

A) All long term care applications for each planning area shall be rank ordered based on points awarded as follows:

i) Compliance with all applicable review criteria of Subpart B – 10 Points.

ii) Compliance with all review criteria of subsection (b) – 10 Points.

iii) Compliance with all applicable review criteria of 77 Ill. Adm. Code 1120 – 10 Points.

iv) The applicant has had an Exceptional Care Contract with the Illinois Department of Healthcare and Family Services for at least 2 years in the past 4 years – 3 Points.

v) Location in a medically underserved area (as defined by the federal Department of Health and Human Services (section 332 of the Public Health Service Act (42 USC 254E)) as a health professional shortage area) – 3 Points.

vi) The existence of Medicare and Medicaid certification at the applicant facility and historic volume at the facility. The following point allocation will be applied:

• In the last calendar year or fiscal year, Medicare/ Medicaid patient days were between 10% and 25% of total facility patient days – 3 Points.

• In the last calendar or fiscal year, Medicare/ Medicaid patient days were between 26% and 50% of total facility patient days – 6 Points.

• In the last calendar or fiscal year, Medicare/ Medicaid patient days exceeded 50% of total facility patient days – 9 Points.

vii) For each of the last 2 calendar years, the applicant institution documents a casemix consisting of ventilator cases, head trauma cases, rehabilitation patients including stroke cases, spinal cord injury, amputees and patients with orthopaedic problems requiring subacute care, or patients with multiple complex diagnoses that included physiological monitoring on a continual basis, of such magnitude that, if placed in the proposed subacute facility, these patients would have constituted an annual occupancy exceeding 50%. If a multi-institutional system, as defined in subsection (c)(2)(A)(xiii), has an exclusive best efforts agreement, then each of the cases listed in this subsection (c)(2)(A)(vii) from the signatory facilities may be counted in computing the 50% annual occupancy threshold – 5 Points.

viii) The applicant has documented that, during the last calendar year, at least 20% of all patient days of the applicant facility were reimbursed through contractual relationships with PPOs or HMOs – 3 Points.

ix) If the applicant, over the last 5 year period, has been issued a notice of revocation of license from IDPH or decertified from the federal Title XVIII or XIX programs – Loss of 25 Points.

x) Staff support for the subacute care hospital model:

• Full time Medical Director exclusively for the model – 1 Point.

• Physical therapist, 2 FTEs or more – 1 Point.

• Occupational therapist, 1 FTE or more – 1 Point.

• Speech therapist, 1 FTE or more – 1 Point.

xi) In areas where competing applications have been filed, 3 Points will be allocated to the application with the lowest positive mean net margin over the last 3 fiscal years. Each applicant must submit copies of the audited financial reports of the applicant facility for the latest 3 fiscal years.

xii) The applicant institution is accredited by the Joint Commission – 3 Points and 1 additional Point if accreditation is "with commendation".

xiii) A multi-institutional system arrangement exists for the referral of subacute patients under which the applicant facility serves as the receiving facility for the system. A multi-institutional system consists of a network of licensed hospitals and long term care facilities located within the planning area and within 60 minutes travel time of the applicant that are interrelated by contractual agreement that provides for an exclusive best effort arrangement concerning the transfer of patients between facilities. Best effort arrangement means the referring facility will encourage and recommend to its medical staff that patients requiring subacute care will only be transferred to the applicant facility – 1 Point per each additional facility in the multi-institutional system to a maximum of 10 Points.

B) A long term care facility's application for the development of a subacute care hospital model must obtain a minimum of 50 Points for approval. The applicant within the planning area receiving the most points shall be granted the permit for the category of service if the minimum point total has been exceeded. In the case of tie scores, HFSRB shall base its selection on considerations relating to location, scope of service and access.

3) HFSRB Prioritization of Previously Licensed Hospital Applications in Chicago

A) All applications for sites previously licensed as hospitals in Chicago shall be rank ordered based upon points awarded as follows:

i) Compliance with all applicable review criteria of Subpart C – 10 Points.

ii) Compliance with all review criteria of subsection (b) – 10 Points.

iii) Compliance with all applicable review criteria of 77 Ill. Adm. Code 1120 – 10 Points.

iv) Documentation that the proposed number of beds will be utilized at an occupancy rate of 75% or more within 2 years after permit approval. Documentation shall consist of historical subacute caseload from one or more referral facilities whose subacute caseload, in the future, would be transferred to the subacute model for care, anticipated caseload from physician referrals to the unit, and demographic studies projecting the need for subacute service within the primary market of the proposed subacute hospital care model – 10 Points.

B) Required Point Totals – Previously Licensed Hospitals

The applicant within the planning area receiving the most points shall be granted the permit for the category of service. In the case of tie scores, HFSRB shall base its selection on considerations relating to location, scope of service and access.

d) Project Completion

1) Since the purpose for establishment of this category of service is to evaluate the alternative delivery model for effectiveness, these projects are not complete until the model is evaluated and the decision made to adopt or not adopt the model as an ongoing licensed level of service separate from an alternative delivery model. A discontinuation permit will not be required of a facility holding a subacute care hospital model permit if the facility elects to discontinue the model but retain licensed subacute care beds. The subacute care hospital model project shall be considered complete as of the date IDPH is notified of the discontinuation. If, during the course of the model evaluation period, an approved provider of the subacute hospital care model elects to discontinue the category of service, a replacement provider of the same type may be approved by the State Board. If a need for an additional subacute care hospital model exists, applications shall be approved in accordance with subsection (c). Any alteration to the subacute care hospital model during the life of the permit is subject to State Board review.

2) All assurances and charges for service presented in the application shall be in effect for the life of the permit unless altered with the approval of the State Board.

3) A subacute care hospital model shall have 24 months from the date of permit issuance to become operational. Failure to begin operation in this time period shall result in the permit becoming null and void.