S54803

TASK FORCE ON
HEALTH PLANNING REFORM

REPORT OF PROCEEDINGS had of the above-entitled matter before the Task Force on Health Planning Reform at the Thompson Center, 100 West Randolph, Chicago, Illinois, on the 9th day of June, A.D. 2008, at the hour of 10:07 o'clock a.m.

MEMBERS PRESENT:
SENATOR SUSAN GARRETT, Co-Chair;
REPRESENTATIVE LISA DUGAN, Co-Chair;
SENATOR PAMELA ALTHOFF, Member;
MR. GARY BARNETT, Member;
SENATOR BILL BRADY, Member;
MR. PAUL GAYNOR, Member;
REPRESENTATIVE RENEE KOSEL, Member;
REPRESENTATIVE LOUIS LANG, Member;
MS. CLAUDIA LENNHOFF, Member;
SISTER SHEILA LYNE, Member;
MS. HEATHER O'DONNELL, Member;
MR. KENNETH ROBBINS, Member;
MR. HAL RUDDICK, Member; and
MS. MARGIE SCHAPS, Member.

EX-OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO,

MR. JEFFREY MARK, and

MR. BARRY MARAM.

ALSO PRESENT:

MR. GREG COX,

MS. MELISSA BLACK,

MR. KURT DeWEESE,

MS. THERESA EAGLESON, and

MR. MIKE JONES.

CO-CHAIR DUGAN: We'd like to go ahead and open up the meeting of the task force, so we're going to call it to order.

We'll just have everybody introduce themselves that's here and then in Springfield also, the ones in Springfield.

Can they hear us? Kurt, can you hear us?

MR. DeWEESE: Yes, yes, we can.

CO-CHAIR GARRETT: And then we have people on the phone.

Let's just go around. We'll introduce ourselves, then we'll go to Springfield, and then we'll go to the phone.

Jeff?

MR. MARK: Jeffery Mark, Health Facilities Planning Board.

MEMBER O'DONNELL: Heather O'Donnell, Center for Tax and Budget Accountability.

MEMBER LENNHOFF: Claudia Lennhoff, Champaign County Health Care Consumers.

MEMBER SCHAPS: Margie Schaps, Health and Medicine Policy Research Group.

MEMBER GAYNOR: Paul Gaynor, Illinois

Attorney General's Office.

CO-CHAIR DUGAN: Lisa Dugan.

MEMBER LANG: Representative Lou Lang.

CO-CHAIR GARRETT: State Senator Susan Garrett.

MEMBER RUDDICK: Hal Ruddick, SEIU.

MEMBER ROBBINS: Ken Robbins, Illinois Hospital Association.

MEMBER BARNETT: Gary Barnett, Sara Bush Lincoln Health Center.

CO-CHAIR DUGAN: Springfield, Kurt?

MR. DeWEESE: Kurt DeWeese, Speaker staff.

MR. JONES: I'm sorry. Mike Jones, HFS, we'll be joined by Theresa Eagleson, our Medicaid director after awhile.

MS. BLACK: Melissa Black, Senate staff.

CO-CHAIR DUGAN: Anybody on the phone?

MEMBER KOSEL: Renee Kosel, State Representative.

MEMBER ALTHOFF: Pam Althoff, State Senator, on her way down and on the phone right now.

MS. HACK: Susana Hack representing Barnes Jewish.

CO-CHAIR DUGAN: Okay. Then I guess that's it for now. We'll start with the first action item, the approval of the May 12th minutes of the meeting.

CO-CHAIR GARRETT: Are there any changes or observations?

CO-CHAIR DUGAN: Questions?

CO-CHAIR GARRETT: Is there a motion to approve the minutes?

MEMBER LANG: So moved.

CO-CHAIR GARRETT: Moved by Representive Lang.

Is there a second? Heather, second, approval of the minutes?

MEMBER O'DONNELL: Second.

CO-CHAIR GARRETT: Second. Okay. All in favor say aye.

(The ayes were thereupon heard.)

CO-CHAIR GARRETT: Opposed?

Seeing as there is no opposition, we will approve the minutes for the record.

CO-CHAIR DUGAN: Did somebody on the

phone have a question? Okay.

So I think we'll get started then right away with the testimony from the representatives that we have here today, Ralph Martire from the Center for Tax and Budget Accountability. Do we want to start with Ralph, and then Dave Buysse from the Office of the Attorney General?

So Ralph, do you want to start?

MR. MARTIRE: Yeah, there is a PowerPoint, and I think that they were going to ask you to scatter.

CO-CHAIR DUGAN: Do you want me to move my head?

MR. MARTIRE: Or you could be -- I mean, you would certainly add an interesting graphic. You may be blind by the end of the presentation.

While we're getting that ready, just real quickly, the Center for Tax and Budget Accountability is a bipartisan group that looks at all big, state, local, and national public finance issues, health care financing, tax policy, economic policy, all those things.

What we try to do is take a database

approach to our analysis and suggest ways that would be good public policy no matter if you're sitting on the democratic or republican side of the aisle to finance the essential services government does provide.

What we're going to try to do today is take health care in Illinois and put it in context of our economy because our changing economy is very much impacting what's going on with health care.

So from the get-go, you ought to understand that Illinois is a large and very rich state. We have the fifth biggest economy of any state in the country with almost $600 billion a year. In fact, if we were an independent country, we'd have the 27th biggest economy in the world, a larger economy than Saudi Arabia or Ireland, so a pretty big and rich state.

That said, we are not keeping up our economic competitiveness. In fact, we've lagged behind both the midwest and the nation over the last 20 years in economic growth, and the prime reason for that is losing high-benefit, good-paying manufacturing jobs.

We've lost 26 percent of those jobs just

since 1990. That's more than both the nation and the midwest generally, and what we've replaced these jobs with have been low-wage service sector jobs. So the new jobs coming online can average about 29 percent less than the jobs they're replacing, but they don't just come with lower wages. They also come with fewer benefits.

So today in Illinois, one of the major changes from this transition in the work force is today over 40 percent of the private work force does not have employer-provided health insurance. So wages are going down, and a significant portion, well over 40 percent of the work force, does not have employer-provided health insurance.

So today in a state that is big and rich overall, what you see is 27 percent of our population is either uninsured or on some sort of public coverage like Medicaid. That is a huge percentage. It's over a quarter of our population. We gave you the specific numbers, but the bottom line is the private sector is very much pushing demand to the public sector to cover increasingly health care costs for more and more families, including working families.

Now, the safety net put together to meet this increasing health care cost that's being pushed to the public sector really consists of three primary elements, right.

There is Medicaid and SCHIP-type federal-state partnership programs. Then there is public hospitals and public health care service centers provided around. Then the final aspect of the safety net are nonprofit hospitals, and nonprofit hospitals do play a key role in the safety net. As the data demonstrate, the main role that they play in our safety net is providing charity care, but we have to ensure that that charity care is being provided or the safety net will have gaps.

Now, charity care is defined under Illinois law as pretty much the provision of either free or reduced care to patients who simply can't afford their treatment. That's the essential element of what we expect from nonprofit hospitals for providing them with their very specific tax expenditures through tax breaks.

We are giving them a tax expenditure, and in exchange for expending these dollars, we are

expecting back charity care.

Now, you all know this, but we've just -- because we're a tax policy think tank at times, we like to talk about this somewhat ad nauseam. You know, a tax expenditure is pretty much the same thing as a direct expenditure. So in the direct expenditure process, the General Assembly or whatever the legislative branch is appropriates money to spend on very specific items.

In a tax expenditure, rather than appropriating tax revenue we have raised, what happens is we say you, private company, whatever your commercial concern is, you don't have to pay taxes you otherwise would have to pay, and in exchange we're expecting you to deliver a very specific benefit back.

So, for instance, in the business sector for economic development, we will advantage certain businesses in the same sort of competitive industry over others by giving them a tax break in the expectation that they'll generate, let's say, job growth, et cetera.

In the charity care area, what we expect back is this free and reduced care for a

substantial portion of the tax expenditure that we invest in them.

Now, there are four main tax expenditures provided to nonprofit hospitals: federal income tax exemption, state income tax exemption, local property tax exemption, and local sales tax exemption, state and local sales tax exemption.

There is another benefit, of course. There is a bond financing as a nonprofit that you get. You get the ability to generate donations, but we didn't cover those. We had no way to analyze those. So we took the top four tax expenditures given to finance nonprofit hospitals.

Now, for the income tax side, both the state and federal, the legal standard that hospitals have to satisfy is very easy. It's a community benefit standard. This standard generally has been interpreted as providing any health-related benefit in the community. In fact, the IRS has even issued a ruling saying if a hospital simply provides needed health care services to those who can pay for it, it's fulfilling this role.

So really those tax expenditures that cover sale -- excuse me, income taxes at both the state

and federal level, pretty much hospitals are going to be able to satisfy their burden of providing a community benefit for those very simply, and I don't think there's any question on that.

The property tax exemption in Illinois, though, is very much tied to this charity care standard, this standard of free or reduced cost to low-income patients.

The traditional Supreme Court case test for this, of course, Methodist, and everyone here is probably familiar with that, but the bottom line is, this is the case from which all others have generated that first talked about the free and reduced care, that a nonprofit hospital had to really not place any burdens in the way of an individual that was low income that needed this assistance, that it had to make it generally available, and that it was really all about free and reduced care.

Now, state law doesn't define how much charity care a nonprofit hospital has to provide. That's nowhere defined, nor are things like, for instance, income eligibility limits. So most hospitals determine whether they're going to give

charity care to, let's say, someone at 200 percent of poverty all the way up to 400 percent of poverty, and those are all based on a hospital's internal decision-making process. There's really no state rubric or ruling that covers that.

But we do know that there are a couple of things that probably can be used or counted as community benefits that do not count as charity care. I mean, key among these is debt collection practices, so bad debt. When a hospital actually bills and then engages in collection practices against a low-income patient and then discovers they're low income and unable to pay, that is not a charitable act under Illinois law. There is case law on that that's very clear.

The second community benefit that hospitals do provide, but does not count as charity care, is the Medicaid shortfall, sort of the difference between the actual cost of caring for Medicaid eligible patients and the reimbursement rates paid to nonprofit hospitals. So that shortfall, and it is a shortfall, does not count as charity care. Once again, there is case law directly on point for that.

Recently, there was the Provena Covenant case which created some question on the charity care issue, but interestingly enough, it initially held that the specific nonprofit hospital did not provide adequate amounts of charity care, and it somewhat expanded the definition of who would qualify for charity care.

So they said Provena really didn't just have to look at the income level of the patients coming in, but the overall financial condition. So someone was earning a $100,000 a year, for instance, and they couldn't afford a $75,000 hospital bill.

Well, neither of those were traditionally in the Supreme Court's analysis of what constitutes charity care; and even though the Illinois Department of Revenue upheld this ruling, a circuit court without issuing an opinion just said, No, you know, we disagree. That was the opinion, but it didn't change the standard, and the standard for the property tax exemption is very much still charity care, free or reduced cost of care.

We would assume that that same standard

applies to the exemption from state and local sales taxes as well simply because the statutory language creating that exemption is virtually identical to the language creating the property tax exemption. So there's no reason to assume a different legal standard would apply to the sales tax exemption than does to the property tax exemption.

CTBA, looking at the health care funding crisis that was facing Illinois, decided to analyze whether or not we were getting charity care value back that was equivalent to the value of the property and state and local sales tax exemptions; that is, tax expenditures being provided to nonprofit hospitals.

Now, the first sort of curve ball in making that determination is the assessor doesn't assess the properties of a nonprofit hospital. So we had to pick a methodology for making that assessment, and the methodology we selected was that of Nancy Kane. She's a Harvard University professor, and we selected her methodology for a couple of reasons.

Reason No. 1, it is nationally recognized as

a valid model.

More importantly from our standpoint, Reason No. 2 is that in those instances where Nancy Kane's model has been utilized and where the local assessor does assess nonprofit hospital property, her valuation method came up very close to, if not right on what the local assessor was doing. So it seemed to very much approximate what was happening in the real world.

The final reason is in Cook County when the assessor does look at for-profit hospital property, he uses a combination of the income method, slash, replacement method, and Nancy Kane's is an income method. We couldn't look at the replacement method simply because we don't have the data.

So once again, it fits in with how the assessor does -- in Cook County at least, evaluates for-profit hospitals, it is a nationally accepted method, and it has approximated the values placed on nonprofit hospitals in those jurisdictions where that happens and we've used the Kane model.

Here's really the main finding that we came

up with and why we focused so much of our attention on charity care. If you look at the value of the tax relief provided or the tax expenditures given to nonprofit hospitals in Cook County, what you see is almost two-thirds of the value, over 64 percent is property tax relief. We estimated 209 million for about 21 hospitals.

Now, interestingly enough, the assessor, Assessor Houlihan, recently did an evaluation on nonprofit hospitals in Cook County, and he came up with a slightly bigger number. He came up with about 240 million. So ours was a little conservative, but believe it or not, I tend to be conservative as does can everyone at CTBA. So we wanted to have a projection that we knew would at least be in line.

The second biggest part of the tax expenditure given to nonprofit hospitals is the state and local sales tax exemption clocking in at over a 100 million.

So right there between the property tax exemption and the state and local sales tax exemption, the two tax expenditures directly tied to charity care, you've got 96 percent of the

benefit in tax expenditures given to nonprofit hospitals.

Then we looked at the actual charity care provided, just taking the numbers off of the community benefit reports, and what we found was that $105 million was being provided in charity care or roughly one-third of the total value of the tax expenditures spent on nonprofit hospitals.

We then pulled out the bad debt line, and we found that there was about $181 million in bad debt, and there's a very interesting thing here. In many cases, the individuals who count now as bad debt would have qualified for charity care if so identified when they first came into the process.

Now, there are some problems with that, and some of those problems are people are sometimes reluctant to talk about their income levels When they come into the process, and some procedures in place are difficult to capture that.

But at absolutely no cost to hospitals, what we found that was very compelling was, if 50 percent of the bad debt could have been caught on the front end as charity care, you could cover

almost the full value of the property tax exemption at absolutely no additional cost to hospitals.

We thought that that was compelling, that this could be a win-win for both the hospital provider community and for low-income patients that are trying to access free or reduced care in the hospital system. So we thought that that was an opportunity to design this sort of win-win that CTBA looks for in these complicated financing things.

I've mentioned a lot of these stats. I will say this. We really think it's essential that the charity care portion of the tax expenditure be dollar-for-dollar because of a couple things that are coming down the line.

I mean, No. 1, unless, let's say, a new president comes in and changes some of these rules, under current law, Cook County alone is scheduled to lose about $500 million in federal Medicaid transfers over the next five years. That's going to be a significant cost coming into Cook County, and that's under current changes to federal Medicaid law that are coming into place.

Second, there has been an increase in uninsured and in Medicaid eligible patients in Illinois. The increase in the uninsured since 1987 is 650,000 folks; and then just since the year 2000, we've had another 300,000 folks in Illinois become eligible for Medicaid.

Put that together, that's almost a million individuals that are now eligible -- that are either uninsured or eligible for Medicaid; and as I said before, the private sector is very much pulling away from providing health care benefits with over 40 percent of the work force not getting employer-provided health care benefits, and most of the work force seeing their incomes decline and their wages decline.

I mean, we've gone from having manufacturing being the top employer in our state in 1990, it has now dropped to fourth, and our No. 1 employer is low-wage service at over 30 percent of the work force.

One other thing about challenges to the health care system. In the communities of individuals impacted by the loss of health insurance from their employers, over 57 percent of

Latinos who are employed do not get employer-provided health insurance, so we see a very significant impact there, which brings us back to charity care.

We, as taxpayers, fund charity care to fill gaps in the Medicaid SCHIP public health care system. We pay for it. We pay for it by not collecting this tax revenue that we expect in return a public benefit to be generated on, and it's really essential that we make sure that it provides the role it's supposed to provide.

In your handouts, you'll see a quick summary of the legal standards that apply to the different exemptions delivered and the amount of the tax relief that each of those exemptions delivers.

In going forward for the CON process, it would seem to us that in any certificate of need process, an analysis of charity care to be provided one way or another should be incorporated in the process. Either you say, Look, if you're going to open this new facility, we expect X percent of cost, X percent of revenue, whatever you select as the rational metric to be devoted to charity care, so that we know this community in

this area will have that safety net filled. We think that that's a very rational thing to do and something that could really be an important part of the CON process going forward.

You may also want to look at the past record of providers in charity care, and somehow say, Well, if you get your charity care overall in a complex system up to X or Y, then maybe we can grant the CON, that kind of thing.

So there's a lot you could do in the CON process to ensure charity care plays its vital role in filling the gaps in the health care safety net, but what I'm trying to emphasize from a bipartisan think tank standpoint is, is the public does finance charity care. We do finance it directly through these tax expenditures; and given the changes in our private economy, it's just essential that this role be played and these gaps be filled. Thank you.

CO-CHAIR GARRETT I think we have questions from our committee. Ken.

MEMBER ROBBINS: Let me start, and I barely know where to begin, Ralph.

MR. MARTIRE: Good morning would work.

MEMBER ROBBINS: Good morning.

And I have great respect for the work that you've done, and we have invited you up to talk to our board --

MR. MARTIRE: Oh, I'm sorry. Let me see if I can turn it off. Power off, press again.

MEMBER LANG: That's better. I can't see, but --

MR. MARTIRE: Sorry.

MEMBER ROBBINS: We have invited you to our board to give us an analysis on the state of finances in this state, but I was extremely disappointed in the report that came out in 2006 because I thought it was sloppy work, which I think is not characteristic of what that center normally produces.

I'll just give a few examples. In calculating the -- looking at Cook County hospitals in calculating the value of sales tax exemptions, it applied a 9-percent City of Chicago service tax on all hospitals whether or not they were in Cook County, and a number of them are not, whether or not they were in Chicago, and a number of them, of course, are not in Chicago.

When you talk about the legal standards, yes, charity is part of what the law requires a hospital to provide in order to be tax exempt, but it is not the sum of what the law permits to be counted. For example, there is a phrase that you see in many treatises and court opinions on tax exempt status which talks about relieving the burden of government, and that goes on well beyond just the charity care.

CO-CHAIR GARRETT: Wait, can you explain what that means, Ken?

MEMBER ROBBINS: Yeah.

CO-CHAIR GARRETT: What do you mean relieves the burden of?

MEMBER ROBBINS: This may be an over-simplification.

CO-CHAIR GARRETT: That's okay.

MEMBER ROBBINS: But if you did not have a system of nonprofit tax exempt hospitals in this country, then I guess you would do what other countries do as well. The government would have to own and operate hospitals to provide care to the public.

So part of this charity is sort of a gift to

the community of providing the care that the community needs by some entity other than government. It does require that all who apply for and need charity care need to get it, but it doesn't provide any specific amount, and it does take into account a much broader range of things.

For example, when the Illinois Community Benefit Act was enacted by the legislature several years ago, it talked about the value of charity care, things like language assistance, shortfalls from government-sponsored programs like Medicaid and Medicare, donations in kind or cash made by hospitals, education and research, which if the hospital wasn't there to do it, somebody else would have to step in and do it, most likely the government again, and bad debt.

So all of these things, it seems to me, need to be taken into account when we try to determine whether society is getting the benefit of the bargain.

When you look at the Provena case, which Ralph mentioned, the assessor in that case actually thought that the value of the tax exemption to Provena was somewhere around 1

percent of its revenues, and yet the kind of formulation that Nancy Kane or others would suggest would be two or three times that amount.

So it is definitely not settled in the actual practice of those examples of how we value hospitals, that the numbers that we used in this report are the kinds of numbers that actually are generated in the real world.

For example, Ralph said that in looking at investor-owned hospitals, which are taxed by one method, which is a part of the Nancy Kane model, he tried to draw a correlation here that doesn't exist. She has got two factors in Chicago. They use one factor when it comes to investor-owned hospitals.

So to put all of the nice language up there on the wall, it seems to me, misleads in a number of areas the amount of community benefit that ought to be counted toward the benefit of the bargain and even misleads on how you calculate the actual value of the tax exemptions that hospitals get.

I guess the other thing I would suggest is, we really have two questions here, and we'll get

through it, I'm sure, after Mr. Buysse makes his comments when we get back to the broader question.

I think the questions are: What ought we to expect of hospitals in providing care that meets the benefit of that bargain, and then whether the certificate of need process is the right place to do it. We have to address that second question when we have a broader discussion about the issue of how you take the exempt status of hospitals, what they do to earn it into account in a process that really can't.

MEMBER GAYNOR: Ken, let me ask you a question.

MEMBER ROBBINS: Yeah.

MEMBER GAYNOR: Are you actually contending that under Illinois State law for tax exempt status, that community benefits is a factor under the law? That's a yes or no question, please.

MEMBER ROBBINS: Like most of your questions, there is something in between.

MEMBER GAYNOR: No. Is it part of the six standards under the law?

MEMBER ROBBINS: No, it is not.

MEMBER GAYNOR: Okay. My next question, did anything that Mr. Martire say contradict your point that one of the factors is relieves the burden on government? Did anything he say contradict that point?

MEMBER ROBBINS: By the implication that charity care is the thing that you look at and the most important thing that you look at, yes.

MEMBER GAYNOR: Did he say that?

MEMBER ROBBINS: I think that in the --

MEMBER GAYNOR: Because I didn't hear that.

MEMBER ROBBINS: -- the report that they put out in 2006, and I know this is all based on that report, very specifically that was said.

MEMBER GAYNOR: You also said that you -- you said that his work was sloppy because he calculated the value of sales tax exemptions at 9 percent on all hospitals, even though some of those hospitals at 9 percent is attributable only to Chicago-located hospitals, and there were other hospitals that were included that are outside of

Chicago to get to that number.

Has the IHA recalculated that based upon hospitals that are located outside of the Chicago area, the City of Chicago?

MEMBER ROBBINS: Actually, I think we have, Paul. I don't have that with me. I would be happy to get it for you.

MEMBER GAYNOR: Okay.

MEMBER O'DONNELL: I'd also like to point out that we acknowledge in the study that we used a 9-percent rate, even though some of the hospitals were located outside the city, because to calculate the rate where each hospital was, was virtually impossible. So we've acknowledged some of the problems in our methodology and some of the problems with the data available.

MEMBER ROBBINS: Heather, I appreciate the fact that you made that acknowledgment, but it seems to me that it goes to the issue of how credible the actual report itself is if we can't be accurate, and I don't --

MEMBER O'DONNELL: Well, let me just point out some of your reporting with respect to community benefits, and this is what hospitals in

our study reported as a community benefit.

MEMBER GAYNOR: Even though we've acknowledged the community benefit is not a factor under state law for tax exempt status.

MEMBER O'DONNELL: The hospitals in our study are required by Illinois law to report bad debt at cost. It says that in the statute. It says that in the instructions for the community benefits report.

The hospitals in the study reported a total of bad debt community benefit of 488.8 million; however, this based on cost was $307 million in excess of cost.

MEMBER ROBBINS: Say that again.

MEMBER O'DONNELL: A bad debt -- the hospitals reported, many hospitals reported a bad debt as charges on your community benefits report. This is not what is required under the law.

MEMBER ROBBINS: I agree.

MEMBER O'DONNELL: And the difference between cost and bad debt is not a community benefit.

So they actually reported a community benefit with respect to bad debt of $307 million

over and above what the law requires.

CO-CHAIR GARRETT: Can I just interject?

MEMBER ROBBINS: Would it be your position to say that under Illinois law, charity care is the only consideration?

MEMBER GAYNOR: No, what I'm trying to -- you seem to have made the point that charity care -- that he was overemphasizing it and not -- somehow playing fast and loose with state law.

But now you talk about the state law, and we've established that you were talking about community benefits that have nothing to do with establishing tax exempt status under state law.

CO-CHAIR GARRETT: Can I just interject here?

MEMBER ROBBINS: Sure.

CO-CHAIR GARRETT: I think where we're going is we're debating issues that are all relevant, but we don't have, I think, a clear definition in state law on how charity care -- bad debt applies to getting to where we're trying to go right now. So we don't have a clear definition of how bad debt can apply to charity care.

MEMBER GAYNOR: No, what we have is -- and in fact, we're working with the hospitals on that issue. Mr. Martire was very generous in his point that hospitals are not -- they're actually cheating themselves because they should be getting an extraordinary -- they should be getting a lot of credit for what is now classified as bad debt, but not being classified as charity care.

CO-CHAIR GARRETT: Right.

MEMBER GAYNOR: Part of that is not identifying early on in the process, in the application process, and this is also -- there's some troubles with the hospitals getting the information from the patients, which I know the hospitals have been working on in order to be able to establish that, in fact, it is charity care, it's not bad debt, and the hospitals should be getting credit for that, and I think Mr. Martire is trying to give them credit for it.

CO-CHAIR GARRETT: Right. All I'm saying, Paul, is -- I agree with you, but I think what we don't have is a formula so that can happen.

MEMBER GAYNOR: That's true.

CO-CHAIR GARRETT: We're debating whether he's playing fast and loose or whether the Illinois Association doesn't have -- has different sets of numbers.

In order to move this issue forward, maybe one of the goals of this committee is to come up with a precise formula so the hospitals can translate that bad debt into charity care when appropriate. So there is not just case law, I think as Ralph was pointing out, but we have specifics.

Does that make sense to you before I move on? There's a lot of area for interpretation.

MEMBER GAYNOR: There is no doubt about that.

CO-CHAIR GARRETT: Okay. That has to change.

MEMBER GAYNOR: As the Illinois Supreme Court in its infinite wisdom has set forth a six-factor test. It's a balancing test. Ken is right that there are other things, and one of the other things is it relieves the burden on government. There are six parts. They are all considered.

And at the end after the fact, the Judge and then the appellate court and then the Supreme Court use it, and they make a determination of whether they think that enough of the factors have been met.

CO-CHAIR GARRETT: I'm saying instead of having to go through the Supreme Court to have them weigh in, if we could, if we go in this direction, make it very clear what the standards are and how to apply those standards.

MEMBER GAYNOR: Well, we're not going to be able to -- with the CON task force, be able to make it so that they can get their status as a tax exempt entity --

CO-CHAIR GARRETT: No, but it is --

MEMBER GAYNOR: -- is maintained. You know, we don't have that power. The Court has that power.

One of the things we could do is, is that we could use the CON process as a way that the hospitals can show or establish, you know, as Mr. Martire suggested, perhaps a certain percentage in order to go forward with the project, or there are many different ways to do

this.

Then obviously, whatever method or way that we came up with doing this, the hospitals would certainly get credit for that when there was an analysis of whether they were, in fact, meeting their tax exempt status.

CO-CHAIR GARRETT We're saying that those standards, that criteria, whatever it would be, if this is the proposal we -- one of the proposals we end up making, it has to be defined.

CO-CHAIR DUGAN: I think the proposal is that it should become part of the CON process. I mean, we're saying if we go that way, then we're going to have to have more.

MEMBER GAYNOR: Right, but we just have to be talking on the same page because talking about community benefits in this context will not help the hospitals, because even if we said we'll give you 100-percent credit under community benefits for this, this wouldn't alleviate the problem in meeting the factors that have to be met under the court, you know, the test.

MEMBER ROBBINS: But if we were going

to have this become part of this process, we would be perfectly free to use the value of all of the community benefits that are required to be reported; correct?

CO-CHAIR DUGAN: The CON process.

MEMBER GAYNOR: We could if we wanted to, but we'd be ships passing in the night, and it wouldn't have anything to do with what Mr. Martire is talking about right now. We could do that.

MEMBER LENNHOFF: Can I say something? As somebody from Champaign County where Provena Covenant and Carle Foundation Hospital are located, two hospitals that did lose their property tax exempt status, one issue I think that's really important to consider is from the community and the consumer perspective when we're talking about bad debt.

First of all, I wanted to say I really appreciate your presentation, and the recommendations seemed very common sense from my experience as a health advocate in a community that has dealt with hospitals who lost their property tax exempt status, who were denied charity care, and instead pursued bad debt.

I think one of the things that we have to remember is, in the pursuit of bad debt, what happens to the consumer? What happens to the patient?

Now, in our community, and maybe it was an aberration, but some of the folks who should have been qualifying for charity care were instead being incarcerated, and that was front-page news on the Wall Street Journal a few years ago and so on, and I know that that's a little bit abhorrent.

But the other thing that's less abhorrent that happens is that if somebody is being pursued for bad debt, they become intimidated. Consumers don't necessarily know that there is a law that says that if you're in a crisis, you can go to the emergency room, and it doesn't matter if you owe a bill, and that you will receive care. People don't know that.

So if they've had experiences with a hospital pursuing them for bad debt, and they can't pay, and the hospital is aggressive, the consumer, the patient will withhold going to the emergency room, they will withhold getting care, and then when they do finally go, they are sicker,

they are in deeper crisis, and, you know, their outcome will be worse.

Now, we've seen one of our hospitals, Carle Foundation Hospital, move -- do exactly what you're saying. They are taking advantage of looking at their bad debt and finding ways for qualifying people realizing that they missed them somewhere along the way in the process and now Carle Foundation Hospital is up to 3 percent charity care. And they're not hurting people who owed them money, but who should have been getting charity care, and therefore, really didn't owe them.

So I do appreciate your presentation and the recommendations, and one other thing I want to add is all the while that this was going on, our hospitals were saying we're doing community benefits, and they would issue glossy brochures about what they were doing; and from a real perspective of most of the consumers in the community, I hate to say it, but those community benefits didn't amount to much or were really beneficial just for a very small segment of people in the community.

CO-CHAIR GARRETT: Dave.

MR. CARVALHO: Unless I'm taking it too far in a different direction, I have a slightly different tack I wanted to ask you about in the study and on this issue.

As Claudia mentioned, there's a statute, EMTALA, a federal statute that requires certain care to be provided at a hospital, regardless of whether it's for-profit or not-for-profit, if a person comes to the emergency room in an emergent condition.

So one of the questions I had about this study, and other people who have addressed this topic, is whether there is a baseline of what after the fact, what we call charity care, that is really driven just by the fact that EMTALA mandates that certain care be provided to people without regard to their income level.

So, in fact, one of the things that's a little bit weird, if you look at the data, the charity care for for-profit hospitals is not tremendously different than the charity care for not-for-profit hospitals, which suggests that if you're operating a hospital in an environment

where there is an EMTALA statute, there is a certain amount of charity care that you're going to provide whether you want to or not. You have to.

So one of the concepts that I've wondered about why there's not more discussion is sort of, you know, voluntary charity care as opposed to federally -- through EMTALA-mandated charity care, and whether in making some sort of test as to whether a hospital has met its charity care obligation for a tax exempt purpose, you ought to subtract off the charity care that you determined by looking at what for-profit hospitals do as just the cost of opening the door and calling yourself a hospital. You will de facto do some charity care because EMTALA says you have to treat people, and some of those people are going to be of limited means, and so they will get what gets translated through the process as charity care.

But giving a non-for-profit hospital full credit for all their charity care against some test when for-profit hospitals are providing almost the same amount of charity care in many instances because it's just the cost of doing

business seems to actually overstate the charity care and overcredit a hospital against the tax exempt status.

Have you seen that issue discussed?

MR. MARTIRE: David, We didn't analyze that issue just because we couldn't get access to data on the private -- the for-profit hospitals. So we couldn't get that data in any sort of coherent or detailed form, so we couldn't make that analysis, but I think it's a legitimate point.

To just respond to another point I think actually Ken and I agree on completely, you know, the goal is for these nonprofit hospitals in exchange for the tax expenditure to be relieving government of a cost. If you're giving a tax expenditure at three times the rate of the charity care coming back, you're not relieving government.

Flip it to a direct expenditure. If we were giving $300 million to a human service provider, an education provider through a direct appropriation, we sure as heck would expect $300 million worth of services coming back. I mean, that's how it works, and that's how tax

expenditures are supposed to work as well.

So from a value-to-government standpoint, the whole reason we made that tithe was to take it out of the realm of the nebulous, Gee, what might we expect and put some numbers on it.

And I will emphasize one other thing. Not only has the Nancy Kane methodology been accurate in other states where nonprofit hospitals are analyzed, but when we did it here in the Cook County region, we came up with a more conservative number than the assessor himself.

So the bottom line is, we didn't do anything to try to overestimate the value of these benefits. We tried to be very conservative, and where we didn't have the ability to slice the data very fine, we put that in the report, that this data was not sliced fine.

I don't think that's sloppy work. I think that's honestly telling the world where there might be an issue with your methodology because you couldn't get the data to solve it out.

So I take a little bit of offense to that because the amount of time spent on that report and getting it vetted, and we submitted advanced

copies to the Illinois Hospital Association for them to vet as well, we had nothing in this report -- we had it vetted by Nancy Kane herself. We had it vetted by others.

I mean, the bottom line is there's nothing sloppy in there, and any place at all where there might be a question on data, we noted it.

MEMBER ROBBINS: Ralph, I didn't intend to offend, and I'm sorry if that's the way it came across.

What I think is sloppy is the conclusions that are reached based on the imprecision of the data that you acknowledge is imprecise.

The other thing with respect to --

MR. MARTIRE: That's a minor part of the data.

MEMBER ROBBINS: -- EMTALA, EMTALA requires all hospitals to treat emergency patients. It does not require them to write it off as charity.

MR. CARVALHO: My point was, if you've got a charity care policy, you're going to wind up -- you certainly can't not put somebody through the charity care policy who comes in to your

emergency room under EMTALA.

So just opening your doors and putting up an emergency sign and then being under an obligation to provide care under the circumstances inherently attracts a certain amount of charity care, which is why, I presume, that the for-profit hospitals have a charity care level that's not that much lower than the not-for-profits because they, too, are not going to be able to bill and collect from somebody who is at 60 percent of the federal poverty level. They are going to write it off in charity care as well.

So there's a certain baseline of charity care that just goes along with being in business. So I would think if you do a test, you'd want to look at the amount over that baseline; otherwise, you're giving non-for-profits credit for something that even for-profits are doing.

MEMBER ROBBINS: That goes well beyond --

MR. CARVALHO: I don't know that it does.

MEMBER ROBBINS: -- even the Methodist tests.

CO-CHAIR GARRETT: I think our goal is to -- Hal, I don't want to step in -- is, you know, this is a really good conversation because whatever we come up with as a proposal that defines the CON process, I think that this has to be taken into consideration.

And the problem with it right now, it just seems so obvious to me, is that it hasn't been clarified, that there is so much room for interpretation, and I am curious about the not-for-profit hospitals.

Are you saying that, Dave, if you are a for-profit hospital and you have X number of dollars dedicated to charity care or spent on charity care, that you should receive some sort of a -- you're not saying that. But should that question be asked?

MR. CARVALHO: Here's what I was saying --

CO-CHAIR GARRETT: I mean, if you're for-profit and you're giving the same as a not-for-profit, and you don't get any of the benefits, that's really not fair either.

MR. CARVALHO: So the flip way of

putting it is, it's just like, you know, anybody who is in business is going to recover something less than 100 percent of their billings. In any other sector, we just call that part of doing business.

MEMBER ROBBINS: Bad debt.

MR. CARVALHO: Bad debt, yeah. Here we've got this tradition in health care that somebody who is making 10 percent or 50 percent of poverty level, rather than go through -- but a low one, you know, rather than sending them a bill and trying to collect it, you just write it off from day one, and we call it charity care.

My point is that for-profit hospitals do it too. So if you're looking at something to give credit to a non-for-profit for doing something that's truly charitable as opposed to just part of doing business, then the credit you should give them is for the part above what everybody does because --

CO-CHAIR GARRETT: Above a standard that's been established.

MR. CARVALHO: Yes, exactly, because the for-profits, just by the -- you know, they are

not being charitable, they are just being realistic if you can't collect from somebody who doesn't have any resources.

CO-CHAIR DUGAN: Is there a level in that federal government -- what do you call that?

MR. CARVALHO: EMTALA.

CO-CHAIR DUGAN: -- that actually says you have to -- or does it just say you have to provide care no matter who it is?

MR. CARVALHO: It says you have to provide care unless -- it's misunderstood by some people into thinking that you can go to an emergency room and get all the care you want.

CO-CHAIR DUGAN: Right.

MR. CARVALHO: You can only get care for emergent circumstances. So, for example, if, you know, you're in a car crash, and it's an emergency. If you have breast cancer, you cannot go to an emergency room and say, I need my chemo. That's not an emergency.

So when someone says, Oh, uninsured people can get all the care they want in an emergency room, that's not really true. They can only get -- they're only obligated to receive emergency

care, and there it's only up to the point that they are stating it.

MEMBER RUDDICK: A couple observations and then a question.

First, in terms of -- this has been a regular discussion, but with the other presenters, we've usually raised in terms of questions and allowed the presenters to respond. So I want to make sure that we give Mr. Martire sufficient time. I know he has responded a little bit, but if there are some other points that have come up, had they been asked in the form of questions, he might have been able to respond a little more. So we should make sure to leave that.

Another observation I have with respect to the sales tax issue is that less than one-third, a little under one-third of the benefit has been attributed to the tax expenditures attributed to sales tax. So even if you shave that by a bit for those hospitals that are within Cook County but outside of Chicago, I think the main point still stands with regard to the imbalance between the tax benefit and the expenditure.

Then I wanted to -- this is a question, and

I don't know if you'll be able to comment on this based on your data, but in some ways, I think that the report is very generous toward at least certain hospitals because it lumps all hospitals together. If you looked, I would assume, at a Mercy or a Roseland or one of those kind of hospitals, the amount that they are spending on charity care is greater, and the tax benefit they are receiving is less.

So if you took those -- we have been struggling for a definition, but if you took those safety net hospitals out of the equation at least hypothetically, wouldn't the picture look even worse for your major large, more successful nonprofit hospitals? Is that a correct assessment?

MR. MARTIRE: Do you remember the range, Heather, of the cost? I don't remember that number off the top of my head.

MEMBER O'DONNELL: The cost of the tax benefit?

MR. MARTIRE: Of the amount of charity care per hospital ranged from X to Y, and I forget that range.

MEMBER O'DONNELL: I just have off the top of my head, I don't have it in front of me, I have the average charity care is a percent of total expenses, which was 1.8 percent, versus the tax benefit compared to total hospital expenses, which was 3.7 percent.

CO-CHAIR DUGAN: So we don't have a report that shows all the hospitals in Cook County that you did the test on?

MEMBER O'DONNELL: Yes, we do.

MR. MARTIRE: Yes, we do.

MEMBER O'DONNELL: I mean, I've got this report, and I'm happy to distribute it.

MR. MARTIRE: We'll redistribute the full report to the task force certainly, but yeah, absolutely, that's the case.

Our feeling on the sales tax data is to somewhat ameliorate the impact. It's not even as overstated as Ken would indicate because we took a three-year average and that took out peaks and valleys. It reduced the overall expenditure level.

MEMBER ROBBINS: But if your average is using the wrong percent, it's still a wrong

outcome.

MR. MARTIRE: But it's a minor differential. I mean, even if it's a differential of even, let's say, 20 to 30 million at the highest end, that's still less than the differential between our estimation of the property tax value of the property tax exemption and what the assessor came up with.

The bottom line is, this estimate materially is accurate, and the only qualifications on that are data qualifications that we weren't able to get, but it doesn't change the material conclusions.

We took every step throughout the process to underestimate the value of the tax exemption. We wanted to get a low-ball figure just to see if, at a very basic level, government was getting anywhere close to dollar for dollar in what they were investing, and no matter how you slice this data, the answer is going to come out no.

MEMBER ROBBINS: The only thing you counted was charity care; right?

MR. MARTIRE: That's the only thing that counts for property and tax exemption in

Illinois.

CO-CHAIR DUGAN: We're getting --

CO-CHAIR GARRETT: We need to back off on this.

MR. MARTIRE: Charitable purposes, yes, a six-point test.

CO-CHAIR GARRETT: Let me ask a question.

So if we are to better define or better differently define the CON process, Ralph, would you suggest that we take into consideration the ratio between charity care and non-for-profit and even maybe for-profit hospitals in determining the elements of a CON application?

MR. MARTIRE: You know, I think it absolutely ought to play a role, and it absolutely ought to play a role because of all those demographic factors I threw at you with the rising demands that are going to be placed on the public sector to subsidize health care in one form or another, because the private sector is very much pulling away from it, even for workers, much less for the significant increase in the uninsured and the folks on Medicaid. So it should absolutely be

part of the process.

Now, you have a very sophisticated task force. I mean, if you want to tie it to total cost, if you want to tie it to some of the suggestions David made, create a baseline for what for-profit hospitals are doing and move it above there, those are all very rational things to take under consideration.

We just feel that to ensure that safety net is hitting on all cylinders, any time there's going to be an expansion, it would be to the public interest to ensure that that expansion take into account the amount of charity care we can expect to be delivered at the new facility or the expanded facility.

CO-CHAIR DUGAN: I have a question. Are you done, Senator?

CO-CHAIR GARRETT: Well, I was just going to ask a follow-up.

So somebody said over here, and I think it was Paul, that it appears that right now some of the hospitals aren't getting full credit, maybe that's the bad debt, for their charity care. Am I a little bit off on that?

MR. MARTIRE: That's correct. If they were able to improve their intake one way or another.

SENATOR GARRETT: Right.

MR. MARTIRE: This is a complicated thing. This is not a no-brainer for the hospital system. I mean, a lot of individuals are reluctant to talk about their income status, so there are some issues there, but if we could do a better job capturing it at the front end really at no cost to hospitals, at least 40 percent of this differential could go away, at least, and maybe more.

CO-CHAIR GARRETT: And that's a huge chunk of change.

MR. MARTIRE: Yes.

CO-CHAIR GARRETT: So let me just direct my question then to the Hospital Association.

How would you feel if we defined, we came up with a formula that really included charity care, bad debt, and all of that that helps hospitals understand or participate in the CON process so it's more equitable?

MEMBER ROBBINS: I think we would particularly be interested in the "and all of that."

CO-CHAIR GARRETT: I know that, but and all that. I guess this conversation shows that there's a lot that needs to be looked at.

Nonetheless, from the hospital's perspective --

MEMBER ROBBINS: This may not be the time or place --

CO-CHAIR GARRETT: Okay.

MEMBER ROBBINS: -- in terms of whether it's appropriate for the issue to be part of the CON process as opposed to what the definition of value is.

CO-CHAIR GARRETT: Don't they go hand-in-hand?

CO-CHAIR DUGAN: They're saying -- the Hospital Association is saying should it be part of the CON approval, at least the Hospital Association is saying maybe that's not even something that should be.

MEMBER GAYNOR: I don't think they're saying that.

CO-CHAIR DUGAN: I'm trying to be nice.

MEMBER GAYNOR: I'm going out on a limb, but I don't think they're saying that.

CO-CHAIR DUGAN: I want to ask this one question, if that's okay.

I want to make sure that, because I know that, you know, safety net hospitals are supposed to be helping with the burden -- take the burden off of government. So I just want to ask a question about the Medicaid and the rates and the reimbursement that hospitals get for the care that they provide to people that are there on Medicaid.

So that rate we all know, of course, is low. So we know that hospitals don't get reimbursed. Now, I do have some concerns, and we've talked before about the rate that they charge, but that's a whole issue, but is it not true that hospitals do not get paid what their costs are?

MR. MARTIRE: Oh, absolutely true, but there's also Illinois case law directly on point that says that differential between their reimbursement rate and their cost, their Medicaid reimbursement rate and their cost is not charity

care. It doesn't count under charity care.

CO-CHAIR DUGAN: Well, I know, and I understand that.

MEMBER ROBBINS: Illinois case law?

CO-CHAIR DUGAN: But I'm just saying, but is that not something that possibly also should be looked at when -- I'm not saying that I'm all on the side of the hospital. I mean, what I'm saying is that if we say we want safety nets to take off the burden of government, then I think it's a little bit unfair for government to say, but we're not going to count it, the loss you get from Medicaid.

MR. MARTIRE: And we agree with that. We agree with that. It just depends on the standard.

MEMBER GAYNOR: I think that the hospitals that we had actually proposed, our office, that the hospitals do get credit for that, for Medicaid, not Medicare --

MR. MARTIRE: Right.

MEMBER GAYNOR: -- because Medicaid is a need-based program. So you can show that it's, you know, the needy that are the recipients of the

care, and that it's rational then -- even though I think Ralph is right that there are no cases that say that they can get credit for that, but I think that it's rational to say that they should.

CO-CHAIR DUGAN: I think as we go forward, that that's something also that should be --

MEMBER KOSEL: Renee Kosel on the phone. Why did you decide not to include the Medicare in that reimbursement?

MEMBER GAYNOR: Because it's not a need-based program, and the reimbursement rates are much higher.

MEMBER KOSEL: The reimbursement rates are higher, but still in many instances they are below cost.

MEMBER GAYNOR: Right, but it's not a need-based program where if you reach the age of eligibility, you get it regardless of how much money you have.

MEMBER ROBBINS: I don't know that you want to have the argument here.

CO-CHAIR DUGAN: Probably not.

MEMBER ROBBINS: Paul and I differ on

this.

MEMBER GAYNOR: I don't look at it as an argument. I look at it as a spirited discussion.

MEMBER ROBBINS: That's wonderful, and I'd be happy to engage in it if you'd like.

CO-CHAIR GARRETT: Okay.

MEMBER KOSEL: If I could for just a minute, if -- and I agree the question is if charity care should be included in the CON process and what role it should play; but should we decide to include it, I think that there needs to be a lot of time and energy spent on how to define what charity care is. I'm hearing an awful lot of things that are going to be --

CO-CHAIR DUGAN: Yeah, I think we all agree on that.

MR. MARTIRE: And we, the CTBA, agrees with Representative Dugan's point that actually the differential between Medicaid reimbursement rates and that they should be something considered, we think that that's a cost imposed on the hospital system that maybe is not necessarily very fair, and we think it should be accounted for

in the system.

CTBA has always taken that position. It's just trying to differentiate the existing legal standards from what is fair in a different process than the CON process. We would be supportive actually of you taking that into account. That's the right way to go.

MEMBER LYNE: I just want to make a --

MR. COX: Madame Chair --

CO-CHAIR DUGAN: We've got Sister --

MR. COX: Madame Chair, from Springfield, this is Greg Cox, Republican staff, will you indulge me in a couple questions?

CO-CHAIR DUGAN: Hold up just a second, Sister Sheila is speaking and then we'll come to you.

CO-CHAIR GARRETT: And everything has to stop when Sister Sheila is speaking.

MEMBER LYNE: I just want to make a few comments. I almost am depressed with the discussion we're having here because it's so -- the whole health care financing, both cost, price, everything, we're not going to solve here. Even when you talk about costs, there are hospitals

that have costs per day twice as much as Mercy Hospital, probably three times as much has Roseland Hospital because we can't afford to have their costs. You know, it's not all, well, they're doing all this high-end stuff in my opinion.

But on the other hand, we, because of our percent of Medicaid, are getting back from Medicaid additional money, but I think you used the word equitable or not equitable. I think that's really -- we have not been good examples, I think, in health care of living up to that standard of equity.

I do think that -- and last time I did mention, I guess it's ridiculous maybe to talk about health care being a public good as is education, rather than a marketable commodity which we've made it in just this discussion we're having here. You want to get more and more, it seems to me, to the for-profit levels.

So that's why I don't think it's affordable that way, but that's another group, I think not this group; but when we talk about some of these things and think we can solve them, I'm not -- I

don't have a lot of faith in that.

CO-CHAIR DUGAN: Who was it in Springfield that wanted to speak?

MR. CARVALHO: Greg Cox

CO-CHAIR DUGAN: Oh, Greg, I'm sorry. Greg, you can go ahead.

MR. COX: I have a quick question. I'm sure any number of people can answer this, but it's my understanding that we use objective criteria to come up with reports, and that the Board has the discretion to follow that report or not follow that report.

So if we were to add charity care to the criteria for which the reports were made, would the Board then be required to follow a charity care mandate on the report, or would they have the discretion not to follow that report?

CO-CHAIR GARRETT: Let me just jump in. I think that's -- we don't have a concrete proposal in place, but what I think we're doing is exploring through this discussion different options.

MR. COX: What would Mr. Martire say? Would it be an objective criteria that the Board

would not have discretion for, or would it be a subjective criteria for which the Board could discount?

MR. MARTIRE: Well, I think the Board has discretion to decide what it's going to do and do it. I mean, one of the great things about having a task force is you guys --

MR. CARVALHO: He's not talking about this. This is the task force. The Health Facilities Planning Board is the Board. So he's talking about what standard should the Board, the Health Facilities Planning Board have, not this task force. You're right, the task force can recommend anything.

MEMBER GAYNOR: It all depends on what we come up with, and then actually Mr. Buysse is going to talk about what some other states are doing in that regard.

MR. MARTIRE: And honestly, I would defer to the task force process on that and see what they come up with. Our recommendation to the task force is that they consider charity care as part of the process of issuing a certificate of need to ensure that there is no gaps in the safety

net.

How the task force resolves that and ultimately makes a representation is going to be a process that I'm sure the task force is going to go through.

MR. COX: I have one more quick question, and I think this is more for Mr. Mark or Mr. Carvalho.

During current Board meetings that I've been to, they ask the applicants whether they intend to serve a certain amount of Medicaid clients or do charity care, is that correct, right now? Do the Board members ask that right now?

MR. CARVALHO: Yes, it is typically a question one or more Board members and one or more staff people will ask because the State Agency report currently includes a chart that shows how much charity care or Medicaid is currently being provided, and sometimes those numbers trigger a question, especially, for example, if the number is zero, as it often is. Now, we're not just talking about hospitals. We're talking about other provider types as well.

So yes, the Board members ask that question.

MR. COX: Thank you. That's all I have.

MEMBER ROBBINS: Has the answer ever been zero?

MR. CARVALHO: ASTCs.

MR. MARK: If I may --

CO-CHAIR GARRETT: Well, that's where I want to come in, the ASTCs.

Go ahead, Jeff.

MR. MARK: Just to expand upon this conversation a little bit directly towards CON, part of the CON mandate right now, the statutory mandate, is to avoid unnecessary duplication, and that's been criticized in some of the reports, the Lewin Report, as restricting competition.

The other way of looking at it is the CON process almost by definition does -- once a certificate of need is granted, gives a facility, a provider essentially a geographic district in which it can operate relatively free of competition.

Our Board has been looking at ways of what should be the societal benefit from getting that CON, not only applying to hospitals and not only

applying to not-for-profit hospitals, but proprietary hospitals, ASTCs, ESRDs, and long-term facilities.

We have been looking at developing rules that would incorporate one criterion or two criteria of many that would address a minimal charity benefit, a charity requirement of some sort of community need. We'd love this task force to help define that.

CO-CHAIR GARRETT: Well, let me just jump in here. So one of the things that I think surfaced a couple weeks ago is that if a hospital were to move into an insured market where the potential charity care, Medicaid, all that was under, let's say, 15 percent, one of the ideas that surfaced was that there would have to be a threshold established -- let's say, it would be 20 percent. So the difference between maybe that 15 and 20 percent would be paid back then to a charity care foundation or something like that that would help all of the safety-net-type hospitals in Illinois.

MR. MARK: We haven't gone that fair.

CO-CHAIR GARRETT: I know.

MR. MARK: That's a different idea. We've been looking at minimal expenditures relative to that industry.

CO-CHAIR GARRETT: Right.

So let me just go -- Ralph, let me ask you a question about the ASTCs. All of this is fine and dandy. To Dave's point, you know, you have these ASTCs that move into a hospital area. Are you with me?

MR. MARTIRE: Uh-huh.

CO-CHAIR GARRETT: Okay. They move into a hospital area, and they wouldn't be moving in there if the infrastructure of the hospital weren't in place. So they're open, ASTCs, 9:00 to 5:00, let's say, very rarely see off-the-street people. They couldn't see anybody at 3:00 in the morning. They may -- may get Medicaid patients, but the ratio between what the hospital emergency room or the hospital in general has to see versus the ASTCs is astounding.

So as we look at the hospital's role in this, what about the -- and I'm guessing. I don't know if this is a fact -- the ASTCS would seem to be a very fast-growing enterprise, at least in

Illinois.

So how can we, if we come up with some rules and definitions for the hospitals, shouldn't the ASTCs be under that same umbrella?

MR. MARTIRE: Yeah, I would think all health care providers in that area, and it may be some sort of cooperative thing where the ASTCs would have to take on X percentage of folks shifted over from the hospital.

CO-CHAIR GARRETT: But what if they can't since they don't have the emergency room situation?

MR. MARTIRE: But not in every instance will it be emergent care. I mean, I think that there's a rational way to get it. Now, I haven't researched the specific issue of how you would do that. I'm sure Heather O'Donnell, the Center for Tax and Budget Accountability, would like to do nothing more than to research that issue, and so I volunteer her for that right here right now.

CO-CHAIR GARRETT: I think it's important to look at that because hospitals are scared -- I mean, their market is going to be

eaten into by profit, and then they're paying for the under- and uninsured.

MR. MARTIRE: Senator Garrett, in my old days as a corporate attorney, I represented a number of stand-alone surgery centers and a number of other things they put together, and they very much were focused on the profit model and how they could turn things around.

They very much understand how they're going to make money off of a given community. So having them subject to this process is not only rational, it's the only fair thing in my mind that you could do.

CO-CHAIR GARRETT: But should it be that they are subjected to the process that goes into the broader charity care, or should they then be subject, the ASTCs, to the local hospital which actually provides the infrastructure?

So it's almost like -- I'm just really rough -- let's say, it's an infrastructure tax almost for an ASTC to go into an area, a wealthy area and glomming onto the insured market, and they're not taking -- it's not so much maybe a charity care issue as it is taking resources away

from a local hospital, and for that maybe they would have to pay a tax to that local hospital which provides, or hospitals which provide an infrastructure for them to do that.

MR. MARTIRE: It sounds like a very logical approach. I really couldn't take a position on that --

CO-CHAIR GARRETT: I know. Okay.

MR. MARTIRE: -- until we ran numbers and data. We are sort of numbers and data --

CO-CHAIR GARRETT: Could you run some numbers?

MR. MARTIRE: Yes, we would be happy to. Heather.

CO-CHAIR GARRETT: Heather.

MEMBER LYNE: Heather is delighted to.

MR. MARTIRE: Did you take that down, Ms. O'Donnell?

MEMBER O'DONNELL: We will be talking about that.

MEMBER LANG: Over the lunch break.

MR. CARVALHO: Dovetailing with your point is a very important point Jeff made that I want to try to restate in a slightly different way

to make it clear.

It's not just related to tax exempt status. It may well be something related to getting a CON or getting a license because this is what happens. We have had this situation come to the Board where there's a couple of ASTCs in an area, all of which provide no charity care, all of which provide no Medicaid care, and someone comes before the Board and wants to establish an additional ASTC, and they come with the commitment that they want to see Medicaid patients and they want to provide charity care, but because the need has already been occupied by the existing ASTCs, their application is turned down because there is no need in the sense of brick and mortar need, but they're the ones who are willing to voluntarily make that commitment to providing charity care and take the Medicaid patients or even Medicare. I mean, at some places people don't even want to take Medicare, but the new applicant gets crowded out.

So that's part of what's driven the conversation that Jeff alluded to is, should the CON process or perhaps even the licensing process

outside of CON impose some obligation on the part to, was it Mark Newton or someone, who had suggested in prior testimony, at least take your fair share of what's in your region.

You may not be able to come up with a state-wide, one size fits all, everybody has to take X percentage, but if the percentage of Medicaid in your region is 10 percent, maybe you should do 10 percent. If the percentage of Medicaid in your region is 2 percent charity care --

CO-CHAIR GARRETT: But you might not be able to see that 10 percent just because of the logistics and the way ASTCs operate.

MR. CARVALHO: What you will have to do, and this came up with -- the same issue came up with the AG looking was at imposing a charity care obligation of a set amount on hospitals. The issue was, but some hospitals are just geographically located in a place where they aren't going to be able to see those people, and what they can do; and some of the ideas that were kicked around in that context was a tradeoff obligation where it was more, like you said, some

sort of fund or a subsidy.

Now, you may be in a region where there are Medicaid people, but your physicians don't see them. You may have to -- you as an ASTC may have to subsidize your physicians to see Medicaid patients because they not might otherwise be able to see them.

You're right. There is no emergency room to, in fact, force them to you.

CO-CHAIR GARRETT: But I think the hospitals may resist this whole notion that we're talking about today. I think even more important if I were in the hospital's position, I would be concerned about the ASTCs and the impact long-term they are going to have on the financial stability of a hospital. So I think that both those issues have to be dealt with together.

I'm sorry. Go ahead, Margie.

MEMBER SCHAPS: Okay. I think that's a really important point. I really appreciate your comments, Ralph. I wasn't totally familiar with some of this.

I think that's a really important point. I think that the hospitals are threatened by the

ASTCs, and they're really biting into some of the hospitals' revenue, and I think there might be a good quid pro quo in the CON process to essentially have a sort of tax on the ASTCs, which they haven't had before, and that might be a benefit to the hospitals.

It might be a way to make the charity care requirements on the hospital a little bit more palatable. So I think there is a potential way to have this be a win-win or a lose-lose, but at least it evens it out.

CO-CHAIR GARRETT: We'll have to wait and see where it goes, and I'm being told that we have to move on.

CO-CHAIR DUGAN: Well, we just want to at least be a little bit on -- let's make sure.

Is there anybody new on the phone just so we get you registered as being at the meeting, whether it be Springfield, if you haven't said you're here, you can say you're here. I see Kathleen Dunn in the back.

Is there anybody in Springfield that didn't tell us that they were here so we can get you on the record? If you want to be on the record.

Okay. I guess nobody wants to.

Anybody on the phone that wasn't on there before?

MR. FOLEY: I'm Charles Foley here in Springfield.

CO-CHAIR DUGAN: Thank you.

CO-CHAIR GARRETT: Okay. Gary wants to --

MEMBER BARNETT: This has been covered obviously in the conversation, but there's a couple points that I'd like to make.

First of all, the complexity of working out the CON process that's going to work will cause us to spend a lot of time or that we ask for an extension if we also introduce the complexity of let's figure out how we're going to calculate charity care, and is there going to be a tax on ASTCs, and so is that going to be in excess of the property tax, how are you going to calculate that. I doubt that we can accomplish all this.

CO-CHAIR DUGAN: Well, we'll see.

MEMBER BARNETT: As far as services provided, we go way beyond that. EMTALA only says you have to have medical screening to determine

whether or not a medical emergency exists.

We do medical screening to find out what the situation is, and we call the on-call physician. You know, that's causing great stress between hospitals and medical staff in which they always have to be on call, for every specialty, a physician on call.

They're brought in. They provide care for that spell of illness. In an OB case, that might be six months of care that the hospital and the doctor will be providing. Half the doctors aren't even employees of the hospital, and their offices are wide open to anyone that walks in.

There is lots of charity being provided, and we've gone to great lengths to try to work out what's bad debt and what's charity. We changed the name to financial assistance. No one applies for charity. They apply for financial assistance. There's brochures all over the hospital and out in the community to make them aware of that, and still rural people are prideful even when their average income is less than the -- rate. So there's lots of --

CO-CHAIR DUGAN: Right. There's a lot

of things that we have to -- and I agree with you. Like you say, and whether or not we're going to need another extension, we can discuss that later, but it's certainly something that everybody has the right to come to this task force and give a recommendation, and that's why we're certainly going to take the recommendation, and then we may decide, you know, that we will or we won't, but it's certainly discussion that we need to have.

But let's go on to Dave Buysse from the Attorney General's Office.

Go ahead, David.

MR. BUYSSE: Good morning.

MR. MARTIRE: Excuse me, I have to actually leave to another -- are you done?

CO-CHAIR DUGAN: Thank you, sir.

MR. MARTIRE: Thank you. I really appreciate the opportunity -- I always appreciate talking with you, Ken -- but I do appreciate the opportunity to come before the task force and really respect the hard work you have in front of you.

CO-CHAIR GARRETT: I want to welcome Senator Brady to the force.

SENATOR BRADY: Thank you. Amtrak was delayed.

CO-CHAIR DUGAN: Okay.

MR. BUYSSE: Thank you. Good morning. My name is David Buysse, and I'm a senior assistant attorney general in the office of Illinois Attorney General Lisa Madigan.

As a member of the Special Litigation Bureau, I have participated in the Attorney General's ongoing investigation of Illinois not-for-profit hospitals since the fall of 2003.

The Illinois Health Facilities Planning Act was first enacted in 1974 pursuant to the mandate of the federal legislation, the National Health Planning and Resources Development Act of 1974. The purposes of the Act are set forth in Section 2.

The 2007 Lewin Group Report, "An Evaluation of Illinois' Certificate of Need Program," correctly summarized the continuing goals of the Act, so the purposes of the Act to be first containing costs; two, improving access; and three, improving quality, all of those things for the general public.

The effectiveness of the CON process in achieving these goals has been a subject of debate for some time. There have been several voices in this debate.

First of all, the Federal Trade Commission and the Department of Justice have primary enforcement responsibilities for the federal antitrust laws. So far in 2008, the Federal Trade Commission has submitted rather similar written statements to committees of both the Alaska House of Representatives and the Florida Senate considering reform of each state's CON laws.

The Commission argues in each statement that a CON law can be a barrier to market entry operating to the detriment of health care competition and health care consumers. The Commission's position is based largely on the joint report prepared by the FTC with the Department of Justice in July, 2004, entitled "Improving Health Care: A Dose of Competition."

In the report, the agencies asserted that on balance, CON programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually

outweigh their purported economic benefits.

Conversely, in 2005, the American Health Planning Association published a critique of the FTC and DOJ study. In addition to questioning the reliability of the studies relied upon by the FTC and the view that health care is simply a commodity like any other, AHPA argued for the value of a CON process as a market-balancing tool.

They said, quote, In a necessarily imperfect, and an increasingly inequitable, health care system, community-based planning and CON regulation are flexible tools that, when used intelligently and objectively, help protect the critical health care infrastructure that is required to meet both expected and unanticipated public need. Market forces are invaluable in balancing the cost, supply, access, and quality of most goods and services. Market fluctuations and vagaries are acceptable for most commodities, but are problematic for essential social goods and services, especially health care, close quote.

Now, last month, the Illinois Hospital Association presented the view that the primary purpose of the CON should be, quote, to prevent

the unnecessary duplication of health care facilities and services in order to preserve access to safety net services across Illinois, close quote.

The Association also acknowledged that the evidence is weak that CON has had an impact on cost containment and suggested that a myriad of factors contribute to health care cost increases over time. Consequently, the Association believes the role of the Planning Board in cost containment should be secondary.

Whatever theoretical approach one takes to the role of CON in health planning, whether it's the free market skepticism of the FTC, the relative enthusiasm of AHPA, or the sort of middle road advocated by the IHA, an important legal effect of CON should be clearly recognized.

When new firms seek to enter a market, existing firms may attempt to deter or prevent new competition. Such conduct is certainly not unique to health care markets. In many circumstances, such conduct may violate antitrust laws. Certain types of anticompetitive conduct may nevertheless be shielded from antitrust scrutiny.

The examples most pertinent to consideration of CON regulation include:

First, the Noerr-Pennington doctrine, which was defined in two U.S. Supreme Court cases in the 1960s which serves to immunize conduct which involves petitioning the government, even when such petitioning is done, quote, to restrain competition or gain advantage over competitors.

Secondly, the "state action" doctrine, which shields many of a state's own activities when a state government is acting in its sovereign, legislative capacity, and also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state.

Now, the FTC statement to the Florida Senate, which was actually delivered in April of this year, suggests that, quote, In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for

operation, close quote.

The protection afforded under these legal doctrines is arguably what allows the use of the CON process to prevent unnecessary duplication of health care facilities and services which might otherwise occur in a marketplace without such a process inhibiting entry.

Now, such protection is obviously an important tool for policy makers in Illinois. The Attorney General believes that the CON process and the protection offered by that process to health facilities should continue to further the original purposes of the Health Facilities Planning Act.

Since access to necessary health services remains an unfulfilled goal, arguably to a greater degree than the prevention of unnecessary duplication of health care facilities and services, the reform of health planning and the CON process in Illinois should mandate specific criteria for the classes of health facilities participating in the CON process to increase accessibility to necessary health services to those residents whose access to such services remains dangerously deficient.

Contrary to the suggestion that efforts to increase accessibility constitute agendas unrelated to health planning, other states continue to recognize the clear connection between the CON process and increased accessibility for indigent residents.

For example, in South Carolina, the regulations for the certificate of need process requires an indigent care plan documenting a facility's provision of indigent care for three years before application and with respect to the anticipated provision of care to indigent patients in the future.

In New Jersey, specific criteria for review of CON applications include, quote, how and to what extent the applicant will provide services to the medically indigent, Medicare recipients, Medicaid recipients, and members of medically underserved groups, close quote, and, quote, the amount of charity care, both free and below cost service, that will be provided by the applicant, close quotes.

Most recently on May 19th, 2008, Florida Governor Crist signed legislation streamlining the

state's certificate-of-need process. While the bill includes a loser pays provision to cover a hospital's legal fees if there is an unsuccessful appeal after a CON has been granted, the review criteria for general hospitals concerning an applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent survived the efforts at streamlining.

What I'm trying to say here is, there was actually a task force very much like this that looked at the CON. There was a program presented, and there was actually discussions with the Hospital Association in Florida which produced a plan which retained CON in a much streamlined fashion, but which also retained the existing requirements regarding the provision of care to Medicaid and other medically indigent people.

Now, in Virginia, the witness from the American Health Planning Association, which previously testified before the task force, alluded to the experience of Virginia, noting that it first repealed its original CON process and subsequently enacted another.

In the Commonwealth of Virginia, the commissioner of health makes final decisions on CON after receiving recommendations from the Department of Health staff and from one of five regional planning agencies.

This commissioner may condition the approval of a certificate upon the agreement of an applicant to, A, the provision of a level of care at reduced rates to indigents or the acceptance of patients requiring specialized care; or B, upon the agreement of the applicant to facilitate the development and operation of primary medical services to designated medically underserved areas for the applicant's service area.

Now, the Virginia charity care requirements are tied to the average regional charity care percentage of acute care hospitals and may change from year to year, which would basically accommodate the concern about trying to impose one size on all health care providers.

Ambulatory surgical centers were actually the first type of facility to which these requirements were applied. The requirement now applies to other types of facilities and medical

equipment, obviously including hospitals.

Facilities in Virginia are required to keep and submit copies of a charity care log that includes at a minimum -- and remember this is within the CON process, that includes at a minimum the date of service, a patient's age, zip code, city and county, procedure or service provided, total charges for the services provided, and any amount charged to the patients resulting from physicians who are not employees of the hospital, which is really quite remarkable given the fact that in Illinois, hospitals deliver charity care and physicians often do, but there's not the same sort of requirement that there is for a hospital.

In addition, any associated physician or medical service billed to the patient must also be tracked. Facilities willfully neglecting to comply are subject to a civil penalty up to $100 per violation per day.

In addition to directly providing medical services at reduced or no cost to the medically indigent, facilities in Virginia can meet their charity care by, quote, facilitating the development and operation of primary medical

services to indigent persons.

Examples of what this might entail include providing transportation, establishing a new service such as a new free clinic, or making a "donation" to a recognized facility whose mission is to care for the medically indigent.

The conditions can be met by the provision of indigent care by the CON conditioned service at a rate equal to or greater than that established on the CON, documented new efforts or initiative to provide primary care to indigents, or finally, direct payments to any organization established under a memorandum of understanding with the Virginia Department of Health as authorized to receive and distribute contributions satisfying the CON condition, including but not limited to the Virginia Association of Free Clinics and the Virginia Primary Care Association.

Now, the charity care conditions remain in effect over the life of the service authorized by the CON and through successive generations when equipment is replaced or upgraded. Applications from facilities refusing to comply with the charity care conditions are recommended for

denial.

Compliance can be enhanced by public disclosure via publication of non-compliant facilities. Facilities which have been deemed non-compliant may be denied a CON for future proposed projects.

According to the Central Virginia Health Planning Agency, the charity care requirements and efforts around enforcement in Virginia have resulted in increased charity care provided by hospitals and other service providers and reduced bad debts, further enhanced outreach by regulated facilities to safety net providers and their patients, and greater collaboration between safety net providers and other health facilities.

Increased efforts to develop services needed by low income persons is another result of these efforts in Virginia, and then finally a better tracking of the charity care provided, which would be akin, I think to what Ralph referred to and several questions referred to that many hospitals would under most rational analyses receive credit for charity care which is now booked as bad debt.

I think an interesting situation in the

health industry is that there is, unless the rift has been healed in the last few weeks, a distinction between the Catholic Health Care Association and the American Hospital Association regarding what should be counted as community benefits.

The AHA believes that, you know, there is a place for bad debt to be counted as a community benefit. The CHA disagrees. The same thing with Medicare, the CHA thinks that that really shouldn't be counted as a community, whereas the AHA thinks that it should.

Now, Attorney General Madigan strongly believes that the original goals of the Act, containing costs and improving access and quality for the general public, provide the foundation for the directives for the task force which the General Assembly enumerated in Section 15.5 of the Act, sort of your walking orders here.

Of particular relevance to accessibility is the directive in Section 15.5(c)(6) regarding, quote, the implementation of policies and procedures necessary for the Illinois Health Facilities Planning Board to give special

consideration to the impact of the projects it reviews on access to safety net services.

In addressing the other directives from the General Assembly in Section 15.5 intended to streamline and rationalize the operation of health planning in Illinois, the importance of increasing accessibility and protecting the health care safety net should not be neglected.

Policies regarding the provision of health care to low income persons should be included in the report to be prepared by the task force and any legislation drafted in accordance with the recommendations of the report.

The task force should consider policies including specific minimum requirements regarding the provision of charity care by classes of health facilities under the purview of the Act, specific requirements regarding the provision of care to Medicaid recipients by the classes of health facilities under the purview of the Act, specific criteria for CON applications regarding the provision of charity care and care to Medicaid recipients, specific annual reporting requirements concerning the provision of such care, and

finally, flexibility in the manner in which such requirements and criteria can be satisfied.

Looking to this sort of creative approach that Virginia has used, recognizing economic realities for particular health care providers as well as the need of indigent people in that commonwealth.

Thank you very much for your kind attention, and I'll try to answer any questions that you might have.

CO-CHAIR DUGAN: Questions?

MEMBER ROBBINS: Just a couple real quick.

CO-CHAIR DUGAN: Certainly.

MEMBER ROBBINS: David, would this contemplate establishing or imposing charity care or other, let's say, minimum Medicaid service requirements to each of the classes that are now governed by the CON process in Illinois?

MR. BUYSSE: I think that our recommendations were somewhat vague because it's really up to this task force to make the determinations; but I think that a definite economic case can be made, and I think

Mr. Carvalho has made reference to the situations, that charity care requirements should be imposed upon other entities within the purview of the CON process other than nonprofit hospitals. I think that the economic case can be made, and it really goes to what Sister Sheila is talking about, it's really based on equity.

MEMBER ROBBINS: So this is not the benefit of the bargain argument based on an entity's exempt status. It's based on the business they're in and sort of a threshold requirement for being in that business.

MR. BUYSSE: Yes, you're right, but I think it's the benefit of a different bargain.

What Ralph was talking about is the bargain with respect to real and sales taxation imposed upon hospitals.

What I tried to point out here is that the CON process, and this has been recognized in the states that have retained the CON process, it allows health care providers to engage in activities that, if they did it without the benefit of a state board, could run afoul of federal antitrust laws and the state antitrust

laws, and so that is a very significant benefit for any health care provider to take advantage of.

So I think that the argument can be made that it is just as valid to premise a requirement to provide charity care on the benefit of that bargain as it is to premise it on the tax bargain.

MEMBER GAYNOR: Also the indirect benefit -- even though it wouldn't be a direct exchange or the benefit of the bargain, the hospitals would also get credit outside of this, you know, process for their taxes and status because presumably they would get credit for increasing their charity care.

MEMBER ROBBINS: Were there any other -- did any of the other 49 states have something like Virginia that you found?

MR. BUYSSE: Well, I mean, I think you know South Carolina, New Jersey, Florida have different types of things. I zeroed in on Virginia, first of all, because the task force had already been introduced to the notion that Virginia was doing this sort of thing, and I thought it would be interesting to sort of drill down a bit in terms of how that plays out, you

know, as they do business.

MEMBER ROBBINS: I appreciate that.

MR. BUYSSE: And I can't say that I've done -- because, for example, Florida, you know, their sort of streamlining legislation was just passed last month. So it's hard to keep track because CON is actually a hot topic in state legislatures around the country. It's not something that's focused in Illinois based upon, shall we say, unique circumstances that sort of gave rise to this task force.

MEMBER ROBBINS: Was it your understanding that in Florida then there may have been a tradeoff between streamlining and these other obligations?

MR. BUYSSE: I believe so. Again, what I thought was very interesting is that your counterparts in Florida, because they wanted to keep the CON process, the governor was basically saying, okay, let's start off -- you know, your counterparts recognized the benefits of keeping CON for sort of deficiencies that don't quite fit into that free market model that the FTC is fond of.

As a consequence, you know, they said, well, let's streamline, and we'll get rid of these criteria, but what was significant is that they retained the criteria regarding Medicaid and charity care.

CO-CHAIR DUGAN: Representative Lang.

MEMBER LANG: Thank you.

I appreciated your report. In fact, I'd like a copy of what you have read to us. I think it would be very helpful.

I guess I want to make sure I understand the core of what you said. So I want to boil it down to one sentence, and you tell me if this is the core of what you said; which is, regardless of whether or not we streamline the CON process, the Attorney General sees a stronger need for a planning process, and in that planning process we must include the needs of the safety net hospitals. Is that pretty much what your report says?

MR. BUYSSE: I think you're absolutely correct that the Attorney General sees a benefit to retaining the planning process, that care for the indigent should be an important component of

that planning process, and that streamlining is something that can be done to the benefit of everyone who participates.

But in the process of doing that streamlining, it's important to sort of keep true to the original goals of the legislation and even the goals of the legislation passed most recently establishing the task force, that you have to look out for people who don't have access to necessary health services.

MEMBER LANG: I want to separate out the CON process from the planning process, which as I see it, are really two different things.

We've heard much testimony and we've had much discussion that while this Board does a lot with the CON process, this Board isn't doing very much planning.

Would the Attorney General see possibly -- let's assume for a second that this task force recommended to do away with the CON process. Would the Attorney General have a recommendation as to what kind of process to put in place to do planning better?

MR. BUYSSE: I have to say that to

answer that question, I'd have to go back and talk to the Attorney General because what I have presented here today would be, you know, her ideas about, you know, what should be done.

Now, recognizing -- as you said it, if one of the things that could be done is the CON process could be thrown out and yet some component of a planning process could be retained, and I think that in fairness, our office would have to look at what sort of options are being considered.

The present sort of position of the office is that the CON process has been part and parcel of those efforts at planning in the State of Illinois since 1974. The success of those planning efforts has been spotty over time, but this is an excellent opportunity to make the changes necessary to try to achieve the goals that were set in 1974.

MEMBER LANG: All right. I think that answered my question. Thank you.

MEMBER BRADY: The previous speaker outlined the legal standards for the four tax breaks that are given.

Is it the Attorney General's opinion that

those are the correct legal standards?

MR. BUYSSE: I think Ralph correctly stated the legal standards that concern tax exemption in Illinois.

MEMBER BRADY: Is it the Attorney General's opinion that those -- that Medicaid qualifies?

MR. BUYSSE: Well, as Ralph I think was very careful to state, existing case law -- and Mr. Robbins might say, well, those weren't hospital cases, but existing case law would say that bad debt doesn't count, Medicaid shortfall doesn't count, Medicare shortfall doesn't count. Okay. That's sort of the case law that's out there now.

The Attorney General, as Mr. Gaynor pointed out, in 2006 introduced legislation trying to address charity care from the perspective of tax exemption and actually said, Well, we think hospitals should, in fact, get credit for Medicaid shortfall for exactly the reasons that Mr. Gaynor pointed out. It's a needs-based benefit, and frankly, in 2006, the difference of the shortfall between Medicare and Medicaid was very

significant. Changes in Medicare have made that change somewhat less significant.

MEMBER BRADY: The Attorney General's point is shortfall in Medicare would not count?

MR. BUYSSE: That's correct.

MEMBER BRADY: And it's her opinion that bad debt is not counted?

MR. BUYSSE: Absolutely.

MEMBER BRADY: So the only thing that would count --

MR. BUYSSE: Again, this is in the context, Senator, of, you know, the analysis under tax exemption law.

MEMBER BRADY: Is it her opinion that if a hospital didn't provide, under that definition, that amount of benefit, they shouldn't qualify for any of the tax exemptions or only a pro-rata share?

MR. BUYSSE: I mean, I think it's important to sort of parse out the legislation that the Attorney General introduced and case law.

What's interesting is on June 18th in Springfield, oral argument is going to be held in the Provena case. Okay. The Department of

Revenue appealed the decision of the circuit court in Sangamon County, and on June 18th, there's going to be oral argument. I can't predict what's going to happen in that case.

But as far as what the Attorney General, you know, thought in terms of the legislation that was introduced, pro rata is something that was not part of the legislation; however, if there was negotiation about that bill in 2006, who knows what might have happened.

MEMBER BRADY: Is it her opinion that Medicaid reimbursement above insurance reimbursement should have an adverse effect?

MR. BUYSSE: You're correct. There are certain circumstances where that occurs. It is a very infrequent sort of circumstance.

We tried to, and I think Sister Sheila alluded to a situation where because of other policies of the state, the biggest providers -- the safety net hospitals, the biggest providers of Medicaid services in the state have supplemental benefits that are paid which, while it doesn't really cover their costs, it comes closer to covering their costs.

The whole notion of --

MEMBER BRADY: What is the Attorney General's definition of cost?

MR. BUYSSE: I mean, the Attorney General's definition of cost in the bill that was introduced was premised upon the use of the cost-to-charge ratio in Medicare cost reports that are filed by all hospitals in the United States.

MEMBER GAYNOR: Which is also being used in the most recent passed legislation on hospital pricing.

MEMBER BRADY: So her definition of Medicare --

MR. BUYSSE: What I wanted to say, that was the definition in that bill.

Now, what I am aware of from the investigation that I've been participating in, and for full disclosure, it's under Mr. Gaynor's direction, I know that there is a remarkable spectrum of sophistication and cost accounting by hospitals in the State of Illinois.

MEMBER BRADY: How long did it take you to figure that out?

MR. BUYSSE: Well, no, but see -- I

mean, everyone can sort of think they know, but I have listened to testimony for hours and hours and hours, and so I have a real feel for the differences in cost accounting sophistication across hospitals in the state.

So there are some people who would be very adept at defining their own costs and verifying their own costs and others not so. The Medicare cost report was used because everyone has to do it, and it's sort of something that people use in other circumstances.

MEMBER BRADY: If the Medicaid rate exceeded the Medicare cost report, would that then be subtracted from the charity care under the Attorney General's opinion?

MR. BUYSSE: The chances of that happening --

MEMBER BRADY: Let's just keep it hypothetical. Mathematically, is that part of the equation?

MR. BUYSSE: It was not part of the equation because it was not something that would occur for any hospital in the State of Illinois.

MEMBER BRADY: Mr. Lang tried to

summarize -- Representative Lang tried to summarize what it boiled down to. I look forward to a copy of the report.

And as I was listening, is it the Attorney General's opinion then that a certificate of need should not be -- I guess what I'm -- obviously, she's trying to say that charity care and the community impact should be tied in to whether or not something is awarded, but what standard? I mean, if it's a for-profit institution, does that mean she doesn't believe that it should -- and it pays taxes, that she doesn't believe we should issue a CON?

MR. BUYSSE: No. I mean, what I think is being suggested here is that across other -- we're not looking here at just nonprofit hospitals. We're looking at, you know, ASTCs. We're looking at the dialysis units. We're looking at for-profit hospitals.

Mr. Carvalho made, you know, a very true statement. There are for-profit hospitals in Illinois that provide vastly more charity care than a number, a fairly significant number of not-for-profit hospitals in Illinois.

I think this is not a secret, the most recent announcement of a hospital closure, which is Michael Reese. Michael Reese has any number of reasons which I am not qualified to judge, but I am aware of the fact that they actually provide a goodly amount of charity care and a very significant amount of Medicaid, yet they still pay taxes.

So in terms of what we're proposing here, if you're going to look at requiring care for indigents as part of the CON process, I think it is economically justifiable to look at all health care providers who are going to be coming to the Health Facilities Planning Board or anything else that you determine to put in its stead for them to consider performance in terms of providing health care to indigent people.

MEMBER O'DONNELL: I'd like to make a comment in response, Senator, to your question.

I think that we need to break out of the conversation as what's required for tax exemption because the CON Board has a very different -- has a very different responsibility and rationale, and I think Jeff and both Dave -- both Jeff and Dave

made the comment that we have to consider the benefit that hospitals are granted in the CON process.

They're actually protected, or that's the intent, to protect them from competition from other providers, and that may be something we need to consider in terms of what benefits they're getting in this process and what they ought to be providing in return.

MEMBER ROBBINS: Heather, if we're not talking about it in the context of a tax exemption, what was the purpose of Ralph's testimony this morning?

MEMBER O'DONNELL: Because I think that's sort of the foundation of why charity care is required in Illinois. Charity care is a piece of the safety net, and it is financed through tax breaks; that is, it is financed in part by tax breaks. I think that is sort of the basis for discussing charity care and how it might apply in this process.

MEMBER ROBBINS: I think you're trying to have it both ways.

CO-CHAIR GARRETT: Can I ask

something?

So how would the Attorney General feel -- I mean, you didn't really talk about the ASTCs.

MR. BUYSSE: Well, I mean --

CO-CHAIR GARRETT: I'm not sure the ASTCs --

MR. BUYSSE: -- by talking about the classes of health facilities within the purview of the Act, basically, there are -- ASTCs are currently within the purview of the Act; and so if it's the task force's determination and then ultimately the General Assembly's determination that this is an appropriate policy decision to be made, I mean, what we're saying is there's an economic rationale for spreading the burden among all health facilities because you're not limited to tax exempt issues.

CO-CHAIR GARRETT: Right. So I guess I -- and I just want to make sure. I see it a little bit differently. I think they should be included if we go in this direction.

My concern is that they're part of the overall formula, and maybe that would go into -- their payment or tax or whatever go into a bigger

fund. My concern is that that shouldn't be the case, and it should be much more localized because they take away from the local market.

MR. BUYSSE: I mean, again, you know --

CO-CHAIR GARRETT: That's not something that you've ever --

MR. BUYSSE: The devil is in the details, Senator --

CO-CHAIR GARRETT: Yeah.

MR. BUYSSE: -- that I think you're alluding to. Virginia, you know, sort of looks at the local market --

CO-CHAIR GARRETT: Okay.

MR. BUYSSE: -- for a determination of what's going to be required. I think that that's not an uncommon approach in those states where this is done.

CO-CHAIR GARRETT: Okay. And I have one other question. Bad debt, I'm getting bad vibes about the bad debt. I'm just trying to figure out how -- and I think what I'm hearing is that this is no real definition of what bad debt means.

MR. BUYSSE: No, no, no.

MEMBER GAYNOR: There is a definition of bad debt.

MR. BUYSSE: Bad debt is defined by accountants. I mean, it's basically uncollected bills.

CO-CHAIR GARRETT: I get it.

MR. BUYSSE: Right.

CO-CHAIR GARRETT: Could it be more legal issues or something like that?

MR. BUYSSE: See, that's what Ralph was talking about.

CO-CHAIR GARRETT: Okay.

MR. BUYSSE: Again, I think Claudia made reference to the fact that there are hospitals in the state that, you know, sort of did business one way, and they've changed the way they've done business.

They have provided more charity care, and it has had -- and I'm not going to say that anyone has a one-to-one tradeoff, but there are a fair number of situations where increased charity care done correctly has resulted in a decrease in bad debt.

Now, the fact is, for hospitals in particular, because they're the ones who have this burden of providing charity care, it's always been uncompensated care. Okay. It's simply the fact that they didn't identify people from whom they would not collect money early enough to qualify under existing standards as charity care.

MEMBER GAYNOR: Because the traditional definition --

CO-CHAIR GARRETT: Okay.

MEMBER GAYNOR: The traditional definition of charity care is at the time that they render the services, there is no expectation of payment.

CO-CHAIR GARRETT: Okay.

MEMBER GAYNOR: But we understand the hospitals are challenged because someone comes in, and the first thing they want to do is treat them.

CO-CHAIR DUGAN: I think Gary said you guys changed the name of what we call --

MEMBER GAYNOR: Financial assistance.

CO-CHAIR GARRETT: So if bad debt is accounted for differently, and it could be charity care, so at the very moment somebody comes into

the hospital and goes through this process, then they would not be in the bad debt column necessarily, they would be legitimately in the charity care column if, in fact, there was a standard or process in place that clearly defined that. Does that make sense?

MEMBER GAYNOR: There is a way, but I think it's unreasonable to expect that in all instances, the hospitals are going to be able to make that determination at the time that the services are rendered.

MEMBER ROBBINS: Especially in the emergency room.

CO-CHAIR GARRETT: But at some point in time they could make them.

MEMBER GAYNOR: They could, and what we need to do is we have to strike a balance --

CO-CHAIR GARRETT: Right.

MEMBER GAYNOR: -- that's reasonable for the hospitals who do face challenges in getting the kind of information they need to make the determination of whether somebody qualifies.

CO-CHAIR GARRETT: Okay.

MR. BUYSSE: Again, in the legislation

that was --

CO-CHAIR GARRETT: I think that's what we have in here.

MR. BUYSSE: It was proposed by the Attorney General -- there was some effort to accommodate that situation by bringing out the time by which you had to identify bad debt farther into the future.

CO-CHAIR GARRETT: Right.

And if you can indulge me, I just have one other question, and that is, the nonprofit versus the for-profit. So does the Attorney General believe that what you're recommending here today should apply only to the non-for-profit, or if we create it properly, it would be a standard that applies to all, which is I think where Dave was going?

MR. CARVALHO: I think, you know, what could be summarized in one sentence as Representative Lang tried to -- I think the one-sentence summary of what Mr. Buysse presented is, if the state provides you with this mechanism, the CON process, to help keep competitors out, the quid pro quo you need to accept is to share in a

fair way the burden of the uninsured and indigent in your service area.

Then the footnote is, and by the way, if you're a non-for-profit, this will be a credit for you against whatever obligation you have as a non-for-profit under the tax --

CO-CHAIR GARRETT: But we don't have a standard for the for-profits.

MR. CARVALHO: Well, this would create the standard.

CO-CHAIR GARRETT: That would create. Okay.

MR. BUYSSE: I was going to say, if a standard should be created, then the standard should apply for all health facilities in those classes under the purview of the Act.

CO-CHAIR GARRETT: But then the non-for-profits --

MR. CARVALHO: The non-for-profits would be treated the same as an applicant, but by the --

CO-CHAIR GARRETT: Even though they don't pay. I mean, the for-profits are paying the taxes and everything like that, and the

non-for-profits aren't, so they're getting a double --

MR. CARVALHO: But it's what Heather said. You aren't getting the benefit of this process that keeps competitors out because of whether you pay taxes or not, you're getting the benefit because the CON process exists. You're getting the benefit, you're getting it whether you're tax exempt or tax paying; and since you're getting the benefit, the quid pro quo you want to get from that benefit is keeping competitors at bay and you've got to take care of the indigent.

CO-CHAIR GARRETT: Then what Ralph was saying doesn't really matter about giving back to the communities, you've got this tax break.

MR. CARVALHO: Other than the context of saying, and by the way, if you're a non-for-profit, since you have this obligation anyway, you shouldn't be all that upset what the CON process does because you're going to get credit for doing it over on the tax exempt side.

MEMBER GAYNOR: And it gives you a perspective on how much is being provided generally relative to --

MEMBER ALTHOFF: Building on all of that, I'm just going to make a comment and then I have a question.

As I sit here and listen to all of this, if we choose to include this as a recommendation in any report, I think it has to be absolutely crucial that a set of criteria is established with regard to this, and then it doesn't become another subjective decision of the Board, the existing CON Board.

CO-CHAIR GARRETT: Yeah, we've already -- we've said that the devil was going to be in the details.

MEMBER SCHAPS: Especially if there's a state that actually lays this out, that could be of some guidance.

MR. BUYSSE: And I'm not suggesting that we just adopt what Virginia has done willy-nilly.

MEMBER SCHAPS: No, it's a place to start.

MR. BUYSSE: Right, exactly. That's why I went into some details because the model is out there if we can adapt it to Illinois needs.

CO-CHAIR GARRETT: Ken.

MEMBER ROBBINS: A question that may be illustrating some of the complexity of all this, without arguing either against or in favor of David's suggestion, let's at least -- if we have a standard, it ought to apply in every situation.

But let's say that you have a situation where a hospital is 60 years old. It absolutely needs to modernize its emergency room to be consistent with current standards of care, and because it hasn't had a lot of resources available to it, it has only provided, if you will, the amount of charity care that that community appeared to need, which might be lower than a place in a different part of the state.

So if you're going to have an absolute rule that says under that circumstance because it failed to meet the charity care test, it also can't provide a modern emergency room to its communities -- I think we ought to think that through.

CO-CHAIR DUGAN: I don't know that that's what was said. I don't think that that's

what was said, personally.

MR. BUYSSE: Again, the benefit of looking at the experience in other states and looking at what, you know, various experts have written about, it is possible -- and I think it's more possible in this context, the CON context to be creative in recognizing what hospitals actually do and still increasing the amount of care to indigent people that is provided.

The tax benefit that, you know, that -- what Ralph was talking about, you know, that is sort of circumscribed by constitutional issues. Okay. This is not so circumscribed by constitutional issues, and I think that the legislature has more leeway in crafting the type of remedy that it wants to have.

MEMBER ROBBINS: And again, I don't want to get into a debate about what percent of this or what percent of that.

MR. BUYSSE: You'll notice I didn't use any percentages at all.

CO-CHAIR GARRETT: Well, let me understand this. So let's say, this kind of new framework we're talking in, and Hospital A wants

to move into an insured market, and they don't have the Medicaid and charity care.

Then would you -- would the Attorney General say, Okay, and for being in that market, all other things considered, if they don't meet that criteria, whatever it is, then they have to pay a tax, let's say, or levy into this charity care foundation? Is she into that?

MR. BUYSSE: Again --

CO-CHAIR GARRETT: Because that would take care of what I think Ken is saying --

MR. BUYSSE: Right.

CO-CHAIR GARRETT: -- because then if there is a foundation set aside, and there is a hospital that doesn't qualify, but still doesn't have the resources to pay for emergency room improvements, then that charity care foundation could help those kinds of facilities.

MR. BUYSSE: Right. That's definitely one alternative that's out there, and one that is used in a variety of circumstances by other states. You know, where you have a pool, and that's going to be used to subsidize health care for low income people.

But, again, I think there are other ways, other ideas like that, and that's why I'm saying this is a fantastic opportunity to look at what's needed and to try to do it because it's not constrained by the same types of things that exist in the tax exemption phase.

CO-CHAIR DUGAN: Well, I think there's a little bit of a CON process too with a bricks and mortar new building coming into a community and an expansion or new equipment in an existing hospital. To me, technically, that would be two different things to begin with. I mean, they come through the CON, but to me, there's got to be two different ways you look at something like that anyway as far as, you know, and so I agree with Ken. Yes.

MEMBER GAYNOR: Well, you also -- because we have been about streamlining, that's something that the hospitals care a lot about, you might say when you require a piece of equipment, that's not something that's -- it's something that might not be subject to the CON process.

CO-CHAIR DUGAN: The CON, correct.

MEMBER GAYNOR: And then in exchange

for that, streamlining.

CO-CHAIR DUGAN: Yeah, there are some things that maybe we shouldn't even have a CON.

Kurt.

MR. DeWEESE: Yeah. Aside from the tax benefit questions, it does seem to me that the comment that David made about sort of requiring some demonstration of your commitment to meeting the need is the key here.

It's not so much whether you're a safety net hospital or whether you're -- whatever your profit or not-for-profit status is, it does seem to me that if the need in the community in terms of beds or specialty care are defined, then it does seem to me that when you apply for a certificate of need, you're trying to meet those criteria and that you're going to serve that community in meeting those particular needs.

If you're an ambulatory surgery treatment center and you come in based on that criteria and you get your CON, but they don't do that, you don't do anything in relation to really meeting those needs, then it does seem to me that there's a real disconnect. It's not so much what your

status is as a for-profit or not-for-profit, it's whether you've gotten your CON on the basis of meeting a community health care need and assuring access to everybody to those services.

And implicit in that is the commitment to providing access to that full array of people. If you don't do that, then those community needs aren't being met, and yes, you probably should entertain an application of somebody who makes that commitment and actually lives up to that commitment.

But it seems to me it's more a matter of how you define the needs of the community rather than what the status of that particular provider is, and how do you enforce whether or not they meet their commitment to meeting that need.

MR. BUYSSE: I would certainly agree with that.

CO-CHAIR GARRETT: Do we have any more questions?

MR. JONES: This is Mike Jones in Springfield. Could I ask you a quick question?

The doctrine of state action immunity, would that not provide us with some unique opportunities

to create innovative cross-facility plans to address indigent care in communities?

MR. BUYSSE: Yes, I think so, and I think it does it in ways that might be more difficult to achieve when you're approaching this from tax exemption. I think, you know, the CON process is better situated for those sorts of things, and there actually are models in Illinois that are very interesting, and, you know, I think can be brought into play as the task force looks for solutions and proposals.

CO-CHAIR DUGAN: I think Representative Lang would like to just make a general statement before we break for lunch.

MEMBER LANG: Thank you.

In the last two meetings I've asked for information, and I haven't received it, and maybe staff could help me get it.

Two meetings ago I asked Mr. Newton representing the safety net hospitals for a number of things which I have yet to receive.

At the last meeting, I had some comments regarding fund sweeps and the Health Facilities Planning Board's independence from the governor's

office. I asked for information that would show that the Board has tried to remain independent of the governor and has complained about fund sweeps, et cetera.

I was promised that the Board has done that, but I haven't received the information, such as transcripts of public hearings that it was complained about such activity. So I'm still waiting for all of that information. If staff could help me get it, I would appreciate it.

MR. CARVALHO: Sure. On the first point, with respect to Mr. Newton, we'll talk to the chair of the committee that he is representing.

MEMBER LYNE: I can remember that very well, and I apologize that you don't have it.

MR. CARVALHO: I saw him last Wednesday actually, and I reminded him that that request was pending.

On fund sweeps, we've looked through the transcripts for the last six months. I could swear I remember it being discussed, and Mr. Mark did not remember it being discussed, and we didn't find it in the transcripts.

So I might have had a private conversation with a Board member where they expressed a concern. It was not in a transcript, and that's why we have not given it to you.

MEMBER LANG: So then I go back to the original question that I had; is there any evidence that the Board has tried to remain independent from the governor's office relative to fund sweeps or other issues?

MR. CARVALHO: No, there's no evidence in the sense of a transcript of the Board seeking to complain about a fund sweep.

MEMBER LANG: How about a public statement, some speech some Board member made being really ticked off about it?

MR. CARVALHO: Well, the --

CO-CHAIR GARRETT: Ticked off about?

MEMBER LANG: About fund sweeps or interference or any other such type of -- any kind of public indication by anybody on the Board that they don't like being tinkered with by the governor's office, whether it be with the budget or anything else?

MR. CARVALHO: Okay. Well, we're both

lawyers so you'll know what I mean when I say you're assuming facts not in evidence, which is tinkering by the governor's office in any aspect of the operation --

MEMBER LANG: Well, then, no, we'll just keep it on fund sweeps.

MR. CARVALHO: Okay. On fund sweeps, there is no record of Board members that I have access to or have found that indicates a Board member has publicly complained about fund sweeps, but I do remember that the appropriation is what the Board has access to out of the fund, and the appropriation has always been less than what's in the fund anyway. So the fund sweeps, as such, have not interfered with the operation of the Board because the appropriation has been there.

MEMBER LANG: But I didn't ask you about whether it interfered with the operation of the Board. I asked you if the Board has complained about the fund sweeps, and I guess the simple answer to my question is no.

MR. CARVALHO: Correct.

CO-CHAIR DUGAN: So I just have a question. What we appropriate in the General

Assembly --

MR. CARVALHO: Right.

CO-CHAIR DUGAN: -- to the Board, do they get it all?

MR. CARVALHO: Yes. Well, I mean, I take that back. There's a 2 percent holdback that --

CO-CHAIR DUGAN: Otherwise, the governor hasn't released all the money that we've ever appropriated to that.

MR. CARVALHO: Yeah, now, we -- and this has been part of the public transcript. This entity, like all of public health, like all of state agencies, has to go through a process to get approval, hiring approval, personal services contracts and the like, and that always has taken longer than anybody likes. So in that sense, accessing the appropriations has been harder than it would be without that process.

CO-CHAIR DUGAN: But do you access it all in the fiscal year we said you were supposed to be able to access it?

MR. CARVALHO: As much as any other program.

CO-CHAIR DUGAN: No.

MR. CARVALHO: No, I mean, none of our programs spend right up to the appropriation. At least, I don't think we've ever spent -- this year we're going to be pretty darn close, I think.

MR. MARK: No.

MR. CARVALHO: No. Well, okay, so we haven't spent up to it, but that would be fair to say about all of our programs. I don't know of any --

CO-CHAIR DUGAN: That would be fair to say about everything.

MEMBER BRADY: Has the Board ever had a formal discussion on the fund sweeps?

MR. CARVALHO: Not the fund sweeps, they had a formal discussion about concerns about the delays in hiring. We can get you that transcript.

MEMBER BRADY: So they are never --

MR. CARVALHO: As I said --

MEMBER BRADY: They've ignored the fund sweeps, and they don't feel that it's within their --

MR. CARVALHO: How many -- there's

been one, two fund sweeps?

MR. MARK: I would suggest that over the last three, four years, the fund sweeps have not been the highest priority in terms of the overall organization of the Board. As we have gone through different chairs and different lack of board members and so forth, I think in terms of organization, there were much more pressing issues that the Board was involved with.

MR. CARVALHO: You will have board members --

CO-CHAIR DUGAN: Yes.

MR. CARVALHO: There will be Board members here, and you could certainly ask them how they feel about it.

CO-CHAIR GARRETT: The way I understand it works, too, for the most part you are funded by the fees that you charge for the applications.

MR. MARK: That is correct.

CO-CHAIR GARRETT: So that's your real stream of revenue.

MR. MARK: But as David pointed out, we can only spend what's appropriated.

CO-CHAIR GARRETT: Right.

MR. MARK: Regardless of what we collect.

CO-CHAIR GARRETT: Well, what's appropriated is in a way taken back because you rely upon your revenue stream from the applications?

MR. MARK: Yes.

MR. CARVALHO: For example, if the fund currently has $3 million in it, and this year you appropriated 1.7, it hasn't happened, but if 500,000 was swept, it would reduce the fund from 3 to 2-1/2; but the appropriation was 1.7, so you haven't bumped into -- the fund sweeps haven't caused a problem here.

CO-CHAIR GARRETT: So is it that the appropriation is a backup just in case you don't get the fees that you need to run the operation?

MR. CARVALHO: The appropriation is out of the fund.

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: It is not out of the general --

MEMBER BRADY: Income.

MR. CARVALHO: So, for example, if the fund has $3 million, and you appropriated 1.7 at the end of the year, if we spent it all, there would be 1.3, plus whatever new was brought in, and that would just keep happening. I think that's approximately right, that there's about 3 million in the fund.

MEMBER ROBBINS: That might mean the applicants are being charged fees that are too high, which is what allows for that excess.

MEMBER BRADY: Or it might mean that we're understaffed, if -- and you would both concur that you're understaffed.

MR. MARK: I would state that.

MEMBER ALTHOFF: That's why it takes so long.

MEMBER BRADY: I would like an answer to it eventually, and I don't expect an answer to this.

Last week there was a conviction, and you two were both involved in the process when we -- when this conviction, alleged conviction was handed out.

If you were better funded -- you were

clearly involved in the process, and you were in existence while this happened. If you were better funded, would those monies have helped prevent the illegal behavior? Would you have been able to better police the environment if you had more resources to fund a better staff?

MR. MARK: I'm not going --

MEMBER BRADY: I did not ask necessarily for an answer to that, but I think that is something that has to come out of this. I mean, we cannot ignore as a task force what happened last week, and you have to answer that eventually and tell us, you know, is part of your lack of resources part of the reason that we were not able to police the illegal activities that occurred over this last six years.

I think that at some point in time you should address that for us because if we can't ensure that this Board and its members and its staff operate ethically and legally, there's no question in my mind we should dissolve it.

CO-CHAIR DUGAN: Right. And I just want to say something, and I certainly understand what you're saying, but I also want to say that --

I mean, you could put 100 people watching over somebody, and if somebody is unethical and they're going to do something, I think they're going to do it regardless of how many people you have on staff.

MEMBER BRADY: They may try.

CO-CHAIR DUGAN: Yes.

MEMBER BRADY: They may try. I would blatantly disagree with the fact that if you had a staff of one trying to manage five Board members and keep them clean, it would be a lot harder than if you had a full staff that could observe that.

I mean, at some point -- I'm not asking for an answer to this question today, but I think it's inherent in our problems and the continuation of this Board and the convictions that were handed down last week that part of our responsibility has to be to make sure that we fund an appropriate staffing level that does police to some extent the activities, and you two clearly were there when this went on.

MEMBER SCHAPS: Is that staff's responsibility?

CO-CHAIR DUGAN: No, I don't think it

is.

CO-CHAIR GARRETT: I've been thinking about this, maybe what we should do, in addition to everything else, this is a broader approach, but to make sure that these Board members are vetted, and we could come up with standards and criteria so that we don't have the same Board member that serves on one board serving on another board that's been rotated around and around and around, and that we know a lot more about these Board members, and that the governor, whomever he or she may be, doesn't have the sole ability to appoint, and as the Senate is responsible for doing, anoint the appointment without knowing a lot more. I think we can make a lot of that -- well, we could include something like that.

MEMBER BRADY: On a follow-up to that, I don't think the governor should have all the nominating decisions.

MR. CARVALHO: I'm on the agenda later today, so that will give me an opportunity to respond to Senator Brady's question, and I will respond; but I would like to say one thing now because if I don't, I expect that one or more

members of the audience is going to jump out of their chairs.

CO-CHAIR GARRETT: Okay

MR. CARVALHO: And that is, the conviction last week was for illegality occurring in the time frame August, 2003, to May, 2004, not over the last six years. There was nothing in that conviction --

MEMBER BRADY: That simply falls within the last six years.

MR. CARVALHO: It does, but the implication --

MEMBER BRADY: Your point is well-taken.

MR. CARVALHO: -- was the time frame was 2003 and 2004, and those Board members no longer serve, but I will respond. Jeff just doesn't want to or need to, but I will respond since I'm on the agenda.

MEMBER BRADY: Well, I wasn't expecting you to be prepared to respond today.

CO-CHAIR DUGAN: We want to say if we're going to eat, it's 12:30. So let's stick around close, and we can get started and hopefully

get back on track time-wise.

(Whereupon, a recess was had from 12:22-12:39, after which the hearing was resumed as follows:)

CO-CHAIR GARRETT: Are we all ready? Go ahead.

MS. MULDOON: Okay. First of all, I'd like to thank you for the opportunity to appear before you today. We're here to speak to you on CON issues as they pertain to the dialysis industry. A person requires dialysis treatments when they enter end stage renal disease or complete kidney failure for which there is no cure.

CO-CHAIR GARRETT: Colleen, I think you're going to have to speak up a little bit.

MS. MULDOON: Okay. The only option for survival is a kidney transplant or, for the majority of patients, dialysis treatment.

Dialysis patients typically receive dialysis treatments three times every week in four-hour sessions just to survive. In addition to the time consideration is the fact that they travel 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 in Fresenius are 65 years or older and 23 percent are 75 and older.

Many of them have significant health issues such as chronic uncontrolled diabetes and/or hypertension, the two leading causes of end sage renal disease. African Americans and Hispanics are disproportionately affected by end stage renal disease, in part because African Americans have a higher risk for hypertension and Hispanics have a higher risk for diabetes when compared to the general population.

As some of you know, Fresenius Medical Care is the largest provider of dialysis 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 a for-profit, our strategic plan is to treat all patients regardless of their payor status or their status as an undocumented alien.

71 percent of our patients are Medicare, 13 percent Medicaid, and only 12 percent 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 are sometimes sustaining 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 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 for 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 support of legislation which continues the Health Facilities Planning Act to 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 the dialysis providers.

At this point, I would like to turn it over to Lori to address those changes.

MS. WRIGHT: Again, my name is Lori Wright, and I am a CON specialist for Fresenius Medical Care. What my position is, is to write all the CON applications for our company in Illinois.

First, I'd like to say that at Fresenius, we feel that the current Board is a Board made up of people with high integrity, and we especially appreciate the fact that the current Chair takes as much time as she does in thoroughly researching and knowing every application that comes before her, and we do appreciate that.

One of the biggest obstacles I think the dialysis industry has is that -- that we would like to overcome is the education of dialysis on behalf of the Board and the staff. We'd like to present an offering to the Board and the staff on dialysis.

We so far have been unable to do that because of the ex parte rule. We usually do about six or 10 applications a year, and generally

almost at every meeting, we have a project up before the Board.

However, we would like to do a public presentation of information, which would include other providers such as DaVita, which is another large provider in Illinois, and any other provider who would like to participate.

We feel that the Board is not thoroughly educated on the hurdles of the dialysis patient. We feel that the dialysis patient differs from a patient who would use -- a hospital patient, a surgery patient, because these patients are chronically ill, they have to receive frequent treatments versus a hospital patient who might go once in a lifetime, maybe a few times.

We also feel that there is a misunderstanding of how a dialysis facility operates, and this is specifically in respect to utilization and also how the utilization rules and travel times differ from urban clinics versus rural clinics.

One of the issues of the rural clinics is that they do not operate in the evening hours. Because the patients are generally ill, they're

elderly, they don't want to travel on the long country roads, especially at night if the weather is bad. So a lot of times this isn't taken into consideration that these rural clinics operate differently than the urban clinics.

Secondly, we would also suggest that the Board be made larger and that it also be made up of individuals to cover a wider variety of the different health care providers that are required to seek CON approval, such as people with hospital backgrounds, ESRD background, an ASTC background, so that there would be more of an understanding of the different types of requirements there.

We also feel that the letter of intent requirement prior to the submittal of an application should be abandoned. We feel it just causes delays. It has also caused costly delays when a provider who has a letter of intent and either changes their site or has to change an applicant, add an applicant, then you have to resubmit your letter of intent, and the whole 60-day waiting period starts all over again.

We also suggest that there be dedicated project reviewers for particular application

types, if possible, to promote consistency.

This is of particular concern for Fresenius which sometimes has five or six applications up at one meeting, along with other dialysis providers, and different reviewers just because they're different human beings may interpret something slightly differently, look at a rule differently, have a different opinion; and the result is sometimes certain criteria is looked at differently on different applications, as well this might also help to expedite the general review process.

We also ask that the Board eliminate the application of the financial review criteria for projects which fall under the capital expenditure threshold, and this would include almost all dialysis projects.

We ask that the CON review process be eliminated for changes of ownership of dialysis facilities and subject this only to the exemption process, which would allow approval by the Chair.

Generally when there is an acquisition of a facility, it's because the facility is going under, and another provider will step in and

purchase it to keep it from closing, and any larger acquisitions are subject to FTC rulings.

We also ask that there be -- the Chair be allowed to approve a CON to relocate an existing facility within the same health service area, if it meets all the requirements and the facility is not adding stations and if there is no public opposition to the relocation.

Generally, a relocation occurs for an existing clinic when either a lease expires and you're forced out, and you want to keep your service available to these patients, or sometimes a building becomes in disrepair, and it would not be feasible to keep repairing the building, and we'd look for a more modern facility.

The lengthy CON review process frequently causes significant issues with timing related to leases expiring and entering a new one, and that's costly and also bad for commerce in the areas where we do business.

Another issue is the 30-minute travel time. Dialysis providers all have their applications looked at in regards to a 30-minute travel time from other providers. The Board in the past has

heavily relied on MapQuest for its travel times, although recently through its new rules, they have been allowing a MapQuest adjusted time, which has helped.

We also ask, though, that while we think MapQuest is a handy tool and it's a good starting point and you have to have somewhere to start measuring, we ask that the Board be required by a statutory mandate to consider all travel studies of the -- the independent travel studies, any particulars to a certain area that cause travel problems, and that this be made part of the State Agency report. Currently they do at times look at that and consider it, but they don't have to.

We also ask that the legislation allowing comment on the State Agency report up to two days before the Board meeting be abolished. This legislation, while most likely was passed in good faith, has caused frequent deferrals of applicants, not just Fresenius, but many other providers. It increases costs, wastes time for both the applicants and the Board, and clutters the Board's agenda.

One piece of legislation which we think

should be maintained is the ability to notify the State Agency of direct factual errors in the State Agency report without concern about violating ex parte rules.

We also feel that the ex parte rule should not pertain to the staff. We have found the State Agency staff to be very helpful and very knowledgeable. They develop good working relationships with the people who appear before the Board, whether they are working with providers or consultants, and should not be -- this communication should be encouraged, and this also I think would result in fewer delays and decreased cost to the system on both ends.

If there is concern about undue influence of Board members to disallow any questions that -- I'm sorry.

If this was a concern that there would be undue influence of staff on Board members, one way to overcome this would be to disallow any questions from staff members to applicants at the meeting other than perhaps legal counsel from the IHFPB.

Staff members would continue to be present

as a resource for Board members. We think this would allow for greater Board involvement and dialogue at the meetings with the applicants and would work well if there was a larger Board.

We suggest at least six months notice when staff changes the interpretation of a rule. At times, an application is significantly delayed due to a change in a longstanding interpretation of the rule.

We are not arguing that staff does not have the right to change the interpretation, but just suggesting that ramp-up time should be allowed to promote firm, fair, and consistent application of the rules.

As an example, we did have a project up for change of ownership, and we had previously submitted applications for change of ownership. We didn't have the current owner as an applicant, and they were passed through.

Then we sent in another one, and we were asked to have the current owner be on the application. So we had to start back at the letter of intent process, so it caused a significant delay and financial hardship on the

provider that we were purchasing the facility from.

We ask that a portion of the application fee be directed to public health initiatives. If necessary, we think 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 different subject matters.

Then finally, the newly proposed rules, while we appreciate all the hard work that has gone into proposing the new rules and developing them, and we have even taken part in some of that, we feel they're becoming much more complicated versus more streamlined. We would urge this task force to reemphasize legislation requiring streamlining of the rules.

We just both appreciate the opportunity that we've had here today to speak before you.

CO-CHAIR GARRETT: Thank you, Lori.

Are there questions? Go ahead.

MEMBER SCHAPS: I really appreciate this testimony, it was great, and I think you have a lot of real useful recommendations.

I'm curious about whether you have ever experienced a case where you've had a CON and somebody, a competitor also had one at the same time, and it was a competitor who was not prepared to provide services to Medicaid or uncompensated care.

I'm wondering if somebody else was ever approved for something and you weren't in an area, and maybe that meant that people who couldn't afford services weren't going to get them.

MS. MULDOON: I couldn't answer that. I mean --

MS. WRIGHT: I don't recall that --

MS. MULDOON: No.

MS. WRIGHT: -- that particular style, no.

MEMBER LYNE: Were you ever denied?

MS. MULDOON: Yes.

MS. WRIGHT: Yes, we have been.

MEMBER GAYNOR: Maybe because of Mapquest?

MS. MULDOON: Yes.

MEMBER SCHAPS: Has it been because there's another facility in the region?

MS. WRIGHT: Within 30 minutes of underutilized according to MapQuest.

MEMBER BRADY: What was the practical time?

MS. WRIGHT: Pardon?

MEMBER BRADY: What was the practical time, real time versus MapQuest?

MS. WRIGHT: Well, sometimes we have actually gone out and driven it ourselves just to see. A lot of times MapQuest sometimes will say 20 minutes, 25 minutes, and then you go drive, and it could be 40. It could be much more. It depends on the time of day.

We've also seen MapQuest change. We had one particular application in, we went before the Board several times, and it changed. It started out being like 31 minutes, and then it was 25 minutes, and by the time we had the final hearing on it, it was 22 minutes. So it seems at times to be unreliable, although, you know, we understand you have to have something to start with.

MS. MULDOON: And it also depends on the time of day you're traveling. Our patients travel all times, all different times, so MapQuest

gives you one time.

MEMBER LYNE: It sounds like you're in some rural areas anyway; right?

MS. WRIGHT: Yeah.

MEMBER LYNE: Is there any competition really? Are there others trying to get in where you are to provide this service?

MS. WRIGHT: The competition in the rural -- there's not that much competition in the rural areas because it's so spread out.

MEMBER LYNE: Right, I would think not.

MS. WRIGHT: But like I said, the rural clinics generally operate with two shifts of patients a day. What, the time is like from --

MS. MULDOON: They usually start earlier in the morning and close by 5:00, and there are usually not as many patients in that area, so that's another reason for the two shifts and the distance. They might travel much further than an innercity patient would travel just because, you know, you can't set a dialysis unit that close to each other in a rural area. You just don't have the patients.

MEMBER GAYNOR: Is the current standard that it's within a half an hour of another facility? Is that what the standard is?

MS. MULDOON: And that the clinic is 80 percent.

MR. MARK: Yeah. What the Board's rules consistently look at is travel time as a measure of physical access, but then they also look at other facilities within that travel time to see if they are at an appropriate utilization level.

MEMBER GAYNOR: Does staff agree that perhaps MapQuest isn't the best way to --

MR. CARVALHO: Following up on Jeff's point, you can see that the implication of this ring of distance is two-fold. It's not only are the patients having to travel more than 30 minutes to get there, it's how many competitors are going to get counted for purposes of figuring out if there's enough -- if there's not enough facilities in the area.

So it would be in the interest of the applicants that we have a smaller circle to look at because then there's fewer competitors. It's

not just a question of whether a patient is going to have to drive 29 minutes or 31 minutes -- 29 versus 31.

Part of the issue of MapQuest is an average over the day, and then traffic studies are oftentimes at peak periods, and so we don't -- Jeff can probably elaborate more, but we don't -- this was all the subject of a rule-making just --

MR. MARK: A few months ago.

MR. CARVALHO: Yeah. All of our rule-makings have been with public comment, and actually there is no inhibition on people giving testimony at our hearings about rules by virtue of pending applications. They just aren't supposed to talk about the pending application.

So this has been looked at. You've got to draw a line someplace, and we've been using MapQuest because it's there.

Now, one of the things that we did in the rules was we applied an adjustment factor to MapQuest.

Jeff, do you want to explain that?

MR. MARK: Yeah. As Ms. Wright mentioned, we have recently adopted new rules to

take care of an issue that Fresenius and others have raised as an issue.

For many years, in the Board's rules we had this term "normal travel time," but it was never defined. So inevitably many of our application processes began this long argument, what's, quote, normal travel time. We have attempted to define that so it's consistent among all applications.

What we came up with after extensive staff meetings is using MapQuest because it's readily available. We researched through MapQuest their methodology, and we make three adjustments: one based on the City of Chicago, and I believe it's --

MS. KHANNA: 1.25.

MR. MARK: -- 1.25 times MapQuest for the City of Chicago, 1.15 times MapQuest for the Chicago metropolitan area and other large counties in the state, including Sangamon. I believe it's --

MS. MULDOON: Champaign.

MR. MARK: -- the Elgin area, Champaign, and others; and then for rural areas, we use MapQuest as MapQuest.

In addition to that, in the rule-making, we provide that applicants, and I think Fresenius does this quite frequently, can do their own independent travel studies. We did have some parameters on there such that they would be professionally qualified travel studies. That's how we came up with this new rule.

CO-CHAIR DUGAN: Did you take into account the fact that there might not be any transportation in this particular rural area?

MR. MARK: Well, what happens, Representative, oftentimes in the discussion of a given application, and I note Fresenius has done that, is point out that they may have an inordinate number of patients who use public transportation in some of your city facilities, or in the case of some rural areas, that transportation is very difficult.

That's not in the rules per se, but that's often a qualifier in the discussion of the application.

CO-CHAIR GARRETT: Go ahead.

MEMBER ROBBINS: Roughly how many dialysis units are there that are governed by the

Planning Board?

MS. WRIGHT: 150.

MR. MARK: That's about right, yeah.

MEMBER ROBBINS: And you've got 95.

MR. MARK: If I recall, between Fresenius and DaVita, the two largest providers, it's about 70 percent of all facilities in the State of Illinois.

MEMBER BRADY: Back to the MapQuest thing, how do they weight it? Do you guys run an average peak?

MR. MARK: The way MapQuest --

MEMBER BRADY: Travel time.

MR. MARK: The way MapQuest was explained to us is it's a free flow. That's what we use.

MEMBER BRADY: My point being is, when you look at this criteria, at the worst time of the day, it might take three times as long as the best. Do you care more about the worst time?

MR. MARK: The way it's defined in the rule is, it's representative of normal travel time, whatever that is.

MEMBER BRADY: I guess, why did you

come up with that rule because it would seem to me if someone needs to get to an emergency room -

MR. CARVALHO: This is only applying to ESRDs.

That's actually an important point to make. We're not talking about heart attacks in emergency rooms. We're talking about ESRDs.

The implication of the 30-minute is two things. One, how big a circle to draw to see how many stations there are in the region; and then two, for the patient's convenience 30 minutes seems like a reasonable time.

Now, the reality is, if on a bad day it takes 45, it means that -- you know, just like if you're going shopping, it's less convenient.

MEMBER BRADY: What about the emergency services?

MR. MARK: And the presumption also is that MapQuest is not representational of emergency vehicles, that if it takes a normal car driving stop lights, et cetera --

MEMBER BRADY: You're still not understanding what I'm saying.

My question is, we've heard complaints that

your version of MapQuest doesn't meet the needs of an emergency during peak times.

MR. MARK: We presume, and we cannot -- we have not been able to create rules for every situation and every geographic area, but we do presume that under emergency circumstances, an ambulance would travel faster than the normal travel time.

CO-CHAIR GARRETT: Do you need an emergency car or ambulance to take somebody to kidney dialysis? Oh, you don't.

MR. MARK: No.

CO-CHAIR GARRETT: My question is sort of along with what Senator Brady is saying, when you come up with your radius or framework of miles from one hospital to another as far as the CON process, it's based on miles?

MR. MARK: It's based on time.

CO-CHAIR GARRETT: It's always based on time? I thought it was based --

MR. MARK: Well, we have had two factors, and it depends on our category of service. For most hospital categories of service, what we have are defined geographic areas as one

parameter. These are physical boundaries in which we can measure the number of patients, the utilization of services, et cetera.

In addition to that --

CO-CHAIR GARRETT: And so that's miles? Does that equate to miles?

MEMBER BRADY: It's an area.

MR. MARK: That would reflect miles.

CO-CHAIR GARRETT: Okay.

MR. MARK: It's a geographic region with boundaries.

MR. CARVALHO: There's Planning Area A --

CO-CHAIR GARRETT: I got it. I know.

MR. CARVALHO: -- and Planning Area B.

MR. MARK: For example, the City of Chicago is broken into three geographic areas.

CO-CHAIR GARRETT: Right.

MR. MARK: Then in addition to that -- in addition to that, we would take the location of the proposed service and apply a travel time radius to it because a facility or a proposed facility may be on the edge of a geographic area, and therefore, we would also measure a

geographic -- I'm sorry, a travel time parameter.

MEMBER BRADY: Just as you've established variations for this, what are your -- you say you can't make a rule for every circumstance, but have you established variations for that?

MR. MARK: Well, the variation is where, at least right now, Senator, the presumption is the variation where the proposed facility is.

MR. CARVALHO: Jeff, I think what he's --

MEMBER BRADY: Just as you have the congested area with a variation of 1.5 versus a noncongested area of 1, what are your variations on rules for this?

CO-CHAIR GARRETT: For kidney dialysis.

MR. MARK: It applies the same rule, and travel time applies the same rules.

CO-CHAIR GARRETT: So is it MapQuest only that applies to -- I'm confused. I'm going to set up -- I'm coming to you for -- I have a certificate of need application for a kidney

dialysis center.

So I'm out of the box if I am less than 30 minutes from the closest current kidney dialysis; but if I'm 32 minutes, I make the cut?

MR. MARK: No, that's not right.

CO-CHAIR GARRETT: Just from the time?

MR. MARK: The time -- there are two things that are looked at. One is there is a geographic planning area under which we have a formula that does a projection on the number of needed stations based on population, based on incidents of disease.

There is a second kind of test, if you will, that looks at the proposed location of this facility and how many other providers or how many other stations are within a travel time radius, and we look at the utilization of those stations in order to determine, is there sufficient capacity now or is more capacity needed?

MR. CARVALHO: So there could be competitors. It's just how -- are they operating at 80 percent? So you look within the circle, and if the competitors are operating at 80 percent, then they don't -- is it 80?

MR. MARK: For dialysis, it's 80.

MR. CARVALHO: They don't count against you.

CO-CHAIR GARRETT: Can we ask Lori or Colleen why you feel that this requirement should be eliminated or adjusted?

MS. WRIGHT: Well, I guess the main thing is the dialysis patient is different. These are chronically ill patients. They have many co-morbid conditions. They're very ill, and this is almost like a job for them.

They have to go three days a week. They have to be there for four hours on the machine. There's set-up time, take-off time, their transportation time back and forth. This is a lot of time. This could be six, seven, eight hours a day for three days a week.

There is no Medicare --

CO-CHAIR GARRETT: Okay. So what does that have to do with the amount of minutes it takes to get there, if it is 35, 40?

MS. WRIGHT: Like even 30 minutes for a dialysis patient would be difficult. I don't know if any of you have family members or friends

on dialysis, but there is no -- Medicare won't pay for transportation. There's very limited Medicaid paid-for transportation. A lot of the providers won't cross a county line or a township line. So they end up having to rely on family members if they're not able to drive themselves.

MEMBER ALTHOFF: I apologize for interrupting, but that can be one criteria of several factors that they look at. So what you're saying is in and of itself you think it should be reduced. You're saying that that 30 minutes should be less; is that what I'm hearing from you?

MEMBER BRADY: It seems to me real time ought to be a factor as opposed to the time --

MS. WRIGHT: Exactly

MS. MULDOON: Yeah.

MS. WRIGHT: MapQuest is the faster time possible. When you do a Mapquest, it will say at the bottom, this is the fastest time.

The fastest patient isn't going to drive the fastest time on the interstate zooming to get there, and then it doesn't take in the reality of, you know --

MEMBER ALTHOFF: So there are adjustments that they've made, though.

MS. WRIGHT: A couple.

MEMBER ALTHOFF: Because they've made them, they're helping but they're not nearly as far as you think it should go.

MS. WRIGHT: Yes.

MS. MULDOON: And sometimes using the independent studies that we've presented, you know, where they're doing it at different times of the day.

MEMBER ALTHOFF: Traffic studies, things from IDOT or from --

MS. MULDOON: Or we hire someone to drive it, actually drive it throughout the whole day, you know, on multiple days and get an idea of what the actual drive time is, and then it gives you the busiest time.

MEMBER ALTHOFF: But they allow that.

MS. MULDOON: Sometimes.

MR. MARK: We have allowed it in the rules, and there are parameters.

MS. WRIGHT: It's allowable, but they don't have to. I mean, it can or cannot be taken

into consideration.

MEMBER BRADY: Aren't there areas -- when I asked about the standard, I don't think you've completely answered my question. You say there are emergency room standards.

Do you have variations like you do for this?

MR. MARK: We do not specifically look at emergencies. Those are not under our purview.

MEMBER BRADY: But for emergency services.

MR. MARK: We don't.

CO-CHAIR GARRETT: Or these things that are freestanding emergency centers.

MR. MARK: Freestanding -- we just said, we're in the process of adopting rules for freestanding emergency centers.

MEMBER BRADY: What if some of these hospitals were denied, and they were needed because you can't get to a hospital -- the right size population, or you can't get to a hospital because of the congestion in a quick enough time, have you established a rule that varies from MapQuest of the quickest possible time?

MR. MARK: Well, Senator, we do not

currently have any specific rules for emergency transport time frames.

MEMBER ALTHOFF: What about just hospitals, Jeffrey?

MR. MARK: Well, what we do have is for medical/surgical services, we have a time frame. For obstetrical services, there is a time frame. For open heart surgery, there is a different time frame. That's all the rules --

MEMBER BRADY: And they're all variations from MapQuest?

MR. MARK: They are all set up -- the normal travel time is defined as applicable to all situations. The number 30 minutes versus 45 minutes differs by service. So that's how it's structured.

MR. CARVALHO: The question is, can we do the adjustment like we just described?

MR. MARK: The adjustment is done uniformly for every situation.

MEMBER BRADY: The bar for some services, is it the worst time versus the average time, or you used average time for everything?

MR. MARK: The reason we selected

MapQuest is it's a universal number that everyone can access, and we took that -- by their definition, it's a free flow time adjusted by time. That's how they explained it to us.

So if the posted speed limit is 30 miles an hour, that's how MapQuest --

MEMBER BRADY: I know how MapQuest works. What I'm trying to ask you is, do you take into consideration that someone may have an immediate need for a service, and that service at 4:00 o'clock in the afternoon may take more time to get to and base it on the most difficult time to get there?

MR. MARK: We do not take a worst-case scenario. What we did do is these adjustments to reflect congestion in different parts of the state.

MEMBER LYNE: May I? Oh, go ahead.

CO-CHAIR GARRETT: Yes.

MEMBER RUDDICK: I wanted to -- if we can leave MapQuest aside for a minute.

CO-CHAIR GARRETT: Please.

MEMBER RUDDICK: There were two other subjects I wanted to ask about.

One is you mentioned in here you treat all patients regardless of payor status, and then you go into Medicare, Medicaid, and commercial insurance. Do you have a policy regarding charity or uncompensated care for people who have no coverage, be it insurance or Medicaid? How do those people get dialysis care?

MS. MULDOON: We accept every patient that comes in the door; and then, you know, we're chronic so we apply for Medicaid, whatever it may be. If they come in with commercial, that's great; but if they come in with no insurance, we would then apply for Medicaid.

MEMBER RUDDICK: So you would accept people --

MS. MULDOON: Absolutely.

MEMBER RUDDICK: And you would continue -- let's say, you help them apply for Medicaid, but they are turned down. You would continue to give them care regardless?

MS. MULDOON: Yes.

MR. CARVALHO: Actually, I was going to ask you a specific. You need to explain because I think most people don't understand

reimbursement in your area. It's very different than hospitals. Medicare is not just old people. Almost everybody can qualify for Medicare.

MS. MULDOON: Almost everybody, 71 percent of our patients.

MR. CARVALHO: Unless you're an undocumented alien.

MS. MULDOON: Or you haven't worked in a certain period of time, and you haven't applied.

MR. CARVALHO: If you're not in the Medicare system. If you're not in Social Security you mean?

MS. MULDOON: Yes. Yes.

MR. CARVALHO: If you haven't paid Social Security tax.

MS. MULDOON: Exactly

MR. CARVALHO: So like tomorrow if I needed to get ESRD and I wasn't covered under the state plan, I could apply to Medicare and be covered. There's not this vast pool of uninsured people to start off with.

MEMBER RUDDICK: That's helpful.

Another question that I was just curious, I think it was really something Jeff said, 70

percent of the clinics are in two companies?

MR. MARK: More than that.

MEMBER RUDDICK: More than 70. I mean, that's a pretty high level of concentration for any kind of business in this sector. I'm just curious what the reasonings are of how the industry has gotten so concentrated.

MS. MULDOON: Well, we're concentrated -- well, a lot of our units are in the city. A lot of people don't want open units in the city because you are going to get mostly Medicaid patients, and it's very, very difficult to operate a facility with all Medicaid patients. It's not profitable at all.

Because we're spread out through the whole State of Illinois, plus we're very, very large, we're in many, many, many cities and many states across, and, you know, we can provide the care to those patients because we make it up on the other end. We would never be able to survive if we were just a small company.

I think we have acquired a lot of those companies who just aren't profitable at all because it's just -- it's very difficult. I know

Medicare pays, you know, 80 percent of the treatment, but when we look at our costs to operate, if we only counted on Medicare, we would be at break even.

So in many cases, you know, we don't see a whole lot. So our innercity units aren't as profitable obviously as our cities in the western suburbs, but we have many more in the city than we do in the western suburbs because that's where the dialysis patients are, and that's where the greatest number are.

CO-CHAIR DUGAN: Is that where you are, mostly in the city and western suburbs?

MS. MULDOON: Yes, in Illinois. We have some rural. There's -- we have rural. We have some in southern Illinois and downstate, we have some facilities, but most of our facilities are located here in the Chicagoland area.

MEMBER LYNE: I would just like to commend you for what you do. It's a very difficult, I think programming that you have, and I certainly agree, we have to have the numbers to make it, so I thank you for doing that.

When I look at the bullet points, I know we

spent a lot of time on MapQuest, but MapQuest is about the sixth bullet here.

The first bullet I think it's -- I didn't read it word for word here, but it sounds like if you could have a moment before the Board to talk about --

MS. MULDOON: And educate.

MEMBER LYNE: Yes.

MS. MULDOON: Yes.

MEMBER LYNE: An education session, and you'll even invite your competition, if indeed you see DaVita as your competition, because it is like people don't understand, and the complexity of it I somewhat appreciate certainly.

But I also would like to say in some support of you, Jeff, they don't do emergencies. That's a fire ambulance, and they're the ones that worry about timing and whether a hospital or a service is close enough. They would be making recommendations if they thought -- like when a hospital closes, you know, people will kind of argue with the fire department or try to get them to support the institution not closing by saying, oh, you know, if that closes, it will take too

long to get the patients service.

So you do have to do some of that whether it's MapQuest -- in the old days, you know, before MapQuest, we all got our own traffic engineers or something to go out there and get the right number, right, to do that.

MEMBER SCHAPS: What's the barrier to doing the education?

MS. MULDOON: The barrier?

MR. CARVALHO: Ex parte means it's outside of the room. If you're in the room, it's not ex parte. I don't think there is --

MEMBER GAYNOR: Is it a matter of practically getting on the agenda?

MS. MULDOON: Yes.

MEMBER LYNE: I would like to say -- if I might say about that, though, I do think you all have to admit, the behavior has changed over the course of the last however many months when there has been some difficulties.

You know, I feel like I have -- if I want to ask a question, think about it for a while, that sort of thing, I understand Why that is, but it is, and, you know, that has to get back to a

normal ability.

MR. MARK: If I may just -- and I appreciate your testimony, and I appreciate your comments; but for the benefit of the task force, I want to point out two things that were mentioned, and I think these have been mentioned previously and will be subsequent to today's meeting.

Ex parte communication and the staff -- anybody can always ask the staff for technical assistance. Staff has always been available to meet with any applicant or any potential applicant and discuss the applicable rules and the process of the Board.

What the staff will not engage in is a conversation on the substance and the merit of an application; but any time, the staff will engage with anybody in technical assistance, and we tried to take this straight from language in the Act, that we will not engage in conversation on the substance of an application.

CO-CHAIR DUGAN: Right, but I think what they're saying is -- and, of course, you tell us that every time we meet. I think they're saying that they want to, in front of the Board --

education of the Board.

MR. MARK: Oh, I'm sorry, that's a different bullet point.

MEMBER GAYNOR: Is there no mechanism for them to get in front of the Board?

CO-CHAIR DUGAN: For them to do that?

MR. MARK: What the Board has been doing, when the Board can over the past few months, when the Board has had a slow time in a meeting, we have scheduled kind of an in-service presentation.

Our first one, I believe was --

MR. CARVALHO: Rural hospitals.

MR. MARK: -- rural hospitals. We had the head of the Rural Hospital Association come in and talk about critical access hospitals.

Most recently, we had the head of the ASTC association come in and talk about the ASTC industry.

We have been planning on setting one up to discuss ESRDs. I will say that the Board has been hesitant to have someone speak who has applications on that agenda, again, from the appearance of perhaps a conflict of interest.

MS. MULDOON: But it would be open to all providers.

MEMBER GAYNOR: They said at any given time, they have six to 10 applications.

MR. MARK: That's true. That's true. So we've been approaching -- we have approached the Illinois Chapter of the American Kidney Foundation to do a presentation on the ESRDs, renal disease, and dialysis.

MEMBER GAYNOR: Just another question because I know you have given this information, and I apologize that I haven't memorized it yet.

The amount of revenue generated from the fee applications per year is how much again?

MR. CARVALHO: Well, It's varied a lot. We've got a charge --

MEMBER GAYNOR: On average.

MR. MARK: It's 2, I think $2 to $2-1/2 million over the past few years, roughly.

MEMBER GAYNOR: And then that relative to your budget every year?

MR. CARVALHO: Well, the approp has been 1.7 the last couple years.

This most recent budget, which I understand

isn't quite chilled in stone yet, was 2.2.

MEMBER GAYNOR: That is appropriated out of the application fund?

MR. CARVALHO: Out of that fund, yes. That's entirely out of the special fund.

CO-CHAIR DUGAN: I have another question just quickly on this same question.

MR. CARVALHO: Yes.

CO-CHAIR DUGAN: Do you have an average of how many applications we have a year that keeps up with this 2.2, just an average?

MR. MARK: Roughly 100.

CO-CHAIR DUGAN: Okay. Thanks. Senator.

MEMBER BRADY: On this issue, do we have any pure state studies on appropriation? In other words, states that have a CON process, a comparison of what we spend on this process versus what they do?

MR. MARK: I'm not aware of any.

CO-CHAIR GARRETT: We've got one in our office, Senator, and Illinois is one of the highest.

MEMBER BRADY: In spending?

CO-CHAIR GARRETT: In the application fee.

MEMBER BRADY: No. What I'm trying to say is if you compare us to another state that does the same thing, is our budget appropriate in terms of the number of applications, forget the fee for a minute, but are we appropriating the right amount of money in terms of a peer group in balance to what we're supposed to be?

MR. MARK: We have not done that study.

MEMBER BRADY: Could we?

MR. MARK: We could.

MR. CARVALHO: What's that association?

MR. MARK: The American Health Planning Association.

MR. CARVALHO: Yeah.

MEMBER BRADY: Would you do that for us?

MR. MARK: Sure.

MEMBER BRADY: Let me ask you this. Are you a publicly traded company?

MS. MULDOON: Yes.

MEMBER BRADY: Do you know what your average return on equity is?

MS. MULDOON: No, I couldn't tell you that.

MEMBER BRADY: Here's what I'd like to know in a comparison with these guys. Obviously, when you build a facility, you go in and do a demographic study, and you know that it takes, for example, a 100,000 population to adequately afford to build and get your return.

MS. MULDOON: Uh-huh.

MEMBER BRADY: You also then say we need to meet X percent of capacity in that demographic area and group. So, you know, you're going to do a study and you're going to say, okay, we know that given the demographics of this age group and so forth, we have to come in, and we need this kind of population and this age group, and then hopefully, that will give us 80 percent of capacity, which makes us meet our profitability standards for our company.

MS. MULDOON: That's not usually the way we look at it, I mean, as far as when we build a dialysis unit in the city. I mean, it's usually

a physician comes to us. They have a need. They have patients in the area. There's a need for dialysis in the area.

As long as we have enough patients, we don't necessarily look at what the payor mix is there. I mean, we --

MEMBER BRADY: You've still got to have some sort of study that says you have enough population to make this investment worthwhile.

MS. MULDOON: Yes, and, you know, sometimes we see that it doesn't.

MEMBER BRADY: I understand that.

MS. MULDOON: And we will still build it.

MEMBER BRADY: I guess what I would like to know is, how does your model for profitability and a reasonable level of profit compare with our model for absorption?

Jeffrey, have we done the same studies?

MR. MARK: No, we have not.

MEMBER BRADY: So how can we know if an investment is prudent if we haven't done demographic studies on -- you know, this is a pretty scientific thing. You know that you've got

great percentages here, 46 percent, 23 percent.

You can go in and get census data and say here's the population we've got here. We know we've got to be at 80 percent capacity to be profitable, which means this is the size we can serve. I mean, I just don't know how we're making these decisions without that kind of study.

MR. MARK: Senator, what we do in our rules, and I assume Fresenius uses similar logic, we look at -- for dialysis in particular, we look at the incidents of renal failure and renal disease, and then the utilization based on that of dialysis facilities. So it's a utilization-based model, not based on population.

MEMBER BRADY: We're trying to make health care decisions for not just the time in the present, but time in the future, and scientifically, we know that X percent of people in this age group are going to need this service. I know from business we look at those demographics. I can't believe we're just looking at history versus --

MR. MARK: No, no, we're not. We're projecting the population out based on the

historical incidence of disease. We apply that to a projected population.

MEMBER BRADY: Based on age?

MR. MARK: Based on age -- age, sex and actually various age groups.

MEMBER BRADY: And we communicate that with the applicant?

MR. MARK: It's all published information on our Website.

MEMBER BRADY: I guess I'd like your company to tell us how legitimate you think to make a prudent investment what the Board says is.

MS. MULDOON: I can provide that to you.

CO-CHAIR GARRETT: Let me just ask a couple questions if you guys don't mind.

You said that you furnish X number of applications, it seems like quite a few applications each year. How much do you spend on just applying for all of these different services generally on an annual basis?

MS. WRIGHT: Legal fees or the work fees or both?

CO-CHAIR GARRETT: Both.

MEMBER LYNE: Both.

CO-CHAIR GARRETT: I guess separate it out, application fees, and by legal fees, do you mean having -- do you have an --

MS. WRIGHT: We have an attorney who represents us at the meetings.

CO-CHAIR GARRETT: And how did you find this attorney?

The reason I've been asking this along is because there is like a cottage industry for certain attorneys, I think, to -- I mean, it shouldn't have to be that you have to hire people above and beyond and then also pay this very high application fee.

MS. WRIGHT: I think a lot of the rules are very complicated, and I think for us, when I started doing it, I didn't know anything about CON. So we turned to an attorney to get educated on how to put the application together.

CO-CHAIR GARRETT: But an attorney who has been through it. You had to look for somebody.

MS. WRIGHT: Right. I'm not sure. One of our southern Illinois clinics had used our

attorney before, and I don't know where they --
MS. MULDOON: We've actually been through a couple of attorneys truthfully.
CO-CHAIR GARRETT: Okay.
MS. MULDOON: And it's really just -- and the attorney we're with right now we've been working with for a while, and she really knows us, as Fresenius, knows the rules, and it just has worked really well.
Lori actually works for our company, but she has been quite expertise in the CON process, and she probably does about 85 to 90 percent of the work for this that we used to have attorneys doing.
CO-CHAIR GARRETT: So separate it out, how much do you --
MS. WRIGHT: Our application fees range anywhere from about $4- to $8,000 per project, depending on --
CO-CHAIR GARRETT: On an annual basis --
MEMBER LYNE: And you said you have six a year or what?
MS. WRIGHT: Closer to 10.

CO-CHAIR GARRETT: So you spend $50,000 a year.

MS. MULDOON: It's just that it might go -- we might have to go to many hearings for the same fees.

CO-CHAIR GARRETT: I'm just trying to get an idea of what it's like.

MS. WRIGHT: Yeah, Maybe 50,000 a year.

CO-CHAIR GARRETT: Maybe 50,000 for the application fees.

MS. WRIGHT: For the application fee, and then our attorney fees per application range from maybe $7- to $25- to $30,000 per application, depending on if a public hearing is called and how many times we have to go back and appear before the Board before we get approval or final denial.

CO-CHAIR GARRETT: So if you combine those together, it's maybe 450,000, 300,000 a year about?

MS. WRIGHT: Yeah, around 3, 350.

MEMBER LYNE: By now don't you have a template?

MS. WRIGHT: Yeah.

MEMBER GAYNOR: What are your gross revenues a year, your Gross revenues a year in Illinois, do you know?

MS. MULDOON: I couldn't give you exactly, but I can get it.

MEMBER GAYNOR: Ballpark.

MR. MARK: What's the gross revenue for Fresenius?

MS. MULDOON: Again, I can get that information to you. I just can't give it to you right now.

MEMBER GAYNOR: And then the other thing I would be interested in is the aggregate amount of uncompensated care provided by Fresenius annually as well. If their net revenues are a ton, then it seems that relative to what it costs to apply, retain their experts, attorneys, or whatever, it may be in line with how big of an operation this is.

MS. MULDOON: It's fully integrated. You know, we do the -- we make our own machines. You know, we have our own lab. There's a lot of things we can do to bring down the costs, and that's what makes, you know, us profitable.

MEMBER GAYNOR: You're more efficient.
MS. MULDOON: Absolutely, absolutely, than some others would, like a single provider trying to open this. An independent trying to open a dialysis unit would be very, very difficult.
MEMBER ROBBINS: For uncompensated care, do you want bad debt to be folded into that?
MEMBER GAYNOR: It depends.
MEMBER SCHAPS: You're nationwide?
MS. MULDOON: Yes.
MEMBER SCHAPS: How many do you have?
MS. MULDOON: About 1,500.
MEMBER SCHAPS: In the country?
MR. MARK: You are, in fact, international. They're an international.
MS. MULDOON: Yes, yes, we're German based.
MEMBER ALTHOFF: Oh, the poor stenographer can't --
CO-CHAIR GARRETT: The other question I had is that you said that you would prefer not to get the -- to have to prepare the letter of intent, and I'm just wondering why.

MS. WRIGHT: We see it as delaying some of the applications. There's times, too, like if you add an applicant to the project after you have submitted your letter of intent, you have to submit a new letter of intent and start the 60-day waiting period all over again, which pushes the project that much further out. It costs more money. Sometimes we have to secure -- we have to secure leases on properties, and then we tell them to go back to the landlord and see if --

MS. MULDOON: We have lost leases because of the delays.

CO-CHAIR GARRETT: Is there a cost for applying for the letter of intent?

MS. WRIGHT: No.

CO-CHAIR GARRETT: And then when you say that each of your applications is around 8,000 or 9,000, what kind of things do you apply for? Obviously, you're not applying for -- well, what are you applying for?

MS. WRIGHT: Oh, a brand new clinic.

CO-CHAIR GARRETT: Well, then let me ask you this, when a hospital applies for a brand new, you know, like an addition, their costs,

their application costs are much, much higher. So I'm wondering if that's weighted, or how does that work?

MR. CARVALHO: It's based on the cost of the project. So hospitals, if you're building a billion dollar new children's hospital, it's a sliding fee scale that's capped at 100,000.

Their projects are much smaller, so their fees are in the 4- to 8,000, but it's a sliding scale based on the size of the project.

On the letter of intent, you know, we don't love the letters of intent either. We need to remind everybody where it came from.

We used to have a law that said we couldn't talk to people about pending applications. We interpreted that to mean, you file your application, it's now pending, you can talk to us about technical assistance, but you can't talk to us about the substance, and you can't talk to Board members.

You changed that law to say impending or pending. So we had to give meaning to what does impending mean; and so what we did was we said, okay, give us a 30-day notice that you're about to

file, and we'll treat that 30-day window as the impending period.

So we created the letter of intent to give meaning to the change in the law that said impending as well as pending. Otherwise, what does impending mean? I mean, the CEO is sitting at his desk thinking maybe I want to expand, is it now impending because he's thinking about it?

CO-CHAIR DUGAN: Our intention was good, wasn't it?

MR. CARVALHO: Your intention was good, and we interpreted it as, okay, we'll create that 30-day window. It has now created the situation they talked about.

Frankly, if you got rid of impending, I think we'd get rid of the letter of intent. Impending came out of the House.

MEMBER LYNE: Impending and pending pretty much mean the same thing, don't they?

MR. CARVALHO: Well, they did until they changed the statute, and then --

CO-CHAIR DUGAN: Until we changed it.

CO-CHAIR GARRETT: Is your business, is it a nationwide kidney dialysis?

MS. MULDOON: (Indicating.)
CO-CHAIR GARRETT: So you're everywhere.
MS. MULDOON: Everywhere, yes.
CO-CHAIR GARRETT: And your competition is the same?
MS. MULDOON: Yes, yes, DaVita is almost as large as we are. We are the largest dialysis company in the United States.
CO-CHAIR GARRETT: In order to be in the dialysis business, it seems as if you have to be, you said, manufacturing your own equipment and all of that.
MS. MULDOON: It helps.
CO-CHAIR GARRETT: It's not like somebody can just set up shop and start?
MS. MULDOON: They do. They do.
MEMBER LYNE: There are some physician groups that I know of --
MS. MULDOON: Yeah, yeah.
MEMBER LYNE: -- have their own --
MS. MULDOON: Yeah, if it's large enough.
CO-CHAIR DUGAN: I have a Provena one

in my district.

MS. MULDOON: Well, DaVita is the same as we are.

CO-CHAIR DUGAN: No, Provena.

MS. MULDOON: Oh, Provena, yes. They do. I mean, there are physician groups --

CO-CHAIR GARRETT: And you're for-profit?

MS. MULDOON: Yes.

CO-CHAIR GARRETT: Okay.

MR. DeWEESE: I had a couple of questions here in Springfield.

CO-CHAIR DUGAN: Yeah, go ahead.

MR. CARVALHO: Just let me finish the one, which was, historically, this has always been referred, I've haven't looked at it recently, as a very profitable business. Is that no longer the case?

MEMBER LYNE: Only that way. Only their way. Truly, don't you think? I mean, it's tough.

MS. MULDOON: It is. I mean, we don't --

MR. CARVALHO: I thought Medicare --

for example, again, back in the day, I heard Medicare was very good at reimbursement. Is that not true?

MS. MULDOON: No, we haven't seen an increase in Medicare for 20 years.

MR. CARVALHO: So it used to be, but it's not now.

MS. MULDOON: No.

CO-CHAIR DUGAN: Let's go to Springfield because we're running a little bit behind schedule here if we want to get out of here by 2:00.

MR. DeWEESE: Just a couple of questions, going back to the distance requirement, is the assumption there that this is a freedom of choice environment, or is the assumption that if it's 30 minutes away, that that's exactly where the patient has to go or can go?

I mean, what is the distance relevancy if the physician has referred the client to a different facility? I mean, isn't your service based upon a physician referral to that service?

MS. MULDOON: It can be. That's why -- no, that's why it's difficult sometimes. I

mean, because the physicians have to see those patients multiple times throughout the month, so they like to have the patients at the same facility, but it is the patient's choice to go wherever they want to.

The physician may refer to a certain facility, but it's the patient's choice what facility they go to. Some will choose the closest to their home. Some will choose to be closer to their physician. It is a patient option.

MR. DeWEESE: So the distance is really sort of an opportunity for them to be closer, but it doesn't necessarily mean like a hospital to an emergency facility. It doesn't necessarily mean that that is really going to be the most proximate that they will actually use. It's just a matter of the patient's choice or the physician's relationship to that facility.

MS. WRIGHT: I would say that the majority of the patients, and especially when the patients come to us and want a new clinic somewhere, it generally relates to travel time. They want one closer to home, and they're sick and elderly, and they don't want to have to rely on

other people to take them back and forth to treatment. You know, 30 minutes -- a 30-minute trip is an hour three times a week. That's three hours travel time a week, and that's their biggest concern.

MS. MULDOON: And there's also -- as the unit gets full, there's limited shifts. So you want -- you know, the first shift or the middle shift, that starts to go away as the unit fills up.

MR. DeWEESE: I guess this is only an issue of many competitors, but there's only a couple of companies. If you have the three most proximate facilities, the same ownership, then it's probably -- my question may not be relevant, but I was just thinking in terms of what the actual utilization patterns were as opposed to what's the closest facility that someone could use, and then in that case, it didn't seem like the distance factor was really relevant.

MS. MULDOON: I'm not quite sure. Our units are --

MR. DeWEESE: About the ownership issue, where you have changes of ownership, if

you're a large corporate entity and there's really only a couple of main companies, what's the ownership issue there? I'm not quite sure.

Is it the fact that you have -- that you're a publicly traded or a corporate -- a large corporation like that, that you have people coming in and out of the corporation because of the actual form of membership? I'm not quite sure that I understand your problem.

MS. WRIGHT: Are you talking when we're acquiring a new facility, change of ownership?

MR. DeWEESE: Yeah. Where does the change of ownership complication come in, given only a couple of real competitors in the state?

MS. WRIGHT: When an independent company, facility is struggling, you know, getting ready to go under, and we want to acquire them, there is a delay with the letter of intent process, and then if there is a change in the interpretation of rules, that further delays the process.

These companies can't stay afloat, and we're trying to expedite the whole process. That's what

the change of ownership is, we're trying to keep these facilities from going under.

MR. DeWEESE: So it isn't a matter of changing of the people, so much as it is the ownership of these individual facilities that you're buying or you're acquiring. You're changing the status of the individual facilities, but it's all the same corporate ownership; right?

MS. WRIGHT: Right, on our end at least.

MEMBER LYNE: And the patients can continue to go where they're going.

MS. WRIGHT: The patients can continue to go where they're going and see their doctor versus, you know, them closing it down.

CO-CHAIR DUGAN: Anything else, Kurt?

MEMBER LYNE: Your point, though, was, I think Kurt may have said it, that you have to go through, you know, unnecessary stuff it seems to, I think, do a good deed, or else those patients would be lost, and you'd have to find them if it wasn't a smooth transition.

MS. WRIGHT: Staff is lost, patients are lost.

MEMBER LYNE: Yeah.

CO-CHAIR DUGAN: Kurt, have you got any more questions?

MR. DeWEESE: Again, I'd just like to go back to the -- maybe it's a part of the issue that's been raised in another session, but the whole idea of the Board having expertise in a given field, and I guess I'm not sure whether you can't get that expertise in some other way rather than having the members of the Board be individually expert in every area.

It does seem to me whether you bring somebody in on an ex-officio basis to the Board or you simply have contracted expertise or the staff has designated expertise, I don't know why there is an assumption that the Board has to have expertise in every area; and even in that, if you have hospital representatives, pretty soon you get into the not-for-profit, for-profit representation, large, small, rural, urban, and I don't know whether there's any end to the type of expertise that people want.

It does seem to me that there has to be some other way to bring expertise to the Board rather

than to think that the Board has to individually -- a Board member individually has to be expert in all matters.

CO-CHAIR DUGAN: Yeah, that's a good point. We're going to have to move on because we're supposed to -- we've got people that have appointments because they thought we were going to be out of here by 2:00 o'clock. So unless there's a new question or a new comment we'd like to make, we'd like to move on.

MEMBER LYNE: I would just like to say one thing. What they're asking for is just to do a little education session, not that they be expert members.

CO-CHAIR GARRETT: No, we understand that.

CO-CHAIR DUGAN: We understand. We'd like to thank you guys for the information, and certainly if we need any more, we'll contact you, but we appreciate you coming in and talking to us.

MS. MULDOON: We appreciate it.

MS. WRIGHT: Thank you.

CO-CHAIR DUGAN: So now we go on. Do

you want to go on to the definition of safety net hospitals, Dave?

MR. CARVALHO: I'll be even quicker than I intended to be.

CO-CHAIR DUGAN: All right.

MR. CARVALHO: In your packet, you'll see two handouts. One is a map with dots all over the place and a table attached, and one is a short little article from the Institute of Medicine, which is an organization under the National Academy of Science.

First, looking at the map, this is responsive to your question, basically, where are hospitals, and in particular the question that's come up from time to time is where are DSH hospitals or where are safety net hospitals or where are, you know, economically challenged hospitals. So we tried to give you a sense of that. The key is looking at the key, which is the color coding and understanding what it is and what it is not.

In particular, there is no agreed-upon standardized definition of what is a safety net hospital. In fact, it goes further than that.

You'll note from time to time, Ken has used the expression safety net services as opposed to safety net hospitals.

So what we've tried to show on this map is, first off, looking at an aspect of the payor mix of the hospitals, and in particular, we do an annual survey of hospitals that asks them to categorize their patients into the category of Medicare, Medicaid, private pay, charity, other public payment and private insurance.

Clearly Medicare is off by itself, and private insurance is off by itself. The other categories, namely Medicaid, charity, and other public payment; and then particularly on the ambiguous ones, private payment are the ones that we added together to give you an idea of that burden that each hospital may have in terms of Medicaid, which as we've talked about is classically paying somewhat less than cost depending on the character of the hospital.

Charity care, which pays you nothing or a reduced charge.

Private pay is the one that's a little complicated because some hospitals interpret

private pay to mean you have no payor source. So, for example, if you look at the questionnaire that the Cook County Hospital fills out, it shows about 40 percent of its patients are private pay and zero percent are charity care.

On the other hand, there may be hospitals that consider the person who shows up and writes a check as private pay. So it may be a slight mischaracterization to include private pay, but looking at the numbers, it looks like a lot of places use private pay as people who don't have a payor source, both the wealthy and the poor.

But the only numbers that were significant are some of the safety net hospitals, so we added those. These divisions of zero to 20, 20 to 35, 35 to 50, and 50 to 100 are utterly arbitrary. I just selected them looking at the data to spread it out a little because there is no standard definition for any of these things.

But if you look at the chart, it shows the color scheme, and I tried to move it from green to red to give you an idea of the stress. So the red are the most distressed, the orange less so, yellow less so still, and the green the least.

Then the overlay to this, some of you have asked about the DSH designation, the so-called disproportionate share hospital designation, and so the hospitals that are designated as a DSH, we used a square for their dot, and for the ones that are not designated as DSH, we used a circle.

The two tables are charts that identify which hospitals are which. You can see the front page of that table lists all the hospitals in alphabetical order, and then the circle with the color and the number that you can find on the map. On the back page, we segregated them by DSH hospitals and non-DSH hospitals.

Let me get to those terms: safety net, DSH, and the two types of DSH, actually.

MEMBER BARNETT: Did we lose Springfield?

CO-CHAIR DUGAN: Yeah, we lose them every once in a while.

MR. CARVALHO: Then we get them back.

CO-CHAIR DUGAN: They come up.

MEMBER SCHAPS: Dave, can I ask you a quick question first?

MR. CARVALHO: Yes.

MEMBER SCHAPS: You say other public payment patients --

MR. CARVALHO: Right.

MEMBER SCHAPS: -- but that's not Medicare.

MR. CARVALHO: That's not Medicare --

MEMBER SCHAPS: Okay.

MR. CARVALHO: -- and it's almost always a very small number, and it might be if being paid for a prisoner in some -- you know, or an inmate, providing services that way, or maybe payment for the hospitalization relating to somebody in an IDF and maybe DHS is paying for it.

MEMBER SCHAPS: Okay.

MR. CARVALHO: So it's usually quite small.

The four-page summary that I've shared with you is from a much, much longer study that the Institute of Medicine did first in 1988, I think, and then updated again in 2000 where they were asked to look at the financial condition of America's safety net, and they produced a report they called, "The Americas Health Care Safety Net Intact but Endangered."

One of the things that you'll see, a recurring theme, and what I'm talking about is, the use of the term and the definition of the term is usually related to the purpose to which you put it.

So they wanted to define the safety net for the purpose which they were going to put it, which was looking at the financial condition of the safety net. So they focused on, first, providers that deliver a significant level of health care to the uninsured, Medicaid and other vulnerable populations. This is in the little box on the front page. This is a synthesis of about a 100-page study.

MEMBER LYNE: Excuse me, Dave.

MR. CARVALHO: Yes

MEMBER LYNE: Did you say, when was this done?

MR. CARVALHO: This was done in 1998, I believe and then updated in 2000.

But they were looking at the financial wherewithal of the safety net at the time, and in order to get that, they first had to define what is the safety net.

So the definition that they chose is in the little box, and it first focuses on safety net providers generally are those that provide a high level of care to the uninsured, Medicaid, and other vulnerable populations; but then for purposes of their study, they looked at what they call the core safety net providers which focused in upon those who had a legal or self-adopted mandate to care for all patients without regard to the ability to pay and who had a substantial share of their patient mix being uninsured, Medicaid, and vulnerable.

If you read the study, they explicitly decided not to put a specific number on what substantial meant because of the recognition that across the country, just as you all recognize within the state, what it may take to be a safety net provider in one community is different than another because of the role that that provider plays within that community. So that was their adjective and noun definition of safety net provider.

Somewhat related but not entirely related to that is the definition of disproportionate share

hospital. The first step backwards, what does disproportionate share even mean?

The concept loosely came about in the early 80s and 90s. The idea being -- and these are stereotype, but the idea being private insurance pays reasonably well. A hospital gets private insurance patients, and they are able to, you know, retain earnings or make money, if you will, on those patients.

Just focus on Medicaid for a moment, if they're in a state where Medicaid is paying less than cost, then obviously, they're losing money on those. So if you look at their mix between how much Medicaid they have and how much private insurance, and let's leave all the payors out for a moment, imagine you've got 90 percent of your patients were insured and 10 percent were Medicaid. You would make an effort to make up the loss you were doing on the 10 percent by the profit you were making on 90, but you would have a ratio of basically 9 to 1 to do it.

If instead you had 50 percent of your patients Medicaid and 50 percent insured, you'd have to be making up the loss on the 50 percent

with the profits on the 50 percent, and you'd have a ratio of 1 to 1 to do it.

So as your percentage of Medicaid goes up, your ability to do that cost share goes down and goes down rapidly. So going from 10 to 50, you've only gone up 40 percentage points, but your ratio of unprofitable to profitable goes from 1 to 9 to 1 to 1. So it goes down dramatically.

So the idea came about at the federal level that to make up for that impact, states and the federal government under the Medicare program ought to have the authority to provide disproportionate share payments to hospitals who had a disproportionate share of Medicaid patients, and that would help them make up for that difference. So it became an authorization at the federal level and also a feature of the Medicare program.

So they defined disproportionate share hospitals, but again, for the purposes that they were defining it, which is just to say, to impact the Medicare payment system and to impact the Medicaid payment system.

Those definitions, the Medicare one is in a

67-page rule that I did not copy to print out for you. We will link it on our Website if you want to peruse it, but it basically looks at your percentage of Medicare patients and your percentage of Medicaid patients. This is for the Medicare disproportionate share designation.

It looks at your percentage of those kind of patients and adds them together and then looks at either the absolute number or where you rank vis-a-vis the mean throughout the state. So if you're above the mean by a certain amount or if you're above certain percentages, then you get disproportionate share designation under Medicare and that leads to enhanced -- or an increase in your reimbursement under Medicare.

For Medicaid purposes, since the Medicaid program is not financed solely by the federal government, but in partnership with the states, disproportionate share was an authorization, not a mandate, and it authorized states to set disproportionate share programs. States did to varying degrees and in varying ways. There was freedom to do it.

There are certain parameters in federal law

about who can be designated and who not because the federal government cares about how much money it's spending to help with this designation.

Illinois has adopted rules to define disproportionate share hospitals and then the payments that go along with that designation. Again, your rules look at your percentage of Medicaid, how you rank, how to test against the mean.

That's also in regulation, and we will link you to those regulations on the Website we have created for you. But both of those use that designation, both Medicare and Medicaid, for purposes of enhancing the reimbursement to hospitals so designated.

So going back to your map, the squares are hospitals in Illinois that under those rules have been designated as DSH hospitals for Medicaid purposes. We did not try to clutter this up anymore by identifying the hospitals that were designated DSH for Medicare purposes. It probably isn't that interesting to your purpose.

CO-CHAIR DUGAN: And the squares?

MR. CARVALHO: The squares are the DSH

hospitals for Medicaid. The circles are not DSH hospitals for Medicaid.

MEMBER SCHAPS: David, how often is that reaccessed?

MR. CARVALHO: I would turn to Mike or Barry.

MR. MARAM: We reassess all the time, and as David said, it's not in a specific formula.

Theresa, we don't really have -- the word "safety net" as David points out is a generic term. What we do is enhance the number of those hospitals that are either high Medicaid or DSH; and, of course, the hospital assessment has brought $2 billion in the last three years, raising their Medicaid payments.

Theresa, do you want to expand on that?

MS. EAGLESON: Yes, Director, can you hear me?

MR. MARAM: Yes. This is Theresa.

MR. CARVALHO: She's the Medicaid director.

MS. EAGLESON: There are different, as the Director was saying, add-on payments for hospitals, one of those being the disproportionate

share hospital payment. I think we have 40-some of those hospitals designated that are Medicaid providers in the state.

There are also other add-on payments that are derived from the percentage of Medicaid that a hospital serves, such as safety net adjustment payments and Medicaid high volume adjustment payments, and there are significantly more hospitals receiving those types of adjustments. I think it's in the neighborhood of 170 for the largest ones.

CO-CHAIR GARRETT: Could I ask a question? So in order to apply for DSH funds, I know that the State of Illinois -- I'm assuming that's part of the hospital assessment, but -- okay.

If we didn't have hospital assessments, would hospitals independently be -- independently be applying for these funds? Are they automatically in this assessment? How does that work?

MR. MARAM: They're both.

Theresa, do you want to expand on that? You have DSH independently of the assessment.

MS. EAGLESON: Yes, sir. We actually have rules, administrative code on the books in Illinois that outline how hospitals qualify for each of these payments. They don't have to -- they have to fill out some information on their uncompensated care costs each year, but beyond that we get most of the information we need off the hospital cost reports that they file with us each year.

CO-CHAIR GARRETT: Excuse me, but do the hospitals apply themselves? Because I was familiar with one hospital that probably was qualified to do it, and they just didn't do it.

I'm just wondering, does the state send a little notice and say you probably could qualify for these DSH funds, or do they just know on their own, or how does that work?

MS. EAGLESON: We do send a letter to require them because the only piece of information --

CO-CHAIR DUGAN: I think the weather in Springfield is messing it up.

CO-CHAIR GARRETT: We can't hear. Can you guys hear us?

MR. CARVALHO: They're frozen.

CO-CHAIR GARRETT: Well, maybe, Barry, you know then.

MR. MARAM: We do, working with them, find out which ones are approaching and are pretty aware of the DSH. Those dollars are again separate from the hospital assessment.

CO-CHAIR GARRETT: I know, but so Hospital A is not part of the hospital assessment, but they most likely are going to qualify for these DSH funds. There's a lot of things going on at their hospital, they may not have even the technical staff to apply for these funds. Do you help them?

MR. MARAM: Yes.

CO-CHAIR GARRETT: Do you apply?

MR. MARAM: Yes.

CO-CHAIR GARRETT: Do you send them letters?

MR. MARAM: Yes.

CO-CHAIR GARRETT: And no one falls between the cracks?

MR. MARAM: You know, I will be glad until Theresa comes back on, but we've stayed

pretty much on top of who our DSH hospitals are.

Do you want to expand on that, Ken?

MEMBER ROBBINS: Yeah, I mean, I wouldn't say that there is no hospital that ever fell through a crack, but I can't know that.

CO-CHAIR GARRETT: Yeah.

MEMBER ROBBINS: But I would tell you that we work very carefully with our hospital community to make sure that those who our data indicates are DSH eligible are involved in the program. I think that's just complementary to what the Department does.

The other thing, I think, and correct me if I'm wrong, Barry, that makes DSH payments unique is they're the only Medicaid-based payment that takes into account the amount of uncompensated care that a hospital does.

MR. MARAM: Very true.

MR. ROBBINS: Because the rest is based on Medicaid, while this is really looking at the uninsured.

SPRINGFIELD: Springfield is back on line.

CO-CHAIR GARRETT: Okay. I guess I'm

done. I know we're in a hurry.

CO-CHAIR DUGAN: Yeah, it's interesting to --

CO-CHAIR GARRETT: It's something I think we need to come up with, and maybe we can't, but can we come up with a clear definition at least for Illinois?

MR. CARVALHO: Well, where I was going with what I was saying was, once you have a better idea of what you want to do with it is what would lead to coming up with a clear definition.

In other words, defining safety net hospitals in the abstract without knowing precisely what you want to do with the definition will be hard.

However, if you come to some conclusion as to what you want to do for that group, and we kind of have a common sense idea of what we mean, then it will be easy to actually define that.

MEMBER ROBBINS: Well, I'll just put one other thing on, too. We keep going back to the enabling statute that created this task force. Section 15(c)(6) makes a specific reference to safety net services as opposed to just safety net

hospitals.

We can take all of it into account, but I think our obligations are at least based on reference to the notion of safety net services.

MEMBER BRADY: I think we need a definition of that by the time we get back.

CO-CHAIR DUGAN: Yeah.

MEMBER BRADY: This is nice and helpful, but I assume throughout this, why are we clearing up the terminology? So we have good data in the future?

MR. CARVALHO: Well, we have --

MEMBER BRADY: I'm not saying this is bad. I'm just simply talking about the issue of private payment. Are you working to define that with the hospitals so they don't have that problem again?

MR. ROBBINS: I'd like to say the solution were simple, and part of it goes back to Hospital Accounting 101, and they have these categories of Medicaid, Medicare, commercial insurance, and then something called self-pay, which some call private payor, and frankly, self-pay is generally no pay, just as private

payor --

MEMBER BRADY: Well, it seems to me that you could define self-pay uncollectible and self-pay collected to give us a better perspective. I hope you work on that.

MR. CARVALHO: We have worked on it and have had conversations, but we don't have it solved yet. I just had a conversation with the hospital the other day where they said, okay, now, where do we put the people -- where do we put prisoners?

MEMBER BRADY: I think that part of what would be helpful to us is if we look at this -- where this is good is I think it's important to know what percent is actually Medicaid, what percent is actually charity. You get zero on charity. You get maybe 70 cents on the dollar on Medicaid. I mean, it would be nice -- where I think you did a great job of starting, I assume you've got the subdata that would allow us to --

MR. CARVALHO: Yes.

MEMBER BRADY: -- have a better picture.

MR. CARVALHO: In fact, if I haven't already, I can distribute the subdata. I didn't collapse it to keep it from you. I collapsed it to make it an easier chart.

MEMBER BRADY: I understand.

MR. CARVALHO: So I can break it out. The other thing you need to remember, which was said earlier today, is there are some hospitals -- in fact, it's by and large the case, the hospital that has very, very low Medicaid is probably the one that's closer to the 70 cents on the dollar. The one that has very high Medicaid is probably closer to, when you add in all the add-on payments, higher -- closer to over 100.

MEMBER BRADY: Is it fair to say that there's just the two categories of Medicaid?

MR. CARVALHO: No, that's what Theresa was saying. There's DSH designation which means the disproportionate payments, but then there are other designations that lead to other add-on payments.

MR. MARAM: We have different add-on payments. We have safety -- to approach the safety net needs, we have add-on payments. The

hospital assessment is substantial, about $2 billion input. So we have a number of different Medicaid add-on payments.

MR. CARVALHO: The reason why DSH is sort of a special one is Congress put a cap on what you can spend and call DSH. So that's part of the issue.

MEMBER BRADY: Do we also have one of these that show all of the CON-licensed facilities? Is it possible you could go in and do one of these and say, okay -- another one for the nonhospitals that say, here's the other licensed facilities we have? In red is the surgery center and --

MR. MARK: We should be able to. We have those data.

MR. CARVALHO: Yeah, the only one I'd probably suggest you don't want is the nursing home because there's a thousand of them, and it will just -- you won't be able to read it. ASTCs are about 120. ESRDs are about 150.

MEMBER BRADY: This may be a stupid question. Looking at this, can you identify places where we've simply got too many?

MR. MARAM: I think that would be hard. I think that you have to approach a safety net hospital in one community may be at a certain percent Medicaid, while in another community they may be substantially lower because there is no services for them.

MR. CARVALHO: I think he means too many facilities.

MEMBER BRADY: Too many beds, too many facilities, just to meet the needs regardless of the payors.

MR. CARVALHO: If you look at our inventory, which is our need profile for the state that's done by region, and the most recent updated one was published just a couple months ago, it will show excess bed capacity or excess beds in all but two planning regions, and it will have a number. The number, for example, in the Chicago planning region is substantial, close to 1,000, 900.

MR. MARK: I think it's over 1,000.

MEMBER BRADY: Have you given us that?

MR. CARVALHO: If we haven't, we can.

MR. MARK: It's quite voluminous.

MR. CARVALHO: And it's interesting.
MEMBER RUDDICK: Do you monitor excess capacity in other areas, like nursing homes and ESRDs?
MR. CARVALHO: Yes.
MR. MARK: Yes.
MR. CARVALHO: There's a similar profile for other -- that's what leads to the part of the State Agency report that says, you know, you want to build a hospital of excess beds, but our data show that for this region, the excess capacity is this or the need is that.
CO-CHAIR DUGAN: That report would be good.
MR. CARVALHO: Yeah, we can get that.
MR. MARK: We have it.
MEMBER SCHAPS: Are we can going to have representatives from long-term care?
CO-CHAIR DUGAN: Well, that's what we're getting into next. I think that's our next thing to discuss, but we are going to.
Dave, are you pretty well done so that we can move it along?
MR. CARVALHO: I'm done. I was just

going to then tell the four things that you've asked for, where they stand.

CO-CHAIR DUGAN: Okay.

MR. CARVALHO: You asked at the last meeting that we work on a summary of testimony to date. Laura McAlpine is working on that. She is doing it using the categories of the statute that Ken just referenced where there's different sections, and she's compiling what testimony that you've had thus far in each of those categories. In fact, apropo she just mentioned to me, you know, there's nothing on long-term care yet, and that's because you haven't heard from long-term care yet.

The Co-Chairs asked us to do a little research to pick up some information about some programs in New York and Massachusetts.

MR. COX: Dave, this is Greg Cox down in Springfield.

MR. CARVALHO: Yes.

MR. COX: Can I get a list of critical access hospitals as well?

MR. CARVALHO: That would be -- oh, the critical access, you mean, the rural

designation?

MR. COX: Yes.

MR. CARVALHO: Yes, that's my office. We can get that.

MR. COX: Okay. Thank you.

MR. CARVALHO: Sure.

You asked us to look into a facilitator, and we shared with you --

CO-CHAIR GARRETT: Well, go back to New York and --

MR. CARVALHO: Massachusetts, we're pulling those. We don't have them yet.

CO-CHAIR GARRETT: And tell everyone what it is.

MR. CARVALHO: Okay. New York and Massachusetts have some programs -- that we don't fully understand yet because we haven't pulled all the information -- that use an assessment on insurance companies to help fund safety net activities. In Massachusetts, it helps fund a pool that provides payments for uncompensated care. At least it did that for years and years and years.

A year ago when they set up the

insurance-for-all program, they folded that into that on the theory that if everybody was insured, you wouldn't need to compensate as many people for uncompensated care because you wouldn't have uncompensated care in the same amount.

MEMBER ROBBINS: But those aren't part of their CON process, are they?

MR. CARVALHO: No, no.

CO-CHAIR GARRETT: It goes into the funds for charity care, covered costs for, let's say, equipment that safety net hospitals couldn't fund because they don't have the --

MEMBER ROBBINS: But not within the framework of the discussion about certificate of need.

MR. CARVALHO: I think the idea was if a recommendation should go up to recommend whatever you want to the legislature, and part of your recommendation was that the rest of the CON process, according to Lewin, was the only remaining reason that made any sense was to protect the safety net, and if you conclude that the testimony you've heard is that the CON process can only be one part of protecting the safety net

and there's four other things that have come to your attention during your study that you might want to recommend, I think that was the context in which the co-chairs were raising the question.

CO-CHAIR GARRETT: Well, let me -- the hospitals in the northern part of the state who are profitable are concerned with some of the insurance providers because they're tightening their belts and talking about reimbursement; and they have asked me to go into -- they specified in New York and maybe Massachusetts -- and it might have been New Jersey, but at least New York because they had a program there that seems to take care of some of these issues.

So are you getting where I'm going?

MEMBER ROBBINS: Not really.

CO-CHAIR DUGAN: Well, we'll get the report.

MR. CARVALHO: We'll pull the information and share it with everybody.

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: You had asked us for purposes of when you get to this stage where you're no longer just receiving testimony, but

actually trying to crash through all the information and come to some conclusions that it might be helpful to have a facilitator do that, and we shared with -- everybody or the co-chairs?

CO-CHAIR GARRETT: I think the co-chairs.

MR. CARVALHO: -- three persons who IPHI has worked with in the past as potential facilitators. All are familiar with health care and have experience facilitating, and so we've shared them with you, and we'll act on your recommendation.

Then one thing you need to be thinking about and we're thinking about is a final report and engaging someone to draft that. If you're pleased with the summary that Laura prepares, you can maybe recommend to us that we just continue along with that. We do need to think in terms of preparing that down the road.

Those are my new business items.

CO-CHAIR GARRETT: The long-term care, we haven't heard from anybody from long-term care?

CO-CHAIR DUGAN: That's in July.

MR. CARVALHO: We haven't identified

specific individuals yet, but we have identified the target date for their testimony, and that was July.

MR. MARK: I believe that's July.

CO-CHAIR GARRETT: I don't know I mean, you guys --

MR. CARVALHO: Yes.

CO-CHAIR DUGAN: I think that's right.

CO-CHAIR GARRETT: Then also we're going to hear from David Dranoff, who is a professor at Northwestern, who is going to talk about charity care issues and the economics of them, and I think he is going to present a paper.

Then I want to bring up one other thing, which we have talked about in the past, you know, having sort of another set of eyes to oversee some of the ideas that are coming out of this task force.

I talked to actually the Attorney General's office, and that would be, for instance, let's say we get a proposal to do X, Y, and Z, I want to have somebody, and I think Paul also agrees, and he would like to, I believe, do this too, have another independent -- we talked about DeLoitte

Consulting, and sort of if nothing else, critiquing it and to do that in a timely way. So we called DeLoitte.

You had said that we have to put everything out for bid, and we told them, and they aren't really interested. I understand that.

But if we do do something under $20,000, I think I would feel better. So I'm just wondering how that works.

MR. CARVALHO: So the objective would be to have somebody to kind of vet especially --

CO-CHAIR GARRETT: Some of these ideas that might come out about --

MR. CARVALHO: -- an economic analysis.

CO-CHAIR GARRETT: Yeah, as more of a business.

MR. CARVALHO: Right. And ideally, so it wouldn't have to go through the RFP process, it would be somebody who would be willing to take $20,000 to do it.

CO-CHAIR GARRETT: Right, or less.

MR. CARVALHO: Or less, yes. I'm open to suggestions.

CO-CHAIR GARRETT: Yeah.

MEMBER SCHAPS: I'm not that clear on what the point is.

CO-CHAIR GARRETT: Paul -- we had talked about Deloitte. So let's say we get a proposal, and let's say David Dranoff comes up with something, and we all think that's a great idea.

So then sitting around here, while we have expertise and some of our expertise is bias, what I want to do is make sure that we vet this with, you know, a source of people who have been around the block, so to speak, and can ask the questions that we might not be able to ask and say, here it is, reconsider this, reconsider that, here's why, here's why.

So then we can all look at that and say, oh, that's hogwash, or gee, those are really important points, and then we would have that information.

MEMBER SCHAPS: Wouldn't it make sense to have somebody in that role who is familiar with how other states do it?

CO-CHAIR GARRETT: They did that.

MEMBER SCHAPS: Oh, they did,

CO-CHAIR GARRETT: We called somebody who is an expert in that --

MEMBER SCHAPS: CON.

CO-CHAIR GARRETT: -- and got him on the phone. We had a back and forth, and I think it would be an appropriate thing to do so we don't go down the wrong path and think we're so great, you know.

MR. CARVALHO: I think the other thing that you had suggested -- and this is just as a total hypothetical. Say, you had a proposal that was keyed off of X percent of every project like thus and such would kick into a fund to do thus and such and you needed to know if you tested at 2, what is the impact, and you wanted somebody to say, well, you know, we project that it would raise X, but it would also have this impact because these projects did not occur, or, you know, you can't levy a tax without having some impact on economic activity.

So I think that's part of what you were looking for was someone to not just vet it from the perspective of, oh, in New Jersey they've done that, too, but actually analyze the impact and

test the numbers.

MEMBER SCHAPS: Right.

CO-CHAIR GARRETT: So we don't come up with our final report, and then everybody --

CO-CHAIR DUGAN: So we don't have good intentions like we were just talking about earlier.

MEMBER BRADY: 20,000 is the bid threshold; is that right?

MR. CARVALHO: Yes.

MEMBER BRADY: I would rather do it for bid, and if someone wants to submit a proposal below 20,000.

For instance, I think Lewin who has studied Illinois health care needs more than anyone I know may not do it for 20, but we're making some pretty big decisions, so if it costs us 80 grand, I'd rather --

CO-CHAIR GARRETT: I don't know if Lewin -- I mean, I don't know. We were looking at it more from sort of a business perspective, somebody who has worked with hospitals.

MEMBER BRADY: Lewin has done Medicaid studies for us. They've done managed care studies

for us.

CO-CHAIR GARRETT: Fine. If you want Lewin --

MEMBER BRADY: I'm just saying we could vote and see what we get for what. I mean, I'd hate to, you know, not get the best because we give them 20 when we --

CO-CHAIR GARRETT: We can do that.

CO-CHAIR DUGAN: Yeah, we can do it. I just think what we also want to do is -- well, one at a time, maybe two -- two, you know, just to kind of look at it from a perspective, and I think the Lewin Report -- I mean, we have the Lewin. We have Lewin's recommendations.

MEMBER BRADY: Well, I don't understand what you're saying. What you're saying is, we're supposed to come up with a recommendation, and we should ask someone to do a cost-benefit analysis of those recommendations, and I just, you know, as much as Lewin has done, they could also do a cost-benefit analysis of what our recommendation is. They may charge us an extra 80 grand, but --

CO-CHAIR GARRETT: And we might be

here for another six months. I mean, what we're trying to do --

MR. DeWEESE: Can I interject a little bit? This is Kurt DeWeese.

CO-CHAIR DUGAN: Yeah.

MR. DeWEESE: I'm just trying to put this into a context over the next three months, and I think to some extent, you need to look at this in terms of what the final report will include and then what happens after that final report is issued.

My sense is, is that November is really the start time for drafting. So if you actually have some technical issues to be resolved before you come to a final piece of legislation, that's where you might need to have more of that technical expertise.

But there are an awful lot of recommendations, and an awful lot of this that is not really going to be that technical, and I think the report could probably speak to some of the rules issues or standard issues that you may want to further develop once you've decided that you want to go in a particular direction by November.

But I don't see -- I guess I'm trying to figure out what kind of technical recommendation or what issue you're going to raise that's going to require that kind of vetting between now and November.

CO-CHAIR GARRETT: Okay. So we're talking right now about sort of, you know, on a hospital wants to expand into an area where there's insured markets, they may have to reach a certain threshold of under and uninsured Medicaid, and if they don't meet that, they can put money into a charity care type of fund. This is a vague approach.

Okay. Let's say, you know, in theory we talk about this as a committee, a task force, and then we get somebody to put it in writing. I want somebody else to say, but wait, or this sounds good, and this doesn't sound good before we go into our final report. I think it's really important to make sure that what we're saying makes sense, and another pair of eyes on this, I think is a good idea.

I don't care if it's the Lewin Report. I don't care who it is. I don't want to be here

next year, you know, talking about the would have, should have, could haves, and I think this is a great stop gap measure.

I've talked to the Attorney General's office. They talked to the person that I had actually recommended. They felt very comfortable doing this. We have some money to spend. It doesn't matter to me who it is, but I think we need to do that. Because I can see that we're not -- I don't feel -- I want to take it away from us just because I think that's important, and I think it's healthy.

MR. DeWEESE: I guess I would agree that if you make a policy decision that you think is applicable to the report or to the system that, you know, like Ken Robbins suggested, is whether you want to put that into this context of this reform, then I think you can make that policy decision and then subsequently develop a more final recommendation from the technical standpoint.

But I think the basic policy decision as to whether or not you want to try and find a way to provide more assistance for charity care, you

know, I think that's probably where you're going to end up in November. I don't know that you're going to have any final agreement on some technical recommendation that --

CO-CHAIR GARRETT: It's not going to be technical, Kurt. It's going to be the overall thrust of, I think --

MEMBER BRADY: Well, maybe we're putting the chicken before the egg.

CO-CHAIR GARRETT: Yeah.

MEMBER BRADY: Maybe we need to come up with what we think.

CO-CHAIR GARRETT: Yeah.

MEMBER BRADY: And then if we think we need a counter balance to it, we go out and find somebody who can do it.

CO-CHAIR GARRETT: Okay. Whenever that is and we come up with something that is sort of moving us in a direction, before we get everybody to facilitate and move us and have legislation, I just want to make sure that we haven't moved too quickly, and that we have another -- somebody else to take a look at this who has looked at health care in Illinois and

across the country.

So we have somebody who could probably -- and the Lewin Group would probably do it for over $100,000. I think that's what this is going to cost. We talked to this person. They said they would do it for under 20,000.

You know, I think it makes -- it confirms, I think that we're on the right track and that we can move forward or we have to move in a different direction before we get to the point where the time has run out, and we have a document that we kind of like, but it might not work.

MEMBER ROBBINS: Do we get to know who this person is before we --

MEMBER BRADY: Well, that's why I think it needs to be an RFP. If what we're -- one way or another, they can do it any way they want. We shouldn't hire someone for 20 grand or even less just because it's convenient. We should look at a bunch of bids and just see. I mean, I want to keep transparency, period.

CO-CHAIR GARRETT: It takes so long, and that's the problem.

MEMBER BRADY: Well, let's make our

decision when we get to it.

CO-CHAIR GARRETT: All right. It's not going to be as easy as you think to get somebody off the street to come in and do that. This person -- his name is Michael Englehart, and he's done work --

MEMBER BRADY: See, if we could keep the governor from sweeping funds, we'd have money to pay for whatever we need.

CO-CHAIR GARRETT: We have money, and I don't have an ownership interest. I just don't want to go the track where many task forces go, and we don't --

MR. MARAM: I don't know how much you've talked about it, but probably 80 percent of hospital financing is done through tax exempt bonds, and although there has been attempts to do Robin Hood plans in different states, from the marketplace, it's usually been a challenge. But just keeping that in mind, most of the financing is done, your large financing is done by tax and bonds. There probably is the greater need to get them to the marketplace.

CO-CHAIR GARRETT: I don't know what

that has to do with it.

MR. MARAM: Well, the fact that most hospitals real need for cash can help. One of the big needs for cash when they build or remodel is doing it through tax exempt bonds. The difficulty is getting to the marketplace.

CO-CHAIR GARRETT: I think, though, that that's not what we're talking about. We're talking about the philosophical direction that this task force seems to be going, and it has to do with charity care and ASTCs and all sorts of things. They are big steps.

All I'm saying is, I don't -- you know, I'll back off of this totally. I want to make sure that when we address the CON process, however it's handled, that before we finalize everything, we have somebody else who -- a group, an organization, who are experts take a look at it. That's all I'm saying, and I'd rather do that sooner than later because my worry is that we're going to be here past our deadline wondering why we aren't moving further along. That's all.

MEMBER BRADY: I've got two things. There's two people I've put forward to the

co-chairs to invite to speak to us. One was Dr. whittaker and the other was one other gentleman who abruptly resigned from the Board. Where are we at on that?

MEMBER SCHAPS: Dr. Whittaker?

CO-CHAIR GARRETT: He is the head of the department of public health.

MEMBER BRADY: Was.

CO-CHAIR GARRETT: Was.

MEMBER SCHAPS: In the capacity that he was in.

MEMBER BRADY: Just as we had Glen Poshard, I asked that those two be brought in front of us to give us their perspective, and I have not heard back. Have they refused?

MR. MARK: I know we conveyed an invitation to Dr. Whittaker. I don't recall a response.

MR. CARVALHO: We checked with Dr. Whittaker about the next three meetings at the time that we asked him, and he has been involved in another activity, but last week --

MEMBER BRADY: He might have some time now.

MEMBER SCHAPS: I doubt it.
MR. CARVALHO: He wasn't available the next three dates through July. So we'll move off into August.
MEMBER SCHAPS: Maybe December.
MR. CARVALHO: Yeah, December would probably be much better.
MEMBER BRADY: And I don't have the name of the other gentleman that I asked. I just remember reading the article, and we tried to invite him to our task force.
MR. MARK: Mr. Penn? Dr. Winters?
MEMBER BRADY: Is it Winters?
MR. CARVALHO: Dr. Winters, and Glen Poshard, and Mr. Penn --
MR. MARK: Mr. Penn.
MR. CARVALHO: -- are the three who have left.
MR. MARK: Gene Verdue.
MEMBER BRADY: I can't remember.
MR. MARK: Again, someone would yell at me if I don't mention this. We have -- the task force asked earlier in the process that current and former Board members present, and we

have five to eight people I know who would very much like to.

CO-CHAIR GARRETT: Well, why don't we set that up for our meeting in August. I think July was pretty much set, but -- so maybe in August we could have a panel.

MR. MARK: That would be great. That would be great, and we'll try to get whoever.

CO-CHAIR GARRETT: And then after that, is there anybody?

CO-CHAIR DUGAN: Is there anything else that somebody wanted to see or hear from that we haven't yet? We think we pretty much have at least had the testimony of what we want.

MR. MARK: May I suggest if any task force members have individuals they'd like to hear from, that they contact either me or Kathy directly, and we'll try to schedule them at the next meeting.

CO-CHAIR DUGAN: We talked about the long-term care.

MR. MARK: Yes.

CO-CHAIR GARRETT: We will see you all in July.

CO-CHAIR DUGAN: Thank you very much.

(Which were all of the proceedings had in the above-entitled matter ending at 2:24 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

I, Joanne E. Ely, Certified Shorthand Reporter No. 84-4169, Registered Professional Reporter, a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this _____ day of _____, A.D. 2008.

_____
Notary Public

My commission expires
May 16, 2012.