Illinois Task Force on Health Planning Reform
Monday, September 15, 2008
10am-2pm

James R. Thompson Center
100 W. Randolph, Room 9-040
Chicago, Illinois

SIU School of Medicine, Telehealth Center
913 Rutledge, Room 1252
Springfield, Illinois

Task Force Members Present:
Chicago: Rep. Lisa Dugan, Ken Robbins, Gary Barnett, Claudia Lenhoff, Paul Gaynor, Margie Schaps, Senator Bill Brady, Sister Sheila Lyne, Senator Susan Garrett, Rep. Lou Lang, William McNary, Senator Pam Althoff

Ex Officio Members Present: David Carvalho/IDPH, Jeff Mark/IHFPB, Myrtis Sullivan (for Carol Adams)/IDHS

Staff Present:
Illinois Public Health Institute: Kathy Tipton, Mairita Smiltars
Legislative Staff- Chicago: Greg Cox
Legislative Staff- Springfield: Kurt DeWeese, Melissa Black
Legislative Staff- Phone: Clayton Klenke/House Republican Staff, Lee Goodson/Rep. Tom Cross office
State Agency Staff: Mike Jones

Public:
Springfield: Mona Martin/Cullen and Associates, Howard Peters/IHA, Charles Foley/Foley and Associates
Via Phone: Bruce Ivan/Health Advocate, Suzanne Hack/Barnes Jewish Hospital

Court Reporter: Joanne Ely

Facilitator: Laura McAlpine, McAlpine Consulting for Growth

Call to Order: 10:11am

Action: Approval of 8-15-08 Minutes
David Carvalho had two changes and a suggestion for the 8-15 minutes.

- On Page 3, change the wording in the first sentence from freestanding "surgical" centers, to "emergency" centers.
- On page 4, under the third open circle, first bullet, instead of "a mental Health facility", name Misericordia.
- Susana Lopatka would also like to have her written testimony attached to the minutes and provided to the Task Force members.

Sister Sheila motioned to approve minutes as amended, and Lenhoff seconded. Motion approved.

Presentation by Joseph Miller, US Deptartment of Justice, Anti-Trust Division

Joseph Miller- I appreciate the opportunity to speak before you today. I work for the US Department of Justice Anti-Trust Litigation One section that deals with health care markets and health insurance. I

have submitted a Joint Statement with Federal Trade Commission for this testimony. I will summarize the highlights of the paper in a few minutes.

- I will start with premise that health care markets (and thus consumer welfare) are boosted with health care competition.
- CON laws impede the efficient performance of health care markets by creating barriers to entry and expansion to the detriment of health care competition and consumers.
- CONs undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs.
- The Department of Justice and the Federal Trade Commission support the repeal of CON laws.
- Fundamental principle- market forces tend to improve the quality and lower the costs of health care goods and services.
- There are benefits to competition in health care
- I will ask you to think about if you can achieve CON goals without restricting competition.
- Usual Justifications for CON
    - Cost containment- this was the original reason given for CON.
        - At the time CON was instituted through the National Health Planning and Resources Development Act of 1974, a lot of health care was reimbursed on a cost plus basis which provided incentives for over-investment.
        - That is not the predominant way of reimbursing today. Today health plans routinely bargain with health providers over prices.
        - Essentially government regulations have changed in a way that eliminates the original justification for CON programs.
        - CONs don't actually contain costs as found in the Lewin Report and other reports.
    - CON laws impose additional costs and may facilitate anti-competitive behavior
        - As a barrier to entry, CON laws interfere with the entry of firms that could provide higher-quality services than incumbents. This barrier depresses consumer choice and reduces the pressure for incumbents to improve quality and offerings.
            - Competition can spur other hospitals to improve performance.
        - Existing providers use the CON process "to forestall competitors from entering an incumbent's market"
        - Incumbent providers sometimes enter into anticompetitive agreements that are facilitated by the CON process
            - West Virginia cases
                - Hospital in Charleston, WV use the threat of objection during the CON process to induce another hospital to not seek a CON for an open heart surgery center needed by residents of Charleston
                - In another WV case, the Antitrust Division alleged that two closely competing hospitals agreed to allocate certain health care services among themselves.
            - The CON process itself may sometimes be susceptible to corruption.
    - CON as a funding mechanism for Charity Care (protecting revenues of incumbents)
        - Incumbent hospitals argue that they should be protected against additional competition so that they can continue to offer services to the uninsured or underinsured

        - The imposition of regulatory barriers to entry as an indirect means to fund charity care may impose costs on all health care consumers
        - CON laws stifle competition that could encourage community hospitals to improve their performance
        - If the goal in IL is to preserve the Safety Net, there are other less costly solutions that CON for doing this
        - It is also possible that CON laws do not actually advance the goal of maintaining charity care. Specialty hospitals generally open in areas of high population growth, and do not siphon off the patients that use Safety Net hospitals.
        - We would ask the task force to weigh the evidence of this justification for CON.
        - Consumers could select alternative avenues of care, but CON is suppressing choice.
        - Look at whether CONs increase charity care- does it work?
    - Look at evidence and see if CON is working. Is there a less restrictive mechanism that could be used?

Question from Jeffery Mark- Did you review the 2004 SPC report that was 360 pages long? I did not read the whole thing, but I did read the 6 pages that address CON. It appears that the primary question addressed by this report was, in fact, a cost effectiveness question. Was the question of access to care or services, quality of services, or community health services, ever covered?

- Miller- I don't remember the details, but the report is on the website. I can't give you a direct answer. I don't know.

Question from Claudia Lenhoff- There is a falacy about consumer choice. Choice happens for consumers of means who are well-insured, are in good financial standing, and can shop around for the best value in medical care if there were more choices. In my community, when a hospital wanted to create an outpatient surgical center, they were clear they would not accept Medicaid. So what choice would those Medicaid patients have had if that outpatient surgical center were to open? I think we need to be clear who we are referring to when we talk about consumers.

- Miller- If the CON is blocking the entry of an ASTC or similar provider, some people would have restricted choice if they are insured. Should all facilities be open to all patients regardless of insurance status?
- Lenhoff- I guess I am saying that we need to be mindful of who we are referring to when we say that "consumers" should have choices.
- Miller- Competition in health care markets should be allowed to proliferate, and if consumers desire these new entries, then they will succeed. There shouldn't be regulatory barriers to health care services outside of the traditional ones.

Question from Rep. Dugan- You said that when CON was first put into place, reimbursement was cost-plus. Why did that change?

- Miller- In 1986, the federal law was repealed to eliminate cost-plus. I don't know the reasons why.

Question from Rep. Dugan- How can an agreement be made through CON that is illegal?

- Miller- The CON process allows competitors to threaten each other. CON itself is not anti-competitive in this instance, but the process is allowing for anti-competition agreements. In WV, two hospitals came to an illegal anti-competitive agreement due to the CON process.

- Dugan- Are you saying throw out CON if some entities are doing illegal things? Illegalities will happen regardless. I am not convinced the CON causes someone to take illegal action because they can.
- Miller- Yes, people can do illegal things with or without CON. The point is that CON invites and encourages this behavior. The hospitals in WV did what they did with the full knowledge of the CON authority. The CON authority was aware and gave it their blessing. The illegalities can be subtle. For instance in Michigan, a group applied for CON to start this new therapy- photon gene therapy centers. The reaction was to change CON laws so that it wouldn't qualify. CON invites collaborations that could violate anti-trust laws.

Question from Paul Gaynor- On page 2 of your paper, it states "in our anti-trust investigations we often hear the argument that healthcare is different". Is it?

- Miller- Different in the sense that most industries think they are special or different. So healthcare is the same as other industries in that sense. The Society of Professional Engineers says that you can't bid for jobs based on price- competitive bidding because it can undercut public safety.
- Gaynor- Is healthcare like engineering? Is healthcare a commodity?
- Miller- Not like steel. The economics of healthcare are different.
- Gaynor- Is it fungible? If I go to hospital A to have my appendix removed, is it the same as going to Hospital B?
- Miller- No.
- Gaynor- Should healthcare be a fundamental right?
- Miller-That is beyond my scope here today.
- Gaynor- Do you personally believe that healthcare is personal right?
- Miller- My point of being here, and my job, is not to talk about personal rights, but to talk about the benefits to competition.
- Gaynor- You list cost containment as one stated benefit. What are the other benefits that a CON state is trying to attain through CON?
- Miller- Protecting charity care by protecting revenue through less competition.
- Gaynor- And you don't believe that works if CON stays.
- Miller- I wanted to steer you to evidence from the Lewin Group report.
- Gaynor- Do you have evidence from states without CON that supports the statement that CON does not contain costs, increase accessibility and improve quality of care?
- Miller- If I understand you correctly, there are two MedPac studies that have addressed that.
- Gaynor- Earlier witnesses have suspected that this is the case, but there is no direct evidence. There are not enough studies. Are you aware of the lack of studies for your proposition?
- Miller- If you are just talking about the fundamental point, I think there are stacks of evidence.
- Gaynor- What about cream skimming?
- Miller- I don't know that evidence proves or disproves it, but it does make sense. I know it is the concern of the community hospitals that ASTCs and the like will skim the cream.
- Gaynor- The goal of ASTCs is to make profit right? They are trying to get patients that can pay. Would you agree that there might be a skimming effort off of a hospital by an ASTC?
- Miller- The evidence from the Lewin Group study was not strong. The location of those ASTC facilities is not close to areas where there is a high Medicaid population.
- Gaynor- Are you mainly relying on the Lewin Group report for your factual statements?
- Miller- No, I read the study and I think it is most directly on point, but there are other studies.

Question from Senator Garrett- W hat is MedPAC?

- Miller- It is an independent group that informs CMS policies.

Question from Senator Garrett- I was surprised that you immediately linked CON with charity care. In Illinois, we don't have a direct link. Our Task Force is considering that perhaps we should directly link CON with charity care. How did you come about that statement?

- Miller- I was putting out there the statements that CON proponents often raise as a reason for keeping CON.
- Garrett- Are you saying that if you do include charity care in the CON process, that this is negative?
- Miller- I was trying to evaluate the argument that CON protects charity care. I was trying to see if that holds up factually. And, if so, is there a less restrictive competition mechanism that would still protect charity care?
- Garrett- In IL, we don't link charity care with the CON process, and we are talking about considering it. So if we did, are you saying that would be bad because there is lack of free market?
- Brady- He is simply saying that if we allow the free market to come in and cherry pick, there won't be anyone around to provide charity care.

Question from Senator Garrett-We've all heard about the collapse of Lehman Bros, and I am not comparing the CON process to the fallout in financial markets. But both presidential candidates say we need oversight. Because we didn't have oversight of the financial markets, it may have caused the downfall. Huge investments are made in healthcare that we can't take lightly. Do you see any comparison for the need to keep some sort of healthcare oversight like CON?

- Miller- CON laws were not originally designed to augment traditional state law licensing and oversight. We are not saying that should be done away with, but that CON is an overbroad mechanism to prevent competition.
- Garrett- So you are narrowly focused on the competition, and you don't see the benefits?
- Miller- I think that you should see if the benefits do exist to CON.
- Garrett- Has the DOJ ever sent IL a letter regarding the CON process in last 20 years?
- Miller- I don't think so, no.

Question from Ken Robbins- Mr. Miller, is it your sense that without CON there would be a free market in healthcare as we see it today?

- Miller- I don't think so.
- Robbins- Abandoning CON suggests that market forces will positively affect the hospital environment.
- Miler- It will positively affect the hospital process overall. But if you are a hospital that loses revenue to new competition, you are not positively affected.
- Robbins- What kind of market competition is there really if, on average, half the revenue of hospitals comes from public aid? And if predators come in and siphon off insured patients.
- Miller- Competition provides benefits. Patients like to have the choice to go to a lower cost facility - like an out-patient facility.
- Robbins- But those same patients that can make the choice could be the very same people who need emergency services of that hospital one day, and that hospital could be closed because it lost revenue due to competition.
- Miller-Look at the evidence critically, and see if it is true.

Question from Gary Barnett- In my hospital we have 16% uninsured patients, 35% Medicare patients, and 17% Medicaid patients. A full 68% of the market would not have access to the services of an ASTC. Only 32% of consumers have any choice. Only CON stops the ASTC from being built. I fail to see how your report is even useful.

- Miller- But there are some people who have choice.
- Barnett- So you are advocating a policy that would benefit 32% of our community?
- Miller- Your community hospital should have the authority to deny choice and protect your revenue?
- Barnett- No I am saying that a state agency should have the authority to review the evidence and make the decision.

Question from Howard Peters, IHA- Isn't is also true that in some of the non-CON states, low income people have basically been abandoned by major medical players and no longer have ready access to healthcare?

- Miller- Are you asking if hospitals are exiting urban centers? I don't know the answer to your question, but the states without CON have other forms of regulation, so I don't know if it is accurate to say what you said.

Question from David Carvalho-You make repeated reference to less restrictive being a better alternative. Does your analysis include what is politically feasible? Getting the legislators to target something that only affects a few areas is very difficult.

- Miller- No the analysis doesn't include political climates.
- Carvalho- You argue for efficiency, not social justice. In your analysis, if you had a hospital in a center of an urban area, and without CON that hospital could move to where more affluent people are, does your analysis state whether that is positive or negative for the people in the lower income community? Have you done a population equity analysis?
- Miller- No, I haven't. But I urge you to look at the evidence.
- Sister Sheila Lyne- I think we are back at the old-new argument. Is healthcare a public good or a marketable commodity? I see it as a public good, like education- every child has a seat, and every person should have access to care. But I am not so naïve to think that we will get back to thinking of healthcare only as a public good.

Question from Rep. Lou Lang- You've argued that competitive forces would allow choice and bring down healthcare costs, etc. Where in that model is health planning?

- Miller- Again, that is a bit beyond the scope of my remarks. There are still regulatory planning agencies in states without CON.
- Lang- Do those regulatory agencies provide incentives to build facilities in areas of great need?
- Miller- I don't know the answer to that question. It depends on the state.
- Lang- So there is no research on that in your office.
- Miller- No. My point is that CON is an overbroad mechanism.
- Lang- If there was no CON process at all, how do we ensure that we don't end up with a bunch of facilities built and there is no charity care at all?
- Miller- I question why you would predict that result. I am not aware of the evidence that would point to that.
- Lang- Is there any evidence in states without CON relative to care for the poor to see what the result is for patient care?

- Miller-There are two studies that we cite in our paper- Lewin Group and MedPAC.
- Lang- Can someone can get us the MedPAC study to review?

Question from Margie Schaps- I've been in this field for 30 years, and I am not aware of any studies that show that patients shop around for healthcare services. I don't think it is true in healthcare. Either that or I haven't seen any studies in 30 years that say that.

- Miller- What I am thinking of are tiered networks in health plans where co-pays go up if patients go to a certain type of facility.
- Garrett- But the insurance plan dictates that right?

Question from Senator Brady- This is an area you can guide us on. If we continue with this CON Board, do you have any advice for us with regards to preventing corruption? And how do we structure the board to prevent anti-trust issues?

- Miller- With regards to corruption, I don't know. A different part of the DOJ works on that. If someone breaks a law in a knowing way, having or not having a CON won't make a difference on that intentional act. My paper discusses some of the pernicious acts that can happen due to the CON process.
- Brady- What about anti-trust? Are we free from anti-trust laws because we are a sovereign state?
- Miller- CON agreements or private agreements without the state involved are in violation of anti-trust laws, but when the state is involved, those agreements are immune.

Presentation by Dr. Gordon Lang, (testifying independently from Illinois State Medical Society)

- Board certified Nephrologist since 1971
- IL legislature passed first bill to cover dialysis treatments for all patients in 1967
- Since then, dialysis has expanded and generates millions of dollars
- Problem today is that there are 2 major providers in the state provide 81% of dialysis treatments. 16% of dialysis services are done by hospitals, 1-2% are offered by independent doctor groups.
- Expensive for nephrologists to open a facility- very difficult to open a dialysis center.
- Hard for nephrologists to establish a practice. Have to join a large group on their terms, takes 5 years to get to partner level.
- The lack of competition in the dialysis market affects quality.
- One can't open a dialysis center in IL without CON approval. CON regulations require that dialysis facilities be a certain distance apart but I argue that this distance is too far. Right now patients have to drive too far for treatment. Southern IL patients have to travel 40 miles for treatment. This affects the elderly too. The problem is that it is hard for older folks to drive through bad weather conditions. It makes it hard for them to get treatment.
- Some south side dialysis centers serving African Americans and Latinos serve hundreds of patients, and that may be too large. The quality of treatment suffers when you have hundreds of patients using the same facility.
- Get rid of CON for dialysis- let the free market do its work.
- Physicians bring the patients. CON is counterproductive, anti-competitive, and hurts quality.

Question from Rep. Lou Lang- I understand your argument. Have any dialysis units been turned down by board?

- Dr. Lang – Yes. A few other doctors and I applied for one in St. Charles, and we were turned down.
- Lang- Your position is that you were turned down, not for lack of need, but from pressure from other providers?
- Dr. Lang- Yes, that is what I think.
- Lang- In your field, what is the danger of having a nephrology center on every block?
- Dr. Lang- The only way people would suffer is if the nephrologist were a bad doctor.
- Lang- So you are only advocating for this narrow area. Do you have an opinion for other types of facilities?
- Dr. Lang- It's a complicated problem. The problem with healthcare today is funding. There should be a single payer, and the government needs to figure out how to fund it. And rich people could then buy a supplemental policy. But everyone should be able to have healthcare, and go to a hospital. How many hospitals have closed in the inner city in Chicago? That could have been during the outpatient care push. Medical students aren't going into primary care- who will provide that care in the future? The primary care doctors refer patients to hospitals. How will someone survive in this economy? ASTCs in rural areas could be a joint venture with hospitals. You need to provide care.
- Lang- should other specialties be immune from CON if we keep it?
- Dr Lang- I would have to look closely at that. Access is the lifeline for the patient. You need to get patients in where they can get care quickly.

Question from Claudia Lenhoff- My question is about outpatient dialysis. Is it costly and how it is paid for?

- Lang- Medicaid, Medicare, and private insurance pay for the first 33 months.
- Lenhoff- How many patients would you have to serve to make a profit?
- Lang- A facility could maybe make money with 2 shifts. With the addition of a 3rd shift you are definitely making money.

Question from Senator Garrett- Most of your patients are elderly. And most are on Medicare.

- Lang- Yes, the average age of a dialysis patient is 62.
- Garrett- The federal government is paying for a large portion of these services. You would think they would have an interest to ensure the dollars are spent in a cost effective way. Has there ever been a time when the federal government has come in and said, for your profession, we are paying the bills and want it to be more open?
- Lang- The government has an interest in the respect that they hire the state to inspect units. The government reimburses fees for service, but does not provide money to build a dialysis center. If I go out and build a dialysis center with my own money, I am the one who loses money if the center fails. I don't think dialysis centers should be regulated by CON, because patients will benefit from the option of more treatment centers.
- Garrett- So right now, if you collaborate with other physicians, you can set up a dialysis center?
- Lang- Yes, if approved by CON.
- Garrett- And you have been denied once.
- Lang- Right.
- Garrett- When it's Medicare, they should have a say in this. When the federal government is responsible for the payments, they should weigh in.
- Lang- I think that I should be allowed to open a facility with my money. The government only pays money if I open a facility and provide reimbursable services.

- Garrett- Yes, you do open it with your money and then get federal reimbursements.
- Lang- About 85-90% of dialysis patients receive Medicare reimbursement. I see a lot of people lose their private insurance, and they have Safety Net to rely on(Medicaid, Medicare.) I bill Medicaid and Medicare for $100 per treatment, and I get reimbursed $16.23. It is not the states fault- but where is the money? That is a problem.

Question from Rep. Dugan- You said how many dialysis facilities are owned by 2 groups in IL?

- Lang- 81% of facilities are owned by 2 groups.
- Dugan- Why don't hospitals do this work?
- Lang- Hospitals were losing money on dialysis and it was easier for them to spin it off. Space is a problem for the hospital.
- Garrett- You don't have to go to a hospital or center for dialysis. Isn't there dialysis you can do at home?
- Lang- When you have elderly patients, who will be trained to help them with their home dialysis machine? And on a daily basis? Who will reimburse for home dialysis?

Question from Kurt DeWeese- What was the staff opinion on your CON application?

- Lang- Staff said there was not a need and the board concurred. They said there was another dialysis center only 30 minutes away at a hospital. My contention is the weather- it is hard for elderly patients to go 30 minutes in snow to get treatment.
- DeWeese- Why is it hard to get facilities in the south side? CON doesn't provide incentive to make those investments on an economic basis.
- Lang- The problem with CON is that they look at usage rates. If nearby dialysis centers aren't at capacity, they won't allow you to build a new one. Also I have talked to nephrologists in other states who won't come to practice in IL due to CON. It's too expensive.
- Garrett- When they say it's too expensive, they aren't talking about reimbursement, but the process to go through CON?
- Lang- Yes, it cost me $86,000 to hire a lawyer for the CON process. Total cost was about $100,000.
- Garrett- That is my problem with the CON process. There is a cottage industry of consultants and attorneys around the CON process.
- Lang- Yes, there is. You can do this process online for free.

Question from Jeff Mark- You cited 81% of dialysis services provided by DaVita and Fresenius. According to our data, 66% of facilities are owned by those 2 companies. I think that is fairly standard percentage across the country.

- Lang- My numbers are from the National Kidney Foundation. According to them, the average is 72 percent. So my numbers may be correct or yours may be. But regardless, I think it is anti-competitive.
- Mark- In my memory of the last 5 years, the board has not turned down any dialysis applications south of I-80 except in one case where they wanted to build right next to each other. It may not be the regulatory process that prevents dialysis centers in rural areas. Also, we have people who do write their own CON applications.
- Lang- I know one person who did wrote their own CON application and was able to open a center in Harvey. But he wasn't a doctor in practice.
- Garrett- $86,000 was your attorney fee or the application fee?
- Lang- It was the Attorney fee, but it may include the application fee.

Facilitated Discussion

Senator Susan Garrett- Laura McAlpine was chosen by the subcommittee to be our facilitator. She will introduce herself before she starts to facilitate the meeting.

Laura McAlpine- Thank you for this opportunity to facilitate your discussions regarding the recommendations the Task Force will establish. Though my main work today is as your meeting facilitator, I have attended almost all of the Task Force meetings up to now, taking minutes with my colleague Mairita Smiltars. I have my own consulting firm, which I started in 2001, and previous to that I was the Policy Director at the Illinois Caucus for Adolescent Health and the Executive Director at the Chicago Women's Health Center. I am a Licensed Clinical Social Worker. My closest experience relating to the work of this Task Force was my facilitation on behalf of the Illinois Public Health Institute for the State Health Improvement Plan process, which was a year-long statewide planning effort.

We are going to try to accomplish three things in the next hour and a half:

FACILITATED DISCUSSION OBJECTIVES

- Discuss and vote on key questions to guide final recommendations
- Prioritize remaining statutory requirements for future discussion
- Establish next steps for the completion of the Task Force

Primarily this is a discussion for the Task Force members. Each of you will get 1-2 minutes to give us your responses. Senator Garrett and Rep. Dugan also will allow the opportunity for staff to participate, based upon approval of Task Force members to cede some of their discussion time. Initially, we will go one at a time to give people time to respond. You can pass if you'd like. There may be time for back and forth dialogue.

Before we start the discussion, I want to review the ground rules.

- Speak one at a time.
- Be open to new ideas. Though you may come from different positions, it is clear that you all care deeply about healthcare for IL citizens. Think about that commonality as you hear others responses.
- Step up, step back. Those who are often eager to enter the conversation, consider stepping back. Those who often wait for the group to discuss before entering the conversation, consider stepping up. I encourage you to switch roles.
- Speak to new ideas. Avoid repeating previous remarks.
- Allow me or Senator Garrett and Rep. Dugan to move us along.
- Try to stay in the conversation as much as you can (i.e. limit distractions like side conversations, cell phone calls, email, etc)

The group agreed to follow these discussion agreements.

THREE QUESTIONS

Laura McAlpine: We will start with three key questions, developed from the Discussion Framework distributed prior to this meeting:

- Question 1- Do we repeal the Act authorizing IHFPB?
- Question 2- Do we keep the board itself or do we close the board and give its functions to another entity?

- Question 3- Do we continue the core functions of the IHFPB – CON (regulatory) and statewide health planning?

Keep in mind the key topics from the statutory language in answering the three questions listed above:

OVERALL IMPACT

- The impact of health planning on the provision of essential and accessible health care services;
- Prevention of unnecessary duplication of facilities and services;
- Improvement in the efficiency of the health care system;
- Maintenance of an environment in the health care system that supports quality care;
- The most economic use of available resources;
- The effect of repealing this Act (authorizing IHFPB)

REFORMATIONS

- More actively address health care needs
- Communication/coordination with other health planning laws and activities
- Primary focus and process
- Evaluations of ASTCs, specialty/alternative health care providers
- Protection of Safety Net services
- Transitional impact on existing applicants
- Funding
- Communication with the public/transparent process

RECOMMENDATIONS

- Optimal size of IHFPB
- Optimal organizing structure of IHFPB
- Long-range health facilities planning
- Treatment of LTC, acute care
- Emerging Trends
- Review process changes
- Enforcement and Compliance
- Conflict of Interest

Discussion re: Question One- Do we repeal the Act authorizing the IHFPB?

- Lyne- no.
- Schaps- no
- Lenhoff- no
- Ruddick- no
- Garrett- pass
- Barnett- no
- Althoff- The current process needs extreme revision. To completely eliminate CON would be short sighted, but we could phase it out. Refocus the whole mission to planning.
- Robbins- No, but I too think there needs to be significant re-examination of mission and process to make sure the efforts of the planning board are focused on important issues. Streamline less important issues.
- McNary- No, and I will echo to a certain extent Althoff and Robbins.
- Gaynor- I agree with Ken Robbins but we need to define what the “important issues” are.

- Brady- Abolish it as it is today. I would hope that from what we've learned we can develop a system to enhance competition, eliminate corruption, bring more expertise, and decide what CON should be involved in. ASTCs and LTC, etc. are needed. My goal is to eventually let the private sector handle it but we need to fund Medicaid appropriately first.
- Dugan- No, and I agree with what Althoff, Robbins, etc said. The Act is good, but goals and objectives needs to be revamped.
- Lang (stepped out)
- Mark - I would ask that if the decision is not to repeal the Act today, deal with getting rid of the sunset or extend it for a long enough period of time for the staff to develop the board. 1-year and 6-month sunsets create dysfunction.

McAlpine – To summarize, the consensus is a qualified no, do not repeal the Act. People want things clarified, defined, revised before it becomes an absolute no, do not repeal the Act.

Discussion on Question 2 and Question 3:

#2 Do we keep the board itself or do we close the board and give its functions to another entity?
 # 3- Do we continue the core functions of the IHFPB – CON (regulatory) and statewide health planning?

- Garrett: Regarding Question #2, I would like to discuss closing the board, keeping the Act in place, but using a different entity to provide healthcare planning.
- Lyne - Without figuring out the core functions, it is hard to answer #2. Have to know what you want to do before you know who should do it. Core functions should be defined.
- Dugan – I don't want to close the board, but I want to give them different responsibilities from the planning end. Personally, I think the board should do more planning and another entity should do CON. I don't know what that entity is yet. Leaning towards having the IHFPB as an appeals Board instead of the decision making board.
- Schaps- I would reverse it- the board is not doing planning now but they are doing the CON process. I would like to have that discussion, but I would vote to have them continue CON but have another entity do planning.
- McNary- I haven't figured out what this other entity is, so rather than talking about closing the board without figuring out what that entity is, I would vote to keep the board if they are doing their charges correctly. Expand scope of IHFPB to answer 4 questions:
    - How can the IL health facilities planning process make healthcare more affordable?
    - Create Better access?
    - Adequately compensate medical institutions, especially those that get Medicaid and Medicare reimbursement?
    - Provide adequate levels of charity care?
- Gaynor- health planning is not really being done and it needs to be done by some entity. I agree that we should keep and expand the IHFPB.
- Lenhoff- Board's function has been more reactive with respect to CON, and not proactive due to board size and staffing limitations because of the sunset. I am interested to look at better resources to help the planning process.
- Brady- I would not keep board as it is. Size and structure and functions don't make sense. Scrap it and start over if we keep it. I don't think we appoint any board to deal with charity care- it should be a function of the legislative and executive branch directive. Way too big of an issue to delegate that function. I don't think the board operates the best it could, with all due respect to participants.

- Ruddick- I like the way William set out four core questions/purposes- I don't care if we keep the board or start over as long as we answer the core purposes. Seems like it would be easier to keep the current structure of the board.
- Barnett- This conversation has reinforced sister Sheila's point- until there is a description of what needs to be done, we can't figure out who does it.
- Lyne- Form follows function.

Laura McAlpine- It is clear that you want to engage in a discussion about purpose. The consensus is that the core functions of the board have to be clearly defined to move forward with form.

- Robbins- I have a process question. When we are done with the questions, will we come back to these issues in a more focused way?
- McAlpine- We designed this conversation today to start by getting a sense of where the group is at with key questions in order to see where we go with in depth conversations. We moved quickly through the question of whether or not to keep the board. Now the debate is about the core function of the Board, what resources get allocated for that work- it is an expansion, reduction, status quo?
- McAlpine- I am now asking how we should prioritize where we are going with our discussion. In the statutory language, you are asked to consider certain questions. There is a whole list of reforms and recommendations.
- Robbins – As long as we understand that there is not consensus on the things written down on the large post-its that capture people's comments and that those points are for future discussion.

The group decided to walk through the statutory topics one at a time, starting with health planning, and using the Discussion Framework as a guide.

Discussion on Statewide Health Planning

- Carvalho- You need to define and get consensus on what you mean by health planning.
- Garrett- Health planning is having a map of state that shows where there is growth, population shift, and availability of healthcare resources in an area. This information should be updated every year.
- Robbins- Is that a health plan or is it analyzing what is in place? It is one thing to count the facilities, i.e. taking inventory. Health planning can be more proactive, and provide recommendations regarding what is identified by the planning. Not just saying there is a lack of service in a particular area. So then what? Does the planning board provide incentives or enforcements to get facilities to open in areas of need? How do you execute a plan?
- Althoff- Building on this, you first need to get an inventory, then decide how to address the needs that arise from that information (evaluation), and then you need a process to rectify issues raised in the evaluation. Then you need to do the process again. Need to have information to start with first so that we can identify problems.
- Barnett- I think of planning in a broad way. Facility decisions shouldn't be separate from funding, manpower and education decisions. Planning should be broad so that it can inform the legislature on a whole host of issues.
- Lang - When we do planning we should invest in a planning board- could be separate or could be a subcommittee of a larger board. We need incentives to build in areas of need and disincentives to not build where not needed. Low interest loans from State of IL to encourage developers to come forward and help build where things need to be built. A good board could do this and provide better overall care.

- Dugan- Rural health planning needs to be tied in to overall health planning
- DeWeese- The Office on Rural Health gives grants for projects in rural areas. Some funding mechanisms for rural health needs are in place.
- Dugan- As we go forward in the state, rural planning is important to tie into this. Right now we have 2 agencies both addressing health care in the state of IL but they don't coincide with each other. Bring it together. Health planning should look at the picture and lay out the future- so that we make decisions based on need. I don't know if we know the true need- and that is vitally important.
- DeWeese- Historically there was a comprehensive health planning organization in the 70's and early 80's. For lack of support, it never achieved what it was intended to do. National Act envisioned determining areas of needs and incentives offered to build facilities in those areas.
- Lyne- The planning needs to be not just for facilities, and needs to be proactive to encourage facilities to go to areas of need and improve quality. Particularly with regards to mental health.
- Robbins- The Act is called IL Health Facilities Planning Act. It doesn't always need to be called that. Health planning goes beyond bricks and mortar. It was mentioned that there is a shortage of primary healthcare physicians coming out of medical school. Workforce issues needs to be addressed. So if health planning only worries about bricks and mortar, another entity should look at the big picture.
- Ruddick- The system right now is almost entirely reactive, i.e. the Board turns down proposals. For a whole range of issues, there needs to be a way to identify a need or problem and be able to produce solutions. Proactive planning will have to take a broader view. Seems that we need a broader view, and have incentives and perhaps penalties. Preservation of the Safety Net should be part of planning. Also examine LTCs and their relationship to assisted living.
- McNary- Top priority of planning should be coordination between local, state, regional, and national governments to avoid duplication and ensure access to affordable, high-quality care for everybody. Make the health planning process predictable, transparent, and efficient – board should give more time for public comment and clear answers to decisions made on applications.
- Garrett- We could implement a silo planning procedure that looks at all healthcare entities (LTC, mental health, etc.) separately and then someone can put the whole picture together. Distinct topic planning that is synthesized at a higher level.
- Lang- People on the board have to have some expertise. Create criteria for board members.
- Brady- Don't know if this will work from government. We ignore plans all the time in the legislature. We create task forces to evaluate our shortages. I am not buying into the fact that we need an appointed bureaucracy to create a plan that will sit on the shelf. The market place can plan better than government.
- Schaps- I think quite the contrary. We've seen what can happen when there is no plan. Facilities need to know where the population is shifting.
- Brady- Entities in the market place are constantly looking at demographics before they open new facilities. And they can probably do it a heck of a lot better than a bunc h of bureaucrats.
- Lang- I don't think it's either/or. The planning part of this would enable us to seek developers to build facilities where we know we need them. That doesn't preclude that the open market allows developers to build where they want to build or plan, but it would allow us to create programs to seek out development in areas of need.
- Brady- I don't disagree that the State of IL needs to determine areas of shortage. But I don't think it needs to be some sort of ongoing board that produces a report every year. I don't want to create a mission and goal to make us feel good and create a board that doesn't accomplish anything.

- Garrett- Business is always planned at least 5 years in advance. I don't think we can afford to not put an established process in place for planning. IDPH should have the planning responsibility, not a Board.
- Brady- Which is my point. My opinion is that as a state we need to consciously look at areas of healthcare but not necessarily create a new board.

Group decided to address the question of what entity should address health planning. The group also agreed that more discussion at a later time is needed about the other bulleted points related to health planning in the statutory language (unnecessary duplication, efficiency, quality, etc.).

Discussion on entity to conduct statewide health planning: Does health planning stay at IHFPB level, or get enhanced and done by another entity (e.g. IDPH)

- Lang- Separate entity or separate unit at IHFPB with independent powers. Planning unit should provide incentives or disincentives.
- Schaps- Agrees with Lang, but the two units should be inextricably linked. If we want CON to function well, it should be closely connected to planning process. Planning could be a staff function.
- Lyne- Agrees with Schaps, planning should be for something real. Planning is not just an exercise. The plan will inform the actions that CON takes.
- Gaynor – Not just planning, but also accessible services
- McNary - I need to know what the other entity is before I can weigh in.
- Garrett- Who does the situational analysis? Not the Board – the Board does the directives. If you have say 11 board members, do we expect them to do the research and come up with all the requirements for health planning? The statute would be compiled by another entity and the board would provide directives based on the statute put before them.
- Brady- First, I think the State of IL needs to do a statewide health access analysis. Then a group should evaluate that, and decide where there are shortages and what needs to be done. We could find someone who can tell us where we are today and what we need to do for better planning. Hard to put the cart before the horse.
- Dugan- I think we've decided we need a better plan, but now we need to decide who does it. If we can decide who does it, we can pull the details together of what we want them to do. I think the IHFPB should be the planning board.
- DeWeese- There are already federally defined underserved areas. There is a foundation for defining areas of resource development. I can see where an entity can review information and pull forth recommendations.
- Lyne- I know there are numbers some place for planning, but it hasn't been interactive. Outside of IDPH, we don't know anything about it. I am not opposed IDPH doing the planning, but it needs to be more accessible and communicated.
- Garrett- If in the statute we have the directives of what needs to be done with planning, I feel the Board should oversee that process. I don't know of a board that does that much work creating reports. I strongly suggest that IDPH update the health planning info on a yearly basis through statute, and have the Board oversee it.
- Carvalho- In fact, a huge amount of what you are talking about exists in different places. SHIP, inventory and access information already exists. What is missing is that there is nobody to foster development of what is missing in healthcare in underserved areas of the state. Right now, the information exists in different places and is referenced in various reports. CON board uses the bed inventory in a reactive way.

- Lang- I am completely opposed to IDPH being the health planning agency. I don't think any agency directly under the governor should do health planning. Have a completely separate unit or part of the board that operates as an independent unit.
- Dugan- When I reference the Health Facilities Planning Board, I don't necessarily mean the current one we have. I think it should be redesigned/revised.
- Ruddick- Sometimes when were refer to the IHFPB we are referring to just the board members and sometimes we mean the professional staff as well. Some sort of professional staff need to do that planning work as the board members can't be expected to that much work.
- Gaynor- Planning is part of the function of what the board will look like- how many members, categorical ,etc, etc. We can go on with this discussion later and reference all of those other details.
- Robbins - There is not enough time to do justice with a discussion on all of the starred items today. Are we just talking about overall health planning or do we discuss the overall impacts individually as they related to the IHFPB? I would recommend that next time we carry on with discussing each of the points under overall planning as they relate to the board.
- Brady- The majority of us decided a board should exist. Now we should figure out what do they do? Why do they exist? What do we want to see the board do? What is the objective of the IHFP Board?
- Schaps- What is the role of the IHFPB?

The group decided to move the discussion to address the question of the core functions of the IHFPB.

Discussion of new question- What should the revised IHFPB entity have as its core function?

- Dugan- There needs to be one entity that does the health plan for the State, and that coordinates with the entity that does the CON process. Two separate entities. Future discussion to enumerate details of what each board would do.
- Gaynor- 2 entities with coordination between CON board and other entity that does the planning. One core function of the CON Board is to be responsive to the planning board (that also has professional staff). CON criteria includes relationship to planning. Or planning could even be done by staff, and then Board members approve applications based on compliance with overall health plan.
- Robbins- Agrees with Gaynor.
- Schaps- Use the plan to ensure setting priorities for serving underserved populations without current access to health care services.
- Lenhoff- I agree with coordination between CON board and planning board. I also think that staffing is essential. There are people who do health planning professionally. Protection of safety net and access should be core functions of the Board. Strengthen capacity for community to have input in the process.
- Lang- Agree with a lot of what I heard. Planning and CON should be separate functions that interact. They ought to be properly funded, properly staffed with professionals, and offer pay for Board members if we decide on it. Board can deal with CON but we should limit what the Board does. Take the whole CON process out of the governor's office. Streamline the application process. Planning board power to do outreach and incentivize healthcare providers.
- Ruddick- The Board should promote access to quality care by protecting needed services from discontinuation or unnecessary competition, and take a more proactive role to promote and enhance services for underserved.

- Althoff- Important for entity to be consistent and identify needs consistently, and ensure we don't inhibit free market from responding to those needs, and assists or guides when needs aren't met by the free market.
- Barnett- There ought to be a separate organization from IHFPB to create a plan that focuses on access and quality and that provides guidance for CON decisions made by the IHFPB.
- Robbins- The state has never really had a health plan. It has budgets. I think it is time that an entity be held responsible for creating a health plan. I can save my comments on whether or not it sits inside or outside of the IHFPB for another time. The board could make legislative recommendations based on where there are shortages of services.
- Brady- I support planning on a periodic basis. CON should somehow balance the free market with preservation of economically challenged areas to preserve services.
- Lyne- I second Gary Barnett's comment.
- McNary- Regarding core functions, Citizens Action has viewed CON certificates as a gift from the state, and thus we believe that the state should expect an investment in charity care and community based initiatives. Prioritize preservation of safety net hospitals.
- Garrett- I want to define a hierarchy. Illinois Public Health Institute, which is separate from IDPH, could do the health planning. The IHFPB could oversee that and make sure it's responsive. There is separation of power. Conflict of Interest for board to come up with a health plan AND making application decisions.

Next Steps

Laura McAlpine- We have one more scheduled meeting in October. We need to decide what we do at the next meeting and if we need additional meetings.

- Garrett- We all want to the same thing with respect to health planning. If we can define that, we can put certain responsibilities on the planning entity versus the board. I think I hear most of us saying that there should be 2 separate entities.
- McNary- I am being convinced we should have 2 entities, but I don't want to lose sight of the functions of the IHFPB.

Group decided to use the October 8th meeting to discuss the CON process and the structure of the IHFPB. An additional meeting was added for October 30th, 10am-2pm. The Task Force members will be provided with a written summary of today's discussion, as well as key questions for the October 8th discussion to consider. Senator Garrett asked for information on how the Illinois Public Health Institute is funded and its relationship to IDPH in advance of the next meeting.

Adjournment: 1:56pm

Minutes respectfully submitted by Mairita Smiltars.