Illinois Task Force on Health Planning Reform
Monday, June 9, 2008
10am-2pm

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

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

Task Force Members Present:
Chicago: Kenneth Robbins, Gary Barnett, Rep. Lisa Dugan, Margie Schaps, Claudia Lennhoff, Rep. Lou Lang, Paul Gaynor, Senator Susan Garrett, Sister Sheila Lyne, Heather O'Donnell, Hal Ruddick, Senator Bill Brady, Senator Pam Althoff
Via Phone: Rep. Renee Kosel

Ex Officio Members Present: Jeff Mark/HFBP, Barry Maram/HFS, David Carvalho/IDPH, , Ginger Ostro/GOMB

Staff Present:
Illinois Public Health Institute (Chicago): Kathy Tipton, Mairita Smiltars, Laura McAlpine
Legislative Staff (Springfield): Kurt DeWeese, Mike Jones/HFS, Melissa Black, Greg Cox
Springfield: Kathleen Dunn (IHA), Theresa Eagleson (Medicaid director)

Court Reporter: Joanne Ely

Call To Order: 10:06am

Action: Approval of 5-12 Minutes
Rep. Lou Lang motioned to approve the minutes, seconded by Heather O'Donnell. Minutes approved.
(Note: At the end of this meeting, Ginger Ostro mentioned that Charles Foley was incorrectly labeled as legislative staff in the 5-12 minutes, when he is actually a lobbyist. Minutes to be corrected.)

Presentation by Mr. Ralph Martire, Center for Tax and Budget Accountability

- The Center is a bipartisan group that looks at big public finance issues- national, state, local. Database approach to analysis.
- IL has the 5th biggest economy in the USA, 27th largest economy in the world
- IL is not keeping up economic edge due to loss of manufacturing jobs
- Replaced the jobs with low wage service sector jobs with fewer benefits
- Today over 40% of the private work force does not have employer provided health insurance
- 27% of IL pop is uninsured or on public health coverage
- Demand is raised on public health care, safety net providers via increased utlization:
    - Medicaid/Medicare
    - Taxpayer-funded public health facilities like Stroger Hospital
    - Charity care provided by non-profit hospitals
- Charity care definition includes free or reduced care to patients who cannot afford to pay for their care
- Charity care is financed through indirect spending in the form of tax breaks to non-profit providers
- Tax expenditure is the same as a direct expenditure- the impact on government is the same whether it spends money directly or foregoes receiving revenue by granting a tax exemption for specified activity
- Tax breaks- federal income tax, state income tax, local property tax, and state and local sales tax exemptions

- Income tax- IRS requires that non-profit hospitals provide a "community benefit" in exchange for exemption. "Community benefit" is not defined. IL state tax is the same.
- Property Tax exemption in IL- tied to free or reduced services for people who cannot pay
    - Methodist law suit
    - Bad debt and Medicaid shortfall do not constitute charity care for property tax exemption purposes
    - Provena Covenant case- didn't change the standard
- Sales tax exemption
- CTBA analyzed the value of tax exemptions to non-profit hospitals and compared it to the amount of charity care provided
    - Based on Dr. Nancy Kane's methodology- charity care standard
    - Findings: value of tax relief provided is mostly property tax relief, then state and local sales tax exemption - these 2 are 96% of the benefit
    - $105 million of charity care was provided- one third of the total tax relief given
    - If bad debt could be caught on the front end as charity care, then the amount of charity care would match the amount of tax relief given
    - Tax benefits received by hospitals studied are three times greater than the charity care provided
    - On average, the cost of charity care provided by the hospitals studied totaled only 1.8% of total hospital expenses
- It is essential that the charity care portion be dollar for dollar for tax exemptions.
- The increase in uninsured and Medicaid eligible people in IL, coupled with looming tax cuts means that there is less money to pay for more people's health care. So non-profit hospitals really need to give the full amount of charity care.
- Tax payers fund/finance charity care through tax breaks. Charity care fills healthcare gaps. Charity care needs to provide services to people that need it.
- If non-profit hospitals identified charity care patients at the front-end of the process, rather than in the collection process, 50% of bad debt costs could qualify as charity care.
- Charity care accountability measures that are fair and financially sustainable should be part of the CON process in Illinois.

- **Question by Ken Robbins**: He was disappointed in the 2006 CTBA report because he thought it was sloppy work that is not characteristic of CTBA. In calculating the value of the sales tax exemptions, CTBA used the Cook County tax rate, even if the hospitals were not in Cook County. Charity care is a large part of what the law requires for a tax exemption but it is not the only thing. If you did not have a system of non-profit tax exempt hospitals, then the government would have to own and operate hospitals. So these existing hospitals provide a community service. All of these things (bad debt, program funding shortfalls, etc.) need to be taken into account in order to see the full amount of service that a hospital is providing to the community. Issues with Nancy Kane's methodology. Ralph's presentation was misleading on the total amount of charity care that hospitals provide. What ought we to expect of hospitals that provide charity care? Is the CON process the right place to do that?
    - Paul Gaynor- is charity care/community benefit part of the six standards under the law for tax exempt status?
    - Ken Robbins- no
    - Paul Gaynor- Ken, you said that CTBA's work was sloppy because of the sales tax, so has the IHA recalculated it?
    - Ken Robbins- I think that we have, and I can get that for you.
    - Heather O'Donnell - we did acknowledge some of the problems in our methodology
    - Ken Robbins- I appreciate that you acknowledge that.

- Heather O'Donnell- many hospitals reported bad debt as a community benefit- $307 million dollars in excess of cost
- Senator Garrett- these debated issues are all relevant, but I don't think we have clear directives in the state law about charity care and community benefits. No clear definition of how bad debt can count as charity care.
- Paul Gaynor- hospitals are cheating themselves because they cannot get "credit" against their exemption for bad debt, even though most of the patients with bad debt would qualify for charity care
- Senator Garrett- There is no precise formula- and maybe the task force should come up with a formula so that hospitals know how much bad debt they can apply towards charity care. We need to make it clear, so that we don't have to go through the Supreme Court.
- Paul Gaynor- we could use the CON process to have hospitals show or establish a certain percentage of charity care to move forward with a project. Hospitals would certainly get credit for that.
- Senator Garrett- we are saying the same thing.

- **Comment by Claudia Lennhoff**- I have one issue to consider from the community perspective. CTBA recommendations seem very common sense. We have to remember what happens to the patient/consumer in the pursuit of bad debt. Some people who should have qualified for charity care are instead billed. Someone who is pursued for bad debt becomes intimidated. Consumers don't know that the law is that they can go to a hospital even if they have bills under collection, so when they do finally go they are sicker and more in crisis. One hospital (in her area) is now trying to do a better job of finding charity care cases on the front end and their percentage of charity care is going up.

- **Question by David Carvalho**- There is a federal statute – EMTALA -- that requires a hospital to provide care in an emergency condition no matter if the patient is insured or not, and this is applicable to both non-profit and for-profit hospitals. And interestingly, charity care in for-profit hospitals is not terribly different from non-profit hospitals. Apparently the effect of the EMTALA law is that you have to provide some level of charity care whether you want to or not and whether you are for profit or not for profit. Should the test for non-profit hospitals to keep their tax exempt status be based on the level of charity care that a non-profit hospital provides minus the base level that for-profit hospitals provide? Have you seen that issue discussed?
  - Ralph Martire- CTBA didn't analyze that piece because we couldn't get data, but I think it is a legitimate point. Tax exemption is given because these hospitals are relieving government of paying for this care. The Nancy Kane method has been accurate in other states, and when it was done here in Cook County, we came up with a more conservative number than the County Assessor. So I don't think we did sloppy work. We did not hide anything in the report, and we had it vetted by many groups, including IHA.
  - Ken Robbins- What I think is sloppy are the conclusions that came about from the inaccurate data. Also, for-profit hospitals are mandated to treat indigent patients in the emergency room, but they are not required to write it off as charity care.
  - David Carvalho- Just being a hospital with an emergency room will attract a certain level of charity care cases, and for-profits do report it as charity care.
  - Senator Garrett- This is a really good conversation to help us with our CON proposal and recommendations. There is so much room for interpretation in this issue. So, to clarify, a for-profit hospital has x dollars for charity care, but they don't get any tax exemption benefits, and is that fair?
  - David Carvalho- Any hospital in business will recover less than they should due to charity care-type cases -- that is just a cost of doing business. So non-profit hospitals should be given tax

exemptions for the level of charity care that is above the level of just doing business. To clarify, hospitals are only obligated to give emergency care without regard to ability to pay – they are not required to give it for free (i.e., they can bill).

- **Question by Hal Ruddick**- Going back to the sales tax issue- even if you shave the sales tax by a bit for hospitals outside of Cook County, I think the main point still stands that there is a gap between the benefit non-profit hospitals receive vs. the amount of charity care they give. I think the report is generous towards certain hospitals because it lumps all hospitals together. A Mercy Hospital is giving a greater amount of charity care and their benefit is less. If we removed the Safety Net hospitals from the data, wouldn't the data look worse?
    - Heather O'Donnell- I'll distribute the report to the Task Force.
    - Ralph Martire- The bottom line is that the estimate is accurate. We low-balled the figure to see if the government was getting dollar-for-dollar for their money and they aren't no matter how you slice the data.
    - Ken Robbins- And you only used charity care numbers?
    - Ralph Martire-That's all we can use because that is all that counts.
    - Ken Robbins- That's my point. Hospitals expend other monies that they do not recoup that may not count as "charity care".

- **Question by Senator Garrett**- Should we expand the definition of charity care? It appears that some hospitals are not getting full credit for their charity care due to bad debt or something.
    - Ralph Martire- Right. If we could do a better job to capture bad debt to turn it into charity care on the front end, we could close the gap by about 40% at no additional costs to the hospitals.
    - Rep. Dugan- IHA is wondering if the charity care piece should be part of CON or not.
    - Rep. Dugan- We know the Medicaid reimbursement rates are low. Hospitals don't get paid the full amount of what it costs to provide the care.
    - Ralph Martire- Absolutely right. The law states that the difference between the actual cost of service and the reimbursement rate is NOT charity care.
    - Rep Dugan- Well should we include that difference as charity care?
    - Ralph Martire- CTBA would agree with that.

- **Question by Rep. Renee Kosel**- Why didn't you include Medicare in reimbursement?
    - Paul Gaynor- Because Medicare is not a needs-based program and the reimbursement cost is higher. You just get Medicare at a certain age regardless of how much money you have.
    - Renee Kosel- Should we decide to include charity care in the CON process, I think we should spend a lot of time and energy to define what Charity Care is.
    - Ralph Martire- CTBA thinks there are other aspects that could be included in charity care.

- **Comment by Sister Sheila Lyne**- This goes back to the whole issue of health care financing – and this Task Force isn't going to solve it. There are hospitals that have costs per day three times what Mercy has. Mercy gets additional money back from Medicaid due to our high percentage of Medicaid patients. This all goes back to health care being a public good rather than a marketable commodity.

- **Question by Greg Cox** - It is my understanding that the HFPB uses objective criteria to come up with reports, so if we wanted to add charity care in that, could we?
    - Senator Garrett- We don't have a concrete proposal in place, we are exploring it with this conversation.
    - Ralph Martire- I think the Task Force is the best place to decide that.
    - Greg Cox- The HFPB ask applicants how much charity care they intend to provide, correct?

- David Carvalho- Yes, the state agency reports discuss how much charity care is provided, and that usually triggers questions amongst the Board members, especially when the level of charity care is 0%.

- **Question by Jeff Mark-** Part of the CON mandate is to avoid unnecessary duplication which has been criticized as limiting competition. What should be the societal benefit of getting CON approval? And not just the societal benefit limited to hospitals, but for ASTCs and LTC facilities.
  - Senator Garrett- Say a hospital opens in a market with many insured people where charity care would be less than 15% of their total care. And say there was an established threshold of 20% charity care for a medical facility. Since this new hospital would not reach the threshold for minimum levels of charity care, that hospital would have to pay back to a Safety Ney Foundation.

- **Question by Senator Garrett**- ASTCs are open 9-5. They don't usually see people off the street and they may only get a couple Medicaid patients. ASTCs are also a fast growing enterprise. Shouldn't the ASTCs be under the same umbrella of charity care standards as hospitals?
  - Ralph Martire- Yes, I think the ASTCs should be subjected to a level of charity care.
  - Senator Garrett- ASTCs go into a wealthy area and glom onto an insured market, so maybe they should pay a tax to the local hospital to provide charity care.
  - Ralph Martire- That sounds logical but I can't respond to it until we run some numbers. Heather can do that.
  - David Carvalho- Perhaps the charity care piece should be tied to licensure to capture everyone. For example, currently an ASTC might apply to the HFPB and indicate that they want to provide charity care. But if the need in that area is already being filled by ASTCs that do not provide charity care, the new applicant is denied despite their willingness to provide charity care. If instead we tie charity care to licensure that would capture everyone.
  - Senator Garrett- I am more concerned about the ASTCs and the impact they will have long-term on hospitals.
  - Margie Schaps-That is an important point, and I appreciate your comments, Ralph. The hospitals are threatened by the ASTCs. There could be a quid pro quo in the CON process -- a tax on the ASTCs that would benefit the hospitals. There is a potential way to make this palatable for both parties.

- **Question by Gary Barnett-** Given the complexity of this work, should we (the Task Force) ask for an extension to make our recommendations? How we should include charity care, etc. is very complex. We could even change the name of charity care to financial assistance. People are prideful and they don't want to apply to something labeled "charity".
  - Rep Dugan- We can discuss later if we need another extension. Everyone has a right to come before the Task Force to give their comments.
  - Ralph Martire- Thank you for the opportunity to come speak. I respect the hard work you have in front of you.

Presentation by Mr. David Buysse, Office of the Attorney General Lisa Madigan

- Member of Special Litigation Bureau- in Fall 2003 participated in the ongoing investigation of IL non-profit hospitals
- IL Health Facilities Planning Act was enacted in 1974 pursuant to the mandate of the National Health Planning and Resources Development Act of 1974
- The purpose of the Act was to halt the increasing costs of health care due to unnecessary construction of health facilities. Halting these increasing costs would make the public more able to obtain necessary health services and would ensure the availability of health care to the general public.

- The 2007 Lewin Group report accurately summarized the three goals of HFPB
    - Containing costs
    - Improving access
    - Improving quality
- Controversy as to whether the HFPB is achieving those goals
    - CON can be a barrier to market entry. The FTC says this is a detriment to competition which would lower costs for consumers. In their view, the serious anti-competition risks far outweigh the benefits of CON.
    - Conversely, American Health Planning Association (AHPA) has argued that CON is a market balancing tool. AHPA argues that market forces are invaluable in balancing costs, supply, access, and quality, but, for essential social goods and services like health care, the market cannot reasonably provide the best balance.
    - IHA- May 2008- Purpose of CON is to prevent unnecessary duplication of services to protect Safety Net. The role of cost containment by the HFPB should be secondary to preserving Safety Net services.
- Whatever approach one takes to the role of CON in health planning- enthusiasm, middle road, or skeptical- the legal effects of CON should be recognized.
    - Existing health care firms often hope to deter or prevent new competition. This may violate anti-trust laws.
    - However, some types of anticompetitive behavior do NOT violate antitrust laws
        - Noerr-Pennington doctrine- conduct immunized when petitioning government
        - "state action" doctrine- shields many of the state's actions when it is acting in its sovereign, legislative capacity or when some other entity or individuals acts on the states behalf
        - FTC statement to Florida Senate suggests that the protections afforded under these legal doctrines allows the CON process to limit competition by preventing "unnecessary duplication of health facilities and services"
- Attorney General believes that the CON process and protection offered to health facilities should continue to further the original purposes of the IL Health Facilities Planning Act.
- Since access to necessary health services remains unfulfilled, the CON reform process should mandate specific criteria for health facilities to increase accessibility to services.
- Examples from other states that have linked the CON process and increased access to services for indigent residents:
    - South Carolina- CON process requires an Indigent Care Plan documenting the level of indigent care given for 3 years leading up to application and what level the facility plans to provide in the future.
    - New Jersey- CON applications must include how and to what extent the applicant will provide services to the medically indigent, Medicaid and Medicare recipients, and members of medically underserved groups as well as the amount of charity care that will be provided by the applicant.
    - May 19, 2008- Florida governor streamlined state CON process, but after a Task Force reviewed the FL process, they retained the existing requirements for charity care levels.
    - Virginia
        - Commissioner of Health makes final CON decision after receiving input from Dept. of Health and from 1 of 5 regional planning agencies
        - Commissioner can require an applicant to provide the following in order for their application to be approved:
            1. Provide a level of care at reduced rates to indigents or accept patients requiring specialized care

        - VA charity care requirements are tied to the average regional percentages of charity care in acute care hospitals. These may change year to year.
        - ASTCs were first facility where these requirements were applied. Now the requirements apply to other facilities and equipment.
        - VA medical facilities are required to keep and submit charity care logs- that includes date of service, patient's age, ZIP code, city, county, procedure or service given, total charges for service provided, and any amount billed to patients. Civil penalty of $100 per day if medical facility does not comply.
    2. Develop and operate medical services to indigent persons in designated medically underserved areas within the applicant's service area
        - Examples of this are providing transportation, establishing a new free clinic, or donating to a facility whose mission is to care for the medically indigent
  - Charity care conditions remain in effect over the life of the service authorized by CON
  - Applications denied if they refuse to comply with the charity care conditions
  - According to Central VA Health Planning Agency, the charity care requirements have resulted in:
    1. Increased charity care provided by hospitals and other service providers
    2. Reduced bad debt
    3. Enhanced outreach by facilities to safety net providers, including increased collaboration
    4. Increased efforts to develop services needed by low-income persons
    5. Better tracking of charity care given
- Illinois
    - 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
    - Implement policies and procedures for the IL HFPB to give special consideration to the impact of application on access to Safety Net services
    - Increase accessibility and protect the Safety Net when making recommendations to streamline and rationalize the HFPB
- The Task Force recommendations should include policies regarding the provision of health care services to low income persons. Policy recommendations could include:
    - Specific minimum requirements of charity care services provided
    - Specific minimum requirements of Medicaid services provided
    - Specific criteria for CON applicants regarding the provision of charity care and Medicaid care
    - Specific annual reporting requirements concerning levels of charity and Medicaid care given
    - Flexibility in the manner in which such requirements and criteria can be satisfied
- IHA and AHA dispute over what constitutes a community benefit

- **Question by Ken Robbins**- Would this contemplate establishing charity care or minimum Medicaid service requirements for each of the classes that are under CON right now?
    - David Buysee- An economic case can be made that charity care requirements be imposed on entities other than non-profit hospitals

- **Question by Ken Robbins** – Will the threshold requirements be created based on what business they are in?

- David Buysee- CON process allows health care providers to engage in activities that could otherwise run afoul of state and federal anti-trust laws. So you can premise a requirement for charity care on that benefit.
- Paul Gaynor- Even with the direct bargain, the hospitals gets the tax exemption for their charity care.

- **Question by Ken Robbins** - Are there any other of the 49 states that require charity care as part of the CON process?
  - David Buysee- SC, NJ, FL. I focused on VA due to their unique implementations. Your counterparts in FL who want to keep the CON process recognized the benefits of CON and streamlined it and retained Medicaid and charity care requirement.

- **Comment by Rep. Lang**- We would like a copy of your report. We want to understand the core of what you said- regardless of whether or not we streamline CON process, the attorney general sees a stronger need for a planning process that includes provisions for charity care.
  - David Buysee- yes, the planning process should retain charity care. Any streamlining of CON should stay true to the original goals and keep mindful of access to care for indigent people.

- **Question by Rep. Lang**- Let's assume that the Task Force recommends to do away with CON- what would the Attorney General recommend in its place?
  - David Buysee- I would have to go back and talk to the Attorney General about that. We would have to know what options are being considered. The AG's position is that this is an excellent opportunity to make the necessary changes to achieve the goals originally mandated in 1974 for the CON process.
  - Senator Brady- Is it the AG's opinion that these are the correct legal standards?
  - David Buysee- I think Ralph Martire correctly stated the legal standards for charity care. AG introduced legislation in 2006 for Medicaid shortfall to be counted as charity care.

- **Question by Senator Brady-** Is it your opinion that if a hospital didn't provide a certain level of charity care, they shouldn't be considered for tax exempt status?
  - David Buysee- I can't predict what will happen with Provena case, but [see transcript]

- **Question by Senator Brady** - Is it her (AG's) opinion that Medicaid reimbursement be above insurance reimbursement?
  - David Buysee- [see transcript]

- **Question by Senator Brady** - What is the AG's definition of cost?
  - David Buysee- [see transcript]
  - Senator Brady- Her definition is Medicare?
  - David Buysee- I know there is a spectrum of cost accounting amongst hospitals in IL. There are some people who would be very adept at providing their own costs, and other not so.

- **Question by Senator Brady** - Is it the AG's opinion that the CON process should include some standards for charity care? If it is a for-profit organization that pays taxes, does she not think they should be issued a CON if they don't provide charity care?
  - David Buysee- We are not looking just at hospitals- but at ASTCs, dialysis centers, etc. There are for profit hospitals that provide vastly more charity care than non-profit hospitals. Michael Reese is closing and they provided a significant level of charity and Medicaid care, yet they paid taxes. I think it is economically justifiable to look at the charity care levels of all entities that come before the CON board.

- **Question by Heather O'Donnell**- What is required for tax exemption? We have to consider the benefits that hospitals are granted, and that may be something we consider as we [see transcript]
    - Senator Garrett- how would the AG feel about ASTCs?
    - David Buysee-There is an economic rationale for spreading the burden of charity care amongst all types of health facilities.
    - Senator Garrett- My concern is that the burden be distributed more locally. I would like the appropriate level of charity care determined on a local level.
    - David Buysee- You can do it on the local level.

- **Question by Senator Garrett**- Bad debt- what is the definition of that?
    - David Buysee- uncollected bills. There are a fair number of situations where an increase in charity care (done correctly) leads to a decrease in bad debt.
    - Paul Gaynor- traditional definition of charity care states that it must be identified up front as charity care. But people are reluctant to state their bad financial position.
    - Rep. Dugan- So change the name to financial assistance.

- **Question by Senator Garrett** – Non-profit vs. for-profit? A charity care standard applied to both?
    - David Carvalho- If the state provides you with the CON mechanism to keep competitors out, the quid pro quo is to share in the burden of providing for charity care
    - David Buysee- The standard for charity care should be created and applied to all health entities- both for profit and not for profit.
    - Senator Garrett- But for-profit facilities pay taxes, so they get a double whammy.
    - David Carvalho- The benefit of CON is to keep the competitors at bay, and so the quid pro quo is to provide charity care.
    - Senator Garrett- So what Ralph said about tax exemption doesn't really matter in that instance?
    - David Carvalho- Non-profit hospitals might have a higher requirement in order to get the tax exemption.

- **Question by Ken Robbins**- Say you have a situation where a hospital is 60 years old and needs to modernize the emergency room to get up to standard levels of care. But this hospital is also in an area with a low level of charity care. So would they be denied with a blanket charity care statement, thus preventing the community from having a modern emergency room?
    - Rep. Dugan- That is not what's being said in this discussion.
    - David Buysee- This is not so circumscribed by constitutional issues.

- **Question by Senator Garrett**- Hospital A wants to move into an insured market and they don't have a level of charity care- so if they don't meet that charity care standard (whatever it is), do they have to contribute to a Safety Net Foundation?
    - David Buysee- That is one alternative that is out there and that is being used in various ways in other states. But there are other ideas out there, and this Task Force is a great place to review these options and see what is out there.
    - Kurt DeWeese- We need to require some demonstration in an applicant's commitment to provide for indigent people. If the need in the community for care is defined, an applicant should be meeting that level of service when they apply for CON. And then they also need to follow through with providing that care.

- **Question by Mike Jones**- The doctrine of state action immunity- can't we use that to create innovative recommendations?

- David Buysee- Yes, I think you can.

- **Comment from Rep. Lang**- At the last two meetings I have asked for a number of things that I have yet to receive from Mr. Newton.
  - David Carvalho- With respect to Mr. Newton, we will talk to the chair of his organization. I also saw him last week and reminded him about that outstanding request.

- **Question from Rep. Lang-** Is there any evidence that the HFP Board is trying to remain independent from the fund sweeps?
  - David Carvalho- As yet, we could not find it in the transcripts.
  - Rep. Lang- Any kind of public statement from anyone on the HFP Board that they don't like to be tinkered with by the governor's office?
  - David Carvalho- First, there is no evidence that the governor's office has in fact "tinkered" with the HFP Board. However, there is no transcript we could find of board members publicly stating their displeasure with the fund sweep. On the other hand, we always spend less than the appropriation, so the impact of the sweep is unclear.
  - Senator Brady- Has the HFP Board had any discussion about the fund sweeps?
  - David Carvalho- No discussion about the fund sweeps that we could find in the transcript, but they have discussed the delay in hiring.
  - Jeff Mark – The fund sweeps have not been the highest priority for the board.
  - Senator Garrett- The way I understand it is that you are funded by the fees you charge.
  - Jeff Mark- That is correct.
  - Senator Garrett- So while money is appropriated to you, the funds are taken back at the end.
  - David Carvalho- The appropriation comes out of the fees that are collected, not out of the general fund.
  - Ken Robbins- Applicants could be charged fees that are too high allowing for extra money to be swept.

- **Question by Senator Brady-** Last week there was a conviction, and you were both involved in the program during the relevant times. If you were better funded, would those monies have helped prevent the illegal behavior? Could you better police the environment if you have more money? This is something that has to come out of this Task Force. You have to answer that eventually- is your lack of resources contributing to the lack of policing that allowed illegal behavior in the last 6 years?
  - Rep. Dugan- Anyone who is unethical will do something no matter the amount of policing.
  - Senator Brady- They would try, but with an appropriate staffing level there would be less opportunity for illegal behaviors.
  - Senator Garrett- The HFP Board members should be vetted so that we know more about them before they are appointed. The governor should not be the sole person to appoint to the board.
  - Senator Brady- The governor should not be the sole appointer.
  - David Carvalho- The conviction last week was for illegalities from August 2003 to May 2004 – not over the last 6 years. I will respond further at a later time.

Presentation by Coleen Muldoon and Lori Wright, Fresenius Medical Care

- Coleen Muldoon began the testimony stating that she will discuss CON issues as they relate to the dialysis industry
- A person requires dialysis when they enter end stage renal disease or failure where the only cure is a kidney transplant.
- Dialysis patients receive treatment 3 times a week for 4 hours to survive. Add to this time the travel time that many patients have to get to and from the dialysis centers.

- Many dialysis patients are elderly and have other diseases that complicate their treatment.
- Fresenius is the largest dialysis provider at 95 centers in IL.
- For-profit but it is in business plan to treat all patients regardless of ability to pay. Only 12% of patients have commercial insurance. 71% are on Medicare, and 13% Medicaid.
- Due to size, we can reach out to many lower income communities because other centers offset the costs.
- Dialysis patients should not have to travel far for treatments, so having many centers as possible is helpful. It is also good that Fresenius can set up clinics in lower-income areas so that low-income people don't have to travel too far for treatment.
- Fresenius is supportive of the Health Facilities Planning Act continuing into the reasonably foreseeable future.
- Fresenius has some recommended changes to streamline the CON process and thus reduce staff time dedicated to review process, and decrease costs associated with the process.
- (Lori Wright- who writes all CON applications- discussed the recommendations)
    - Educational offering on dialysis to HFPB- Fresenius thinks that all members of HFPB are high quality and have integrity, but we would like to educate the board more about the hurdles/obstacles that dialysis patients must overcome to get treatment
        - Fresenius submits 6-10 applications per year, and they generally have one project before the board at almost every meeting. Due to ex parte, they have been unable to do an education session.
        - Willing to do educational session with DaVita and other dialysis providers
        - Rural clinics- do not operate on evening hours due to elderly patients not wanting to travel at night. Board considers utilization based on evening hours, so we want to educate them on that.
    - Want HFPB to be larger and be composed of individuals who are familiar with a wider array of different healthcare services
    - Letter of Intent (LOI) requirement prior to application- abandon that- just causes delays
    - Dedicated project leaders/application reviewers for particular application types- this would eliminate different reviewers interpreting things differently. Promote review consistency.
    - Eliminate application of the financial review criteria for projects that fall under capital expenditure threshold (projects less than X amount).
    - Eliminate change of ownership requirements for dialysis facilities. Subject this only to the exemption process, with an allowance for approval by the Chair.
    - Allow the Chair to approve a facility move if it happens within one neighborhood (lease issue, etc) , and they are not adding any chairs, and there is no public opposition.
    - Applications are measured by the number of existing facilities within a 30-minute travel time. Currently the HFP Board uses MapQuest times as the starting point. Board should be mandated to consider all travel studies that could affect travel times in an area that are submitted with an application.
    - Abolish legislation allowing comments to be lodged on an application up to 2 days before a board meeting- causes frequent deferrals. (Keep the ability to notify the State Agency of direct factual errors contained in a State Agency Report without concern of violating ex parte.)
    - Ex parte rules should not apply to the staff as they often develop working relationships with applicants. If there is a concern that there is any undue influence, disallow staff members to ask any questions of applicants at the meetings and increase the number of board members.
    - At least 6 months notice if staff changes the interpretation of a rule.
    - Portion of application fee be allocated to public health initiatives- raise application fee if necessary.
- CON rules are becoming more complicated, not streamlined

- **Question by Margie Schaps**- Have you experienced a case where you have had a CON application before the Board and a competitor had one at the same time, and this competitor didn't provide Medicaid care?
    - Lori Wright/Coleen Muldoon- I don't recall that particular instance.

- **Question by Sister Sheila Lyne**- Were you ever denied?
    - Lori Wright- Oh yes, we've been denied. Regarding the 30-minute radius requirement, sometimes we will actually drive a route ourselves and time it.
    - Coleen Muldoon- It depends on the time of day that you drive it as well.

- **Question by Sister Sheila Lyne** - Do you have any other competition?
    - Lori Wright- There is not that much competition. We only offer 2 shifts at rural clinics due to travel times and number of patients.
    - Jeff Mark- Travel time is one measure taken into account.
    - David Carvalho- It is not only how long the patient will have to travel to get there, but the 30 minutes also takes into account how many centers are within that area to see what could be added or not. The rules were recently changed to add an adjustment factor to MapQuest.
    - Jeff Mark- For many years the board considered "normal travel time" which was never defined. Open to interpretation. Now we have defined that after extensive research- used MapQuest as a base time. Exceptions are 1.25x for Chicago, 1.15x for Chicago Metropolitan areas and other largely populated areas, and in rural areas we use the MapQuest times straightforwardly. Applicants are allowed to do their own studies on the time it takes and submit that information.

- **Question by Ken Robbins**- How many dialysis centers are there in IL?
    - Coleen Muldoon- 150.
    - Ken Robbins- And Fresenius has 95?
    - Coleen Muldoon/Lori Wright- Yes.

- **Question by Senator Brady**- When you look at the MapQuest times, it might take 3x as long as the posted time to get there? How did you come up with that? What if it is an emergency service?
    - David Carvalho- This 30 minute travel time does not apply to emergency services, just service centers.
    - Senator Brady- Ok. But travel times are provided for emergency services?
    - Jeff Mark- We assume that an emergency vehicle will be traveling faster than the general traffic flow at any given time of the day.
    - Senator Brady- I am hearing that your MapQuest use is not meeting the needs of your applicants.
    - Senator Garrett- Say I am coming to you with a CON for a kidney dialysis center. So I am out of the box if I am less than 30 minutes from the closest other dialysis center?
    - Jeff Mark- No, one test is to look at the number of other centers within a close travel radius and look at their usage percentages.
    - David Carvalho- If other centers within the 30 minute radius are at 80% usage, then it is ok to have another dialysis center in a close radius. The need has to be there.
    - Senator Garrett- so what is Fresenius problems with the travel time?
    - Lori- Wright- Dialysis happens so frequently, and for someone with a chronic disease, it is a hardship to travel far. Also it can be hard to pay for the travel. Sometimes we hire someone to drive the route throughout the day over several days and sometimes the Board will accept that data.

- Jeff Mark- Medical surgical services has a specified travel time, obstetrical services has a time. The acceptable travel time changes with the type of service. We use MapQuest, a free flow time, because it is accessible by all.
- Senator Brady- Why don't you base the travel time on the worst case scenario instead of the best case scenario?

- **Question by Hal Ruddick**- Do you have a policy regarding uncompensated care for people without Medicaid or insurance?
  - Coleen Muldoon-We accept everyone, regardless of status. As a chronic patient, we help them apply for Medicaid or Medicare.

- **Question by Hal Ruddick**- More than 70% of dialysis centers are within 2 companies. Why?
  - Coleen Muldoon- A lot of people don't want to operate a facility within the city because of the issue of Medicaid and Medicare patients. It is difficult to stay afloat. Fresenius stays afloat because we are so large and can subsidize certain clinics with revenue from other patients. We have actually bought and absorbed clinics that couldn't stay afloat.

- **Comment by Sister Sheila Lyne**- It is commendable what you do. On your first bullet, it sounds like you are wanting an education session, which is great.
  - Margie Schaps- What is the barrier to education session?
  - David Carvalho- Ex parte pertains to communication that happens outside the room, so there shouldn't be any issue if the education session happens during a board meeting.
  - Paul Gaynor- Is the barrier the difficulty in getting on the agenda?
  - Jeff Mark- Ex parte communication is standard. Anyone can ask the staff for technical assistance. But we will not engage in a conversation about substantive issues. During slow times, we have scheduled in-service trainings. We have been planning to set one up on ESRDs but we are hesitant to have a training set up by a current applicant. We are trying to have the Kidney Foundation do a training.

- **Question by Paul Gaynor**- What is the budget again?
  - David Carvalho- $2.2 million this year and that appropriation comes out of the fees that we collect.
  - Senator Brady- If you compare us to another state with a similar process, are we appropriating correctly?
  - David Carvalho- I can ask the American Health Planning Association.

- **Question by Senator Brady**- To Lori and Colleen, what is your average return on equity? How does your model for profitability compare to our model for absorption? How can we know if an investment is prudent if we haven't done the studies to show it? How are we making these decisions?
  - Jeff Mark- In particular for dialysis centers, we look at the incidence of renal failure in a given area and the utilization of the dialysis facilities. Utilization model.
  - Senator Brady- We are trying to make health facility decisions for today and the future.
  - Jeff Mark – We make population projections to make these decisions.

- **Question by Senator Garrett**- How much do you spend to apply to the CON board?
  - Lori Wright- Attorney fees.
  - Senator Garrett- How did you find this attorney? I ask because I feel it is a cottage industry for some lawyers when groups are already paying high fees.
  - Lori Wright/Coleen Muldoon- We have used a couple of different attorneys. The one we use right now really knows us. Lori does about 85-90% of the work but we have an attorney, too.

It costs maybe $50,000 a year for application fees. Attorneys can be $7,000 to $30,000 per application depending on how many hearings are called. So it is about $300,000 a year.

- **Question by Paul Gaynor**- What is the gross revenue for Fresenius?
  - Coleen Muldoon- I can get that information for you, but I don't know it off the top of my head.

- **Question by Senator Garrett**- Why no LOI?
  - Lori Wright- If you add an applicant to a project after you've submitted a LOI, you have to wait 30 days, and that pushes a project back and can be financially harmful.
  - Senator Garrett- What you are applying for?
  - Lori Wright- a new clinic.
  - David Carvalho- Their fees are smaller because the project budget is smaller than a billion dollar hospital. The purpose of the LOI is to give the Board a 30 day notice that you will apply so that we know when to impose the ex parte rule regarding "impending" applications.

- **Question by Senator Garrett**- Is Fresenius national?
  - Coleen Muldoon- Yes, and we are the largest dialysis company.
  - Senator Garrett- So it's not like anyone can just set-up a dialysis shop.
  - Coleen Muldoon- They do. But they don't always survive in business.
  - David Carvalho- Historically, dialysis was a very profitable business. Is that not the truth now? I heard Medicare was a good reimburser. Also, the Task Force should note that virtually everyone qualifies for Medicare for dialysis – this is one exception in Federal law to the usual requirement that you be over 65 for Medicare. So the "charity care" issue for dialysis is much different.
  - Colleen- No, we haven't seen increases in Medicare reimbursements in 20 years.

- **Question by Kurt DeWeese**- Back to the distance issue.
  - Coleen Muldoon- It is the patient's choice to go wherever they want to. Some will choose a clinic closer to their home and some choose one closer to their physician.
  - Lori Wright- I would say the majority of the patients choose to go somewhere with the least travel time from their home. The shifts fill up too.
  - Kurt DeWeese- In terms of utilization patterns vs. closest facility for people to use- is the distance a factor when the same corporation owns all the dialysis centers?

- **Question by Kurt DeWeese** - What is the ownership issue you brought up? Not sure I understand your problem? Where does the change of ownership come in to play?
  - Lori Wright- When an independent dialysis center is going under and Fresenius wants to acquire them, there can be a delay with the CON which puts hardship on the current owners.
  - Sister Sheila Lyne- Seems like they have to go through unnecessary stuff to do a good deed.

- **Question by Kurt DeWeese** - The board having expertise in a given field- not sure if that expertise can be given in some other way besides having board members being experts in every single field. Can you have ex officio members with expertise or staff members with expertise? Why is there is assumption that the board members themselves need to be the experts?

- Rep. Dugan- We have to move on. Thank you for your presentation.

Discussion on the Definition of Safety Net Hospitals

- David Carvalho handed out a map and an article from the Institute of Medicine.
  - Where are the Safety Net hospitals? Look at the key which is the color coding.

- There is no agreed upon definition of Safety Net hospital.
- What we tried to show on the map was an aspect of the payor mix.
- We (IDPH) do an annual survey of hospitals that asks them to say how many patients they have on Medicare, private insurance, Medicaid, charity and private payment.
- Many hospitals say private pay is for patients with no form of insurance payment- like charity care.
- What it takes to be a Safety Net provider in one community is different than in another hospital/community.
- States where Medicaid pays less than cost means a hospital loses money.
- DSH (disproportionate share hospital) hospitals are squares on the map. A DSH hospital has a disproportionate share of Medicaid patients which means they have fewer higher paying patients to "cost shift" to. Accordingly, Federal law allows states to give DSH hospitals higher reimbursement rates from Medicaid. There is also a DSH designation for the Medicare program, if your serve above the mean of Medicaid and uninsured patients for your state. Squares on the map are designed DSH for Medicaid purposes, not Medicare purposes. There will be documents on the website that you can link to to read more.

- Barry Maram- The word Safety Net is a generic term.
- Theresa (Springfield- Medicaid Director)- There are different add-on payments for hospitals- 47 odd designates in the State such as Safety Net adjustment payments and high Medicare adjustment payments.

- **Question by Senator Garrett**- How do hospitals apply for DSH funds?
  - Theresa- We have administrative code on the books. The hospital has to fill out some information on their unreimbursed costs, but we get most of the information from their financial reports.
  - Senator Garrett – How do hospitals know they qualify? Do you send them a letter?
  - Theresa- Yes, we send them a letter.

- **Statement by David Carvalho**- To come up with a clear definition of Safety Net, you have to know what you want to do with the definition.
  - Ken Robbins- The enabling statute states that we are obligated to look at Safety Net Services, not just hospitals.
  - Senator Brady- Are we working to define terminology with hospitals so that we don't have to deal with issues again?
  - Ken Robbins- Hospital billing is separated into Medicaid, Medicare, private insurance, and private pay, which often means no pay.
  - Senator Brady- It would be good to know what is actually charity care, and what is actually self-pay/private pay.
  - David Carvalho- Hospitals with a lower Medicaid patient percentage probably get reimbursed about 70 cents on the dollar. With the higher percentages of Medicaid, the hospital is probably getting reimbursement at a level higher than costs with the add- on payments figured in.

- **Question by Senator Brady**- Can you create a map like this for non-hospital CON approved centers?
  - David Carvalho- yes, we can do that. I would suggest that you may not want a map like this for LTC Centers because there are about a thousand of them.

- **Question by Senator Brady**- Are there too many of any of these facilities?
  - David Carvalho- The bed need inventory will show excess beds in all but two planning regions and it will have a number. The number for Chicago is close to 1,000.

- Hal Ruddick- Do you monitor excess capacity?
- David Carvalho- Yes. We use it in the CON process when someone tries to get a new facility and we look at the excess beds in that region.

Discussion on Other Issues- Outstanding Work, Independent Consultants, Future Testifiers

- **Summary by David Carvalho**- on outstanding work:
  - Facilitator- IPHI has 3 resumes, all from consultants that have experience with health related matters and IPHI has worked with.
  - Summary- Laura McAlpine working on it. She is using the outline from the statute. She just commented that we have no information on LTC Centers and that is because you haven't heard from them yet.
  - NY/MA information- Assessment on insurance companies that help fund Safety Net services. CON is only part of protecting the Safety Net so this is a way we can learn about other ways that states have gone about protecting the Safety Net.
  - Final report- we can see if you like Laura's summary and then maybe we continue on with that.
  - Long term care centers- we have not identified people to speak but we have identified organizations.

- **Request from Greg Cox**- Please get the Task Force a list of Critical access hospitals too.

- **Comment from Senator Garrett**- I want to have another independent consultant to critique our recommendations for under $20,000.
  - David Carvalho- Ok, we can do that.
  - Senator Garrett- I want to make sure that we vet this process. Say our report writer is biased, so I want another set of eyes look at it to see if we missed anything.
  - Senator Brady- I would like to see it go out to bid. For instance, Lewin has studied IL health care, but they may not want to do this for less than $20,000. I think we should get the best. We can see if we get any bids for less than $20,000.
  - Senator Garrett- Yes, but then we might be here well over more than 6 months.
  - Kurt DeWeese- You should look at this in terms of what the final report should include. November is the deadline for the final report to start being drafted. There are an awful lot of recommendations. This report won't be that technical. The report could speak to some of the rules and standards issues that you want to look at further.
  - Senator Garrett- We are talking about things now in vague terms. I want to make sure what we are saying makes sense so I want to have another set of eyes look at this.
  - Kurt DeWeese- I agree that you can make a policy decision and then make recommendations with more technical aspects.
  - Senator Garrett- I want someone else to take a look at this who knows healthcare in IL and across the nation. We talked to this person in Deloitte who will do it for less than $20,000, and I think it will help. Michael Englehart at Deloitte said he could do it.
  - Senator Brady- We shouldn't hire someone for less than $20,000 just because it is convenient.
  - Senator Garrett- Ok, but it is going to be harder than you think to get the RFP process going.
  - Senator Garrett- The way that the Task Force seems to be going with regards to charity care and ASTCs, these are big decisions, and I just want an outside group to take a look at it, and I want to make that decision sooner rather than later because our time is running out.

- **Question from Senator Brady**- Where are we on getting Dr. Whitaker and that guy who abruptly resigned from the HFP board to testify before the Task Force?
  - David Carvalho- Dr. Whitaker wasn't available through July.

- Senator Brady- What about Dr. Winters?
- Jeff Mark- We have 5-8 people, all former HFP Board members, who would like to testify.
- Senator Garrett- Ok, I think the July agenda is pretty much set, so how about they testify in August?

Adjourn- 2:25pm

Minutes respectfully submitted by Mairita Smiltars.