# Illinois Task Force on Health Planning Reform
# Monday, July 14, 2008
# 9am-3pm

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:*** Senator Bill Brady, Gary Barnett, Patrick Keenan Devlin, Rep. Lisa Dugan, Senator Susan Garrett, Paul Gaynor, Hal Ruddick, Heather O'Donnell, Kenneth Robbins, Margie Schaps
***Via Phone:*** Senator Pam Althoff, Rep. Renee Kosel, Myrtis Sullivan

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

**Staff Present:**
***Illinois Public Health Institute (Chicago):*** Kathy Tipton, Mairita Smiltars, Laura McAlpine
***Legislative Staff (Springfield):*** Kurt DeWeese, Melissa Black, Greg Cox
***State Agency Staff***: Mike Jones/HFS

**Court Reporter:** Joanne Ely

**Call To Order:** 9:05am

**Action: Approval of 6-9-08 Minutes**

- Senator Garrett commented that the minutes are fairly comprehensive and much improved since the beginning of the Task Force.
- Kurt DeWeese had one change to the minutes. He said that Suzanne Hack is a public attendee, not a staff attendee. Suzanne remarked that she represents Barnes Jewish Hospital.
- Rep. Dugan motioned to accept the minutes with the one correction, seconded by Senator Brady.
- Minutes approved.

**Presentation by Sumantata Ray and Keith Kelleher, SEIU**

- Keith Keller, President of SEIU Heathcare IL and Indiana, began the testimony
    - SEIU is the largest union of healthcare workers across the country and in IL
    - 85,000 SEIU members in IL that provide healthcare (child care, home care, nursing home, hospital)
    - Members work in facilities that come under review of HFPB
    - SEIU believes everyone deserves access to quality care
    - SEIU members try to provide access to quality care but they cannot do it alone
- SEIU asserts the following about CON process
    - CON plays important role in healthcare system- is necessary
    - CON play important role in protecting Safety Net services
        - Noted in the presentation that there exists a disparity regarding access to capital – safety net hospitals are less likely to have access to capital vs. non-safety net hospitals
        - CON helps to combat this disparity but other measures are needed
        - CON is critical to ensuring access to safety net services – and is one of the most important functions of CON
    - CON should be kept permanently

    - CON prevents duplication of services- we can limit the medical arms race that damages the vulnerable safety net hospitals where many SEIU members work
    - CON preserves critical, less profitable services in communities
    - CON creates a place where the public can weigh in on public healthcare decisions that impact community members. Public should always be able to express their opinions.
- Administrative recommendations to improve effectiveness and efficiency:
    - Board sunset should be eliminated
    - Board should continue to review dialysis, ASTC's , etc, and reinstate the power to review nursing home changes of ownership
    - Maintain current 5-member board
    - Continue non-categorical appointments
    - Improve ex-parte
    - Every board meeting should have time for public comment- public review is of utmost importance
    - Use the hospital report card
- CON approval criteria:
    - CON approval criteria should consider:
        - The entire health system, not just individual facilities
        - Increased community input
        - Patient care
        - Charity care- all hospitals have a duty to provide charity care in exchange for tax breaks.
        - Impact study – impact the project will have on patients, workers, the community, and other healthcare providers. Everyone impacted should have a chance to review this application and comment.
- Recommendations to Protect the Safety Net- Sumanta Ray
    - Every hour, SEIU members keep the safety net hospitals going
    - Safety net is fraying and the patients and the workers are falling through
    - Limit medical arms race to protect the safety net hospitals
- Capital stewardship program- engage in capital markets that SEIU participates in
- A Capital Crisis: The Disparities between Rich and Poor hospitals (white paper also available)
    - Definition of poorest – total cash and investments on balance sheet putting them in the bottom quartile of hospitals studied.
    - Definition of richest – total cash and investments on balance sheet putting them in the top quartile of hospitals studied.
    - SN hospitals treat nearly twice the number of self-pay and charity care patients than expected given their capacity
    - Press documents how Safety Net hospitals continue to get squeezed
- In this study, the poorest hospitals are the bottom quartile in terms of cash and investments on balance sheet
    - Poorest hospitals have 7% of beds in IL, but they serve 8% Medicaid, 12% of Medicare
- The Need for Capital- to renovate aging buildings, modernize equipment, invest in health information technology, expand services
    - Average age of facilities is 16 years for poorest facilities vs. 10 years for richest
    - SN hospitals have hard time paying for Health IT like electronic medical records, etc
    - Without 'state of the art' facilities and equipment, you cannot increase number of services offered and cannot attract better paying patients
- Lack of Access to Capital for poorest hospitals is due to:

    - Weak operating cash flows – this is a function of the communities they operate in that have a less favorable payor mix. Charity care, self-pay, & Medicaid comprise 38% of the poorest hospitals patients vs. 20% of richest hospitals.
    - Reimbursement is below cost. Private insurance payers pay above the cost of services. Richest hospitals have 40% private insurance pay patients, while poorest hospitals have 14% of these payers.
    - Low fundraising – SN hospitals have to convince donors to donate to a hospital they will never use in a place where they do not live.
    - Limited access to borrowing (tax-exempt debt) – SN hospitals are completely locked out of this capital market
- Graphs that shows Lack of Capital support
    - Tax exempt bonds- almost 80% of them go to the richest hospitals, poorest hospitals get 0.4% of TEBs. Tax exempt bonds are a federal subsidy.
    - Total cash and investments- 82% of richest, 0.5% poorest
    - Adjusted for per-bed basis:
        - Cash and Investments: richest hospitals $833,715 per bed. Poorest hospitals $40,460 per bed.
        - TEBs- no TEBs per bed in lowest quartile, $416,893 per bed in richest hospitals
- Vicious Cycle- weak operating cash flows and weak fundraising lead to an inability to implement capital plans, which leads to an inability to attract better paying patients to offset worse-paying patients
    - CON process can mitigate this cycle and ease this disparity.
    - Public intervention from a variety of entities can strengthen our healthcare system.

Question from Rep Lisa Dugan- Why can't poor hospital access TEBs?

- Kelleher- You have to have a fairly strong balance sheet in order to get a TEB. If you don't have a good rating, you have to purchase a credit enhancement, and the SN hospitals often don't want the larger loans that other hospitals can afford to repay.

Question from Senator Garrett- Don't some of these SN hospitals get Disproportionate Share Hospital (DSH) funding that wealthier hospitals don't get?

- Kelleher- I believe some SN hospitals do, but I don't think it is the case that richer hospitals don't receive any DSH funding.
- DSH is reflected in per-bed cash .
- DSH funding not significant enough to offset the disparity in lack of capital.

Question from Senator Garrett- Does the SEIU analysis factors in everything, including hospital assessments?

- Ray responded that yes, the analysis does factor in everything, and the data is from 2005 which is the most recent year that the SEIU could get a complete data set.
- Garrett responded that she thought that hospital assessment funds were not received until 2006.
- Ken Robbins stated that if the SEIU used 2005 data, they probably didn't analyze the hospital assessment because the payments were delayed in getting to the hospitals.
- Paul Gaynor replied that he doesn't think the hospital assessment solved the problem of this disparity
- Sister Sheila stated that the assessments are a big help, but they don't help enough for Mercy to invest in capital infrastructure
- David Carvalho- TEBs have to be repaid by something, so there has to be a cash flow above and beyond operating costs to repay it. If SN hospitals are just covering operating costs, they can't get TEBs.

Question from Rep. Dugan- What can be done within the CON process to address this disparity? What does the CON have to do with this problem other than limiting duplication?

- Kelleher- when Bethany re-evaluated and became an LTC instead of acute care facility, Loretto (the nearest hospital) lost $2 million dollars because everyone who used Bethany went to Loretto. That is how the CON process can affect it.

Question from Ken Robbins- He appreciated the recognition of unmet capital needs of SN hospitals, but, other than the example of Bethany, is it the SEIU's view that CON is largely responsible for the capital shortfall or is it more likely that inadequate reimbursement systems are more responsible?

- Kelleher responded that a combination of factors creates the disparity
- Robbins- So even if we kept CON and took this disparity into account in the CON process, would it be more likely that these SN hospitals would be able to access capital?
- Kelleher- CON is a key factor but not the only thing that would allow SN hospitals to access capital. Higher reimbursements would also help.
- Robbins- there are very few hospitals that wish to compete with SN hospitals in the geography they serve. It is my impression that this disparity is caused by inadequate reimbursement under Medicaid, and the total failure of society to insure uninsured patients. If we are really trying to open capital markets for these hospitals, I think focus should be on those issues as well as CON.
- Kelleher- Yes, you are right- those issues are key.

Question from Ken Robbins- The SEIU does not stand for the proposition that no hospital should ever close- Michael Reese for example- I am guessing that the HFPB will approve that given the declining quality record of that facility.

- Senator Garrett added a comment about the hospital report card. It isn't just about the money and insurance, but there is a factor of looking at low-performing hospitals in CON process.

Question from Margie Schaps- Why take the position that the CON Board should maintain 5 members?

- Kelleher- We have adequately been able to present our position to the 5 current members, so that would be a good mix for us.

Question from Senator Garrett- Regarding public participation at Board meetings, I was surprised to hear that there is no opportunity for this at board meetings. Is that the case and, if so, why?

- Jeff Mark- There are strict restrictions on ex parte communications. The Board has decided that all comment needs to be in public record, so there are public meetings.
- Senator Garrett- But the board members don't attend those meetings.
- Jeff Mark- There are transcripts taken at the public meetings.
- Senator Garrett – I have never heard of a public meeting where there isn't time for public comments. And I don't understand how ex parte plays into that?
- Jeff Mark- There is a prescribed mechanism for public comment that is transcribed into record.

Question from Senator Garrett- Why reinstate the nursing home change of ownership requirement?

- Kelleher- A large for-profit nursing home chain bought about 5-7% of the nursing homes in IL, which is huge. Manor Care is owned by Carlyle Group which is a huge corporation. If change of ownerships are not monitored, there is the possibility of pump and dump operations where new owners simply improve the facilities and then resell them. In our white paper, we recommended that any sale of 3 or more nursing homes to one entity should come before the CON board.
- Kelleher – We want the CON process to be required when an ownership change of >3-5 LTC facilities.
- Rep Lang sponsored bill to get LTCs out of the CON process, and he is not here right now to comment.

Question from Senator Garrett- a point of clarification about tax exemptions-is it for all hospitals or just non-profit hospitals?

- Robbins- Only not for profit hospitals get tax exemptions. That is the baseline for consideration for tax exemption.
- Robbins- There are 25 for-profit licensed hospitals in IL, out of 211 total hospitals, so roughly 10%.
- Garrett- If I were a hospital, why would I want to be for-profit if I could get not-for-profit tax exemption?
- Gaynor- Profit.
- Robbins- Investor-owned hospitals are just that- they expect to get a reasonable rate of return. Non-profit hospitals do not have shareholders- the community is the shareholder.
- Garrett- What types of tax exemptions do the non-profits get?
- Robbins- Federal income tax, state sales tax exemptions, etc
- Garrett- Is Northwestern for-profit?
    - Simultaneous responses- Northwestern is Not-for- profit.
- Garrett- Are the biggest hospitals often not for profit?
    - Simultaneous response of Yes
- O'Donnell- The Property tax exemption is bigger in the city than downstate- it is huge in Chicago.
- Gaynor- If you buy a flat screen TV as a non-profit hospital, there is no sales tax.
- Schaps- IL has more not for profit hospitals than most states.

Question from Rep. Lisa Dugan- Where are the 25% of the poorest hospitals?

- Ray- concentrated in Cook County

Question from Ken Robbins – How many hospitals are in the bottom quartile?

- Ray- We got data for 147 hospitals (out of 211 in IL). We only studied not for profit hospitals- not private or public.
- Garrett- Would this non-inclusion skew the data?
- Carvalho- Stroger doesn't use the typical TEBs- they issue their own bonds.
- Sister Lyne- There are haves and have nots. I don't know if CON is the right place to deal with this disparity. But we have to stop hospital closings. Mercy is feeling the influence of Michael Reese closing. Thankfully Reese went down slowly, otherwise it would have completely overwhelmed Mercy. Health care should be a public good, not a marketable commodity, but it doesn't behave that way.

Comment from David Carvalho-Regarding hospital location- If the community is improving around a SN hospital, the new neighborhood members may not use that hospital because of its bad reputation on quality. New community members may continue to use another hospital that has better amenities. So the location of a hospital does not always determine its clientele.

Comment from Hal Ruddick- How much impact does CON really have on SN hospitals? These hospitals are still in economic trouble despite the existence of CON. CON is necessary to protect the SN but CON alone is not enough to protect the Safety Net. That is the context in which we have to look at this. We have to look at other issues.

Question from Senator Garrett- Regarding public participation- has it always been this way with the HFPB or in the past did the public have an opportunity to comment?

- (Audience member asked to respond to the question) Billie Paige- Yes, it is has always been that way.
- Jeff Mark- Before ex parte, there were one-one conversations going on that never made it to public record.
- Sister Sheila- In the past, the Board members would sometimes invite the applicant to speak.

- Jeff Mark- I'm not saying that ex parte is good or bad. Public testimony is gathered and put into a transcript. The board members read that and sometimes have staff research allegations from public comments.
- Garrett- It's hard to follow through on that. Do you bring the information from the investigations back to the Board? Are the people who are unhappy with the process invited back?
- Jeff Mark- It's all public. We inform everyone in the same way. Staff will make in open public session their report to the board and the public.

Question from Greg Cox- What exactly is a "poorest" hospital?

- Sumanta Ray- The criteria is cash and investments. We broke it down into the lowest quartile and highest quartile.
- Cox- So a SN hospital could conceivably have a higher operating margin than a non-SN hospital and still be in the bottom quartile?
    - Ray- yes they could

Question from Greg Cox- Can you share the data you used?

- Ray – The data is publically available as an IRS Form 990 from each hospital.
- Cox- So since you've done the legwork, can you share the data with us?
- Ray- Yes, we can do that.

**Presentation by Dr. David Dranove, Northwestern University**

- Dr. Dranove is the Walter McNerney Distinguished Professor at Northwestern's Kellogg School of Management, and is Director of the Center on Health Industry Economics. He has been researching competition in health care markets for 25 years, and has published extensively.
- Dr. Dranove expressed his pleasure to be at the meeting to testify and stated that he has worked with Paul Gaynor and Lisa Madigan.
- His presentation was entitled: Healthcare on the Brink- an Integrated Solution to the IL Health Care Crisis
    - The Problems:
        - The safety net is tattered
            - 1.75 million uninsured in IL (according to Kaiser Family Foundation)
            - Medicaid is underfunded
        - Providers are eager to expand in some parts of the state
            - Many prospering areas need new providers (Chicago suburbs)
            - But other communities are forsaken
        - System of regulating providers is ineffective
            - Unnecessarily bureaucratic and cumbersome
            - Politically challenged
    - Integrated Solution
        - Reweave the SN through a "floor and trade" system of charity care
        - Make it every institutional providers responsibility to do their part
        - Give providers the freedom to determine how to meet responsibilities
        - Liberate providers from onerous regulations
    - Tattered SN
        - There have always been uninsured people- numbers rising in both absolute and percentage terms
        - Nonprofit providers, community centers, and medical professionals have always provided charity care
            - Charity care is declining

            - CC is less than 1% of hospital net revenues in IL
            - CC is less than 7.5% of hospital "community benefits"
            - More uninsured face financial barriers to care- people are one illness away from financial ruin
        - Prosperous providers are not located where the need for charity care is the greatest
    - Growing Challenge
        - Limited Medicaid funding is squeezing SN providers
        - Medicare reimbursements are falling
        - Funding from government is falling, and new organizations (ASTCs, specialty hospitals) meet growing needs for care but do not always do their part for the SN/uninsured
    - Should Providers Meet This Challenge?
        - Non-profit hospitals have been obligated to provide CC or free/discounted care to indigent patients
        - Many NP hospitals are located far from need for charity care
        - For profit providers pay taxes
        - Other institutional providers (ASTCs, specialty hospitals, etc) have no such obligations
        - Yet all institutional providers must compete for the same pool of insured patients
        - Should they all have a charity care obligation? Dr. Dranove would argue yes.
    - Problem with CON
        - CON is costly and time consuming
        - CON does eventually facilitate growth but rarely in areas where the SN is weakest- so new providers contribute very little to mending the SN. In some cases, new providers draw lucrative insured patients away from SN providers.
        - CON is valued by providers- it is a license to prosper and a protection from competition. Providers are looking to grow in areas where they will gain financially. They want to operate in areas where there is opportunity to make money. CON limits competition, thereby increasing the opportunity for a provider to make money.
        - It is reasonable to ask CON recipients to do their part, in exchange, the state should reform the CON process
        - CON reform and the safety net are inextricably linked. If CON protects competition, providers should give back to support the greatest need – safety net services.
    - Integrated Solution
        - Ease CON restrictions- make it easier for providers to meet growing needs of all populations
        - Tie CON to aid for the SN
            - All providers obtaining CON should have an obligation to help mend the safety net
            - Applies regardless of ownership or type of facility
        - Re-affirm responsibility of all nonprofit providers to mend the SN, not just those seeking CON
        - Allow providers freedom to determine best course of action, through a "Floor and Trade" system of charity care
    - Ease CON
        - Increase $$$$ threshold for CON review
            - Small projects unlikely to cause grievous harm to system
        - Eliminate burdensome aspects of review process
            - Example- replace financial projection requirements with oversight from bond market. Not the responsibility of Board members to determine financial projections.
        - Re-evaluate computation of utilization and need projections

        - Eliminate micromanagement of facility construction
            - Costs of construction are the responsibility of the provider and its lender – let's assume they will get it right.
        - Fundamental question – does the community have a need? Does this applicant meet this need? Use epidemiological models to answer this question.
    - Tie CON approval to Charity care
        - Providers covet CON- it is a license to prosper
            - CON conveys protection from excessive future competition
        - Provider should give back to the community
            - One-time obligation based on a % of the capital costs of project
            - Annual obligation based on total revenue
            - Providers may obtain exemptions based on level of Medicaid and charity care provided
            - Applied to all CON applicants, not just hospitals
        - Obligations enforced through "Floor and Trade" methodology described below
    - Benefits of CON reform
        - Removes unnecessary oversight
        - Reduces times and expense of obtaining approval
        - Allows provider to determine how to best meet needs of indigent patients
        - Providers who receive CON get something of value from the state; this proposal assures that they give something back
        - Protects providers currently serving needy populations by exemption from further contributions
        - Rules apply to all providers
    - Meeting the Nonprofit Obligation
        - Nonprofit providers have historically been our SN providers
        - NPOs have drifted from this obligation
        - Reaffirm this mission through a "Floor and Trade" system
        - The same floor and trade system will be applied to all CON beneficiaries
    - Floor and Trade
        - NPO providers should meet a minimum standard of CC based on % of net revenues
            - Providers can offer direct charity care
            - Providers may instead form financial partnerships with designated SN hospitals
        - NPO providers that fail to meet Floor and Trade obligation must contribute an elevated % of net revenue to the state to be used for CC
            - Encourage providers to form partnerships in private sector, particularly regional partnerships
    - Benefits of Floor and Trade
        - Dramatically increase resources for CC
        - Keep funding in private sector
        - Encourage hospitals to forge partnerships
        - Helping SN hospitals survive actually helps all hospitals

Question from Patrick Keenan Devlin- On the slide "Ease CON", can you re-explain the burdensome aspects of CON review process?

- Dranove- I worked with Edward Hospital on a CON application, so I understand the IL CON process and I have seen less burdensome CON processes in other states. In IL you have to spell out the size of the hospital and how big every ward is going to be, you need letters from every doctor under the sun saying that they will send patients to the hospital- there is a lot of busy work involved. The

fundamental question is - does the community have a need, and can the need be met by existing providers?

Question from Margie Schaps- Do any other states use "Floor and Trade?"

- Dranove- No, but I just went to a conference and shared these ideas. My colleagues were really excited. This is a small kahuna plan that could do a fair amount of good without massively changing the system.

Question from Jeff Mark- Going back to "burdensome review" and the example of letters from doctors- this is one of the ways that Board members determine need. How else would one project need if we did not require letters?

- Dranove- Epidemiological evidence can be used. I know Ken (Robbins of IHA) would have a laundry list of changes he would like to make. I would rather have a conversation about it, not sit up here and testify on those changes.

Question from Jeff Mark- What is your source for Charity Care numbers?

- Dranove- From information given to me by David Buysse
- Buysse- It is information from Community Benefit reports.
- Mark- That report includes a limited number of hospitals, and excludes public hospitals, hospitals under a certain size, and private hospitals.
- Buysse- Correct, 147 hospitals (out of 200+ in IL) filed this report.
- Mark-So it is not the entire picture
- Sister Lyne- Appreciates Dr. Dranove's thoughtfulness and believes that reports can always be made more complete. However, "Floor and Trade" gets at what Safety Net providers think is fair.

Question from Ken Robbins- It is less clear to me how a hospital in Carbondale, which is meeting the needs of its community through charity care and technology- can be held accountable for a tattered SN hundreds of miles away in Chicago? There are legal standards, one of which is that a hospital should provide CC to all who apply. Why would my hypothetical hospital in Carbondale have any requirements to the Safety Net in Chicago if the Carbondale hospital is meeting the needs of its community?

- Dranove- That is a good question and this is an issue that should be discussed. Tax exemption extends beyond local boundary.

Comment from Heather O'Donnell- While the standard is that you have to provide Charity Care to all who need it and apply for it, hospitals often send bills, and so community members do not go to get care because they are fearful of getting a hospital bill.

Comment from Ken Robbins- The legislature can hide behind CON and not really raise Medicaid/Medicare reimbursements which would really help the SN.

- Dranove- Economists don't write the laws. While I might personally go beyond what I presented today, I presented this because I think it is doable.
- Robbins- "Floor and Trade" is still a second best solution?
- Dranove- This is a positive step. There are other things I might recommend that are more pro-competitive. I think this would be a dramatic improvement. If anyone has read my books, they would know that I am not a fan of CON.

Question from Senator Brady- What is the total cost of insuring the uninsured?

- Althoff- and what is the total number of people uninsured? And why don't they have insurance- because it is too expensive so they elect not to get it or because they are uninsurable?
- Dranove- It is both.

- Althoff- Any idea of the breakdown?
- Dranove- perhaps half and half?
- Carvalho- It is nowhere near half and half in IL. More people cannot afford insurance than are uninsurable. (Numbers from the Adequate Health Care Task Force)
- Dravove- The typical person who falls ill in the US generally loses half of their life savings. There are a substantial number of people who would have more financial peace of mind if more charity care was offered.

Question from Senator Brady- Would you advocate a tax over and above the tax benefit that these hospitals receive? Would you give the CON process the license to tax to cover whatever your definition of CC is?

- Dranove- Those that receive CON are prosperous organizations going into prosperous regions. I would not go so far as to implement additional taxes personally, but you as a Task Force would have to come to that.

Question from Senator Brady- Why only pick on CON and not medical licenses?

- Dranove- Good question. You can make the tent bigger and bring in medical licenses. I would be comfortable with that.

Question from Senator Brady- The SEIU says that one of the concerns is capital and how it differs in areas. Recently the CON board allowed 2 hospitals, in Joliet and East St Louis respectively, to move from poorer areas to more prosperous areas.

- Garrett- Is that relevant?
- Dranove- It is fair for the state to expect something in return if a hospital is allowed to go to a more prosperous area. I believe the hospital should give something back.

Question from Senator Brady- How do you regulate the hospitals to make sure that they are charging the patient when they can?

- Dranove- Good question. You will have to define what charity care is and when to offer it.

Question from Senator Garrett- Say a non-profit hospital open in a prosperous area and makes a certain amount of revenue. Would they give a certain % of their revenue to another hospital they partner with or to a state agency?

- Dravnove- My personal preference is to not give the money to a state agency- keep it in private sector.
- Garrett- We will have to create a formula to determine the threshold. I live in Lake County which is the second highest area for for-profit hospitals, so I accustomed to dealing with those.
- Dranove- The bigger we make the tent, the smaller the impact on each type of provider. Also, we don't want to frighten providers out of the state with these reforms.
- Garrett- So what you are describing is giving something back- and the formulas would have to determined later.

Question from Senator Garrett- ASTCs open in profitable areas also, and are generally open near a profitable hospital so that they reap some of the profits from that community. How would ASTCs give back? Would they give back to the local hospital that they are taking profits from?

- Dranove- ASTCs do siphon patients away from traditional hospitals. This process would find a way to get revenues from these ASTCs.
- Garrett- ASTCs are really dependent on their local hospital, so, in my opinion, it is worth looking at a different formula for them so that the local hospital doesn't lose twice. We have to be careful that we are not overrun with specialty ASTCs.

- Dranove- Cream skimming is a concern. The federal government had put a moratorium of specialty hospitals because of this. We have to think carefully on how to apply the formula to ASTCs. Some are doing their share, but most are not since they are not bound by their mission to provide Charity Care.

Question from Senator Garrett- I agree on some CON limits. I think hospitals that want to add equipment to their hospital should not come before CON. Question- who oversees finances? Say Hospital A moves into Libertyville, IL and then has to give money to the Charity Care Foundation- who oversees that?

- Dranove- I have not sorted that out yet with the AG's office. I am hoping to make the oversight as small as possible. The Health Facilities Planning Board will oversee the partnerships to ensure they are happening.

Question from Gary Barnett- The tattered SN system, and your Floor and Trade plan, will get us from Point A to B. If this was implemented what percentage of the problem will be solved?

- Dranove- The higher the levy, the more you solve the SN problem, but the more you put providers at risk. My point of view is that we have moved away from the traditional mission.
- Barnett- If we are going to go through this effort to solve the charity care crisis, I think it is fair for you to express an opinion on what percentage of the problem will be solved if your plan was implemented in a balanced way.
- Dranove- We can use an example – if the current standard is 7.5% for charity care, and we raise it to 30%, that would bring in a billion dollars for charity care. We would then have to lower community benefit requirements. If we ask hospitals to pump money into a new area, the money will come from somewhere.

Question from Ken Robbins- Would this plan apply only to new hospitals moving in to prosperous areas or to all hospitals, even if they are not a prosperous hospital?

- Dranove- There will be waivers for certain hospitals. If you get a CON, no matter who you are, there is an obligation. Non-Profit hospitals have a mandated obligation to provide Charity Care.

Comment from Rep. Lisa Dugan- The Medicaid system in IL is not working. As legislators, we could raise taxes to fund Medicaid better. Either way taxpayers in the state will pay. As we go forward, we have to find a way to help save the SN. Access to healthcare is a right. I appreciate concerns about why downstate hospitals should be responsible for the SN system in Chicago, but I think the whole state has to be responsible for the whole state. I think the CON process is problematic. Question on easing of CON and the micromanagement of facilities- do we actually have someone who checks to make sure the applicants are building the facilities correctly?

- Dranove- In the planning process, you have to submit documents to the board on the design and cost.
- Mark- The cost per square foot for national standards is a test of the cost of the project. We have standards for major department based on square footage or per bed.

Question from Senator Garrett- There are rules around the amount of charity care. Are questions asked to hospital applicants about what their Medicaid population might be or Charity Care forecast would be?

- Mark- We do not currently have any rules along those lines. There are no formal requirements. But the Board has asked in the past year or so about the level of charity care that each institution will provide.
- Garrett- So none of that is taken into consideration?
- Mark- Correct, and that is compliance with legislation.

Question from Ken Robbins- The standard you refer to – is it statewide or determined by geographic area or a standard based on community need?

- Dranove- You don't want to ask me what I think because I am so Chicago centric.

Question from Senator Brady- Say we make insurance affordable so everyone can afford to buy it. Do you think the hospitals will increase what they charge in order to cover the revenue percentage that they have to donate to the CC Foundation?

- Dranove- You are referring to cost shifting. I studied cost shifting in IL in the 80's with the growth of selection contracting. Whether it is a level playing field or it has gone too far, cost shifting is not what it used to be. Hospitals today can't pass off as much of their costs of doing business. But "Floor and Trade" is a tax on profits, not a cost of doing business.
- Brady-I disagree. You are taxing their revenues.
- Dranove-The rates of failure of hospitals are lower than most businesses, so they are being protected.
- Brady- You are arguing that this cost shift wouldn't take place?
- Dranove- Research evidence (Mike Morrissey book) strongly suggests that cost shifting is minimal or non-existent in the area of selective contracting.
- Brady- What is your opinion of CON?
- Dranove- I don't think CON is a good thing.
- Brady – Do you find that it is harmful?
- Dranove- Yes, it stands in the way of the market. Instead of market forces determining which facilities can grow and prosper, the incumbent providers get the benefits.

Question from Patrick Keenan Devlin- Is the CON process necessary to keep in place for a "Floor and Trade" system?

- Dranove- No, you can just increase the non-profit obligation separate from the CON process.
- Keenan Devlin- Would that be the ideal result?
- Dranove- My ideal reform would #1 be to try to do something along the lines of the MA health plan. It would be a dramatic upheaval for this state but doable. It would require lots of endowment. Number 2 would be to get rid of CON, increase the non-profit obligation, and put money into Medicaid so that they are not second class patients.

Question from Sister Sheila Lyne- If non-profit hospitals are not repaying the system through charity care, should they no longer be tax exempt?

- Dranove- Non-profits in the state have certain obligations that they must meet, and the AGs office determines if they have met the standards. IF we move in the direction I have suggested, you would lose something if you do not meet or comply with the "Floor and Trade" regulations- and that could be tax exempt status.

Question from Senator Garrett- What are the benefits to hospitals if we pursue this?

- Dranove- By making the tent bigger (i.e. bring in ASTCs, specialty hospitals, etc.) we will bring more in to the system to help the Safety Net. Some hospitals might think twice about opening ASTCs.

Question from Senator Garrett- There was a hospital representative who testified and he called me up and said that his facility does a lot of good. If one hospital donates land to another hospital, how would that compute into level of charity care?

- Dranove- Say Lake Forest hospital looks to the north and sees a disproportionate amount of Medicaid patients, and they see that if those northern hospitals close, the Medicaid patients will come to Lake Forest, so Lake Forest partners with the northern hospitals to keep them in business.
- Garrett- I want to pursue this and I don't want hospitals to think they are being penalized. "Floor and Trade" should be a positive.

Question from Ken Robbins- Would "Floor and Trade" apply to Long Term Care?

- Dranove- Absolutely. Providers need reassurance that today it is 1%, tomorrow 2%, and next year 4%.
- Garrett- There should be a cap.
- Dranove- How do you prevent legislators from changing their minds?

Question from Mike Jones- There are sales of carbon emission credits from low polluting companies to high polluting companies- is your "Floor and Trade" idea similar?

- Dranove- Yes, it is. With "Floor and Trade", you provide the care or you pay someone else to do it.

Question from Kurt DeWeese- It is rhetorical to talk about the cost and time of the CON process especially when you talk about the value gained by approval of CON. I am not sure if the hassle of CON is that extensive if the applicant has to demonstrate need. A lot of people talk about excessive regulations, but it seems to me that the hospital will recover those costs through the benefit given to the provider.

- Dranove- The value of CON exceeds the cost, and that is obvious because providers are still applying. The cost to apply is still considerable. Some of what is done in the review is costly and the value is not that great.
- Robbins- The CON application process is very expensive because you have to hire the lobbyists, lawyers, architects, etc
- Dranove- I would love to find a way to fulfill the valid purpose of CON without incurring these costs.
- DeWeese- Those costs are not well documented and depend on the size of the project.

Question from Kurt DeWeese- My other comment is what happens when these facilities have to pay additional resources? It presumes that you have some mechanism in place to apply those resources to meet those needs. How do you identify the needs of the community that would be met by these additional resources?

- Dranove- Terrific point. It is important to think about the qualifying use of the funds. I would hazard to say that any Safety Net provider in the state would have no shortage of ideas on how to spend additional capital available to them. I would rather not have the Safety Net providers go to a State group to determine who is worthy of the additional funds. We do need to have some criteria for a qualifying expenditure- but for the most part it should be left in the hand of the providers.

Question from Greg Cox- You said that cost shifting is greatly diminished given the current climate of insurance industry. However, if we apply this charity care requirement to only the facilities that apply for a CON, wouldn't that have an adverse impact on the facilities that apply for CON, and thus an adverse impact on access to healthcare?

- Dranove- First is a non-profit obligation to provide charity care in exchange for tax exemptions. Second, all providers get a benefit from the CON, and CON is sought out by providers that are likely to be prosperous- so there is a second obligation in addition to the non-profit obligation or instead of NP obligation.

Question from Greg Cox- The average operating margin is 3% for a hospital and 1% goes towards charity care. If we obligate a 5% standard for charity care, wouldn't you be mandating that the hospitals lose money?

- Dranove- I couldn't imagine a 5% obligation. In my discussions with the AG office, there has been nothing close to 5%.
- Garrett- The idea is not to put hospitals out of business.
- O'Donnell- The total uncompensated care cost for a hospital is a combination of bad debt and charity care. If you get bad debt on the front end and make it charity care, the hospitals total costs do not go up.
- Dranove- The goal was to give a framework today with parameters that would be put in place later so that everyone can get on board with something that would improve the system.
- Cox- Patient care is not what generates profit margin in the hospitals. Hospital profit is driven by investments.

- Dugan- Today we are just listening to opinions, no decisions are being made yet.
- Cox- The HFPB can make their own decisions around charity care because they have the discretion to do so.
- Dugan- Correct, and that is why we are here examining the HFPB.

Comment from David Carvalho- When you talk about improving Medicaid funding, I just want to make sure that people have this factual information in mind. The base reimbursement rate is low, but there are add-ons that increase the reimbursement so it comes close to cost. Safety Net hospitals probably are close to covering costs with Medicaid payment add-ons. Hospitals in top quartile are getting low Medicaid reimbursements below costs. You don't have to inflate everyone's Medicaid reimbursements to improve the Safety Net. But this is from the provider perspective. From the client's perspective, they may feel like a second class citizen because their reimbursement rates are so low.

- Sister Lyne- Safety Net hospitals costs are so much less than those of upper end hospitals. So even though we are reimbursed close to cost, the total amount of money recovered is still lower than a high end hospital.
- Dranove- It is the chicken or the egg situation. Are your costs low because you don't have any money to pay for higher costs?
- Carvalho- The take away is not that Safety Net hospitals are doing fine financially, but that it won't take as much money as may be thought to make an impact on SN hospitals.

Comment from David Carvalho-My other comment is in response to recent hospital movements approved by the Planning Board. One hospital was approved to move from Joliet to New Lenox. This was a move of 3 miles. The East St Louis move was from one economically challenged area to another economically challenged area.

Comment from David Carvalho- You create bureaucracy to change the market, simply to create bureaucracy – it is hard to do a market intervention without creating bureacracy. With regards to cost shifting- CON interferes with the market place, sometimes to reduce costs. For example, a hospital in an affluent area that doesn't have to increase amenities because there is no competition that would have better amenities.

- Dranove- You intervene in a market , you create bureaucracy, you create winners and losers. Pharmaceutical industry is a good example of where some make a lot of money as a benefit of the market. You can't get drugs from Canada because it will cut into profits. I don't know what the right amount of money is for SN and CON. But if where it is coming from is more valuable than where it is going to.

**Presentations from Long Term Care Representatives**

**Dennis Bozzi- Life Services Network**

- Long term care centers and hospitals are close in many ways but are very different organizations.
- I passed out some photographs of what the senior living market looks like.
- Life Services Network is a senior living association. There are major differences between hospitals and LTC centers. Hospital patients are not residents. Senior living is a home where people live and age in place. Long-term care centers are places where you can live, grow, and enjoy life. They are campuses of independent care. The smallest component of a long term care center is the health component. We don't fit in to the same medical model that was discussed today.
- We take care of older people- aging has deficits but our role is to make sure that people can still continue a high quality of life.
- The fee assessed for CON applications is an issue for LTC because we pay for the non-medical part of the project.
- CCR variance is important part of the process. 5 apartments to 1 nursing home bed.

- In the past, the square foot maximum allowance for CCRC was 414. This is where people live, not stay for a week, so the square footage should be raised.
- Revise bed need methodology for LTC centers.

**Judy Amiano- Riverside Health Care**

- In 2008, we went through a CON process as a provider of a LTC senior residence.
- We provide a home environment- not much episodic care. The average length of stay is 18 months.
- 414 sq foot per bed is maximum- that is too low.
- When preparing CON you have a built-in set of restrictions. Consumers want a private room model, and that is not really allowed in the current CON restrictions. Need a contemporary approach.
- Price per square foot- $183 limit. Is challenging given current construction costs. Darn near impossible. Hard burden on providers who are trying to construct comfortable homes for seniors.
- Amend process based on scope of project. My project was a 40 bed expansion to an existing facility, and I had to jump through the same number of hoops as a brand new provider. Seems like a waste of resources. Could there be a fast track process or a shortened review process?
- More frequent updates to rules. (Jeff Mark responded that updates were done in 2006 and again in 2008).
- More contemporary methodology for computing need.
- Nursing beds are only one component of a CCRC campus. These applicants have to pay $100,000 in CON fees because the entire scope of the project is so large, but the skilled nursing beds are just a small, small percentage of the total number of beds.

**Billie Paige - Shea, Paige, Rogal and Associates**

- HCR Manor Care operates facilities in 20 states. We have watched nursing home and manor homes for a very long time.
- Cost and quality would be impacted positively by CON reform. The federal government mandated CON boards to lower costs and increase quality, until 1980's when Reagan reversed the law.
- IL did disband the health services agency (HSA). State board still functions the same way as 20+ years ago, and this is a major problem.
- Recommendations for CON Process:
    - Limit criteria for LTC applicants to need, financial viability/feasibility, and quality issues.
    - Size is important to the cost of the project, but the IL size cap is lower than other states.
        - Most states have abandoned review of capital costs.
    - We want a simple bed need formula that is not concerned with how far one LTC facility is from another.
    - Some LTC providers are not fully utilized because they are older facilities that do not have private rooms (which are currently in demand). Some providers are under-utilized due to low quality issues.
    - Misdistribution of beds can be solved by permitting the sale of licensed bed operating rights from one provider to another. One facility can increase beds to comply with increased demand, and another provider gets cash to improve their facility.
    - HCRC reimbursement rate- IL Is 28$^{th}$ out of 29
    - Representation of LTC on the Planning board needs to happen again. Previously to the current board, there was always an LTC rep. on the HFPB.
        - Healthcare facilities who must apply to that board should have a rep on the board- LTCs, dialysis, ASTCs.
    - 5 members is not enough. Need at least 9 members. 4 reps from various industry-regulated agencies and 5 consumers. Need a majority consumer board.

- Tremendous lag in filling vacancies on the board. Lack of timely appointments has emphasized that there should be a time limit on how long a seat should be open before filled. Two occasions when the board cannot meet because they could not get a quorum.
- Staff could spend time communicating with the applicants on developing an application. Ex parte is too strict- it prohibits you from talking to the staff (and of course the Board) except for the most perfunctory things. Simple question about compliance can't even be answered by the staff.
- Fines- far too many of them, far too high. With respect to LTC, you can look at examples of NJ, FL, MD.

Question from Senator Garrett- why would you be fined?

- Paige- For things as simple as not filing an annual report.
- Garrett- And what are the fines?
- Paige- The highest I used to see was $7,500. But now they can be as high as $100,000.
- Schaps- What violation is $100,000 for?
- Paige- The applicant went over the approved amount of the project and requested an extension which got lost. Then they requested closure, and then the board was disbanded. Some of this was the applicant's fault and some was the Board's fault.
- Mark- We levy fines when there are fairly significant infractions to the Boards rules. Mr. Urso went over this that the board establishes the threshold of the fine based on statutes, but the Board can negotiate a lower fine.
- Carvalho- If you are intervening in the market, you have to have consequences
- Paige- It goes back to being able to talk to the staff. I think there would be fewer compliance issues if the staff and the applicant could communicate in advance of submitting an application.
- O'Donnell- So you have a problem more with communication than fines?
- Paige- No, but the fines are too large now. This goes back maybe 10 years. The fines were never applied quite like they are being applied now- to the maximum. There should be a minimum, a continuum, and a maximum.

**Paige Presentation con't**

- Issue with CCRC and the application fees. My client, Franciscan Sisters of Chicago is building The Claire, a 37-story building that costs over $200 million dollars. Only $7 million of it was for skilled medical beds. The HFPB reviewed the application as a whole entity and assessed fees on the $200 million.

Question from Reg Dugan- Why would we do that?

- Jeff Mark- My understanding of the rationale is that the total project costs are considered in the total financial feasibility because you cannot consider one floor separate from the whole project.
- Dugan- But in these types of facilities, usually the independent living is separate somewhat from the skilled medical facility.
- Mark- Yes, I don't totally understand why we assess fees on the whole project cost. We don't review the details of the whole project outside of the skilled medical beds.
- Paige- We should only have to tell the Board how we came to the cost for only the part that the Board is reviewing, not for the whole project. The state used to review all sorts of non-clinical components in CON applications- from the size of chapels to parking garages to gymnasiums. Now they only review the clinical components, but you still need to submit costs for non-clinical components.

**Paige presentation con't**

- HFPB has low staffing rates because the sunset dates continue to pop up every couple of years and no one wants to work there.

Comment from Senator Garrett- There is less staff, but more consultants.

- Paige- I assume that consultants have replaced staff because it is hard to get people to work somewhere that might shut down.

**Pam Comstock, Health Care Council of Illinois and Terry Sullivan, IL Counsel on Long Term Care**

- Health Care Council of Illinois represents 600 facilities, serving 66,000 residents, and employing 53,000 people.
- The Nursing home side of the business is like a square peg trying to fit in the round hole of the Health Facilities Planning Board process in IL
- Primary focus of the HFPB is centered around hospitals and hospital concerns. CON was developed with a hospital focus. Sometimes we are out there as a different kind of business serving a different type of client, and we want you to realize that today. And we want to be a resource to you.

Request from Senator Garrett: Asks that the Long Term Care Representatives meet separately to hash out the final proposal to the Task Force.

- Terry Sullivan states that Charles Foley is also a resource.

**Comstock and Sullivan presentation con't**

- Six proposals to CON process
  - #1- Due to the significant differences between the hospital and the nursing home delivery system, nursing homes should have a separate Planning Act, a Board of experts in long term care, its own set of regulations, Certificate of Need application and approval process- all separate from the hospital planning process. We are different. I am not saying that what Billie Paige presented wouldn't work, but they way things are structured now, it puts us at a disadvantage in the process.

Question from Senator Garrett- Couldn't you come together to make a proposal to amend the current form of the board instead of creating another bureaucracy?

  - #2 – The bed need formula for nursing homes should reflect the market impact of assisted living and supportive living facilities on nursing home occupancy. About 40% of our rehab residents are discharged within 90 days. Some nursing homes have 100% turnover within a year due to this. The long term residents are much sicker these days and take up a lot of resources. Well seniors are seeking out other community options.

Comment from Rep. Dugan- Nursing homes are now fulfilling an additional function for the community as a rehab facility.

  - #3- The bed need formula for nursing homes should be updated annually.
  - #4- Replacement, modernization, conversion or service changes of existing bed that involve no increase in beds should be a streamlined process (within 60 days). There should be no occupancy requirements for this category.
  - #5- The square footage maximums for long term care beds should be eliminated to reflect consumer-driven market trends toward larger private rooms.
  - #6-As in Ohio, facilities should be able to buy or sell existing excess CON and license capacity and relocate those beds from one facility to another within a local planning area or within a 45-minute drive.

Question from Heather O'Donnell- Are there rules and regulations addressing specific types of facilities?

- Mark- Absolutely. LTCs have a separate section of the rules as each service does.
- Dugan- When were those rules written?
- Mark- They were written some time ago, but we are in the process of updating them. We invited LTC representatives to participate in the rules update process.
- O'Donnell- You don't feel those regulations are sufficient? Have you been sitting down with Mr. Mark to update the rules?
- Comstock- I was not aware of the fact that I could sit down with the department on the rule formulation process.
- Mark- I could document the number of times that your organization has been invited to participate.

Question from Sister Sheila Lyne- On your document with 6 recommendations- the sixth one refers to the regulation in Ohio that allows one facility to sell a bed to another facility.

- Mark- I have told the LTC community to submit a proposal to the Board. We are not averse to these concepts, but we need a proposal to be submitted.
- Sullivan- Communication has changed between the staff and LTC applicants. There used to be an LTC rep on the board as well as a subcommittee. Nursing homes are far less complex- simpler than a hospital.

Question from Senator Garrett- Who do you go to now if you want to talk about LTC among the HFPB staff? Who is knowledgeable?

- Sullivan- short of Mr. Mark saying that we can call when we want to, there has not been a dedicated rep for the past 6 years
- Garrett- What prevents you from calling Mr. Mark and visiting him?
- Collective panel response- nothing. As long as we don't discuss a specific application, we can talk to Mr. Mark freely.
- Garrett- Sounds like there is a communication breakdown.
- Comstock- We are lacking a collaborative effort.
- Garrett- What is the reason? I feel there is a wall here.
- Paige- No issue on Mr. Mark's part. I find him easy to communicate with. But if you have a representative on the board, you get immediate feedback and they take responsibility for protecting their industry.
- Sullivan- I feel that the Board is so focused on hospitals, even down to LTC hospitals. But long term care senior living centers are really different.
- Garrett- When the IHA wants to change things, they draft legislation and try to get legislatures to sponsor it. Why don't you do that?
- Comstock- We are in the process of drafting a comprehensive reform package due to the creation of this Task Force. It would be nice to have a more collaborative relationship to talk about areas of concern to us and to have people on the Board who would understand our perspective, not just the hospital perspective.
- DeWeese- I don't think that you need a guaranteed member on the board. Maybe there should be a technical advisory committee.
- Paige- All I was suggesting was that when there was an LTC member on the board, that person communicated issues to the LTC associations sitting on this panel. It was more timely and efficient.

Question from Senator Garrett- Why did SEIU recommend keeping the Health Facilities Planning Board at 5 members?

- Ruddick- The board was reduced in number at the time when there were issues.
- Paige- No, the board was reduced so that the sun could shine on fewer members.

Comment from Sullivan- The six (6) recommendations we have in our paper reinforce the recommendations given by the other panelists. This combined LTC panel sitting here today could easily come up with combined recs.

Question from Hal Ruddick- You are not recommending that assisted living come under CON process?

- Sullivan- No because HFS reviews and licenses those facilities.

Question from Hal Ruddick – You are recommending that the state gives you a license for a certain number of beds, and then you could sell those beds? Those beds then become an asset.

- Sullivan- How many unused/unoccupied beds are out there? Facilities hold on to unused capacity because to get rid of it would lower the entire value of the facility. But if you sell beds, it doesn't increase the total number of beds in an area.
- Paige- To be specific, you are selling operating rights to X number of beds. The state still retains authority to regulate the beds, but the sale doesn't have to go through the CON process.

Request from Senator Garrett- Please give us specifics when you come together to make your recommendations.

Question from Hal Ruddick- If your facility was 80% occupied, you can't modernize?

- Sullivan- Correct, you need a 90% occupancy standard in order to modernize. Why have that standard? Modernizing doesn't mean adding beds.

Question from Kurt DeWeese- Backtracking to the composition of the board. When we had a 13 member Board, there was a representatives from the union, a nurse, and physicians. Currently, there is general opposition to categorical appointments in this type of a Board. On that basis, it seems like some ex officio non-voting members could provide that technical input without changing the non-biased voting members.

- Paige- Kurt, you are right.

Question from Margie Schaps- Can anyone explain the history of nursing home change of ownership legislation?

- Comstock- Legislation surfaced for 3 reasons. Changes of ownership happen on the nursing home side more often than on the hospital side. Nursing homes can change hands 3 times a year for financial reasons. There was also a backlog of 120 Change of Ownership applications the year we passed the bill. Owners had financial difficulty, and there were buyers, but the process took so long, the buyers were leaving. There is also a parallel process in the IDPH licensure section for change of ownership. So we were doing it twice- licensure and planning board.
- Garrett- Is this public information?
- Comstock- Yes. Rep Lou Lang was the sponsor in the house and Sen. Ira Silverstein in the Senate.

Question from Ken Robbins- Up to this point, most of our conversations have been hospital centric in this Task Force. Why is LTC regulated by HFPB in the first place? Is the goal the same for hospitals- access, cost, quality?

- Mark- The only time an LTC would come before the board is to establish a new facility, renovate for over $9 million, or for a significant (over 10%) increase in beds. LTCs do not come before us for discontinuation or change of ownership. They come under our jurisdiction because it says so in the statute. And the statute does not differentiate the reasons for that.

Question from Ken Robbins- Others have asserted that the purposes of CON are not met with respect to hospitals. Would people say that about LTC?

- Mark- I don't know

- Sullivan- The answer comes down to Sheridan road which had an access of 9,000 beds in the 1970's when LTC came under the jurisdiction of HFPB. People thought there needed to be a fairer and more equitable way to develop nursing home beds.

Question from Ken Robbins- To what extent do LTC centers provide charity care services?

- Comstock- Depends on how you define charity care. Some say that all Medicaid patients, due to low reimbursement rates, constitute charity care.
- Bozzi- Also there are discounts.
- Garrett- I think Robbins is getting to whether LTC would fall under Floor and Trade.
- Cox- 90/10 mix of non-profit to for-profit in hospitals. Nursing homes- 70% for profit to 30% not for profit.
- Robbins- Floor and Trade was applicable to anyone who applies for CON because it provides an economic benefit by restricting competition. Floor and Trade not just for non-profit entities. So LTCs would come under that.
- Paige- It scares me to death. There was a point when hospitals were going to be treated as utilities. On the one hand you have health planning. And I don't think that should be linked to charity care. It will come across as punishment or reward. That isn't what health planning should be.
- Dugan- And many of us up here are trying to find the planning in the "health planning" part of this.

Request from Ken Robbins- Can all the LTC representatives get together and let us know where you stand on this (Floor and Trade)?

- Garrett- And don't tell us just where you stand, but give us recommendations that we can implement or use to make a formula. We have a bipolar system that has combined health planning and protection of the safety net.
- Amiano- I agree with Billie that this morning's proposal scares me. I don't think that a CON protects me.
- DeWeese- Medicaid formula puts restrictions on bed room size.
- Sullivan- I understand why Medicaid has a formula. But consumers are driving what is happening right now for the LTC industry, and that shouldn't come under CON. Consumers should have some say in what their homes will look like. CON shouldn't be reflective of standards developed in 1960's and 1970's.
- Lyne- keep LTC and acute care separate.

Question from David Carvalho- In listening to the testimony, I don't see why LTCs are covered by CON at all. What public purpose is being served with continuing the regulations for LTCs? You are for the most part for-profit entities, and why are we limiting competition for for-profit entities – it may be protecting the industry, but what public purpose is being served?

- Sullivan-In the 1970's it served to balance the number of beds throughout IL.
- Garrett- Don't answer now –think about it and get back to us.
- Sullivan- Also 2/3 of LTC residents are on Medicaid, so it is a public health issue.
- Ruddick- Since government is financing a large part of the industry, that would be a reason for it to be regulated.
- Dugan- Regulation yes, but through CON? I don't think it is necessary.

Question from Pat Comstock- What is the timeframe for us to get you our recommendations?

- Dugan/Garrett- a month. Work with us or Jeff to get back on the agenda.

Question from Senator Garrett- selling nursing homes- is this profitable?

- Sullivan- no.

- Comstock- Some are, some aren't.
- Sullivan- Nursing homes are being sold because the current owner can't make ends meet.
- Garrett- Are a lot of new owners just showing up?
- Comstock- No, there is a lot of consolidation. Economies of scale are helpful.
- Paige- Manor Care was bought by HCR and it became HCR Manor Care. Carlyle Group came in to buy HCR Manor Care at the same time the bill passed. There might have seemed to be collusion, but there wasn't.
- Comstock- The Manor Care-Carlyle sale was an anomaly, not typical of what normally happens.
- Ruddick- Yes, it was an anomaly, but the state did not have the authority to look into the Manor Care-Carlyle sale as much as it could have.

Request from Senator Garrett- If we are looking at Floor and Trade approach, how can we learn about how nursing homes are bought and sold? I just want a position paper on that.

Question from Senator Althoff- Back to Paige's comment about fines. Is that with regards to all applications or just LTCs?

- Paige- I was referring to all applications. If you have a compliance issue, you are subject to a fine, and right now they are all at the maximum.
- Althoff- Can HFPB respond to that?
- Mark- Fines are not issued for applications. Fines are levied if you do not submit annually required data, and we sent two reminders before fining. The fines given at the maximum rates were intended to be a deterrent. Billie Paige was referring to far more serious offenses, like a project going above the permit level without coming back to the board for a correction. Our legal staff is currently levying fines to the highest level, but most times that dollar amount is drastically reduced. And often the Board will settle for services being given to the community instead of a fine paid to the Board.

**Presentation by Village of Plainfield- Jeffery DeMint**

Note: David Carvalho and Jeff Mark have to excuse themselves as the Village of Plainfield is a current applicant to the HFPB and this would be in violation of ex parte. Anyone who is staff for IDPH in the area of Health Facilities Planning will have to excuse themselves for 15 minutes.

- Currently an application is in front of the HFPB by Edward Hospital to build a hospital in Plainfield. This application has been delayed many times.
- 40,000 residents live in the western suburbs of Chicago. We are here to talk about CON from a municipality perspective.
- We are very impressed that the Task Force was created and that you are looking at high growth areas and how those rules are implemented.
- As a municipality, we are here to talk to you about the patients of hospitals, who are our residents.
- Plainfield is in the middle of the fastest growing suburban area in the country bounded by Joliet, Naperville, Aurora, and Bolingbrook.
- With those patients in mind, there are things that CON can't and shouldn't address, such as roads. How do our residents access healthcare? We spend 80% of infrastructure costs on road building and maintenance.
- We as a community have a railroad that comes through our town, and it cuts off half of our population from access to healthcare.
- We have very little control over the growth of our population.
- Please look at :
    - High growth areas
    - Public testimony heard by board members

    - Clear process. In 6 years we have gone through 3 applications through one provider to get a healthcare facility in Plainfield. This is a long process for a growing community that has not been well-served. 6 years is not a clear cut process.
- We eagerly await the Task Force outcomes.
- As a third party, we want to make sure that you hear our perspective

Request from Rep. Dugan- Give us written suggestions on how we can make the CON process better. And then as a Task Force, we should get recommendations from a rural municipality, etc.

- Jeffery DeMint of the Plainfield Village Board is here to discuss the 6 year trip to nowhere. Plainfield as a 38,000 population with no hospital with in a 35-45 minute drive. Our residents are not getting rapid healthcare that other communities have. We have one of the lowest patient to bed ratios. Why then won't the planning board give us a hospital? One reason is that the local hospitals have excess beds. That is archaic thinking. Has the Edward Hospital proposal become a personal issue for certain task force members? David Carvalho and Jeff Mark ask most of the questions about it and seem to be negative towards our application.

Question from Ken Robbins- I know you don't like the outcome so far, but what about the process could be improved?

- DeMint- We have a definite need in our area. When we have to drive 35-40 minutes to get emergency care, that is unfair and unthinkable to our residents.
- Robbins- Is that due to incorrect travel time methodology and/ or bed methodology?
- DeMint- We will submit a handful of recommendations that gets to this issue. Retail shopping centers can get along ok when they are side by side, why can't hospitals do that too?
- De Mint- As a high growth area, there needs to be an open process so that residents of District 813 can be heard. Also 6 years is too long for the residents of Plainfield to wait for a hospital- seems to be a poor way to do business.

Question from Senator Brady- Do you think the criteria is too subjective?

- DeMint- Yes.

Question from Senator Brady- Do you feel it is unfair that you have to appeal back to the same body that denied you? Should there be a different appeal board?

- DeMint- Yes, and we are concerned that Plainfield residents are not asked to voice their opinions.

Question from Sister Sheila Lyne- Have you had public testimony?

- DeMint- Yes, but no Board members were there. We filled our space 6 different times to get testimony from residents. Those meetings were very long. There were some dissenting opinions from other local hospitals.

Question from Sister Sheila Lyne- And the 35-40 minutes was determined by traffic experts?

- Garrett- The point is that the municipality does not have a voice in the process.

Question from Kurt DeWeese- What is the status of your application?

- DeMint- The Village of Plainfield does not have an application in front of the HFPB. Edward Hospital does. Plainfield Village does not have a voice.
- DeWeese- I understand that, but can you just tell us the status of the application?
- DeMint- Deferred again.

- DeMint- HFPB has a degree of discretion, but I feel that it is fairly wide. You have all talked about the Safety Net today. It applies not just to very poor communities, but to average communities like Plainfield. Because we are an average community on the edge of Chicago, we get overlooked.
- DeMint- Section 12-5 for District 813. Review that to see why it is not helping this community as it was intended to.

**Adjourn- 2:31pm**

Minutes respectfully submitted by Mairita Smiltars.