S55542

TASK FORCE ON
HEALTH PLANNING REFORM

REPORT OF PROCEEDINGS had at the above-entitled matter before the Task Force on Health Reform at the Thompson Center, Second Floor, Room 2-025, 100 West Randolph Street, Chicago, Illinois, on the 30th day of October, A.D. 2008, at the hour of 10:13 a.m.

PRESENT:

SENATOR SUSAN GARRETT, Cochair;
REPRESENTATIVE LISA DUGAN, Cochair;
MR. GARY BARNETT, Member;
SENATOR WILLIAM BRADY, Member;
MR. PAUL GAYNOR, Member;
REPRESENTATIVE LOUIS LANG, Member;
SISTER SHEILA LYNE; Member;
MR. WILLIAM MC NARY, Member;
MR. KENNETH ROBBINS, Member;
MR. HAL RUDDICK, Member; and
MS. MARGIE SCHAPS, Member.

PRESENT ON THE TELEPHONE:

REPRESENTATIVE RENEE KOSEL, Member.

EX-OFFICIO MEMBERS PRESENT:
MR. DAVID CARVALHO and
MR. JEFFREY MARK.

ALSO PRESENT:

MR. KURT DEWEESE and

MR. GREG COX.

ALSO PRESENT ON THE TELEPHONE:
MS. SUZANNE HACK and
MR. BRUCE SIMON.

ALSO PRESENT IN SPRINGFIELD VIA SATELLITE:

MS. MELISSA BLACK;

MR. MIKE COSANTINO;

MR. CLAYTON KLENKE; and

MR. HOWARD PETERS.

COCHAIR GARRETT: Okay. We are ready to go.

Thank you everybody for coming, our Task Force members as well as those in the audience. I'm assuming everybody has their packets with their agenda, et cetera.

Before we start the meeting, is there a motion to approve the minutes of the October 8th meeting.

MEMBER LANG: So moved.

MEMBER ROBBINS: Assuming this hasn't changed -- is my name indicated as being present? Which I was, and I don't think I see it.

COCHAIR GARRETT: Did -- Ken Robbins, for the record, was not absent; he was present, if we could reflect that in the minutes.

Is there a second?

MEMBER LANG: Can we have a debate about it?

COCHAIR GARRETT: Representative Lang seconds the motion with the change that Ken Robbins will be included.

So today what we've done is we've had a request to hear testimony from Annette Kenney,

Vice President, Network Development, Edward Hospital Services Corporation.

We are allowing a 15-minute testimony. So given that we have a very full agenda, if we could get started on that right away. We do have a Court Reporter here who will make sure that this is part of the public record, and then after that, our Court Reporter will be leaving us to our own devices.

So if we could have Annette come forward. Thank you very much.

MS. KENNEY: I do appreciate you taking the time to allow me to testify here. I did submit written testimony. In the interest of time, I'm not going to read through that; I will paraphrase.

COCHAIR GARRETT: Before you begin, I think we have to see if there's anybody on the phone. We forgot to do that and then also recognize our Springfield attendance. And why don't we take roll. I'm sorry for that.

Do you want to start with Kurt Deweese.

MR. DEWEESE: Kurt Deweese with the speaker staff.

COCHAIR DUGAN: Representative Lisa Dugan.
MEMBER LANG: Representative Lou Lang.
MR. CARVALHO: Dave Carvalho representing Director Arnold.
MEMBER SCHAPS: Margie Schaps, Health and Medicine Policy Research.
MEMBER GAYNOR: Paul Gaynor, Illinois Attorney General's Office.
COCHAIR GARRETT: Susan Garrett, State Senator.
MEMBER ROBBINS: Ken Robbins, Illinois Hospital Association.
MEMBER BARNETT: Gary Barnett, Sara Bush Lincoln Health Center.
MEMBER RUDDICK: Hal Ruddick, SEIU.
MR. MARK: Jeff Mark, Health Facilities Planning Board.
MEMBER BRADY: Senator Bill Brady.
COCHAIR GARRETT: To those on the phone, if you could chime in.
MEMBER KOSEL: State Representative Renee Kosel.
MS. HACK: Suzanne Hack.

MR. SIMON: Bruce Simon.
COCHAIR GARRETT: So that's it with our phone line. Okay, the Springfield viewership, do you want to identify yourselves.
MR. KLENKE: Clayton Klenke with the House republican staff.
MS. BLACK: Melissa Black, Senate staff.
MR. PETERS: Howard Peters, Hospital Association.
MR. COSANTINO: Mike Cosantino, IDPH.
COCHAIR GARRETT: Thank you.
Please proceed.
MS. KENNEY: As I mentioned, I did distribute my written testimony. I will paraphrase; I know you do have a busy agenda. There's a lot of "planner speak" in the testimony, so I apologize for the technicalities of it. I do hope you had an opportunity to review it.
First, I want to say that I do agree with much of what I've heard here throughout this process that the state truly would benefit from a better health planning process. What I've seen is we've got a CON process, but it's running

without the context of a good statewide health plan. This puts everybody in a difficult position. It puts the Board in a difficult position, the CON staff in a difficult position, certainly the applicants, as well.

Second, clearly just because you have a lot of rules doesn't mean you're doing effective health planning. In my written testimony I shared my concern about how Public Act 05005 was implemented.

Now, this act was intended to address some of the rules affecting bed supply and access to hospitals in high-population growth areas, but I don't think it really worked out that way. One would have thought that the bed-to-population ratio areas would have increased as a result of this law, but that didn't happen. And, frankly, I thought it would.

You know, I know when I tried to model the impact on Planning Area A-13, which is Will County, I anticipated a need for 150 additional beds. When the State came out with its need to termination it was 12. Now, I wouldn't expect that we would match exactly, but certainly when

you're off by 138 beds, you have to start questioning, okay, what's -- you know, what are we doing wrong here, and when the future bed-need-to-population ratio in the highest planning area of the state actually decreases after this law is implemented, then you really do have to scratch your head and wonder.

What we found out is -- and, you know, I credit Dave Carvalho and his staff and Jeffrey Mark and his staff for working through the process with us. We found out that depending on what input you put into the formula, you come out with wildly different answers.

Please don't misunderstand here. I don't bring this up to show that I was right and they were wrong, even though I do think I was right here. That's just me; I'm a little stubborn that way. But, you know, it shows me that even with some of the rule changes that, you know, Jeff thankfully has shepherded through over the past few years, we're still a long way from a CON system that has transparency, that has predictability and that is ensuring equitable access across the entire state especially in high

growth areas. So that's my point there.

In my written testimony I attach the IDPH inventory to highlight the fact that we really do have issues here. I attach another page that shows the disparity in bed-to-population ratios across the planning areas. And you can see that we've got huge spreads in the availability of hospital beds in the state, with Chicago having surplus of over 4,000 hospital beds and then the highest growth areas of the state, Will County, northern Kane County, McHenry County, not having enough beds. We also see that in Chicago bed-to-population ratios are over three beds per thousand population. In those high growth suburbs I mentioned it's around a .8, 0.8 bed per population. Again, you know, you would expect some discrepancy here, but that's a really wide gap. I think that's very extreme.

Again, clearly I do see this as a planning issue and something that I hope that the State will continue to work on, but I also see it as a personal issue. I personally live in one of these high-growth suburbs, so I know what it's like to bring my kid to the hospital, you know,

during rush hour.

The current plan is telling me it's okay for me to travel 30 minutes or up to 45 minutes to a crowded emergency department, and I think that's easy to say if you live in Chicago and you've got the luxury of two to three hospitals within walking distance, but if you live where I live, it's not so easy.

Surely I think as a state we want to minimize duplication; we definitely don't want to overspend, but we also want to ensure access, and I don't think there's been enough focus on that to date. It's clear to me that unless the rules guiding the supply of hospitals continues to change for the better, access in the high-growth areas is not going to improve. I think Public Act 05005 was a step in the right direction, but, frankly, I don't think it went far enough.

To start to address some of the inequities that I just spoke about you've got to address a few things, being the state bed need formula still.

First, the utilization input into the formula needs to be current, not three years old, as it is now, and I think it should be updated

every year.

Second, the migration factor used in the formula should be higher, and it should be consistent across all categories of service. Right now you've got an 85 percent for obstetrics; you've got a 50 percent for med-surg; you've got a zero percent for ICU. The pieces just don't fit together, and I think it's contributed to some of the inequities that I spoke about. I recommend the 85 percent migration factor across the board.

Third, the formula needs to acknowledge that all residents of the planning area, those who have historically used hospitals within that planning area and those who have traveled outside the planning area, are both impacted by the same population growth.

Now, that sounds like a very common sense principle, but that's not really how it works in the formula. It's a technicality that I find very hard to explain, but I do think it's an important input that needs to be paid attention to.

I've got, as you can imagine, a whole mess more ideas, but I will stop there as these being

some of the high points.

My last point is that, you know, I will acknowledge that the changes that I'm talking about really won't impact most areas. Frankly, I don't think that access is that much of a problem in all areas across the state, but it is a problem in some areas, and I think those are the ones that are geographically large and very spread out, the ones that have grown substantially over the last 10 years and the ones that have substantial amounts of out-migration.

So I'll stop there and answer any questions.

COCHAIR GARRETT: Are there any questions from Task Force members?

(No response.)

COCHAIR GARRETT: I'll ask a question, then -- well, maybe I should ask Jeff.

How often do you update something like the migration factor, which seems to be a sticking point?

MR. MARK: If I may, Madam Chair, just to explain this migration factor, migration is a net zero sum gain. If our formulas add bed

need to Area A, it's at the expense of some other area.

COCHAIR GARRETT: Can I just ask, though, if your population is growing, though, and you're shifting -- you're saying you're shifting, but your population is actually going up.

MR. MARK: Absolutely, and that's exactly what the formulas do. They take the state of Illinois population projections and base the bed need on those projected populations.

COCHAIR GARRETT: But in a specific high-growth area that I think Annette is speaking to, do you factor that in, or do you just look at the whole state?

MR. MARK: No, we do it on specific areas. The population projections -- and Dave might be able to elaborate on this further.

MR. CARVALHO: Let me jump in.

To specifically answer your question, the migration factor doesn't change. The inventory is updated annually using the migration factor.

So as Annette said, the migration factor is 85 percent for certain services, it's 50 percent for other services and zero for other services.

That's one piece of a formula that also has in its calculation population numbers and utilization numbers, and all those go together and multiply. That's recalculated every year.

The migration factor itself has been consistent, because it's set by rule for a period of time, and then when the statute changed and asked the Board to reevaluate what it should be, it was set again by rule, and the rule goes through JCAR and all that. So it was done by rule.

The current migration factor is 85 percent for OB-GYN, 50 percent for med-surg, zero I think for ICU.

If you'd like me to address several issues she raised, I'd be happy to. Otherwise, I can do one question at a time.

COCHAIR GARRETT: Can I ask, why is it 85 percent one time, 50 percent and zero for another?

MR. CARVALHO: As Jeff started to explain, migration -- all of this relates to the issue of calculating the need in an area, and what you see when you look at the data, as you can imagine, is that some people in one planning

area are getting their care in another planning area at any given point. So I live in the far south suburbs, and I brought my daughter to Children's Hospital. So some of the actual utilization of facilities in a region is from people outside the region.

So the question when you're doing a calculation is of how many beds, how many facilities are needed in any given region. You want to look at, A, the services being provided in the region, and, B, the services being provided to the people who live in that region went somewhere else. The migration factor is used to take into account that "somewhere else."

Now, where I would disagree with Ms. Kenney in her written testimony is she said there's no rational reason for having a different migration factor for different services, and I would say, actually, if you thought about it for a moment, you very much expect different migration factors for different services, because people do not make the same decision about where to deliver a baby as they might where to have surgery, as they might in some event that puts them in an ICU.

Nobody gets put in an ICU because of an accident and says, "Oh, gee, if the ICU had been in my region, I wouldn't have had the accident in San Diego."

So for the different categories of service you might expect a different migration factor, and, in fact, the rule has a different migration factor for OB-GYN versus med-surg versus ICU.

MEMBER LANG: Thank you. I have two questions; one for Jeff, and one for Ms. Kenney.

In your comments, Jeff, I thought I heard you say that migration factor creates a zero sum gain; if you add beds somewhere, you have to remove them somewhere else.

MR. MARK: That's exactly correct.

MEMBER LANG: Why?

MR. MARK: That the migration -- the way the statute is written, in fact, dictates -- and it corresponds to the historical rules -- is that we compensate an area for out-migration by subtracting that demand from the area that has the in-migration.

So, for example, if population from outside of the Bloomington area are going to Roman Hospital

as a referral hospital or a reference hospital, according to the migration factor, we would subtract those patient days out of Bloomington and put them back in the adjacent planning area to reflect that need there. That's the way migration works.

MEMBER LANG: Is it possible they could both have increased need simultaneously?

MR. MARK: Not by the migration factor. There may be other factors.

MR. CARVALHO: I'm a math guy, and Jeff's an architect.

What migration factor is doing is saying, how much need do you calculate in this area attributable to the fact that some people here are getting their care somewhere else. The assumption when you do that is the people getting care somewhere else would be getting their care in the local area if only the buildings existed for it to happen. The opposite side of that assumption is if the buildings existed, they wouldn't go get their care in the other planning region. Therefore, the need in that planning region that looks like it's there because that

person was going there isn't there anymore.

So Dave Carvalho stops getting his care downtown and gets it locally because the need calculation holds me in with the migration factor, and the need for me to be downtown doesn't exist anymore.

MEMBER LANG: But let's presume that while you create services in your local area so you don't have to come downtown and the migration factor would tend you to want to remove beds from that area, there could be other factors that would add to that need, new buildings in that community, et cetera.

So that's a separate issue? So while you're subtracting, you could also be adding to the area in a different way?

MR. CARVALHO: A different part of the calculation would add -- that would be the population.

COCHAIR GARRETT: But are those factored in on a regular basis?

MS. KENNEY: But the data is 2005. It's updated every year, but the data's still 2005.

MR. MARK: The base data where we

started was 2005. We use the projections established by the State of Illinois, which presumably have built into them rapid population growth or population decline. They are sorted specifically on the geographic areas. They're sorted further on specific age groups.

MEMBER LANG: You said State of Illinois. Who? Department of Public Health?

MR. MARK: Who developed the projections?

MR. CARVALHO: The official state projections on population used to be done by DCEO. I think DCEO has contracted it to one of the companies out there that does this. Then my Center for Health Statistics, which is another part of my office, takes those state projections and breaks them down into the planning regions, because as you can imagine, DCEO doesn't care what our planning regions are; they create projections by community. So our people take the community projections and then recalculate them to correspond to planning areas.

MEMBER LANG: I'll just comment, and then I have one question for Ms. Kenney.

I'll just comment that whoever does those population projections, they ought to be -- whatever board we create at the end of this process ought to be responsible for doing its own projections. I don't think we should allow them to take someone else's projections. I think whatever board we create, whether it be one board or two, one for planning, whatever, they ought to be doing their own population projection.

COCHAIR GARRETT: I'm just a little confused, and I apologize for jumping in, but we've got this 2005 population number that we're using, but is that population number -- for instance, when we get applications in 2007, do you update that 2005? Because we have to be able to see forward when you're seeing that there's a huge -- so that's factored in? Because that's not what I'm really -- that is factored in.

MS. KENNEY: Well, from 2005 to 2015. So it's not a rolling.

COCHAIR GARRETT: When your hospital applied, when you have an argument with the migration factor, did they add the population --

MS. KENNEY: You know, I don't know

that I'm supposed to be talking about my application here. So I'd rather avoid that.

COCHAIR GARRETT: Does the formula include the projected increase in population based on when a hospital is estimated to be completed?

MS. KENNEY: Up until 2015.

MEMBER LANG: I have one additional question of Ms. Kenney.

This is a completely different issue, obviously, about the board, et cetera.

So we've had a lot of talk here about the public hearing process, and I know there was an extensive public hearing which some described to us kind of like a circus out there. I've heard from lots and lots of people in that community about the process.

What changes would you suggest we make in the public hearing process to make it more smooth?

MS. KENNEY: Well, I'll go back to my Massachusetts roots. I think there were plenty of problems there, too, but one thing that worked well in that process is the staff -- and I can't remember if board members, but at least the staff

reviewing the applications attended the public hearings. They also spent time with the applicants to really, truly understand what's going on in that local area. That's something that I think is missing here. So some kind of involvement and attention to the public hearings I think is a good thing.

I think it's great that the public has an opportunity to speak, and they should, and they want to, but they've got to be heard.

MEMBER LANG: Should that public hearing, in your opinion, have give and take with the decision makers?

MS. KENNEY: Give and take -- for example?

MEMBER LANG: Today board members don't necessarily show up. People make testimony, and they're basically talking into a tape recorder. Should there be someone to have give and take, to ask questions, to bounce ideas back and forth?

MS. KENNEY: I think if there was somebody to ask questions to, it would be good, but it would be a hard thing to do. It would be

hard to manage that -- it might be hard to manage that process. That's something I'd have to think about, but the concept is good.

A lot of people don't understand how this works. We talk about this formula. It's actually a very sophisticated, very good formula, but you have to look at, you know, does it work well, and to me, the proof is in the pudding. Where you still end up having unanswered questions about access, it's not working well.

So to have somebody who can answer -- the public could ask questions of is a positive. I'm not sure whether that would be in the traditional public hearing forum or something else.

I think what we do need is a much more open process than we have. When there are issues like this, when a planner anywhere in the state says, "Hey, something looks odd here," I'd like there to be more give and take about, "Is something wrong with the formula? Is something wrong with the rules? Is something unique about this area that might change?" I don't think we have that now.

COCHAIR GARRETT: But you can't bring that up at the hearing?

MS. KENNEY: You can testify. You don't get back and forth.

MEMBER LANG: I have one more quick comment. If you could tell all those hundreds of people that you mailed out to that we didn't decide whether or not they should have their hospital, I'd appreciate it.

MS. KENNEY: It takes on a life of its own. I'm telling you, people are passionate about access to health care; they are.

MEMBER LANG: It would just be nice if they knew it wasn't this group.

MS. KENNEY: I think there's a lot of frustration and for good reason.

MEMBER LANG: Thank you.

COCHAIR GARRETT: Senator Brady.

MEMBER BRADY: Migration factors, what data are you using?

MR. CARVALHO: As you may know, there used to be something called the Illinois Health Care Cost Containment Council, which collected the UB92 -- now I think that it's a UB04, which is a form for every discharge. So for every person that's hospitalized in Illinois there's a

form that's created and sent to the State. We've inherited that responsibility when you dissolved the Illinois Health Care Cost Containment Council.

So there's about 1.6, 1.7 million discharges in Illinois every year. It goes into a giant database, and it tracks information about residence of the person who is the patient and the place where the care is being given. So all that's tracked.

One thing you need to know, this entire formula is mechanical. There's no subjectivity to this.

MEMBER BRADY: What I'd like to see is your mechanical formula in this case, and your mechanical formula in this case -- because these migration factors, if the accountants or the mathematicians are pure, should work out the same, and I'd like to see why they aren't.

MS. KENNEY: We spent a lot of time on that.

MEMBER BRADY: You've got a complaint about what they're doing, so we'd like to see it to evaluate that difference.

Jeff, the other area in which it's not a

zero sum gain is if we do a better job of either importing or not exporting in and out of Illinois?

MR. MARK: Absolutely.

MEMBER BRADY: Do you take that into account?

MR. MARK: We do not. What we do -- inherent in the way the formulas are structured -- and these are structured by rule -- we have built into it the effect of inmigration to the state of Illinois.

So, for example, patients coming to Chicago teaching hospitals from Indiana are counted. We do not -- we do not take into account those residents leaving Illinois and going elsewhere. In an ideal planning world, perhaps we should. We do not have the data.

MEMBER BRADY: So we don't have a benchmark really on the net effect of that?

MR. MARK: We have some preliminary data. Dr. Chung from GSU, who testified before this group, he compiled some of that data for us, but we've not utilized those in any formal way.

MEMBER BRADY: I'd like to see that,

because it would also be a good thing to know how much business we're losing to other states and jobs that we're losing.

The population issue, I guess what I'm confused about is it's pretty simple; you usually have one general place that says, "The likely population when the project is complete will be X."

Now, she's complaining you're using three- to five-year-old population.

MS. KENNEY: No, utilization inputs are three years old.

MEMBER BRADY: Are we hand in glove here on population numbers?

MS. KENNEY: Well, I guess when I think of -- let's say -- it's almost 2009. If I put a project in in 2009 and we're supposed to be projecting forward --

MEMBER BRADY: Your completion date is 2012, and we pick a window between 2012 and 2015 and say, "This is the average population for it to complete." What I'm trying to get at is, what population variable do you use?

MR. CARVALHO: What you look at in a need calculation is the population on the date of

projected opening.

MEMBER BRADY: I didn't hear you. Opening?

MR. CARVALHO: Right. That's why we have 10-year projections, because nobody comes to us with any projects that are going to open more than 10 years from now, unless you build it in your back yard.

MEMBER BRADY: But the simple answer is, it's opening day?

MR. CARVALHO: Yeah. So we have those population projections. The test for need is what is the need going to be when you open. If the need were today, nothing would get built.

MEMBER BRADY: Absolutely, but you don't look at what the need is on an average between the first day it's open and the fifth year it's open? Do you think that's a weakness? Because they shouldn't have to come back every year until the statistic finally hits the point. I mean, we know what the population is going to be five years after they open, or we can estimate, the same way we can estimate when they open.

MR. CARVALHO: I'm not conveying this very well. All of the different pieces of this formula work together.

MEMBER BRADY: I understand. I'm talking about the population component.

MR. CARVALHO: I'm getting to that. If you were going to look at the date that it opened, then the test you would use to meet that would be one thing. If you were going to look at the average over five years, the test you would use would be a different thing.

So we have tests that are based on the year of opening. If you suggested to change the test to a different range, you could do that. I'm just telling you, then the other formulas would be different, as well.

MEMBER BRADY: Do you agree with that, that the population data should be based on the day it's opened?

MS. KENNEY: Well, I think you have to continue to anticipate the future beyond that.

MEMBER BRADY: So you'd like to see a variable maybe for the average of the first five years open?

MS. KENNEY: I think that makes sense, especially in a big project.

MEMBER BRADY: Do you disagree with the way they calculate the population on the day it's open?

MS. KENNEY: What I found out after I really dissected this formula, they're using two different sources. That's one of the problems, I think, statistically. They've got IDPH estimates for 2005; they have a different source --

MEMBER BRADY: These are population estimates; is that right?

MS. KENNEY: -- for population for 2015. So you're kind of almost using different assumptions.

MEMBER BRADY: Why wouldn't we give the applicant the benchmark that we're going to use and only use one so they know if they've got a chance?

MR. CARVALHO: We publish what we do. There are several different issues that Annette's raised.

MEMBER BRADY: I'm just trying to stay focused on population.

MR. CARVALHO: Right. The analogy I've used -- do you know what a slugging percentage is where you look at your singles, doubles, triples, home runs, at-bats?

MEMBER BRADY: We used to think about it in fighting.

MR. CARVALHO: That, too. A slugging percentage -- we use data -- because there's multiple things you multiply to get to a number, we use data from the most recent year we've got for all of the components.

The analogy I would use is you would not do slugging percentage looking at your home runs this year, your singles last year, your doubles three years ago, your triples two years ago and your at-bats last year; you've got to use numbers from the same time.

So because there's several numbers that get multiplied together -- one is utilization; one is population; one is migration factor -- one of the complaints in the testimony is for each component we aren't using the most recent data available, and the reason we don't is because for each component the year of the most recent data is not

the same.

Utilization we can get much more -- a different time frame than population estimates we can get. So we align so that data we're looking at are apples to apples, all in the same year.

It is true that it means some components of the calculation there is more current data, but it is not for the same year as other components.

MEMBER BRADY: Again, I'm sticking to the population estimate. Do we communicate to the applicants what population estimates we're going to use?

MR. MARK: Yes.

MEMBER BRADY: But you just said we use two.

MS. KENNEY: They use two different sources.

MEMBER BRADY: Two different sources will come up with two different estimates. So which one do you base it on?

MS. KENNEY: Well, you base it on their published population projection for 2015.

MR. CARVALHO: Let me explain. We're using a term that I don't think laymen use the

same way that planners do.

There's a difference between a population estimate and a population projection. A projection is a forward-looking number; an estimate is dicing the number you've got into pieces.

So, for example, if someone says to you that the population this year in DuPage County is 3.2 percent African-American, that's an estimate, because no one did a census this year, but someone is dicing up this year's numbers based on what they think.

MEMBER BRADY: Got it.

MR. CARVALHO: If someone said to you, "I think the population in DuPage County in 2012 is going to be a million," that's a projection.

MEMBER BRADY: But we use estimates up-to-date, projections prospectively.

MR. CARVALHO: Different people were doing -- the projections is the official state projection of the population going forward. The estimates is our folks dicing that into planning areas. That's the estimation.

COCHAIR DUGAN: And DCEO is doing the population one -- whatever the heck it's called.

MR. CARVALHO: DCEO does the projections that feed into our folks carving it up into planning areas.

The reason why there is one state projection is because transportation looks at that; health looks at that; Medicaid looks at that; everybody looks at that, and it kind of makes sense for everybody in government to be working off the same projections.

MS. KENNEY: But they may have a different base than the IDPH base. It is very complicated.

MEMBER BRADY: It gets very arbitrary.

MR. CARVALHO: I don't know if it's arbitrary. It's very mathematical.

MR. COX: But someone has to be wrong, because projections don't arrive at the same conclusion.

Can you just give us what you guys have done, and we can look at it to see why they don't arrive at the same conclusion?

MR. CARVALHO: We can share all the information.

The part of the testimony that I think you're referring to is Annette said she sat down after the statute was passed and figured out what she thought it was going to be.

I don't believe -- tell me if I'm wrong -- I don't believe at the time you did that you were fully familiar with the methodology we used, so you used your own methodology.

MS. KENNEY: No, I really did go through the bed-need policy, but I did make different assumptions.

MR. CARVALHO: After the fact, when we sat down, we realized there were different methodologies.

MR. COX: What are the differences in methodology?

MR. CARVALHO: For example, I believe when Annette first did the calculation she did use the most current information for each of the components to do the multiplication out and then afterwards learned that we don't do that. We say, "If you're going to calculate a number, you

use the same number for all of your components."

MR. COX: If I could have those, I would appreciate it.

MR. CARVALHO: The reason why Jeff and I are comfortable having this conversation, whereas, we weren't comfortable when the Village of Plainfield came in, is because it goes to the issue of the inventory, which is applicable to all applications. If we couldn't talk about something that goes to all applications, we couldn't be here on any of your discussions.

So we just want to stay focused on inventory, not on your particular application.

COCHAIR GARRETT: Renee, if you're talking, we're not picking up everything.

MEMBER BRADY: Your first point was -- I wrote it down --

COCHAIR GARRETT: Renee, Renee, can you hear us?

(No response.)

MEMBER BRADY: Well, anyway I wrote down that you said you think they should use current census versus three-year-old census.

MS. KENNEY: I do.

MEMBER BRADY: You're talking about population?

MS. KENNEY: No, no. No, that's the most recent utilization. The reason being -- and I think this is why --

MEMBER BRADY: Okay. That's utilization. I understand your logic. We just can't get utilization data that's more current than three years old?

MR. CARVALHO: The population numbers are older, I believe. The projections were done at one point in time, and they were projected out 10 years, and since, as I said, none of our applicants come in with stuff that's going to be done 10 years out, the population numbers are not updated on an annual basis.

Utilization information, however, we do get every year. So utilization numbers are updated annually, but we use information from the same year when we do the multiplication out.

COCHAIR GARRETT: I have an idea, because we can't -- this is all very technical -- did you want to say anything, Lisa?

COCHAIR DUGAN: No.

COCHAIR GARRETT: I think that -- and it's one formula versus another formula. That seems to be the problem. There seems to be somewhat of a pattern with that, as well.

I think we should just absorb this, and as we reconfigure and think about what we're going to do is just to the committee members, do not lose sight of this conversation.

MS. KENNEY: It is technical. It's complicated. I'd be happy to work with the group to allow them to understand a little better.

COCHAIR GARRETT: I realize you've come in, you've had those technical assistance meetings, but when a business moves into an area, and they do their own projections -- because they don't want to go out of business, they want to understand the population -- it seems a little weird to me that you -- a hospital being the business and the State's sort of keeping control over who comes and goes, and if the formulas don't mesh, that's problematic. And I think, hopefully, we'll be able to have a better way of understanding.

MS. KENNEY: There's a disconnect,

and it's -- the last thing I'll say is the proof is in the pudding. If it was working as well as it could be, I don't think we would have so much inequity across different areas.

COCHAIR DUGAN: I'm sorry. The population number that we use that I understand goes for 10 years when they first get it, is everybody in agreement that at least the projected population figures that we're using haven't changed?

You estimate that Will County is going to grow by this much, but as we all know, Will County -- so are the figures true as to how you project but you find out we're off by 10,000 people? Do we do that regularly?

MR. CARVALHO: The only good thing about the projections is we're all using the same ones.

But, absolutely, if you did a projection, for example, 20 years out, don't give anybody a nickel for that. The reason why we're only doing 10 years out is most statisticians don't have much confidence more than five years out, but we're doing 10 because it's necessary for this system.

COCHAIR DUGAN: And I'm not saying

that's wrong. What I'm saying, though, is when you're looking at what we're looking at, which is, is there a need, to me there might be a problem if our 10-year projection maybe was a little off. Then I think we need to be using more recent numbers to say, "Hey" --

MS. KENNEY: In a way, you do, because you check that against, again, I would hope more recent utilization numbers. So it's not the only thing you do look at, but, you know, you do have to look forward.

As planners, you're used to working with imperfect data. Nobody's got a crystal ball, but you have to make reasonable judgments that this is probably close to right.

COCHAIR DUGAN: Thank you.

MS. KENNEY: Thank you.

COCHAIR GARRETT: Thank you so much for coming in, and we will take your testimony very seriously.

(Which were all the proceedings had in the above-entitled matter at the hour of 10:53 a.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF K A N E)

I, Paula M. Quetsch, Certified Shorthand Reporter No. 084-003733, CSR, RPR, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct, and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand this 4th day of November, A.D. 2008.

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Certified Shorthand Reporter