S55297

TASK FORCE ON
HEALTH PLANNING REFORM

REPORT OF PROCEEDINGS had of the above-entitled matter before the Task Force on Health Planning Reform at the Thompson Center, 100 West Randolph, Chicago, Illinois, on the 15th day of September, A.D. 2008, at the hour of 10:11 o'clock a.m.

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

EX-OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO, and

MR. JEFFREY MARK.

ALSO PRESENT:

MR. GREG COX,

MS. MELISSA BLACK,

MR. KURT DeWEESE,

MR. MIKE JONES, and

MS. MYRTIS SULLIVAN.

CO-CHAIR GARRETT: I will call the meeting to order, and I think if we -- let me get my agenda out before I start.

Have we all read the August 15th minutes? If so, if there are any changes or questions? If not, is there a motion to approve the minutes?

MR. CARVALHO: Senator, I had two suggestions. On Page 3, the top line, it says, "New rules are in effect for freestanding surgical centers." That should say "emergency centers."

And then on Page 4, in the third circle, first square, three lines up, the sentence says, "For instance, a mental health facility." I would just suggest changing that to one facility. I know the name of the facility, and I wouldn't even know the adjectives to describe it in a generic way. So why don't we just say -- I suggest you say "one facility didn't like a decision we gave."

CO-CHAIR GARRETT: Is there a reason why we shouldn't name the facility?

MR. CARVALHO: Well, I don't think the witness named it.

MS. LOPATKA: I did.

MR. CARVALHO: Okay. Misericordia.

CO-CHAIR GARRETT: Okay. Then I think we should include the actual name.

MR. CARVALHO: Okay. The suggestion there would be, "For instance, Misericordia didn't like the decision."

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

MEMBER LYNE: So moved.

CO-CHAIR GARRETT: So moved. Second?

MEMBER LENNHOFF: Second.

CO-CHAIR GARRETT: Second. Okay.

MR. CARVALHO: Senator, one additional thing, I think at the time that Chairman Lopatka gave her testimony, she had asked if she could supply you with a copy of her testimony to include with your minutes, and we have that, and it wasn't attached. So she has requested if we could do that.

CO-CHAIR GARRETT: To disseminate?

MR. CARVALHO: No, just to include with the minutes as an attachment.

CO-CHAIR GARRETT: Okay. Sounds great.

There is a motion to approve. All in favor

say aye.

(The ayes were thereupon heard.)

CO-CHAIR GARRETT: Opposed say nay.

(No response.)

CO-CHAIR GARRETT: The minutes have been approved as amended.

I think what we should do because we have our phones going and the TV monitor going, if we could just go down and introduce who we are. We'll get everybody on the phone to introduce who they are, and then we'll go back to our TV screen and get everybody on board.

So could we start?

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

MEMBER ROBBINS: Ken Robbins, Illinois Hospital Association.

MEMBER BRADY: Senator Bill Brady.

MEMBER LYNE: Sister Sheila Lyne, Mercy Hospital.

CO-CHAIR GARRETT: State Senator Susan Garrett.

CO-CHAIR DUGAN: Representative Lisa Dugan.

MEMBER GAYNOR: Paul Gaynor, Illinois Attorney General's Office.

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

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

MS. SULLIVAN: Myrtis Sullivan, Illinois Department of Human Services.

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

MR. CARVALHO: Dave Carvalho, Illinois Department of Public Health.

CO-CHAIR GARRETT: Then for those who are on the phone line, could you introduce yourselves?

We don't have anybody calling in?

MR. SIMON: Bruce Simon.

CO-CHAIR GARRETT: From where?

MR. SIMON: With -- hospitals.

CO-CHAIR GARRETT: Okay. You're a lobbyist, Bruce; right?

MR. SIMON: Right.

CO-CHAIR GARRETT: Advocate for health care. Anybody else on the phone?

MR. CLANKY: This is Clayton Clanky with the House Republican Research Staff.

CO-CHAIR GARRETT: Anyone else?

MS. HACK: Susanne Hack, representing the JC. I don't know about everybody else on the phone, but I can really hardly hear anything.

MR. CLANKY: It is pretty low today.

MS. GOODSON: Lee Goodson from Representative Tom Cross's Office, and I agree with the sound issue.

CO-CHAIR GARRETT: Is there a way that we can turn up the volume so they can hear us? We can hear you by the way.

CO-CHAIR DUGAN: Yeah, where's that thing that usually sits up there?

MS. McALPINE: The technician said today they're doing it through the video equipment.

REPRESENTATIVE DUGAN: Tell the technician it doesn't work real well.

CO-CHAIR GARRETT: Well, since we're going to be here for, you know, three or four hours, can we get --

MS. McALPINE: I'll go find him.

CO-CHAIR GARRETT: Okay. Thanks. So we're trying to remedy that situation, phone callers.

All right. Anybody else on the phone that needs to weigh in? Got everybody?

Springfield, can you hear us?

MR. DeWEESE: Kurt DeWeese, speaker staff.

MS. BLACK: Melissa Black, senate staff.

MR. JONES: Mike Jones, Department of Health Care and Family Services.

MS. MARTIN: Lona Martin, Cullin and Associates.

CO-CHAIR GARRETT: Is that Kathleen Dunn?

MS. DUNN: It is. Thank you for helping me, Senator.

MR. PETERS: Howard Peters, IHA.

MR. FOLEY: Charles Foley, Foley and Associates.

CO-CHAIR GARRETT: I just have a question. Foley and Associates, are -- what are you? Who are you? Health care advocates? Okay.

Okay. I believe we are good to go. On the phone, are we any louder? Can you hear us any better?

PHONE CALLERS: Yes, I can.

Good.

Thank you.

CO-CHAIR GARRETT: It works both ways. We can hear you loud and clear.

Okay. Let's get going with our first witness, United States Department of Justice, Antitrust Division, Scott Fitzgerald and Joseph Miller.

Is Scott with you?

MR. MILLER: Scott is with me. Yes, he is.

CO-CHAIR GARRETT: Do you want to come up, Scott?

MR. FITZGERALD: Joe is going to represent me.

MEMBER ROBBINS: Madame Chairman, could I just ask?

CO-CHAIR GARRETT: Yes.

MEMBER ROBBINS: I know that Mr. Miller has come all the way from Washington,

and I don't want to deny him this opportunity, but I am puzzled about why at this stage of the game when we know we have so little time to complete our report that we're not proceeding to do the business as I thought we were going to be here to do today, rather than listening to more witnesses on top of all those we've already had.

CO-CHAIR GARRETT: Okay. So a while back, the State Med Society requested that the Department of Justice come and testify.

We talked about having you come in August. They couldn't do it in August. They had to work in a collaborative way to get their testimony in sync is the best way to say it. So this was really the -- we would have preferred August, but it didn't work that way, so we're going to allow them to testify.

MEMBER ROBBINS: Haven't we already heard from the Medical Society as witnesses?

CO-CHAIR GARRETT: Well, you know, I -- we have, yeah, but I think this is a different perspective, and I think that there's no reason for us to deny people to testify. We may agree with -- as you know, we've been hearing --

MEMBER ROBBINS: To me, it's not a question frankly of agreement. I look forward to hearing what he has to say. I'm just concerned at this late stage of the game and as far behind as I think we are trying to get something done by November.

CO-CHAIR GARRETT: Well, let's just pretend a half-hour is not going to make a big difference, and I think we should proceed, if everybody else is in agreement. I don't see how we can deny him the right to testify.

Mr. Miller, please proceed.

MR. MILLER: Thank you. I appreciate the invitation to speak here. My name is Joseph Miller. I'm the assistant chief of the Litigation I Section of the Antitrust Division.

CO-CHAIR GARRETT: Can everybody hear? I just want to make sure. Okay. You need to talk louder.

MR. MILLER: I'll start again. I appreciate the opportunity to speak. My name is Joseph Miller. I'm the assistant chief of the Litigation I Section of the Antitrust Division of the U.S. Department of Justice.

The Litigation I Section has responsibility for enforcing the antitrust laws with regard to health care and health insurance, so that's why I'm here today.

We have submitted, I think you have it, a joint paper that we drafted with the Federal Trade Commission, with whom we share responsibility for antitrust enforcement in health care, and I'll just summarize that paper in a few minutes today and be happy to take your questions.

I'll start with the premise that health care in -- the competition in health care markets benefits consumer welfare, that you get increased innovation, quality, choice, price competition, and that certificates of need restrict competition and generate consumer harm.

So the question I'm going to ask you to think about as you draft your report is: Can you achieve the policy goals that are sometimes associated with CONs without the consumer harm that's often generated by the restriction in competition?

Our paper lays this out in some detail, and I notice there is a large -- you know, it

coincides a bunch with the Lewin Group report. So I don't think any of these points are going to be particularly new to you, but this is our perspective.

So the paper goes through, and we examine the justifications for CONs and starting with cost containment, which was the original reason for at least the proliferation of the CONs.

CO-CHAIR GARRETT: Please talk louder.

MR. MILLER: Okay. So in the paper, we look at justifications sometimes given for CONs and try to evaluate them.

First, we start with cost containment, which was the original reason given for CONs. At the time that they became popular, a lot of health care was reimbursed on a cost-plus basis which provided an incentive to spend a lot on facilities and equipment. That, of course, is no longer the predominant way of reimbursing in health care, so that reason is not valid.

There has been a lot of empirical work cited in the Lewin Group study as well as elsewhere that says that CONs don't actually contain costs as one might predict they would. So, you know, the

evidence on cost containment as a justification for CON I think is weak.

The second and I think more prevalent today reason people give for CONs is a funding mechanism for charity care. What we would ask the task force is to look at the evidence and weigh it against what has to be significant costs associated with CONs.

So the main costs I'm thinking of and the obvious ones are the consumers who would have selected alternative avenues of care, and they can't do that because the CON has suppressed that alternative.

So there may be a single-specialty hospital or another facility that would have been -- an imaging center would have cost less money, would have been more convenient. There's a host of reasons people choose those facilities. That's not available to them. Those consumers are harmed.

I'd also ask you to look at whether it actually works, whether CONs actually increase charity care. You've had evidence in the record from Lewin Group and from MedPAK that CONs don't

actually have that effect of protecting charity care. Controversial points and perhaps not intuitive, but that's the evidence that I see.

There's a more subtle and related point that competition that would be suppressed can spur existing hospitals to improve performance, and this is related to perhaps why CONs have not had the effect that some had hoped of protecting community hospitals.

So those are the main reasons for charity care. Obviously a big issue, and, you know, I would ask you to look at the evidence to see if it's actually -- if it's actually working. If CONs actually have the effect of protecting charity care; and if there is some evidence for that, that you credit whether you think that there's a less restrictive mechanism to fund charity care that doesn't have the anti-competitive effects that CONs have.

The last point I want to make is, aside from what effects they have, they can facilitate -- CONs can facilitate anti-competitive behavior; that is, they can provide cover for private agreements that are illegal under the antitrust

laws, or agreements that are not illegal, but the simple use and abuse of the process can impose costs and delay that's not associated with the benefits of CONs.

The Justice Department has filed two cases in the last few years and issued a closing statement on another case that we're investigating that was -- where the behavior was cheered by the legislature in Vermont.

So in the two cases in West Virginia, we found that there were private agreements surrounding the CON process. A dominant hospital used the threat of a CON delay to get a private agreement to locate a facility in a place that would have been less convenient for consumers.

Also in West Virginia we filed a case where two hospitals divided markets based on threats of CON delay and said, you know, we'll do heart if you do cancer, and the benefits of the potential competition for those services was lost.

That's what I have today. I'd be happy to take your questions.

CO-CHAIR GARRETT: Are there any questions from committee members?

Why don't we start way down?

MR. MARK: Thank you. First, thank you for coming and taking the time to be here.

I have a couple questions, and I did review the 2004 FTC report that was approximately 360 pages. I did not read the whole thing. I did read the six pages that address certificate of need.

It appears, from my reading, that the primary question that was addressed by this report relative to certificate of need was, in effect, the cost effectiveness of the legislation and the programs.

For the record, was the question of access to care, access to services, community health parameters, quality of service delivery -- were these ever examined in any detail whatsoever?

MR. MILLER: Sitting here, I don't remember the record in enough detail, but all that is available on video and the FTC Website. So whatever the testimony was at the time is available.

MR. MARK: None of that appears in the summary or in the report. That's why I'm asking.

MR. MILLER: I can't give you a direct answer. I don't remember.

MR. MARK: Okay.

CO-CHAIR GARRETT: Claudia.

MEMBER LENNHOFF: Thank you also for coming here and for the paper you all submitted.

I guess I just wanted to make a comment, and you can respond to it, if you want, but I think there's a fallacy a lot of times when we talk about consumer choice. I feel like a lot of times we are talking about consumers of means, people who are well-insured and have good financial standing and actually would be in a position to shop around if there were more alternatives open.

In my community, when an entity wanted to create an outpatient surgical center, they were very clear that they would not be accepting Medicaid or uninsured patients. So what choice would those patients have had?

I think it's important to -- I don't know if you have any qualifications for what you mean by consumer choice, but I think those are important considerations. Are we talking about low-income people or people of means?

MR. MILLER: Well, this is a logical point, and then I'll maybe get to what I think you're driving at. If people of low-income means have one place to go to get, let's call it, charity care or somebody is going to fund that care, if the CON is blocking the ambulatory surgical center or the imaging center or whatever it is, some people would have the choice of going to the other place. So their choices are restricted. They're consumers whose needs account for something.

I think the question, if I'm understanding the question you're getting at, is, would opening that CON harm the ability to provide the charity care to somebody who is indigent, or are you saying should all new facilities be open to everyone regardless of ability to pay?

MEMBER LENNHOFF: I guess I am saying that. I guess I'm saying that when we're talking about choice and consumer choice and as provided by competition, that really we should be clear that we're talking about consumers of means and not low-income consumers and uninsured consumers.

MR. MILLER: There is one other

example to think about, and the Federal Trade Commission had a hearing on this in the last couple of months; and that is, the proliferation of mini-clinics or other avenues of providing health care aside from what we think of as traditional settings; and the message was the same, that, you know, competition should be allowed to proliferate. If these turned out to be things that consumers desire, then they'll succeed.

But there shouldn't be -- you know, there shouldn't be legal or regulatory barriers aside from the traditional ones of health and safety to prevent them. So mini-clinics might be more geared toward somebody who may not need a full panoply of emergency care services, but might go to an emergency room for, you know, something that doesn't require that amount of care.

CO-CHAIR GARRETT: Did you have --

CO-CHAIR DUGAN: Yes. I just want to ask. You said it used, back when the CON was first put into place, the cost-plus, which now is no longer the case. Why would that change?

MR. MILLER: Federal law encouraged in

1974 -- it's in the paper. I forget the name of the act.

CO-CHAIR DUGAN: Yes.

MR. MILLER: But there was an act that encouraged -- or the method of reimbursement was cost-plus, and that CONs were also encouraged by the law, I don't know if they were mandated, but they were encouraged by the law as a way of containing the incentive to overbill. In 1986, that law was repealed.

CO-CHAIR DUGAN: That's my question. Why would the federal government -- first, they wanted it this way, and it works; and now they say, we're not going to do it that way, and now it doesn't work anymore. I guess I'm just curious. Why did they decide to change it?

MR. MILLER: I don't know the particular legislative intent as opposed to the history and the explanation for where we are today.

CO-CHAIR DUGAN: Okay. One other thing, you said something about how can -- and I just want to ask the question. You said something about protecting agreements that were made that

were illegal. I guess I'm a little confused. How can an agreement be made -- through the CON process, how can an agreement be made that's illegal to begin with?

MR. MILLER: Let me back up there. So the CON process provides opportunities for people who would otherwise be competitors to threaten each other, to say we will use the CON process to thwart you unless you agree with me to do something anti-competitive.

So here it's not the CON itself which is anti-competitive, but the CON process provides that structure to reach these otherwise anti-competitive agreements.

The example that we have in the paper is in West Virginia where there was an agreement to divide markets for heart services. So two otherwise private companies, private hospitals came to an anti-competitive agreement, something that was per se illegal under the antitrust laws, using the threat of a CON proceeding to do that.

CO-CHAIR DUGAN: So the certificate of need -- so I just want to make sure I understand. The certificate of need process or the parts of it

that may provide the benefits that we're looking for, we're saying to throw it out because there might be some hospitals out there that don't do the right thing or some entities that don't do the right thing. I guess I'm just confused.

That's your stand, that maybe it's not needed because it allows people to do things that are illegal? I mean, that's going to happen no matter what you have.

MR. MILLER: Perhaps it would happen.

CO-CHAIR DUGAN: I mean, I'm not saying it's right to do things illegal, but it happens in everything.

MR. MILLER: Right.

CO-CHAIR DUGAN: I guess I'm just not convinced that the CON causes someone to take illegal action because they can.

MR. MILLER: Correct. People will do things that are illegal whether or not there's a CON statute. That's true. We find people violating the antitrust laws in states with and without CONs.

CO-CHAIR DUGAN: Okay.

MR. MILLER: So that's absolutely

accurate.

The point is that it invites and encourages this, and in West Virginia -- I don't mean to pick on them, it's just where we found these violations. A lot of what was going on was with the knowledge of the CON authority in West Virginia. So that is -- they were not explicitly blessing it, but they were involved, and they were sort of encouraging this sort of thing.

CO-CHAIR DUGAN: Well, maybe we can stop the encouraging by the process that possibly takes place.

MR. MILLER: Yeah.

CO-CHAIR DUGAN: I guess I was just a little thrown, you know, I was just concerned when we say that maybe we shouldn't have CON because it encourages or because someone takes illegal action, that that's the fault of the CON.

MR. MILLER: Right, and it can be more subtle than that. We sent a letter to Michigan in June where there was a proposed change to the CON laws involving proton beam therapy centers. There was a -- it's a different, I don't know if it's new, but it's a different form of oncology

treatment, different than traditional photon X-ray oncology.

There was a group that was trying to -- that had applied for a CON in Michigan to introduce this new therapy. The reaction was to change the CON, and it would have -- you know, by reports to us, it would have qualified for the CON.

The reaction was to change the CON law so it wouldn't qualify, and this was done, I don't know if at the behest, but the beneficiaries were the existing competitors, who, again, I don't know their motivations, but would have had their revenues protected, you know, by the new laws if this competing technology was excluded.

Again, nothing illegal, but it involves -- it invites this sort of collaboration that may otherwise violate the antitrust laws.

CO-CHAIR DUGAN: Thank you. I appreciate that.

CO-CHAIR GARRETT: Paul.

MEMBER GAYNOR: Thank you. I'm Paul Gaynor from the Attorney General's Office. Thank you for coming in today.

MR. MILLER: Sure.

MEMBER GAYNOR: It says on Page 2 of your paper, "In our antitrust investigations, we often hear the argument that health care is different."

Is health care different?

MR. MILLER: Well, it's different in the sense that most industries think that they are special or different and that the general laws of economics either don't apply in the normal way or apply in a way that would make the antitrust laws not work for their industry. So health care is the same as a lot of other industries in that sense.

The case that I think best stands for this proposition is the Supreme Court case where the Society of Professional Engineers had a rule saying that, you know, if you were part of the society, which involved most professional engineers, that you can't bid for jobs based on price, and the justification was engineering is different. There's a lot of public interest in not having bridges collapse, and there's a lot of public safety, and that competitive bidding would undercut that. The Supreme Court rejected that

argument.

MEMBER GAYNOR: So is health care like engineering? I'm asking. I really -- is the provision of health care a commodity in your opinion?

MR. MILLER: It's not a commodity in the sense that steel or aluminum is a commodity, where there's predictable effects by closing supply and things of this nature. The economics of health care markets is distinct from the economics of other markets.

MEMBER GAYNOR: Is it fungible? Is the provision of health care fungible? Is it a fungible service?

MR. MILLER: I'm not sure I understand.

MEMBER GAYNOR: If I go to Hospital A to have my appendix removed, is it the same as going to Hospital B to have my appendix removed?

MR. MILLER: No. I think economists would think of health care as a differentiated product, not a fungible product.

MEMBER GAYNOR: Do you think that health care is different in the respect that it

should be a fundamental right for people?

MR. MILLER: That's beyond the scope of my remarks.

MEMBER GAYNOR: I know I'm going beyond the scope because I'd like to probe a little bit about what goes into this paper.

Do you believe -- do you personally believe that the provision of health care should be a fundamental right for people?

MR. MILLER: I'm going to side step your question a little bit. I'll give you an answer, but obviously, follow up if you'd like.

My point in being here today is not to -- and my job is not as broad a scope as the task force's job; that is, there's lots of policy considerations in health care aside from the ones that we're talking about.

My point to you is to take into consideration the benefits of competition, the costs associated with lost competition from CONs, and to be skeptical and to take a look at the evidence to see if, you know, the other benefits sometimes people talk about with CONs actually are realized.

MEMBER GAYNOR: What are those other benefits? Because mainly what you talk about is the benefit that is -- that we're trying to obtain through the CON process is cost containment. That seems to be the main thrust of what's in this paper.

What are the other benefits that you know of that the CON state is trying to attain?

MR. MILLER: Funding mechanisms for charity care that is protecting the revenues of hospitals that might feel threatened by a competitor coming in, and the argument is that the extra revenues would be used to cross-subsidize otherwise uncompensated care.

MEMBER GAYNOR: And you don't believe that that works with CON states?

MR. MILLER: Well, what I wanted to do was to, you know, cite you to the evidence from MedPAK and from the Lewin Group, which does not suggest that's the case.

MEMBER GAYNOR: So are you aware of direct evidence in other states without CON where -- for example, you contend in the paper, our concerns about the harm from the CON laws are

informed by one fundamental principle: market forces tend to improve the quality and lower the cost of health care goods and services. So that's the premise that you operate from.

Is there direct evidence in other non-CON states that supports this statement, direct evidence that supports the contention that you're making in this paper?

MR. MILLER: That competition works in health care?

MEMBER GAYNOR: That in other -- where there is not a CON process, take a non-CON state where just the market dictates, is there direct evidence that that has contained costs, that it has increased accessibility, and that it has improved quality of care? Are you aware of any direct evidence of that from non-CON states?

MR. MILLER: I think that's what -- if I'm understanding your question, I think the MedPAK -- there has been two MedPAK studies that have addressed that, if I'm understanding you, but I think that's the evidence I'd cite to you.

MEMBER GAYNOR: Because we've had other witnesses earlier on that said that they may

suspect that that's the case, but that there's no evidence of this in the non -- there's no direct evidence of this. There isn't enough studies of the non-CON states to support that proposition.

Are you aware of that, or have you heard that there isn't enough direct evidence of that?

MR. MILLER: For the proposition that?

MEMBER GAYNOR: For your proposition that market forces tend to improve the quality and lower the cost of health care goods and services.

MR. MILLER: If it's just the fundamental point, yeah, there's entire stacks of libraries of journals that are devoted to this.

MEMBER GAYNOR: With direct evidence from non-CON states?

MR. MILLER: I believe so. I'm afraid I'm missing your question.

MEMBER GAYNOR: Okay. I'll move on.

How would charity care be funded if there's not a CON process? How do you envision that because my understanding -- let me ask you this.

Do you agree with the premise that certain wealthier institutions, including ambulatory surgical centers, when they open a facility, let's

say a community hospital, that they skim off the most profitable patients, the insured patients, the patients that are covered by certain government programs? Are you aware of that, and do you agree with that contention?

MR. MILLER: I don't know the evidence. It certainly would stand to reason. It makes sense that that's what they would be going after are the more profitable patients, and I know that's the concern of the community hospitals, although --

MEMBER GAYNOR: I mean, ambulatory surgical centers are for-profit entities; correct?

MR. MILLER: Yes.

MEMBER GAYNOR: So their goal is to make a profit; right?

MR. MILLER: Although nonprofits also have goals --

MEMBER GAYNOR: I know, but I'm asking -- I'm using the example of it, or a wealthier nonprofit institution, we can talk about that. They're trying to get patients that can pay; right?

MR. MILLER: Yes.

MEMBER GAYNOR: Would you agree then that that might have -- that there could be a skimming effect off of a community hospital from an ambulatory surgical center or, for example, a new hospital that opens up or an existing nonprofit hospital, wealthier, that might expand into a certain service area?

MR. MILLER: It would make sense. The evidence that I know is from the Lewin Group study that looked at that. It did not find strong evidence of that.

I think their explanation was the location of those facilities tend to be not very close to where the charity care is being provided. So it would look in the faster-growing suburbs, look to expand there.

MEMBER GAYNOR: Because you have cited to the Lewin report a few times, are you mainly relying upon that report as the foundation for the opinion or the view that you're expressing here today factually?

MR. MILLER: No, it is a cite. I read the study, again, and it's -- you know, I think it's most directly on point, but we have had these

views before the Lewin Group produced their study.

MEMBER GAYNOR: I'm done.

CO-CHAIR GARRETT: If I could, thank you, I have a few questions, too.

Mr. Miller, you had said that MedPAK had done two different studies. What is MedPAK?

MR. MILLER: It's a federal advisory board to advise, I think, it's CMS on Medicare and Medicaid policies.

CO-CHAIR GARRETT: Is it an independent organization?

MR. MILLER: I believe it's independent, yes.

CO-CHAIR GARRETT: What?

MEMBER LYNE: I'd say so.

CO-CHAIR GARRETT: Okay. I just wanted to make sure.

So I've been actually criticized because I have linked in some of my statements charity care with CON, and I was surprised when you started testifying, you immediately linked charity care with CON.

So tell me -- because it's really not the way we have it now in Illinois. There isn't a

direct link. We have put it out there that maybe there should be, maybe we should include in our process, if we still continue with the CON process, to look at the charity care aspect of it.

I'm just curious how you came from just the CON process to linking it with charity care?

MR. MILLER: I don't know if I was trying to link it with charity care. I was trying to examine the justifications that CON proponents often put out for retaining CONs, one of which is protecting the revenues of hospitals that provide charity care and that if you remove the impediments to competition, that those revenues perhaps would be lost, and charity care would suffer. So I was trying to look at that as opposed to whether CON should --

CO-CHAIR GARRETT: So you're saying that if that is true, let's say you make those links, that it would have a negative effect, that your final conclusion is if you do include charity care in the CON process, that that's not a positive effect. That's a negative. Is that what you're saying?

MR. MILLER: I'm not sure I understand

the question. So maybe -- let's see if I can rephrase it and tell me if I'm getting at the right thing or not.

CO-CHAIR GARRETT: Okay.

MR. MILLER: What I was trying to do is to evaluate the argument for keeping CONs in place as a way to protect existing charity care. So what I'm looking at is, does that hold up factually or not? Do you actually see charity care protected by CONs; and if so, is there a less restrictive-of-competition method to achieve the same result? That's what I'm asking you to look at.

CO-CHAIR GARRETT: Okay.

MR. MILLER: I'm afraid I haven't gotten at your question.

CO-CHAIR GARRETT: So let me just rephrase it back to you.

We, in Illinois, for the most part, we don't link charity care with our CON process. So if we did do that, there is some talk about considering that, are you saying -- would the premise be that you're working from that that would not be a good thing, that would most likely be a bad thing

because there wouldn't be this free-market force in place?

MR. MILLER: I think I agree with what you just said, although let me refine it a little bit to make sure I'm clear.

CO-CHAIR GARRETT: You guys from Washington --

CO-CHAIR DUGAN: Federal.

MEMBER BRADY: You're confusing what the attorney general talked about charity care. He's simply saying that if we allow the free market to come in and cherry pick, then there won't be anybody around to give charity care, not tying it.

MR. MILLER: Right. So if your proposal is to keep CONs, but to make something explicit about them for charity care, we haven't evaluated that, but the same argument that we --

CO-CHAIR GARRETT: Okay. That's all I needed. Okay.

Go ahead.

MR. PETERS: May I ask a question?

CO-CHAIR GARRETT: Can I just finish? I just have one more question to ask.

Before I finish, I want to welcome Senator Althoff, William McNary, and Representative Lang to the meeting.

So on the way, you know, we're all hearing about Lehman Brothers, you know, big talk all weekend. So like everybody else, I'm listening to the candidates that are running for the highest office and what their response to this is.

Maybe I didn't get it right, and I'm not comparing the CON process to the fallout in the financial markets, but both candidates have implied at least that we need to have a structure, we need to have oversight.

In fact, because we didn't have that, it may have been one of the factors that has caused this downfall; and without the oversight to understand exactly what's going on, keeping your finger on the pulse, it may have proven to be problematic.

So if we use the CON process -- because in my mind, it is a little bit different. There are huge investments made in health care, you know, building a hospital, adding to the infrastructure, all of those things. That's something that, you know, we can't take lightly.

Do you see any comparison to continue oversight, whether it's the CON process or something vaguely, you know, familiar with the CON process, or would you just like to throw out the baby with the bath water?

MR. MILLER: You know, the CON laws --

MEMBER ROBBINS: And stop beating your wife while you're at it.

MR. MILLER: Right. The CON laws were not, you know, originally designed to supplant or augment the traditional state law licensing and regulation and oversight. So we're not saying that all that should be done away with, but that the CON simply forbidding the competition is an overbroad method of achieving that particular goal.

CO-CHAIR GARRETT: So then your premise is that there's collusion. There's potential collusion with the CON. That's how you look at it, and you're pretty narrowly focused on that. You don't really see the benefits of the CON process, from what I can understand.

MR. MILLER: Well, CONs have lots of costs associated with them.

CO-CHAIR GARRETT: Yes.

MR. MILLER: My point is that I think that the benefits of the CONs you should examine to see if they're actually there; and the ones that you just mentioned, the health, and safety, and welfare sorts of considerations were regulated by states before CONs and continue to be regulated by states that don't have CONs.

CO-CHAIR GARRETT: Okay. And then one last question, you talked about sending letters to different states and challenging them. Has the Department of Justice ever sent a letter to the State of Illinois in the last 20 years or even 10 years regarding our CON process?

MR. MILLER: I don't think so, no.

CO-CHAIR GARRETT: Somebody else had a question. Ken.

MEMBER ROBBINS: We'll note for the record that Mr. Gaynor and I may be on the same page for a moment here.

CO-CHAIR GARRETT: Take note of that, everybody.

MEMBER BRADY: As long as you identify when you're not.

MEMBER ROBBINS: All the other times.
MEMBER GAYNOR: I don't think he needs to identify.
MEMBER ROBBINS: Mr. Miller, is it your sense that with or without CON, and maybe more precisely without CON, that there would be a free market in health care as we understand it today?
MR. MILLER: No, I don't think so.
MEMBER ROBBINS: But I have the sense that abandoning CON suggests an expectation on your part that market forces will somehow positively affect the hospital environment.
MR. MILLER: It will positively affect the competitive process; but if you're an existing hospital and you have a monopoly that's about to be undercut by a new entry, then no, you're not positively affected.
MEMBER ROBBINS: Well, forget whether the hospital itself is positively affected. What kind of market competition is there really out there when half of the revenues of most hospitals on average, some much higher, come from public payment sources like Medicare and Medicaid, with

Medicare in this state paying roughly 91 or 2 percent of cost, and Medicaid at best on average paying somewhere in the low 80 percent of cost range?

If you then anticipate a market environment where I'll call them "predators" can come in and take away those patients that are actually generating the revenue to the hospital that allows it to not only provide charity care, but to provide a broad range of services to the rest of the community, I have a hard time understanding how that has a positive effect on patients.

I could put a question mark at the end of that, if you like, or I would just invite you to respond to my statement.

MR. MILLER: Yes. Well, I think, you know, competition does provide these benefits. Customers who are -- I'm sorry, patients, you know, do like to go to or some patients like to go to or have the choice of a lower-cost facility than a general hospital if you can get your surgery done someplace for less money or someplace that's more convenient or on an outpatient basis. There are benefits to competition for people who

would like to make those choices.

MEMBER ROBBINS: But those same patients who would like to make the choice of going to, let's say, an ambulatory surgical treatment center might be the very same people who need emergency services in a hospital emergency room that is available 24 hours a day, seven days a week, but whose ability to adequately support that benefit to the community is impaired by not having access to the patients whose revenue allows them to do that, perhaps.

MR. MILLER: Perhaps, the point in the paper is to, you know, ask the task force to look at the evidence critically and see if that's actually true. If it is true, if there is a less restrictive way of achieving that goal than a CON.

CO-CHAIR GARRETT: Gary.

MEMBER BARNETT: Just so you know, I'm the CEO of a community hospital in a rural area. 17 percent of our population is uninsured, 16 percent are covered with Medicaid, and 35 percent are covered with Medicare. A doctor that wanted to build a surgery center doesn't accept any of those. 68 percent of the market wouldn't have

access.

So your whole report only addresses 32 percent of my market, only 32 percent have any choice.

MR. MILLER: Okay.

MEMBER BARNETT: They couldn't have gotten into the ambulatory surgery center had it been built, and only CON stopped that from happening. 68 percent have no choice. So I fail to see how your report is even useful.

MR. MILLER: Well, there are people there who still have a choice -- that don't have a choice now as a result of the CON process.

MEMBER BARNETT: So you're advocating a policy that serves 32 percent of the people in my community. Our community hospital board can't make decisions that way. Our board has to serve everyone.

CO-CHAIR GARRETT: Do you have a response to that or just --

MR. MILLER: More of the same, that is, I think what you're saying is that, you know, your community hospital should have the authority to deny the choice to people and to protect your

revenues because it's good for your hospital.

MEMBER BARNETT: No, I'm saying that a state agency -- I'm saying that a state agency ought to have the opportunity to review the evidence and reach a decision, and that's what CON allows.

CO-CHAIR GARRETT Okay. I'm going to try to move it along, and I know there's questions, but if we could be really brief because we have a time constraint.

So, Howard? Can we just go to Howard for a second? He's had his hand up there in Springfield land. Howard?

MR. PETERS: I'll withdraw my question. I think it's been covered. Thank you.

CO-CHAIR GARRETT: Okay. Does anybody have a question that we haven't covered?

Senator Althoff? Women first.

MEMBER BRADY: Of course, I would have it no other way.

MEMBER ALTHOFF: I'd just put this out there for the whole group, not necessarily for you to address, but all the questions I'm hearing, how do states -- I know that half the states in the

union don't have a CON process.

So tell me how they deal with all of these concerns that we're addressing if the CON process is absolutely crucial and needed. How are they surviving? Have there been studies that draw that comparison?

CO-CHAIR GARRETT: Do you have a response, Mr. Miller?

MR. MILLER: Well, how are they surviving?

MEMBER ALTHOFF: They're, obviously, still providing health care to broad groups of people. How are they dealing with that if they don't have a CON process? How does it work?

CO-CHAIR GARRETT: She's giving you an opportunity to say all the benefits of not having a CON process.

MR. MILLER: Right.

MEMBER ALTHOFF: I thought that was a softball question.

MR. MILLER: I got that, but there's -- I'm sort of dumbfounded by the number of choices one would have. There's lots and lots of states without CONs. I think about half the

states don't have CONs who are managing to get by. There's probably more competition in those states, so the otherwise protected incumbent community hospitals might be having to compete harder, innovate, things like that in order to protect their revenues or generate new revenues.

MR. PETERS: Isn't it also true that in some of those states, a lot of urban centers, especially wherein there's low-income people, have basically been abandoned by major providers?

MR. MILLER: I'm sorry. Are you asking whether hospitals are exiting urban centers? Is that the question?

MR. PETERS: In states where there are no CONs and therefore providers can come and go as they wish, isn't there evidence that in many states, that communities wherein poor and low-income people live no longer have ready access to health care?

MR. MILLER: I don't know the answer to your question, although I will, you know, tell you that states without CONs generally have other forms of regulation. So I don't know if it's accurate to say they can come and go as they wish.

CO-CHAIR DUGAN: Okay. Howard?

MR. PETERS: Yes.

CO-CHAIR DUGAN: Okay. Thank you. Dave, keep it short.

MR. CARVALHO: I will. Two questions, you've made repeated reference to something that's less restrictive being a better alternative. Does your analysis include whether -- as an economist or from the perspective, review of less restrictive, it is politically feasible?

In other words, oftentimes the less restrictive analysis leads to targeting something to deal with a particular problem, but the political process may not lend itself to targeting. The political process is terrible at targeting because you have legislators from all across the state, and getting them to target something that only affects a couple of areas -- and that often happens.

So have you done a political analysis as to whether your less restrictive alternatives you posit are hypothetically better are, in fact, politically relevant?

MR. MILLER: No, I haven't.

MR. CARVALHO: Then the second question is, again, economists tend to focus on efficiency and much less on equity and social justice and some of the issues that Paul raised.

So, for example, under your analysis if you have a hospital in a community that's in the center of the city, let's posit a small area, and without CON that hospital or a competing hospital can pick up and move 15 miles out of town where more affluent better insured people are, at the end of day, you don't have any more resources in the community. They have just moved.

Does your analysis get to the issue of whether it is positive or negative for people who are less affluent to lose their facility to people in the region who are more affluent to get to the facility. In other words, do the future population equity issues enter into your analysis?

MR. MILLER: No, they don't. There's lots of policy considerations, you know, before the task force that we don't address; that is, to simply try to make explicit what we think of as some of the tradeoffs and to, you know, urge you to look at the actual evidence; but beyond that,

there's other considerations that you have that are beyond the scope of what we talk about.

MR. CARVALHO: Thank you.

CO-CHAIR DUGAN: Sister.

MEMBER LYNE: It's very simple. I think we're just back at the old argument, new argument, whatever. It's really just whether we see health care as a public good or a marketable commodity, and a lot of this arguing is because we haven't decided. Some like myself see it as a public good, like public education. Every child has a seat. Every patient, every human, every resident, every person in Illinois should have access.

All this thing about the for-profit, not-for-profit, I think is part of our problem. I'm not so naive as to think we're really going to get back to where health care started, which was a public good. I want to make that point. It started as a public good, and then it became in some instances very wealthy.

CO-CHAIR DUGAN: Representative Lang, did you have --

MEMBER LANG: Yes, I have a couple.

I'll try to make them brief.

CO-CHAIR DUGAN: Thank you.

MEMBER LANG: Thank you for being here today.

So you've argued that because of competitive forces in the marketplace, if we just don't have a CON process, we just leave it alone, the competition alone will bring down the costs, et cetera.

Where in that model do you leave room for planning? How then does the state go about planning and reaching out and saying, Hey, why don't you a build a hospital here, we really need one; or why don't you don't build it there, we really don't need it there?

MR. MILLER: Again, a bit beyond the scope of my remarks, but I will say that there are still regulatory agencies, there are still planning agencies, there is still that sort of work, I think, that goes on in states without CONs. There is still health care regulation.

MEMBER LANG: So do they provide through those regulatory agencies where there's no CON process, do they provide incentives for

building a facility where it's needed and disincentives for building one where it's not needed? Is that how they regulate the marketplace?

MR. MILLER: I don't know the direct answer to that question. I think it would depend state by state and the authority of those agencies.

MEMBER LANG: Is there any research in your office on that issue?

MR. MILLER: No, but my point was that CONs are perhaps an overbroad method to do what you're talking about. There's more narrowly tailored ways to achieve some of those results.

MEMBER LANG: One other quick area, what do we do about a situation where if we went this way and there was no CON process at all -- and by the way, I haven't determined in my own mind that we should or should not have one; but how do we ensure that we don't end up just with a bunch of facilities built where everybody is cherry picking, and forget charity care, there is no care at all for anyone?

MR. MILLER: I question why one would

predict that outcome. There's lots of states that have repealed CONs who aren't in that role. In other words, I would want to understand why you would predict that would be the result.

MEMBER LANG: It's not a prediction. It's a question.

MR. MILLER: I'm not aware of the -- I think the answer is, I'm not aware of the evidence that would point you in the direction of thinking something like that would happen.

MEMBER LANG: Is there any evidence from states without CONs relative to the issue of caring for the poor, lower socioeconomic strata? Is there some evidence that we could point to to see what the result is for patient care in those communities and states without CON?

MR. MILLER: To recite in the paper, and this is not our original research, but I would point to the MedPAK studies that have looked at this and the Lewin Group study, which was specifically for the task force, addresses that issue.

MEMBER LANG: I'm sure someone will get those for us. The Lewin study I know we've

seen, but I don't believe we've seen the MedPAK.

CO-CHAIR DUGAN: Well, we can certainly request that.

MEMBER LANG: Thank you very much.

CO-CHAIR DUGAN: I just want to say as we go forward, especially with this witness, because we have another one coming up; but to keep it focused on the area that he's trying to -- that he's just on, which is, of course, the --

MEMBER SCHAPS: I'll just be real quick. I've studied this for 30 years myself, and I'm not aware of any studies that show that patients shop around as you refer to.

I mean, costs for refrigerators are kept down because people shop around and compare costs, but I don't think that's true in health care, at least I've never seen a study that showed that, and you said it's true, so I'm just curious about where that comes from.

MR. MILLER: Where patient choice comes from?

CO-CHAIR GARRETT: The MedPAK study, sort of the summary of the MedPAK study that you --

MEMBER SCHAPS: That patients do shop around for cost and make their decisions based on that.

MR. MILLER: What I'm thinking of or at least an aspect of what I'm thinking of might be tiered networks in health plans. So the patients have incentives -- their copays go up if they go to one part of the network instead of the other, narrow panel plans, things of that nature. So there's incentives, there's financial incentives for patients to go to one facility or another.

MEMBER SCHAPS: Okay.

CO-CHAIR GARRETT: But isn't that based on the insurance plan that dictates that?

MR. MILLER: Yes, but the insurance must -- the insurance plan, you know, must contract with the health care facility to provide that.

CO-CHAIR GARRETT: Right, and they negotiate with them. Okay.

CO-CHAIR DUGAN: I think Senator Brady had a question.

CO-CHAIR GARRETT: Okay. Senator

Brady.

CO-CHAIR DUGAN: He's our last question.

MEMBER BRADY: In an area that I think you might be able to give us some guidance and your expertise, and that is, if we continue with this Board, do you have any advice for us in the area of corruption, how to work our way away from it? As you know, we've been under investigation, and there was a trial and corruption and convictions.

Secondly, do we have any concerns, if we continued this, in terms of how we structure it so that we aren't at risk of antitrust legalities?

MR. MILLER: On the corruption point, I don't have anything specific for you.

MEMBER BRADY: In all your studies, in all your hearings, you haven't looked into corruption in other boards and influence pedaling?

MR. MILLER: No. I mean, there's --

MEMBER BRADY: You really haven't?

MR. MILLER: No.

MEMBER BRADY: What does the Department of Justice do?

MR. MILLER: Well, maybe it has to do with the way that we're sort of structured. I only do civil work. I don't do criminal prosecution, and the fraud and corruption is actually done out of another part of the justice department.

What I'm talking about with CONs is presuming, or it doesn't really have an -- well, as I was discussing with Senator Garrett, if somebody is going to actually break a criminal law in a knowing way, I don't know that having a CON or not having a CON is really part of what I'm trying to talk to you about. That's an intentional act.

What my paper tries to address, though, is some of the more subtle but still pernicious agreements that can be reached under the cover of a CON if the CONs provide the opportunity for competitors to talk; but directly to your point on corruption, I don't have anything in particular.

MEMBER BRADY: What about antitrust?

MR. MILLER: So is the question, are there --

MEMBER BRADY: Are we free from

antitrust violations as a sovereign state, or are we subject, and what do we do if we are subject?

MR. MILLER: Okay. The anti-competitive effects in the agreements that might be reached by the state entity itself are immune or exempt from the antitrust laws. So CON agreements -- or if private competitors without the -- without the state involved were to achieve these results, it would be illegal.

The reason it's not illegal is because the state is involved. So there's an exemption or an immunity from the antitrust law. As there is for using or abusing the CON process, that might otherwise be illegal, but because it's considered petitioning activity, you know, covered by the First Amendment, it's not.

CO-CHAIR DUGAN: Okay.

CO-CHAIR GARRETT: Okay. Are we done?

Dave, did you get your questions?

CO-CHAIR DUGAN: Yes, he did.

CO-CHAIR GARRETT: Okay. Thank you very much.

CO-CHAIR DUGAN: Thank you.

CO-CHAIR GARRETT: We are a tough

crew. We really appreciate your testimony. Thank you for coming from Washington D.C.

MR. MILLER: I appreciate the opportunity to discuss this with you.

CO-CHAIR GARRETT: And thank you, Scott, as well.

We have now Dr. Lang, who is going to provide a short testimony.

Dr. Lang, I've got the Illinois State Med Society. Are you -- this is the question: Are you representing their views or just as an independent?

MR. LANG: No, I'm an independent.

CO-CHAIR GARRETT: Are you a Board member of State Med?

MR. LANG: No, I'm not.

CO-CHAIR GARRETT: Okay.

MR. LANG: I just called them to see what was going on and how I would get to the task force.

CO-CHAIR GARRETT: Okay.

MR. LANG: Basically, I think you have this, and I know this has dragged on for a question-and-answer period. So I can read this,

or if everybody has read it, I'll just go through it fast, whatever you'd like.

CO-CHAIR GARRETT: If you could just quickly summarize it.

MR. LANG: Okay. Basically, I'm a nephrologist. My name is Gordon Lang. I have been in practice since 1971, and I want to commend the state because when I first became a fellow at Presbyterian St. Luke's Hospital, the State of Illinois introduced the first program in the United States to take care of dialysis patients. This was funded through the state, and there we went -- basically, you had to have -- a hospital had to have certain requirements, and it was only in a hospital that dialysis was provided.

Those were committees. You sat on committees to decide who would live and die, and there were patients who were not over 50 who could do home dialysis initially and were transplant candidates. Medicare came in in '72, and the program obviously expanded. It's now a very expensive program. For 400,000 patients, it's about $15 billion.

The problem that we have in Illinois --

initially, the CON worked when it came in. The problem we have in Illinois today is that there are two major providers in the state, Fresenius Medical Care and DaVita, and they control 81 percent of the dialysis performed in this state.

Some hospitals control about 16 percent, and there are some small companies that control 1 or 2 percent, so it's very difficult to open a dialysis unit going through the CON process. It's very expensive for a nephrologist who wants to open a facility, No. 1; and No. 2, the CON allows the facility to expand by two chairs. So every time they're -- plus then they have to be at a certain percentage filled or not filled. So it's very difficult for me to go in and open a dialysis unit.

No. 2, if a nephrologist wants to join or go into a practice, it's hard for him to get into a practice. He can come in and get into practice. There are two major groups: Associates of Nephrology, which was my old group, and it's called Northern Illinois -- NANI, Nephrology Associates of Northern Illinois.

There are some other small groups on the

south side which are a little larger, and so it's very difficult. You have to come in on their terms. The partnerships may take five years. The problem that arises is that many times in some of the groups, not in all of the groups, the senior partners take care of most of the patients. So this affects quality.

Also if you look at the city versus the rural area, in the rural area, it's very hard to open a unit, which is just the opposite that was raised with a hospital and an ASTC, because you can't open a dialysis unit unless you get approval.

So now you have patients who have to travel a long distance or a longer distance to get their dialysis treatment. In talking with Willa Lang who was going to do a survey for me to query doctors what they feel about the CON specifically for dialysis, many patients, so she was told, in southern Illinois and the rural areas missed their dialysis because they may have to travel 40 miles.

The other problem that I have with elderly patients -- because this is a disease that's affecting the elderly. If you look at what's

called chronic kidney disease, it's really affecting the elderly. As we age, as our brains fail, so sometimes do our kidneys.

So the problem you'll have is -- I have a gentleman who is 72. He may start on dialysis. His wife is 71. He now has to come to a dialysis facility. The wife has to drive him or he has to drive through the snow. If you're downstate, you may have to drive through ice and snow. So this becomes very difficult for patients to get to the dialysis unit, and so they may miss their treatments. So for this reason I think the CON specifically in dialysis is not working anymore.

If you're looking at the south side where there may be more African-American, more Hispanic patients, the units may have 200-some patients. I'm not sure this is delivering good quality.

Perhaps in the earlier stage when I was doing this I thought, well, we'll build a big unit, and that might be better. But I found with my experience you may need a smaller unit so the nurses, the technicians know the patients, and the patients feel that they're part of a system, they're part of a group, kind of a family.

For this reason, I think we have to get rid of the CON for dialysis. Let the free market work. It's going to be hard enough because most of the physicians who are tied to these large corporations basically have medical director agreements, and they're prohibited from entering into a medical director agreement with another provider; and, obviously, the most important thing is that physicians are the people who bring the patients, the same as they're the people who bring the patients to the hospital.

So for this reason, specifically for the dialysis patient, I think the CON is counter-productive and anti-competitive and interferes with the quality of patient care.

CO-CHAIR GARRETT: Okay. Any questions? Representative Lang.

MEMBER LANG: First, full disclosure, we are not related.

MR. LANG: Right, we're not, no.

MEMBER LANG: I have no doctors in my family whatsoever.

MR. LANG: I have no political people.

MEMBER LANG: You have no legislators

in your family.

MR. LANG: Right.

MEMBER LANG: Thank you for being here today.

I understand the argument you're making, but I do have a couple questions.

MR. LANG: Sure.

MEMBER LANG: The first question is, are there any dialysis units that have been turned down by the Board?

MR. LANG: Yes.

MEMBER LANG: So can you give us an example of one or two that have been turned down and your opinion why they might have been turned down?

MR. LANG: One that was turned down was one that I had applied for a certificate of need maybe a couple years ago with some other doctors. I'm in St. Charles, and basically, there was a need -- we thought there was a need. The Board said there wasn't a need, and obviously, pressure came from the providers in that area, the hospitals and also the other dialysis units, Fresenius, and the hospitals out in the -- further

out. So that was turned down.

MEMBER LANG: I'm sure there will be those who would agree or would disagree with it, but your position would be that it was turned down not because of an issue of need, but because of an issue of pressure from other providers saying we've got this covered, we don't need this facility?

MR. LANG: I think that's how most of them get turned down. You use need to say that it's not needed, but there's certainly -- you know, there's pressure there. We know there are lobbyists who are hired by these people, and, you know, as an individual or two physicians, it costs enough just to hire the lawyers, let alone to do the CON, let alone now hire lobbyists.

MEMBER LANG: I understand the argument that says if you do away with the CON process, let's say for a hospital, and people are building hospitals everywhere, and people can cherry pick, and as I said before, there could be people that fall in the cracks because they're poor, they don't have insurance, and those facilities eventually aren't available for them.

But in your particular field, what would be the -- what would be the danger, if any, of having a nephrology department on every block? Who does that hurt?

MR. LANG: If the doctor is good, it's not going to hurt anybody. If he's a bad doctor and he's not delivering care, he's going to suffer.

MEMBER LANG: So your opinion would be that the only issue there is, is that those who are already in the field don't want the competition basically.

MR. LANG: Absolutely.

MEMBER LANG: So you're only advocating in this narrow area. Do you have an opinion on whether we should have a CON process for other types of clinics, hospitals, and facilities?

MR. LANG: I would say, you know, it's a complicated problem. I think, to be specifically honest, the problem with health care today is the funding. So I'll answer it that way.

In other words, I was a history major out of Duke. I always thought there should be a single

payor. I think there should be a single payor, and the economists should figure out how we're going to fund it, and there should be one level thing for everybody.

If a guy from Lehman Brothers has the money today, he could go out and buy a supplemental policy. If he wants to go to Northwestern and get his care there and thinks he's going to get better care there, then fine, let him go there. If they want to charge more, they could charge more. But everybody should be able to have health care, and they should be able to go to a hospital.

In other words, if you look at the City of Chicago, because I've been here since 1971, how many hospitals have closed? In the inner city, St. Anne's, which I used to work in the emergency room, which is a good hospital, Columbus closed, Henroten closed.

That was when the DRGs came in, and maybe there was a reason to do it, and then we pushed for outpatient care. If you look at what's happening today, 2 percent of medical students coming out of the American medical schools are going into primary care.

Who is going to deliver the primary care in the future, and what happens -- excuse me from the Hospital Association -- but the hospitals, what they do is they forget that the primary care doctor admits to the hospital. So what they do is they try and take away services.

So some doctors to see how they're going to survive, but the nurses want raises, their staff wants raises, and yet they're getting cut. They were going to get a 10-percent cut. Luckily the Senate and the Republicans in Congress gave us a 1 percent increase. Now, how is somebody going to survive when we see what's happening in the economy?

Suffice it to say, I would say for an ASTC, I think, you know, in the rural areas, maybe work with the doctors. I mean, I think that's been done in other areas where they've done joint ventures. You work to provide care. I mean, that's the bottom line. I mean, everybody should do well and survive, but you really want to provide care.

MEMBER LANG: One last question I think I have. Are there other specialties that

you think ought to be immune from the CON process if there is a CON process?

MR. LANG: I would say I would have to look at that specifically. If you're talking about -- you know, I think the surgical centers basically are the CON process.

I would have to look closely at that. I think, you know, I know a lot of orthopedists are moving out, and part of that is for patients to get better care. They're only there 24 hours. They're not staying there a long time, and you can get a patient in and out.

A classic example is the nephrologists have opened as an extension of their practice, access, and the access is the thing that's the lifeline for the patient. It clots many times. What you need to do is get the patient in someplace where he can have it declotted.

Sometimes because the hospitals are busy, it may take them a day or two to do this. Where if you can call the access center, and you know the people, and you know they're good, and you send them there, and it's about the same thing.

As I say, it's an extremely difficult

problem, and I think a lot of it, as I mentioned, is related to funding.

MEMBER LANG: Thank you.

CO-CHAIR GARRETT: Claudia.

MEMBER LENNHOFF: Thank you for being here. I just had a question for you about nephrology or outpatient dialysis and the costly thing. It's primarily paid for through Medicare; is that correct?

MR. LANG: Medicare, Medicaid, and private insurance for the first 33 months.

MEMBER LENNHOFF: Okay. What size of a facility, if you had the capacity to create a facility of your own, how many stations or how many patients would you have to serve to be able to, you know --

MR. LANG: You know, I would have to look at how big I'd build it; and if I have it, let's say, in a rural area where it would be smaller and maybe get back to doing some self-dialysis with the good patients, you could maybe get -- make money with two shifts and eight patients or 10 chairs. Many times what we did -- when you had the third shift is because that's

when you made money.

MEMBER LENNHOFF: Thank you.

MR. LANG: But the point is with older people, I think we as nephrologists should look at where do we break even and where do we make some money. Obviously, this it the United States, and we all want to make some money.

CO-CHAIR GARRETT: I have just one question.

MR. LANG: Sure.

CO-CHAIR GARRETT: So most of your patients are elderly?

MR. LANG: I would say. The average age now I think is 63.

CO-CHAIR GARRETT: So for the most part, they're on Medicare?

MR. LANG: They're on Medicare.

CO-CHAIR GARRETT: So the insurance reimbursement is Medicare, which is federal --

MR. LANG: Right.

CO-CHAIR GARRETT: -- dollars.

So I'm just curious if you have -- I mean, you know, sort of thinking about this, if the federal government is paying for these services,

you would think they would have an interest in ensuring that those dollars are being spent in an effective, cost-effective way.

So to the testimony from the Department of Justice, this whole free-market system, have you -- I mean, has there ever been a connection where -- maybe I should talk to some of the Board members out there -- where the federal government has basically come in and said, Look it, for your particular profession, we're paying the bills, and we want it to be more open? Have you ever had any communication with them on that, or is that something that's crossed your mind?

MR. LANG: Not specifically because the state has the mandate to CON. Certainly the government has an interest in that because the government hires the state to go in and inspect units. So that's done all the time. I think the state recently has increased their overview -- oversight of the dialysis units and have found some that were deficient in providing certain things.

I think the government says you as -- because they don't have -- CON is gone in dialysis

in most of the states. The government says, you can go out and build a unit, that's your money; and if you lose, that's fine. We'll reimburse you what our rate is, and the rate has gone down which means we at least were able to provide better care at a lower cost, but we'll provide -- you know, we'll cover you, we'll pay your fees, but we're not going to pay for your building.

So if three doctors wanted to get together and put a million dollars into building a dialysis unit and it doesn't go, that's too bad. I've been in that situation, so I know, you know, it's a tough thing, but that's life.

CO-CHAIR GARRETT: So in a way you can, if you want to, independently, if you collaborate or combine with other like physicians, you could set up a kidney dialysis?

MR. LANG: Correct, right today if we passed the CON.

CO-CHAIR GARRETT: Exactly, so that you have to go through that CON process.

MR. LANG: Correct.

CO-CHAIR GARRETT: You have been denied at least once.

MR. LANG: Once, right.

CO-CHAIR GARRETT: I'm just wondering if when it comes to Medicare reimbursements, that we have much -- you know, if we keep some of the CON process, when it's Medicare, that they really have a say in this, that they -- that the Board that makes the decision, the Health Facilities Planning Board, that when the federal government is responsible for the payments, that there is much more of a weigh-in maybe from the federal government on Medicare on this since they're the ones that are footing the bills. Does that make any sense to you?

MR. LANG: They don't do that.

CO-CHAIR GARRETT: I know they don't.

MR. LANG: No.

CO-CHAIR GARRETT: I'm just thinking ahead. I'm just thinking ahead.

MR. LANG: No, I think in dialysis, it's a factor where, you know, the physicians could partner with somebody. I mean, some of them have partnered with these major companies and said, okay, this is where we should open a facility.

But I think it should be -- it should be where if I want to open a facility, and I think it's better for my patients, I should be allowed to do that. It's my money that's going in. If I never open it, the government is out no money. If I open it, then they'll pay fees for me; but if it doesn't make it, then the patient is going to have to go to another unit.

CO-CHAIR GARRETT: I think it's an interesting concept because the money isn't -- well, there are some Medicaid dollars, but in a way you are really on your own, and it's a federal reimbursement, I'm guessing, 90-some percent of the time?

MR. LANG: It's, sure, about 90, 85 percent, and then there's Medicaid that covers the other -- covers a large percentage, and then private insurance covers it for a period of time, in other words, for the first 33 months.

I have a patient who is on peritoneal dialysis. He initially had $5 million of insurance. His wife retired. It went down to 2 million. Then they said, well, no, it's not 2 million. He worked for United Airlines. You've

used up your benefit. It was $300,000. So now he has just Medicare and no secondary insurance.

So basically, when I send him the bill, I say, you know -- he says, I know I owe you some money.

I say, don't worry about it. You know, when you get your insurance, fine.

I mean, that's the problem. That's a problem not just of dialysis. That's a problem in this country today. I mean, I've seen how many people -- because I do a little primary care. I've seen people out in the suburbs come in. They've lost their insurance. Luckily they have the safety net program for the state and they're on Medicaid.

And what do I get? You know, I bill a $100 for my service. I get $16.23. It's not the state's fault. Where are they going to get the money? It's a major problem for this country that we have to address health care, and it's a right, but it's also something that people have to be reimbursed.

You know, I feel good about medicine. I'm an older physician, I can say, with the gray hair,

but I still enjoy practicing medicine, and I enjoy seeing my patients.

CO-CHAIR GARRETT: Okay. Any other questions?

CO-CHAIR DUGAN: I just have one.

Doctor, you said that 16 percent of dialysis treatment, 16 percent are done at hospitals, and then you said 87 percent is done by these two companies.

MR. LANG: 81 percent, about 16 percent by, you know -- well, usually they're smaller hospitals out in the rural areas. Like Northwestern had a facility, and they sold it to Fresenius.

CO-CHAIR DUGAN: That was my question. Why is it that hospitals as far as this type of medical health care -- why aren't more hospitals doing it?

MR. LANG: They were losing money because when they have to do the cost report for dialysis, they were, let's say, getting 137 from Medicare. They have to put in all those things like the library, the kitchen, so it was easier for them to spin it off into a private -- you

know, one of their private organizations. So that's the problem.

CO-CHAIR DUGAN: Thank you.

CO-CHAIR GARRETT: Is it the space that it also takes up? I know Highland Park used to have a kidney dialysis ward or whatever.

MR. LANG: Space is one of the problems. In other words, when I started with dialysis at St. Joseph's Hospital on the north side, we were in a little room where we had three machines. So space becomes a problem then.

CO-CHAIR GARRETT: I also thought that a lot of the kidney dialysis, the procedures are portable now, that you don't really have to go into a hospital as much.

MR. LANG: There are portable machines. One is there is peritoneal dialysis where you put a catheter in somebody's abdomen and use the lining of the abdomen for the filter. The other one is a new machine called Next Stage, where you can do it at home.

The problem is when you have elderly patients, who is going to be trained to do this, and so this is a problem that we're dealing with.

You know, if they have a younger person, maybe they can go home, and there's talk about doing this daily, that people might do better on daily dialysis. There's a study in Canada. Again, who is going to do the reimbursement?

So these are problems that we're facing, that there may be better modalities, but we don't know how to do it yet.

CO-CHAIR GARRETT: Thank you.

CO-CHAIR DUGAN: Thank you.

CO-CHAIR GARRETT: Thank you very much.

MR. DeWEESE: I have a question here in Springfield.

CO-CHAIR GARRETT: All right.

CO-CHAIR DUGAN: Go ahead.

MR. DeWEESE: This is Kurt DeWeese.

You mentioned in your response to Representative Lang's questions that you thought that there has been a counter decision with regard to the need of the facility that you applied for.

CO-CHAIR GARRETT: Kurt, can you talk up a little bit?

CO-CHAIR DUGAN: Kurt, we can't hardly

hear you.

MR. DeWEESE: What was the staff opinion with regard to your application, and did the Board concur with that staff opinion?

MR. LANG: There was no need.

MR. DeWEESE: There was no need.

MR. LANG: And I think the Board concurred.

MR. DeWEESE: So you were taking issue with the standards, not necessarily the finding?

MR. LANG: I was taking issue -- we were taking issue with the findings, that there was a need, and they said there were two -- basically, what it was, we said there was a need; and they said no, there isn't a need because it was 30 minutes to drive to the hospital, and my contention at that time was that the patients are older. If it snows, how are you going to get somebody to drive 30 minutes to a hospital to get his dialysis treatment when he can drive five minutes to St. Charles. That was the major problem.

MR. DeWEESE: The other point that you made was with regard to the emphasis on rural

and downstate areas and the south side of Chicago. What is it? Is it the standard that makes it difficult to get those kinds of facilities in those areas or just strictly the economics of it?

MR. LANG: It's -- I'm sorry.

MR. DeWEESE: It would seem to me that the certificate of need process doesn't necessarily provide the incentive or the economic basis for making those kinds of investments. It's strictly the economics. Unless you're suggesting that, again, the standards are such that it's prohibiting certain companies or individuals from going and then investing in those kinds of things.

You talked about the only way that maybe a unit in southern Illinois could work is if it was very small and you could be guaranteed sort of a patient load.

MR. LANG: Obviously, you need a patient load, and you would obviously look to see what the patient load is; but the problem is that the certificate of need, if they say, well, we're only at 70 percent here and 20 of our patients are coming from some other place, then, you know, we're not going to let you open a facility.

I can speak because I know a number of people who do run smaller dialysis companies that do joint ventures with physicians, and they're afraid to come into Illinois because of the certificate of need. They said it's too expensive.

MR. DeWEESE: And that has happened in rural and downstate areas?

MR. LANG: As I said, I had talked to Willa Lang, who is the executive director of the National Kidney Foundation of Illinois. This is not the National Kidney Foundations's point of view. She said that she has heard from people, the Kidney Foundation people in downstate Illinois, that that is the problem. So it's not my direct observation.

CO-CHAIR DUGAN: Thank you.

CO-CHAIR GARRETT: I just have one question that sort of hinges on Kurt's questions.

So when they say it's too expensive, it's not the reimbursement, it's the hiring the lawyers --

MR. LANG: Yes.

CO-CHAIR GARRETT: -- and preparing

your application?

MR. LANG: Right. The lawyer's fees.

CO-CHAIR GARRETT: How much did you spend when you --

MR. LANG: $86,000 for a lawyer.

MEMBER SCHAPS: What was your total cost, do you know?

MR. LANG: The total cost probably was a little over -- at that time, it was maybe a little over $100,000.

A CO-CHAIR GARRETT: You know, this is the problem that I have with this. It's created a cottage industry of connected -- was your lawyer somewhat connected to the -- I mean, was that person recommended to you because he or she --

MR. LANG: He was recommended by another physician who has two facilities out in the northwest suburbs.

I know the people who are connected. I called one up just recently to open a peritoneal dialysis program where you don't need a certificate of need, and I asked what would it cost to get this? She said, well, $20,000. I went online, and it would cost me nothing if I

want to do it.

So, I mean, this is the thing. It's a cottage industry. I mean, the lawyers have to pay for their new things, which are -- you know, fees are now $450 an hour. I can't afford that anymore.

CO-CHAIR GARRETT: Thank you. Jeffrey.

MR. MARK: Yes, thank you.

Thank you, Doctor, for your testimony.

Just a couple of clarifications -- the first thing, you cited 80-some percent of dialysis care being done by the two companies, DaVita and Fresenius. That may be the number of treatments.

I just want to clarify for the task force, according to our data, 66 percent of dialysis facilities are owned by those two companies, and I believe this is typical throughout the country, not just in Illinois.

I don't know if that is, in fact, significant.

MR. LANG: The figures I got were from the National Kidney Foundation. So your figures may be right or mine may be right, but anyway, the

average number throughout the country is 72 percent.

MR. MARK: So that is for the two companies.

MR. LANG: For the two companies.

MR. MARK: So if that's the case, then our numbers are lower than that.

MR. LANG: Unless my numbers are right.

MR. MARK: I'm not saying -- you're absolutely correct.

MR. LANG: But the point is, even in that situation, I think -- in that situation, I think there are a number of physicians who are now looking at doing joint ventures. They sold their facilities and are going back and doing joint ventures with these companies.

You know, I was involved with a company that sold to Fresenius, and basically, at that time, I probably would have felt differently; but at this time looking at what it's like, and what has changed, I think that it is anti-competitive. Even at that time, it was anti-competitive.

MR. MARK: The other point I wanted to

raise is, to my memory, in the last five years, I don't believe the Board has turned down any ESRD application south of I80 with one exception; and that is a situation where two facilities were being proposed in towns immediately next door to each other, and actually in that case, they wound up working it out, where one said we're going to go ahead, and the other one withdrew.

So I would contend that it may not be the regulatory process that is precluding facilities in more rural areas.

The last point I wish to make is we do know of instances where people have written their own CON applications, and we have staff to assist people with that.

CO-CHAIR GARRETT: Do you want to comment on that?

MR. LANG: I know one person who wrote his own application, and he opened a facility in Harvey. The only reason he opened the facility was because the other people weren't taking -- they were very slow to take Medicaid patients.

MR. MARK: But he was approved?

MR. LANG: He was approved.

MR. MARK: And he wrote his own application.

MR. LANG: That's the only one I know.

MR. MARK: Thank you.

CO-CHAIR GARRETT: And let me just hinge on to that.

MR. LANG: Excuse me, he wasn't a doctor, though. Excuse me, he wasn't a doctor in practice.

CO-CHAIR GARRETT: So $86,000, was that the application fee, or was that just the attorney's fee?

MR. LANG: That was the attorney's fee.

CO-CHAIR GARRETT: So in addition --

MR. LANG: He may have included the application fee in there.

CO-CHAIR GARRETT: Okay. So out of pocket, it was $86,000.

MR. LANG: Right.

CO-CHAIR DUGAN: I think that's all. Thank you.

CO-CHAIR GARRETT: Thank you very much.

MR. LANG: You're welcome. Thank you.

CO-CHAIR GARRETT: So now, we're in the -- are we having lunch?

CO-CHAIR DUGAN: Get your lunch, and we're going to be back in 10 minutes. We're going to start at 11:45.

CO-CHAIR GARRETT: We are going to hear from the facilitator who is going to begin the process with us.

(Whereupon, a recess was had from 11:39-11:55 p.m., after which the hearing was resumed as follows:)

CO-CHAIR GARRETT: All right. So we have Laura McAlpine --

MS. McALPINE: Nicely done.

CO-CHAIR GARRETT: -- who has been chosen by our subcommittee to be our facilitator, and I believe you have sent out some information as to how this is going to go.

You might just want to start.

MS. McALPINE: Sure, sure, I would be happy to.

Well, thank you for the opportunity of

facilitating this discussion today. I have been almost at all of the task force hearings. I was not at the first one, and I was not at the August one, but I'm here really with two different hats.

My main work today is as your meeting facilitator for this discussion; but I also, along with my colleague, Mairita Smiltars, have been taking notes for all of the hearings and getting them back to you in the form of the minutes. So I've had the opportunity to hear the testimony and your dialogue along the way, which I think will help this discussion as well.

Some of you know me. I have been doing consulting, I've had my own consulting firm for the last seven years.

Before that I worked for 12 years at the Chicago Women's Health Center, which is a nonprofit health center on the north side of Chicago. I'm a licensed clinical social worker, so I did social work as well as being the executive director.

Then I was the policy director at the Illinois Caucus for Adolescent Health for five years before starting to be a consultant.

Some of you were part of the state health improvement plan planning team, and I did facilitate that planning team process, which was a year-long process or so. So that probably most closely resembles my experience related to this task force, and I also do a fair amount of strategic planning with nonprofits, primarily health programs.

I actually just came back from Alaska where I did the strategic planning retreat for a national group called Pathways Into Health, which is a consortium of universities, tribal colleges, and tribes to promote Alaskan natives and their communities in the health sciences professions.

So that's a little bit about who I am.

What we're going to do today is try and accomplish three things in about an hour-and-a-half.

The first is to discuss and vote on key questions that will help guide your final recommendation. These are questions that were developed with Senator Garrett and Representative Dugan, and I'm going to go over those in a minute.

We're also going to then use the framework

discussion format, which is based on the statutory language, to prioritize what other discussions we want to go to in future meetings.

We think these first three questions that we're going to present in a minute are kind of like peeling back the onion. So we're going to get to what we think are higher level questions and then start drilling down into the more detailed questions that need to be answered based on the initial answers to these first three questions.

Then thirdly, before we leave here today, we're going to try and take some time before 2:00 o'clock to establish the next steps to figure out how to continue to move the discussion forward.

So in terms of how I want to facilitate, primarily this is really a discussion of the task force members, and we're going to take about 30 minutes for each question, if we need that much time, which means that each one of you will get one to two minutes to make your remarks.

I fortunately have a cell phone with a satellite clock on it, and so I will be timing you that way, and you'll be able to tell that I really

want you to wrap up because either I'll start looking at my cell phone a lot, and it's not because I'm reading my email, or because I'll start walking closer and closer to you, and that's my way of saying if you can just wrap up your remarks.

The other thing is, Senator Garrett and Representative Dugan do want to give you the opportunity to let your staff or other people who are part of the hearing today chime in if you think it's necessary, and then in that way you would be giving up some of your time, just because there are enough task force members here, that in 30 minutes, if you each have one to two minutes, you would be using up all the time.

So initially when we answer the questions, I am going to go one at a time to give people the opportunity to respond. You can pass, or you can say, you know, someone else already made my comment. I don't need to make an additional comment.

We may have time then for back-and-forth dialogue, or we may not, and I'm going to look to Senator Garrett and Representative Dugan to help

decide, is it time to put something forward to vote, or do we need to continue to have dialogue?

MEMBER ROBBINS: Could I just ask a question?

MS. McALPINE: Yes.

MEMBER ROBBINS: These three questions we're going to talk about, maybe I missed it in the materials that were provided, have those been sent to us?

MS. McALPINE: They have not. So I'm going to give them to you --

MEMBER ROBBINS: So without having a chance to give very much thought to them as opposed to --

MS. McALPINE: Well, not exactly. All of you received the framework discussion, and the three questions are in the framework discussion. It's just that we chose which ones to start with.

MEMBER ROBBINS: Okay.

MS. McALPINE: There's multiple questions in that framework discussion.

In fact, Ken, you did respond to it, which is nice.

MEMBER ROBBINS: Yes, I did.

MS. McALPINE: We did get two responses.

CO-CHAIR DUGAN: One of two.

MS. McALPINE: Right. So we did not get enough to summarize the responses and give them back to all of you, which is why we chose to just pick a starting point and have that conversation.

So these are not different questions or questions you all have not had the chance to think about already.

Senator Brady.

MEMBER BRADY: A question on these three questions. You're not suggesting that we're not limited to the framework discussion?

MS. McALPINE: I'm not suggesting that. I'm suggesting that the three of us chose three questions to start the conversation with, and then we are going to prioritize after that where we go after trying to answer those three questions, and it might help if I got to those questions so that we can clarify them.

MEMBER GAYNOR: I have one. This is not a speak now or forever hold your peace

situation?

MS. McALPINE: Not that I'm aware of.

MEMBER GAYNOR: Okay.

MS. McALPINE: Right?

CO-CHAIR GARRETT: No, I think this is --

CO-CHAIR DUGAN: We want to start is what we're trying to do.

CO-CHAIR GARRETT: We're just trying to start.

MEMBER GAYNOR: I'm just trying to figure out what the expectations are.

MS. McALPINE: Okay. I really will get to the three questions pronto, but let me say that in order to make my job a little bit easier and to make sure we get through in the time frame, I usually ask a group to agree to certain ways of having the conversation, and I have been privileged to watch you all have conversations with each other now for a number of months, so I know you actually do all these things without specifically stating them, but to remind you.

Obviously, one person speaks at a time, and I'll try to help with that if there gets to be too

much interruption.

Be open to new ideas. It's clear to me that all of you care very much about health care for the citizens in Illinois. You may come from very different positions on that and have different ways of trying to improve that, but it's clear to me that you care a lot about that particular issue, and you have a reason to be here in this room making these important decisions. So I just want to put that out there again. You may already know that, but think about that when you listen to each other.

Step up, step back is about those of you who routinely are the first to answer the question. You're out of the box right away with what you think. There are those of you who are more reticent to come out right away. You like to listen to what the group has to say, and then you come forward with your remarks.

You probably know who each other is in the room. So I'm encouraging those who step up to think about stepping back, and those who step back to think about stepping up. Because now is the time to put your ideas out there in somewhat of a

faster time frame and to give room to everybody on the panel to do that.

Speak to new ideas, avoid repeating previous remarks. Again, this is a time issue thing. I'm going to be jotting down on here the bigger ideas so to help that move along.

Again, allow me to move along, or allow me to turn to Senator Garrett and Representative Dugan to say, okay, hold up. Let's see where we need to go here.

And cell phones, most of you have them on vibrate. Try and stay in the conversation as much as you can. I know you all have other important business to attend to, so obviously, you may need to read your email or take a phone call, whatever; but as much as you can, this is really going to be a tight time frame, try and stay in the conversation.

Okay. So can the group agree to that? Anything we're missing?

Okay. Great.

This I already discussed. These are objectives for our discussion.

Okay. So our first question is: Do we

repeal the Act authorizing the Planning Board?

That's going to be our first question because it was the feeling of Senator Garrett and Representative Dugan that if we know where people stand, is it a yes or a no, then it makes it easier then to continue to unpeel the onion, right, and to figure out, okay, if we're not authorizing the -- if we're saying that we want to repeal the Act, certain things follow from there. If we're saying we are not going to repeal the Act, it flows from there. Okay. So that's Question No. 1.

I'm just going to split these for the moment.

Question No. 2: Do we keep the Board itself, or do we close the Board and give its functions to another entity?

So you can see where we're going with this triangle; right?

MEMBER ROBBINS: These are in the framework, these questions?

MS. McALPINE: Yes. Under overall impact, repealing the Act is the last point.

Okay. So then the third question: Do we

continue the core functions of the Board, one being the CON process, the regulatory process, and the other state-wide health planning?

CO-CHAIR GARRETT: Laura, can I just interrupt?

MS. McALPINE: Sure.

CO-CHAIR GARRETT: I didn't envision it as a triangle. I think when we talked, it was more like all three of those questions would be out there.

MS. McALPINE: Okay.

CO-CHAIR GARRETT: Because it may be that they need to be discussed openly, you know, at one point in time, not from an either/or type approach. I'm not sure if that's where you're coming from.

MS. McALPINE: It can certainly -- we could certainly do it that way. I'd like to suggest we do start with the first question. That's why we do have three. It's a tripod to put them up in that way.

If we can start with the first one, and then I'm happy to move through the next. It's just that it may be a -- we may decide this is a logic

process, and once you go through one, it goes to the next. We may decide it's not.

Okay. Does that help?

All right. So let me do that.

So if it's all right, can we start with the first question? Do we repeal the Act authorizing the Illinois Health Facilities Planning Board?

Sister Sheila.

MEMBER LYNE: No.

MEMBER BRADY: Out of the box.

MEMBER LYNE: I thought she was talking to me. I was reticent before.

MS. McALPINE: She steps up. That is so great. You stepped up. Okay.

Margie Schaps.

MEMBER SCHAPS: No.

MS. McALPINE: Okay.

Claudia.

MEMBER LENNHOFF: No.

MS. McALPINE: Okay.

Hal. Thank you.

MEMBER RUDDICK: No.

MS. McALPINE: Hal is a task force member.

CO-CHAIR DUGAN: I'm just saying, just task force members?

MS. McALPINE: Okay. We're starting with that, and then if you guys what to give your --

CO-CHAIR GARRETT: Are these absolute answers? If you answer one, can you participate --

MS. McALPINE: Let me say one thing. You don't have to just say yes or no. You get a minute or two to beyond yes or no.

CO-CHAIR DUGAN: That's what I was thinking, yeah.

MS. McALPINE: They started out with yes or no. They stepped up.

CO-CHAIR GARRETT: If you aren't a yes or no, could you reserve your response for Question 2 or 3?

MS. McALPINE: Sure. Sure.

CO-CHAIR GARRETT: Okay. I'm going to pass.

MS. McALPINE: Okay. Gary.

MEMBER BARNETT: No, and I'll wait and see if there's a yes before I respond.

MS. McALPINE: Okay.

MEMBER BRADY: You don't get to do that.

MEMBER BARNETT: If everybody is a no, we can move on.

MS. McALPINE: Okay. Let's go that way.

MEMBER ALTHOFF: I'm not either a yes or a no. I think that the current process needs extreme revision. I believe that to completely eliminate the way it currently exists is short-sighted. It needs to be phased out if that's what we intend to do, but I think the overall mission of this process needs to be restated and refocused more on planning.

MS. McALPINE: Okay.

MEMBER ALTHOFF: And that's all I'll say for right now.

MS. McALPINE: Okay. Great.

Ken Robbins and then William.

MEMBER ROBBINS: My answer is no, but I would also want to add that I, too, think there needs to be significant reexamination of both the mission and the process to try to make sure that

the efforts of the Planning Board are focused on important issues and that there be processes that could streamline the handling of less important issues.

MS. McALPINE: Okay. William.

MEMBER McNARY: My answer is no, and to a certain extent, I will echo what Senator Althoff and Mr. Robbins said.

MS. McALPINE: Okay. Great.

Sorry, Jeff, the only reason I keep turning away from you is because of your ex-officio status.

But should I not do that? Should I assume that ex-officio members get the --

CO-CHAIR GARRETT: I don't think they're allowed to vote. I don't know, are they?

CO-CHAIR DUGAN: No, I would say not.

CO-CHAIR GARRETT: They can't.

MR. MARK: We're not allowed to input?

CO-CHAIR GARRETT: Right.

MS. McALPINE: I thought I saw a hand. Paul and then Senator Brady.

MEMBER GAYNOR: I agree with Ken Robbins.

CO-CHAIR DUGAN: Oh, no, that's twice in one day. Mark this down.

MEMBER BRADY: For different reasons.

MEMBER GAYNOR: The only caveat is, as with beauty, it's in the eye of the beholder. He used the words "focus on important issues and streamline." I agree with that. We just have to define what the important issues are.

MS. McALPINE: Okay. Senator Brady.

MEMBER BRADY: I would vote to abolish it as it is today. If given a continuation of the existing circumstances as we have heard them or not, I would vote to abolish it as of today.

I would hope that from what we've learned, we could develop a system that would work more to enhance competition, to eliminate the corruption that I think this lends itself to because of the structure, to bring more expertise; and I think we also need to look at the difference between what we should be involved in, from nursing homes to dialysis to emergency rooms and so forth.

So my goal would be that eventually we wouldn't need one, that we would, in fact, be able to let the private sector make these decisions;

but frankly, I'm not sure that ever happens until we fund Medicaid at an appropriate level.

MS. McALPINE: Okay. Great.

Does anyone on the task force want to weigh in? Yes.

CO-CHAIR DUGAN: I'm a no with what Senator Althoff said and Ken Robbins and Paul. I think the Act is good, but it definitely needs to be changed as to what the goals and objectives are of the Health Facilities Planning Board.

MS. McALPINE: Okay. Anybody else?

CO-CHAIR GARRETT: How about our phone, any other voting members on the phone?

MS. McALPINE: I don't think there's any other task force members on the phone or in Springfield.

CO-CHAIR DUGAN: The only one that would be would be Renee Kozel, and I don't think she's on the phone.

MEMBER GAYNOR: And Heather O'Donnell isn't here.

Lou will be back.

CO-CHAIR DUGAN: Was there someone?

CO-CHAIR GARRETT: Lou.

MEMBER GAYNOR: Lou, he'll be back.

CO-CHAIR DUGAN: Oh, Lou will be back.

MS. McALPINE: Okay. Does anyone want to yield a minute to Jeff Mark or anyone else from the ex-officio group to comment on Question 1 before we move on to Question 2?

Okay. Jeff.

MR. MARK: My comment won't take that long. I'll leave the decision whether or not to repeal, that's up to the legislature.

One thing I would ask, if the decision is not to repeal the Act today, that there's enough time given in the statute to either get rid of the sunset or extend it to an appropriate length of time where the staff and the program can develop and do its job appropriately.

The one-year sunset, the two-year sunsets, the six-month sunsets have been dysfunctional to the program.

MS. McALPINE: Okay. So I would say the consensus of the group is sounding like at this point in time, the answer to that question is no, but a qualified no. But there's a number of things that people would like to see clarified,

defined, revised in order for that to move from a qualified no to an absolute no.

Does that sound about right? Okay.

So how about if we move to Discussion Question No. 2, which is: Do we keep the Health Facilities Planning Board, or do we close the Board and give its functions to another entity?

Now, this is where you might want to merge into Question 3, which is: Do we continue the core functions of the Board, which are the CON process and state-wide health planning?

Those two questions are obviously related.

CO-CHAIR GARRETT: I'm going to take a lead. I'm going to say that for Question No. 2, I would like to at least discuss closing down the Board, keeping the Act in place, but using another entity or process to provide health care planning.

MS. McALPINE: Okay. Sister Sheila.

MEMBER LYNE: I would have a hard time saying that without doing Question No. 3, without figuring out what are the core functions, what do we want to do, and then determine what's the best structure for it.

MS. McALPINE: Okay. Do you want to

weigh in on what you think those core functions are or should be?

MEMBER LYNE: I would have to take a look at some of the papers I have here in front of me, you know, before I could do that.

MS. McALPINE: Okay.

CO-CHAIR GARRETT: But I said I wanted discussion on it.

MEMBER LYNE: They are related.

CO-CHAIR GARRETT: Right.

MS. McALPINE: And you're saying yes, and you want to define the core functions.

MEMBER LYNE: Yes. You've got to know what you want to do and then the structure. Often we do it the other way. I think that we have an opportunity here, but, you know.

MS. McALPINE: Other folks?

CO-CHAIR DUGAN: I don't want to close the Board, but I want to give them a different responsibility, more from a planning end, and I do not -- so if we get to, I guess, that comes into Question 3. Personally, the Board, like I said, I think should be more of a health planning, and I think another entity has to be the CON.

MS. McALPINE: Okay.

CO-CHAIR DUGAN: Of some type, I don't know what that is yet.

MS. McALPINE: So just to clarify, so you do think that the Board itself should do the planning, not the CON, somebody else should do the CON, or are you open to figuring out which one?

CO-CHAIR GARRETT: Who makes the decision ultimately? That's what we're saying.

CO-CHAIR DUGAN: Right. And I kind of was even leaning towards the Health Facilities Planning Board possibly being the appeals board of the new CON.

MS. McALPINE: Okay.

CO-CHAIR DUGAN: I don't know if that's going to work. That's just --

MS. McALPINE: Okay. But that's your initial thought.

CO-CHAIR GARRETT: Who would you suggest makes the decision?

CO-CHAIR DUGAN: I don't know. That's not one of the questions. I don't have to answer that. I mean, that's where the discussion is going to come in. I just don't know.

MS. McALPINE: Okay. Margie.

MEMBER SCHAPS: If I understood what you said, I think I would reverse it. It seems to me that the Board is not doing planning now and that they are doing the CON process. So I'd like to have the discussion about what it should do. If I had to sort of vote now, I think I would vote to keep them doing the CON process and have somebody else doing the planning because that's not happening.

MS. McALPINE: William.

MEMBER McNARY: I haven't figured out what this other entity is or what it looks like. So rather than talk about closing the Board without a discussion of what that other entity is, let me weigh in on the fact that we keep it and expand its duties.

In other words, if the Health Facilities Planning Board is doing a good job of approving the construction, rehabilitation, remodeling of health care facilities and acquisition of medical equipment and substantial changes in the scope of facilities or discontinuing facilities, if they are doing that, containing costs through the CON

process, that's a good thing.

And maybe we need another entity, but maybe we're talking about expanding the scope of this Illinois Health Facilities Planning Board to answering four questions.

How can the health planning process more effectively control costs in Illinois to make medical care more affordable to the consumer and the taxpayer?

Two, how can the health planning process provide better access to health care services?

Three, how can the health planning process adequately compensate medical institutions, especially those that disproportionately serve the underinsured, the uninsured, and the Medicaid populations?

Lastly, how can the health planning process ensure that hospitals provide adequate levels of charity care?

I think if we can answer those four questions, and I'm open to a discussion of whether we let those duties stay within the Illinois Health Facilities Planning Board or whether we move those four functions to another entity.

MS. McALPINE: Okay. Paul.

MEMBER GAYNOR: Yeah, I agree with William. I think it's been -- one of the things that's been hammered home in this process is it appears that there isn't planning really in Illinois, and that function must be done by somebody or some entity, so, you know, with that in mind.

MS. McALPINE: Okay. Claudia.

MEMBER LENNHOFF: I would agree to keep the Board, and I agree with the comments of the previous speakers.

It seems to me like the Board's function focusing on the CON is planning-related, but it's been more reactive, you know, rather than proactive, and partially due to the constraints that have been talked about here -- the size of the Board, the staffing limitations, the comments that people have made about the sunset and so on.

So I would be interested in looking at, you know, better resources to actually facilitate the planning process.

MS. McALPINE: Okay. Senator Brady.

Then I'm sorry, Hal, by sitting back, I keep

missing you.

MEMBER RUDDICK: I know. Is anyone sitting here?

MS. McALPINE: Not at the moment, we'll squeeze him in when he comes back.

Senator Brady.

MEMBER BRADY: I would not keep the Board as it is. I don't think there's -- I think it's been clear to me that the size of the Board, the structure, and the functions don't make sense. So I think we need to take what we've learned and scrap it and start over if we're going to keep it.

I would not -- with all due respect to your desire to look into charity care, I don't think we appoint any board, though, to deal with charity care.

If we're going to deal with charity care, it should be a function of the legislative and the executive branch directly, not something that we push off into this appointment board that -- to me, it's just way too big of an issue to delegate that function, and that's not where it should be.

But the Board, I don't think with all due respect to the participants, I don't think

operates the way it could based on testimony we have heard, based on size, based on structure, and so forth. So I think we have to start over.

MS. McALPINE: Okay.

MEMBER RUDDICK: I think I agree with a lot of what's been said. I especially like the way William set forth some four core purposes.

I would suggest that -- I don't have a strong feeling one way or the other about the Board versus another entity as long as we define the core purposes and resource the ability to achieve those core purposes; and my guess is, it might be easier to do that within the structure of the Board rather than creating some whole new structure that we don't even know what it is.

The biggest issue to me wouldn't be so much the bureaucratic form that it took as to the purposes, whether the purposes are appropriately defined and resourced.

MS. McALPINE: Okay. Gary.

MEMBER BARNETT: I think the conversation here has reinforced Sister Sheila's point several minutes ago. Until there's a description of what needs to be done, then it's

impossible to evaluate whether the current Board is in the best position to do it.

MEMBER LYNE: And remember form follows function. I didn't remember that until now.

MEMBER BARNETT: It really is true. As you said, we frequently do it the other way around and eventually either come up with a bad solution or eventually realize, well, I guess we better decide what it's going to do.

MS. McALPINE: Okay. Well, I just want to make sure that people who wanted to weigh in on this question more directly get a chance to do that because it does sound like we're starting to move other into this third question.

I would say, just like we were able to summarize, it sounded like the majority, the consensus is we're not repealing the Act. It's clear that people want to engage in this discussion.

Some people leaning toward, well, maybe it makes more sense to adapt the Board we already have. Some people saying maybe there's a hybrid solution, and we give some functions away. Other

people saying maybe we scrap the Board altogether.

So this is less of a clear consensus than on the first one because what you are saying in a consensus way is we have to be really clear what are the core functions and the definitions to then decide what stays with what entity.

Does that sound right?

MEMBER ROBBINS: Could I ask a process question?

MS. McALPINE: Sure.

MEMBER ROBBINS: When we all get through with our one or two minutes on core values and core responsibilities, is it your expectation that you or somebody else will then sit down and determine what a consensus was or whether there was not a consensus, and we will then come back to some of these issues in a more focused way?

MS. McALPINE: I think -- let me explain it, and then I'll let Senator Garrett and Representative Dugan jump in as well -- was that we really wanted to first get a sense of where the group is at on how -- where do we need to go with the conversation? Are we staying at a certain level where we're debating whether this Act should

even be in place or not, or are we really going to go pretty quickly to Question 3? We are getting here much faster than I think the three of us thought we might, but we also felt like we had to start somewhere. So we picked a starting point, and it seems like we're pretty quickly moving to this notion of do we want to start talking about the core functions.

Now, what we may decide to do, and you all have the discussion framework in front of you. You've all read it. One of the things we may do today is just prioritize which ones of those items in that framework you want to start with for a more detailed conversation.

Maybe that will lead you to defining the core functions, but first we wanted to see could people even start articulating right now what are the core functions that they think need to then be discussed in more detail.

So when it came to a motion, I was only going to turn -- the co-chairs wanted a motion if you were still kind of stuck on Question 1 and the group was split do we repeal the Act or not. Right?

So we didn't get stuck there. We went past that, and it sounds like people are even saying the debate isn't yet about whether the Board should be eliminated or not.

The debate is about what are the core functions of what that Board does, what are the resources that get allocated for that work, and is it an expansion, is it a reduction, is it a status quo? It sounds like that's where the discussion is headed right now.

Does that answer your --

MEMBER ROBBINS: Not really, no.

MS. McALPINE: Okay. Well, then maybe --

MEMBER ROBBINS: While I might agree with some of the things that Bill said, there was one thing he said that I would not agree with, and I suspect that will happen among all of us as we go through this.

MS. McALPINE: Right.

MEMBER ROBBINS: And so I guess what I'd like to know is, when I next see something back on this, am I going to see something that says, well, the consensus was the four points that

Bill made and were agreed to or the four points that are agreed to, unless Ken objected to one of them.

Where are we going with this? Because that will sort of help me understand where I should inject myself into some of the conversation --

MS. McALPINE: Sure.

MEMBER ROBBINS: -- or sit back and say, good, we're laying out a bunch of things, but now we're going to come back and talk more seriously about them.

MS. McALPINE: Right. Right. I understand your question. You're trying to know when is it the deciding point, and this is when you start ferociously putting out your views, which everyone would want to do.

MEMBER ROBBINS: I'm not sure I would put it exactly that way.

MS. McALPINE: Well, you know, I'm a social worker. This is how we see things.

So let me ask you two what you think.

MR. DeWEESE: Could I make -- excuse me, could I make a comment just for clarification, if that's possible? Is that all right?

MS. McALPINE: Sure.

MR. DeWEESE: Once the general consensus is to keep the Board, the enabling Act creating the task force, as you look in your framework, really does spell out an agenda and even injects some particular criteria that the process should answer.

I mean, one of the things that it does suggest is that there be a reallocation of the decision making between the state agency and the Board, and it also suggests that the composition of the Board be reconsidered and the level of expertise that the Board has.

I mean, it does spell out an agenda, and in my sense of it having participated in the writing of that, there were some specific issues and directions that once you come to the conclusion of keeping the Board or keeping the process, that then you would proceed with.

So I guess I would go back to the basic agenda that was in the legislation when you're making some of those policy decisions about where the authority rests for making certain decisions and even the scope of what the Board is going to

do.

I do believe that the enabling legislation kind of predicts some of the answers to the questions and some of the comments that people are making.

MS. McALPINE: Kurt, just to answer that, you are predicting where the three of us were going with our own planning. After doing these three questions, I actually have it up here on my Post-It that you can't see, but it is using the statutory language and asking the group to start to prioritize what are the things we need to look at first.

So just to give you a sense of that, because this is to Kurt's point, that in the statutory language that set up this task force, there were certain things that you were all asked to consider, certain points about the overall impact, obviously one of which was possibly repealing the Act. We have said that.

Then there's a whole long list of reforms that you all have in front of you in that discussion framework, and there are also a whole host of recommendations, like optimal size and so

forth.

So I think our notion was that if as a group you could get through these first three questions pretty quickly, this Question 3 may just take us directly to these other three sheets of paper.

What we would want to prioritize is in the statutory language of the legislation, where do you want to start with the conversation? What needs to be talked about first? Is it something as big as health planning, or are we going to go right to the size of the Board?

So, again, this notion of peeling back the onion, you all as a group have to decide how to talk about that with each other. This question of, do we continue these core functions, I think was the way the three of us thought we could start to get into this level of detail.

So maybe what I need to do, and I can figure out how to do it -- I mean, again, you all have the discussion framework in front of you, but one way that I helped them to prioritize is for them to see what their choices are and then have them start to choose.

This kind of setup is a little difficult,

but often I give people sticky dots which I do have with me, and you all go up and vote. That may not be the easiest way to do that. We could do it that way, but I think what we wanted to, at the very least, walk away from with this meeting was a sense of the group on those three questions, and then a decision about, all right, how are we going to start talking about all these other issues next? Which ones do we start with, or which are the most important for us to discuss?

Okay. So let me just say, it sounds to me like the conversation about Question 2 can move on; is that right? There's no one else who wants to weigh in that I haven't given the opportunity to weigh in about that one?

MEMBER ROBBINS: As long as it's clear that what is contained on that page represents things that we will want to talk more about --

MS. McALPINE: Yes. Right.

MEMBER ROBBINS: -- as opposed to saying yes, this is how we feel about those four things.

MS. McALPINE: Correct.

MEMBER ROBBINS: There's no problem

with any of the things being up there for future conversation. I would have a problem with the assumption that somehow there's a consensus on those things.

MS. McALPINE: There is no consensus.

CO-CHAIR DUGAN: I can assure you, Ken, that's not what -- this is to just get us to a point where we know, okay, where do we start with the discussion. Because this is going to be a long-time discussion discussing that part of it. So it's really just to get us ready for the next time.

MEMBER GAYNOR: I found myself agreeing with Ken Robbins again.

CO-CHAIR DUGAN: Okay. I've had enough of this.

MEMBER GAYNOR: I'd just like to say that that was what I meant when I said speak now or forever hold your peace.

MEMBER SCHAPS: I think the rest of us should just go away, and --

CO-CHAIR DUGAN: Yeah, three times in one day.

MEMBER BRADY: Enjoy it while you can.

MS. McALPINE: So let me say something before I let you talk.

One thing I didn't -- I forgot to mention another trick I have. It's called a "parking lot." If you start talking about things that we don't have time to talk about in this meeting but you want to make sure get addressed in the future, tell us that, and Mairita will quickly jump up and write them up there. Okay. It allows us to stay focused on the questions at hand. That was just one thing I forgot to mention.

The other thing is that these are the points in this statutory language. Okay. So now it comes time to prioritize, and I actually think what would be helpful to even focus your own thinking is for you to take some time and right now pick your top three for this group to have a conversation about and write them down because I think --

MEMBER LYNE: Where are you? Which one are you on?

MS. McALPINE: I'm on all three now because this is what's in the statute.

MEMBER LYNE: Okay.

CO-CHAIR DUGAN: Thank you.

MS. McALPINE: Okay. The overall impact, we could talk about health planning and what that should look like. We could talk about prevention of unnecessary duplication. We could talk about efficiency, quality. We have already talked about this one, the possible repeal of the Act authorizing the Health Facilities Planning Board.

Okay. These are the recommendations. These are the reformations, but that's not necessarily -- there may have been other things that came up during the testimony that you all want to talk about that aren't listed here. I don't know.

And you two would probably better answer that than I can, whether the task force can go beyond what's in the statutory language that established you and say, we think the Health Facilities Planning Board should do X or another entity should do Y, and that that should be part of our recommendation.

CO-CHAIR DUGAN: So that I understand it, and I think I do, but this is what the task force legislation said, Okay, task force you go

and find out and research and come back with answers to this more or less.

MS. McALPINE: Exactly, tell us something about these things.

CO-CHAIR DUGAN: So those are the things that we're required by the legislation in order to do. So we have to hold conversations on this stuff; correct?

MS. McALPINE: You have to hold conversations or at least respond to it in some way and say, We thought about that, and we have nothing to say, I suppose.

CO-CHAIR DUGAN: And then if there's anything additional that might fall into the general area of legislation --

MS. McALPINE: Right.

CO-CHAIR DUGAN: -- that can go up there, and we can get to that as we go forward.

MS. McALPINE: Right. Right. I mean, there is an other category in the legislation, other issues that you deem important to talk about.

Senator Garrett.

CO-CHAIR GARRETT: I just need some

clarification --

MS. McALPINE: Sure.

CO-CHAIR GARRETT: -- on funding. You know, one of my big concerns is the overall cost to apply, to hire attorneys, to get through the process, whether or not we have a Board or don't have a Board. Is that included -- would that be funding --

MS. McALPINE: Yep.

CO-CHAIR GARRETT: -- or is that a parking lot issue?

MS. McALPINE: No. I think --

CO-CHAIR GARRETT: Okay.

CO-CHAIR DUGAN: That's everything we have to discuss.

MS. McALPINE: For the moment, how about -- I need you all to help decide this. Do you want to just go one-by-one and pick your top three, and I'll score it for you, and then we'll start the conversation there, or do you want to let your co-chairs decide what we start the conversation with?

CO-CHAIR GARRETT: Go one-by-one, that way we can all sort of dive into it and not have

to make priorities, but that could actually change.

MS. McALPINE: So meaning you want to start at the beginning of the legislation and walk through it, or do you want to give each person the ability to say what are the top three discussions they want to have as a group?

CO-CHAIR GARRETT: Well, how does the Board feel about this?

MEMBER BRADY: I think we should walk through each one of them.

CO-CHAIR GARRETT: Are we in agreement that we'll just walk through them one by one? Okay. Let's do it that way.

MS. McALPINE: Okay.

MEMBER LYNE: And not long explanations.

MS. McALPINE: Okay. So if we start --

CO-CHAIR DUGAN: This is where we're actually discussing -- this is where we're actually going to start to discuss.

MEMBER LYNE: After we eliminate some of them.

CO-CHAIR DUGAN: No.
MS. McALPINE: No.
CO-CHAIR DUGAN: As part of the statute, we've got to answer all those.
MS. McALPINE: Okay.
MEMBER LYNE: What did you do with the first one?
CO-CHAIR DUGAN: It's over the second one.
MS. McALPINE: I'm sorry. I put it over the second one. Only because then I need a fourth Post-It or an easel, I mean, so that I'm able to write and make notes on what you think.
MEMBER LYNE: There's nothing crucial underneath that?
MS. McALPINE: What's underneath it are the recommendations, which is the third section of the statutory language.
MEMBER LYNE: Okay. Put it back.
MS. McALPINE: Well, you know, I am a product of 12 years of the Chicago Catholic school system, so wherever Sister Sheila wants to start.
MEMBER BRADY: Where is your ruler?
MS. McALPINE: Okay. So the first one

is health planning.

Welcome, Senator Lang.

MEMBER LANG: Do you want to start over now?

MS. McALPINE: No. Okay.

So health planning is a big conversation; right? So now I think we need to figure out how we're going to talk about that. Maybe have people weigh in on what their thoughts are on what form of recommendation this task force should take about health planning. Does that sound like the right way to start the conversation?

MR. CARVALHO: Laura?

MS. McALPINE: Yes.

MR. CARVALHO: Can I facilitate your facilitating for a second?

MS. McALPINE: Sure.

MR. CARVALHO: On this particular topic, everyone who has raised this topic, has always stopped after the words "health planning," and not gone on to describe what they mean by health planning, what it would look like, what enforcement, how it would be operational-wise.

So I would encourage you, if you're going to

try to get consensus that you want more health planning, that you also get consensus on what you mean by that.

MS. McALPINE: Okay.

MR. CARVALHO: Thank you.

MS. McALPINE: Okay. So we're starting with health planning; and noting what's in the statutory language and also hearing what Dave just said, what are people's thoughts about health planning?

CO-CHAIR GARRETT: Well, I'll start. It's having -- I think we've asked for this information -- a map of the state and understanding exactly where the population shifts are, where we're seeing growth, what the situation analysis is with health care access in those regions or those areas.

To get this type of information on a regular basis, and I don't remember exactly how long it's been since we've had some in-depth planning and updates in place, but I'm going to put out every -- within every year, and that could be something that could be discussed, but I'll put it out there just to get it going.

MS. McALPINE: Okay.

MEMBER ROBBINS: Is that a health plan, or is it sort of analyzing what is in place? I'm not saying this very well.

It's one thing to just count the hospitals, the ATSCs, the long-term care facilities and put them all on a map. That's an inventory.

Health planning can also be much more proactive and say, you know, in the middle part of the state, we've got a serious issue in the provision of mental health services, and that's a form of health planning.

But then it's the next step, and I think somebody was alluding to that. David was. So then what? Okay. Does that mean that the Planning Board would in some way be able to, if not require someone to enter that market and provide that service, or if you don't go into that market, you can't get approved for something else that might be needed in a different market? What's the mechanism likely to look like?

Those are all very important questions, and you could put a plan out there, but then how do you actually get some execution to it, and what

are the powers you would want somebody to have or to not have to enforce that.

MS. McALPINE: Okay. I think I saw Senator Althoff and then Gary.

MEMBER ALTHOFF: I'm building on exactly what Senator Garrett and Ken stated, that basically, you have to first get an inventory. You have to understand what our current issue is, what the current situation is.

Then you have to decide how to address the needs that were identified from that information. You know, whether we have shortfalls, whether we see pockets of areas that need additional health care, or we have too much health care someplace. That's the evaluation portion.

And then I think you need a process on how to go further, what the next step is, and then you need a continuing evaluation process for the future. You know, as we see health care change and move forward, there are going to be areas that we identify as future resources or future trends, and we need to be able to plan for those as well.

So, I mean, that's kind of how I think this Board has been talking about doing it; but as

Senator Garrett said, we have to have information to start from first, so we can identify what the issue is, what we're dealing with there.

MS. McALPINE: Gary and then Representative Lang.

MEMBER BARNETT: I think about planning in a much broader way than just providing information to the Board that's going to make facility decisions, but the facility's decisions shouldn't be separate from the funding, separate from the education of manpower decisions.

I would suggest that yes, we need health care planning in the State of Illinois, but it needs to be on a much broader basis so that it can serve the legislature when they're considering all kinds of issues, and it could also serve the health facility decision-making process.

MS. McALPINE: Okay. Representative Lang.

MEMBER LANG: Thank you.

There were a lot of good ideas there, but I think the planning -- we ought to invest in this planning board. If it's a separate board, or in the big Board, we're going to keep the big Board,

we ought to invest in somebody the power to provide incentives and disincentives. Incentives to build where we need things built, and disincentives if you're going to build where we really don't need something built.

There could be a lot of different incentives, low interest loans by the State of Illinois and other such things. The idea would be to encourage developers to come forward and help them build where we need things built and make it easy for them to build where we want things built.

Say to them, well, we know you want to build it there, but how about this? How about you're having trouble raising the money to build that thing, and we'll provide you the money you need or some of the money you need and half the interest you were going to pay somewhere else if you just build it 100 miles to the west.

Those are the kinds of things that a good board would be able to do, and it would provide better overall care, I think.

MS. McALPINE: Okay.

Representative Dugan.

CO-CHAIR DUGAN: The one thing with

the health planning, we have in the state the rural -- what is it called -- the rural health --

CO-CHAIR GARRETT: Board.

CO-CHAIR DUGAN: -- board? Do you guys know?

Kurt, what's the name of that, can I ask you?

MR. DeWEESE: Well, there was the office of rural health, and there is an Act we talked about rural and downstate resource development, and that provides authorization for grants to develop resources in certain areas based upon different project applications, and this was an Act that was referenced in a recent Senate and House task force on rural health and money to underserved areas.

This is an area that we probably could have and should have been providing funding for quite some time, but there is an existing law that provides at least some funding mechanisms for resource development.

CO-CHAIR DUGAN: Okay. From the health planning standpoint as we look at this, especially when we talked about getting ideas on

numbers of things, I know that this particular group also has some kind of information already in place as they looked at the rural areas.

I think as we go forward in the state, I just think in the health planning, we should try to tie them, or at least as best as possible, together because, again, I see where we have two agencies both addressing the needs of health care in the State of Illinois, but yet they don't coincide with each other.

So I think as we move forward with the planning part of it, then I think we need to look at what's already in place in Illinois and maybe bring it together because I think some of the questions can be answered, you know, that particular way.

And I agree with whoever it was that said it, the health planning, I think needs to do two things, one like kind of look at the picture and lay out the future of what we need, so when the CON, if it stays in place, that we're actually making decisions based on the need.

I haven't been convinced yet that we're actually -- and I don't mean anything against the

Board, but the true need. I don't know if we know the true need, if we don't even have any kind of a picture as to what's out there and what may or may not be needed. So I think that's vitally important. In order to do any kind of certificate of need, the planning part of it also has to be in place.

MR. DeWEESE: Historically, there was a comprehensive health planning entity under the Department of Public Health back in the 70s and early 80s. The National Health Planning and Resources Development Act actually required that there be a planning entity in each state.

We had something called a State-Wide Health Coordinating Council, and, in fact, there was a separate state office headed by Dr. Leppert, I believe; and just for lack of support, I don't think it ever achieved what it was intended to do.

But the National Act actually envisioned that there would be an identification of areas and resources that were needed in the state, and then there would be financial resources or incentive plans that would be offered to these areas, or there would be people coming in with resource

development applications that would then be focused on by the state.

That was a predecessor statutory framework that was really never fully implemented.

CO-CHAIR DUGAN: Okay. Thanks. I think my two minutes are up, Kurt.

MS. McALPINE: Sister.

MEMBER LYNE: I think the other piece of it -- I remember when there was that plan in place. It seems to me, currently, it's in their heads maybe or somebody comes in whether it's within or without -- outside of a certain distance than it's agreeable or not.

But the planning needs to be also not just for a facility, but to be proactive in trying to make those things happen, rather than waiting for an entity to say, oh, I think I'd like to go there and do that, and that would really respond also to quality.

I'm thinking -- I have kind of a soft spot in my heart about mental health -- that, you know, my own opinion, that it's kind of pitiful the way we're doing it now, and we certainly aren't proactive about it. I should maybe give a little

bit of -- something about that, but it's not nearly enough, and I think we can't be satisfied if nobody comes forth and just say, well, nobody came forth, when we should be doing that.

MS. McALPINE: Okay.

MEMBER ROBBINS: Could I maybe build on that a little bit?

MS. McALPINE: Ken, let me say one thing before you build on it, and then I'll let you go back to it, and I know Hal wants to jump in.

I do want to say, in the statutory language, it talks about the overall impact and health planning with all of these variety of issues. So prevention of unnecessary duplication, efficiency, quality, economic use of resources, and some of you are starting to reference that, but I just want to draw your attention to that language so that you're not missing anything in that language for the purposes of this discussion.

So that being said, Ken, and then Hal.

MEMBER ROBBINS: The Act is called the Illinois Health Facilities Planning Act. That's just what it's called now. It doesn't always have

to be called that.

But I think something that Sister said struck a chord. Health planning goes beyond the bricks and mortar; and so, for example, a reference was made earlier today that we have a shortage of primary care physicians coming out of medical schools these days. That might be something that somebody who was responsible for putting a health plan together might want to think about, not just where a clinic or a hospital would be built.

So it's possible that if you are going to have an entity that worries about bricks and mortar, perhaps there would be a different entity that worries about the larger picture of demographics and the kinds of care providers you need to meet those demands.

MS. McALPINE: So work force issues; right?

MEMBER ROBBINS: As an example.

MS. McALPINE: Okay. Hal.

MEMBER RUDDICK: This word "proactive" keeps coming up a lot, and I think part of the reason it does is the system right now is almost

entirely reactive.

The only authority the Board really can do is to turn down someone's proposal to build something, and I think there's a sense in a whole range of issues, whether it's the preservation of the safety net hospitals, for example, or the other areas in our work force or mental health we just identified, but there needs to be a way to identify a need or a problem and have a plan to address that problem.

You can't save safety net hospitals only by turning down construction projects that might compete with them. You need to go beyond that, and so the proactive planning probably means taking somewhat of a broader view of the subject, whether it's the safety net hospitals -- you can use other examples.

In long-term care, it sounds like, I may be wrong, but if I understand it correctly, we look at sort of how many nursing homes there need to be, but we don't look at the assisted living or supportive living or home community based services and how that fits together with the appropriate number of nursing home beds in an area.

So it seems that this needs to be a broader view, and then having some authority to have both incentives, as Representative Lang said, and maybe penalties as well that could encourage things to move in the direction that it needs to go.

MS. McALPINE: William.

MEMBER McNARY: For many of the reasons that were articulated earlier, you know, a top priority of planning should be to have some coordination with national and state and regional and local governments and health care institutions not only to make sure that we prevent -- this is No. 2 on overall impact, which I'm speaking on now -- unnecessary duplication of those services, but more so to ensure that affordability to access to high quality care for everybody is there. That's one.

Secondly, speaking on behalf of the public interest, I must say that any changes in policy and procedures that make the Illinois Health Facilities Planning process predictable, transparent, and efficient requiring that the Illinois Department of Public Health and the Illinois Health Facilities Planning Board provide

timely and appropriate explanations of its decisions and establish more effective procedures to enable public review and comment on the facts set forth before projects are final.

MS. McALPINE: Okay. William, with that, I think you are delving into some of the deeper recommendations and reformations that we're going to go to.

MEMBER McNARY: Right.

MS. McALPINE: So I'm noting that, but I don't necessarily want the group to dive into that right this second. So you're foreshadowing --

MEMBER McNARY: For two reasons, No. 1, I don't want to speak again; and 2, I'm getting ready to go to the bathroom.

MS. McALPINE: And you're afraid you'll miss it. Okay. Thank you.

CO-CHAIR GARRETT: Can I add something?

MS. McALPINE: Sure.

CO-CHAIR GARRETT: Back to one of the most recent comments, so if you do have almost like silos when you're planning -- mental health,

long-term care, assisted care -- whatever it would be, so it's not -- and I'm speaking as I'm thinking through this, but, you know, you don't want to mesh necessarily everything together.

So if the Planning Board could address these on their own and then maybe somehow sort of see how they all work or don't work together, but to not, you know, to have almost like a silo planning procedure that takes a look at all of these different health care entities separately, and then somebody could ultimately put the whole picture together.

MS. McALPINE: Okay. So the way that I have written that is to have distinct topic planning that is synthesized at a higher level.

CO-CHAIR GARRETT: So you don't diminish the need for mental health or whatever it would be.

MS. McALPINE: Right. Okay.

Representative Lang.

MEMBER LANG: I also think it's appropriate to add whatever plan we put into place for planning, whatever kind of board it is, the people on the board have to have some expertise.

We have to create some kind of a criteria for board members.

If it's a separate board or whether it's part of the Health Facilities Planning Board, whatever we make of it, either way, these folks have to have some expertise. They can't just be people plunked out of the air by the chief executive, this one or any one. So we have to have some background on these.

MS. McALPINE: So anything else on health planning before I move into the reformations?

Senator Brady.

MEMBER BRADY: I used to be the capitalistic devil's advocate.

In my experience in government, I frankly don't know that an annualized committee that's supposed to come up with a plan to tell us our weaknesses will really serve much of a purpose. We ignore plans all the time in the legislature.

I mean, frankly, I don't know if we need another government entity to do this, and I do think from time to time the legislature may say, let's create a task force to evaluate under this

resolution our shortages, and, you know, from that standpoint; but I'm not buying into the fact necessarily that we ought to have some appointed bureaucracy that comes back to us with a plan that probably will sit on a shelf.

I think it may have more -- the marketplace I think can plan better, frankly, than we can in government.

MS. McALPINE: Okay. There's a couple people that want to respond to that.

MEMBER BRADY: I bet.

MEMBER SCHAPS: I think quite the contrary. I think in health care, we've seen what happens without a plan; and that is, if we want to be able more to make responsible decisions about where we build health facilities or where we have a hospital or a long-term care facility, they can't do it without some kind of analysis of the population trends and where pockets of poverty are moving.

We're seeing such huge demographic shifts in this state right now, that without somebody looking at that, and saying, gee, DuPage County isn't what it used to be 10 years ago.

MEMBER BRADY: Well, in defense of what I said, I think people look at that every day, you know, the marketplace. Edwards wants to build a hospital in Plainfield. They're looking at it. The marketplace is constantly looking at providing these services.

So I think there's plenty of private sector investment out there that's willing to say, Wait a second, here's something I can provide here and meet.

Now, the legislature, on the other hand, if it were to fund properly Medicaid, if it decides it wants to be in that, that's the solution. You know, we can provide all the incentives to meet shortages, but the marketplace is telling us right now where they think there are shortages, and their evaluation in my opinion is a heck of long-shot better than a bunch of bureaucrats sitting around and doing it. I just have more faith in the marketplace telling us that.

MS. McALPINE: Okay. Let me let Representative Lang make a comment, and I think we may be ready to shift over into the reformation, which will get then into much more of the specific

details of what you want to talk about.

Representative Lang.

MEMBER LANG: Thanks.

Bill, I don't think it's either/or. So I understand your point of view that says if people want to invest millions of dollars in a facility, who are we to stop them, and that may or may not be a direction we want to go.

But the planning part of this would enable us to go out and seek developers to build facilities where we know we need them. That doesn't preclude the open market if we create a bill that would do that. It wouldn't preclude us from allowing the open market to let developers build where they want to build or to let them plan as they want to plan; but this would allow us the flexibility to create programs where we seek people that want to provide health care.

MEMBER BRADY: Lou, if you're talking about, okay, we've got a shortage of primary care docs, we've got a shortage of nurses, we've got a shortage of these facilities in this area, I don't disagree that the State of Illinois needs to evaluate those shortages and share those and then

determine whether or not it wants to provide incentives.

But I don't think it's got to be an ongoing annual function of some bureaucratic board. I think it can be done, as we do many things; and that is, pass a resolution that says we want to see an overall comprehensive study of our shortages, and then we'll determine.

I don't think it needs to be -- you know, we had this thing someone said before I was in the legislature and before I was in high school that existed that we didn't do anything with either.

I mean, I just don't want to create some mission and goal just to make us feel good and have it be another bureaucracy that doesn't achieve anything. I think oftentimes, single impetus, major emphasis, tell us what we need now has more value for us in planning than something we're hearing from every year.

MEMBER LANG: Well, I don't disagree with that.

MS. McALPINE: Can I say, Representative Lang, you missed the group agreements at the beginning for how we're doing

this discussion.

MEMBER LANG: That's why I wasn't here.

MS. McALPINE: That was really smart. I'm going to shift to Senator Garrett, and then I'm actually wanting to shift us to reformations because we're getting to that.

CO-CHAIR GARRETT: Back to Senator Brady, business is also planned. You know, most businesses, even non -- even public entities plan for five years in advance.

I think if we're going to have a scatter-shot approach, we will do the resolution, and I don't think we can afford to be in that trick bag any longer. That's where we've been, and you can't just pass a resolution and expect a group of people to come together and do this overnight. It takes a long time, and if we have something established and in place, it will be an ongoing process.

I disagree, however, that the board -- there should be a board that does this. I think we've got to -- you know, the board, if we keep a board, those duties and responsibilities should be

defined; but I think that either -- the Department of Public Health should have this responsibility, and it should be inherent in what they do, and then we have that picture.

MEMBER BRADY: Which is to my point, I'm of the opinion that you talk about what the function of whatever we replace this with or it does.

CO-CHAIR GARRETT: Right.

MEMBER BRADY: My opinion is, as a state, we need to consciously look at our health care needs in this state, but it's not this appointed board.

CO-CHAIR GARRETT: I'm saying take it back -- I would agree with you. We need to do it, but I don't want a board to sit down and have this task in front of them.

MEMBER BRADY: Which is why I'm saying, if we're talking about the Health Facilities Planning Board and the CON process, I think this should be different than that. This shouldn't be a part of that.

MS. McALPINE: Okay. Can I say that we're about to get into that conversation in more

detail because if we move to reformations, the very first reform is to enable the Health Facilities Planning Board to undertake a more active role in health planning. So I think that's where we are in the conversation; right?

CO-CHAIR GARRETT: I'm saying no.

CO-CHAIR DUGAN: She's saying no.

MS. McALPINE: Okay.

CO-CHAIR GARRETT: I don't think the Board should initiate. I think whatever they do, they shouldn't -- they should respond to applications or whatever it would be.

MEMBER BRADY: Well, why did we not go into the other, overall impact discussion?

MS. McALPINE: Well, actually some people made points to all of those things, and if you want to go back to that and finish those. I mean, you as a group started moving well into the detail of this particular reformation, so I was going to let the conversation go in that direction, but if you want to hold it and finish -- because that's why I asked you to look at your language a little bit ago.

Is there anything else about unnecessary

duplication, efficiency, quality, and economic use of available resources?

Now, remember, I know, you know, maybe we all haven't memorized the statutory language, but it's a bit repetitive. So some of this overall impact is going to show up again in the reformation.

MEMBER BRADY: I thought we were going through each one by topic and discuss it.

MS. McALPINE: We are, but the topic, the overall topic for that is health planning.

MEMBER BRADY: What are the other stars for?

MS. McALPINE: Because those are the elements under health planning that the statutory language is asking you to consider for health planning, just for health planning.

MEMBER ROBBINS: I'm not sure that I read it that way. If we're talking about the responsibilities of the Health Facilities Planning Board on the legislation that is like the legislation we have now, then I think each of those deserves a specific conversation.

If we're talking about the subject of

general health planning outside of the framework that we presently have under the Health Facilities Planning Act, then maybe all of those are sunsets for health planning.

For example, prevention of unnecessary duplication historically fell into the jurisdiction of the Planning Board. That can be within a broader health planning understanding, or it can be within the framework of what they are assigned to do, or it may be in both places.

So I'm not sure that it's just discussing health planning. It helps us understand what the rest of those star issues ought to -- how much of our attention they ought to command.

MS. McALPINE: So I think all we would then need to decide as a group is that we're going to shift from the way we've expressed it in the discussion framework that was put together because it really was about explain how health planning affects the overall health system with those identifiers.

So the question of do you want to discuss separately how the Health Facilities Planning Board prevents unnecessary duplication and its

relationship to efficiency and quality, we can have that discussion. You all as a group would just need to decide that's where you want to go with it.

I'm just walking through the discussion framework, and it was the other way in which the question was developed.

CO-CHAIR GARRETT: Can somebody do something about that?

Okay.

MS. McALPINE: So we don't have to move into the reformation section if, Ken, what you're saying is you would rather spend some time talking about prevention of unnecessary duplication as it relates strictly to the Health Facilities Planning Board. Is that what you're saying?

MEMBER ROBBINS: I think the distinction that I'm trying to make is, if we want to focus on just the broader issue of health planning, we can talk about all of these other things in that context.

MS. McALPINE: Right.

MEMBER ROBBINS: So long as if we in

some future conversation are going to talk about the responsibilities of a Planning Board and then go back to some of these very same issues.

CO-CHAIR GARRETT: So my question is, I get the health planning, but are we -- is there a consensus, maybe that's the best way to say it, to keep the health planning within, let's say, the Department of Public Health?

CO-CHAIR DUGAN: No, we haven't come to that consensus yet.

CO-CHAIR GARRETT: Or do we want to, when we're talking about health planning, have that responsibility for the Board? Because it's confusing when you're talking about health planning if you haven't really thought out who is going to be responsible for it, in my opinion.

MS. McALPINE: So you're offering a question then?

CO-CHAIR GARRETT: Yes.

MS. McALPINE: We could have the group answer that question Does health planning stay at the Health Facilities Planning Board level? Maybe get enhanced -- I mean, you talked a lot about enhancement. We heard a lot of testimony

that planning has not been the main work of the Board for a while, that the CON process has, planning less so.

So essentially the question is, if it stays at the level of the Health Facilities Planning Board, clearly that's an expansion, I'm thinking; right?

CO-CHAIR GARRETT: I think so.

MS. McALPINE: Or does it go to a different entity like the Illinois Department of Public Health? Is that your question?

CO-CHAIR GARRETT: Yes.

MS. McALPINE: Okay. So stay with Health Facilities Planning Board as it stands or new entity for planning, which could be IDPH; right?

Does everybody get the question?

Okay. Who wants to weigh in on that?

Representative Lang.

MEMBER LANG: I don't know that IDPH is in that.

MS. McALPINE: No, it's not. I just mean it's separate. That probably is a better word, separate.

CO-CHAIR GARRETT: Separate from the Board.

MS. McALPINE: Separate from the Board.

MEMBER LANG: But that wouldn't necessarily be IDPH either.

MS. McALPINE: No, this is an --

MEMBER LANG: Okay. It's an example. That's fine.

MS. McALPINE: Do you have a yes or no?

MEMBER LANG: I think it should be a separate entity or -- or at least a separate unit at the Board level with independent powers.

Because if the planning unit, whoever it is, does not have teeth, then it's irrelevant. So it's the planning unit that ought to be able to provide the incentives or the disincentives.

MS. McALPINE: Okay. Margie Schaps.

MEMBER SCHAPS: I think I agree with Lou, but I would add that they have to be inextricably linked. If we want the CON process to have any validity, it seems to me it's got to be inextricably linked to a real planning process

that has real goals and real incentives and real disincentives, otherwise, it's not worth anything.

MS. McALPINE: So you're agreeing that a separate entity or a separate unit, but linked to CON; is that what you're saying?

MEMBER SCHAPS: Yeah. It's a staff function, and to me it doesn't -- I don't feel strongly that the staff is within the Health Facilities Planning Board or it's separate at IDPH. It doesn't matter to me where it is as long as it's connected very closely to this process.

MS. McALPINE: Sister.

MEMBER LYNE: I'd like to agree with that, too, because the planning has to be planning for something real, not just for an exercise, and the real is in the whole CON and getting services where services need to be.

MS. McALPINE: Okay. Paul.

MEMBER GAYNOR: In fact, just picking up on that, we've been talking about health planning, but if you look directly at the statute, it says the impact of health planning on the provision of essential and accessible health care services. So just picking up on Sister Sheila's

point, it's not just --

MEMBER LYNE: I was quoting.

MEMBER GAYNOR: Yeah.

MS. McALPINE: Okay. William.

MEMBER McNARY: I will say what I said earlier. Until we figure out what that "it" is, we ought to get to the is, I am not for -- I may be for making sure that we expand what we know we have as opposed to trying to create something else or overburden an already overburdened Illinois Department of Public Health.

CO-CHAIR GARRETT: So if you have Board members, let's just think this out, and we have, let's say, 11 Board members, are we expecting these Board members to do the research and come up with all the requirements, which I think would be written in the statute. I don't see boards as being responsible for putting together all of the, as we call it, the situation analysis. That would be written in the statute.

It would be compiled and put together by another entity, and the Board then reviews or makes decisions or provides directives. I can't imagine us having a board willing to put in that

kind of time and energy at no cost on top of it, and it could be working at cross purposes. I think it would be a dangerous proposition to have that.

MS. McALPINE: Okay. Senator Brady.

MEMBER BRADY: Again, this is something along the lines of what Sister Sheila said earlier. It seems to me that it's hard to put something together when we don't have the knowledge.

To me, my recommendation would be, the first thing the State of Illinois needs to do is conduct a state-wide health access analysis, and then a group would evaluate that and decide what the state ought to do in terms of planning.

But without knowing where our shortages are and so forth, we're dealing with a lot of hypotheticals, and I think we could maybe find a document or find someone who can tell us where we are today versus -- as opposed to where we should be, and then the discussion about how to best facilitate facilities and human resources to best meet the people of Illinois would be a plan that would come together after that. To me, it's hard

to put the chicken -- or excuse me, the cart before the horse.

MS. McALPINE: Senator Dugan, I think Kurt is actually trying to speak. We lowered the volume on him.

CO-CHAIR DUGAN: Yeah.

MS. McALPINE: I'm sorry, Representative.

So, Kurt, why don't we let Representative Dugan go first, and then I'll come to you. Okay?

MR. DeWEESE: Okay.

CO-CHAIR DUGAN: And I just want to say, and maybe I'm getting off base here, I think that's what we're trying to decide. We all decided that we need to have a plan. I think what we're trying to decide here is who should do it, the Health Facilities Planning Board that now sits there or the Illinois Department of Public Health or an entity of another sort.

MS. McALPINE: Right.

CO-CHAIR DUGAN: If we're all agreeing that we need to plan, then we need to decide who is going to do it. I think that's where we've got to get then.

MS. McALPINE: Right.

CO-CHAIR DUGAN: Then once we decide, if we can decide, then what we want that group to do is all the details of what we're saying we want them to get us this information, but I think we'll continue to keep going around and around if we don't say we want the Health Facilities Planning Board to be that group, do we want IDPH to be that group, or is there another group?

I just think we've got to find out who the group is.

MS. McALPINE: Do you want to say in your opinion who it should be?

CO-CHAIR DUGAN: Yeah, but I said it at the beginning. I think the Health Facilities Planning Board should be the planning group.

MS. McALPINE: Okay.

MEMBER SCHAPS: Could we ask David Carvalho to describe the shift process because I think some of this is already in place.

CO-CHAIR DUGAN: Oh, I think Kurt is supposed to --

MEMBER SCHAPS: I was not called on.

MS. McALPINE: You were not called on.

So, Kurt, I'm sorry, we had turned the sound down on you because of the cell phone interference.

MR. DeWEESE: I was just going, for background purposes, to indicate that there are already both a federal- and state-defined shortages in medically underserved areas. So to some extent, we have a foundation for identifying some of the areas where there are resource development needs.

I could see where ultimately a planning entity would be able to pull together some of the existing information about these shortage areas, and you may have spot zoning questions here in relation to a particular project; but at least the board, a board would be in a position of deciding whether or not a project that was being proposed in one area would not only conform to that need, but if they wanted to do it somewhere else -- it could be like the East St. Louis example where they made the contingency that they would retain a certain base of services in a community if they wanted to go somewhere else. They would have that express authority to do that based upon some

planning recommendation that that community needed a particular type of service or facility.

MS. McALPINE: Did that answer people's questions?

MEMBER LYNE: I would just add, I think our -- my sense is that the -- I know that there are numbers someplace, probably in the Illinois Department of Public Health, but it hasn't been interactive, nor do we, who are not part of the Illinois Department of Public Health, know very much about or anything current about it.

So I'm not opposed to it being in the Illinois Department of Public Health, but it's got to be the larger picture of determining where things need to be.

CO-CHAIR GARRETT: Which would be in the statute. They would have whoever it is do X, Y, and Z.

MEMBER LYNE: Yes, and keep up.

MS. McALPINE: well, just for the sake -- Hal, one second.

Just for the sake of moving us along, I'm wondering, Senator Garrett, if you feel like you got enough of a sense of this, or do you want some

more --

CO-CHAIR GARRETT: I think I may be the only one thinking this, so I just want to make it clear just to make sure I'm on the wrong page; but if we have in statute the directives, what needs to be done when it comes to planning, I believe that that needs to be done by an entity the Board oversees that that is done properly.

The Board -- I have never known a board to actually do research, pull things together, and present a report; and I'm just worried that if we've got them doing that, it's hard enough to recruit the right kinds of Board members. We might be, you know, counterproductive.

But my very strong suggestion would be either the Department of Public Health or a different entity through statute working to get all that information on an annual basis.

MS. McALPINE: Okay. So here's what I'm -- all right. I think I'll let Dave Carvalho make a point, and then I'm going to move us to another conversation.

MR. CARVALHO: To respond to Margie's point, I think the very most important thing you

need to know is what Representative Lang said, because, in fact, a huge amount of what you're talking about already exists in different pieces and places around the state.

There's a state health improvement plan prepared pursuant to statute that many of you participated in. There's information about inventory. There's information about access.

What there is not is any therefore currently attached to any of this. This is what Representative Lang was getting at. If there's nobody to foster the development of what is missing, but rather the only thing that exists is for a board to say no or yes as people come up with proposals to do it, then that's what's missing.

There's no document denominated the state health access to health care plan, but almost all of the pieces that would be part of the descriptive part of that are there. What do we do with it? That's what's missing.

CO-CHAIR GARRETT: It brings it together.

CO-CHAIR DUGAN: I have a question.

What do we do with it now?

MR. CARVALHO: Right now, it all exists in various pieces. It is referenced in studies, when the legislators ask us questions.

CO-CHAIR DUGAN: Do we use it in the CON process in any way, shape, or form?

MR. CARVALHO: All the inventory information is used in the CON process.

CO-CHAIR DUGAN: Okay.

MR. CARVALHO: But remember the CON process is reactive.

CO-CHAIR DUGAN: I understand that.

MR. CARVALHO: The parts that say there's a need for this over there or there's a need for this over there exist out there, but in the absence of somebody coming forward to meet the needs, it doesn't have a relevance to the CON process.

MS. McALPINE: I know Representative Lang had his hand up.

Just for a time check, we're going to close out this conversation in about 10 minutes to then go into next steps, which we were going to give 30 minutes to.

So I think where we're at is we're trying to kind of figure out the details more of the health planning. I want to acknowledge What Ken had said earlier that we have not necessarily gone into unnecessary duplication, efficiency, quality, those other issues, and I haven't let a few people talk that wanted to talk.

So I'm thinking maybe for what we can do with the time is spend another 10, 15 minutes, you know, digging a bit deeper into this health planning question, seeing if some of those other issues need to be talked about, and then get to, all right, what are we going to talk about at our next meeting? Because we still have a lot, even on the reformation side, to get through, much less the recommendation side.

Okay. Does that sound right?

So Representative Lang.

MEMBER LANG: Well, first, I appreciate David's comments, but I don't think I like the next thing. I am completely opposed to IDPH being the planning body. I just wanted to get that out there.

MS. McALPINE: Okay.

MEMBER LANG: I don't think that a state agency that's directly under the governor, this governor or any other governor, ought to be doing the planning. That is my view. I don't know who will agree or not agree, but I don't think it should be there.

THE REPORTER: Would you speak up?

MEMBER LANG: Nobody ever said that to me before.

MS. McALPINE: Do you have a suggestion of who should do it?

MEMBER LANG: I would say either a completely separate unit or part of the Board.

MS. McALPINE: Okay.

MEMBER LANG: But operating as an independent unit giving advice to the Board.

MS. McALPINE: Right. Okay. I think you had said that already.

Health planning, does anyone else want to weigh in on this notion of who should do it or weigh in on any of those other elements of health planning?

CO-CHAIR DUGAN: I just want to clarify something that I said so that -- not that

anybody really cares, but --

MS. McALPINE: We all care. We really care.

CO-CHAIR DUGAN: When I say Health Facilities Planning Board, I don't necessarily mean the Health Facilities Planning Board that's here now.

MS. McALPINE: Okay.

CO-CHAIR DUGAN: I believe, and that's what I was just saying to Senator Garrett, I think we need to fix the names of what we're talking about. I'm just talking about there should be a Health Facilities Planning Board that does the planning.

Now, whether or not it ends up being the same people just changed around with what kind of knowledge they have to have, like Representative Lang, said that possibly could be. So the one we have now, but we just kind of redesign it; or we call the one we have now, depending on what their duties are, something different.

So I just wanted to kind of make that clear when I'm talking about a separate entity, it could very well be that.

MS. McALPINE: Okay. Hal.

MEMBER RUDDICK: Just as a clarification, I think sometimes when we say the Health Facilities Planning Board, we mean the Board members, however many there are.

CO-CHAIR DUGAN: Correct.

MEMBER RUDDICK: But it could also be meant to be and their professional staff. Now, they don't have a lot because of the way it's set up, because of the sunset provision which has caused a lot of good staff to leave because the mission may not be that clearly defined.

So I think kind of the way to get around that would be to, you know, to clarify some set of professional staff under somebody's authority would have to have responsibility for this.

Now, they might be under IDPH or they might be reporting to that Board, but I don't think we could expect the Board members --

CO-CHAIR GARRETT: Right.

MEMBER RUDDICK: -- to do that coming together once a month, or even once a week, they're not going to do that planning work.

CO-CHAIR GARRETT: Thank you for

clarifying. That's where I am.

MS. McALPINE: Okay. And I'm also noticing we're doing a lot of side conversations, which might be fine, but it also --

CO-CHAIR DUGAN: Did we agree not to do that?

MS. McALPINE: No, you didn't. Actually, there was not one of those.

MEMBER GAYNOR: That's in the staying in the discussion as much as possible.

CO-CHAIR DUGAN: Yeah.

MS. McALPINE: Well, they're staying in the discussion, they're just staying in a separate --

CO-CHAIR DUGAN: We're all going to get sent to the parking lot.

MS. McALPINE: so I'm wondering if anyone wants to weigh in again on this where does the planning sit or move to what Ken had been raising about should we be talking about some of those other elements under health planning?

MEMBER GAYNOR: I would just say to wind this up, where the planning should sit, that I think is part of the function of also what the

Board is going to look like.

So it kind of spills over into the larger -- you know, how many members will we expect, and what's the composition of the Board? Are we talking about that they're going to be full-time professionals? Are we talking about categorical appointments?

Are we talking -- so I think that in order to go on with this discussion later, we'd have to have some of those conversations and then be able to talk about where is the planning going to be and where do we expect this to come from.

MS. McALPINE: Did anyone who wanted to weigh in on this direct question of where it should sit want to jump in because I know a couple of people have had more than one chance?

Okay.

Ken, did you want to take us through any of those particular elements, or does anyone else on this task force want to walk through any of those other particular elements under overall impact?

MEMBER ROBBINS: Under overall health planning?

MS. McALPINE: Well, at this point, I

think you should answer it the way you want to answer. You know, you were making the distinction. The way you got it in your discussion framework was that those were elements under health planning, but you're raising the idea that those are distinct elements about the Health Facilities Planning Board that the task force should discuss; right?

MEMBER ROBBINS: Yes.

MS. McALPINE: Right. So you get to answer it whichever way you want. How about that?

MEMBER ROBBINS: Well, I don't know how much time we have, but I'm sure we don't have enough time to do justice to all of these things in light of the schedule we have today.

MS. McALPINE: Right.

MEMBER ROBBINS: So I guess my suggestion would be that when we convene again, that we first of all decide -- the main question is whether we're just talking about overall health planning, or whether each of these has a relevant impact on what a Health Facilities Planning Board should be responsible for once we decide what that Planning Board should look like and what its job

description is.

MS. McALPINE: Okay.

MEMBER ROBBINS: And I note that Paul nodded his head, but he's afraid to say he agrees with me.

CO-CHAIR DUGAN: Don't even say it. Four times in one day is just too much.

MS. McALPINE: Senator Brady.

MEMBER BRADY: I'm having a little bit of difficulty moving this Board because I kind of think that -- and this is off track, but I kind of think that since the majority of us decided that a board ought to exist, the next question we ought to ask ourselves is, what should the board do? Why should it exist? You know, charity care, should it exist for safety net services? Should it exist to protect other hospitals? Should it exist so we don't have overbuilding?

I don't even know if we know that because once we determine -- and I can argue -- I can even argue how it could best do something that I don't agree it should be doing, but I'd like to know what we want to see it do. Why should it exist?

It seems to me we're going at issues that

are hard to answer until we know what the objective of the board is.

So I guess I'm completely taken off track, but I'd like to see us in the last half hour today air why we think it should exist and then how it best could exist for those purposes.

MS. McALPINE: Okay. Margie.

MEMBER SCHAPS: Well, I agree with what you're saying. I think that is the next step. Let's kind of brainstorm, What is the role of this, and then obviously, we think health planning is related to it, but there are other responsibilities.

MS. McALPINE: Wait. Wait, Kurt, I have to turn you back up, and then we'll go back to Representative Dugan.

Okay. Go ahead.

MR. DeWEESE: I would just like to suggest in response to Senator Brady's comments that to some extent, that question is answered in the statute in terms of the scope of what the Board should be doing at least with regard to certificate of need and with regard to planning and the criteria and the development of the plan

on a regular basis. So I think there are some elements of the statute that do enumerate those questions.

Now, whether it goes beyond that to the health planning function and how you define that may be just sort of an additional question about how that's defined, but again going back to the statute, I think some of the questions that are being raised are dealt with in the statute.

MEMBER BRADY: Kurt, I don't disagree that some of those things are raised in the statute, but I don't think the statute gets us to a conclusion. The statute gives us guidance, but we've got to decide. If we're going to put a report together as a recommendation, we've got to decide why we want to do it.

We can't go backwards just because the statute says these things to discuss. I think we just -- do any of us -- you know, we've said that it looks like there might be a need for it, at least the majority, so what is that need? Not just yeah, but what is that need? What's it there for?

CO-CHAIR GARRETT: Maybe we should

just go right down and ask everybody.

MS. McALPINE: Yes.

MR. DeWEESE: Just as an example, the statute does talk about the Board focusing on major expansions and where projects are dealing with volume sensitive services. So to some extent, it is focusing on a narrower scope of what the Board is doing in relationship to certificate of need.

CO-CHAIR GARRETT: But, Kurt, we may want to change that.

MEMBER BRADY: Just as your statute, Kurt, doesn't talk about charity care, I don't think I'm going to win the argument we shouldn't.

MEMBER GAYNOR: It actually does talk about charity care.

MS. McALPINE: Okay. Now, let me step in for a second. I just turned Kurt down.

What I want to do is put in front of you --

MEMBER BRADY: Let me just for the record say I don't think that's fair to Kurt.

MS. McALPINE: Okay. I think because we have about -- let's see time-wise, right, we have 30 minutes left.

So what I heard Senator Garrett say is she would like to have us go down the row and have people answer the question, which if I have heard it correctly is, what are the core functions of the Health Facilities Planning Board; right?

CO-CHAIR GARRETT: The current version or a different version.

CO-CHAIR DUGAN: What we want.

MS. McALPINE: What you want. But I do want to say, what Kurt keeps trying to go back to is, absolutely, there are key questions in the statutory language. These are the highlights of what those key questions say.

You have it in front of you in a discussion summary. So you can certainly say that is a key question you want this group to discuss and have that be part of your description of what you want the Health Facilities Planning Board to do; right?

So maybe I'm not articulating clearly your question, but -- so, in essence, we're going to get a sense from the group, what are the issues you really care about that you want to make sure, A, get discussed, and likely that's the thing you're going to want to make sure ends up in

legislation.

We're going to figure out what all those things are, see if we have time to discuss any of them today, or this is simply going to help us get to the next meeting agenda. Does that make sense? Okay.

So what the revised entity should have as its core function? Is that the right question? I'm turning to my co-chairs. Is that the right question?

Okay. But I'm going to move this around a little bit. You guys have your paperwork in front of you, and this allows me to be in the middle.

So what I'm going to do, I'm going to do something really tricky, I'm going to start from these two and go that way, unless you say you want to weigh in at the end. Otherwise, I'll go that way. (Indicating.)

CO-CHAIR GARRETT: I have been very verbal about this. I'd --

MS. McALPINE: You want to step back.

CO-CHAIR GARRETT: -- rather hear what everybody else has to say.

MS. McALPINE: Do you want to start or

wait?

CO-CHAIR DUGAN: No, I can start. I'll go right back to what I said the first time. I think that there needs to be two -- I think whether you call it the Health Facilities Planning Board or something else, there needs to be one entity that does what I consider the health plan, the planning process for the state, and then that coordinates with the entity then that is going to do the CON process.

MS. McALPINE: Okay.

CO-CHAIR DUGAN: You know, I think it's two separate entities. I don't even know if we've gotten to that point yet, you know, or if that's what we're agreeing to.

But to me, one does health planning, which could be a lot of things like Ken says. There could be a lot of different things we want them to list in the statute that the Health Planning Board is going to do, but then somehow we tie it in.

Then the CON issue to me is a whole other issue with a board or a group of people or whatever we want to call it, and then the details of how we're going to address the changing of how

the CON does it. To me, it's two completely separate issues.

MS. McALPINE: Okay. And then the discussion for the future would be to enumerate what those details are.

CO-CHAIR DUGAN: Correct.

MS. McALPINE: Okay. Great. Paul.

MEMBER GAYNOR: Do you want me to go first?

MS. McALPINE: Were you too far out of the conversation?

MEMBER GAYNOR: No. I think that one of the core functions is -- and I agree with Representative Dugan that there has to be coordination between the entity that's going to determine CON and another entity, whether it's the Board or some other entity that's doing the planning.

So I think that one core mission, one core function is to be responsive to whatever the planning body is, and it might be that their core function is to do planning and coordinate with itself.

CO-CHAIR GARRETT: I guess the question is, so is the board, this new board, are they going to do the planning only, or is that what we're trying to --

CO-CHAIR DUGAN: That's only my idea that there should be two entities.

MS. McALPINE: And Paul is saying there should be two entities.

CO-CHAIR GARRETT: Right.

MS. McALPINE: But the one that does the planning also has to have a responsive element to it.

MEMBER GAYNOR: It could be within the Health Facilities Planning Board staff, that you give them staff, and you say staff is going to -- on a yearly basis going to have a core planning function; and then it could say that -- and then when making a determination, and I'm not sticking to this, but just by way of example, when making a determination, when you're saying criteria whether to grant or deny a CON, one of the criteria would be is it in accordance with the overall plan that's been -- the state-wide plan that's been written, you know, or developed.

MEMBER ROBBINS: I hate to say this, but I agree with you.

CO-CHAIR GARRETT: This is a good thing.

MEMBER BRADY: I don't know.

MEMBER GAYNOR: So I think --

MS. McALPINE: Okay. You're almost --

MEMBER GAYNOR: Okay. Fine.

MS. McALPINE: Are you done?

MEMBER GAYNOR: There's a lot more I could say. If you want me to be done, I'm done.

MS. McALPINE: Thank you.

Margie.

MEMBER SCHAPS: I'm not quite sure how to articulate this, but I want to say something about using the plan to ensure set priorities for serving underserved populations that don't have access to health care services currently.

MS. McALPINE: Okay. Got it.

Claudia.

MEMBER LENNHOFF: I agree with a lot of what's been said already about coordination between the board that oversees the certificate -- or carries out the certificate of need process and

the health planning aspect.

I think that staffing is really essential, and there are people who do health planning professionally, and I think having good staffing levels to be able to provide support to the boards and others that have to make decisions would be good.

Absolutely, protection of the safety net and access, I think, is a very core function.

Another thing, maybe this is a little bit off, but I wanted to go ahead and raise it if this is my one minute to speak or whatever.

I think that I'd like to see some way to strengthen the capacity for communities to have input in the certificate of need process. My community has a lot of input, but that's because, not tooting my agency's own horn, but we do have an organization that's fairly sophisticated and monitors these things, but a lot of communities do not.

MS. McALPINE: Okay. Great.

CO-CHAIR GARRETT: That would be in the reform.

MS. McALPINE: Yeah.

Representative Lang.

MEMBER LANG: Thank you. I agree with a lot of what I've heard. I definitely think there ought to be separate functions that have to by statute interact, have to be responsive to each other's needs.

But I think they ought to be properly funded with professionals up and down the line, including significant pay for board members, if that's what we need to do. They need to be properly staffed, and that staffing has to be completely separate and apart from the political system.

In fact, I would find ways to take this whole process out of the governor's office and make it run as a separate and significantly different kind of entity to the greatest extent possible.

There's no reason we can't have a board that deals with CON, but we should limit what the board has to do. There are perfunctory or easily formulized applications that pretty much always or almost always get approved. There's no reason to burden the board with that when they have so many other more important things to do.

I would also give the planning board significant powers to do outreach and to maximize their ability to incentivize health care providers.

MS. McALPINE: Okay. Hal.

MEMBER RUDDICK: I would say that one of the key functions is to promote access to quality care, and that means both protecting needed services from either being discontinued or from unnecessary competition from cherry picking, but also take a more proactive role to promote the development of services and the enhancement of services to underserved areas and populations.

MS. McALPINE: Okay. Great. All right. Now, I'm going to go to the other end and start with Senator Althoff.

MEMBER ALTHOFF: Well, I will start with stating that I think that it's extraordinarily important for whatever the entity is to be consistent, that they need to identify the need consistently, and then ensure that we don't inhibit the free market from responding to those needs, but that we also -- or that it also steps in and assists or guides when that need

isn't being met by the free market.

I'm stopping there.

MS. McALPINE: Okay. Gary.

MEMBER BARNETT: I believe there ought to be an organization separate from the Health Facilities Planning Board to create a plan that focuses on access and quality.

MS. McALPINE: Okay.

MEMBER BARNETT: And that it provides guidance for the CON decisions made by the Health Facilities Planning Board and other activities.

MS. McALPINE: Okay. Ken.

MEMBER ROBBINS: This state has never really had a health plan. It's had budgets, and I think it is time that an entity be held responsible for creating a health plan. I can save my views on whether it should be inside or outside of the existing Health Facilities Planning Board maybe for another time.

But I do think it's important that an effort be made to develop a plan, and one argument for perhaps putting it outside of the Planning Board is that they have other responsibilities than the ones we have traditionally associated with the

Board.

If there was a shortfall in adolescent psychiatric care in all of central Illinois, which I think there is, it might be in a position to make legislation recommendations, funding recommendations, staffing, education recommendations that are much broader than merely whether a hospital or clinic should be built in any particular place.

MS. McALPINE: Okay. Thanks.

Senator Brady.

MEMBER BRADY: I, too, support the concept of a plan on a periodic basis, that if the CON process were to continue, it would rely on -- frankly, the only thing I think it should do is somehow balance the markets, or the free market with the preservation of some economically challenged areas so that services continue to be offered.

MS. McALPINE: Okay.

MEMBER LYNE: I absolutely second Gary's comment.

MS. McALPINE: Okay. That's it?

MEMBER LYNE: Yes.

MS. McALPINE: Okay. William.

MEMBER McNARY: Speaking about the core function, Citizen Action has always viewed the certificate of need, the CON certificate granted to hospitals and long-term care facilities and dialysis centers and ambulatory surgery centers by the Board, we see that as a gift from the state; and thus, we believe that the state has every right to expect from those health care institutions in return an investment in charity care and community-based initiatives.

The Lewin report basically says that our greatest concern is the financial health of safety net hospitals. So we share the Lewin Group's concern for the prioritization of safety net hospitals. So in addressing how to establish equitable compensation and regulation protocol for the health care system, we think instinctually prioritize safety net hospitals.

So I just want to say with the core, when you're talking about what the core function is, that's what we would say.

MS. McALPINE: Okay.

CO-CHAIR GARRETT: If we were to

define a hierarchy, I would have actually the Public Health Institute. I think that's a separate entity from the Department of Public Health. I think you guys are familiar with it. They could actually be responsible for the planning, which would be in the state statute on what that really involves. So a separate entity from the Department of Public Health, the Public Health Institute do the planning.

Then the board would oversee that and make sure it's responsive. If we keep the CON process in place, they would approve all of that. There is a separation of power. I think there would be a conflict of interest if we have, you know, the board, who is making the decisions come up with the plan.

So this Public Health Institute could easily do that. It's comprised mostly of, I think, consulting contracts and things like that, so it could continue like that, be funded accordingly, maybe separate from everybody, but have a defined planning obligation.

MS. McALPINE: Okay. So everybody has weighed in on this particular question. We've got

14 minutes left.

So I think what we can do with it is really decide what our next step should be from here. We have one more scheduled meeting in October, right, that's on the calendar? So I think I'm going to look to the two of you to see if there's a way for us to get some more input.

I mean, I think people laid out a pretty nice framework of the kinds of discussion they want to get into next. From my perspective from this meeting, we have a lot that we could work with to plan an October meeting, but it could be that the group wants to do this differently. There's a lot of detail left to go through, and as we all know that phrase, the devil is in the details. So I think I'm looking to you two to say -- if you want to recommend where we go from here.

CO-CHAIR GARRETT: Well, I think if we can define exactly the hierarchy of this -- I think it really is coming down to hierarchy. We all want pretty much the same thing. We want the planning. We want to make sure it includes all the details that we talked about, but who is going

to do what?

If we can define that, then I think it's a matter of sort of putting some responsibilities on the planning entity and then on the board, and the planning entity could be called a board, but I think that just has to be defined better.

I think everybody stated there should be two different entities, the planning entity and then a group that oversees that or follows through on the CON process, however that looks.

MEMBER SCHAPS: That should be separate?

CO-CHAIR DUGAN: I've always thought there was supposed to be two.

CO-CHAIR GARRETT: I think there's some agreement, so it's just a matter of --

MEMBER McNARY: I didn't agree, but I'm open. Again, I'm being convinced that there should be two, but I will say that I don't want that to mean that we abolish the stated goals of the Health Facilities Planning Board without knowing what that second it is.

MS. McALPINE: So would it be accurate to say for the moment that the next meeting could

focus on the structure maybe of the CON side? We spent a lot of time talking about health planning. Maybe we should start with the CON side and what the Health Facilities Planning Board becomes, how it evolves or gets revised, and then go back into health planning and talking about, okay, if that's still a separate entity -- but maybe setting aside the notion is it separate or not, define then the functions and how that would be staffed, and then go back to the conversation of who does what.

CO-CHAIR DUGAN: And you can't -- we've got the health planning one.

MS. McALPINE: Uh-huh.

CO-CHAIR DUGAN: Okay. Since we have a lot of -- there's a lot of ideas on here of what we would want to see that board do or whatever we call it, so next week or the next meeting, we'll have that listing, and then we can.

MS. McALPINE: Yes.

CO-CHAIR DUGAN: So we're already partway there as far as what we want.

MS. McALPINE: Right. We certainly have a lot of ideas.

CO-CHAIR DUGAN: And now we're going

to do the CON, what we want -- how we want that to function or what changes we want to see or how we -- you know, what's going to be part of how the CON process is going to work.

I think that's going to end up being just like this was. There's going to be a lot of different ideas on what we think the CON -- how it should proceed, and then I think we're going to need at least two meetings in October. I think one to kind of get those two things, and then hopefully, by the time we're done with the next one, maybe we're getting a little closer to coming together.

CO-CHAIR GARRETT: Or maybe even one more meeting in September.

CO-CHAIR DUGAN: Yes.

MEMBER GAYNOR: The next meeting is October 8th.

CO-CHAIR DUGAN: Then from that meeting we can book -- do you want to book another one in October because I think we're going to need two?

MEMBER SCHAPS: Why don't we try and book it now? So people can get an idea.

CO-CHAIR DUGAN: Yeah. Okay.
MS. McALPINE: What did he say?
MEMBER LYNE: Something about elections. I don't know.
MEMBER McNARY: Some of them have elections.
CO-CHAIR DUGAN: Oh, some of us have elections.
MS. McALPINE: But you're all going to win; right?
MEMBER SCHAPS: I think we all have an election.
CO-CHAIR DUGAN: So we had one October 8th; is that what you said?
MEMBER GAYNOR: It's at 10:00 a.m. on October 8th is what I have on my calendar.
CO-CHAIR DUGAN: Yes, I do, too.
MEMBER BRADY: I mean, do you think two meetings are necessary?
CO-CHAIR DUGAN: Yes.
MEMBER BRADY: Maybe a full day of meetings?
MEMBER SCHAPS: On October 8th, we need to end sort of by 2:00 or 3:00.

CO-CHAIR GARRETT: What I think he's saying, instead of doing two meetings, if we came at 10:00 and left at 4:00.

MEMBER SCHAPS: That doesn't work.

MS. McALPINE: We only spent an hour and a half on this.

CO-CHAIR DUGAN: That's true.

CO-CHAIR GARRETT: Yeah.

MS. McALPINE: We did all that testimony in the morning. Even if we started at 9:00. I mean, that's still a lot more time than you had today.

If you could get through in the amount of time it took you to talk about health planning, you got through the CON part -- I don't know that might be harder.

CO-CHAIR DUGAN: I guess if you look at it from that standpoint.

MEMBER GAYNOR: At the very least, why don't we start at 9:00, unless anybody is adverse to that.

MEMBER BRADY: I can't be. I've already scheduled something that morning because I thought it was 10:00 o'clock.

MEMBER GAYNOR: Okay.
MEMBER ROBBINS: Could I suggest just for the sake of looking at our calendars, that we at least tentatively schedule a second meeting in October.
CO-CHAIR DUGAN: Yes, I think so, too.
MEMBER ROBBINS: And if we don't need it, that's fine.
MEMBER GAYNOR: I agree.
CO-CHAIR GARRETT: I'm going to be gone the middle part of October.
MEMBER SCHAPS: How about late?
MEMBER ROBBINS: October 22nd, just throwing it out?
MEMBER GAYNOR: We're been doing them on Mondays. How about October 20th?
CO-CHAIR GARRETT: But you don't need me. I can be on the phone.
MEMBER SCHAPS: How about the 27th?
MEMBER GAYNOR: The 27th?
CO-CHAIR DUGAN: Does October 27th work for everybody? Can we at least put a hold on it?
MEMBER BRADY: I can't.

MEMBER GAYNOR: Cannot?
MEMBER BRADY: No.
CO-CHAIR DUGAN: Give us a date then.
MEMBER ROBBINS: What if we just emailed in our calendar availability dates?
CO-CHAIR DUGAN: Yeah, let's try that.
CO-CHAIR GARRETT: I'm going to be gone until the 29th.
MEMBER SCHAPS: How about Thursday, the 30th?
CO-CHAIR DUGAN: When are you leaving?
CO-CHAIR GARRETT: The 21st.
MEMBER GAYNOR: How about the 20th?
CO-CHAIR GARRETT: How about the 20th?
CO-CHAIR DUGAN: Senator Brady, the 20th of October?
Can you guys be in by phone, though, or something? I mean, there's no way we're going to find a date that everybody can be here.
MEMBER RUDDICK: What's the problem with the 30th?
CO-CHAIR DUGAN: Because the senator is going to be --
CO-CHAIR GARRETT: I can do it on the

30th. The 30th works for me.

MEMBER GAYNOR: Senator Brady?

MEMBER BRADY: As far as I know, it does.

CO-CHAIR DUGAN: Okay.

MEMBER ROBBINS: The 30th.

MEMBER SCHAPS: 30th.

CO-CHAIR GARRETT: I can't come until 10:00, though.

CO-CHAIR DUGAN: That's fine.

CO-CHAIR GARRETT: Okay. the 30th, just mark down 10:00.

MEMBER ALTHOFF: Lisa, are you available on the 30th?

CO-CHAIR DUGAN: I'll change my calendar. If everybody else is available, I'll just change my calendar.

MEMBER LANG: So the 30th is going to be at 10:00?

MEMBER GAYNOR: Yes.

MS. McALPINE: 10:00 to 2:00. Now, are we leaving them both 10:00 to 2:00, the 8th and the 30th?

Okay. So the 8th and the 30th are both

10:00 to 2:00.

CO-CHAIR DUGAN: Right, at this point.

MS. McALPINE: Okay. And we'll work with getting a location.

CO-CHAIR DUGAN: Well, for right now, we'll leave it 10:00 to 2:00, and if we see after the next meeting that we need to move it to a little bit later, we always can do that.

MS. McALPINE: Yeah, we may not, given that we didn't use all the time.

Okay. It's 1:53. So what do you two want? We have seven minutes left.

CO-CHAIR DUGAN: So we understand it, you're going to put this all together. Then are you going to send something out to all of us?

MS. McALPINE: First you two.

CO-CHAIR DUGAN: We send it out to the rest of the members?

MS. McALPINE: I mean, it will be the same function as how we've always done the minutes, and, you know --

CO-CHAIR DUGAN: Okay.

MS. McALPINE: -- the staff of the Illinois Public Health Institute will help.

Mostly it's Mairita.

CO-CHAIR GARRETT: I think we've made great progress. So we're in agreement more than we're in disagreement, and at this point, that's a good sign.

CO-CHAIR DUGAN: Ken, or does anybody on the task force, is there anything special you would like to see between now and the next meeting, otherwise it will be just like the minutes?

MEMBER ROBBINS: The only thing I would ask is if we are actually going to be asked to address specific questions, that we have access to those in advance, so we can better prepare for them.

MS. McALPINE: Sure.

CO-CHAIR DUGAN: And I would just say just from our end, that framework, the framework part, Ken, is kind of everything that we're basing our facilitating on, those framework questions.

So if there's anything in addition to those framework questions that you don't see that you want to make sure that we're going to discuss, that's where we can make sure we put it on the

parking lot, so we don't forget them later on as we go forward.

MS. McALPINE: Do you still think people should fill those out? I mean, we've only had two task force members do it.

CO-CHAIR GARRETT: I think it's going to be hard to, for some to make commitments before we have a discussion.

MS. McALPINE: Okay.

CO-CHAIR DUGAN: So let's just assume that the framework questions are the things that we're going to be discussing.

MS. McALPINE: Yes.

CO-CHAIR GARRETT: But I would like to explore a little bit about what the Public Health Institute does --

MS. McALPINE: Okay.

CO-CHAIR GARRETT: -- how it's funded, and what it's relationship is with the Department of Public Health. If we could get that in.

MS. McALPINE: Sure.

Okay. You guys did a great job. Congratulations.

CO-CHAIR GARRETT: Thank you.

(Which were all of the proceedings had in the above-entitled matter ending at 1:55 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

I, Joanne E. Ely, Certified Shorthand Reporter No. 84-4169, Registered Professional Reporter, a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this _____ day of _____, A.D. 2008.

_____
Notary Public

My commission expires
May 16, 2012.