Task Force on Health Planning Reform
Monday, April 14, 2008
8:30am - 12:00pm

James R. Thompson Center
100 W. Randolph, Room 2-025
Chicago, Illinois

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

Task Force Members Present:
Chicago: Ken Robbins, Claudia Lennhoff, Paul Gaynor, Hal Ruddick, Senator Bill Brady, Gary Barnett, Sister Sheila Lynn, Senator Garrett, Margie Schaps
Springfield: Rep. Lou Lang, Senator Pam Althoff
Via phone: Myrtis Sullivan, Rep. Lisa Dugan, Rep. Renee Kosel

Ex officio Members Present:
Chicago: Jeffery Mark/HFPB, David Carvalho/IDPH
Springfield: Mike Jones/IHFS (representing Barry Maram)

Staff Present:
IDPH (Chicago): Frank Urso
Legislative Staff (Springfield): Melissa Black, Kurt DeWeese, Charles Foley, Ginger Ostro
IL Public Health Institute Staff (Chicago): Kathy Tipton, Laura McAlpine, Mairita Smiltars

Court Reporter (Chicago): Joanne Ely

Call to Order - 9:05am
IL State Senator Susan Garrett called the meeting to order and began by reviewing the agenda. She had Task Force members introduce themselves. The Task Force decided to wait to receive hard copies of the 3-10 and 3-12 minutes before approving them.

Update on Task Force Member Travel Reimbursement Procedures
David Carvalho introduced Yolanda Jones of IDPH (in Springfield), who provided an overview of the travel and reimbursement procedures.

- Yolanda said the Task Force is on a receipt reimbursement basis. There is no per diem expense rate.
- Task Force members will have to keep their original receipts, and the original receipts will have to be turned in.
- Task Force members can use the same travel reimbursement sheet and it can be printed from a document online.
- The form is self-explanatory- you put your name, location (IDPH), social security number, traveler's name and address, and ensure that everything is consistent with regards to your name, etc. You must fill in your headquarters and residence which will be your home address. The year, date, and month must be filled in completely.
- Task Force members should try to get state-rate lodging. In the event this does not happen, the Task Force members can be reimbursed for the entire lodging amount.
- Mileage is currently reimbursed at .485 per mile until June 30th when it will go up to .505 per mile.
- Save your parking receipts.

- Keep track of your tolls.
- Sign the travel reimbursement form in blue ink, not black. David Carvalho asked Yolanda to explain how Task Force members could get the state lodging rate if they do not have a state ID. Yolanda answered that she can get each Task Force member a state ID if someone can provide her with their picture. They will then be entitled to the state government rate for lodging, trains, etc.

Presentation by James Tierney, IL State Medical Society, and Janet Nally, American Medical Association

Jim Tierney introduced himself and Janet Nally, an attorney with the American Medical Association, who has done much research regarding CON programs. The AMA is a clearinghouse of medical research for state medical societies. AMA is located in Chicago, and Jim was glad to have Janet here to provide information.

(Note: Janet Nally read from her testimony, submitted in written form to the Task Force- "Statement of the American Medical Association, Certificate of Need, April 14, 2008". Note-taker did not take notes as her presentation was lifted directly from her written testimony.)

Jim Tierney had brief remarks following Janet's testimony. The CON process began decades ago and it was certainly appropriate at the time it was instituted. But the healthcare finance system has since changed drastically and has negated the need for CON process. Jim urged the Task Force to consider this information as well as studies that show CONs in other states. The IL State Medical Society opposes continuation of the CON process and it also opposes expanding CON's into physician offices. There are many underserved areas in Illinois with regard to physicians and the IL State Medical Society is concerned that expanding CON would put a further impediment to physicians opening offices in Illinois, especially in underserved areas.

Question by Paul Gaynor: Asked Janet to comment on the statement that "Physician-owned hospitals attract comparatively healthy patients, leaving general hospitals to treat the sickest cases". This so called practice of "cherry picking" is being addressed at the federal level. Paul wondered about Janet's position as she stated this practice should be handled at the federal level but disputed that physician-owned hospitals actually cherry pick.

- Janet responded that she doesn't think that physician-owned hospitals go and seek out certain patients and certain procedures.

Question by Ken Robbins: Asked if it was Janet's contention that there is no problem with cherry picking or that it is better addressed at the federal level versus a state CON process?

- Janet responded that any concerns are best addressed at the federal level through DRG reform.
- Ken Robbins further stated that he assumes the federal legislators are not making these DRG assertions in a vacuum but are working on this issue because they perceive there are problems.

Question by Ken Robbins- Asked the presenters to comment on this fact: Medicaid patients comprise 13% of patients in community hospitals, but only 3% in specialty hospitals.

- Jim stated that the IL State Medical Society wants to see community/general hospitals do well because they are important to everyone in our state. St. Francis closed, but he doubted that was because of a specialty hospital or ambulatory care center opening nearby and taking business away. St. Francis probably closed due to low reimbursement rates for Medicaid. Jim saw no correlation to St. Francis closing and specialty hospitals being open in that community. Specialty hospitals should be reimbursed at a fair rate as well. Healthcare finance system is geared towards getting patients the highest level of healthcare at the lowest price. Insurance

companies can mandate if someone gets a procedure done at a certain place based on quality and cost. Specialty hospitals can save patients and insurance companies money. If the same service can be given at a lower cost, then why wouldn't patients and insurance companies choose that provider?

- Ken responded that he can see why an insurance company would want to send someone somewhere where it costs less, but these facilities don't have a responsibility to provide a full range of 24-hour services to the community. Ken doesn't think Jim answered his question by stating that insurance companies prefer specialty hospitals due to lower costs.
- Jim replied that specialty hospitals pay taxes and don't get the tax breaks that not-for-profit hospitals receive. It is highly unlikely that specialty hospitals would spring up all over the state. For the most part, doctors like to work at their community hospitals and they work with their administration. There is a significant financial risk to start a specialty hospital, so there is not a huge demand among physicians to start them. Physicians are not the deep-pockets they once were. For the most part, the medical capital is held by hospitals.
- Ken clarified that when he said "community hospitals" he was not separating between for-profit and non-for-profit.
- Jim responded that for-profits hospitals give an average of 7.5 hours of charity care a week. Therefore he believes that charity care is delivered irrespective of what type of hospital it is.

Question by Paul Gaynor: Stated that Jim made an important point that specialty hospitals are for-profit businesses. And to that end, they serve only a small share of Medicaid patients who cannot pay for their own care.

- Jim responded that he suspects that may be correct, but he doesn't have any hard facts to show that.
- Janet stated that yes, the percentage of charity care in specialty hospitals is lower than in general hospitals, but she also does not have statistics to show how much lower.
- Margie Schaps reiterated that Ken Robbins gave the statistic of 3% versus 13%.
- Paul Gaynor further stated that this statistic identifies the practice of cherry picking.
- Jim responded that insurance companies will choose the facility that is best for the patient. If there is a high-quality facility that offers a procedure at a lower cost, then why wouldn't they do that? Also, some specialty hospitals have exclusive contracts with physician groups.
- Janet further states that a physician may just want to have more control over the management of the facility too.
- Sister Sheila stated that this statistic is reflective of the location of the hospital too. Specialty hospitals are located where the income is higher, so you will get this Medicaid disparity.
- Senator Susan Garrett pointed out that the ASTC's are in more affluent areas and are open 9-5. Patients that need access to medical care outside of those hours are going to go the emergency room, not the ASTC, and those patients are more likely not to have insurance.
- Jim responded that you need to find a way to cover your costs, regardless of what type of center it is. You can't suggest that general hospitals can't make a profit off their emergency services. You may get a higher degree of patients on Medicaid who visit the emergency room. And that state probably reimburses at a rate far below the actual cost of care. It is not the specialty hospitals' fault that the state doesn't reimburse at a fair rate.
- Senator Garrett responded that whether or not the state reimburses at a fair rate, the location of the hospital or ASTC is going to influence who uses these services.
- Janet stated that her testimony showed that there was no evidence that specialty hospitals harm general hospitals. Patients want to have choices.
- Senator Garrett responded that ASTC's are open 9-5 on weekdays, so they are different than general hospitals.

- Janet responded that hospitals serve a need and a demand, and a hospital doesn't have to be everything to everyone.
- Sister Sheila interjected that the CON process served to help the state plan, and she would rather have a body to look at planned growth rather than have growth willy-nilly.
- Janet responded that the CON system is not the way to get there because it is a relic of our healthcare system that reimbursed in a different way.
- Sister Sheila responded that the whole healthcare system need to be turned on its head, but CON exists for a reason, which is to protect the Safety Net hospitals from failing due to competition. There are other agencies besides the HFPB that take care of other pieces of healthcare, but in the meantime it is detrimental for some hospitals to have these specialty hospitals operating in their community.

Question by Senator Bill Brady- Stated that the AMA and IL State Medical Society are advocating for elimination of CON board at least as it refers to non-nursing home facilities. Asked if they were saying that CON is an archaic system and free-enterprise should take over.

- Jim responds that given how fees are regulated, physicians and hospitals can charge whatever they want.
- Senator Brady responds that regardless of the personal feelings of Task Force members, it is possible that they will not repeal the CON board. IL State Medical Society members are all over the state, and there are some areas that are underserved and suffering. Is it the position of the IL State Med Society that there is a shortage of physicians and medical facilities?
- Jim responded yes to this question, and further stated that physicians are attracted to places where they can practice medicine. Where they can practice is very important.
- Senator Brady responded by stating that in the April CON meeting, 3 hospitals were denied. Would the IL State Medical Society physicians say that there are areas in the state where we are not building enough facilities? The CON board will do what the Task Force legislates it to do. Give the Task Force some things to do to make it a better system.
- Jim replied that less regulation is better. CON is an impediment to building facilities where they are needed. He suggested that the economics of building a facility in some of these areas is just not worth it due to the high Medicaid population and the financial risk being too high. Furthermore, in Chicago, where the population is very high, he doesn't see the wisdom to preventing hospital growth by not approving CON applications.
- Senator Brady replied that he wants specifics as the Task Force is not going to abolish CON but reform it. Give specific improvement action steps.
- Jim replied that the IL State Medical Society would be happy to work with the Task Force to devise a system that is more appropriate, simplified, and less bureaucratic.

Question by David Carvalho- The AMA study and AHA studies both have self-interest. *Health Affairs* last month said that there is reason for concern that physician-owned hospitals will continue to unravel the Safety Net. IDPH also has data along these lines. The percentage of Medicaid patients and charity care are both lower at ASTC's than at public hospitals. If a physician has an ownership interest in a facility, then they do have more of a vested interest beyond being paid a physician fee. Exogenous means something else is affecting the results other than what the data captures. Most specialty hospitals opened in rapid growth states without CON (like TX, CA, and LA), while Illinois is a more mature state with CON. So when you look at data from physician-owned specialty hospitals, it is not always completely applicable to Illinois and the CON status of the state may not be the most important difference between the states.

- Jim replied that physician-owned specialty hospitals are typically for-profit tax-paying facilities. Other hospitals have a legal mandate to provide charity care.

- David replied that the not-for-profit hospitals are not mandated to take a certain amount of Medicaid patients. Those hospitals with emergency rooms will have a higher rate of Medicaid patients.
- Jim replied that it is a matter of fairness to the physician and the patient. Service providers should be adequately reimbursed- artificially low reimbursement rates will ultimately lead to scarcity of service providers. If you want to have policies that do not adequately reimburse, you will always have scarcity. The cost shift from private payers to insurance companies and Medicare has caused this. Medicare reimbursements rates have not gone up in the past 8 years and during that time, the costs for care went up by 30%.
- Margie replied that community hospitals would be thrilled to have higher reimbursement rates and no one in this room would disagree that reimbursement rates should be increased. The Task Force is concerned about hospitals that serve the poor in our state. When you open a hospital in their area it takes away the few insured patients that have decent reimbursement rates in that neighborhood, and that will ultimately hurt the vital Safety Net community hospital.
- What are the differences in salaries of hospital/facility administrators and physicians between nonprofit and for-profit hospitals and ASTCs?

Question by Hal Ruddick- stated that what Jim and Janet are proposing (to repeal CON) is pretty risky. There are some assertions that CON doesn't help Safety Net hospitals, but he doesn't think the evidence shows that. The CON by itself will not fix the reimbursement problem. Could you take away this regulatory system without negatively impacting the Safety Net? The Lewin Report had problems with the definition of Safety Net hospitals, etc, so Hal wouldn't cite that report as evidence to eliminate CON. Asked Jim and Janet to explain how the elimination of CON would not hurt the Safety Net hospitals.

- Jim responded by using Mercy Hospital as an example. He doesn't see a physician-owned specialty hospital or ASTC going up anywhere near Mercy Hospital to compete.

Request by Senator Pam Althoff- she would like the Task Force to receive at their next meeting a map and a list of all the hospitals in IL to reflect the disproportionate/underserved areas.

Question by Rep. Lou Lang- stated that Jim and Janet have indicated that the Task Force should do away with this CON process and let medical providers make these decisions of where to open medical facilities on their own. He questioned that if CON were eliminated; would Jim and Janet see a need or place for some sort of planning body to identify areas in the state that would need a facility?

- Jim replied that he does believe there is a place for a planning body to share data with anyone interested in improving access to healthcare. Population data, population shifts, incidents of disease, other demographic information like age- IDPH could do that.
- Rep. Lang responded that he was going beyond statistics, etc. Would there be a need for a planning board if we went to a free enterprise economy?
- Jim responded that yes, this would be an appropriate role for a state agency
- Rep. Lang further questioned if it has to be a state agency. If not the state Health Facilities Planning Board, could it be out of the confines of the state?
- Jim responded that as long as the info is valid, shared, and collected appropriately, it doesn't matter if it is a state agency or not.

Question by Rep Lang- asked if Jim thinks this CON process ought to be eliminated or curtailed for all facilities, including nursing homes, etc?

- Jim replied that the IL State Medical Society opposes extension of CON into physician offices under any circumstances.

- Rep. Lang replied that the IL State Medical Society should perhaps propose a plan to let the Task Force know how the current process should be amended or changed. Rep. Lang's viewpoint is that all witnesses should not just take one point of view, but give the Task Force options in all directions so that we may take your wisdom.

Question by Kurt DeWeese- requested a further explanation about cherry picking solution- does the DRG system reform have the potential to affect these types of planning decisions as compared to CON.

- Janet responded that she can provide the Task Force with further details but she doesn't have everything in front of her to make a statement at the moment.
- Kurt further asked if the Task Force can have any information about whether specialty hospitals are physician-owned or corporation-owned? As he understands it, there are not a lot of physicians who want to open hospitals but many corporations that do.
- Janet replied that she doesn't have any statistics on that, but 52% of physician-owned hospitals are joint ventures with acute care hospitals. She will try to get more statistics on this topic.
- Senator Garrett responded that she thinks many of these physician-owned hospitals initially have investors who come in for the down payment and then physicians are able to buy in as an ASTC becomes financially successful- it is a partnership. Recommended that the Task Force should look into this.
- Kurt further stated that in a place like East St. Louis, where retaining community access to healthcare is vital, CON could be the only way to guarantee that hospitals are built in areas with need.
- Senator Garrett stated that the Task Force had to move on to the next speaker. No one on the phone has a question. She thanked Jim and Janet for their testimony and stated that the Task Force looks forward to receiving their recommendations.

Approval of Minutes

Senator Garrett stated that she would like to amend a statement in the March 10th notes. The statement currently reads that Task Force members will bring ethics issues to the Task Force Chairs (Senator Garrett and Rep. Dugan) and they will bring the issue to Mike Luke. Senator Garrett would like it amended to read that any Task Force member can contact Mike Luke with an ethics issue without first going through Senator Garrett or Rep. Dugan.

Motion approved to change this sentence in future minutes.

Task Force member complained that there was not enough specificity around Al Dobson's testimony about exogenous factors.

- David Carvalho stated that these are intended to be summary minutes and they will not necessarily capture everything word for word. The court reporter was present for that testimony and so there is a transcript of the complete exchange.
- Senator Garrett asked for an excerpted transcript of Al Dobson's testimony to be attached to the minutes handed out next month.
- David Carvalho stated that IDPH will have the minutes available online, though this feature is not live yet.

Motion to approve 3-10 and 3-12 minutes as amended. Motion passed.

Presentation by Mark Newton- Association of Safety Net Hospitals

Mark stated that he is the co-chair of the Association of Safety Net Hospitals, which is a group of 10 hospitals in the Chicago area. He is also President and CEO of Swedish Covenant Hospital on the north side of Chicago, and he is a board member of IHA. His testimony is from the perspective of a Safety Net hospital.

- In his past and current positions, he has been involved for over 10 years in CON processes and task forces. He has witnessed the tremendous impact that CON provides to protecting SN hospitals.
- His job is at an urban hospital with a high Medicaid Inpatient Utilization Rate (MIUR)- it is in the mid 40's at Swedish.
- SN hospitals have found a way to be challenged and respond to financial risks while also expanding and providing services.
- Since 2000, 2 hospitals have closed in the Swedish Covenant neighborhood, and another has stopped providing OB services with another hospital threatening to stop OB services. This was a loss of 500 beds and 300 jobs.
- In these last 8 years, Swedish has put $140 million dollars into building new facilities, services, and staff.
- Swedish is surrounded by ASTC's and they are a competitive force.
- The mission of Swedish Covenant is to provide healthcare to people regardless of their insurance standing- this is a moral mission. The operating license comes with a need to support the community.
- Capital gains are restricted by the price of technology, increased regulatory burdens, and low reimbursement rates. Do not ask Safety Net Hospitals to invest in a medical "arms race" that pits us against better financed competitors.
- ASTC's choose to enter the market and are not obligated to service the entire community population. They tap into the high reimbursement areas of medicine and threaten the funding base of SN hospitals. Cherry picking is devastating to urban hospitals and we need CON to mitigate this risk.
- For example, Mark knew of a patient who was told he needed to provide an $800 cash deposit for an endoscopy even though he was insured- when he didn't have the money, the doctor told him to go to the hospital and they could find a way to write off the cost.
- There is a 100% cash on cash return for investment into ASTC's. Physicians at ASTC's refer self-pay and uninsured patients to the SN hospitals while also siphoning off the highly insured patients from the hospital.
- Mark provided an example of the way Swedish Covenant worked with the CON board to open a cardiac surgery unit in 2000. Since then, Swedish Covenant has performed over 1100 surgeries and has less than a 2% mortality rate. The Health Facilities Planning Board trusted Swedish Covenant and worked with the hospital administration to make this unit happen. Had the open heart program not been approved, the current financial health of Swedish Covenant would be in jeopardy. If a specialty heart hospital were to open near Swedish Covenant, it could irreparably harm the financial health.
- Recommendations:
    - IL needs an effective planning process. Mark supports the continuation of CON because it increases access to care for Safety Net patients.
    - Industry reps should be part of the planning board because they are better informed and ask better questions.
    - Applicants need open communication with the staff, and ex parte works against this goal.
    - Medicaid levels provided by free-standing facilities should be equal to that of the two nearest hospitals.
    - CON process needs to be structured in a way to protect SN hospitals who want to expand while preventing free-standing facilities from expanding without regulation. Hospitals are in desperate need of capital funds to expand facilities- SN hospitals need funding. SN hospitals need to grow and be strengthened and be protected from a free market that would harm the care for uninsured people.

Question from Senator Garrett- in 2002, the IL Legislature passed legislation that put together the Hospital Report Card to evaluate hospitals on a set of criteria. Are you familiar with that?

- Mark responded that yes, he is familiar with this legislation.
- Senator Garrett further stated that if either a Safety Net hospital or private hospital wanted to expand, the HFPB should know how healthy the hospital is.
- David Carvalho clarified that there are two quality measurement pieces of legislation that will be implemented later this year- 1) Hospital report card- will show nurse staffing ratios and hospital-acquired infection rates. 2) Consumer guide to health- pricing information across different hospitals for the 30 or more procedures with the greatest differences in quality and costs.
- Senator Garrett asked Mark if he thinks these quality measurements will have an impact on the CON process.
- Mark replied that this data is an inexact science.
- Senator Garrett asked why he would say that.
- Mark responded that every hospital wants to do the right thing, have the best staffing ratios, etc. But paying for that is the challenge. Every hospital CEO strives to have the best possible hospital. In spite of low funding, SN hospitals do a remarkable job. The hospital report card data needs to be taken with a grain of salt until you see the gap that has developed in the last 10-15 years.

Question from Senator Brady- asked Mark to clarify his statement that a CON should not be approved unless they accept the Medicaid rate of the nearest hospitals.

- Mark responded that any free-standing surgery center, diagnostic center, etc needs to provide a level of Medicaid care that is equal to the average of the 2 nearest hospitals. These free standing medical centers should treat a level of Medicaid patients that is commensurate with the level of Medicaid that hospitals see for this particular treatment.
- Senator Brady asked if any state has implemented this.
- Mark replied no.
- Senator Brady asked why people go to free-standing surgery centers.
- Mark replied because their physician recommends it.
- Senator Brady asked why a physician would recommend this.
- Mark replied because of economic motivation (ownership return) and efficiency.
- David Carvalho stated that the findings of a study in Journal of Health Affairs indicated that physicians of physician-owned facilities will refer their insurance patients to their owned facility and refer non-insured patients to the hospitals.
- Senator Brady asked if there are any studies that found that fees are lower at ASTC's rather than SN hospitals.
- Mark replied that he is unaware of any studies that show that. ASTC's tend to force down hospital reimbursements.
- Senator Brady stated that insurance companies find that ASTCs charge less and so they prefer their clients to go there.
- Mark replied that ASTC's may charge less but the physicians get the economic benefit. Furthermore, different medical areas get reimbursed differently by Medicaid. For example Medicaid is a better payer for OB services than private insurance companies. But with chest x-rays, that it is not the case.

Question by Claudia Lennhoff- asked Mark if he would mandate that new ASTC's serve a certain percentage of Medicaid patients (equal to the 2 nearest hospitals), would he also mandate a percentage of uninsured charity care as well? For example, Champaign county is in a healthcare crisis because

there is lack of physicians and a lack of insurance. People are getting very sick and they can't get the care they need.

- Mark replied that there is a logical consistency to mandating both Medicaid and uninsured care. The challenge is that one size does not fit all. One should not mandate levels of charity care and Medicaid care on a state level- you need to look at the micro community where medical facility is. You would approve a CON based on the average level of charity care and Medicaid care in that particular area, but you can't ask every medical facility to provide at that level.
- Paul Gaynor stated that he had asked Paul Parker if any states look at charity care when approving, and Paul Parker responded that Virginia will ask CON applicants to ratchet up their charity and Medicaid care to the median level of service in the region.
- Mark replied that he would say that is appropriate. A 5-mile radius sounds appropriate.

Question by David Carvalho: Commented on Mark's testimony about membership affiliations of the HFPB. In August 2003, the Planning Board just moved from a categorical membership to a non-categorical membership. This was because the nursing home person tended to always make the same comment, the union person made the same comments, the hospital made the same comments. The planning board looked more like a legislature. Members of a non-categorical membership act more like judges. Right now the board members have worked at hospitals, but they do not represent hospitals.

- Mark stated that it is his view is that people with experience are more important than people without experience. He agrees that people can get lock stepped to represent a certain constituency in a categorical membership. Perhaps the vetting process could be opened up. He clarified that his testimony did not say categorical membership was important- just experience.

Question from Hal Ruddick- stated that he very much appreciates Mark's perspective. There is currently a dire problem with hospitals closing and downsizing- obviously the current system is not protecting the Safety Net enough. Can Mark recommend anything else to protect the SN hospitals? Mark can submit ideas in the future too.

- Mark replied that many free-standing diagnostic centers- such as MRI or CT-scanner centers- are owned by physicians and they refer their patients directly to those entities. As long as these centers are not reviewed by the CON process, they are not captured in the Net, but they are licensed to operate.
- Jeff Mark stated that free-standing diagnostic centers are not required to have a license besides a nuclear regulatory license. They do not go through the CON process in order to open.
- Mark replied that these centers have a business license from the state of IL.

Questions by Hal Ruddick: Hal asked that besides insuring access to capital for SN hospitals, does Mark have any other recommendations?

- Mark replied that he'd have to give more thought to that. Not sure the planning board is the right place to oversee quality or capital funding in the state.
- Senator Garrett asked why Mark doesn't think the HFPB should oversee quality. What about the hospital report card, etc? She thinks that a lot of decisions are arbitrary because the board operates without data on the health of the hospitals.
- Mark replied that he wishes there was an easy answer, but quality of healthcare is an immense issue. One can come up with hundreds of measures on what makes a high quality hospital but there is not an easy way to say that. People don't understand the numbers and what those mean. So he doesn't think the planning board will solve anything by regulating capital expenditure and quality by throwing out a lot of numbers.

Question by Rep. Lang- commented that he had trouble understanding why the relationship of other facilities near to a hospital and their relationship to a CON process meant anything to Mark.

- Mark replied that healthcare is a social right which all people should have access to.
- Rep. Lang responded that clearly we agree on that. He cares about health care. His question refers to free-standing clinics that pick up insured patients which then cuts into the profit of the SN hospital.
- Mark replied that that is at the heart of his comment. In the long term, these clinics will erode the viability of SN hospitals in their community.
- David Carvalho stated that some folks have proposed that each clinic should have a threshold of Medicaid care uniform across the state. But if you look at the micro level, then it will not be "one size fits all". Each individual area and their unique level of Medicaid care will have to be taken into account.

Question by Rep. Lang- Suppose the Task Force voted to end the CON process - He assumes that Mark wouldn't like that. If the CON process is ended, but Mark is concerned about cherry picking- what should the Task Force do to protect the Safety Net?

- Mark replied that his answer is within his testimony. He doesn't feel there is an adequate process in place to protect the Safety Net in the instance of removing CON.
- Re. Lang stated that wasn't his question. The Task Force wants to hear from witnesses about other options, not just "my way or the highway". The Task Force hears about your preference. If you don't get your preference, what can be done to protect the SN hospitals?
- Mark replied that he can give an initial response and give it further thought. Reimbursement levels are the key. The task force would need to take care of the SN financially without the CON board.
- Rep. Lang responded that the Task Force assumed that much. But what specific legislation would Mark need? If the free market determines health facilities, then the Task Force needs to hear from you what we need to do to protect the SN hospitals. Not just "we need money", but how much money. How to make the system work better for the Safety Net.
- Mark replied that he'd be glad to provide the Task Force with additional comments in a written format.

Presentation by Mark Mayo- Ambulatory Surgical Center Association

Mark Mayo's thoughts are based on 30 years in healthcare planning and delivery in IL. He was in Illinois in the 1970's when there was an actual health planning process, not just CON standards. He conducted CON for Lake, McHenry, and Kane counties. He also served as an administrator of ASTC since late 80's. He has been Executive Director of his association since 1998. He told the Task Force about his past perspectives to illustrate that he is committed to health planning in Illinois and to a coordinated system of health delivery. He is familiar with CON process.

- There are 110 ASTC's in IL that provide surgical procedures to 340,000 patients, with 2,000 staff, and 4,500 physicians.
- Our association has gone on record before to say we support the continuation of the CON process and the IL health facilities planning board. IL is the only statewide association of ASTC's that continues to support CON. We recognize the need for health planning and the need for community hospitals.
- Hospitals are not the only place for healthcare services. Hospitals cannot alone serve the needs of the IL public.
- There is a site of service reimbursement differential on whether you perform a service in a physician office, ASTC, or hospital.
- Surgery Centers offer efficiency, specialization, and convenience.
- SN hospitals shouldn't have a special right to be protected under CON, but they should earn the right.
- Physicians drive the hospitals and surgery centers.

- Recommendations:
    - the HFPB should use CON for only to approve new facilities in existing categories of service, and to approve the closing of facilities. Change of ownership should be done through IDPH, not planning board.
    - Support 5-year planning cycle, not 10-year planning cycle.
    - We believe that CON process should give greater consideration to public testimony. Physical presence is important but people should also be able to speak.
    - IDPH Licensure and Health Facilities Planning Board should work more closely together- single specialty, multi-specialty licenses that relate to CON application.
    - No protection for SN hospitals- it is unsound and undermines competition. Federal government determined that ASTC's had 84% of the cost of a hospital on the same type of patient (now 65%). Gov't pays the hospital more for the same procedure- site of service differential.
    - State HFBP should develop its own findings and issue those findings back to the applicant. This would allow the applicant to focus clearly on the state's concerns for refusing an application. Also helps transparency in the process- everyone is clear as to what happened and why.
    - Finally, this task force has several significant tasks before it. One is how you might reform or replace the system and the other is how this task force will be viewed to restore confidence in the CON board in the providers and public eye. It is incumbent to restore faith.

Question by Margie Schaps- asked how the association would respond to Mr. Newton's comment about mandated Medicaid/uninsured rates of service.

- Mark Mayo responded that with regard to charity care, ASTC cases come to us from physicians. In his experience, over half of the physicians on medical staff in a licensed ASTC have no financial interest in the ASTC we work for.
- Senator Brady asked if Mark Mayo could survey his membership and get that information.
- Mark Mayo responded that yes, he can. Physicians bring their patients to an ASTC for efficiency. They can perform 2,3,4 operations and be back in the office by 11am. It is the physician that brings the patient to the surgery center. If the physicians want to bring in charity care cases, they are welcome to do so.
- Margie asked how would the ASTC's feel about a requirement rather than a personal choice?
- Mark Mayo responded that his physicians are already providing charity care- ASTC's are viewed as an extension of the physician's office. Up to a few years ago, IL would not allow ASTCs to participate in the Medicaid program- we had to ask for the right. From a health planning standpoint, he thinks everyone should do their part. For example, outpatient surgery is in many cases an elective procedure, a quality of life issue. Public aid won't pay for that. Even some insurance companies refuse payment to ASTC's because they feel it is a procedure best done in a doctor's office. Hospitals receive community benefits- no taxes, endowments- ASTC's don't get those. Because of state requirements that all surgeons must be on staff at a licensed hospital, there must be a reason the doctor is leaving the hospital for 10-20% of his cases. These doctors are still members of the SN community. I agree we need to provide some level of charity care, but I am not sure what the level is.

Question by David Carvalho- asked about Mark Mayo's comment about having a written record when the board denies a CON application. There are plusses and minuses to that. Dave's initial reaction is that the board meets every 6 weeks. If something is to be drafted, it will have to be done by staff for consideration by the board at their next meeting 6 weeks later. Then the applicant gets the document at that 6 week mark, and then there is another 6 weeks until the next HFPB meeting.

- Mark Mayo responded that what he referred to is when the applicant does not get a clear answer as to why their application was denied.
- Senator Brady asked why the HFPB can't provide a response within a week.
- David replied that the staff can draft it within a week but they can't send it out to the applicant without board approval. Under the Open Meetings Act, there is no proxy approval. Nothing is done off line. So by default the board would have to approve the draft decision at the next meeting 6 weeks away.
- Senator Brady recommended that a matrix of recommendations should be kept.
- Mark Mayo agreed that the HFPB staff needs to draft the response and get the document out. The timing is problematic, but in unclear cases, but it would be helpful for applicants who don't understand the reason for their denial.

Senator Brady asked about the confidence level of the CON board. Does Mark Mayo have recommendations on how to handle it?

- Mark Mayo replied that answers to the confidence issue will come out of this public Task Force vetting process.

Senator Garrett suggested that if fewer applications were decided upon at each HFPB meeting, maybe there could be more information written up on each application

- Mark Mayo responded that the process is such that the board members get only a few days to read/respond to an application before a meeting. That is why public comments should be more central to the process.
- Senator Garrett asked if the public comments could be incorporated when the staff writes up the CON decision.
- Mark Mayo responded that it is too late at that point. Public comments should really be summarized and given in the application materials to the board members.

Question by Rep. Lang- Asked if HFPB board members should attend public hearings, not just HFPB staff. Should all board members be at public hearings? Assume we made it worth their while by giving a salary.

- Mark Mayo replied that he doesn't think that's practical. He thinks the HFPB staff should be able to summarize public comments and factual data and present it in the application materials to the board members. He thinks it is hard for the board members to read through every single piece of paper.
- Rep. Lang responded that he doubts any board member is reading all 10,000 pages of an application.
- Mark Mayo responded that he is concerned that when you have a sensitive issue where the public has a lot of passion, that the board isn't currently hearing those comments, and they need to hear public feedback in the future.

Question by Susan Garrett: asked a question about the planning process- what was it and how has it changed? Is the current evaluation process relevant?

- Mayo replied that it will be.
- Senator Garrett responded that that was not her question.
- Mayo responded that it's not relevant without planning. If the state expands data collection, that will be helpful.

Senator Brady asked Mark Mayo to clarify a comment he made about waiting to be called in by the HFBP to discuss acceptance of Medicaid.

- Mark Mayo replied that he is waiting for an invitation from the health facilities planning board to discuss the acceptance of Medicaid.
- Jeffery Mark clarified that the Health Facilities Planning Board members want in-service educational sessions that address critical issues for hospital associations, etc. Past in-service opportunities have included the ASTC industry and ASTC's come in to do trainings too.
- Senator Garrett asked Mark Mayo how long he has waited for his invitation.
- Mark Mayo replied that he has waited for 3 months.
- Senator Brady stated that he would like Mark Mayo to make that presentation to the Task Force.
- Mark Mayo responded that he would be happy to come back.
- Margie asked for clarification on the contents of the presentation.
- Senator Brady stated that the presentation is on charity and Medicaid work that ASTC's do.
- Mark Mayo replied that is some of the presentation, yes. ASTC's are permitted the right to Medicaid reimbursement.
- Ken Robbins clarified that ASTC's have to apply with the state to be a Medicaid provider. Some ASTC's have done this and some haven't.
- Mark Mayo replied that this is correct. Also the payment systems that ASTCs use do not collect charity or Medicaid reimbursement.

Request by Senator Brady- asked how many licensed health facilities exist in IL, including hospitals and every other facility. Earlier today the Task Force asked for a map of the Safety Net hospitals that shows where there is a disproportionate amount of SN hospitals or lack thereof. Senator Brady would also like to see how many emergency rooms/hospitals have opened in the last 15 years. He also wants to see the ASTCs that have applied for Medicaid reimbursement and who has not.

Comment by David Carvalho concerning the ownership structure of ASTCs. These came into full bloom in the early 1990s, and the rules treat them as a joint venture. The pathway to opening an ASTC if you are in partnership with a hospital is easier.

Other Business

Senator Garrett announced that the Task Force has reached the end of their allotted meeting time. The IL Hospital Association has yet to testify. After a short discussion, the Task Force motioned to have IHA present first at the next meeting. Senator Garrett also proposed that the next meeting on May 12 begin at 9am and end at 2pm. If anyone has suggestions for speakers, please forward those to Senator Garrett, Rep. Dugan or David Carvalho.

Adjourned at 12:10pm

Minutes respectfully submitted by Mairita Smiltars.

too.

CO-CHAIR GARRETT: Okay. I'm just trying to move it along. Thank you very much, Mr. Parker.

MR. PARKER: Thank you.

CO-CHAIR GARRETT: Al Dobson from the Lewin Report is next.

Thank you, Mr. Dobson, for coming. I just wanted to clarify. You are no longer with the Lewin Group, but you are the one that worked on this report?

MR. DOBSON: Yes, I'm no longer with the Lewin Group. I'm in a spin-off company, so to speak, Dobson, DaVanzo. I speak for myself today, not for the Lewin Group. That was the first thing I was going to say. Thank you.

Okay. I'm here today to present the study that was last presented to the Commission on Government Forecast And Accountability February 22nd, 2007. Primarily I'm going to present essentially -- I'll use the slides we used during that presentation. There's a few things that I have discovered since then that I will make a comment, some of which I think will be helpful to

your discussion.

In terms of what I'd like to discuss today, I'll start with the purpose, the methodology, a little bit about your program. You folks probably know more about it than I do at this point, but we had some comments about how the program is structured.

We looked at benchmark states to get some idea of how the other guys do it, and that's in our report. They've done some studies on what they think they've found, and again they were kind of confusing, conflicting, and they changed their mind from study to study; but nevertheless, the benchmark states tried to understand what the outcome of their efforts were.

Interpretation of the national literature, certificate of need and market structure, and I believe the previous speaker, Paul, mentioned that as the patterns of providers. That's something that we thought was worth looking at, and indeed there are some differences there; and then market performance in terms of cost, the quality, and access. We made some recommendations, which I'll go over today and then some conclusions.

The purpose of our study was to conduct a comprehensive evaluation of your program. We had to take a particular look at the sunset provision, and at the end of the day, we felt our job was to say whether you ought to keep the certificate of need, wade it through, or keep on going with it for a while.

At the very end of the day, we said you probably ought to keep it going under some very restrictive conditions and probably for about three years. We'll come to that again.

We interviewed stakeholders in the state to determine how effective the planning had been. We talked to some academics. We talked to some people who had been on the board. We talked to some folks in the state. We looked at the literature from other state's CON projects.

And we performed some quantitative analyses ourselves. We primarily looked at the pattern of providers, and we looked at margins of safety-net hospitals, which was new to our study. It hadn't been heretofore presented.

Your program was established and comprised of five members that oversee the CON applications.

You've had various comings and goings of the configurations of your board. It regulates capital expenditures by health facility, bed expansions in existing facilities, and numerous categories of services.

And as Paul mentioned, we have a table at the end of our report that goes across many states and gives you in great detail what facilities and the control that other certificates of need have across the country. You might find that of some interest to see how the other guys -- what they regulate, not how they regulate so much, but what they regulate. It's a grid at the end of our report as an appendix.

Your program, as are many others, is funded by applications ranging from a couple thousand dollars to a 100,000.

Now, the benchmark states we looked at: Washington, Michigan, Virginia, and New York, we called these folks up. We read some of the writings on them trying to get a sense of how it is they worked.

The first thing we noted is that their approval rating was comparable to yours, 82 to 91.

Yours -- with a little help from the board, we kind of had to work on that table a bit -- we came out to about 92 percent.

I think the point of it is, after it's all said and done, the approval rates are fairly high. That's tricky business because a lot of people think they might apply. They kind of get a sense they're going to get turned down, and they don't apply. So the top-on-the-bead effect may be strong here, and considering the 92 percent, these are the ones that were actually decided on.

There may have been more people out there that thought about it, but didn't do it because you had the process in place. So it's not altogether clear how to interpret the 92. It clearly isn't a straightforward 92, but it's still a high approval rating.

In terms of the benchmark states, CON rarely reduces the health care costs in the benchmark states, with the potential to increase costs in some situations. I think, as you've heard from the previous speaker, that's highly controversial.

The competition folks say if you have certificate of need, you reduce competition. If

you reduce competition, you may reduce -- if you don't have competition, you may increase your prices. The 2004 FTC report was very clear in their view on that. Other people are quite less clear on the situation as to whether the decreased competition would actually increase costs as opposed to decrease cost which was the purpose or intent of CON.

Attempts to maintain health care access to all populations have been only marginally beneficial for the benchmark states. Many of your questions that you asked the previous speaker certainly go to the point of safety-net hospitals, and that's an issue I'll dwell on today.

Specialty hospitals might undercut community hospital's ability to serve indigent patients was a statement that we made. I'll say a bit more on that later. On the specialty hospitals, we had a few dot points which I will tick off.

Disproportionately are for-profit and have physician owners, tend to serve profitable patients for various reasons. It's a very complicated business about how patients end up at various hospitals through the referral process,

lots of reasons why hospitals end up -- patients end up where they do, and again, how they end up with a slightly more favorable mix of patients or how they get there is a very, very complicated story.

They're located in non-CON states. Most of your for-profit specialty hospitals don't even try to get a certificate of need. They just go to the states that don't have certificate of need. So most of your specialty hospitals have -- physician-owned specialty hospitals are located in certificate-of-need states.

They may be more efficient than community hospitals, but the evidence is inclusive. The Medicare Advisory Commission has spent some time looking at the efficiency, and essentially, they say they provide a different product so they have a slightly higher cost per case, and they're new. Of course, new institutions have higher capital costs.

So it's kind of hard to figure out whether they're more efficient or not because it's a slightly different product, single rooms, more nursing per staff, et cetera, et cetera. So

you're providing a little different program at a slightly higher cost with very high patient satisfaction.

Nevertheless, at the end of the day, the evidence is inclusive on whether they're more efficient than the community hospitals.

They have quality that is equal to or higher than the community hospitals. Mortality rates tend to be slightly lower, the average length of stay is lower, readmission rates are higher, and their complications tend to be as good or better than community hospitals.

By injecting competition in the marketplace, they may enable providers to lower the unit payment. The advocates of specialty hospitals refer to the notion of the wake-up call. The wake-up call meaning that when they come to town, everybody pays attention, and they may try to provide better service than they had before.

If nothing else, there becomes a bit of an issue about how you treat physicians, and there's a lot of competition by community hospitals in areas that have specialty hospitals about how you treat the physicians on your staff, et cetera, et

cetera.

Now, ambulatory surgical centers, Paul mentioned that you get a different pattern of providers in states that have CON. You clearly do. One thing is that the market share of hospital outpatient departments is moderately higher, and the share of ASCs is moderately lower when you have certificate of need. I think that probably stands to reason. We were able to demonstrate that empirically. The conclusion then, CON states have fewer specialty providers and ASCs.

Now, interpretation of the national literature, in the early days, I suppose CON laws were designed primarily to contain costs by regulating capacity. We have analyzed the national data on the number of beds by hospital relative to optimal occupancy.

Optimal occupancy is a tricky business. We used old 93-641 planning rules that were put -- formulas that were put in place. We applied it to all areas in the country, the market areas, and we found that surplus beds, quote, on surplus beds as a percent of staffed beds were higher, that would

be slightly higher in non-CON than CON states. Conclusion: CONs limit bed capacity.

That said, on the cost containment side, and I think Paul was pretty clear, and we agree that there hasn't been a lot of recent work on cost control of certificate of need because in many ways it's an issue that states are resolving. It's not as much of a national issue as it used to be since the early 80s. So there hasn't been that much work done on it.

At any rate little recent work has been done on accessing CON's ability to reduce health care expenditures. Now this is a key question that one of you folks -- Heather -- yes, that Heather asked; and that is, what about those states that stopped doing certificate of need?

There's a paper entitled, "Does removing Certificate of Need Regulations lead to a Surge in Healthcare Spending?" The Journal of Health Politics, Policy, and Law, June 23rd, 1998, Pages 455 to 481 by Sloan and Conover.

MEMBER O'DONNELL: Can you repeat that?

MR. DOBSON: It's in my paper. It's

in the footnotes.

MEMBER O'DONNELL: Okay.

MR. DOBSON: It's the Journal of Health Politics, Policy, and Law, June 23rd, and it's footnoted in our paper under that topic.

They concluded, as did we after reading the paper, that states that had removed CON did not experience a raise in spending on cost relative to other states.

It occurred to me in listening to your discussion, the Medicaid program, the Office of Actuaries keeps state spending data by state. It has for several years now. If you wanted to look at each state's spending per capita, those data are available, and you can probably do a study that would contrast certificate of need and non-certificate of need by spending by per capita population.

I'm sure that when you were through with it, you would be as confused as you are now because there's all kinds of reasons, and I would defer to California why certain states drive their expenditures. Yes, ma'am.

MEMBER ALTHOFF: Just real quickly,

did you notice the reverse? When you were doing this, you said when the CON process was eliminated there wasn't necessarily an increase in cost. Was there a decrease in cost? Did that come into play?

MR. DOBSON: I think it's fair to say that they couldn't find much of anything.

MEMBER ALTHOFF: Okay.

MR. DOBSON: Yeah, and I think Paul in his statement was very careful to say, when you're looking for the positives, you don't find those, but you don't find the negatives either. It's kind of like it doesn't seem to make a lot of difference.

Now, quality of care is -- yes, yes, David.

MR. CARVALHO: I've got a question that dovetails with what you and Paul said on this topic, especially -- Paul indicated that the trend towards having CON or not kind of grew organically out of the market in that state, the growth patterns in that state, the maturity of that state, the geography of the state.

So the question is, how would you ever draw conclusions looking at CON states versus non-CON

states if the reason that makes them be a CON state or a non-CON state are the underlying differences in the state in the first place?

MR. DOBSON: Very good question, we economists call that endogeneity. When you've hit endogeneity, you're dead meat. It's a very difficult question to resolve.

I will note something though. The certificate-of-need states tend to be states that aren't where the most rapidly growing populations are. The fellow who used to -- Tom Skelly, he used to run CMS, in a speech once said that the for-profit industry, which he now represents, so he may have been biased, really represented the Hill-Burton of its day in the 90s because that's who were building the hospitals. They were building them in the southwest where the population was growing, and those are the very states that don't have certificate of need.

So you'll find the specialty hospitals. You'll find a preponderance of for-profit hospitals. You'll find less charity care. You'll find all sorts of things in the southwest in those population states.

I think your point is well-taken. To attribute that back to any given thing would be very difficult to do because they're very different states, very different dynamics, very different politics, very different views of what regulation is; and then to lay it back to any given state, whether that's because of or in the absence of certificate of need would be a very dangerous business. I think that's kind of where you were heading. I believe you're exactly right on that.

So that said, the cost containment, very little recent work -- I'm just going to repeat that because, you know, if the goal is to contain cost, you're probably not going to get there with certificate of need.

The literature consistently has repeated that year after year after year. The guys who shut down didn't necessarily run into troubles, they didn't get better, they didn't get worse, they kind of muddled along I guess like everybody else.

So if the explicit goal is cost containment, I don't believe that supports a continuation of

the program, as we said, so it's all in the report.

Now, quality of care gets a little more interesting because to the extent that you focus on certain procedures, primarily heart procedures, because that's where most of the work has been done. In a few hospitals, like in Maryland, for instance, if you've got a few guys doing the most services, you're going to get better quality of care. If you have lots of guys doing a few services, you're not going to get as good a quality of care. That's pretty well documented in the literature.

That said, mortality and other statistics, you can't track it back through the CON, probably because of what you say, there's so much going on, that it's very difficult to lay it back to CON. So in those states that have certificate of need, even though practice makes perfect, you really don't find a whole lot of difference in mortality.

As we say here, CON may, underline may, lower mortality slightly, but findings are mixed. Yet again, an issue where you would think it would be pretty straightforward, but the data doesn't

support that certificate of need demonstrably improves quality.

In those areas limited to the heart, limited to CABGs, you may find some differences, but again that's a matter of volume, and you can get volume a lot of different ways. You might argue specialty hospitals provide volume, provide higher quality of care, and they're certainly not certificate of need. They're the antithesis of certificate of need, but they do provide high quality. Yes.

CO-CHAIR GARRETT: I have a question. So the way you gauge your quality is based on mortality?

MR. DOBSON: No, no, that was just a for instance, ma'am.

CO-CHAIR GARRETT: Okay. So back to what we were saying before, in your experience have you seen that CON practices across the country -- did any of them first and foremost focus on quality, meaning if there's a hospital report card or some sort of measure to compare if a hospital wants to expand or add some kind of a specialty?

MR. DOBSON: As you asked that question, I was thinking the answer I might give you when you asked it, which you did, I'm kind of thinking that what people are doing is they're moving towards pay for performance, and they're kind of divorcing the planning thing, and basically saying, we've got to pay for this stuff, so when we pay for it, why don't we load up our quality measures?

As you probably know, CMS has several demonstrations in place, I believe a national demonstration on pay-for-performance. The idea being that you carve out a point or two of payments for whatever your favorite measures of quality are, and then those hospitals that do it get paid on it. Those that don't perform well, they'll hold back -- they don't get the hold back.

Just in this most recent Medpac report on nursing homes, they suggested two quality measures. Let me see if I can remember them. One is a return to the community, and the other is readmission to hospitals that are unwarranted. They say maybe that could be pay-for-performance measures that they would build into the nursing

home industry. And I don't remember what the cost --

CO-CHAIR GARRETT: You're looking at accountability, which I think Heather or somebody else brought up. I'm looking at initially giving permission.

MR. DOBSON: No, I'm with you.

CO-CHAIR GARRETT: Okay.

MR. DOBSON: And one thing we noted in the report is, even if you did do that, and I think Paul touched on this because it slips over into licensure, somebody asked the question do you monitor this? How on earth do you monitor it?

I would guess, in fact, we say in our report if anything there's a -- you know, even if you did this, there's a certain laxity in trying to figure out, okay, here are the criteria. Every year you track people. Typically, no, and if you do track people, what do you do about it if they don't do it?

It's a very difficult business, but I think by and large that has not been the norm. I agree with Paul on that, but I think that it is going to become more of the norm on the payment side

through pay-for-performance, at least there's a lot of pressure on that, and a great big demonstration through the Medicare program.

MEMBER ROBBINS: Al?

MR. DOBSON: Yes.

MEMBER ROBBINS: Do you have an opinion as to whether it is likely to be more effective to improve quality through payment reforms as opposed to through the certificate of need process as it relates to issuing new certificates of need based on prior quality?

MR. DOBSON: You know, my take is that payment for -- I'm a finance guy, as you well know. You know me well. So you know my answer is going to be the finance side is probably the better side as opposed to the regulatory side. That's a personal bias, and I'll just tell you straightaway that it's a personal bias.

I think you're going to do better on the finance side than on the regulatory side. Although you have to regulate the payment to do that, but nevertheless I think if you're going to improve quality, you know, as opposed to certification and such, payment for -- at least it

stands as a potential, yet to be proven.

MEMBER ROBBINS: Thank you.

MR. DOBSON: So that's quality of care. Now, the next page is kind of an amazing page. We looked at access, and we asked ourselves a question, well, safety-net hospitals by and large are about having enough money to cost subsidize their care, no mission, no margin, so to speak.

So we looked at the non-CON states, the CON states, and you'll see that the non-safety-net total margins are actually higher than the CON margins, and similarly for the certificate of need. Absolutely what you wouldn't expect.

You would expect that certificate of need states with the protection for the safety-net hospitals would do better. We found the opposite. We did this over and over and over again because frankly, I didn't believe it until about the 10th run, and then I said, okay, I'll get off you guys, the guys who were working, making the runs.

Now, since we did this, there's a report by -- it's an inquiry of fall -- a fall inquiry, Dr. Schneider wrote it. They looked at all the

hospitals in the country, all the areas in the country, at specialty hospitals and non-specialty hospitals, and they looked at the margins of those hospitals in areas that had specialty hospitals, and darned if they didn't find exactly the same thing we did.

I'm going to read you a quote here in just a minute from our report when I get there that we were kind of saying, if you really believe these findings, it might give you a little different view on how you -- on what you think about certificate of need, and it said, well, we've kind of done this, you know, one set of researchers finds a finding, so what.

But there's another set of guys totally independent of us in a different study with a different purpose, and they found essentially the same thing. I'll just pass that on. I'll give you the citation, make of it what you will. But it does suggest that this kind of finding, counterintuitive that it is, may be correct. I had enough ifs and maybes in that to get by with that.

Nevertheless, my point is I think well-taken

that there's maybe something going on out there that just isn't counterintuitive except for the fact that maybe competition does what people say it does; and when you get a lot of competition, they do get a wake-up call, and they do improve their efficiency, and they do improve their service structure. Yes.

MEMBER ROBBINS: Al, I was puzzled by this as well when your original report came out, and in part, because it has not been my observation, at least in Illinois, that there is great competition for serving the areas that safety-net hospitals in Illinois presently serve. So I'm not sure I understand how competition somehow sharpens the ability of our present safety-net hospital population's ability to have higher profit margins.

MR. DOBSON: And, you know, let me tell you -- how we define safety-net hospitals is perhaps important here because you can't go to the Medicare files and say is this a safety-net hospital? What you find -- you can't even find bad debt and charity in the Medicare cost reports because it's not -- it's reported now, but it's

not as crisply as it might be.

So what we did is all those hospitals that had a quarter of their discharges in Medicaid, make of that what you will, but that was our rough proxy. The Schneider guys had a much sharper view of what a specialty hospital and non-specialty hospital was within the community, and again, they found essentially the same result.

Again, because in effect you're saying we're a little different here in Illinois, and you know I know your state well because I have worked for many years in your state, and I know about the very complex financing mechanisms and disproportionate share, and I know how important safety-net is in your state.

That was one of the reasons we were very cautious to the end and basically said pay attention to safety-net because I know in your state, as opposed to across the country, it's a big issue, you've got to pay attention to it, and that's why we didn't just say do away with certificate of need because it doesn't control costs.

So we were very cognizant of that, and I

think we tried to pay attention to what you're essentially saying, hey, we're a little different in Illinois. We have a long tradition of safety-net hospitals; and I think there's some fear, at least in my mind, that they may unwind, and maybe one of the things that we say in our recommendation is you've got to pay attention to that because if the fear is right, that may be one of the sharp focuses of how you think about it. Back to your notion about should we be planning, maybe one of the things you should pay attention to is your safety-net hospitals.

Now, that said, counterintuitive, it is what it is, but it does suggest that across the country in general competition seems to work by and large in safety-net and non-safety-net areas -- CON and non-CON areas.

MR. CARVALHO: I'm glad you have that up here because when I first read it, I also had a question, and I've never had a chance to ask it. Your report focused on looking at the row versus the row below it. In other words, the row that has 3.2 versus the row that has 1.3.

MR. DOBSON: We did it kind of

simultaneously. We did a regression, and we did it simultaneously.

MR. CARVALHO: Well, I mean, the discussion looked at the row that is non-CON --

MR. DOBSON: Yeah.

MR. CARVALHO: -- and safety-net versus the row that is CON at 1.3.

What I looked at was the columns, which is the column of non-safety-net versus the column of safety-net.

MR. DOBSON: Yes.

MR. CARVALHO: And in every state, if you look at the difference between the margin of a non-safety-net hospital and the safety-net hospital, it's about 2.6, 2.7, and then overall 2.7. So what your data shows was that the safety-net hospitals' margin lags behind the non-safety-net hospital almost the exact same regardless of whether you're still --

MR. DOBSON: We saw that, too.

MR. CARVALHO: So then it raises the question, okay, well, if the difference between safety-net and non-safety-net seems to be pretty fixed, why would the margins for everybody be

higher in the non-CON state if the premise of the non-CON state has greater competition? Normally greater competition doesn't lead to higher profit margins. It theoretically leads to lower profit margins.

MR. DOBSON: I'll tell you what Schneider says in his paper, and this gets back to your other question of endogeneity, because the Schneider paper deals with that at great length. They try maybe 10 different -- I don't know, lots of different models, lots of different dependent variables, lots of formulation, lots of econometric structure.

Then at the end of the day they say, you know, we kept doing this over and over and over again, and we found the same thing. It is counterintuitive. They said, as I did, that it's counterintuitive, but they said it may be two things. No. 1, that there's sort of a ride-up of profits across the country generally. It's been good years for the hospital industry, the last two or three years, maybe the last one hasn't, but in general it's been pretty good.

What's maybe going on is there's a selection

bias in where the specialty hospitals in their case and where the safety-net hospitals, which was your point exactly, and it may be those are generally faster growing, wealthier, more profitable states, and what you're really picking up is an economic effect as opposed to a CON effect.

But what you're not picking up is that CON magically saves safety-net. It just doesn't. What we're probably picking up here is a broader economic effect of where CON is located, in the Schneider paper, of where specialty hospitals are located, and they're the same basically.

Ken, yes.

MEMBER ROBBINS: I'm sorry, no.

MR. DOBSON: Oh, I thought that you were --

MEMBER ROBBINS: At some point I want to get into the business of safety-net, but if there's a better time to do it.

MR. DOBSON: Sure. When we get to our conclusion, I think that would be a better place.

MEMBER ROBBINS: Okay.

MR. DOBSON: So at any rate, this is a

fascinating table. We found corroboration of it after we put the report out. If nothing else, it suggests that CON in and of itself doesn't seem to be anything that protects the safety-net hospitals in any major, visible, viable, right-in-your-face kind of way.

Now, on the next page, I think that it is pretty clear, just as Paul said and I'll say, CON does impact on market structure, and that may be -- there may be a turn on that about safety-net hospitals. I'm not sure, but you can control market structure because folks have. It limits the number of specialty providers, and it limits bed capacity. That it does.

It doesn't seem to impact market performance. I know that's a contradiction, but it seems to have little or no ability to control health care expenditures.

Indeed, you know, if you believe the DOJ and the FTC -- and I think Paul was right. I'm a little skeptical of those guys. They are ideologues on their market, on economics -- may increase costs by reducing the competition, that would be CON, may have minor impact on the quality

of care, again, in that isolated case when you do more heart, you probably get better, but it's very hard to find; but it does redistribute expenditures amongst providers especially from potential new providers to incumbents.

CO-CHAIR GARRETT: Can you explain that to me?

MR. DOBSON: Now, which one?

CO-CHAIR GARRETT: The one you just said.

MR. DOBSON: Oh, sure. If you have CON and you don't let anybody new come in, obviously the new guys aren't in the business, so you're redistributing monies away from new entrance to the guys that are there. CON, if it does nothing else, protects the guys that are there. I'll just say it does. That is consistently stated over and over again in the literature.

CO-CHAIR GARRETT: But with the new people, let's say you have hospitals that are in place in Illinois, and they want to expand versus the hospital, which is sort of --

MR. DOBSON: well, fair enough, maybe

I should have said new capacity, as well as new providers. If you have somebody new that wants to come in and you say no, obviously, you're redistributing resources away from them to the guys that are there. If you have a hospital that wants to expand and you say yes, then that expansion favors them as opposed to the guy across the street that you didn't say yes to.

It's a redistributive device in terms of who is doing what. I mean, for sure it does that. Like your ASCs, you've got fewer of them in CON states. You don't have any specialty hospitals in CON states. You have slightly fewer beds in CON states, and the ASC thing is very clear. You've got a lot fewer ambulatory surgical centers, and a lot more inpatient ambulatory care.

So you are redistributing resources. It's kind of up to you guys to decide whether that's a good thing or a bad thing, but it's clear that it does that.

CO-CHAIR GARRETT: Okay. Let me just give you a scenario.

MR. DOBSON: Sure.

CO-CHAIR GARRETT: In Region A, you've

got four hospitals that want to expand into Region A. All those four hospitals are viable hospitals within, let's say, a 50-mile area. So those same hospitals are vying for expansion in that one particular region.

MR. DOBSON: That's right.

CO-CHAIR GARRETT: So then it becomes political sometimes on who gets that expansion. So I guess I'm not sure I really -- I understand what you're saying, but I'm not sure it really makes sense because some of the same incumbents are competing for that additional expansion.

MR. DOBSON: But what if an outsider came in and said, I want to do it.

CO-CHAIR GARRETT: What do you mean by an outsider?

MR. DOBSON: A hospital that isn't one of the four, but a potential fit.

CO-CHAIR GARRETT: Okay.

MR. DOBSON: Then it would be swayed away from somebody. Say, just to make up some --

CO-CHAIR GARRETT: I mean, they're all considered outsiders to a certain extent.

MR. DOBSON: Well, fair enough, but

nevertheless, your point is well-taken, that if one of those folks wins, it's redistributed back to that one particular hospital.

CO-CHAIR GARRETT: Right.

MR. DOBSON: If a hospital outside of the market area came in, which happens all across the country, and I'm not talking just here in Illinois, then they build a new hospital or they buy an existing hospital and expand it, obviously, if CON stops that, then it would be redistribution from the local guys away from -- to the local guys away from the people from the outside that wanted to invest in the community.

CO-CHAIR GARRETT: I get it. I just --

MR. DOBSON: Okay. Well, let's do the ambulatory surgical centers.

CO-CHAIR GARRETT: Yes.

MR. DOBSON: This may be clearer. Let's say that there's a firm in the south that really is big on ambulatory surgical centers; and they said, we're going to come in, and we're going to build, just name a number, ambulatory surgical centers in your state; and you said no, that's the

last thing in the world we want.

Clearly, you have redistributed away from those guys, favoring the outpatients or those who have -- I don't know if you have ambulatory surgical centers in the state, but those few that exist as opposed to the guys who are going to come in and invest. That happens every day in this country.

CO-CHAIR GARRETT: That makes sense.

MR. DOBSON: Okay. Fair enough. Good. Okay.

So we're on -- CON does not substantially impact market performance. It doesn't seem to control expenditures very much, and minor impact on quality. It does redistribute expenditures among providers, especially potentially new providers, in this case my ambulatory surgical center guys, and tentatively does not maintain access to care by protecting safety-net hospitals.

There again the margin findings, and the fact that all across the country, safety-net -- you know, we're having trouble with safety-net hospitals. It's a big issue, and much of the politics in the Medicaid program is about

protecting safety-net hospitals.

One thing that we said in the report is that, and I want to be a little careful here, but say that you have an inner-city hospital that says, we're going to close down, and we're going to the wealth of the suburbs. Well, you know, you might say not so fast. Slow that down a little bit, but obviously, you can't keep people open forever.

But you might be able to slow it down a little bit and say, if you're going to move, you're going to have certain restrictives. You're going to have -- I don't know what. That's up to you folks. I think the unbundling of the safety-net is something that you might be able to do. I'm very careful about might be able to do at least for a limited time to stabilize an unwinding of safety-net hospitals in Medicare communities by people relocating.

Now, I'm just going to read a paragraph that we have in the report, read it into the record: "Realistically, the greatest effect that CON laws have is that it retards the shift of relatively profitable services from the inner-city into the

suburbs. Through our research and analysis, we could find no evidence that safety-net hospitals are financially stronger in CON states than in other states.

"Illinois already has several programs that explicitly fund safety-net hospitals: the Cook County intergovernmental transfer program, the hospital assessment program, the critical hospital adjustment program, the legislature," that's who I was talking to at the time and now you folks, "should judge whether the present funding level in aggregate is adequate or whether funding should be increased. If such policies are adequately funded, it would be appropriate for Illinois to consider the usefulness of the CON program."

In code, if you've already got it covered, even the one thing we recommend might not be needed if you otherwise have your safety-net hospitals covered. That's an issue that is so complicated I couldn't pretend to answer it for you.

All I know is in working in this state for many, many years, the way you handle your safety-nets is extraordinarily complicated,

extraordinarily political; but on the other hand, I think you may be getting into that business through the CON. If you think about safety-nets, how you want to preserve them, what other ways to preserve them there are, i.e., direct funding as opposed to a certificate of need that says you can't open here, you can't open there, kind of thing.

One point -- now, I think that's -- that's on Page II of the executive summary for those who are transcribing this and want to go back and get that. It was II, last paragraph, full paragraph of the executive summary.

So after all of that, we came up with some recommendations. We were a little bit torn as a staff on the recommendations because on the one hand, as economists we thought, you know, CON doesn't seem to do very much. On the other hand, to Ken's point, you have very particular issues in your state. The safety-net hospitals are extraordinarily important to health care delivery.

So we thought if there was some way you could use, I'll call it nontraditional ways of using your program and focus it on the safety-net

hospitals, maybe that would be a really useful thing to do.

So during this period, review evidence on CON's impact on safety-net hospitals, and that is to say the next three years is what we recommended.

Evaluate other policies that support safety-net hospitals, and we just put an e.g. in there, but the paragraph I just read you, I read that on purpose because it dovetails with this recommendation.

And we did recommend then in our text, but not here so much, careful scrutiny of CON if these policies are adequate. In other words, if there's a safety-net problem and you have another way to fix it, maybe the regulatory approach isn't the way, but the payment approach -- back to my finance bias as opposed to my regulatory bias.

Consider a more proactive charter for Health Facilities Planning Board -- now, this gets to, I believe, Senator Susan, I believe it was your question about what's the difference between regulation and certificate of need, and where do you kind of draw the line between what certificate

of need does and what it might do.

And then how do you follow up, I think is another question. If you have sort of provisions, how do you ensure that they're met over the years as opposed to when somebody does, I promise you I'll do it, and then five years later you have no idea what they're doing.

So I guess if you kind of get into this thing, and you're into the safety nets, and you say if you do such and so, we'll let you open or close or whatever, I think you've got to have a way to track it or there's no real accountability to the system. I think that was a very good question that one of you asked, and I would concur with that.

So then this distribution of care across the providers really had to do with inner-city, outer-city, where you're located, where you're providing the care, and how you're funding your safety net.

One thing that's in the literature that I have become a bit more aware of since we wrote this report -- these are policy guys. Now, they don't sit in your chairs, and they've got

different considerations. They're awfully fond of saying, you know, the way to handle the safety-net is not so much the regulation, but it's payment somehow to the safety-net hospital.

In paper after paper, they always end -- they have this little policy discussion. And they say, well, the way to fix this isn't regulation, it's just somehow or other the finance, which I know is very difficult, very complicated, and maybe even impossible at the limit, but it's certainly a goal, I believe.

So we had some comments about the board membership, but I think that -- it was at the time we looked at it, it seemed like the board was kind of small. We thought that -- we thought folks weren't getting paid, and the burden on these guys was pretty high.

We thought that the board might focus its responsibility almost on reviewing new facilities and then monitoring the viability of the safety-net hospitals, which we believe in our report called it the nontraditional way of viewing certificate of need.

So at the end, we had some conclusions,

which by now should be no surprise to you because of my presentation. Traditional roles of CON are not justified by the evidence in our view. CON has little or no impact on unnecessary and excessive capital expenditures and inconclusive evidence on quality. CON may affect market share across providers, again outpatient versus ambulatory surgical for sure, and perhaps in a certain way, safety net and non-safety-net, suburban/inner-city.

Nontraditional rationales for CON deserve consideration, especially in an uncertain world. Safety-net hospitals need protection, although explicit transfers of funds may be more direct policy tools, and again, this business that the literature suggests that as an alternative to regulation.

The relative balance between the potentially harmful effect on community hospitals as opposed to the beneficial effect on competition has yet to be ascertained. Although I must say that the Schneider finding on top of ours kind of is coming back and saying maybe it's the location, maybe it's endogenous, but it does seem as if

certificate of need in and of itself isn't protective of safety-net hospitals, at least in our analysis, and the Schneider one is sort of a variant of our analysis.

That would conclude my remarks. I had some other points, but I really am through with my presentation, so that's my remarks.

MEMBER SCHAPS: Okay. You're suggesting a possible role of monitoring and keeping track of safety-net hospitals. Are there any other states that have that as part of the CON program?

MR. DOBSON: You know, I think Paul's answer was pretty good, and I am not fully expert on that, but I know your state. I know some of the conditions. I know what an issue it is, and I know you probably as a group ought to pay -- I mean, I'm recommending that you pay attention to it.

I don't know what the other guys do, but I'm thinking that you probably should. I mean, that's just my recommendation as an individual, not obviously as the Lewin Group, but the Lewin Group Report said the same thing.

MEMBER RUDDICK: I'm wondering about the measure you've used to access the impact on the safety-net hospitals is just the margin, and just hypothetically, it seems like you could look at some other factors like, do some of them close, or are the safety-net hospitals that are there able to maintain a full range of services, or do they have to get out of a lot of services because of somebody competing, and then those services are no longer available in the community? So broader than just the margin of those that --

MR. DOBSON: We use margin as a proxy. I agree with you completely. The Schneider paper, you're going to think I'm a real geek, but Footnote 17 addresses that issue. In it they say, as near they could tell, this business about quitting the services because you're got a little pressure and you're keeping your margin by dumping all the nonpaying, they seem to think that isn't what happened.

That's one guy and one footnote. We wouldn't take that to the bank, would we, Ken? But nevertheless, it was one person's opinion on what happens there. Yes, Ken.

MEMBER ROBBINS: Maybe to build a little bit on where I think Hal was going and again also expand a little bit.

You make constant reference to safety-net hospitals, which are a very important subset of the delivery system, an essential subset of the delivery system in Illinois.

But I would argue that there is another way of looking at the safety-net that goes beyond a hospital and talks about safety-net services, and that those safety-net services can be found in many communities.

So if you had in Bloomington a Level One trauma hospital that lost money in providing Level One trauma services, but that service was needed in Bloomington, and a specialty hospital came in and decided to do all of the commercially insured cardiac care that is also being provided by this Level One trauma hospital, the loss of that revenue for that cardiac service would endanger the ability of that hospital to continue to serve as a Level One trauma hospital, so that the CON barrier to entry that you describe does more than just deal with the issue of inner-city safety-net

hospitals or rural safety-net hospitals, but the continued existence of safety-net services in areas that you might not normally think of as the home of safety-net hospitals.

Then to kind of build on what I think Hal was saying, is if you do have an inner-city or other traditionally safety-net hospital that is trying to provide a full range of services to its community, one of the characteristics of those hospitals, of course, is that they have a relatively small number of commercially insured patients. They may have a decent number of Medicare patients, but they have a very large number of Medicaid and uncompensated care patients that they provide care to.

If an ASC, for example, a surgery center, were to decide to locate an operation within that safety-net hospital's area, but didn't do very much charity care, if any at all, didn't do very much Medicaid, if any at all, but only did the Medicare, which in Illinois tends to be a higher payer than Medicaid, and did a lot of the commercial insurance patients that are in that area that were going to the hospital, that did

help them support the bottom line that you describe, doesn't that sort of farming out of a core of services that are provided to sort of the very few commercial patients that hospital was seeing, doesn't that begin to jeopardize the financial viability of that safety-net hospital?

MR. DOBSON: You know, your logic is impeccable, and I don't disagree with it, but the Schneider paper doesn't find that across the country with the most recent data. That Footnote 17 really goes to your issue.

I think what -- I'm just guessing what happens here, that if you've got a community that's in tough shape, and they're having trouble supporting that Level Four trauma center, I don't think the specialty guys, at least the big guys, they're not going to go there because they're going where -- let's face it, they're going where the money is.

Where the money is -- Schneider's kind of guess is -- I mean, it's not a guess, it's his conclusion, that where your specialty hospitals tend to be is where the patient flow is, where the populations are growing. Apparently, at least as

of '04 with his data, there's enough dollars to go around.

But if you've got a tough community, and you put another competitor in, and I don't care if it's a community hospital, I don't care if it's a for-profit specialty hospital, it's going to be a tougher community.

I'll just give you some numbers that go to this. They're national numbers. Nationally, you've got roughly 5,000 hospitals, plus or minus. You've got about 3,500 to 4,000 ambulatory surgical centers. You've got about 100 specialty hospitals.

Now, I know if you're in a community that all 100 of them are located in, you'll have a heck of a time running your business; but, you know, the national statistics are probably picking up what they're picking up because where the specialty hospitals are, A, are favored communities in terms of the economics and growing populations. They're not going where, you know, they're not going to make a living starting their hospital, and they seem to be kind of riding the wave of prosperity where they locate.

But you're exactly right, but I would just say there's so much more of the other guys to worry about, the other community hospitals, the inner-cities that are moving out to the suburbs.

If you go to Indianapolis, Indiana, which is a favorite place to talk about, I actually did some side business there. It is total chaos, absolute chaos. Is it specialty hospitals, no, it's not. It's everything.

Now, I don't know how you fix everything, but that seems to be what's going on because the business community hasn't paid attention, the government hasn't paid attention. It's been hands off in that state for many years. In that situation, everything is the threat, you know. It's really hard to even imagine how you fix it.

So I gave you a long-winded answer to it. I agree with you completely. There would be situations where letting another competitor for-profit, specialty, anybody in that community, it would be a hard thing to do for the guy who is there, but in general, it doesn't seem to work out that way. That's the only thing I can say from observation. In general, it doesn't seem to work

out that way.

But in certain instances, it probably has to work out that way, but it's all the competition, not just, you know, picking on a few for-profits or not-for-profits, or specialty hospitals, or the ASCs.

Yes, there's two folks. To the left, way in the back there.

MEMBER BRADY: Two things, and I don't know if you did any interviews with some of those, but one of the things that I've been told through the marketplace is that Ken's fear is relieved to some extent because those folks are equally afraid to go in, run someone out of business, and then they'll be saddled with the whole thing. Have you found that in any interviews?

MR. DOBSON: That's just a version of what I said is that the folks who are investing in specialty hospitals certainly are investing with the prospect of return.

MEMBER BRADY: But what I'm saying is they know they can come in and probably pick it off, make a short-term profit, but in the mid- to long-term run, they run the other guys out of that

business and end up getting theirs.

MEMBER ROBBINS: Well, I think it's less likely that they would run them out of business than it is that the hospital that's providing these high-risk services would decide to drop some of those services.

MEMBER BRADY: That's what I mean, run them out of that business.

MEMBER ROBBINS: I don't think the specialty hospital cares if there's a Level One trauma facility in the community as long as it continues to get its commercially insured cardiac care patients.

MEMBER BRADY: I guess what I hear, talking in the marketplace is they worry about that. That whole picture means that in the mid- or long-term, it's less attractive to them. Is that --

MR. DOBSON: It makes sense to me, but I haven't specifically -- I mean, I've been -- I know that side of the industry pretty well. They do have the long-run in mind, and they do situate themselves in a place where they say we're in business to stay. They're not doing

chicken-and-egg stay. They're doing health care.

MEMBER BRADY: You said Indianapolis is in chaos.

MR. DOBSON: Well, I should be careful with that.

MEMBER BRADY: Does that mean that people go without care, higher rates of care?

MR. DOBSON: Higher rates of increase, extreme competition.

MEMBER BRADY: You said two things that don't necessarily --

MR. DOBSON: I'm sorry?

MEMBER BRADY: Higher rates of what?

MR. DOBSON: Higher rates of care, lots of competition.

MEMBER BRADY: What do you mean higher rates of care?

MR. DOBSON: The utilization rates seem quite high, and they seem to be growing rapidly, and employers are kind of wondering how to fix it, and I think --

MEMBER BRADY: And then higher competition.

MR. DOBSON: Yeah, it's like lots of

competition. It's like unbridled. I think even Adam Smith would say -- did say that there has to be a certain amount of regulation in the marketplace, and maybe that's --

MEMBER BRADY: In some markets.

MR. DOBSON: In that state, maybe you've passed that point where folks just weren't paying attention. That was sort of my observation. It may not be correct, but I talked to a lot of people in the state, and they were really quite fearful that it was a runaway system, and they were trying to figure out how to fix it.

MR. CARVALHO: Al, I think there's a fact you assume that everybody is familiar with, but I'm not sure everybody is, the Dartmouth Economists Study that showed that in some places when you have more providers than average, you actually wind up with higher utilization because it's like -- it's counterintuitive, but nonetheless --

MEMBER LYNE: More MRIs are done.

MR. CARVALHO: Yeah, more MRIs are done where there's more MRI providers, not necessarily because it's a standard of care, but

everybody has to keep their equipment going.

MR. DOBSON: I know, but, you know, the Mark Chassin Study that countered the studies from the folks in New England basically say if you look at the proportion of, and God knows how to determine this, necessary and unnecessary care in high-use areas, it's about the same.

It's like you get more of the good stuff, and you get more stuff you'd rather not have. You get more of all of it. That was Chassin's paper several years ago.

I know the Dartmouth guys don't agree with that, and I was at a two-day conference where he spoke the whole two days about the Dartmouth, you know, Lindberg findings, he and now his son. Of course, they make the point that you made, and other people in the room said not so fast. You've got sick belts in the country where you kind of need the use. You've got growing populations in the country. It's very contentious.

Yes, way back, I'm sorry, were you --

MR. MARAM: So, in effect, you're saying that proliferation doesn't necessarily create induced demand, that the numbers of

facilities doesn't really create an induced demand.

MR. DOBSON: No, I would say that if you have more facilities, by and large you're going to get more care. The issue is whether it's good or not, and does it take Ken's neighboring hospital and put it out of business.

I think those are -- you're going to get more care if you have -- I mean, way back to Romer's law, which we're all familiar -- I guess we're all familiar with it. Basically, the guy said about 50 years ago, I don't know, a long time ago, if you have more hospitals, you get more care.

I think it's hard to argue that if you put a hospital on every street corner, you wouldn't get more care. Which was -- you know, that was the basic premise of CON, but, you know, it didn't work. So it's very curious. You'd think that if you control the supply, you'd control expenditures, but it didn't work. Yes.

CO-CHAIR GARRETT: So you touched on a little bit about the recommendations in the Lewin Report regarding the board members, and I think

specifically in the report it says they should have more expertise.

MR. DOBSON: Yes, it did.

CO-CHAIR GARRETT: Okay. So looking at, I mean, all of this information coming at us, I'm not just asking your opinion, it appears as if the states throughout the country that have the CON process probably have a multitude of different ways in which that process is set up and it operates.

MR. DOBSON: Yes.

CO-CHAIR GARRETT: And it could be that if we kept a CON process, we could modify it. We could -- in talking about the charity care requirements, if we're going to do certain things, we could be very specific in how we deal with the CON process in Illinois.

It seems as if, and I may be wrong on this, that we don't have a clear-cut sort of process in place. We go helter-skelter, and it can be political. It can be corrupt. It can be a bunch of things that nobody really wants to talk about.

But what I want to ask you is that it appears also to me that the staff and the board

are the ones who are the gateway to approving or disapproving or setting the requirements for this.

Do you find in your observations that there is a big difference between how the staff and the board members decide on things and establish criteria and do all of that from state to state?

MR. DOBSON: I really am not an expert on that.

CO-CHAIR GARRETT: Okay.

MR. DOBSON: Paul seemed to be. Is he still --

CO-CHAIR GARRETT: He seemed to focus on Maryland and Virginia.

MR. DOBSON: Yeah, he knows a lot more than I do about this stuff.

CO-CHAIR GARRETT: So I'm just wondering --

MR. DOBSON: No, I do not. I am not an expert in this.

CO-CHAIR GARRETT: Okay. Do you think that makes sense? That if you carefully thought out what you were doing, carefully hand-picked board members, and you understood what the position of the staff and the board members were,

you could actually have something that could work, rather than having something like in Indianapolis?

MR. DOBSON: Yeah, I actually thought a couple of things, and now I'm saying within the confines of the Lewin Report.

We basically said the word "nontraditional" means you're not going to find this in a cookbook somewhere. So we were recommending to you, you're going to have think out of the box a little bit. In order to do that, you're going to have to get people who really understand the industry.

I don't disagree with Ken's statement that you want to look at services as well as safety-net hospitals per se, and you want to protect -- you want to protect both sides of that. I know that's a pretty tall order because nobody in the country has really done it very well.

But I guess we thought it was the right thing, the right question to ask, and I think we could expand it easily to Ken's comments, services as well as facilities.

Then how do you do that? We figure you'd better have some people that understand the issues, and that meant you had to select your

board members pretty carefully, and I think it's up to you folks, as I gather, to select a mandate. This is what we want the board to do. Here's the general parameters. You get people that understand the issues and away we go.

I don't want to be flip, but, I mean, I don't know how else to say it.

CO-CHAIR GARRETT: Right.

MR. DOBSON: Except that I think your thinking is just -- or ours was, you've got to have a mandate. That's for sure. We're thinking the traditional mandate just doesn't seem to be all that helpful, but there are things that need to be done in your state, and we thought a very knowledgeable board with a streamlined process might be helpful to do it.

CO-CHAIR GARRETT: Because when you don't have a knowledgeable board, then really what you're setting up is a staff to make the decisions and the recommendations, and that may be fine, and it may be that way in other states, but then why have a board, almost to kind of be the buffer.

MR. DOBSON: Yeah, I think the board is a buffer between --

CO-CHAIR GARRETT: Yes.

MR. DOBSON: -- all sorts of -- all sorts of --

CO-CHAIR GARRETT: Right. I agree with the report that how knowledgeable, at least in the past, it's been. That doesn't mean they aren't now. I mean, just looking at if they're political, but enough of that.

CO-CHAIR DUGAN: I have a question on cost, and I don't even know if you can answer this, but as I look at what we say is the CON and the non-CON, there's really not much of a difference in cost.

When we looked at that study or when we did the study, did it take into account, because, of course, I just found this out recently in the last year-and-a-half about this, did it take into account insurance companies and negotiated rates and all of that type of thing in both profit and nonprofit and safety-net hospitals?

MR. DOBSON: This is going way back now. It's a quite distant memory, but we at Lewin did a study for a Midwestern state. I think it was one of the last big comprehensive studies done

on CON, and we had everything we could think of factored into the regression equation.

We used the Herfindahl Index, which is, you know, a geek's measure of competition that the FTC uses. We had supply, we had this, and we had that. As near as we could tell, after we adjusted for those kinds of issues -- and this is like 10 years ago minimum at some point in my recollection because I remember I reviewed the final paper before it went out.

We tried to adjust for, just as the Schneider paper does, tries to adjust for all those, we call them, co-variants that might affect the outcome. You're never really going to get past this business about endogeneity; that is to say, if you get things to happen in certain states, it may be because of all kinds of reasons, and the thing you're looking at isn't what's driving it. It's things you can't see. But we tried to adjust for endogeneity as best we could.

Our answer was it doesn't look to us like CON controls cost much. Other people did different kinds of things. Frank Sloan is one of the best health service researchers in the

country, and he did a follow-on study. His study was comparable in spirit, and he didn't see that it made a lot of difference when you gave it up as opposed to whether you had a certificate of need.

So we tried to do that, but, you know, there's things which -- you just can't measure certain things, and econometricians, at the end of the day, have to admit their failings on. You do the best you can. You find consistent results.

That's why I was kind of excited as a researcher to find that somebody else had replicated the counterintuitive findings that we found, you know, working for you. Yes.

MR. MARAM: Inasmuch as the market forces don't really apply to the consumer-driven choices because most people have health insurance often, and they're not making a major decision on whether to take a test or not as much as somebody without those insurance values.

Do you see it as more of a utility regulation, or are you saying that even without the market forces, it doesn't seem to matter? The individuals aren't really seeing the cost of health care when they go to the doctors.

MR. DOBSON: Well, maybe that's why we didn't find any differences between CON and non-CON states because the overwhelming thing that's going on here is the way health care is financed, and the regulatory powers weren't even remotely strong enough to overcome the fact that we have third-party, we call them, moral hazard, if you have insurance, you get more than you otherwise would.

Those features in our health care system may be so powerful that it was really, you know, fighting against a very strong wind with the CON. That's speculation on my part, but I think your observation is exactly right. Health care is different. The way we fund it is different, and the regulatory things we put upon it are different. Sometimes they work, but oftentimes they don't. Yes.

MR. RUDDICK: Going back to the counterintuitive table --

MR. DOBSON: Yes.

MR. RUDDICK: -- that we spent so much time talking about. So one of the things I heard you mention was it's hard to come up with a

definition of what a safety-net hospital is, so you took one at 25 percent Medicaid expenditures.

MR. DOBSON: We did that for empirical reasons. We couldn't go into a book somewhere and find for every hospital in the country where there was safety-net. If we had spent a jillion dollars, ask Ken, I bet we could have figured it out, but we didn't have a jillion dollars of your money, and Ken wasn't on my rolodex that day.

So we took what we thought was a reasonable proxy, and that was 25 percent of Medicaid. I understand that's -- Sister Sheila, you probably would find a little shortcoming in that, but, you know, as a proxy, over the years if you've got a lot of Medicaid, you've got things that are co-variant with that. So we figured it was a reasonable proxy, it's not the best, of course, but it's what we had -- I'm sorry? Does that seem reasonable?

MEMBER LYNE: It seems too low to me.

MR. DOBSON: Yeah. Well, you would have gone higher than a quarter.

MEMBER SCHAPS: Well, you didn't say it was uncompensated care; is that correct?

MR. DOBSON: We couldn't find it in the statistics because Medicare doesn't record it. They're starting to, but it just isn't coming in good yet, so we couldn't use it. That would have been our first choice. You got it.

MEMBER SCHAPS: Exactly. Right.

MEMBER RUDDICK: So that was kind of my follow-on question was, did you experiment, because you said you looked at that table like 10 times, did you plug in different definitions and see whether the data changed?

MR. DOBSON: It wasn't that so much as I was just a little concerned my guys messed up the files because when you get a result like that, you're back to those programmers over and over and over again until you've totally exhausted every question that you and three or four other guys could ask, and we kept getting the same thing.

But we didn't really -- they may have worked a little -- I don't recall whether we tried different thresholds. I was more concerned about the basic result. I just wanted to make sure that if somebody else were to do it, they would find the same thing we did, and fortunately somebody --

or unfortunately, somebody did come along and found about the same result we did in a different study.

MEMBER ROBBINS: That was a national calculation?

MR. DOBSON: Yes, it was.

MEMBER ROBBINS: Did you try at all even using your same definition to look at Illinois?

MR. DOBSON: We did not.

MEMBER ROBBINS: So we don't know whether there's anything unusual about Illinois that make that number larger or smaller.

MR. DOBSON: The thing of it is, these models break down, as you well know, Ken, because you've looked at hundreds of them in your career, they break down pretty badly when you get fewer observations. We kept our stuff pretty much at the national level. We were having trouble enough making our numbers that we were comfortable with, and using all the data in the country, as opposed to -- I know you've got a lot of hospitals in the state, but we were nervous about a state-level analysis. Yes.

MEMBER BRADY: We're back three years or more in that order?

MR. DOBSON: Three?

MEMBER BRADY: Three years or more in that order, and you were to evaluate the effect in states that did away with the CON on safety-net?

MR. DOBSON: That was -- the Sloan study was 1998. So that meant his data were probably a few years earlier than that.

MEMBER BRADY: Yeah, but if you were to say, okay, in every state that did away with the CON, three or more years.

MR. DOBSON: Oh, I see what you're saying.

MEMBER BRADY: And then start three years ago because there really wouldn't be -- it would probably take at least three years before the elimination of CON would have an effect.

MR. DOBSON: That's true.

MEMBER BRADY: So if you did that and you went in that order, do you have any evidence on the effect those states had on safety-net?

MR. DOBSON: No, we do not.

MEMBER BRADY: What would it take to

get that?

MR. DOBSON: I mean, the guys -- we could probably -- I don't know. That's a question -- I can't answer it off the top of my head.

I mean, if we were to take the data we had, the Lewin folks had, that's not me now, the Lewin folks had, and we were asked the question differently and to block the data differently, aggregate it differently, it shouldn't take that long, assuming they kept the files and all.

Then we'd have to really understand your question a little bit better than I just understood it, but I think I get the drift of it.

I think we used those states that currently have CON and those that don't, and I think the thing unwound, Paul, didn't it, about 10 years -- in the Reagan administration was when the major breaks took place.

MR. PARKER: Yeah, we had about 11 repealed CONs in the five years after the end of the National Health Planning and Resources Development Act, and then we had a number of years where no one repealed, and then we had

Pennsylvania, Ohio, and Indiana in the 90s.

MR. DOBSON: See, so you kind of need that in your criteria because these states have been out of the business of CON for a long time. So I think our study kind of met your criteria just the way we did it because there's such a long lag between when they quit and the current data, that you've got that three years in there.

CO-CHAIR GARRETT: Okay. Are we --

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

Kurt DeWeese here in Springfield. In terms of your basic conclusion about CON has little or no impact on unnecessary capital expenditures, I guess I have kind of an intuitive concern about whether or not we really -- whether the process itself really has much to do with denying those types of expenditures, because essentially, people bring projects to this process that they know are going to be approved.

I mean, they essentially tailor their applications, and they go in knowing what the criteria are, and so the likelihood of them being disapproved or their projects being modified

really doesn't show the sort of effect of the process.

You may have some denials. You may have some modifications, but essentially, people are bringing projects to the board that are going to probably meet the criteria.

MR. DOBSON: In my comments, I note at the top on the data effect, and we did pick up in our interviews what you have said, of course, but we also pick up the notion that when you have certificate of need, and people take it seriously, as to a certain level in this state it was, then a lot of folks just don't bother to come forward because they know they're going to get turned down anyway.

You get into some interesting discussions, as we got into with some of our interviewees, that, well, if you didn't have certificate of need, it may be the same result anyway because as your four guys that wanted to go to the suburbs awhile ago, they kind of stare each other down, and maybe only one of them or a couple of them say they're really going to do it, and the other guys back out, or maybe all four come forward,

Indiana-like maybe, or maybe only one.

It's hard to tell, you know, whether all four are going to come forward in your example, or they're going to kind of sort it out themselves and say, gee, there's only so much cardiology we can do there, only a couple of us are going. You do get the bad result, all four come sometimes, but by and large maybe people sort themselves out.

In answer to your question directly, I think that your certificate of need -- you're right, it's 92 percent approval, but you're probably getting folks that don't apply, and you would think that that would be restrictive, but the data suggests that it's not over the country over the years. It just hasn't seemed to have done that much, any of it restrictive on the actual deals where the guys that didn't come forward -- on the data factor.

CO-CHAIR GARRETT: I'm just trying to keep everybody in line with our schedule. So unless there are any other questions, thank you very much, Mr. Dobson.

Maybe what we should do, since the food is here, grab a sandwich and a drink and then hear