S54330

TASK FORCE ON
HEALTH PLANNING REFORM

REPORT OF PROCEEDINGS had of the above-entitled matter before the Task Force on Health Planning Reform at the Thompson Center, 100 West Randolph, Chicago, Illinois, on the 10th day of March, A.D. 2008, at the hour of 9:21 o'clock a.m.

MEMBERS PRESENT:
SENATOR SUSAN GARRETT, Co-Chair,
REPRESENTATIVE LISA DUGAN, Co-Chair,
SENATOR PAMELA ALTHOFF, Member,
MR. GARY BARNETT, Member,
SENATOR BILL BRADY, Member,
MR. PAUL GAYNOR, Member,
SISTER SHEILA LYNE, Member,
MS. HEATHER O'DONNELL, Member,
MR. KENNETH ROBBINS, Member,
MR. HAL RUDDICK, Member, and
MS. MARGIE SCHAPS, Member,

EX-OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO,

MR. BARRY MARAM, and

MR. JEFFREY MARK.

ALSO PRESENT:

MR. KURT DE WEESE, Legislative Staff, in Springfield.

CO-CHAIR GARRETT: Okay. We are ready to start. I'd like to welcome everybody.

CO-CHAIR DUGAN: Yes, welcome.

CO-CHAIR GARRETT: We are looking for our agenda. We're going to try to move along quickly to stay on task.

Before we approve the minutes, can we start at the end of the line and have everybody here introduce themselves? I can't see your name tags.

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

CO-CHAIR GARRETT: Would you mind talking really loud?

MEMBER ROBBINS: Ken Robbins, Illinois Hospital Association.

MEMBER RUDDICK: Hal Ruddick, SEIU.

MEMBER LYNE: Sister Sheila Lyne, Mercy Hospital, Chicago.

MEMBER O'DONNELL: Heather O'Donnell, Center for Tax and Budget Accountability.

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

MEMBER GAYNOR: Paul Gaynor, Illinois Attorney.

SPRINGFIELD: Chicago, this is Springfield. We just lost your audio.

CO-CHAIR DUGAN: Representative Lisa Dugan. I'm sorry?

SPRINGFIELD: Check that the microphone isn't muted and that the cables are all still plugged in.

CO-CHAIR DUGAN: Can you hear us now?

MEMBER ALTHOFF: State Senator Pam Althoff.

SPRINGFIELD: Now, we got you. Thank you.

CO-CHAIR DUGAN: State Representative Lisa Dugan.

CO-CHAIR GARRETT: State Senator Susan Garrett.

I know that Representative Lang is coming to be part of the conversation over the phone. So he's probably trying to dial in as we speak.

I see that there are lots of materials here for us, not very organized the way they delivered them, but nonetheless we have information as we sit here.

As I'm looking at this agenda, I just want

to make sure -- I'm not sure -- we have a recommendation for an ethics officer. Yes. Okay.

I think we need to approve the -- well, we also had changes in the January 31st meeting minutes, and I don't see that on the agenda, and I asked that it be on the agenda because we made changes to the January 31st.

Dave.

MR. CARVALHO: They've been distributed. It doesn't need to be on the agenda, unless someone thinks that there is a mistake on them.

CO-CHAIR GARRETT: Okay. We had made changes, but we don't have to approve these minutes --

MR. CARVALHO: No.

CO-CHAIR GARRETT: -- the amended minutes. Then is there --

MEMBER ROBBINS: Excuse me, Madame Chairman.

CO-CHAIR GARRETT: Yes.

MEMBER ROBBINS: I don't want to beat a dead horse, so I'll just make the observation.

CO-CHAIR GARRETT: That's what we're

here to do.

MEMBER ROBBINS: In the minutes, and I think it's the minutes of the 1/31 meeting --

CO-CHAIR GARRETT: Yeah.

MEMBER ROBBINS: -- it changed --

CO-CHAIR GARRETT: Right.

MEMBER ROBBINS: -- reference Point 5 on Page 1, I didn't think captured what I thought we had said an interim report on May 1st was about.

CO-CHAIR GARRETT: Do you want to read specifically what it said?

MEMBER ROBBINS: It says, "The task force discussed targeting May 1, 2008, as a date for interim recommendations and tasked Kurt DeWeese to present a proposal at the next meeting."

I think what Kurt presented, very appropriately, was a timing discussion.

CO-CHAIR GARRETT: Right.

MEMBER ROBBINS: But I think we had said that by May 1st, we would see if there were any interim substantive recommendations --

CO-CHAIR GARRETT: Right.

MEMBER ROBBINS: -- that ought to be made.

CO-CHAIR GARRETT: That we can review.

MEMBER ROBBINS: If that's the understanding, I don't need any changes.

CO-CHAIR GARRETT: I think so, and I think that Kurt actually -- I don't know who.

CO-CHAIR DUGAN: It may be --

CO-CHAIR GARRETT: Yeah, it's in the actual body of the minutes, the legislation, which should sort of supersede the implication that we do want to change it in the minutes.

MEMBER ROBBINS: One of the things I thought we had talked about as a possibility was perhaps we want to look and see whether it was important to do things like increase the size of the board before we reached the end of the report.

If there were things like of a substantive nature, I thought we had set ourselves a sort of May 1st deadline to decide whether or not that type of thing would be done, and I don't think that this captured -- and Kurt's report I thought was on another very important thing, which was the timing.

CO-CHAIR DUGAN: And I think the way that Kurt addressed it was within the February 11th where we did the legislation that says as may be necessary at any time, but the final report shall be November.

Because in the February 11th -- and I think that's how we addressed it because there was so much concern about whether or not if there was something that we wanted to do prior, that we all agree. So "as may be necessary" is I think how we finally decided to address that, and that's how we got it in the legislation also.

CO-CHAIR GARRETT: But I think what he's saying is the contradiction; right?

MEMBER ROBBINS: As I said, I really don't want to beat a dead horse.

CO-CHAIR GARRETT: Right.

MEMBER ROBBINS: If there's a sort of general agreement that we have the option to make earlier interim recommendations --

CO-CHAIR DUGAN: Right, and I think there is.

MEMBER ROBBINS: -- I'll let that go.

CO-CHAIR GARRETT: Okay. So we'll

leave the January 31st meeting minutes alone, and is there a motion to approve the February 11th meeting minutes?

MEMBER ALTHOFF: So moved.

CO-CHAIR GARRETT: So moved. Is there a second?

CO-CHAIR DUGAN: Second.

CO-CHAIR GARRETT: All right. Then we have approved the minutes.

Now, have you received the resume? I don't know if it's in this. We have a recommendation for an ethics officer, Mike Luke.

I don't know, Dave, did you include a resume or anything?

MR. CARVALHO: That's the first time I've heard his name, so no, I don't --

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: I did not get the resume.

CO-CHAIR GARRETT: Well, I'm going to pass along the resume that was sent to me. Mike is associated with the Attorney General's Office. We were looking for more of an independent ethics officer, and this is especially important, I

think, when it comes to ex-parte and the Open Meetings Act that we, in fact, have somebody who has this type of background and experience.

So I know this is -- you can quickly take a look through here. Is Mike here?

MEMBER GAYNOR: He actually works out of our Springfield office.

CO-CHAIR GARRETT: Okay.

MEMBER GAYNOR: And he is our office's ethics officer.

CO-CHAIR GARRETT: Okay.

MEMBER GAYNOR: At the first meeting, you may recall that there was discussion about someone from our office. He is our ethics officer, so I asked him. He is willing to serve.

CO-CHAIR GARRETT: So is there any discussion on recommending Michael Luke to be our official ethics officer?

MEMBER LYNE: I move we recommend him.

CO-CHAIR GARRETT: Okay. Is there a second on that?

MEMBER SCHAPS: Second.

CO-CHAIR GARRETT: With that then, I think we have consensus that Michael Luke will be

our official ethics officer.

I think the best way to work through this is if anybody has questions, to either contact Representative Dugan or myself, and then we will sort of help facilitate that rather than going directly to him. So then we will have some oversight on that, making sure we're aware of what the issue may be. Is that okay?

Okay. I think we're ready to go with Paul Parker from the American Health Planning Association, who is going to give us a national review of the health facilities planning boards in other states.

MR. PARKER: Good morning.

CO-CHAIR GARRETT: I guess Lisa is telling me, in our folder, we have a copy of the PowerPoint. Okay.

Welcome, Paul.

MR. PARKER: Thank you. I'm here representing the American Health Planning Association. I'm on the board of directors of that association. I might let you know, too, that I am also the chief for hospital services policy and planning and the chief of the certificate of

need program for the State of Maryland. It's called the Maryland Health Care Commission.

I'd like to cover the history of State health planning and certificate of need very briefly. I know some of you probably know a little bit about the background of how our current health planning and CON programs have evolved.

CO-CHAIR GARRETT: Can you speak louder? Can you guys hear back there? Okay.

MR. PARKER: Then I'm going to talk about the current status of certificate of need programs in the country, what some of the broad recent trends have been, and how CON programs have changed, and briefly touch on some of the unresolved questions. I know that everything seems to be unresolved when you study CON, and unfortunately, I'm going to do some more of that for you.

From the 1940s to 1960s is when we actually started seeing the first medical facilities planning activity in this country on a voluntary basis. Usually in the bigger cities of the United States, when you had United Way and Community Chest type organizations starting to fund hospital

capital development, and the need was perceived in cities and in regions to do some coordinated planning on capacity to satisfy the accountability that was demanded by some of those public funding efforts and community funding efforts.

The Hospital Survey and Construction Act, Hill-Burton, right after World War II, was kind of a consolation prize. When Harry Truman didn't get national health insurance, we got the first program where the federal government was actually providing serious money for building hospitals and other types of health care facilities in the United States; and along with this federal money, requirements came for states to actually for the first time start doing systematic inventories of their facilities, doing some capacity needs assessment, and planning.

1966 to 1973, regionalization, the concept of regionalization got a push from the federal government through the Regional Medical Programs Act. This was really focused on the three big causes of death: heart disease, cancer, and stroke; and the concept was the federal government should facilitate and to some extent fund the

development of regional centers for research, education, and clinical care that would then be networked with community-level hospitals to improve the type of care being provided in these three disease areas.

Then in the late 1960s, the comprehensive health planning program of the federal government, this was not regulatory, but it was federal money to state agencies called the A Agencies to do comprehensive health planning.

The idea here was we needed to move beyond the strict medical facilities type of planning that was done in the Hill-Burton plans and really look at health in a more comprehensive way, look at the entire range of issues in factors in health status, manpower issues, environmental issues, and place facilities planning in the context of comprehensive health plans.

There was also funding for the B Agencies, which were regional health planning agencies that fed their work up to the state.

Also during this period, we were seeing the establishment of state CON programs. Actually, I think the first was in New York a little before

1967, 1964; but during this period, we see a number of states adopting certificate of need programs to try to regulate capital spending by health facilities, and we had about 25 states develop certificate of need programs before they were mandated by the federal government, which we'll get to in a minute.

Also during this same period, we see amendments to the Social Security Act where the federal government is basically saying we want to regulate capital payments for facilities, and so their funding state agencies, which ended up for the most part being these A Agencies that were funded in the comprehensive health planning legislation, to actually review and approve capital projects by health care facilities; and without those approvals, the Medicare program was withholding depreciation and interest, reimbursement, you know, for the for-profit facilities, also withholding return on equity payments.

1974 to 1986, the National Health Planning and Resources Development Act, building on the comprehensive health planning legislation of the

60s, much increased funding for state health planning and development agencies; and for regional health systems agencies, this legislation created over 200 regional health planning agencies.

This built on comprehensive health planning by also adding regulatory teeth. It mandated that all states develop certificate of need programs, and as I said, about half of them already had by this time. If you didn't, they were going to withhold various types of federal health funding.

That national planning effort did not last very long. It died in the Reagan administration in the 1980s. The mandate for CON ended, I think in 1982, and I think the law was actually repealed, I believe, in 1984.

So after the gas ran out of federal efforts for promoting health planning and certificate of need regulation, what we've seen since that time is continuation in most states of health planning and CON regulation. A very limited number of regions, I think there are four states that still have some types of regional health planning agencies that get involved with their states.

I'll focus a little bit on these last two bits of history. As I said, federal funding of state health planning and development agencies under the National Health Planning and Resources Development Act, so this was really the federal law that really set the framework for state health planning and CON that still continues today in most states.

The federal funding of regional health systems agencies, mandated comprehensive state health plans, and these were based on national guidelines. When we talk about why this federal effort didn't last very long, I think this is one of the reasons. The national guidelines were very controversial, basically setting quantitative standards that they wanted states to adopt in their state health plans.

So there was a lot of consternation that the federal government was being -- while it was setting up state and regional planning, it was also being extremely prescriptive about how that planning should take place.

Again, we mentioned that most states -- or not most states, but about half the states had

certificate of need programs before that, and they were mandated under this law. Actually, I said repealed in '84. Here, I've got repealed in '86, so hopefully that's the right date.

So post-P.L. 93-641, 11 states eliminated CON programs fairly quickly after the demise of the federal legislation in 1984 to 1989, and there's a map coming up here where you can kind of see the pattern that developed here.

Three states eliminated CON programs between 1995 and 1997. We actually had a couple of states, Indiana and Wisconsin, who eliminated CON, revived it. Indiana has since repealed it for a second time. Wisconsin's program is now, I believe, limited to pretty much regulating nursing home programs.

Then outside the continental United States, we have -- well, D.C. is in the continental United States. We also have programs in Puerto Rico and the Virgin Islands.

Here is the current pattern with the colored states being the states that still retain some type of CON program. As you can see, east of the Mississippi River, we've only had Indiana and

Pennsylvania that eliminated CON.

The great plains states, for the most part, got rid of it. Two big states, California and Texas, were early repealers of CON.

Current status, 36 states and the District of Columbia have CON programs. Of those, seven states limit their CON regulation to long-term care, nursing homes, chronic hospitals, or long-term care hospitals, and/or home health care and hospice services.

29 states regulate hospital and acute medical care facilities to varying degrees, so a more comprehensive scope of regulation in most states that still retain CON.

27 states control the establishment and expansion of ambulatory surgical facilities. 25 states continue to regulate some types of major medical equipment projects.

Most states require review of certain types of medical care facility and service projects regardless of what the cost of those projects are, but most states also employ as part of their scope of CON project capital expenditure levels and use those as one factor defining the need for projects

to obtain a CON.

To characterize certificate of need regulation, I'm kind of going to go through some slides here that indicate what the most common features are.

Most CON programs regulate the establishment of hospitals; nursing homes; intermediate care facilities for the mentally retarded; ambulatory surgical facilities; high-end diagnostic imaging facilities, positron emission tomography, magnetic resonance, computed tomography; radiation therapy facilities; and still renal dialysis facilities.

It's also common for the introduction of services to existing facilities as new services to be regulated. On the hospital side, kind of the planner-defined discrete inpatient services, such as pediatrics, obstetrics, psych, substance abuse, medical rehabilitation, neonatal intensive care, nursing home services, introducing cardiac surgery or cardiac catheterization, especially therapeutic, cardiac catheterization angioplasty regulated in most states, organ transplantation, again, introduction of the high-end diagnostic imaging services, although certainly MRI and CT

have become more standardized in the hospital setting, radiation therapy, renal dialysis and swing beds. Those are hospital beds that can be used part-time for acute care and part-time as nursing home or long-term care beds.

Then expanding capacities, even if you have the service, but you're expanding the capacity to deliver that service. For some things, that's fairly common. In the scope of CON regulation, hospital beds and nursing home beds fall into this category, operating room capacity, again cardiac catherization lab capacity, the diagnostic imaging units, the expensive ones and radiation therapy, linear accelerators, gamma knifes.

Then this slide shows a few things that are less common, but you still see it in a considerable number of states. Home health and hospice services being regulated under certificate of need, lithotripsy, assisted living facilities, especially when you have Medicaid participating in paying for those types of facilities, air ambulance services, ultrasound, burn care units.

Capital spending thresholds used in CON, currently, they range from -- and that's not one

dollar, that's supposed to be $1 million to $15 million. The national median is approximately $2.3 million dollars.

They usually come into play in CON regulation for health facility renovation and modernization projects. They aren't usually applicable to bed expansion or new service projects. In other words, there's a discrete definition of projects that require CON no matter what their capital cost.

So the capital spending thresholds kind of come into play as kind of a backstop. If you're not doing something that specifically requires a certificate of need because of the nature of the project, but it costs a lot or it costs above whatever your threshold is, then you need a CON anyway.

A lot of states have distinct equipment spending thresholds as opposed to facility expansion or renovation or, you know, building project thresholds. These range up to $6.7 million. The median is approximately $1.4 million. There is a lot of nuance that, you know, we really can't get into here in how these are

used from state to state. So I'm just trying to give you kind of a broad overview.

Recent trends in certificate of need regulation, I think it's fair to say that certificate of need has always generated kind of broad levels of dissatisfaction ever since it's been around for the last 30 years.

I think to some extent that reflects the general dissatisfaction with health care cost and health care access and health care insurance issues that's there in the body politic, and certificate of need tends to be something that, you know, often becomes episodically quite visible in states.

It's something that the state is trying to do, and most people, you know, immediately say, well, this is about containing health care costs. That's what CON is all about. So I think that's where that broad dissatisfaction arises.

On the other hand, I think when you look at the history of the last, you know, 20 years especially, since the federal impetus for health planning dissipated, in most states it's not, you know, a huge flash point. There has been quite a

bit of stability in CON regulation and quite a bit of, you know, kind of noncontroversial gradual evolution of these programs as they've matured and incremental changes.

Then you have a few states where it just seems to be, you know, a big battle year after year. Do we keep it? Do we get rid of it? Do we make big reforms? Do we make small reforms? There's several states where you certainly see that pattern.

I think broadly speaking, I think it's fair to say that we have seen incremental reductions in the scope of regulation over the last 20 years. You know, the number of types of projects and the types of services that require a CON for the most part have been more and more limited over time, and obviously, because of inflation, we've seen incremental increases in the capital spending thresholds that certificate of need programs use.

A lot of times, you know, when states make what looks like a big jump going from $1 million or $2 million to $5 million or $10 million, but what they actually find is it really doesn't change the level of CON activity to a large extent

because they're not capturing -- they're not seeing those smaller types of -- those smaller types of capital expenditures being regulated in the first place.

I should have put something else on this slide because I think it's important to recognize that CON is guided by some sort of state health plan or state medical facilities planning effort. There have to be some sort of standards or guidelines that are used to make these decisions on capital projects.

MEMBER DUGAN: Hold on just for a second. Whoever is on the conference call, can you mute your phone because we keep hearing it out here?

Okay. Sorry.

MR. PARKER: The point I was about to make is that another very broad trend we've seen is that states have really moved away from the concept of comprehensive health plans or very broad state health plans, which was something that the federal programs of the 60s and 70s mandated, and are now typically using what might be referred to as state medical facilities plans or really --

really not plans, really more like, you know, project review standards that are typically adopted in state regulation and are very much focused on certificate of need regulation.

They're not placing medical facilities regulation in some sort of broad context of what are the health status issues and what are the broad scope of health-related issues in this state.

They tend to be very much focused on for this particular category of project, what are the appropriate standards to apply in assessing need and looking at accessibility to this particular facility or service and looking at what cost effectiveness means in delivery of this particular type of service. So that's something I probably should have put on this slide.

In substitution of certificate of need with other regulatory regimes, moratoria, probably not so much in the last 10 years, but certainly before that we did see a lot of states kind of taking a breather from certificate of need as project review and saying, well, for this category of project, we're just going to not let anybody do it

for a while.

I think in many cases this can be viewed as, you know, a failure of effective planning in those programs. This is very common, just a very common feature in the 80s, and I think through the 90s in controlling nursing home bed supply in a number of states.

Again, I think it was -- it came from a perception that state CON programs were allowing overbuilding of nursing home capacity during an era when we did see nursing home use rates decline, and the CON programs weren't picking up on that trend quickly enough.

Licensure as a substitute for CON, this is something that has gotten a lot of discussion, although we don't think we have really good models of how licensure could be reformed to achieve some of the same types of objectives that we might want to try to achieve with CON.

Medical facilities licensure in most states is very much focused on minimal standards as far as what types of facilities you need to have, what type of minimum staffing levels you have to have, what sort of minimum set of process

characteristics you have to have in delivering medical facilities care; and it is not something that historically has been used to control supply or to really be used as a way of regulating the quality of care.

In other words, you know, kind of the idea of issuing licensures and saying, okay, you're now going to be held accountable with this license to achieve certain outcomes or certain levels of quality that we're going to measure; and if you don't achieve them, we're going to yank your license, and you're going to have to eliminate the program.

That's what a lot of people kind of talk about is, hey, why can't we do that with licensure? Get rid of CON, and since we're already doing medical facilities licensure, and no one is proposing getting rid of that, maybe licensure can kind of reform itself to pick up on some of those areas; but it's a radically different approach to medical facilities licensure than what we've seen.

These last couple of things I'm putting in here, lotteries, fraud and abuse oversight, I put

those in because we're -- in Maryland -- Maryland is a state that I would say is one of the states where we don't have CON -- a perennial CON debate, but we do have a perennial CON debate about home health care. Why are we still regulating home health care? Most states don't. In Maryland, we do.

This is an area where it clearly makes a difference. Maryland has 50 home health agencies, and a population of about 5-1/2 million. If you go across the river to Virginia, where they stopped regulating home health under CON in the 1980s, that's a state that has about 6-1/2 million people, and it has about 300 home health agencies.

What you see in a lot of states is such a chaotic situation in home health right now with so many people entering the business, that the ability of licensure programs to keep up with any sort of reasonable oversight of what's going on with these facilities, it just isn't happening.

The debate that we're having in Maryland now is, you know, if we get rid of CON, and there's a lot of support for that, what do we need to do in terms of licensure? Because we're fully

expecting, and we have some real sense of this because we occasionally open up a jurisdiction for new agencies, and we get a flood of applications. It's a three-ring circus in terms of trying to, you know, actually come to decisions among the large group of people who want to enter these areas.

There's going to have to be a lot more inspectors hired for licensure, and we're assuming we're going to have to really start doing some fraud and abuse oversight. Because this is a problem in states in the home health care area that a lot of states are grappling with right now.

And the lottery, Florida actually -- the idea is currently being discussed in Florida of let's have a lottery. So we're actually going to control the growth and the number of people who can get into the home health care business simply by having everyone buy a ticket, and we're going to basically say, okay, this is how many new ones we're going to have in the state right now, and we're going to pull them out of a jar. So you didn't win this year, but, you know, come back next year, and you can take a shot.

Obviously, you know, I think there's going to have to be some minimum kind of entry requirements met to get into the lottery, but I kind of like the idea. I'm pushing it in Maryland.

Unresolved questions, I think these two questions are probably going to be familiar to maybe some of you who have looked at the studies that have been done recently in Illinois. Is CON regulation effective or beneficial? What are the true costs of CON regulation?

You know, we've had academic reports, consultant reports, some empirical analyses, although most of those are pretty dated, and we've had the Federal Trade Commission weigh in on CON most recently in 2004, and what is the consensus?

I think the Lewin Report that you've had done, and I guess you're going to hear more about today, does I think represent a fairly good overview of what the consensus of these studies have been. There isn't good evidence that CON regulation broadly controls health care costs. There's some limited evidence that it probably does have a beneficial effect on quality for some

specific types of services.

It clearly has an impact on kind of the pattern of health facilities development that we see, you know, I just mentioned the home health example, in ambulatory surgery, in a number of cardiac surgery programs, certainly in the number of specialty hospitals, in nursing home bed capacity.

I think there's fairly strong evidence that CON regulation does alter the pattern of development that we see for specific types of services, but I don't think there's strong consensus among the analyses.

Some of the reports, many of the reports that you see in recent years are certainly not coming from disinterested parties, and I think there are some exaggerated claims as far as what the true cost is of CON regulation. So the policymaker's quandary is, you know, who and what to believe.

From the American Health Planning Association's perspective, we think that some of these studies are fairly problematic in terms of the reliability of some of the data that's being

used.

From my experience, I'm always trying to look at states that don't have CON and compare them with states that do have CON, especially my mid-Atlantic states that surround me in Maryland.

One of the problems is that states that got rid of CON for the most part got rid of data collection, too. You really can't even ask some fundamental questions to get at what the pattern of development has been for some of the typical services that were regulated under CON in these states.

Even states that have, that are giving you some data on numbers in terms of inventory and utilization of facilities, you really have to drill down in many cases and make a lot of compromises in terms of trying to get comparable datasets to do a good analysis.

Unfortunately, and maybe kind of remarkably since we've had so many planning and CON regulatory programs for so many years, data is tough. We don't think that we necessarily have good quantitative tools to do the analysis, and we don't think the right questions are always being

asked.

You can try to do fairly, you know, broad-based analyses that I think do give you some answers on some of the questions, but we don't think enough of these studies are really looking at, you know, the areas where we clearly see differences in the pattern of development among states that have CON versus states that don't have CON or have different types of CON regimes and really drilling down on, okay, well, what does it mean that, you know, all these specialty hospitals have been developed in states that don't have CON? What difference is that making in terms of cost, quality of care, access to care?

MEMBER O'DONNELL: I have a quick question. Sorry to interrupt.

MR. PARKER: Go ahead.

MEMBER O'DONNELL: Are you saying that there are no good reports in states that have done away with CON to show what the effects have been?

MR. PARKER: In states that have done away with CON, so a state report that's kind of looking at, okay, we got rid of CON, and here's what happened.

MEMBER O'DONNELL: What are the consequences to safety-net hospitals, on health care costs? I mean, it's on, I think it's Slide 9, there are several states that no longer have CON.

MR. PARKER: Right.

MEMBER GAYNOR: Including California and Texas.

MEMBER O'DONNELL: And Texas that are huge states. So I was just wondering if there has been -- I would imagine studies have been done sort of comparing before and after, what the consequences are, good or bad.

MR. PARKER: I am not aware of a study, a before-and-after study for California or Texas or actually any state that has repealed CON that focuses specifically on before and after.

There have been studies I've seen that look at what happened in those states after CON in terms of facilities development.

MEMBER O'DONNELL: Can you tell me about those, or is that something on your --

MR. PARKER: In Texas they had a huge building program for nursing home beds in the

mid-1980s after they got rid of that, and so Texas imposed a moratorium for a long time on Medicaid certification of nursing home beds. They actually let you build nursing home beds in Texas with a moratorium, but you couldn't be certified for Medicaid, which essentially meant that very few nursing homes were built.

Ohio, which is one of the more recent states that got rid of CON, there has been some studies there. It hasn't been nursing homes, but ambulatory surgery and imaging centers.

I was actually a CON director in Virginia before Maryland. I'm moving my way up the East Coast. In 1991 when I started working there, Virginia was sunsetting CON regulation and was actually entering the third year of a three-year phase-out of all CON regulation with the exception of nursing home beds.

CO-CHAIR GARRETT: Isn't it just the opposite for us? We don't have any real oversight on the long-term care approach. They don't have to -- well, they don't have to come for any type of a --

MR. CARVALHO: Jeff Mark can tell you.

CO-CHAIR GARRETT: Okay. Jeff.

MR. MARK: Currently, what we have in Illinois is to establish a facility, a long-term care facility, requires a CON. To significantly expand beds, it requires a CON. To discontinue or change ownership, it does not require a CON.

MEMBER SCHAPS: So what happened in Virginia?

MR. PARKER: They brought CON all the way back. Actually they brought it back so that its scope was broader than it was prior to the deregulation, and it was because the number of MRIs doubled in three years in Virginia. The number of cardiac catheterization labs doubled. The number of linear accelerators doubled.

I think there was broad consensus, you know, in the late 80s supporting the idea of deregulating. The notion was, well, you know, health care financing has changed, we now have managed care organizations, we have HMOs building market share in the state, hospitals and other types of facilities other than nursing homes are a more conventional type of entrepreneurial risk than they were back in the days of cost-plus

reimbursement, so maybe we don't need CON anymore.

I think there was a sense that, okay, we're going to see some development of freestanding centers unbundling the typical package of services and facilities that were provided in hospitals. We are going to see physician entrepreneurs and national companies come in and build some surgery centers and imaging centers.

But no one, I thought no one in the state realized, you know, the kind of proliferation of facilities that we were going to see, and it kind of scared people, I think.

MEMBER BARNETT: Mr. Parker?

MR. PARKER: Yes.

MEMBER BARNETT: What happened to the use rate for cardiac cath procedures and surgical procedures in Virginia? Was that tracked?

MR. PARKER: It went up rapidly, and it was a bit of a lagging use rate. So for the first few years, a lot of these MRI centers struggled, and cath lab utilization was pretty low; but by the mid-90s after they brought CON back, we started seeing use rates really go up very rapidly in most of these areas. A few of

these new facilities closed down, but not very many. Most of them hung in, and they went up.

So I am frustrated, I think as probably you are, that we don't have more kind of clear studies of, you know, what happened. I think a lot of states repealed CON and weren't that interested in finding out what happened.

I think there was -- and, you know, a lot of states -- when I look at California and Texas, and I ask myself what happened there in the 1980s. My theory is that those are states that are really growing rapidly. I mean, you know, their populations were growing rapidly in the 60s, 70s, and 80s.

I think it was harder to do CON regulation and more frustrating to do CON regulation in those states because unlike kind of the eastern part of the United States, where you actually saw states that were grappling with the idea in the 1980s of, boy, we have like over-built health care systems. We have too many hospital beds.

We have this dynamic of, you know, suburban hospitals really starting to, you know, siphon off the demand that we used to see at the large urban

hospitals and our academic medical centers.

Those problems weren't the problems of California and Texas. California and Texas actually needed to build hospitals, and they needed to build a lot of nursing homes. They needed to build a lot of facilities, and I think the drafting of CON regulation, especially prescriptive CON regulation, which was the model that was coming from the federal government at that time, really didn't work very well in the those states.

Then if you look at the other states that got rid of CON in the 1980s fairly soon after the national impetus went away, states like, you know, Wyoming, I mean, where there might be one or two cities that, you know, you actually might want to think about how do we, you know, do some resource allocation in these areas.

But, you know, even having a CON in those programs, I mean, typically the CON program was one guy in the State Capitol because there just wasn't that much capital spending, and they certainly didn't have, you know, the boys in the suits from Nashville descending on those states

and saying, let's build ambulatory surgery centers and imaging centers. You know, the population density just isn't enough in those states that there was ever a lot of juice to do CON programs.

CO-CHAIR GARRETT: Senator Althoff, do you have a question?

MEMBER ALTHOFF: I do. Heather, did you get your answer sort of, or not really?

MEMBER O'DONNELL: Well, I mean, I think the answer is that there aren't a lot of studies that have been done, and I guess that's -- do you want to go?

MEMBER ALTHOFF: No, no, finish.

MEMBER O'DONNELL: Because I also, in addition to wondering if there are reports, I mean, there must be public data on hospital closings in these states or facilities closing. Because I think another concern of doing away with CON programs is that safety-net hospitals will suffer.

So there must be -- even if somebody hasn't collected the data, it seems like the data might be readily available to determine what happened, say, in California and Texas when CON went away

with respect to some of these safety-net providers.

MEMBER ALTHOFF: Right.

MEMBER LYNE: They talk about, you know, the planning from what it was and the state aid down to what it is now. Ken, you should know that, right, the IHA probably has it?

MEMBER ROBBINS: They probably have some information. I don't know if it's exactly what Heather is looking for, but --

MEMBER LYNE: But in terms of --

MEMBER ROBBINS: -- the actual number --

MEMBER LYNE: -- the number --

MEMBER ROBBINS: -- of decrease of hospitals --

MEMBER LYNE: Yes.

MEMBER ROBBINS: Yes.

MEMBER LYNE: Yeah, they can.

MEMBER ROBBINS: An analysis of why that happened is probably another issue.

MEMBER LYNE: Right.

MEMBER ALTHOFF: I guess my question kind of sort of building on that is, what I'm

hearing is, where the CON process went away, you said that there also was proliferation of different types of facilities.

Did we also see health care costs go down? Was there any type of measure now that there was no CON, there was more competition, and so the actual access cost to some of that health care went down?

MR. PARKER: I think most of the studies that have looked at that issue have found that there isn't much difference in states -- in cost in states that retain CON or maintain the CON program over the study period versus states that didn't.

CO-CHAIR GARRETT: Let me just jump in here. In California where -- they don't have a CON process, you know, I've spent time there. A friend of mine has his own MRI center. The reimbursement for MRIs is under $500. So I beg to differ with that. I think there has been at least in one state in one particular field a significant decrease.

He doesn't like it. He would rather have the CON process because it would be less

competitive in his -- he could get a higher reimbursement. I was shocked because I had an MRI, and I think it was like in the thousands of dollars.

I don't know how that works with the insurance industry and how they can reimburse let's say $500 for an MRI versus thousands of dollars when they're basically the same, but each state obviously has their different reimbursement rate for whatever reason. Maybe somebody has an answer to that down there from the hospital.

MEMBER LYNE: I could find it out.

CO-CHAIR GARRETT: It was remarkable This was like a couple of months ago. It's not dated information.

MEMBER BARNETT: I think you might be talking about two different things, but I would prefer that Mr. Parker answer the question. You're talking about the fee for an individual service. I think Mr. Parker is talking about the overall cost for all the health care, and then perhaps do it on a per-person basis. In most states, when you have a proliferation of MRIs, you'll see more MRIs done.

CO-CHAIR GARRETT: Right.

MEMBER BARNETT: So the total cost for that population, I think your point is, doesn't necessarily go down just because the cost of one of those might be less.

CO-CHAIR GARRETT: I see what you're saying. I just don't know if that's a factor. I mean, there's a big difference between $3,000 for an MRI and $500 for an MRI.

MEMBER O'DONNELL: Well, it sounds to me like that $500 was -- are we talking about reimbursement from Medicaid?

CO-CHAIR GARRETT: No, I'm talking about insurance. You know, my own husband actually went to him because of convenience. That's how I learned about this.

MEMBER O'DONNELL: I mean, there's a huge difference between like cost to provider and what Medicaid reimbursement is.

CO-CHAIR GARRETT: I know.

MEMBER O'DONNELL: And then what insurance pays.

CO-CHAIR GARRETT: Right, but that's what he gets, and it was under $500 per -- whether

you're paying for it through your own pocketbook or whether it's being reimbursed through insurance. That is his rate.

CO-CHAIR DUGAN: That's what he charges?

CO-CHAIR GARRETT: That's what he gets reimbursed.

CO-CHAIR DUGAN: Okay. But is that what he charges?

CO-CHAIR GARRETT: He charges what he gets reimbursed. It's the same.

I mean, have you heard any of that? I mean, is that something that's striking to you or --

MR. PARKER: No.

CO-CHAIR GARRETT: -- just kind of an anomaly?

MR. PARKER: My experience in the mid-Atlantic states and in Maryland is that it's very common to see MRI facilities charge $1,000 to $1,500 for an MRI procedure. They don't get that from insurance companies. They get about $500.

CO-CHAIR GARRETT: But here in Illinois, correct me if I'm wrong, it's in the thousands.

MEMBER LYNE: I don't think they're quite that much, but I can find it out.

CO-CHAIR GARRETT: I've had them. I know that's what they are. Maybe I'm the only one.

MEMBER LYNE: I could find out.

CO-CHAIR GARRETT: So no comment, you just think that my MRIs are more expensive than anybody else?

MEMBER ROBBINS: Remember there may be the distinction between a charge and what an insurance company actually pays.

MEMBER LYNE: That's right.

CO-CHAIR GARRETT: I get that.

MEMBER ROBBINS: Okay. Beyond that I --

CO-CHAIR GARRETT: I am saying it's not the same. He has actually offered to come here to testify, and maybe we'll want to bring somebody in from a different state at some point. I just thought it was striking.

MR. PARKER: Well, we've kind of gotten into questions. I'm pretty much done here. The point I was going to make about the

Federal Trade Commission report, which it gets a lot of play especially from folks who, you know, would like to get rid of CON, the 2004 report really kind of focuses on the idea of CON is bad because it limits market entry, so it's going to limit the number of competitors for medical facility services.

It kind of accepts as a given, well, that's bad, you know, and then goes on to not do studies of its own, but in our view kind of cherry picks the studies, some of the studies that have been done to try to make a case that any time you limit market entry, you increase cost, you reduce the quality of care, you reduce access, you limit innovation, and you reduce efficiency and service delivery.

We just don't think there's really good studies that indicate that that's the case. We don't think there's really good studies that show that states that have CON regulation versus states that don't have CON regulation really have statistically significant differences in these factors.

MEMBER O'DONNELL: So there are some

studies though.

MR. PARKER: Yes.

MEMBER O'DONNELL: Can you maybe give me the names of a couple studies?

MR. PARKER: I can certainly do that after this meeting.

MEMBER O'DONNELL: Okay.

MR. PARKER: I think if you look at your report that was done by Lewin, I believe last year, if you look at the bibliography there, I think you'll see some of those studies.

MEMBER O'DONNELL: Okay.

CO-CHAIR GARRETT: Anybody else have any questions?

I had just a couple. We in Illinois, it's not a -- I think there was originally a clear directive that we should have an overall comprehensive health plan that when we look at hospitals that need to expand, we could compare what our health plan was supposed to be. We haven't really come up with that as far as I know.

But in other states where they have the CON process, do they have something to compare so if a hospital wants to expand, can you say, well,

here's where we need to be, and here's what our overall goal is; and therefore, if you meet the criteria, you can expand?

MR. PARKER: Yeah, you know, every state uses some sort of --

CO-CHAIR GARRETT: Criteria.

MR. PARKER: -- criteria and standards for reviewing certificate of need projects, including hospital bed expansion projects. I think the state of the art, you know, really -- really varies from state to state.

I think that in general, my view is that states have tended to devote, you know, an inadequate amount of resources to really doing good planning and analysis and doing it on a continual basis to keep plans updated.

CO-CHAIR GARRETT: So for those states that don't have a CON process, do you think that they have almost like within an agency criteria that's established, basically what we should be having here in Illinois?

We have the hospital report card. It's a bill that passed a couple of -- three or four years ago that basically was set up to compare

hospitals that report favorable outcomes and those that don't, and that would be something that we could use as a comparison model. For some reason that hasn't been implemented as of yet, but it would be something that could be referred to.

I'm wondering if there's a way to get a breakdown from different states that have a CON process and the states that don't have a CON process and what their criteria is.

MR. PARKER: Well, when you say states that don't have a CON process, I mean, states -- in those states, if you're a hospital and want to expand or if you want to build a hospital, generally all you have to do is get a license.

CO-CHAIR GARRETT: Okay. So it's not based on --

MR. PARKER: So no one is looking at need.

CO-CHAIR GARRETT: Are you sure it's not based on like a hospital report card approach? You know, if Hospital A wants to expand, and they're not really performing well, and they've got some problems, just automatically then based on a few other things, they could expand? Nobody

looks at the well-being of the hospital, so to speak?

MR. PARKER: I'm not aware of any state that doesn't have CON that would actually attempt to regulate what hospitals can do in terms of expanding or relocating or replacing through a licensure approach or a performance evaluation approach. Where they say this hospital, yes, you can because you have good outcome measures. This hospital can't.

I think in general to some extent that's kind of the idea that's talked about when people talk about, can we replace CON programs with something more like medical facilities licensure? Can licensure actually start doing something like that?

CO-CHAIR GARRETT: So has that gone anywhere? I mean, we're talking about it now, but do some states have something like that in place where there is more criteria than, you know, a check-off list if they don't have a CON process?

MR. PARKER: I think the first state that is trying to make a real clear effort in this is Ohio. I think there was this idea that in Ohio

we might try to regulate through licensure, through medical facilities licensure some of the things that were considered to be a value under their old CON program.

Specifically, for example, I think what's been talked about, and I don't know how far they've gone in implementing this. I don't think very far. But the idea was, well, maybe we need to license open heart surgery in hospitals, which is a radical idea. People don't license specific services like that. Hospitals get a hospital license in just about every state, and that's it. It's a hospital license. It might say the number of beds you can operate, but typically, it doesn't say much beyond that.

So if you reform licensure to say, okay, we're also going to require that you get a specific license to offer cardiac surgery, well, you could actually write licensure regulations that say, okay, first of all, as part of your licensure application -- and, you know, what you're doing is basically, you know, replicating a CON-type program.

You can say, well, first of all, we want to

see evidence that you're going to hit 300 cardiac surgeries a year, and that every physician -- every cardiac surgeon who does surgery at your facility is going to do at least 100 a year. You could incorporate that as part of the application.

Then you could also say, look, this is a three-year licensure. It goes away if you don't hit these marks in three years. You've got to basically close down your programs, say goodbye to your surgeons, you know, write off the operating rooms and the equipment.

CO-CHAIR GARRETT: That hasn't been tried yet officially.

But here's my question. So let's say there's Hospital A, and they're not -- they have a bad reputation. Their standards may be lower than other surrounding hospitals, but Hospital A wants to expand, and let's say they have the resources to do that.

And this is sort of a philosophical question, maybe, if there's some criteria based on their performance, could then an agency or a Health Facilities Planning Board type thing say no, you can't expand because you have not

performed well in so many certain areas?

Isn't it about providing not just access, but quality access? I'm just wondering if that's something that has come up, and I guess I'm hearing no.

MR. PARKER: Well, I'll tell you what we do in Maryland. We do bed-need analysis. We do bed-need projections in Maryland. So we actually have standards that incorporate a method for assessing how many beds are needed in various areas of the state, and that guides, you know, our review of expansion proposals.

CO-CHAIR GARRETT: But that's just -- I mean, that's beds.

MR. PARKER: Right.

CO-CHAIR GARRETT: It's not performance of hospitals.

MEMBER SCHAPS: Quality is -- quality is not a factor.

CO-CHAIR GARRETT: I got it.

MEMBER SCHAPS: Yes.

CO-CHAIR GARRETT: Well, it takes me awhile.

MR. PARKER: Excuse me. Let me tell

you to what extent quality does come in as a factor. One of the standards -- and that methodology is not driven by quality considerations. It's driven by utilization, you know.

CO-CHAIR GARRETT: Right.

MR. PARKER: If you're operating your medical/surgical beds at, you know, 87 or 90 percent average annual occupancy, and you're running into peak census periods a lot of days during the year where you can't move patients to a bed from your emergency room because you don't have enough beds available, you're going to do well in that methodology. It's going to identify a need for more bed capacity at your facility, and that's still the primary consideration in Maryland.

We have a hospital report card in Maryland. We have had one for years. It's on our Website, the Maryland Healthcare Commission. You can go look at it. We have a nursing home report card, too.

CO-CHAIR GARRETT: How does that factor -- does that factor in at all in your

health program?

MR. PARKER: We have a standard that says if you're doing any sort of hospital projects, not just bed expansion, but anything, if you're a hospital, and you're here for a CON, what it says is, we look at 11 performance measures that are measured in our report card. They're kind of the standard Hedis measures that you also see Medicare using.

If you are in the bottom quartile in the State of Maryland, the bottom 25 percent in terms of your compliance with those quality measures, then as part of your CON application, you have to provide to the commission for their review a plan, in essence a correction or a plan of improvement. You need to say what you are going to be doing to bring yourself up above that bottom 25 percent on each of the measures that you fall below 25 percent.

CO-CHAIR GARRETT: And how does that work in Maryland? Is that something that --

MR. PARKER: Well, it's only something that we've had recently. So it's like, you know, I don't know how it's working.

Again, you know, whether that's going to be a primary consideration, I mean, you know, most hospitals are going to be able to tell us something about what they're trying to do.

CO-CHAIR GARRETT: But wouldn't it -- I mean, to say --

MR. PARKER: So I think it's a very kind of initial approach to try to incorporate what you're talking about.

CO-CHAIR GARRETT: But if a state -- if there is a directive, there's a state directive, whatever the state would be, is that it had to not just be based on quantity, but quality, it seems to me that this hospital report card could have some sort of a positive bearing.

And then I have just one more question to Jeff, is he still here? What is the status of our hospital report card, the implementation of that, or is that a Dave question?

MR. MARK: That's a Dave question.

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: The hospital report card in Illinois should be out towards the end of the summer. The measures that are in the hospital

report card, however, are first, nurse staffing ratios; and second, hospital acquired infection ratios.

So there's a separate report that is called the Consumer Guide to Health, that will be quality measures relating to the 30 or more most commonly performed procedures that have the greatest disparities.

So it's not the same -- the hospital report card and the Consumer Guide to Health will not have the same sort of measures that Paul mentioned, and actually your question and this topic kind of dovetails with something I just need to find out from Paul.

Paul, do you have comparative review?

MR. PARKER: Yes.

MR. CARVALHO: Okay. Maryland has comparative review. One of the things that you'll also want to think about as you think about how quality measures might factor in is if you have a region and it has one hospital, and that hospital -- and there's a need in that region, and so that hospital has come in to apply to expand, if they are in the bottom quartile -- and keep in

mind, 25 percent of the hospitals will always be in the bottom quartile, that's just how quartiles work -- you aren't in a position of choosing from among hospitals as you might be if you had comparative review. You're in the position of saying yes or no to expanding community need.

Paul described a process where that applicant would come in with a plan of correction, but it is only a plan.

MR. PARKER: Right.

MR. CARVALHO: And it doesn't guarantee that they will get out of the 25th quartile.

CO-CHAIR GARRETT: In Illinois when we evaluate applications, do we take -- obviously, we don't, it appears, because we don't have these things ready to go that none of this criteria is being considered.

MR. CARVALHO: Similar to what Paul described, if we had a need-based analysis, there are a variety of standards, performance on Hedis measures or performance on hospital report cards.

CO-CHAIR GARRETT: But nothing to do with quality at this point.

MR. CARVALHO: It is not.

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: And as I say, keep in mind the context about comparative review. So, for example, if you had comparative review, and you had two hospitals coming in competing to meet a particular need in a region, the issue of quality would play out differently than if you didn't have comparative review as we do not; and right now it would be, in effect, first come, first serve in a region.

So the interesting question is if you have a first come, first serve process, the first to cross the line process, how does a quality thing enter into that? If you know the one who is second in line has higher quality measures, do you move them in front and de facto have comparative review?

CO-CHAIR GARRETT: I don't know, but I would think that would be something that should be evaluated.

MR. MARK: If I may, Madame Chair.

We do have within the current rules and in looking at revising the rules, we have a few very

limited quality measures in specific services. One in particular is in dialysis where we have specific standards of hemacrit -- I'm asking -- hematocrit targets for the quality of the dialysis.

We have in open heart surgery, we have quantities of minimum procedures, which according to the American College of Cardiologists, is a proxy for minimum qualitative standards, but these are limited in our existing rules.

CO-CHAIR GARRETT: Right.

MR. MARK: We are looking at more.

CO-CHAIR GARRETT: Okay.

MEMBER O'DONNELL: Do any states have accountability measures built into, let's say, the quality review or the comparative review where they just do a plan, but is there any follow-up after they submit the plan to determine whether or not they have actually followed through with the plan and they have improved?

MR. PARKER: Well, yeah, as Jeffrey was pointing out, I think, you know, the types of things that -- the types of standards that typically you see in most states for cardiac

surgery, for example, there is a minimum volume standard that in reviewing a proposal for a new cardiac surgery program, for example, and this is the case in Maryland, there has to be reasonable evidence that you'll be able to hit that target, and it's because the American College of Cardiologists said, you know, that should be the volume that a program like that hits in order to maintain good outcomes.

Any cardiac surgery program that's given a CON in Maryland, and I think you see this in other states, too, it is conditional on meeting those targets within a certain number of years. So in Maryland, when you get a CON to start a cardiac surgery program at a hospital, you have to agree that if you don't meet those targets within a certain number of years, that your CON gets voided.

MEMBER O'DONNELL: Has that ever occurred? I mean, is there a follow-up?

MR. PARKER: It has not occurred.

MEMBER O'DONNELL: It has not occurred, but if you had a facility that doesn't meet the target --

MR. PARKER: That's right.

MEMBER O'DONNELL: -- there's no follow-up?

MR. PARKER: No. We don't have that many cardiac surgery programs in Maryland. So they are -- they've got high volumes.

MEMBER GAYNOR: I have another question on a different topic.

MR. PARKER: Well, let me follow this up, too, because I do want to tell you about something that Maryland is doing now, and this kind of also maybe dovetails into what you can do outside of CON regulation, and again, I think this is something you're seeing in other states.

There was a major study done of primary angioplasty, the Seaport Study, and Maryland was heavily involved in that. The researchers are from Johns Hopkins who initiated that.

So you're looking at people who present at an emergency room with certain types of heart attack, and the idea was when we had fairly good evidence that doing an emergency cardiac catheterization, an angioplasty, to open up the occluded vessel really -- and, you know, produced

much better results when you could do that very quickly for certain types of heart attacks in the emergency room, should we consider letting hospitals that don't have cardiac surgery do that in their emergency room?

If they have a cardiac catherization lab, and if you have good invasive cardiologists who can be on call and can do an emergency cardiac catherization, is that something that we should allow?

Because traditionally we haven't -- and you see this in most states, the idea of doing therapeutic cardiac catherization, angioplasty, when you don't have a cardiac surgery program in the same hospital has been a no-no. It's been considered to be, you know, dangerous because if you have a complication during an angioplasty, then you have to take somebody across town to get the surgery, the emergency surgery, and that's a problem.

Well, they did the research study and found that basically if you maintain some good screening criteria to make sure you're really identifying the people who are going to benefit from primary

angioplasty; and if you do some certain numbers, we can probably pretty safely allow this to go on. You're not going to have -- it's going to be very rare when you have a need for emergency surgery.

So in Maryland, what we've started over the last couple of years, and it's -- you could say it's kind of like CON, it's the Maryland Healthcare Commission who is actually reviewing proposals and actually having to approve these, but we're basically -- we call it a waiver.

A hospital that comes in and shows that, yes, you know, we're going to have the cardiologist available so they can do this very quickly 24 hours a day. We're going to be able to get people from showing up at the door of our emergency room into the cath lab within 20 minutes, and we're going to hit some minimum numbers. Those are around 50 a year is what we're looking at in Maryland.

Then we will -- you don't have to file a full CON application. You don't have to go through the whole rigmarole and the whole process. You can ask us to waive the requirement that you have a surgery program at your hospital in order

to do angioplasty, but it's limited to primary angioplasty.

So we now have a whole bunch of hospitals in Maryland who have gotten those waivers, and in the last year, they've been initiating primary angioplasty in their emergency room, and some of those are going to go away. We've gotten rid of two already. They just didn't perform.

They didn't even meet their first year numbers, not only in terms of building enough numbers where we were comfortable in letting them continue to do that, but also, you know, their times weren't good in terms of getting a high percentage of patients into that cardiac cath lab quick enough and getting their vessels open.

They were doing primary angioplasty on heart attacks where they really shouldn't have been, where there isn't good evidence that that's the kind of one that you need to do on an emergency basis.

CO-CHAIR GARRETT: All right. We're going to have to -- I'm sorry, we have such a limited time, Paul and then Kurt.

MEMBER GAYNOR: I just have a question

on one topic; and that is, are you aware of any CON states that either as a condition for approval or that there's some factor that the amount of charity care that is provided by an institution is considered in the CON process?

MR. PARKER: I think actually requiring minimum levels of charity care as a discrete standard I think is fairly rare. I think most states, and Maryland is one of these states, require that you have a charity care policy, and that that policy have certain features in terms of the speed with which you give people a financial assistance decision in terms of having a sliding fee scale.

Other states, and Virginia because I'm familiar with it is one of these states, they automatically condition every CON on charity care; and for hospitals, what they do is they look at the median level of charity care --

MEMBER GAYNOR: Which state was that again?

MR. PARKER: Virginia. They look at the median level of charity care given in the most recent year in the region in which you're located.

They pull out the two academic medical center hospitals because those basically serve as kind of surrogates for public hospitals in Virginia and have huge amounts of charity care. So they don't -- they don't include those.

But for community hospitals, and if you are below the median, they basically condition you on coming up to the median, and so what they're attempting to do is ratchet up charity care over time.

MEMBER GAYNOR: And is there a follow-up on that? Is there any kind of accountability on the back end to see that you come up to the median?

MR. PARKER: There has been, and it's very difficult because the people who have failed, basically the follow-up procedure is, give us a plan of correction. Tell us what you're going to do.

In fact, I think that they're now moving in Virginia to basically allowing hospitals who are in affluent suburban areas to basically, rather than meeting a charity care as a percentage of revenue type of standard, which has been the

traditional way to condition, letting them do other things, like give a certain amount of money to a primary care clinic that takes care of the indigent or funding other types of outreach programs for the indigent as a substitute for actually -- you know, it's a substitute for keeping medical staff on your hospital staff who are actually willing to see a lot of indigent people and admit them. I mean, that's really what we're doing.

MEMBER GAYNOR: Have you ever heard any discussion about -- let's say, a hospital goes in and we're going to spend a billion dollars on a huge building.

Have you ever seen any discussions in any CON states about tying the amount of money that an institution is proposing to spend on a project, and then in turn requiring, say, okay, you're going to spend a billion dollars on a new building, we think that you should not just bring up to the median, but you should be spending X dollars or whatever, providing X dollars in charity care to poor people in relationship to this new building that you're building?

MR. PARKER: I'm not aware of people directly trying to tie an expenditure level to a charity care provision.

CO-CHAIR GARRETT: Okay. Thank you. Kurt, if you have a couple of questions, and then we need to move on to the Lewin Report.

MR. DeWEESE: Yes, thank you. I'm here in Springfield.

I just wanted to have you review, if you would, the different structures in the different states. We have our separate Health Facilities Planning Board. Some states rely on just their administrative agency. In Maryland, I guess you have your Health Care Commission, which is probably the equivalent of our Health Department.

I'm wondering if there is some consistency or uniformity or preferences to what the structure would be. One of the things that the task force is charged with is looking at whether or not we maintain the existing structure or modify it in some way.

MR. PARKER: Actually, if I'm not mistaken, I think one of the appendixes in the Lewin Report actually might go through that in

terms of state by state showing you whether it's a state health commissioner, like one person making a final decision on a CON, or if it's a commission or a panel or a counsel-type of process; and actually, I don't know what the exact breakdown is in terms of the number of states that differ in that type of decision-maker.

I think most states -- I think the majority of states don't have a single decision-maker. They actually use some form of council or commission process that's voting on CONs, and I don't have an opinion on which is better. I actually work in states that have both.

In Virginia, the state health commissioner is the sole decision-maker. He was appointed by the governor, and the structure that's set up there is that he gets two recommendations which are not binding. He gets a regional recommendation, and he gets a recommendation from his state staff. They're not binding, but if he disagrees with them, he has to state why in writing, and he has to use the state health plan as a basis for defending why he is not following the recommendations.

As a staff person, I kind of like that, dealing with one person. It gets a little messier when you're dealing with a large group, but I think there may be some accountability issues there.

The Maryland Healthcare Commission, by the way, too, is not part of the Maryland Department of Health and Mental Hygiene. It's a separate independent state commission that's charged with doing the certificate of need program and quite a few other things. It covers a wide range of things, but it's not directly involved in the public health mission of the Department of Health.

MR. DeWEESE: But it does have broader activities, a broader scope beyond just the CON process in Maryland?

MR. PARKER: Yeah, we're the commission that does performance evaluations. So we produce the report cards on HMOs, hospitals, nursing homes, ambulatory surgery centers.

We also regulate the small group market for health insurance in Maryland by establishing what the minimum benefit plan is that can be marketed to those groups, and we do a lot of other things,

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

from Governors State. Dr. Chung, if you want to come up.

(Whereupon, a recess was had, after which the meeting was resumed as follows:)

MR. CHUNG: I am Dr. Kyusuk Chung. I am the chairman of the department of health -- at Governors State University.

CO-CHAIR GARRETT: We have to be quiet.

MR. CHUNG: I'd really like to thank you for inviting me to appear before you to share the findings of my various studies that I have conducted for the past three-and-a-half years.

Actually, CON is a very complex issue, and factual information is very difficult to obtain, but I will try to give you as much objective information as possible.

My presentation is built upon various studies. One is that I compared the Illinois CON process with four other states in various aspects, and several others, including very extensive testing and modeling of Illinois bed-need methodology.

Bed-need methodology, for example, I've been trying to deliver my message, hey, we need to adopt finer age group when we project bed need. Right now, CON uses three age groups, from 0 to 14, 15 to 64, and 65 and above; but I have been trying to deliver my message, hey, we need to adopt a finer age group because now we are experiencing an aging population, and the elderly population is driving force behind, driving force, major driving force of demand. For example, my finer category of age group, includes from 0 to 14, 15 to 44, 45 to 64, 65 to 74, 75 to above.

Then another thing I tried to say is, we need to take into account interstate migration, and I have been doing a lot of testing with regard to migration factor. The problem is I am only given one hour. So unless you have given me say at least five hours, I don't think I will be able to go into detail on all of these issues in depth. So if you invite me next time, then I will definitely go into the bed-need methodology issue in depth.

Okay. Let's turn to Page 2. For comparative assessment, I selected four states:

New York, Florida, New Jersey, Michigan, because they have a size of supply and demand, and perhaps they are similar to Illinois. They are among the top six states in terms of elderly population and size.

As I said, elderly population is major driving force for health care demand and the number of hospital and nursing home beds. So if you pay attention to this table, Florida is the top state in terms of number of elderly population, and then New York, Illinois, Michigan and New Jersey. Actually, I omitted Ohio because Ohio CON regulates long-term care only. So I decided to not include Ohio.

Then these columns, you see number of beds, hospital, and nursing home, residential, psychiatric beds. Okay. So basically, if you look at the graph in the next slide, see New York is the most stringent, one of the most stringent states that regulates CON, and then Michigan follows, and then Illinois is in the middle, and then New Jersey and Florida belong to a similar group. So I basically included New York, Michigan, New Jersey, Florida.

Another reason, many other reasons behind my decision to include the four states was that New York and Michigan currently have a similar level of CON that Illinois had prior to the 2000 Amendment Act, and then New York is often considered a benchmark state not only for CON services, but also CON-related methodology for need determination.

And Michigan is one of the front-runners in revamping CON standards and criteria, a major source of criticism for CON, as you know; and New Jersey and Florida have been implementing the in-field regulation of CON. So these are all of the states that might give us lessons, okay, besides they have similar health care system to Illinois. Okay.

Okay. Comparison issues, I will talk about first, how do steps taken to determine the course of action differ? How does call structure differ? Lastly, I will talk about my testing and modeling work with regard to interstate migration.

Okay. How do steps taken to determine the course of action differ? New York has been inactive in taking steps to determine the best

course of action for CON board and CON process. I will tell you why. New Jersey and Florida follow the path toward CON repeal. I will mention that. Michigan has taken steps to strengthen CON.

Okay. This slide shows time line for CON reform. Florida sharply increased threshold for capital and medical equipment in 1987. By 1997, Florida did not review CON and monitoring criteria only.

About 15 years later, Illinois shows a similar pattern. In 2000, Illinois removed CON permit requirements for most medical treatment and sharply increased the capital threshold to many of the issues of leveling the playing field that hospitals have raised against physician groups offering the same service, such as cardiac catheterization.

These actions seem to indicate that Illinois will follow the same path New Jersey and Florida have taken, that is toward phased-in deregulation.

What does phased-in deregulation mean? New Jersey and Florida first expedited some categories subject to full review, then exempted those categories, and finally removed any CON

requirements. That's phased-in deregulation.

For example, New Jersey and Florida exempted ASC, ambulatory surgery center, while three states included in the comparison, Illinois, New York and Michigan, still review them.

What happened -- what happened after Florida and New Jersey removed the CON requirements? New Jersey has since licensure law as an alternative to traditional CON regulation allowing for less restrictive market entry to establish new clinical service programs.

This alternative involves the use of an ongoing process of monitoring how programs are functioning to assure quality of care rather than rely on direct limitations on the number of programs to achieve higher volumes of service and thus a greater likelihood of scheduled and consistent service provision.

New Jersey and Florida CON programs can be viewed as providing some insights on how the traditional CON program may be evolving in this direction. A careful evaluation of reforms that New Jersey and Florida have started will ensure that their experience can serve as a model for

Illinois, if Illinois is to follow in their footsteps.

On the other hand, New York has been inactive in taking steps in determining the best course of action for CON and CON process. Why? As you see, as we saw from the table, New York is second to the top, number of elderly population, and number of hospitals. It's top number of hospitals and nursing homes. Top state in terms of the number of nursing homes. That's right.

So what is going on in New York is, New York is totally occupied by the issue of excess capacity in acute hospitals and nursing homes in the state. So currently, New York is implementing the commission recommendation of reducing excess capacity in hospitals and nursing homes. So they don't have time to think about reforming CON at this time. That's why New York is inactive in terms of reforming CON regulations, fine-tuning bed-need methodology.

Okay. Florida -- Florida has gone one step further. Just last month, Florida governor proposed CON repeal, as you know. He mentioned delays in CON process. According to him, since

2005, 20 of the 27 CON applications are still in litigation. What that means is new proposals can't move along, and they're just stuck there because of the numerous lawsuits and appeals.

In 2005, in Florida, 28 out of 38 CON applications were denied. I'm not sure if this number is initial decision or final decision, but 80 percent is quite shocking. Right.

In 2006, approval rate got even worse. However, in 2007, only 22 percent of applications were denied. I don't know why the change suddenly reversed.

Okay. Let's talk about Michigan. Michigan has gone through several lawsuits, litigation, appeal, but Michigan, unlike Florida, took the quite opposite path.

In 1997, the then Governor, John Engler, appealed decisions in two longstanding certificate-of-need cases to higher courts. At the time, lower courts had overturned agency denial on two construction projects. Both cases originated in the mid-1980s.

Due to concerns about lack of clarity regarding both process and standards in CON

resulting in the overturning of too many CON decisions by the courts, Michigan substantially revised its problem.

Instead of repealing or significantly scaling back CON law, Michigan took steps to develop, improve, update, review criteria and standards. Michigan established a specific process for developing and approving standards used in making CON decisions.

It further created a five bipartisan CON commission within the Department of Public Health. The commission's members are appointed by the governor and responsible for reviewing and approving standards.

Although CON appeared in controversy similarly across the states, Michigan and Florida, there is contrast. They have taken different paths.

Florida took a path to deregulation, and Michigan tried to strengthen CON criteria and standards. So two different approach in front of appeals, litigation, okay, under the same similar circumstance.

All of the examples of what Michigan is

doing in order to strengthen CON process is to put emphasis enforcing post-CON standards. Here look at the table, I would like to take this example of showing how diligently Michigan has been trying to put CON in shame. Okay.

The CON office monitors implementation of and approve the project until it is licensed. CON schedule approved with conditions and monitored every year to assure that the required services are being provided.

Here is the standards. Look at the standard on new open heart surgery, minimum number of surgery for applicant by third year, in case of Michigan, 300. Right.

So all the states have post-CON standards. In case of a new open heart surgery minimal -- in case of new open heart surgery like minimal number of surgeries, like 300 in Michigan, 500 in New York, New Jersey, 350. Right.

Then those two states are not strongly enforcing this standard. Right.

MEMBER O'DONNELL: What are they doing to follow up? What is the CON board --

MR. CHUNG: The CON commission, let me

show you this is --

MEMBER O'DONNELL: What are they doing when they don't -- when they follow up and they're not meeting the standards?

MR. CHUNG: Yeah, there should be some kind of sanction or a penalty, I'm sure.

MEMBER O'DONNELL: Is there? Do you know?

MR. CHUNG: Yeah, I -- I will get to that question later.

In other states, there is no regularly scheduled post-CON review to determine whether the standards are being met. However, unlike other states, Michigan is working hard to enforce the post-CON compliance or standard.

This table shows how Michigan makes post-CON reviews to check if the standards are met.

Unlike Florida, Michigan developed -- has developed two years schedule for checking CON standards. So this table, right, is about CON commission work plan -- CON commission work plan. This is a two-year plan for each commission, right, for updating CON standards.

So if you take a look at this here, for

example, January, 2007, air ambulance services, there is a PH. PH means public hearing for initial comments on review standards.

2008, January, 2008, saying here hospital beds, DR. DR means discussion, receipt of report. So they developed two-year plan, right, for creating CON standards. So this suggests how diligently Michigan CON works to update CON standards. I'm sure Illinois has been doing the same thing.

As I said, Michigan has not scaled back CON law, even though Michigan appears at a similar level of CON appeals and to controversy in the past and in recent years. Michigan law requires update the standards every three years.

So far by comparing the five states, I want to show you which state took what path, what kind of a path. As I show, Illinois is at a crossroad. Why crossroad? Florida, New Jersey, right, decided to adopt phased-in deregulation. Michigan decided to strengthen CON, right, following the five states.

So, I mean, Illinois is at crossroads, whether they will follow Michigan path or New

Jersey and Florida path.

From now on, I would like to talk about how to improve Illinois CON, assuming that we will keep CON. One picture that Illinois CON does not have, but other states have is batch processing. New Jersey, Florida -- New Jersey, Florida Michigan adopted batch processing.

Batch processing enables comparative review or competitive review for similar types of application in terms of planning area, in terms of project type, or in terms of need methodology can be batched.

The batch processing makes comparative review possible so that inconsistent decision-making can be minimized. Okay.

Here is an example, Florida. Florida adopt batch processing. Florida batches two times a year for each of the following two categories: first, hospital beds and facilities; and second category, other beds and programs.

The second batching cycle is scheduled for the 25th of January this year for the category -- the first category, and the 3rd of October for the second category. As you can see here, summary of

need projections is published in F.A.W. On January 25th, letter of intent, right.

MEMBER SCHAPS: Can I interrupt a second? This is really a question for Jeff.

How does it work in Illinois? Can hospitals come in --

MR. MARK: We don't have --

MR. CHUNG: Applicants submit their applications any time.

MEMBER SCHAPS: Okay.

MR. CHUNG: Yeah.

MEMBER SCHAPS: So this facilitates comparing --

MR. CHUNG: Comparing same type of project --

MR. MARK: If I may --

MR. CHUNG: -- same type of project for selected -- selected category of service, not all.

MEMBER SCHAPS: No, I understand.

MR. CHUNG: Not all.

MR. MARK: Dr. Chung, if I may point something out here.

MR. CHUNG: Yeah.

MR. MARK: In Florida, if there is no need projected, do they accept applications?

In your next slide, you show that they first generate need projections and then accept letters of intent. If there is no need projection, do they accept --

MR. CHUNG: In Florida, they wouldn't accept when there is no need, right, but, again, please remember that this batch processing is for selected number of categories. It's not all, right.

Okay. So far I talked about the findings from the first comparative assessment. Okay. From now on, I would like to talk about selected findings from studies on CON methodology.

As I said, unless I have enough time, I don't think I will be able to go to each one of the issues in that, but I just give you some kind of introductory information so that you are aware of issues in terms of bed-need methodology.

Planning area, how do planning area and migration adjustment differ? Illinois planning area is based on community area or township. Michigan is based upon zip code, and New York is

based upon county.

Is there overlap of a planning area in Illinois, no, but Michigan overlap is allowed because Michigan planning area is based on facility, and New York, no overlap. Okay.

Migration adjustment, actually we just adopted 50-percent migration adjustment factor. We used to have -- Illinois CON used to have 15 percent.

MR. CARVALHO: Dr. Chung.

MR. CHUNG: Yes.

MR. CARVALHO: Just to clarify, we adopted 50, 5-0. We used to have 15, 1-5.

MR. CHUNG: Yeah. 1-5, 15, yes. 15, we adopted 50, 5-0.

Okay. Since Illinois is partially facility-based and Michigan is completely facility-based and New York is not facility-based at all, we need to include migration factor.

Michigan does not need because in Michigan, there is no patients that migrate between planning area and planning area, and New York no migration between planning area and planning area. I will get to that issue later. Okay.

So Illinois, there is a need for migration factor to be applied, but let me give you -- before we get to this slide, let me -- New York used regional average rate and applied it to an individual planning area.

That means in Illinois case, recalculate use rate for each one of the planning areas. For example, there are 41 planning areas in terms of medical/surgical pediatric, and recalculate use rate for each one of the planning areas. There might be wide variations.

But in New York case, they calculate region-wide use rate and apply to one of -- all of the planning areas. So they try to get rid of possibility of disparity among planning areas. So there is no need for New York to apply migration factor. We will get to that later.

Illinois is the only state -- Illinois is the only state that use migration adjustment factor. No other states do. I will talk about this in the next slide.

This table actually clearly shows you why Illinois need to use migration adjustment factor. This table is a migration matrix for selected

planning areas in Region A.

Actually, some of you here, you know, Mr. Carvalho and Jeff, they've already seen 41-by-41, huge-size table that includes 41 planning area by 41 planning area. I cannot include here, right. Right, 41 planning areas because 41 planning areas plus six neighboring states, interstate migration, so 41-by-41.

But here I just give you an idea. That's why I just include only a selected number of planning areas in Region A.

The first set here 0.67 means 67 percent of resident patients in Planning Area A-01 used their own hospitals. Okay. That means 33 percent of patients in planning area A-01 used hospitals in other planning area. Of course, there are --

MR. MARK: Dr. Chung.

MR. CHUNG: Yes.

MR. MARK: Just for the task force members' information, Planning Areas 01 through 03 are the three planning areas that make up the City of Chicago.

MR. CHUNG: Yeah.

MR. MARK: So you can put this in

context.

CO-CHAIR DUGAN: And I just want to remind everybody, too, we've got until about a quarter to 1:00, just to stay on track. So questions -- 30 minutes of presentation, 30 minutes of questions, since we're tying them together, just so everybody --

MR. CHUNG: I started late, so you should give me 25 more minutes.

CO-CHAIR DUGAN: Right. I'm not saying you only have 25 more minutes. I'm just saying question-wise, everything has to be done, questions and everything by quarter 'til.

MR. CHUNG: Okay. So you can read this matrix in detail. The row indicates planning area or region. Okay. The column indicates the planning area of hospitalization. So, of course, Planning Area A-01, yes, in-migrate, in-migrate patients too. Look at the first column, right. That means that there are some patients from Planning Area A-02, A-03. That's in-migration.

Then this way, that's out-migration, and then I included six states. The six bordering states include: Michigan, Indiana, Kentucky,

Missouri, Iowa, Wisconsin, okay, the six bordering area.

MEMBER SCHAPS: I'm not sure I understand. This doesn't tell us about how much is migrating into, say, Chicago from different places.

MR. CHUNG: Different places, yeah, different places, 67 percent. There is a number provided by --

MEMBER SCHAPS: Right.

MR. CHUNG: And 67 percent of patients utilize the Planning Area A-01 are coming from that same planning area.

MEMBER SCHAPS: Right.

MR. CHUNG: Right.

MEMBER SCHAPS: How about from --

MR. CHUNG: That's why I deleted all the numbers because I give you just clear -- I tried to make you understand clearly. Of course, I have numbers here. I have the volume-by-volume chart. So that's -- okay.

Then who, why do people migrate? Anybody idea -- yeah.

MR. CARVALHO: Dr. Chung, I think what

she's trying to say is, for example, 67, is that saying that 67 percent of the people who live in Planning Area 1 get their care in Planning Area 1, or is it saying 67 percent of the care in Area 1 is to people who live in Planning Area 1?

MR. CHUNG: Yeah.

MR. CARVALHO: Which one is it?

MR CHUNG: Yes.

MR. CARVALHO: It's one or the other. The second one?

MR. CHUNG: The second one.

MR. CARVALHO: Okay. 67 percent of the care in Planning Area 1 comes from people who are in Planning Area 1.

MEMBER SCHAPS: Yes, I'm just curious about where the 33 come from.

MR. CHUNG: So why do people migrate? Because it's a voluntary and rational decision. Hey, I would like to get service from famous doctor, and my insurance okay. I have a contract that accepts hospitals in other planning area, right, and my primary physician refer me to hospitals in other planning areas. That's more like voluntary and rational decision, but there

are involuntary, inevitable reasons, right. There are two reasons. Okay.

So here, people migrate for various reasons. We have data -- we have data across planning areas differentiating between voluntary rational migration and involuntary forced migration.

It is unclear at this time as to what an appropriate adjustment factor should be for not only intrastate and interstate migration pattern.

So actually Jeff and I have discussed this a long time, how CON came up with 0.05 percent migration factor in the first place a long time ago. Nobody knows. Nobody knows.

Following the recent requirement, the board changed the migration factor from 15 percent to 50 percent. Applying migration adjustment factors is based on the assumption that residents who out-migrate have to due to insufficient number of hospital beds. That's the assumption. But some, as I said, are a voluntary and rational decision. Hey, people are willing to go out of the planning area, right. So this assumption might be wrong.

Where there has been little updated evidence supporting this assumption, our finding is that a

substantial portion of residents in some planning areas migrate to other states. Okay. This is a phenomena for further study. Let me give you some basic idea of planning area here

So a likely Illinois planning area which are based community -- this is an arbitrary figure. This is facilities we find in market area. So hospital -- that's just kind of arbitrary hospital, not real hospital.

So you can safely say, right, and there is a planning area line. That's an arbitrary line. Okay. And people from that area migrate over, and patients, regional patients could come to the hospital, and then the other patient, regional patients are just here, primary market area could go to the Hospital X, even though there is a clear line between the planning area.

Real example, this is a real example as to why do we see migration. This figures shows that it is inevitable. Migration is inevitable. It happens. Look at this. Here Elmhurst Hospital and Hinsdale Hospital, they are located just about on the line, okay, bolder line. So you can easily think that a lot of patients living in the other

planning area could come to the Hinsdale Hospital, right.

So some hospitals located near a planning area boundary may have a primary market area which is serviced regularly from other planning areas. This illustrates migration patterns caused by a planning line. So migration is -- should we withdraw planning area so that such migration can be minimized? Tell me. So we need to revisit this issue later.

So basically, let me show this is satellite picture of the same hospital, Hinsdale Hospital. Look at it, right, Hinsdale Hospital. So Hinsdale Hospital is at the far east corner of Hinsdale. In this case I294 makes the boundary of the planning area. So look at the residents of the areas east of I294 may go to the hospital. So this one can give you an idea, right. Migration inevitably takes place.

Okay. Then, okay, should we have to adjust for interstate migration? So far I talked about planning area within the boundary of Illinois. Now I would like to talk about interstate migration. Look at the picture. Look at the

picture.

See, there are many major referral hospitals, tertiary referral hospitals located on border, like here St. Louis, border of Kentucky, Iowa. See, there are many -- especially downstate. We don't have major referral hospitals in downstate, but then we do have major referral hospital in Kentucky, right. So look at this.

So our study took into account interstate migration patterns using various data, right. This Illinois data was required because we have to come up with our make-up because the one data doesn't have this portion, the other data doesn't have that portion. So we need to include all the data. So look at -- you can see in this picture, migration inevitably happens.

Here, this is map drawn from my own data analysis. Okay. I became interested in the issue of interstate migration. You have to look at this map. So this pattern shows that Illinois is primarily a net out-migration state with four times greater M-S/P, medical-surgical/pediatric, and 3.2 times greater for ob-gyne, out-migration numbers and in-migration.

So look at here. The dark blue is eight planning areas. Like, this is one planning area. 37 percent of regional patients all out of state to receive health care. Look at E-03, E-03 where Kenneth Hall Hospital reside, see. Then the Planning Area B-02, about 30 percent go out of state. So look at this. Look at this.

So the residents in these border states have to migrate due to lack of hospitals. There are some reasons here. Again, voluntary and rational decision, involuntary, inevitable reason. Out-migration tends to make -- since if they migrate due to insufficient number of beds, right.

But there was no data available in terms of this kind of data about this migration pattern when I started this project. So we really spend a lot of time contacting the sister states trying to get the data and take into account interstate migration and find that this layer of out-migration take place in our state.

I still remember that Missouri, the department of public health, Missouri, the guy was really stubborn. Why he wouldn't allow me to use their data, I don't know, because of them we --

they covered the area about, we would find out 10 Medicaid patients coming out of St. Louis area to go to Washington Medical Center or on the other side. So if you look at this map, you'll see Illinois is a net out-migration state.

Example: Kenneth Hall Hospital, the only -- this hospital is the only full-service in East St. Louis area. Kenneth Hall Hospital tries to move some outpatient service and merge it with their main hospital, right, something like that, right. So the inner-city residents might lose outpatient facility, and the mayor of the city and the residents of the city rally against movement. You see articles, video.

So declining patient population, here they actually give us the reason behind their decision. I mean, the hospital give us the reason behind their decision to move. They measure declining patient population, right.

So let's look at the E-03. Actually, I showed you an earlier picture of E-03. This first block of columns is before taking into account interstate migration. The second block of columns is after taking into account interstate migration.

See E-03. See how patients who are out of Illinois go out of E-03 to get health care service. Before interstate migration 1781, after 3020.

And in-migration there is no big difference because nobody could be coming to this area to get health care services unless you got car accident or something. So you have 74.7-percent increase.

So this table shows how serious it is, the interstate migration issue is. So in other words, if you do not take into account interstate migration, you wouldn't be able to, okay, fully capture real demand and real projection, bed-need projection, right.

Okay. Instead of giving you a recommendation, I just summarized what I have discussed.

We have found phased-in implementation of deregulation as begun in Florida and New Jersey, and we saw batch processing as used by Florida, Michigan, and New Jersey; and then we saw Michigan's rigorous efforts to update and enforce review criteria and standards and monitor performance; and then lastly, I showed you a case

of interstate migration, the phenomena of interstate migration.

This concludes my presentation. I will be willing to answer any questions that you might have.

CO-CHAIR DUGAN: Are there any questions?

You did such a fine job, Doctor, that there isn't any questions.

MR. CHUNG: Well, I need more time to talk about the other issues.

CO-CHAIR DUGAN: Yes. Well, we certainly appreciate it. Everybody knows we have the PowerPoint in the packet, so we can review that.

Thank you very much.

Yes.

MR. CARVALHO: As we make the transition to the presentation on financial matters, as long as we've got a little bit of a lull, why don't I help you all put your documents in order?

CO-CHAIR DUGAN: Okay.

MR. CARVALHO: One last thing before

we give her the break, let's just keep going, Representative Dugan, if you'll recall, you had made a recommendation that generally we did not need a court reporter, but when we had presentations we would.

CO-CHAIR DUGAN: Correct.

MR. CARVALHO: So for the morning presentations, we've had the court reporter. The idea of a working lunch and a court reporter don't work because the court reporter also has to eat.

CO-CHAIR DUGAN: Yes.

MR. CARVALHO: So with your permission, why don't we give the court reporter a break and do these ministerial tasks without the court reporter?

CO-CHAIR DUGAN: Okay.

(There followed proceedings outside the record.)

CO-CHAIR GARRETT: So you have 11 full-time, some part-time, and those are contractual.

MR. MARK: Correct.

CO-CHAIR GARRETT: Then you've got this multitude of temporary service.

MR. MARK: No, the contractual would be the part-time.

CO-CHAIR GARRETT: Well, then there's this other contractual of Gale Elder, Tammara Shawgo.

MR. MARK: Yeah, those are the contractual people.

CO-CHAIR GARRETT: Okay. These are the contractual. Then you've got the employees, and then you've got the temporary services which is a hefty amount of money.

MR. MARK: Well, as Dave mentioned, temporary kicks in when people resign and move on elsewhere, and we have a vacancy waiting to be filled.

CO-CHAIR GARRETT: I'm just asking this question because, you know, I have a business office and we have temporary people, too.

But you have 11, plus the five or six that are on contract every year, and then you've got the Blueprint Copy. They do all the work. I mean, they make all the copies. You've got all these others. So I'm just wondering, A, what everybody does, the 11 people, and then why do you

have to expend so much money in temporary services?

We may be able to get that information on what the total cost is. I think Deanna might have it here, there are two different firms; but a significant amount of money in personnel, and then when you look at the contract that they have with Blueprint, I mean, $25,000, that's a lot of copying. Then there are others besides that that might be in a different category not listed on this sheet for copying and other things. So it just seems like so much money and so many people.

MR. CARVALHO: Senator, I think maybe what's happening here is you've never looked this closely at a $1.7 million program, but for a $1.7 million program in state government, 11 employees for a program that sends literally two boxes of stuff to each of the board members every six weeks, having $25,000 worth of copying -- these numbers --

CO-CHAIR GARRETT: But then you have copy machines in your office. You have people there that I'm guessing -- I'm just wondering. I mean, I've got Xerox for $20,000. You know, all

sorts of sides that we're not seeing in front of us right now.

MEMBER BRADY: Maybe we ought to get the auditor general to come to our next meeting.

CO-CHAIR GARRETT: I have talked to the auditor general. They have never audited -- they have audited the mission statement or whatever, but they've never audited the real dollars, and I've spent a lot of time looking at this. It just seems like such a huge expense with no oversight or no --

MEMBER BRADY: Can't we change that?

CO-CHAIR GARRETT: Well, I'm trying to bring it up so everybody understands.

MR. CARVALHO: I have six divisions in my office.

CO-CHAIR GARRETT: Yes.

MR. CARVALHO: Every one of them would be the same story. Who are you anticipating would be providing the oversight? Jeff is the line manager of this division. I'm his deputy director. My boss is the director. Every one of them has to sign off on everything that comes up the chain. All of it is subject to -- audit.

CO-CHAIR GARRETT: The only --
MR. CARVALHO: -- audit.
CO-CHAIR GARRETT: -- that I saw were Jeff and you and whoever, this chief of staff.
MR. CARVALHO: Lynn Golden has to sign.
CO-CHAIR GARRETT: Yes.
MR. CARVALHO: The director signs. My business manager signs.
CO-CHAIR GARRETT: But they're stamped -- a lot of them are stamped signatures.
MR. CARVALHO: Yes, but that's --
CO-CHAIR GARRETT: But do you discuss it with your board? I mean, I don't --
MR. CARVALHO: It's not their appropriation.
CO-CHAIR DUGAN: So the board really has no idea -- I'm not saying no idea, but the board really has no input as to what we may decide that we need at the Department.
MR. CARVALHO: No, they do not decide which --
MR. MARK: I would suggest that the board, and we could defer to Acting Chair Lopatka,

but I would suggest that the board is not really interested on that micro a level as to how we copy versus in-house and outside.

MEMBER ALTHOFF: Go to more detail, is the board ever presented any type of budget whatsoever, so that they see a budget at year's end?

MR. MARK: We did this year present a gross budget to them with an overview explanation.

CO-CHAIR DUGAN: Have we ever done it before this year?

MR. MARK: We have not done it prior to.

MR. DeWEESE: Senator, this is Kurt DeWeese.

CO-CHAIR GARRETT: Yes.

MR. DeWEESE: The planning board, I don't believe, is a separate corporate entity, and by statute, the Department provides the support services to the board; therefore, the role of the Department is in terms of actually managing the support cost for the board.

The board is simply acting on the applications. It's not there to provide oversight

of the expenditures, I don't believe. It's not like the finance authority or some of those where there's a separate corporate status.

CO-CHAIR GARRETT: I get that. I'm just wondering if -- I mean, does anybody -- does it matter -- I guess maybe this question has already been answered that it doesn't matter -- if there's no --

MR. DeWEESE: If anything, my understanding is that this process is resource-deprived in relation to what we're expecting it to do.

CO-CHAIR GARRETT: Why do you say that, Kurt?

MR. DeWEESE: Because I understand -- well, part of it is, at least more recently, is that they're having a hard time to keep the staffing that they've got because of the uncertainty of the board, but also you have to look at it in terms of the different responsibilities that come to it with these applications and what we're expecting of them in terms of the level of expertise that they need to make these kinds of reviews.

At least that's the feedback that I've been getting is that the Department probably doesn't have sufficient resources to do much more than what we're asking them to do, especially now when they're being asked to also provide administrative support to the task force, as well as continue to do what they're supposed to be doing in reviewing these applications and responding to the board.

CO-CHAIR DUGAN: And I think, Kurt, I think that's our question. We're trying to find out here exactly what it is that they are able to do or what part of it they do do.

As we've heard, I guess they gather the information from the application and then turn it over to the board. I think at least from my perspective, I am trying to find out exactly what it is we are asking them to do, and then what they're able to provide, and possibly if they're having a problem providing it, where is the problem.

I think that's what we're trying to find out here -- if we're spending -- I mean, if we're doing what we're doing, and we're still not -- that part of the problem that we believe possibly

in the CON process is because we don't have what we need as far as a state, then I think that's what we're trying to look at to decide what we may have to do.

So I think I was just wondering did the board, the Health Facilities Planning Board, have anything to do with what happens as far as expenses so if we do need something more, who has to do the asking?

Now, I understand the board wouldn't come back and say, hey, we'd like to have three more reports from Governors State. That's what I was trying to figure out. Is it coming from the staff, and it's the staff that makes the determination? That's all I was trying to find out, was who actually makes the determination as to what we need to make this process work, and it sounds as though the Department makes it.

MR. MARK: If the task force would desire it, I'd be happy to break down the resources and how they're allocated right now, the number of people doing what, and generically what roles in the program. I'd be happy to.

MR. CARVALHO: They have the 2007

payroll. Maybe just go down and tell what --

MR. MARK: That doesn't tell the entire story.

MR. CARVALHO: I know. That's why I said, why don't you go down and tell them --

MR. MARK: I mean, we could do that.

MR. CARVALHO: Sure.

MR. MARK: Would you like to do that in July, '07?

CO-CHAIR DUGAN: Like I said, we're just trying to find out if something is not working, what do we believe may be part of the issue of why it isn't working? We see now what we spend, but if something is not working. Kurt says we're short anyway. Let's figure out where we need to go.

MR. CARVALHO: We have been short in line item people, and so that's why Jeff has augmented them with the personal service contract people. So you have the list of line item people, that's the 11 people. You have the list of personal service contract people. That augments what Jeff set out do. In the most recent --

CO-CHAIR GARRETT: What about all the

temporary, the 100, I mean --

MR. CARVALHO: There's not 100,000.

CO-CHAIR GARRETT: The bill for temporary service, and then there's another one. This is in Chicago and one is --

MR. CARVALHO: Right, but are you looking at the charges to the agency for temporary services throughout the agency or this program? This program --

CO-CHAIR GARRETT: The way I understand it, David, is that it's for this, but trust me, it's very confusing because there's so many different --

MR. CARVALHO: What dollar amount do you have?

CO-CHAIR GARRETT: We'll look it up. I think there's two agencies lists.

MR. CARVALHO: Right. Because, as I said, the State went out for a bid for services of a temporary nature, and then when any program -- my rural health program has tapped into temporary services.

CO-CHAIR GARRETT: Right.

MR. CARVALHO: My IPLAN program has

tapped into temporary services. We tap into that contract which has been negotiated for the State as well.

CO-CHAIR GARRETT: Okay. So maybe the easiest way to look at this -- because it's been confusing. We've requested and then rerequested to get it. It may be because, and you've even said this yourself, your salary sometimes is paid out of the Hospital Facilities Planning Fund No. 524 or 368, I've got them all mixed up, and sometimes it's not.

MR. CARVALHO: Right.

CO-CHAIR GARRETT: So I'm just trying to -- I mean, maybe this is a petty issue, but it seems like the oversight and the accounting of the dollars because there are different funds, and you've got the bigger Department of Public Health, you know, on top, it isn't clear. The fact that it took so long to get this information, and it's really interesting, but it doesn't -- it's not cohesive.

MR. CARVALHO: Well, let me respond to that, too. Part of the reason why it's taken a long time to get this information is that --

especially of a historical nature, for a line management person like Jeff or like me, information about what we spent on contracts three years ago, five years ago, seven years ago, nine years ago, who was employed, what their salary was is largely irrelevant, and so it's not stored. The information that we have in an electronic fashion that is easily accessible tends to be this year, last year, maybe three years ago.

So our delays have been in trying to figure out within the agency where do we go to find out who was employed in 1979? Where do we go to find out what was charged to this fund in 1982?

CO-CHAIR GARRETT: But if --

MR. CARVALHO: That's where we've been delayed. We could have had this two weeks ago if you had just wanted this year.

CO-CHAIR GARRETT: But there is no, I guess, you know how different departments have to have everything sort of formalized. You know, it seems as if you guys were scrambling around to get the information because there's different accounts.

Even as we're looking at these vendors, we

admittedly don't have all of the vendors, and maybe that's because they come from a different account. Sometimes your salary, as an example --

MR. CARVALHO: Yes.

CO-CHAIR GARRETT: -- is paid from this account and sometimes it isn't, so you know.

MR. CARVALHO: Let me explain why that is, too. About five years ago when we took the legal expense in-house, we realized that the amount of departmental resources devoted to supporting the activities of the CON program were going up and were going up substantially.

So we did a study about four years ago -- well, a study, I mean, somebody pushed some numbers and how it adds up, and it was in the nature of $250- or $300,000 a year of in-kind overhead support, which is -- you know, all the overhead at the agency that gets devoted to any particular program is a pro rata share. We added it up, and it was about $250- or $300,000.

Then we started looking at, well, what's a mechanism for recovering some of that, because it's not appropriate for a program that's supposed to be stand-alone and supported by its own

expenses to be costing the agency that much.

We toyed around with different ideas. I talked to three chairman ago and talked about one approach, I talked to two chairman ago about another approach, and we never actually implemented anything other than in a, well, rough justice sort of a way, we can occasionally charge my salary or somebody else in the process who supports this program.

So that was a rough justice way to recover some of the overhead, and it didn't nearly approach $250- or $300,000, would that it could.

In fact, in the upcoming budget, what we have proposed is -- the budget that was introduced a couple of weeks ago. What we have proposed is that the $1.7 million, roughly, the appropriation of last year, go to 1.9 to cover the additional expenses of the program, and then go further to 2.2 million to allow for the agency to recover from the overhead and other support that's provided. So we are accounting for that in a straightforward way instead of in the rough justice way that we have done in the past.

MR. MARK: Could I make one

clarification since I think this -- my perspective on this is important?

The guts of the program, what we have, the vast majority of our expenditures are on professional fees, on salaries and benefits.

We have including myself and seven full-time equivalents, seven full-time employees, professional employees in the program. Three of these are in review that conduct all of these application reviews. We have two people who do nothing but the data collection, and one person who is responsible for the compliance issues after the permits are issued.

So the guts of this program is really on the shoulders of three full-time equivalents who conduct a bulk of the reviews.

CO-CHAIR GARRETT: But, Jeff, let me just interrupt you.

MR. MARK: Yes.

CO-CHAIR GARRETT: A lot of these vendor contractors, and Ink Well comes to mind, and all these personal service contracts, I looked at them, and they're duplicative. They basically review all of the applications.

So you've got the former Advocate employee from Ink Well reviewing. You've got your personal service people reviewing, and then you've got your full-time employed people reviewing.

MR. MARK: But please keep in my mind, those professional service contracts, they're all part-time, none of them are full-time. So we have the equivalent --

CO-CHAIR GARRETT: Well, you know, I'm glad you brought that up --

MR. MARK: Yes.

CO-CHAIR GARRETT: -- because part-time, Carolyn Smaron.

MR. MARK: She's an administrative law judge and has nothing to do with review.

CO-CHAIR GARRETT: It says review contracts. That's what it said. I read the -- $92,000 a year.

MR. MARK: She's an administrative law judge.

CO-CHAIR GARRETT: Claire --

MR. MARK: Claire Burman --

CO-CHAIR GARRETT: Burman.

MR. MARK: -- is our coordinator for

rules development.

CO-CHAIR GARRETT: But my point being is that you say your staff is doing all this, but you have either a backup or a --

MR. MARK: These are additional positions.

CO-CHAIR GARRETT: It's very expensive additional services, and, you know, we're talking -- I think I came up with somewhere about -- at least in one year $670,000, and that's just building right here, and that's just those backup, on people that support your full-time employees to do the review and compliance.

The question mark is, why do you need so many, and to Kurt's point that maybe you don't have enough, but something is --

MR. MARK: Well, again, I would be happy to go over them one-by-one. I'm not sure if you want -- if this is the appropriate forum.

CO-CHAIR DUGAN: No, but maybe, Jeff, you can give us just kind of a listing of the people and what they -- like you just said, what they do.

MR. MARK: Could I prepare that for

distribution?

CO-CHAIR DUGAN: That would be great.

MR. MARK: I would be happy to do that.

CO-CHAIR DUGAN: Then I think at least we'd have it all on one, and it would tell us what they do.

MR. CARVALHO: Because I think we obviously are not doing a good job of communicating because if you look at what these people do, Jeff alluded to one just a moment ago, Claire Burman.

The board has been under a mandate for several years now to redo all of its rules, and during the training session, we talked with you all about what a substantial, substantial body of work rewriting all of the board's rules has been, hundreds of hearings and gathering all this information, running all of it through the JCAR process. Jeffrey certainly has supervised that, but that has been Claire Burman's work. That is what Claire has been doing.

That process -- I mean, I'm amazed at how much Claire has gotten done when you look at what

she has been paid to substantially rewrite all the rules in this program and conduct that whole process. She has nothing to do with the review of projects. She is to do rule rewrite, and somehow Jeffrey has managed to get it done with just that one person.

CO-CHAIR DUGAN: Well, and that's what I think when he gives us that list, we'll better know in detail, David. I think that's what the problem is. We don't know where all of the money --

MR. CARVALHO: Right. And the reason why we also gave you this grid is when you start a personal services contract, and backup isn't quite the right word, it's to deal with -- maybe backup works for some of it -- to deal with, you know, when you start the year, you don't know how many applications you're going to get.

CO-CHAIR DUGAN: Right.

MR. CARVALHO: So if you look at the contracts that we've provided, that's that thick stack in the back. If you look at the actual expenditures, you'll see that when you sign a contract with somebody, it's an agreed-upon rate

for up to a maximum amount; but then during the course of the year, in most instances, you don't get to that maximum.

So Ray Passeri, off the top, I think his contract would permit up to $100,000.

CO-CHAIR GARRETT: He's in Florida, and we're paying him just a lot of money. I mean, it's --

MEMBER LYNE: Unless I'm not reading this right, I don't see a lot of money.

MR. CARVALHO: $14,000 last year.

CO-CHAIR GARRETT: Okay.

MR. CARVALHO: 11,000 the year before.

CO-CHAIR GARRETT: I have $37,000 on a contract that's included in here from March 1st, '07, to February, '08.

MR. CARVALHO: That's the up-to amount. In other words, when you sign a contract in state government, it has to say what is the maximum and --

CO-CHAIR GARRETT: So he gets basically $1,000 a month.

MR. CARVALHO: But if you look at the chart, the one that's sideways, it shows how much

actually was spent in fiscal year '07 on Ray Passeri, and it was $14,456.

The contract is written at the start of every fiscal year as if he could be available for 1,000 hours at his billing rate, but, in fact, he was called upon to do a lot less than that.

MR. MARK: We would like him to be available for more --

MR. CARVALHO: Yes.

MR. MARK: -- but he simply isn't.

CO-CHAIR GARRETT: Okay. Sorry I had all the questions.

MEMBER BRADY: I'm a little confused. The headline on the agenda says that we're going to discuss with you the financial operations of your organization, but Mr. Carvalho started off with giving the experience of your board. Susan got into questioning whether or not there were summaries or what? Is this a segment in our agenda where we're simply discussing the financial aspects of this board?

CO-CHAIR GARRETT: Budget, I thought it was budget.

MEMBER BRADY: The budget process.

CO-CHAIR DUGAN: Discussion of the process.

MR. CARVALHO: I started off with the defense of the board because I was remiss to not have done it sooner.

MEMBER BRADY: Okay. But Susan then got into -- I guess what I just want to make sure is there's some very serious questions that we have about the operation, the relationships of the people we're talking about, and the board members and how they come about their decisions.

When are we going to discuss that, or is that something you want to get into now?

MR. CARVALHO: Well, we did a presentation on that during the two training sessions. We had the whole flow chart that showed --

MEMBER BRADY: Yeah, I understand that.

MR. CARVALHO: -- exactly how people report to whom.

CO-CHAIR GARRETT: I mean, we have a few minutes. So if you can put that in and ask some questions. It's sometimes like pulling

teeth.

MEMBER BRADY: It is, and I think it's going to take more than a few minutes, in my opinion.

CO-CHAIR DUGAN: Yeah, I think it's another --

CO-CHAIR GARRETT: Why don't you say some of your issues, and maybe we can get started, and then in the next meeting, we can do something more?

MEMBER BRADY: Okay. Just to clarify for the record, and maybe my memory doesn't serve me as well, communication between staff and board member is permitted.

MR. MARK: Yes.

MEMBER BRADY: But not disclosed. In other words, it's not ex-parte communication, and conversations can happen privately between board member and staff.

MR. MARK: That is correct.

MEMBER BRADY: And we're not privilege to those.

MR. MARK: It's considered employee-to-employee communication.

MEMBER BRADY: In light of some recent issues with others, those give us a great deal of concern, those private conversations. It just gets into this whole framework, I think, of how these decisions are made.

As indicated before, whether you want to talk about a ranking or a summary or a recommendation or whatever, staff is in a position to make recommendations to the board, and the board is to weigh those subjectively in terms of overall approval and weigh certain ones based on that.

Staff therefore has a heavy influence through that document, which is the only opportunity, as I understand it, the only opportunity a board member has to discuss that application with anybody.

MR. MARK: Prior to the board meeting?

MEMBER BRADY: After an application has been made, otherwise, they are subject to ex-parte communication.

MR. MARK: Senator, if I may, just in terms of custom, the way we actually carry this out, and let me just clarify this because maybe

there is a misconception here.

As stated before, an application comes in, it's processed by staff, staff does an analysis and statement of findings. Yes, you're compliant; no, you're not.

At some point in our process in preparation for the upcoming meeting, customarily, myself and the Chair get together a week prior to the meeting, and I should point out that that's normally attended by our chief legal counsel, and we sit down collectively, and we go through with usually the supervisor of review, we go through each application: what are the key issues? What are the findings?

We do not at that time -- on behalf of staff, we do not attempt to influence a decision one way or another. Our intent is to make sure the Chair is aware of the issues, and that's what we attempt to do.

MEMBER BRADY: And I guess -- and we understand that. At least some of us have concerns about the fact that where all these discussions are part of ex-parte communication disclosure, that is not.

MR. MARK: That's correct.

MEMBER BRADY: Clearly there is a great deal of opportunity to influence in that. I mean, just take an example. It's been customary for at least the past two chairmen after those meetings to be the lead vote every time, if I am correct.

MR. CARVALHO: The first vote.

MEMBER BRADY: The first vote -- well, I guess is there a difference between lead and first?

MR. CARVALHO: I didn't know what you meant by lead, but --

MEMBER BRADY: I think you know what I meant. The first vote, lead vote seems to be the custom, and I think there's some of us that have a concern about that these private conversations take place, as you just indicated, and then that -- those are really the only other types of conversations that take place privately, as you have indicated; and then that person is the first to vote, which really gives I think the whole issue of transparency a new meaning here, which is a big reason I think we're in the trouble we're in

on Dearborn Street versus where we think we ought to be. Any comments on that?

MR. MARK: Well, I would only point out that we are the only -- we are the staff to the board members, and we are the staff to the Chair. They have no other staff to assist them with any of this material.

Dave, do you want to answer that?

MR. CARVALHO: Again, I think -- and maybe even after the meeting is over, if someone here, if we could get a copy of a State Agency report. I think you really need to look at a State Agency report and see what's in it.

You know, on the first page, there will be a chart that says there are seven other hospitals within 30 minutes, and here's the utilization in their OR. You know, three instances that utilization is below what our standards are.

This is all dry stuff. I mean, it's not, in our opinion, there's 30, you know, this many hospitals. In our opinion, utilization is, in our opinion there's three. I mean, it's all very dry stuff.

So all of that is summarized in the State

Agency report. That is what our staff does. Our staff doesn't go through and say this is a nice looking project, or this is a great set of blueprints, or this is a really good financial plan. They're testing it against the rules that have been adopted through the JCAR process and just saying it's this way or the other.

It's all dry stuff, but then the applicants can come up and say, oh, your staff included a hospital here which is really outside of 30 minutes or something like that. That's all dry stuff, too.

When you sit down with the Chair, and I occasionally sit in on the meetings, I usually don't have the time. But, you know, it's going through and saying, okay, on this one, there were four big negatives in the rules and you just want to refresh the Chair's recollection as to how those rules apply because it's going to come up in the meeting. There's not a lot of opinion in all of this.

MEMBER BRADY: If it's that dry and it's that mathematical, then why do we need board members at all?

MR. CARVALHO: Because at the end of the day, as Jeff said, if the -- for example, if you were to go through with Chairman Lopatka and say, they're negative on this rule because the cost per square foot in the application shows that it's 403 and our standard is 400. That's out of compliance.

So if there were no board, if there were just staff, you'd either have Jeff exercising his discretion to say, well, 403, that's not too bad, or applicant, I want you to go back to the drawing board and come in at 399, or you have the board doing it.

MEMBER BRADY: Which means sometimes those are accepted but out of compliance, and sometimes those are not accepted, which gets back to my point is --

MR. MARK: By the board, not by staff.

MEMBER BRADY: Absolutely, but staff, you, your legal counsel --

MR. MARK: Yes.

MEMBER BRADY: -- were the two people that had a private meeting with the chairman of the board prior to the chairman making a lead

vote. Now, if you can't see the public's scrutiny of that entire process --

MR. CARVALHO: If you met with the Chair before the meeting with the applicant's CEO or somebody like that, yeah, but, I mean, every one --

MEMBER BRADY: So you're defending those private meetings?

MR. CARVALHO: Between a person and their staff, yes.

MEMBER BRADY: So you think it's appropriate for the chairman of the board and the executive secretary to meet and discuss an application that ends up being subjective because it's close knowing full well that the chairman of the board is going to place the first or lead vote?

MR. CARVALHO: Yes.

MEMBER BRADY: You don't see any problem with that?

MR. CARVALHO: And I don't want to pick on Sister Sheila, but I would suspect that before she goes into her board meetings, if she's got issues on the agenda with her board, she meets

with her staff beforehand and makes sure that they apprise her of --

MEMBER BRADY: We're not talking about a board whose members are being investigated by the U.S. prosecutor. We're not talking about a board whose members can cause delays that are more or equally expensive to the denial of a project.

What we're talking about here is, I think, a transparent situation that the public can lay trust in, and you haven't convinced me, given the answers to the questions I have just asked, we are yet there.

MR. CARVALHO: First off, the current members of the board, none of them are being investigated; but second, there's two possibilities --

MEMBER BRADY: First off, I didn't indicate that any of them were.

MEMBER LYNE: It sounded that way.

MEMBER BRADY: Pardon me?

MEMBER LYNE: It did sound that way.

MEMBER BRADy: Then I apologize.

CO-CHAIR GARRETT: I'll tell you what I think we should do because I'm getting --

everybody down here is saying that we're going to have to pick this up again, and I think we should, but I think in summary what this does is whether you -- we've had corruption. Hopefully, that's obviously not happening now to the best of our knowledge, but you don't want a process in place that leaves things like that open for interpretation, for things to go wrong.

I think what we're trying to point out without pointing our finger is that there needs to be tighter, you know, maybe more oversight, more accountability, more transparency from what the staff's relationship to the board is, and for me at least, an oversight on how the money is being spent and why it's being spent and how it's being spent.

MR. DeWEESE: Senator?

CO-CHAIR GARRETT: So if we can agree to move on. Yes.

MR. DeWEESE: Senator, if I can just interject here, and maybe it's not the most appropriate comparison, but when we reviewed the composition and the relationships of staff to the board and that kind of thing, I know that the

Speaker was looking at the commerce commission as a model, and I don't believe in that circumstance the staff is precluded from or is in any way acting any differently than what this board does in relation to its staff. There certainly has to be input from the technical side before a final decision.

The commission members, the board members don't have the capacity, especially if they're not being paid, to do this independently. So they certainly have to rely on the technical expertise and support of somebody, and in this case, it's the staff in the Department.

CO-CHAIR GARRETT: I don't think there's any disagreement, Kurt. I think what we have to do -- because if we're going to, A, reform the process, we have to have this kind of information, and it's difficult to ask these questions. There's no accusations being made.

But I think we just need to understand how it works, and, you know, maybe the framework would be the same as the commerce commission, but, you know, maybe not. I think that's for us to decide ultimately.

So if we can move on because I think we have to, and then, Senator Brady, we can figure out a way to address this later because I do think it's important and I know that Representative Dugan does, too.

MEMBER ALTHOFF: I apologize because I'm going to have to sneak out early.

I would, just going back to what was stated earlier, make a suggestion, because obviously, we thought it was a good idea because we have already started with that.

With regard to budgeting, there's no way, shape, or form that I would ever assume that it's the board's responsibility to create, draft, and operate a budget; however, I would assume that today when we are so sensitive about what the responsibility of all boards are, I would certainly hope that a budget would be presented for review, and then at the end of the year, again, presented and just kind of reviewed again to see where the expenditures did go and where they were going.

I'd just throw that out to you. I don't think -- I think that's what staff is for is to

take it, draft it, present it, and then manage it, and then again just for the board to kind of supervise, oversight and make sure that that's exactly where the monies are being spent as per your approval. That's I think all we are trying to get at.

CO-CHAIR GARRETT: That's correct.

MR. MARK: That sounds like a good idea.

CO-CHAIR GARRETT: It's hard to dig that stuff up, but it should be a very --

MEMBER ALTHOFF: -- never anything else.

CO-CHAIR GARRETT: Okay. Shall we move on? Okay. We're going to move on. Thank you.

Anne Murphy, is Anne here?

MR. MARK: If I may, Ms. Murphy called me and informed me she may not be here today due to her having to testify at a federal trial. I believe our other attorneys are here. Our other two attorneys are here.

CO-CHAIR GARRETT: Okay. Good afternoon.

MR. URSO: Good afternoon.
MR. SILBERMAN: Good afternoon.
CO-CHAIR GARRETT: Whoever wants to go first. Mark would probably be the one to start out because you -- you were only there two years starting in 2006, maybe you're --
MR. URSO: Let me just maybe correct the record. I have been counsel to the Health Facilities Planning Board since 2003.
CO-CHAIR GARRETT: Okay.
MR. URSO: But general counsel for about the last year, year-and-a-half after Mark left.
MR. SILBERMAN: And I was with the Illinois Department of Public Health as the deputy general counsel, and then in 2006 took on the acting role as the general counsel of the Health Facilities Planning Board.
CO-CHAIR GARRETT: So I think we're here just to get an understanding of what your role is, and then we could ask questions and let the committee members.
You decide. Toss a coin.
MR. URSO: I guess I can start.

Essentially, we provide legal services, as Mark said, to the Health Facilities Planning Board. I am also deputy chief counsel to the Illinois Department of Public Health. So I wear several hats, like Mark and I have done in the past.

To the Health Facilities Planning Board, I provide legal services to the staff, to the executive secretary, and to all the board members. So in other words, I counsel them about criteria standards and the Code and the Act, in terms of the applicability of those things. I answer questions about interpretation of the statutes, interpretations of the Code.

We discuss potential conflicts of interest. Sometimes I discuss those directly with board members. I discuss them directly with the executive secretary.

We talk about potential and actual ex-parte situations, as Senator Brady has brought up. We try to get those out in the open. Mr. Carvalho has brought to my attention when he has been communicated to on various matters and seeks my opinion. Does this appear to be ex-parte

communication? Staff members, including Mr. Mark, present communications, emails, letters, telephone calls in terms of analysis of that ex-parte communication.

Much of my time is spent on the applicability of the Act and the rules in terms of applications, in terms of questions that come before the board, in terms of questions that come before the executive secretary. So I spend a lot of time doing that.

The majority of my time also is litigating all the compliance matters, and the majority of the compliance matters are post-compliance -- post-permit compliance issues; and so therefore, I spend a lot of time litigating those, negotiating those, settling those, going to administrative hearings on those in terms of litigation.

I also monitor the types of cases that go to the judiciary system. Many of the cases are lawsuits that go to circuit court, and so I'm monitoring and working with the attorney general's office because they, in fact, represent the board. So I've been working very closely with the attorney general's office in terms of strategy and

approaches and assistance in terms of litigation that goes beyond the administrative level.

I also attend all the board meetings, of course, and it just so happens that I sit right next to the Chair. So the Chair has an opportunity, if she so desires or I have an opportunity, to ask me a question about interpretation, or I can help her in terms of if she has a question on her mind in terms of, you know, are we getting into an area here that perhaps we shouldn't be getting into. Because all the material that comes before the board at a board meeting should be material that the board is aware of.

In other words, no new material should come before the board. In other words, the volumes of information that we talk about that go to the board members, sometimes -- I recall some project files being 25,000 pages on one of the new hospital applications to some that may be a couple hundred pages.

There may be questions that the Chairman has at the board meeting, and so I try to answer those, and we try to stick to the four corners, so

to speak, of the application and all the material.

If the applicants at a board meeting try to get into new information that's beyond the scope of where we're at at this point in time, if they want to try to intervene and present new information, there's methods, and there's options to do that, but not at a board meeting.

I try to assure that we stay on track. I help with motion formation at board meetings. At times, we go into closed session. We make it very clear what the reason is we go into closed session. I am very aware of the topics that we talk about in closed session.

I will tell you the foremost reason that we go into closed session is to talk about litigation and litigation-related matters, and that, in fact, is an exemption to the Open Meetings Act. So there's a reason, and we state in open session the exact section of the Open Meetings Act that is to be utilized when we go into closed session.

I also in many respects -- I'm cognizant of the Robert's Rules of Order and parliamentary procedure. So I have to make sure that we adhere to that -- to those avenues.

I try to be cognizant of the court reporter, because the court reporter gets tired at times, we give the court reporter a break, and that's very important to me because I want to make sure that everything is transcribed and transcribed properly.

At times some of the board meetings can be a little contentious and six people are talking at the same time. I try to negotiate that and tell everybody that everybody has to talk at one time so that the court reporter can get a very good record of what's being done.

I consult with board members many times during meetings if they have a question about conflicts, if they have a question about the media approaching them, you know, how they might want to deal with that. So there's a constant dialogue that's going on at the board meeting.

I guess that's in a nutshell just to let you know some of the things that -- Mark has been in the same role -- he and I were both involved in.

What kind of questions might you have at this point? Yes.

MEMBER SCHAPS: You mentioned that

part of your role is monitoring compliance.

MR. URSO: Yes.

MEMBER SCHAPS: So could you talk a little about that? Is that compliance as being the board might say, we want you to improve X or Y by 20 percent?

MR. URSO: Actually, the majority of compliance issues are someone who violates the Act or the Code. In other words, when someone gets a permit or an exemption, there are a number of steps they have to follow which we call post-permit requirements.

If they don't do that, and this is where the majority of our compliance issues stem from, if they don't do that, then statutorily we have fines that we can issue. We can, in fact, revoke a permit, although in the history of my being with the board, we have never done that. So these are sanctions that are issued.

MEMBER SCHAPS: Have you invoked fines, though?

MR. URSO: Yes, we have. Yes, we have.

MR. SILBERMAN: And if I could just

draw a distinction, there's two types of litigation, whether formal or administrative that can occur.

One is when a lawsuit is brought involving the board where the attorney general's office acts as the counsel to the Health Facilities Planning Board or its individual members; and in that circumstance, the general counsel acts as a liaison to the attorney general's office basically so that counsel from the attorney general's office has someone they can go to to act as liaison with the board members.

The other circumstance is when it's an administrative hearing, and that's when there's a violation of the board's regulations or acts, and the board makes a determination to initiate a compliance action in any given circumstance, and those are handled by counsel for the board.

MR. URSO: I don't know if we answered your question. Did we?

MEMBER SCHAPS: Yes.

MR. URSO: You said do we issue fines and do we obtain sanctions. Since about 2004, we've collected approximately $2.7 million in

fines and services in kind. So it's not all clean money, so to speak. Sometimes what --

MR. SILBERMAN: We need clarification on that phrase.

MR. URSO: Bad word, solely money.

MR. SILBERMAN: Basically, just to clarify that --

MR. URSO: Sorry about that.

MR. SILBERMAN: -- and now seems like a good opportunity. I have one disclaimer I do need to offer, which is when I'm offering an opinion, it's on behalf of myself, not our firm or our firm's clients.

But I think what Frank is meaning is this: one of the things that we've utilized as the board and as its counsel is resolving compliance matters with in-kind services, where effectively instead of just a payment of money to resolve an issue, utilizing that opportunity to create health care.

So the amounts that I think Frank is referring to would factor that in, but the idea of a hypothetical health facility would agree to provide screenings or services or testing which had a value to it, instead of just give money to

the Planning Act to resolve a case.

So I didn't like the use of "clean money."

MEMBER ROBBINS: Could I ask a question on what he just said?

MR. URSO: Yes.

MEMBER ROBBINS: With respect to requiring in-kind services --

MR. URSO: Yes.

MEMBER ROBBINS: -- is that something that is just reached by agreement between the board and whoever the provider is, or is there something in the statute that specifically authorizes these two types of sanctions?

MR. URSO: There is nothing in the statute that supports the authority to do this. This is purely, purely an arm's-length agreement between the board and whoever the noncompliant party is.

It's an avenue in which services can be provided back to the community because there are some loose guidelines that we follow, that the board has allowed us to follow in terms of deciding if a services-in-kind settlement would be acceptable and appropriate.

So in other words, we often look at services that this particular facility was not planning on providing. It wasn't in their strategic plan. These are things above and beyond. Okay. These are services directed toward insured and uninsured parts of their population.

These are services that have to be valued at cost. They can't be valued at markup. So if we have a $50,000 services-in-kind situation, those are true dollars.

MEMBER ROBBINS: Is that contained in the rules of the board?

MR. SILBERMAN: There is nothing in the Act that provides it other than the idea that the whole purpose of the board is to increase access to health care and to provide additional services to underserved communities.

MEMBER GAYNOR: But you have the backdrop of the ability to assess penalties.

MR. SILBERMAN: Absolutely.

MEMBER GAYNOR: So presumably the leverage that you bring to bear in that potential negotiation is that you can penalize them so that it's part of a settlement if they're providing

in-kind services.

MEMBER ROBBINS: I'm not suggesting that what you do is wrong.

MR. SILBERMAN: No.

MEMBER ROBBINS: I'm just trying to understand.

MR. SILBERMAN: There's nothing that prohibits it. There's no express using of in-kind services, but as Paul pointed out, where it says you can levy a $10,000 fine, there is nothing that prohibits saying we can either take $10,000 in fines to be paid into the Health Facilities Planning Act or something of equal value that even furthers the purpose of the board.

MEMBER SCHAPS: How do you decide? Where does that come from?

MR. URSO: What?

MEMBER SCHAPS: Whether you're going to do a fine of money or the services.

MR. URSO: Well, the notices go out. The noncompliant facility is made aware of the notice -- of the fines by a notice that are statutorily driven. The statute sets forth the amounts and the types of fines.

So, for instance, if there's cost overruns, there's a formula that we follow that statutorily provides guidance to us. If someone starts a major project, renovation, modernization without a permit, that's a violation, and there's statutory provisions about that. So, I mean, there's different categories.

One of the areas I think that if we're going to retain that system, and I offer to the task force, we need, I think, to revise that whole statutory scheme.

CO-CHAIR DUGAN: Do you give everybody the offer of in-kind instead of dollars? Do you give that to anybody that's not in compliance? Does everybody get the offer of possibly doing in-kind?

MR. URSO: Let me tell you that when we follow the language of the statute, we give huge fines, huge fines. The expectation of the board, at least in my discussions with my client, is that they're not interested in getting, you know, a $3 million fine from Peoria Hospital.

What they may be interested in, and, in fact, what worked in Peoria was that this hospital

in association with the local health departments, and that's one my caveats early on, is why don't you take a look at what the local health departments think the needs are in the community?

In this particular case, they thought prenatal care was needed in the Hispanic community. So their $250,000 services-in-kind agreement was to establish a prenatal clinic in a low-income area and make sure that they had staff that could cater to the Hispanic population. What they did is they now continued this clinic beyond that, but it was based upon our dialogue that they initiated with that particular clinic.

CO-CHAIR DUGAN: I think that's commendable. My question just was, do we make that offer to everyone that is not compliant that we have the right to fine? Is the policy, I guess, let's look to see if there's a health care need out there and give that same opportunity? So we don't have one place that has to actually pay the Health Facilities Planning Act $3 million, whereas then another health care facility gets to start new programs instead of paying the fine?

I'm just asking, does everybody get that

same opportunity?

MR. URSO: As far as the way I deal with this, everyone is given the opportunity to either discount or waive that fine if they're willing to offer services-in-kind. That's the way I put it.

Now, there's one exception to that. We had a number of $1,000 fines. You can't do much with $1,000 in terms of services-in-kind. So in those kind of situations, you know, we had talked briefly about services-in-kind, but you're really not going anywhere with that.

MEMBER LYNE: They pay the $1,000.

MR. URSO: They for the most part pay the $1,000.

MR. SILBERMAN: If I can add one aspect, and I apologize for talking over Frank, which is any time there is a compliance action that involves the provision of services, it involves reporting requirements, where you make sure it's not a question of we promise we'll do it, but you actually then have to provide reports to the board and to the staff to show that it's been done.

Therefore, when dealing with a minimal fine, you could end up spending more money than the original fine amount in tracking and keeping tabs on what was and was not done.

CO-CHAIR GARRETT: So when you get these fines, whether they're in-kind or they actually paid the full amount, is that listed somewhere? Is that something that, again, is transparent, so we can --

MR. URSO: All settlement agreements become public.

CO-CHAIR GARRETT: Okay. Do you have that, like if you wanted to go back in 2006, 2007, 2008, and see what the settlement agreement was and how did that money -- did it come back to the Department of Public Health, or did it go into a community? Can we get that information?

MR. URSO: Yes, definitely.

CO-CHAIR GARRETT: How do we get that?

MR. URSO: From the point where we have a compliance officer now -- Mr. Mills has been with us for how long?

MR. MARK: About a year-and-a-half, two years.

MEMBER GAYNOR: Actually, we do have some -- I don't know if this is comprehensive, but we do have examples of it in the March 6, 2007, signed by Secretary Mark and Mr. Urso, I guess it's a response or a supplement, however we want to take the Lewin Report -- it has an attachment that lists I don't know if this includes all of the in-kind settlements, but it does reference examples of in-kind settlements.

MR. URSO: Senator, for sure, as far as we can go, I can give you what you're interested in, the settlement agreements.

CO-CHAIR GARRETT: Okay. So I'm just looking -- it doesn't have -- oh, does it? Are these the dates? For instance, Vista Health is right here, is that in May, '02?

MR. URSO: I need to see what you're referencing here. Is this the Lewin Report response?

CO-CHAIR GARRETT: Vista Health has set up a foundation when they thought they were sold, and all of these dollars I thought came from the foundation, not from a settlement, but maybe the settlement went into the foundation.

MR. URSO: No, I think what we're seeing here is when you take a look at these, you'll see a docket number, and that immediately tells me that's a legal docket in the second --

CO-CHAIR GARRETT: Okay.

MR. URSO: Those are our docket numbers that designate to me immediately that these are cases of noncompliance or other violations and the settlements, in this particular case, are services-in-kind settlements.

Now, sometimes there's a mixture. I'll be quite honest. Sometimes, and I think you might see it in some of these where they pay part of a fine and also did services-in-kind at a certain value.

MR. CARVALHO: Senator, two things, the Vista thing you're thinking of is when a nonprofit becomes acquired by a for-profit.

CO-CHAIR GARRETT: Right.

MR. CARVALHO: That's the AG's office. That's totally separate. That's about a charitable trust.

These are things -- and to a certain extent the analogy of a prosecutor is a good one because

the things that lead to a fine on this board range from you filed your papers late to you closed your facility without going through the process -- that's kind of a bad one -- to you went $1 million cost overrun, and so Frank and before him Mark and before him Anne has always worked with the board to tailor the situation to the crime, so to speak.

If you filed your paper late, and it's $1,000 fine, according to the statute, then, yeah, maybe they'll just say give us $1,000 because that paperwork isn't just paper to put in the file, that's how we compile the inventory.

CO-CHAIR GARRETT: Okay. It's just there's no date, and I'm just wondering --

MR. CARVALHO: What you've got is not -- it's always good to look at what is the question that was the answer to. What you've got was not in response to a question, could somebody please put together a list of all of the settlements.

CO-CHAIR GARRETT: Okay. And if, in fact, the fines have been paid and, I mean, verification --

MR. CARVALHO: Pardon?

CO-CHAIR GARRETT: Just verification, I guess, I mean, they were asked to do. I'm assuming somebody oversees that to make sure that happens.

MR. CARVALHO: Yes, that report was put together in response to the Lewin Report. What Frank has said is he can put together a report with Mike Mills for 2007.

MR. URSO: If you want settlement agreements, I can find out the status because they have to report back to us on the progress of completing the settlement terms, and that includes the services-in-kind and any monies. You know, a lot of these are directed at the health department clinics. Have they, in fact, paid those monies? So Mr. Mills is our compliance officer, and he can find out the status of those, and I can get that.

MR. SILBERMAN: The only thing I guess I would say in sort of a little more answer to the how it's worked out, the comparison to looking at it from the prospective of a prosecutor is, I think -- as a former prosecutor before I came to public health, you work with your client to just figure out what's the right resolution.

CO-CHAIR DUGAN: And I would just like, if possible, I don't know if this can be done, but I'm interested also in the fact of the ones we made in-kind settlement agreements with and the ones we may not have and the reasons why these guys don't have an in-kind settlement agreement.

MR. SILBERMAN: Some people have no interest in -- they just pay a fine and be done, in my experience.

CO-CHAIR DUGAN: Then just tell me that's what it is.

MR. SILBERMAN: And there are some people who -- again, where this birthed from was partially the idea of taking a negative situation and creating a positive one.

CO-CHAIR DUGAN: I think it's a very good program.

MR. SILBERMAN: Part of it, though, is it's amazing that when you ask any entity to pay a fine to the government versus the creation of health care, there are people who said they'd rather increase the amount to create health care than to pay a fine. So some of it's

psychological.

MEMBER SCHAPS: We get a lot of benefits out of it.

CO-CHAIR DUGAN: Oh, yeah, I think it's a very good program.

MR. SILBERMAN: But that's one of the important aspects that was factored in is that -- and Frank said it, but I want to reiterate it because it's really one of the core things -- somebody charges $1,000 for an MRI, but the actual cost is $100. They get credit for $100 as far as the compliance action. It's not done at billed rates. It's done at the actual cost involved because otherwise people are going to -- we're going to, just let's figure out where the highest profit margin is and get this done as quickly as we can.

MEMBER GAYNOR: In a hypothetical, would that be -- it could be a hospital or an institution that isn't necessarily providing a lot of charity care in the first place?

MR. URSO: It could be.

MR. SILBERMAN: And there's some institutions -- like some areas of health care

where it's harder to do in-kind service. Like hypothetically, a dialysis center, but there was always a known -- there have been circumstances where there's been considerations of just financing a public health project that wouldn't have existed but for the compliance action.

MEMBER ROBBINS: Frank, is the converse of your answer that it could be, but in many cases or in some cases it could not be? Paul asked you about whether these are hospitals that do a lot of charity care.

MEMBER GAYNOR: No, that's not my question.

MEMBER ROBBINS: Okay. Maybe I misunderstood.

MEMBER GAYNOR: I'll tell you exactly what I'm asking him. I'm asking him -- because we have found it's public knowledge through our investigation and studying this issue for four years that there are many nonprofit hospitals that are providing diminimus amounts of charity care.

If they say it could be that -- please correct me, it could be where you did an in-kind settlement, wherein they get credit for charity

care that they otherwise should be providing. Okay. So it's not really, you know, any -- they should be doing it in the first place. So it's not really a fine to them.

MEMBER ROBBINS: We could have a debate on your basic premise, but this isn't the place to have it.

CO-CHAIR GARRETT: Right, this isn't the place, but I think once we get a listing, I would like to see five years of the settlement, the action that was taken, and if, in fact, that money was somehow, you know, given to the health department or whomever, how it was actually -- some sort of verification.

MR. URSO: We'll find out the steps, sure.

MEMBER O'DONNELL: I have a question on -- you said that you negotiate on behalf of your client. Who is your client? Is your client the State, or is your client the hospital?

MR. SILBERMAN: Okay. When I was the general counsel to the board, the client is the board.

MEMBER O'DONNELL: Okay.

MR. SILBERMAN: And therefore, that's where you get --

MR. URSO: The authority comes from the board. The board is made aware of every settlement proposal that, you know, meets certain screening criteria, so to speak.

For instance, if you have a huge fine, and they want to do $100 in free blood pressure screening, well, that's not going to get past me. Okay. I mean, it has to be substantial. I'm being honest with you.

So then I bring that or when Mark was there, you know, we brought these proposals to the full board, and they discussed it. Sometimes they ripped them apart. Sometimes we were way off base. Sometimes they said that's not enough.

I remember specifically when we had a physician on the board, previous physician, somebody wanted to do blood sugar screenings. And he says, those kits cost about $2. He said they're going to do 100 of those, and that's no money at all. So, you know, we had to go back and revamp it and continue our discussions and get everything on the right track.

MR. SILBERMAN: So, I mean, the client is the board, but at some point, the client is the people of the State of Illinois. I'm not saying that flippantly. I mean, when I was a prosecutor, your client -- you know, when I was an assistant state's attorney, the client is the people.

So the idea is trying to figure out what the right thing to do is. There's not a framework. There's not a X equals Y, you know, you don't know this situation warrants a 10-percent reduction in the fine or a 40. You just use your experience.

You know, Frank has been involved with the board longer than anybody, you know, as their counsel, and you see what happens in every case, and you do learn to understand where the right guideline should be, and then that information is given to the board, who has the discretion to make the decision.

MR. URSO: Let me make one more point here that I think is really important. The board is really concerned about not only the front end, but the back end. In other words, if someone comes along and says, as we've had, you know, we're going to do vision and hearing screenings,

we're going to do blood pressure screenings, PSA screenings, what's going to happen with all the negatives? What's going to happen if they find something through these screenings?

The board is always hammering away at me saying, Frank, okay, they found these problems, what are they going to do with them? So any deal we make, we make sure we fill it in, that we follow through. All right. What's going to happen here? Who is going to see these screenings? What's going to happen with these negatives? Where is this patient going to go, so those kinds of questions.

MR. SILBERMAN: I apologize. I keep asking Frank since he's still counsel for the board, I've got to get his opinion or his approval to talk about some stuff.

There was one thing Frank and I spent a good amount of time on where it was going to provide a breast cancer screening, but one of the things we figured out was it was to do so for a lower-income community, but the way it was going to happen would create a circumstance where they couldn't then qualify for the State-funded program.

So we killed the whole idea because the idea of, congratulations we've given you the information and prohibited you from being able to get the care necessary. You know, the foresight is put into these resolutions to make sure the referral structures are in place, to make sure that at the end of the day it is creating the health care that we want.

CO-CHAIR DUGAN: I have a question, and I don't mean this like a -- but I just want to make sure I understand.

MR. URSO: If it's as bad as what I said.

CO-CHAIR DUGAN: Exactly, and yours was on the record, too.

So when we start these programs or this health care access because of particular compliance issues, I guess my question is, from a health planning standpoint, which is, of course, I think what we're all trying to get to here when we get done, you know, hopefully by May, I think it is that they want us to get done.

So you're planning these health care benefits to the people, but they only come into

play if a health care facility or somebody is not following the law; am I understanding this correctly?

MR. SILBERMAN: I can tackle that as a concept.

CO-CHAIR DUGAN: Yeah.

MR. SILBERMAN: I think every community -- every community that has a public health department, whether they have their own or whether they're covered by a regional, has budgetary issues. Everybody has wonderful ideas that can't be implemented because of a lack of budget.

So what ends up happening -- whether it's a health care facility, whether it's a community, so what ends up happening is because the compliance action exists totally separate, you then force them, because one of the other things, and I think Frank mentioned it, but I'll reiterate it, is this can't be things that were previously budgeted for. This can't be things that were already planned.

What oftentimes happens is, you'll have, let's say, a private health care, and it will turn to the local community and identify what's a need

that's not being met, that exists, but for budgetary reasons hasn't been met, and you take that situation. That's where it really does turn a negative situation into a positive. Because it's not that the health care needs don't exist, but is there available funding to address every single health care need?

CO-CHAIR DUGAN: And I agree with you. I'm not saying that it's a bad idea. I guess I'm just trying to comprehend the fact that, yeah, my hospital, if they do wrong, that in my district, I'll get possibly some more benefits for my lower-income people because we're going to make my hospital do it because of a fine because they didn't follow the law.

But people that followed the law have had those same needs in their communities. The way we've got it set up, and I'm not saying it's bad, so don't take it the wrong way -- I guess I'm just trying to say maybe we need to look at as we go further with this thing, looking at something that if we have these noncompliant issues which put programs, health care access back into the community, then I guess I want to look at the

possibility of possibly health care needs that are in all the districts in Illinois, not just possibly someplace where a hospital decided not to follow the law.

MR. URSO: The important thing that I think we accomplish, and maybe not even knowing it, is we're forcing health care facilities -- hospitals, nursing homes, ASTCs, ambulatory surgical treatment centers, dialysis centers -- we're forcing them to talk to other health care providers or health care assessors in that area, which they don't do that often that I've seen.

CO-CHAIR DUGAN: Right.

MR. URSO: So we're telling them, go talk to your local health department, go talk to other people that know what's going on in the community and see what the needs are. That's what I think we need to continue.

CO-CHAIR DUGAN: I agree.

MR. URSO: We need to continue that kind of dialogue because many times they're very narrowed-minded. We have to take care of our bottom line, and we're concerned about our bricks and mortar and our patients, but they don't look

beyond that and see what the community needs are.

That's where the local health departments come into play. That's where clinics, neighborhood clinics, low-income neighborhood clinics come into play. I think there has to be more dialogue. We are in a sense forcing that hand.

CO-CHAIR DUGAN: Right. Like I said, I just think we need to expound on it to where we can even provide more benefit for those places that are, the hospitals that are providing the charity care and those kinds of things and have a good rapport. That's all I'm saying. I think it's a good idea. I just want to see it maybe --

MR. SILBERMAN: I won't disagree with you.

MR. CARVALHO: Representative, one of the recurring themes today is actually what role does the Department play in various things, and in this one, I'd say it's as consultant, which is to say the board kind of comes up with some ideas, and when, for example, that breast cancer was coming through, well, we wanted the breast cancer -- breast and cervical cancer.

We knew that it would have the consequence that Frank and Mark mentioned that if the screening didn't come through our program, the person wouldn't be eligible for the care down the road, so we were able to say, oh, you know, great idea, but here's why it might be a problem.

Then we also know because we certify all the local departments as well with IPLAN, which is a five-year plan of their needs, assessment of the needs of their community and identify the top three priorities.

So again, we knew if you send one of these facilities to their local health department, there would be a ready-made plan of action of what are some unaddressed needs in the community that they could then work it out. So we act as a consultant on these, but the ideas come from the board.

MEMBER ROBBINS: I actually wanted to go in a different direction. So if others have other questions --

MR. URSO: Can I make one more comment that I just thought of to Representative Dugan?

Many times we get into other areas besides the area that the facility is in because when we

take a look at settlements, and let's say it's a rural long-term care facility that, unfortunately, had some compliance issues, but they're part of a common ownership or a network of other facilities, so what the board has approved in the past is you can be -- you can provide services-in-kind not only in your community, but if you're associated with other facilities, the board has been receptive for you to have health care or screenings in other parts of the state where you might have other facilities.

So it may be a compliance in a facility community, but they are getting the benefit also, and that happens at times.

CO-CHAIR GARRETT: So let me just follow up and then -- I just want to make sure that the board, that you guys -- for instance, Lake County was deserving of $235,000, part of it goes the to Health Department, part goes to Health Reach.

Can you then send a letter to them, the Health Department, saying there has been a settlement, you will be receiving $60,000, and you send it to Health Reach? Do you do that? Is

there a paper trail of how this is going to be implemented?

MR. URSO: There's a settlement agreement.

CO-CHAIR GARRETT: Right.

MR. URSO: That's signed off by board counsel, facility counsel, finalized by the board. The board signs a final order.

CO-CHAIR GARRETT: Right.

MR. URSO: Many times the details of who has to report to who, who has the burden of making sure the money goes there is many times on the facility, but they have to report that to the board. You know, most of the settlement agreements, they have to report back, and they appendage letters they've sent to the clinic or to the Health Department saying they've satisfied, and that's when I take a look at the status --

CO-CHAIR GARRETT: Well, I think we need to just for my -- I spend a lot of time in Lake County, and I've never heard of this.

MR. SILBERMAN: And Senator Garrett, we also, in my experience previously, and I can't imagine it's changed, but money doesn't go to any

organization without previously getting their involvement.

CO-CHAIR GARRETT: I just want to make sure they're paid.

MR. URSO: Absolutely.

MR. SILBERMAN: So the facility who entered into the agreement has to report it to the board, and I think that's what you're asking for, but it's also we coordinate with the facility -- or with, like let's say a particular health organization in Lake County, they report that they got the money.

CO-CHAIR GARRETT: So you do have a paper trail then.

MR. SILBERMAN: There should be.

MR. URSO: We should have a paper trail on everything.

CO-CHAIR GARRETT: We'll wait and see. Ken, your turn, sorry.

MEMBER ROBBINS: Total change of direction here. Over the years, we've had a number of statutory changes to the Planning Act, and I'll use one as an example, but it's only just that, an example, changes in the ex-parte

communications.

As people who have had to try to enforce all of that and yet have a responsibility for a smoothly operating efficient system of determining whether applications are in order and for the board to make its decisions, I realize why some of those changes were made, but do you have an opinion as to whether any of those kinds of changes, no matter how well-intended, have tended to make it harder to be efficient and whether it is a benefit, a reasonable trade-off between efficiency and an attempt to resolve the issues that created this in the first place?

MR. URSO: Well, I can tell you during our tenure with the board that we have tried our best to curtail outside discussions to the best of our ability and to make sure that the board is transparent, as Senator Brady mentioned, and that the business of the board is conducted in open session, and we have really strived to do that.

When there is ex-parte communication, it does happen, that is something that's discussed in open session. So everybody who is at that open session hears what the trail was, so to speak, of

that ex-parte, and how it was inappropriate.

Then that's also -- that particular ex-parte communication is communicated to the ethics, the State of Illinois Ethics Commission. So we really try to work within the confines of the ex-parte dialogue.

At times it's difficult, especially when the terminology about impending and pending was added to it, we really struggled to try to figure out what that means so that we can draw a line and say, okay, if you go over this line, you're in the ex-parte arena.

So we've been struggling with that, and one of the ways that we've dealt with that is the 2006, September, the board instituted new rules with a letter of intent that is needed previously before one submits an application. When a letter of intent is sent to the board, that sets the line. Any communications after that are considered ex-parte.

MEMBER ROBBINS: I know you have worked very hard to try to function within the framework of the laws that were established. I think what I'm asking is, do you think that any of

those laws actually made things more difficult than they need to be in order to -- and yet still be in compliance with the spirit of what I think was trying to be done?

MR. SILBERMAN: Again, opinion of Mark Silberman for what it's worth. Yeah, one explanation is how the ex-parte rule combines with the Open Meetings Act combined with the structure of a five-person board.

Again, I've only had one ex-parte ruled during my involvement with the board. It was already in place when I succeeded Anne Murphy, but the reality of the situation is, with a five-person board, your quorum is three, and the majority of the quorum, one-and-a-half, which means two.

So on the Open Meetings Act, any two board members discussing anything triggered the Open Meetings Act. So that was a practical problem that came up that I don't know -- I mean, that might be exactly what was intended, but it certainly created a certain unwieldyness when you factor it in.

It got to the point where the

conscientiousness that was being displayed, one board member would be going through a 1,200-page application, find Page 988 was missing, but couldn't call another board member to ask are you missing Page 988 also because it was technically discussing business of the board which triggered the Open Meetings Act, and as Mr. Carvalho, Jeff, and Frank, and I'll verify, you know, we all went through with the board members, Open Meetings Act, how it's triggered, when it's triggered, how to avoid problems, the same thing with ex-parte.

MR. URSO: There's been an amendment to the Open Meetings Act since then; therefore, two members can actually talk to each other prior to a board meeting and not in closed session.

MR. SILBERMAN: That would make life easier.

MR. URSO: And that occurred in August of last year.

MEMBER ROBBINS: Again, I'm not -- this is sort of a hypothetical in the sense that I don't know how frequently it occurs, but it's my impression that many of the ex-parte rules changed the way that applicants could communicate with

staff of the planning board, sort of explaining details of the application, getting feedback and guidance and advice back from the staff to say, you know, I think if you guys clarified this point, it would be easier for us to work with. Am I right that some of that is still an issue?

MR. URSO: Well, the staff and applicants can talk in terms of technical assistance, and that is a provision within the current ex-parte statutory provision. So the staff very often has technical meetings with the applicants, so that part remains even today.

MEMBER ROBBINS: Okay. Apparently, I was under the misapprehension that that was still an issue.

MR. URSO: They won't have a technical assistance meeting with a board member. That's crossing the line. They can with board staff, including Mr. Mark or Mr. Carvalho or myself. We have had those.

MR. CARVALHO: Some applicants may also self-censor themselves thinking that they can't talk to the board, and so we don't know how to help them on it, but the -- I mean, the staff,

but they can talk about technical stuff.

Certainly, I am, I imagine Jeff, too, am very clear that if anybody wants to talk to me that we only talk about technical stuff. So if they want to talk about, well, how do you think the board is going to react to this or that, that's not technical stuff, so we can't talk about that. But if they want to say, you know, how many days after I do this do I have until I do that, and then I always tell them to talk to Jeff.

MEMBER ROBBINS: Thanks.

MEMBER BRADY: It's my understanding if I were to call on behalf of a financial advisor and put a good word in with one of the pension boards while an application was not being asked for, that's not ex-parte.

If I were to call on behalf of a hospital in my district and talk to a board member prior to an application, that's not ex-parte.

MR. URSO: I would say prior to a letter of intent.

MEMBER BRADY: In your professional opinion, does that really make any sense?

MR. URSO: Well --

MEMBER BRADY: Because all you have to do again is play around with the system. If the good sister comes to one of her senators and says, you know what, we'd like to get this done. What do you think? Well, let me see, have you filed an application? No.

I mean, just effectively lobby, not ex-parte, prior to the application. So I guess as we're trying to relook at some of the goofy overreaching laws maybe we put in place that actually create more impropriety, would you think that in your professional opinion that maybe this doesn't work the way it was intended, that people could easily, if not are, could easily get around it just by thinking one step ahead of the game?

MR. URSO: Well, I can tell you that I have encouraged all of the board members while I've been counsel to not talk about the substance of any pending, impending, probable application. They may bump into someone at a social event. I've encouraged them to shy away and not be involved in those kind of conversations.

MEMBER BRADY: I mean, you also would not tell them they would need to disclose that if

they did, would you?

MR. URSO: Well, I think, you know, since we have essentially defined impending and pending, which is the ex-parte definition, by the letter of intent, therein lies the line that would define the timetable for ex-parte or something that is ex-parte or not.

MEMBER BRADY: So under the letter of the law as you have defined it, we have only eliminated the solicitation for an application once it's pending, filed. We have not eliminated the solicitation for --

MR. URSO: Forever.

MEMBER BRADY: -- an application prior to it's being filed.

MR. URSO: That's correct.

MEMBER BRADY: Is that a flaw?

MR. URSO: I think it is, but I'm not sure how to correct it as we sit here today.

MEMBER BRADY: We can't correct everything. We can only try.

MR. URSO: But that definitely is. I agree with you.

CO-CHAIR GARRETT: I just have a

question on your relationship. So, Frank, you've been with the Department of Public Health for decades?

MR. URSO: Yes.

CO-CHAIR GARRETT: Okay. So your salary comes from the Department of Public Health --

MR. URSO: That's correct.

CO-CHAIR GARRETT: -- or from the Health Facilities Planning Board?

MR. URSO: No, from the Department of Public Health.

CO-CHAIR GARRETT: Even though you're currently the --

MR. URSO: General counsel.

CO-CHAIR GARRETT: Yeah, for the Hospital Facilities Planning Board.

MR. URSO: That's correct.

CO-CHAIR GARRETT: So there's no differentiation. Do you think it makes sense that the Hospital Facilities Planning Board would pay you out of their proceeds rather than the Department of Public Health?

MR. URSO: All I know is I'm paid from

the Department of Public Health.

CO-CHAIR GARRETT: But do you only do work for -- you do work --

MR. URSO: I do work for the Department of Public Health also. I'm the deputy chief counsel within the Department of Public Health.

CO-CHAIR GARRETT: So as a breakdown, I'm just curious how much time you spend with the Hospital Facilities Planning Board.

I'm just asking why it's coming out of the Department of Public Health's budget when we've got the budget to pay out of the Hospital Facilities Planning Board.

MEMBER SCHAPS: That's what Dave was talking about before, right, that 250,000?

CO-CHAIR GARRETT: Okay.

MR. URSO: Yeah, I think it depends on the number of issues. I think it depends, as we get closer to a board meeting, I am consulted more often, you know, on pending State Agency reports, on issues of applicability of the Act or the rules, on should this person be a co-applicant.

CO-CHAIR GARRETT: Has it always been

that way that your salary comes, even way back, even though you helped on the health -- okay.

MR. URSO: Yeah, my salary has always come from the Department of Public Health.

MR. SILBERMAN: And Senator Garrett, just so you know and to clarify that, before I was ever involved with the Health Facilities Planning Board, I was the deputy general counsel for public health. When I took over as well, I put on an additional hat, it was all extra. So, I mean, I got no -- there was no increase in salary, no new money, but --

CO-CHAIR GARRETT: No, I'm just trying to find how -- to make sure that the money we receive for these services pay your salary, sort of the taxpayers paying for your salary when it could be better spent for the Department of Public Health's project.

But your salary then comes out --

MR. SILBERMAN: It came out of the Department of Public Health, but what I'm saying is I still did everything that the Department of Public Health expected of me and then added to that everything that the Health Facilities

Planning Board needed.

MR. CARVALHO: Mark, she's not worried about whether you were adequately compensated.

MR. SILBERMAN: No, no, wait, Dave, the point that I'm making, though, is you're asking if -- what I'm saying is the way that it's been structured for the last couple of times, it's been additional work. So it's not that what needed to get done for public health wasn't getting done. That's the point I was getting at.

CO-CHAIR GARRETT: Yeah, that never crossed my mind. I was just trying to figure out that the money we receive from fines and from applications go to --

CO-CHAIR DUGAN: Pay.

CO-CHAIR GARRETT: -- pay the people that were working on those, not coming out of the Department of Public Health --

MR. URSO: Did we answer your question, Senator?

CO-CHAIR GARRETT: -- tax-payer funding.

MR. URSO: Senator, did we answer your question?

CO-CHAIR GARRETT: I think so.
CO-CHAIR DUGAN: It's changed. They're fixing it this year.
MR. URSO: Okay.
CO-CHAIR GARRETT: But then on this budget thing, the legal fees for 7 and 8 are about $9,000. I am just wondering then --
MR. URSO: Is that the administrative law judges? I don't have the document.
CO-CHAIR GARRETT: No, that's a different category.
MR. CARVALHO: We'll find out. Have we had outside counsel for anything?
MR. URSO: Recently, we have, but I don't know why it would be showing up now.
MR. CARVALHO: I don't know the detail on that one.
CO-CHAIR GARRETT: Okay.
MR. CARVALHO: By the way, I got the temporary staffing numbers for the last two fiscal years.
CO-CHAIR GARRETT: Yeah.
MR. CARVALHO: I just got an email. 2007 was Manpower, $11,978; and 2006 was Manpower,

$18,412; and Seville, which is like the city in Spain, $23,875. I forget one of those was upstate and one of those was downstate under the master contract.

Between Jeff and I, we can piece it together, but I believe what happened is you lost a secretary, and we had a temp for a while. The office in Springfield lost a clerical person. That's what Manpower and Seville sends us is clerical and secretarial and numbers people.

So when we're in transition between people, you may know, under the way personnel lines are accounted for in state government, when a person quits, their line still gets capped for a period of time as their benefits get paid out, and so you can't refill their job until they've stopped tapping it. So you have to get temporary -- if you need the work done, you have to get temporaries to fill it.

So we can break it down for you, but those are the orders of magnitude of the temporary services.

CO-CHAIR GARRETT: Do we have any other questions or old business or new business or

no business?

MEMBER BRADY: Do we have an agenda for Wednesday?

MEMBER SCHAPS: It was emailed, I think.

CO-CHAIR DUGAN: Yes, it was emailed to us.

MEMBER SCHAPS: Yes.

CO-CHAIR DUGAN: I know that --

MR. CARVALHO: It's short.

CO-CHAIR DUGAN: It's short because of it being a discussion.

CO-CHAIR GARRETT: And Barry Maram is not going to be appearing.

MR. URSO: Can I mention one thing?

CO-CHAIR DUGAN: Yes, certainly.

CO-CHAIR GARRETT: One more thing, Frank.

MR. URSO: Okay. In Section 10 of the current Act, that's what new process requirements are set forth.

CO-CHAIR GARRETT: Yes.

MR. URSO: I would request that this task force take a look at the time frames. They

are unrealistic in many respects, especially where it talks about having the hearing and the entire process completed in 90 days. This is in terms of due process.

CO-CHAIR GARRETT: Well, that goes to the point where some of the other states have that sort of a rotating only, sort of address certain types of applications at certain times of the year, so there's not a lot of other stuff going on, so maybe that would be something that we could consider.

MR. URSO: What I'm talking about is once the case goes into the litigation phase --

CO-CHAIR GARRETT: Yeah, right.

MR. URSO: -- and someone has a right to a hearing, that the statute the way it's currently set up it says that whole process has to be done in 90 days. That's unrealistic. That's all I'm saying is you might want to take a look at those time frames.

CO-CHAIR GARRETT: Okay. So you're going to get all that stuff we requested?

MR. URSO: I'm going to get you the compliance settlements for as far back as I can go

and let you know what the status is.

CO-CHAIR GARRETT: And if there's any documentation that shows --

MR. URSO: I will give you all the paper trails, yes. Because we have compliance files, I'll give you the entire file. How is that?

CO-CHAIR GARRETT: Okay. Perfect, I love that stuff.

MR. URSO: Okay.

CO-CHAIR GARRETT: Are there any other issues that we want to bring up before adjournment?

If there's not, is there a motion to adjourn?

MEMBER SCHAPS: So moved.

CO-CHAIR GARRETT: Is there a second?

CO-CHAIR DUGAN: Second.

CO-CHAIR GARRETT: Our meeting is now officially adjourned. We will see you Wednesday.

(Which were all of the proceedings had in the above-entitled matter ending at 2:35 p.m.)

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

I, Joanne E. Ely, Certified Shorthand Reporter No. 84-4169, Registered Professional Reporter, a Notary Public in and for the County of Kane, State of Illinois, do hereby certify that I reported in shorthand the proceedings had in the above-entitled matter and that the foregoing is a true, correct and complete transcript of my shorthand notes so taken as aforesaid.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this _____ day of _____, A.D. 2008.

_____
Notary Public

My commission expires
May 16, 2008.