S54512

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 14th day of April, A.D. 2008, at the hour of 9:08 o'clock a.m.

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

EX-OFFICIO MEMBERS PRESENT:

MR. DAVID CARVALHO, and

MR. JEFFREY MARK.

ALSO PRESENT:

MR. MIKE JONES,

MR. KURT DE WEESE,

MS. YOLANDA JONES,

MS. MYRTIS SULLIVAN.

CO-CHAIR GARRETT: Why don't we just go through -- does everybody have an agenda?

All right. I don't think we need to go around the table. So we're still waiting. We all have received the minutes via email. So they're going to bring some hard copies down. So why don't we wait until we receive those.

Then let's go into the Task Force Member Travel Reimbursement Procedures. That's handled through Springfield. So if you want to let us know how we can submit our receipts and get the money back, please feel free.

MR. CARVALHO: We have in Springfield Yolanda Jones from the Illinois Department of Public Health who can overview the travel and reimbursement procedures and then respond to questions that may come up on individual situations.

Yolanda.

MS. JONES: Yes. I am Yolanda Jones, travel coordinator for the Illinois Department of Public Health. If I am correct -- correct me, Dave -- this Board is on a receipt reimbursement basis?

MR. CARVALHO: Yes.

MS. JONES: Okay. Basically, the travel procedures are the same across the board for all that are involved. The same rules apply that apply for State employees. The only difference is rather than do a per diem, you will actually keep your actual -- the original receipt, and the original receipt will have to be turned in. You will use the same travel reimbursement form. We can actually provide those to you. They're actually -- we actually have them available on the Internet, and they can be printed off.

You just basically have to ensure that you have your full legal name, Social Security number. We will actually fill in the appropriate codes that you will be paid for, the starting time that you -- Okay. I'm sorry. Can you hear me there?

CO-CHAIR GARRETT: Yes.

MS. JONES: Basically, the form is pretty self-explanatory. You put the name and the location, which would just basically be the Illinois Department of Public Health. You would fill in -- there is a blank on there where you

fill in your Social Security number, your traveler's name and address. You just have to ensure that it's consistent across the board. If you're Martha A. Davis to start with, you will always be Martha A. Davis. You cannot change it. You cannot alter it. That information would be in Box No. 2.

Then you would actually move along to the appropriate account number. We will actually fill in that information for you. Your headquarters and your residence, you must fill that in in order to be reimbursed for that. Your headquarters and residence in this case will actually be your home address. So you just put the home city in which you reside, and then the home would be your residence because you actually are a Board member.

The year, date, and month for public health has to be filled in because the comptroller will reject it. So you will basically put in like today's date, you put 4/14/08. It must be the entire -- the month, the day, and the year.

You keep your receipts. If you took the Metra down and they charged you $2.40 on the Metra, you'd actually put $2.40.

For your lodging information, it has to be within the allotted State rate; however, we do reimburse you. So if in the instance -- because we know there's a lot of times going different locations because of the capacity of a -- a hotel is full, they will not honor the State government rate. So what we ask you to do is just let us know. We will actually get you an exception so that we can actually pay you the actual amount that you have actually stayed in a hotel for those costs.

You just basically go across the form, put in the transactions as they ask. Mileage is .485 until June 30th, and then after that, it's going to go up to .505 per mile. So until June 30th, it will be whatever miles you drive times the .485 multiplied, and that will actually end up giving you a full cost of what your transportation would be.

Parking, keep your parking receipts. We will pay you for parking. If you have tolls, make sure you just know how much you have actually had to pay for a toll charge. We will likewise pay you for that as long as you keep every receipt.

You will put them in the lines across the form and come up with a total, and once your total -- your total has to total across and total down, and then your reimbursement will be submitted in that form.

Ensure that you sign your reimbursement form in blue ink because it needs to be able to distinguish that it is an original signature. So we ask that you be reminded to utilize blue ink when you sign, send them in, and we will process your claims for reimbursement.

CO-CHAIR GARRETT: Any questions from committee members?

MR. CARVALHO: Yolanda, one question I know that comes up, how do the task force members get the State rate if they don't have State IDs?

MS. JONES: Actually we can get them State IDs.

MR. CARVALHO: Okay.

MS. JONES: What we will need is a picture of each of them, and we will create State IDs so that they can take advantage of the State government rates, and that will likewise be airlines, hotels, et cetera. So you must produce

your ID in order to obtain these rates.

So if someone in the Chicago area or who is the support person can get me pictures of each of the Board members, I will -- I actually do the ID. So I will make them IDs and distribute the IDs. As long as they present the ID, they're entitled to the State government rate.

MR. CARVALHO: Thank you.

CO-CHAIR GARRETT: Any other questions from committee members?

Can we make sure that everybody in Springfield identifies who they are and who is there so we know. I notice Pam Althoff is there. Could we just go around that table so all of us in Chicago, we know who is in Springfield?

We can't hear you.

MEMBER ALTHOFF: Pam Althoff.

MEMBER LANG: Lou Lang.

MR. JONES: Mike Jones.

MR. DeWEESE: Kurt DeWeese.

MR. FOLEY: Charles Foley.

CO-CHAIR GARRETT: All right. So we are now waiting for the minutes to approve. They still aren't back. Why don't we just go ahead?

MS. SULLIVAN: Did you introduce the people on the phone yet?

CO-CHAIR GARRETT: Oh, good idea. For those on the phone, do you want to chime in and let us know who you are?

MS. SULLIVAN: I'm Myrtis Sullivan, DHS, from the Office of Family and Health, Community Health and Prevention representing Secretary Adams.

MS. HACK: Susanne Hack, representing Barnes Jewish Hospital.

CO-CHAIR DUGAN: Representative Lisa Dugan.

MEMBER KOSEL: Representative Renee Kosel.

MS. BLACK: Melissa Black, Senate staff.

CO-CHAIR GARRETT: All right. Thank you very much. Thanks for pointing that out.

Okay. Why don't we move forward and go through our testimony. We have the State Med Society here, and I think James Tierney is going to be our first witness.

And if you'd like to come forward, and

Janet? Are you Janet Nalley?

MS. NALLEY: Yes, Janet Nalley.

CO-CHAIR GARRETT: Okay. Why don't you introduce yourself and explain who you're with. You're with the American Medical Association?

MS. NALLEY: That's correct, yes.

CO-CHAIR GARRETT: Okay.

MR. TIERNEY: Good morning, Madame Chairman, members of the task force. My name is Jim Tierney. I'm vice president of State Legislative Affairs for the Illinois State Medical Society.

I have with me today Janet Nalley who is with the American Medical Association, Department of State Legislation. Janet is an attorney who along with her staff has done a tremendous amount of research on a continual basis on the issue of health planning and specifically certificate of need issues.

The AMA serves as a clearinghouse, of course, for the many state medical societies who are confronted with many issues that are common throughout the country and that state medical

societies deal with on a regular basis. So we rely on the AMA to do this kind of research and prepare and deliver testimony for us on some important issues that confront all state governments.

We're, of course, fortunate here in Illinois to have the American Medical Association located here in Chicago; and they, of course, count among their members several thousand Illinois physicians.

So I'm glad to have Janet here today to provide you with a great deal of information and share with you their research on the certificate of need process, which is referenced at the back of her testimony, which I believe has been distributed to all of you.

So Janet, please.

MS. NALLEY: Thank you, Jim.

Madame Chairperson, ladies and gentlemen of the Illinois Task Force on Health Planning Reform, my name is Janet Nalley. I'm an attorney who works for the American Medical Association, Department of State Legislation. I spend much of my time monitoring national and state legislative

and regulatory certificate of need developments, as well as reviewing academic and legislative studies examining CON programs.

I appreciate the opportunity to discuss with you today how the weight of evidence concerning CON programs supports the assertion that CON repeal would be beneficial to Illinois's health care financing system.

First, I'd like to discuss why CON programs do not achieve their stated goals. In terms of CON's alleged ability to meet cost control, quality, and access goals, it can safely be said that the February, 2007, Lewin Report prepared at the request of the Illinois legislature, with which I'm sure you are probably familiar, got it right when they stated that our results are consistent with a body of literature that indicates CON rarely achieves its stated goals.

First, regarding cost, there is a compelling body of peer-reviewed academic studies and state legislative commission studies that demonstrate CON programs have failed to restrain health care costs, and in many cases have actually increased health care costs.

CO-CHAIR GARRETT: Janet, could you just speak up a little bit?

MS. NALLEY: Sure.

My submitted testimony discusses a number of noteworthy academic studies and state legislative commission studies, but at this point in the interest of time, I'll just highlight a couple.

First, two noted public policy scholars from Duke University, Christopher Conover and Frank Sloan, published a study in 1998 that examined the purported cost-control claims of CON over a 20-year period, and focused on whether CON repeal would lead to increased health care costs -- would lead to health care costs.

It concluded that there is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations.

Also in 2006, Georgia State University provided a report to the Georgia Commission on the Efficacy of CON programs that concluded -- and pursuant to a request from the state legislature, that also concluded that across all markets, states ranked as having the most rigorous CON regulations have statistically significantly less

competition than non-CON states and that lower levels of competition are associated with higher costs. It also found that CON regulation is associated with higher private inpatient costs.

So at a minimum, not only would CON repeal not result in higher health care costs in Illinois, but it may actually lower health care costs due to increased competition.

Second, I'd like to address the issue of quality and how CON is not an effective quality improvement mechanism. Although CON programs were developed to address -- were not developed to address quality concerns, some CON proponents have contended that they do promote quality; however, these quality claims have also been closely examined, and the results are at best inconclusive.

The Georgia legislative study I just referenced stated that while there is considerable variation on a number of dimensions of quality across markets, there is no apparent pattern with respect to CON regulation and no statistical correlation.

Another Conover and Sloan study was

commissioned by the Michigan Department of Community Health in 2003 to evaluate Michigan's CON program, and it stated that its research findings are inconclusive regarding the ability of CON to improve quality, and they added that it may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost-effective means such as regulation and licensing and/or outcome reporting to the public.

Finally, I'd like to address the issue of access and that there is little evidence that CON positively affects access to care. For example, the 2003 Michigan study that I just referenced stated that CON has a limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured.

A 1999 study performed by the Washington State Joint Legislative Audit and Review Committee on the effects of CON and its possible repeal concluded that not only had Washington's CON law had no effect on improving access, but in some instances, CON rules are used to restrict access

by preventing the development of new facilities.

The second area I'd like to address deals with issues regarding physician-owned facilities that compete with general hospitals. To the extent that the Illinois legislators are concerned about the effect that CON reform may have on general hospitals in Illinois, I want to emphasize that the best evidence indicates that specialty hospitals have had no negative effect on competing general hospitals and their ability to provide community services.

First, there are numerous federal studies that support this conclusion. Since 2005, there have been six reports issued by GAO, CMS, and MedPAC that have examined a range of specialty hospital issues and have found that not only are general hospitals largely unaffected by competition from specialty hospitals, but specialty hospitals actually stimulate a competitive environment in many markets, which can have positive effects on the quality care.

Specifically, the 2006 GAO report found that there was little evidence to suggest that general hospitals made substantial operational or service

changes or discontinued a service due to specialty hospital competition.

Also MedPAC's 2006 report found specialty hospitals do not have a statistically significant effect on the total revenue or total margins of community hospitals in their markets.

In addition to federal studies, there are also a number of studies on states without CON programs that support these federal findings. Specifically, two states, Kansas and Texas, are two states without CON programs and studies highlighting their experience demonstrate this.

For example, a 2006 Kansas study conducted by the Kansas Health Institute in partnership with the Kansas Department of Health and Environment determined that the entry of specialty hospitals did not clearly impact overall general hospital revenue and margins.

Similarly, a 2006 study by Mathematica Policy Research on the impact of specialty hospitals in Texas from 2000 to 2004 did not find an adverse net impact on the operating margin, total margin, or uncompensated care as a percent of revenues of general hospitals due to specialty

hospitals. In fact, this study found that admissions to both specialty and general hospitals increased during that time period.

Further the Lewin Study that I mentioned earlier concluded that its collective research and analysis did not support the argument that CONs provide a protective effect for safety net hospitals' financial status. In fact, it found that hospitals in states without CON programs had margins than those hospitals in states with CON programs.

The findings of these studies help to address the criticisms posed -- raised against physician-owned hospitals.

First, they answer the argument regarding self-referral and over-utilization. Both MedPak and CMS have found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer these patients to that hospital or have increased utilization rates.

The 2005 CMS report recognized the constraints placed on physicians with regard to where they refer their patients, given that physicians working for networks affiliated with a

community hospital may be contractually obligated to refer those patients to that hospital.

From this perspective, the impact on physician referral patterns is more likely to be attributed to the significant growth of the number of physicians directly employed by hospitals or other medical centers than to the growth of approximately 200 specialty hospitals when compared to the vast number of hospitals nationwide.

Also critics of physician-owned hospitals also cite concerns about so-called "cherry-picking," however, this issue has also been addressed at the federal level.

The Department of Health and Human Services stated in its 2006 final report that it believes that the best way to deal with perceived unfair competition is to make the DRG payment system more accurate. In fact, measures are currently being implemented by CMS to reform Medicare's DRG classification system and adjust reimbursements to more closely reflect health status upon admission.

Finally, I'd like to take into account the nature of the financial arrangements of these

physician-owned specialty hospitals. Just as in other business ventures, there is a significant amount of risk that goes into opening up these facilities, risks that physicians will not necessarily want to take on alone or would be hesitant to do so.

A 2003 GAO survey of specialty hospitals found that 30 percent of specialty hospitals had no physician investors; and for half of the facilities with physician investors, the average individual physician ownership share was less than 2 percent.

The 2006 CMS-funded study in "Health Affairs" found that ownership incentive appeared to only matter when ownership levels far exceeded the average.

Also in many instances, physician-owned hospitals involve some type of joint venture between physicians and a hospital or corporation. According to the Physician Hospitals of America, there are currently 194 existing physician-owned hospitals; and of those hospitals, 103 or approximately 52 percent are joint ventures with general acute-care hospitals.

I came across a recent article in "Modern Healthcare" that I thought was interesting and illustrative of this type of arrangement in Texas, home to more physician-owned short-stay hospitals than any other state in the nation.

Rather than resisting these hospitals, some prominent hospital systems have chosen to embrace them by partnering with physicians to develop these physician-owned hospitals. These hospitals consistently earn high ratings in both patient and physician satisfaction scores, and the revenue is invested back into the not-for-profit hospital on its mission.

I'd like to conclude by saying that I applaud the Illinois Legislature --

ON THE PHONE: Excuse me, can you move her a little closer to the mike, or move the mike a little closer to her?

CO-CHAIR GARRETT: You'll just have to speak louder.

MR. TIERNEY: We don't have a microphone.

MS. NALLEY: I'd like to conclude by saying that I applaud the Illinois Legislature for

its willingness to scrutinize its CON program, as a number of the other 35 states with CON programs are doing, which includes Alabama, Alaska, Florida, Georgia, and Missouri. In fact, the Georgia State Legislature just recently passed on April 4th of this year significant comprehensive reform of its CON law.

I hope that you find this information useful as you think about your own state's CON program, and I would be happy to answer any questions.

Thank you for having us here today.

CO-CHAIR GARRETT: Is there a way to move the speaker closer or move this table over there? There seems to be a -- yeah.

(There followed a discussion outside the record.)

CO-CHAIR GARRETT: We're trying to make the sound a little bit louder for you guys.

Okay. So, Jim, do you want to follow up, or do you want -- how does the committee feel about asking questions and then asking Mr. Tierney to provide testimony, or do you want to hear the testimony all at once?

Why don't we go ahead.

MR. TIERNEY: Well, I just have brief remarks, and then we would be happy to answer any questions that you might have.

As you know, you know, the certificate of need process began decades ago, and it was certainly appropriate at the time that it was instituted, and I don't think we have an argument with that. But, of course, the health care finance system has changed drastically since the certificate of need process was instituted.

In our view, the change in the health care finance system, along with federal and state regulations with respect to reimbursement, have really negated the need for the certificate of need process, especially as we know it today.

So we would urge you to consider those facts along with others and certainly the studies that have been performed throughout the country with respect to CON as you make your recommendations.

As we oppose the continuation of the CON process quite strongly, I must also state at the same time that we certainly oppose extending the certificate of need reach into physician offices where it has not existed in the past.

Certainly, you may consider, and I suppose you might recommend that CON be continued for hospitals and ambulatory surgical treatment centers, but we would certainly urge you not to extend its reach into physician offices.

Certainly, we have a number of impediments already in the state that serve to discourage physicians from locating practices in Illinois. We have many underserved areas in this state for physicians, and I certainly would hope that you would not raise any further impediments to -- that would discourage physicians from locating their practices in Illinois.

In the meantime, as you continue your discussions, I hope you would not hesitate to ask us for further information. We would certainly be happy to provide that to you and would welcome any other opportunity to appear before you as you deem necessary.

CO-CHAIR GARRETT: Why don't we let the Chicago committee members ask questions first, then we'll go to Springfield, and then the phones.

All right. Go ahead.

MEMBER GAYNOR: I have a question for

Ms. Nalley. I'm Paul Gaynor from the Illinois Attorney General's Office.

I just would like you to comment on this statement: "It is also well-documented that physician-owned hospitals focus on the more profitable services and/or less complex, higher-income, and better-insured patients."

Is that your experience of which you know about specialty --

MS. NALLEY: It is not, and I think that it goes back to the issue of cherry-picking that I think is proposed quite often. I'm sorry.

That goes to the issue of cherry-picking that I had mentioned in my testimony. As I discussed there, that issue that has been raised is being addressed at the federal level, any concerns as far as addressing of the DRG payment system and classification system.

The Department of Health and Human Services found that that was the most appropriate means to addressing any concerns related to that, but they also, you know, are quoted as being perceived as an unfair competition.

MEMBER GAYNOR: So you're saying it

should be handled at the federal level, but you dispute the fact or the contention, I should say, that physician-owned hospitals focus on more profitable services and/or less complex, higher-income, and better-insured patients. You dispute that contention.

MS. NALLEY: I do not think that they go out looking for that. I think they do specialize in certain procedures, and I would say their specializing is not necessarily a per se negative thing. In fact, there's a lot of beneficial aspects of that, and we've seen a lot of good results from these facilities as a result of the specialization in certain procedures.

MEMBER GAYNOR: But within that specialization, do they focus on more profitable services?

MS. NALLEY: I don't see that as being -- the focus wasn't seeking out certain profitable services over others. I think it results in a procedure level, and there may be differences, but I don't think we see that as being sought out.

CO-CHAIR GARRETT: Any other

questions? Go ahead.

MEMBER ROBBINS: Perhaps to pick up a little on what Paul was asking. I'm Ken Robbins from the Illinois Hospital Association.

Is it your contention that there is no problem, or that it is better addressed at the federal level than through a CON process?

MS. NALLEY: I would say that any concerns regarding this issue -- I don't think it's something that is intent or inherent with the specialty hospitals, that they're seeking out profitable patients --

CO-CHAIR GARRETT: Can you speak up?

MS. NALLEY: Okay. I'm sorry.

I think that any concerns are best addressed at the federal level through the DRG classification and changes.

MEMBER ROBBINS: And your assertion is that those changes are now being made at the federal level?

MS. NALLEY: Yes, they are.

MEMBER ROBBINS: But they're not making them in a vacuum. I assume they're making them because they perceive there to be a problem.

MS. NALLEY: Well, and they're to address perceived unfairness or unfair competition, not stating that that is necessarily a founded instance, but that it would address any perceived unfairness.

MEMBER ROBBINS: In a 2006 study by MedPAK, it was reported that for physician-owned specialty hospitals, the median percent of Medicaid patients served was 3 percent in heart hospitals and 13 percent in community hospitals.

Wouldn't you agree that that represents an issue that needs to be addressed?

MS. NALLEY: I would say that that's -- that that alone does not per se say anything negative with specialty hospitals, that they actually as an overall matter present more uncompensated care when considering the volume of uncompensated care that they deal with as well as taxes, that general hospitals have a --

MEMBER ROBBINS: I was talking about Medicaid patients.

MS. NALLEY: Well, I definitely don't see that being a problem with what they focus on and the work that they do, and that they're -- you

know, I don't know.

Jim, do you want to answer that?

MR. TIERNEY: Well, yeah, let me try and address some of the issues and concerns with respect to community hospitals and these types of important hospitals that serve our communities.

You know, speaking for the medical society and our physicians, we, of course, want to see our community hospitals do well. They provide a critically important service, and they're very essential to, you know, all the citizens of our state.

You know, we've seen recently in the newspaper about St. Francis and the unfortunate closing or suggested closing of that hospital. I doubt that it was a specialty hospital or a physician hospital or an ASTC or anything like that that is causing the significant losses that particular hospital is experiencing.

It is essentially perhaps a higher population of uninsured patients and uncompensated care; and perhaps even more importantly, the under-reimbursement that our state government gives virtually all of our health care providers,

whether that's a hospital, physician, pharmacist, or whomever.

I see no correlation between what's happening in south Cook County with competition from specialty hospitals.

I think it's incumbent upon our state, and we have come forward this year to the legislature asking for increased physician reimbursement for Medicaid. It's costly, but, you know, the state has made promises to the poor of this state to cover them, yet given the reimbursement levels, there is no access for that coverage.

So the same I think is true for community hospitals. They need fair reimbursement from the state to cover those services that they offer to our Medicaid clients. That's critically important, but, you know, that hospital did not fail because of competition from a specialty hospital or an ASTC or whatever.

Secondly, I want to make the point as well about how our health care finance system works. In today's world, insurers are trying to, of course, find the highest quality care that can be delivered at the lowest possible price.

Sometimes -- you know, most of the surgical procedures in this state are precertified by these insurers, and these insurers as well oftentimes select where that procedure will be done.

If, in fact, this insurance company or private insurance company has a contract with an ASTC or in some cases around the country a specialty hospital, they will guide, if not require that that procedure be done at that facility based upon quality and cost. Obviously, there is no competition among quality and cost without competition between facilities. So you need to keep that in mind.

It's often -- the physician is not going to get paid any more or any less, I don't think, regardless of where that procedure is going to be performed. You know, there are fee schedules, and they're tight. Physicians just don't bill and say, Gee, I can make this much over here or that much over there.

These payments schedules are rather strict. Physicians cannot just charge whatever they want because they have contracts with private insurers, or they have performed the procedure according to

the strict Medicare payment guidelines or Medicaid payment guidelines.

So I can see how private insurers might guide people to perhaps an ASTC or a specialty hospital, Ken, because it's going to save the patient money. It's going to save the insurance company money. There's tremendous pressure among everyone, I suppose as there should be, to bring the cost of health care down. And if a physician or in many cases an insurance company can get the same service, provide it at significantly lower cost, then I suspect we ought to expect that they'll do that.

MEMBER ROBBINS: Jim, I can see why an insurance company would prefer to send a patient to someplace where it might cost less because I can also understand that they don't have the community responsibility to be sure that a full range of services are in place like a community hospital would have: emergency room services, trauma services, high-level ICU services, 24-hour a day availability.

While I'm not -- and I'd like to keep the focus on my comments on the specialty hospital. I

think the ASTCs represent a different issue.

I don't think it's an answer to the concern about specialty hospitals to say that insurance companies might find it preferable to send patients to some place when they don't have that other community responsibility.

MR. TIERNEY: Well, keep in mind also these specialty hospitals are probably for-profit and would not enjoy the tax benefits that our not-for-profit community hospitals have; and as a tradeoff for those tax benefits, you know, they are expected to provide that type of service and essentially receive a subsidy for doing so.

These other facilities will be paying taxes. These other facilities will be paying taxes; and, you know, if the government decided that they should have the same types of tax benefits as not-for-profit hospitals, and I'm not -- you know, and even not-for-profit hospitals, quite frankly, are not not-for-profit.

Did you get that?

So, you know, I understand the concern.

Let me say this about specialty hospitals in this state. You know, even if the certificate of

need process were to be repealed or discontinued, you know, I do not suspect that specialty hospitals would sprout up all over this state. I think that's highly unlikely.

For the most part, I think physicians have very good working relationships with their hospitals. They like working at their hospitals. They cooperate with the administration to try and deliver high quality care in this state.

There are significant risks, economic risks, if you will, to starting these types of facilities. For the most part throughout the country, I know that even where some of these specialty hospitals have been started, they were having their own financial difficulties and were ultimately, guess what, purchased by not-for-profit hospitals.

So I think physicians are not just, you know, wanting to go out there and start these specialty hospitals. For the most part, I think you see a lot of cooperation among physicians in hospitals to start joint ventures.

You know, physicians, quite frankly, in this day and age are not the deep pockets that perhaps

they once were. For the most part, the available capital for investment in the health care system belongs to hospitals which have amassed some significant reserves, to say the least, in this state, some perhaps not so much as others.

But nonetheless, there are hospitals in this state that do quite well, and we're glad to see them do quite well because, you know, they're in a position to reinvest their capital in the future of health care. We have wonderful hospitals and institutions, learning institutions in this state, and we hope it remains that way, and that does take quite a bit of money.

Health care is not cheap; and if we decide to do it on the cheap, I think we're going to suffer considerably in terms of not just access, but also quality.

MEMBER ROBBINS: Just one point of clarification; when I was talking community hospitals, I wasn't distinguishing between the for-profit or not-for-profit community hospitals. Even for-profit hospitals have 24-hour emergency rooms, intensive care units that are very sophisticated, very sophisticated.

So the distinction I make when I talk about the differences in admission of Medicaid patients and the kinds of patients that are admitted to specialty hospitals, it does not distinguish between for-profit and not-for-profit.

MR. TIERNEY: I have a point. You know, physicians on average in this state perform about 7-1/2 hours per week of charity care much like our hospitals do. That averages out to well over $50,000 a year according to the latest studies I've seen in charity care. I believe that charity care is delivered irrespective of the facility.

So I -- you know, we both have those obligations, both professionals and institutions, and, you know, we hope both live up to that.

CO-CHAIR GARRETT: I mean, let's -- Paul, I thought you were going to follow up on that.

MEMBER GAYNOR: I mean, you make an important point, Mr. Tierney, that specialty hospitals are for-profit entities, right, their business -- they're --

MR. TIERNEY: I suppose they could be

organized differently, but I think for the most part they are for-profit facilities.

MEMBER GAYNOR: Okay. And to that end, they tend to treat only a small share of Medicaid patients and rarely treat patients who cannot pay for their care; isn't that right?

MR. TIERNEY: I don't have any hard statistics on that. I will perhaps trust what Mr. Robbins said. I suspect that that may be correct, but I don't have any hard facts in front of me.

Do you know, Janet?

MS. NALLEY: That a percentage of Medicaid --

MEMBER GAYNOR: They take a lower, a much lower percentage of Medicaid patients.

MS. NALLEY: A relative percentage is lower.

MEMBER GAYNOR: It's much lower; right?

MS. NALLEY: I don't have the statistics in front of me.

MEMBER SCHAPS: Ken said 3 percent to 13 percent.

MEMBER ROBBINS: Yes.

MEMBER GAYNOR: So isn't that cherry-picking right there? Haven't we just identified that that is cherry-picking then?

MR. TIERNEY: Well, I wouldn't necessarily characterize it as cherry-picking. You know, physicians, depending upon their patient mix, if you will, are typically going to choose the facility that's best for their patient.

If they can do a procedure at a facility where it costs less and yet quality is assured, I think they perhaps would choose the lower-cost facility. I don't see anything wrong with that.

MS. NALLEY: There are nonfinancial reasons, as Jim is saying, for a physician to refer to a certain facility having to do with patient choice, scheduling issues, equipment, quality.

Also investment in that facility, it might not be -- there are other nonfinancial reasons that a physician might want to invest in a facility. They might just want to have more control over the management of the facility, the decisions made, the equipment used. Those are all

valid reasons to be considered.

MR. TIERNEY: Frankly, I'm not sure where specialty facilities are located, and we don't -- we have very few in this state, so I'm somewhat unfamiliar with them because we really don't have any here in Illinois that I'm aware of.

MEMBER LYNE: Not just the specialty hospital, but the ambulatory care, and it's about location, the thing is location, right, where the income is higher?

MR. TIERNEY: Sure. Well --

MEMBER LYNE: I mean, there's no question about where you're going to get this disparity between the higher Medicaid versus lower Medicaid.

MR. TIERNEY: Well, if you're a physician, and you're licensed to practice medicine, and you have studied all your life to do so, I mean, you want to practice your profession.

Keep in mind that there are some hospitals in this state, in fact, there could be many of them, that have exclusive contracts with certain physicians or physician groups to provide a particular service.

So, for instance, if you have a number of hospitals in the area or perhaps one or two that have an exclusive contract with a group of physicians to provide, let's say, orthopedic surgery, that means other physicians who want to perform orthopedic surgery are frozen out and have no alternative, but perhaps to start their own facility; otherwise, they're going to move to another state, and I'm not sure that does the State of Illinois or its citizens any good.

CO-CHAIR GARRETT: I think what the point is is that the ambulatory surgical centers locate in more affluent areas, and that's understandable, but they're open 9:00 to 5:00.

So when you've got the emergency room patient who needs to get to -- have access, they're not going to go to the ambulatory surgical center, they're going to go to the hospital, which, you know, I guess it's somewhat like cherry-picking. They have nowhere to go but the hospital, and many of those patients are under- and uninsured, whereas at the ambulatory surgical center, it seems to be a clientele that has insurance.

MR. TIERNEY: Well, I'm not going to disagree with that. I suspect if you gave, you know, these ASTCs the tax breaks that a community hospital gets, they might redesign their facility; but, you know, let's face it, if you're going to start, you know, an ASTC or any other type of health care facility, including a medical practice, then you need to try and find a way to cover your costs and to make a profit.

CO-CHAIR GARRETT: But the costs are borne then back on the hospital. I'm just making the point that I -- the way I understand it, it's not that these centers are problematic, but only that they're open during like a 9:00-to-5:00 workday; and unfortunately, people who get sick or have, you know, problems, that doesn't happen only 9:00 to 5:00.

MR. TIERNEY: Well, the last time I got a bill from a hospital for emergency service, it was rather significant. Suggesting that hospitals somehow do not -- are not in a position to earn a profit from operating an emergency room I don't think is necessarily true. There is no question that overhead is significant for

providing that service, but hospitals -- hospitals charge for providing that service.

CO-CHAIR GARRETT: Right, but --

MR. TIERNEY: Now, they may have -- and part of the point, I suppose, is that okay, you get a higher degree of Medicaid individuals visiting emergency departments --

MEMBER LYNE: And certainly --

MR. TIERNEY: -- that may be true; right? At Mercy Hospital, I am sure that's entirely true, and at certain other facilities in this state, I'm sure it's quite certain -- quite true as well. How much does the state reimburse for providing those services? Probably far under the cost.

So is it some other facility's fault that they have a facility and are offering high quality, low quality care that the state is under-reimbursing hospitals for the services they provide? There's a disconnect here about cause and effect that I think you need to give serious consideration to.

CO-CHAIR GARRETT: The ASTCs tend to want to locate in affluent areas. I believe

that's true. I don't have the numbers or maps or anything like that in front of me, but I'm pretty sure that's correct information.

So if they go to locations where there is a large population of people who have insurance, and they have sort of their own cutoff clientele, then the hospitals, you know, who tend to be more centrally located off the main roads and everything like that are going to get the under- and uninsured.

Whether or not the state does a good job of paying the hospitals and the doctors at this level I think is inconsequential because they're getting all of those patients that the ASTCs most likely won't get.

MS. NALLEY: Just in response to that, I'd like to go back to what I had said earlier in my testimony that that is the case that, you know, general hospitals, their nature -- by nature they are different than specialty hospitals.

However, there is no evidence that general hospitals are being harmed by these specialty hospitals. In fact, I cited a couple of examples where both general and specialty hospitals have

improved in a number of areas as a result of increased location.

I think it's also important to go back to the original point of CON back in the 1970s was not to cost subsidize general hospitals, not to have -- focus on central health communities. It was to deal with the cost-plus reimbursement system back in that time.

Our health care system has evolved tremendously since then, and we are now dealing with consumer-driven health care. Patients want choices. They want to have options.

CO-CHAIR GARRETT: But it's not a level playing field. You know, I don't want to get in this argument. It's 9:00 to 5:00 versus 24/7, and on weekends, those guys aren't open as far as I know either. So that's all. I just wanted to make that point.

MS. NALLEY: And I understand that. I guess I would just say that, you know, they are different entities; however, I don't think all hospitals have to be everything to everyone. I think that they're -- you know, specialty hospitals are just that, they specialize, and they

serve a purpose, and they serve a need. If there is a demand there, they are serving that demand.

MEMBER LYNE: One of the focuses of the CON, I think, is about planning community by community. That's their major, I think, purpose, and it's for that -- this whole thing you're talking about now, I'd rather have a body looking at that than willy-nilly.

MS. NALLEY: Well, you know, I would say with a lot of things, the goals behind CON that are declared -- controlling costs and access and quality -- are all noble goals, and we all want that for our health care system; however, I think the CON system is not the way to get there because as Jim has described, too, it's kind of a relic of our health care system dealing with a problem that was a certain type of reimbursement back in the day that is no longer the case.

So it was not created for planning purposes. It was not created to cost subsidize, and the DOJ actually testified just to that point last year in the Georgia State Legislature.

MEMBER LYNE: I would certainly say that the whole health system probably needs to be

turned on its head.

CO-CHAIR GARRETT: That's a different task force.

MR. TIERNEY: A bigger one.

MEMBER LYNE: To be realistic about it, it is -- CON is for this reason, what you're talking about now. There's other agencies, et cetera, for other reasons to take care of other pieces of health care, and as we know, we're not getting a perfect system; but in the meantime, it is detrimental to some hospitals to have this kind of competition maybe at the edge of their community, although it's getting to be a little better, and that would be potentially lost to the community hospital if there are ambulatory services.

MEMBER BRADY: The AMA and the Illinois State Medical Society are promoting the elimination of the CON process and the Health Facilities Planning Board at least as it has to do with nonnursing home facilities?

MR. TIERNEY: Well, yes, and we haven't addressed the issue of nursing home facilities.

MEMBER BRADY: Both your positions are that this is an archaic system that needs to go away, and the invisible hand of free enterprise ought to take over the investment decisions of facilities?

MR. TIERNEY: Well, I don't know that there's an invisible hand of free enterprise in the health care system given --

MEMBER LYNE: I can tell them no.

MR. TIERNEY: -- given how fees are regulated. You know, I wouldn't say physicians could go out there and charge anything they wanted for the services they provide or that hospitals could go out there and charge anything they wanted for the services they provide. You know, that perhaps used to be the case years and years ago. That is not the case now.

MEMBER BRADY: I don't think I said that.

MR. TIERNEY: Well, you mentioned free enterprise.

MEMBER BRADY: Right.

MR. TIERNEY: Well, physicians --

MEMBER BRADY: Charge more in a free

enterprise system --

MR. TIERNEY: Pardon me?

MEMBER BRADY: Let me go back for a minute.

MR. TIERNEY: Okay.

MEMBER BRADY: I just want to set the stage here.

Regardless of what you believe and what I believe, there's a good chance that we will not eliminate the CON process, nor will we recommend to do it.

I have concerns about two things here: one is to eliminate, or two is to reform. My question deals with you've got practitioners who rely on these facilities. If your members all rely on these facilities throughout the state, there's a hue and cry that we have some under -- areas that are under-invested and that are suffering.

Would the Illinois State Medical Society's position be that there is a shortage in medical facilities in this state?

MR. TIERNEY: Well, in certain areas especially there are a shortage of both physicians and medical facilities.

MEMBER BRADY: Would one lead to the other? In other words, would the shortage of facilities, is that leading to maybe a shortage of physicians?

MR. TIERNEY: Well, certainly, physicians are attracted to facilities where they can practice medicine. Having collegial relationships with fellow physicians, having hospitals or other facilities, whether they would be ASTCs or specialty hospitals or whatever that are available to them and where they can practice are very important.

MEMBER BRADY: Just recently, let me get to a specific, and neither you or I sit on the board, but in the April meeting, three hospitals were denied in an argument that they were under-accessed areas than they needed to be.

Would your physicians -- do you have evidence, or do you have any background that there are areas of this state where we're not building enough facilities and where denials are taking place? And I have had a lot of people around the state tell me, you know, we can't get to a facility in a timely enough fashion.

Does the Illinois State Medical Society's membership have a position on that? Because part of what we've got to do is decide on a formula. We can only expect this board to continue to do what we legislate it to do.

And I guess what I'm saying is you're -- not just talking about denial, but give us some formulas that we need to do to make it a better system.

MR. TIERNEY: Well, obviously, I think less regulation is better. I don't think there is any question about that.

To the extent that CON is an impediment to building facilities where they are needed, I think there are a number of factors that go into it. I'm not aware of, for instance, facilities being denied in certain areas of southern Illinois, where there is a significant need for both physicians and facilities.

I would suggest to you that the economics of building a facility under any circumstances in some of these areas is just not worth it. It is taking too large of a risk, and you are likely to fail because you have either large uninsured,

large Medicare populations, large Medicaid populations; and the chances that you're going to survive in building a hospital, an ASTC, a specialty hospital in some southern Illinois areas -- the risk is just too great.

But we firmly believe that, you know, in areas like Chicago where a number of these facilities have been denied, I don't see necessarily the wisdom of it. I think that a lot of hospitals around Chicago have made a very strong case for expanding into areas where there has been significant population growth.

You know, I again go back to Blue Island. They saw a way to get out of their doldrums by trying to compete in areas where they thought they could increase their revenues and survive, yet were denied. You know, that was kind of an interesting point.

MEMBER BRADY: What I'm looking for are specifics. You know, we had a Senate Republican task force and this task force. I really -- if I had to gamble, I would say we're not going to abolish CON reform.

I think your Society could help us in coming

up with some specifics. Do we need more members of the board? Do we need more segmented representation on the board? What about under-utilized areas and so forth?

Do you think you could come back with some --

MR. TIERNEY: We'll take a look at that. You know, I can understand some political realities I think as well about, you know, the future of CON, and we'd be happy to work with you to try and devise a system that we think is more appropriate, perhaps less bureaucratic, simplified.

I think we'd probably share some ideas with the hospitals on that. I wouldn't be surprised if we did. So, yes, we would be happy to do that, work with you to try and accomplish that.

CO-CHAIR GARRETT: Dave, do you want to?

MR. CARVALHO: A couple things. First off, what folks have been citing from, one was the AMA study and one was an AHA study; obviously, they both have some self-interest. So what I'd like to cite from is from the Center of Health

Affairs which specifically answers the question you posed and said there was no answer.

In particular, in an article this last month, it said there is reason for concern that physician-owned facilities will contribute to a further unraveling of the classic safety net findings that physicians at physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics.

We don't have to look just at Health Affairs studies. We have our own data which we shared with the task force, our data being the data collected at the Department of Public Health.

If you look at Medicare at ASTCs and Medicare at outpatient hospitals, you are right, the percentage is about the same, 29 percent. So to the extent that tinkering at the federal level with DRGs could influence referral patterns of Medicare, I think you may be right there.

But if you look at Medicaid, which has nothing to do with federal DRGs, Medicaid is 3 percent at ASTCs in this state, and Medicaid is 17

at hospitals.

If you look at charity care .2 percent at ASTCS, and it's 11 times that, 2.2 percent, at hospitals. So I do not understand and would disagree that tinkering with federal DRGs would affect referral patterns for Medicaid or for charity care.

The other thing, you said there is no difference to a physician who gets paid or she gets paid the same regardless of the facility; but if the physician has an ownership interest in the facility, and the facility receives a facility charge, then there is an economic difference to the physician because he or she has a share of the facility charge, whereas the facility charge at a hospital would go to the hospital.

And then the last point I wanted to make was, the testimony from the fellow from Lewin last week, he used the word endogenous, and unless you happen to be an econometrician, you probably don't know what he means when he says endogenous; but I actually was trained as an econometrician, so I want to bring that into this conversation.

Endogenous is when there is something going

on other than what the data capture that explain the difference. A silly but useful example would be to look at the temperature patterns in different states and note that states that started with H seem to be warmer than states that don't. So maybe one way to improve the climate in your state is to change the name to something that starts with H.

MR. TIERNEY: So moved.

MR. CARVALHO: In particular, 96 percent of the physician-owned limited services hospitals that opened in 1990-2003 were located in states without CON. So if they can then do studies that look at the data of the experience of physician-owned specialty hospitals, you are already self-selecting between states that are in CON and states that are not.

And the reason why this is relevant to this whole endogenous variable thing is Al Dobson, you know, pointed out that it is not a random variable whether or not CON is in a state or not. It tends to be the states that are rapidly growing south and southwest that are non-CON states than states that are more mature and historical than non-CON

states.

You at your peril make assumptions about what the data are showing based on the CON status in the state or not when you could just as easily be looking at differences that exist between mature well-built states and growing rapid states.

In particular, you know, you should look at the evidence that shows where you have the largest number of physician-owned specialty hospitals are states like Louisiana and Texas and California; and if you look at the state of safety net in Louisiana, there is nothing to recommend it to Illinois.

MR. TIERNEY: Well, let me just go on to remind you that, you know, typically these are for-profit facilities. They pay taxes. The other hospitals we're talking about by and large are not-for-profit facilities that do not pay taxes and have a legal obligation to extend the type of charity care that you're talking about.

I would suggest to you --

MR. CARVALHO: There's no -- Medicaid has no -- the not-for-profit status of a facility doesn't impose any obligation or not with respect

to Medicaid. That's a choice.

MR. TIERNEY: Well, I would --

MR. CARVALHO: A hospital has less of a choice because they have an emergency room, and so if a patient comes through, they have to take them.

MR. TIERNEY: So the hospitals do not count the differential between Medicaid reimbursement and their costs and their charity care?

MR. CARVALHO: The hospitals count a whole bunch of stuff towards their community benefits, and that's a whole other dialogue that --

MR. TIERNEY: Well, I'm just trying to make a point.

MR. CARVALHO: But I don't even think the -- I don't think the AGs office is recognizing that, no.

MR. TIERNEY: My only point is, is that physicians will be happy that -- you know, we see this in Medicaid and physician private offices as well, and it's really a matter of fairness. It's a matter of fairness to the physicians, as

well as a matter of fairness to patients that regardless of who is providing the care and where, that they are adequately reimbursed for the cost they incur to provide the service.

Unfortunately, our state ignores this principle time and time again and year after year. Until you understand the fact that these artificially low cost containment or artificially low reimbursement rates will ultimately -- ultimately lead to scarcity.

If you want to have policies that do not fairly reimburse, whether it's a physician or a hospital, for the care they're providing, you're always going to have scarcity; and regardless of what laws you pass, you're not going to overturn that fundamental law of economics. You're going to lose, unfortunately, but that's the case.

You know, it perhaps used to be the fact that hospitals and physicians could make up the difference for low and slow Medicaid reimbursement by charging more to private payors. We all remember the cost shift, but the cost shift is dead. It doesn't exist anymore.

Private payors are reducing -- have reduced

their reimbursement rates to physicians over the past few years significantly. They have pegged their reimbursement rates to Medicare, and Medicare rates to physicians have nominally gone down significantly. They have not been increased for approximately eight years, I believe, while practice costs have gone up approximately 30 percent. We were losing pace with those -- with inflation.

MEMBER SCHAPS: I'm sorry Sister Sheila is gone. A lot of these community hospitals would be thrilled to have Medicare rates. What they're dealing with is uncompensated or Medicaid rates.

I think the issue of fair reimbursement is not -- that's really not on the table here. I think all of us at this table and probably in this room would agree reimbursement rates need to be looked at and changed.

But I think what we are concerned about is the hospitals like Sister Sheila's and the community hospitals that serve the poor in our communities across the state, that when you tinker around the edges, and you take just the marginal

patients who can pay, and Blue Cross does pay a lot more money than Medicaid pays for a service, so we aren't talking about a level playing field here. It's not all the same, and the differential is not entirely gone, and I think you know that.

MR. TIERNEY: Oh, I didn't suggest there wasn't a differential. All I'm suggesting to you is that we could recover the difference between, for instance, in Medicaid where -- you know, I've been working with Children's Hospital and the University of Chicago Comer Children's Hospital on increasing Medicaid reimbursement for physicians there.

They tell me, and this is their own study, that Medicaid covers one-third of the cost of providing the care for physicians, one-third of the cost of providing the care. Certainly Blue Cross/Blue Shield and Medicare do not exceed, you know, two-thirds over and above the cost of providing the care.

All I'm suggesting to you is that you can't make up the differential. There's always been a huge differential, but in today's world, you can not make up that differential.

MEMBER SCHAPS: And I'm saying when you tinker around the edges and take away the patients from those like the safety net hospitals that are really on the edge, and we just saw one close last week in our community, when you take away the few patients that can pay or have decent reimbursement, you are messing with a very fragile system that can't afford to be messed with and does need some regulation to keep it intact.

MEMBER RUDDICK: I'd like to follow up on that because there are a lot of -- what you're proposing, if we were to agree, it's pretty risky to repeal a whole process that's in place, and the impact that Marge, you know, just talked about.

There are some assertions that are being made that the CONs don't help safety net hospitals, that process, and I don't think the evidence bears out that assertion. I mean, you've got in bold face, CON does not improve access to care. And then you say the Michigan study, which I haven't read the whole study, but the part, quote, says it has a limited ability to address issues raised by care for the uninsured.

Well, we can all agree, I think, that CON by

itself is not going to fix the problem of the uninsured in this country or community safety nets, right, Medicaid rates, and what kind of insurance programs are available to the uninsured, all of those things.

But the evidence -- I think if we were to consider what you're saying, given the fragility of the safety nets, we'd have to look at evidence that would show you could take away this regulatory system without adversely impacting hospitals that are already in trouble.

We asked -- you wouldn't know this, but when we had the gentleman who wrote the Lewin Report here at the last session of the task force, a number of us raised some serious questions with the particular part that you referred to about comparing the CON to the non-CON states with respect to the safety net hospitals.

So I think that doesn't -- that particular part of that report, there were problems with the definition of safety net hospitals. There were problems that he looked only at margins, he didn't look at services provided, and he didn't look at the location of hospitals. So I wouldn't cite

that. So that's kind of a point.

But I guess the question at the end of this point would be, if we were to consider what you're recommending with respect to the CON process being eliminated, explain to us how we could be secure that that would not hurt the safety net hospitals that are already having trouble because common sense -- Sister Sheila has expressed it very well, Marge expressed it -- as you take patients away, you will hurt those safety net hospitals. So tell us how it won't.

MR. TIERNEY: Well, I think you presume -- let's take Mercy Hospital, for instance, which I believe is Sister Sheila's hospital, is it not? You know, they do a wonderful job. I know many physicians that practice there and love the hospital very much and are happy to go there. They're not going to go out and start competing, if you will, with Mercy Hospital.

I just don't see, for instance, a physician-owned hospital, for instance, going up within -- anywhere in the vicinity of Mercy to try and compete with them. I just don't see that

happening. I don't see an ASTC opening up near Mercy Hospital.

MEMBER RUDDICK: Isn't that part of the problem, too? In a sense, if they take some amount of patients away from community hospitals, they themselves don't want to invest in those communities for the points that Paul raised, they're looking for the more profitable patients, it's going to hurt those community hospitals.

MR. TIERNEY: Well, as I said, I don't think anyone is going to move in there to compete with them; and, if you will, you know, to use your term that's popular, cherry-pick, if you will, paying patients that go to Mercy.

You know, there's a lot of population shift around that vicinity with Museum Park, for instance. I would say most of those people probably have insurance, judging by the looks of those condominiums.

You know, Mercy might do pretty good in the future years with Museum Park, don't you think so?

MEMBER LYNE: That's what we all say. It hasn't changed.

MR. TIERNEY: Then you're going to

have the Olympics, and you'll probably be the hospital for the Olympics. You'll probably get sponsorship money for that. You're going to start looking like Northwestern.

CO-CHAIR GARRETT: Okay. I'm going to try to move on, Jim, before you get in too deep.

MR. TIERNEY: You're going to look like Northwestern before you know it.

CO-CHAIR GARRETT: Okay. How about our friends in Springfield, do you have any questions? Lou or Pam or --

MEMBER ALTHOFF: I just would have a request at this time, it would help me a great deal, could we get a map and a list of all the disproportionate and safety net hospitals as well as the critical access hospitals? Could that be provided to us by the next meeting?

CO-CHAIR GARRETT: We're without staff right now for some odd reason. We will see if we can. I think that's a really valid request because we're talking and not understanding who is who and where they are.

MEMBER ALTHOFF: I think that's the case. Thank you.

MEMBER LANG: This is Lou Lang. I do have a couple of questions for the witnesses. Can you hear me okay?

MR. TIERNEY: Yes.

MEMBER LANG: Okay. You folks have indicated that you think -- the bottom line of your testimony is that you think we should do away with this process and just let medical providers make these decisions on their own, and I'm not sure whether I agree with you or not, and that's not really where I want to go with my question.

My question would be, if we did that, do you see a need or a place for some sort of a planning body to say, here's an area of the state where we have a need, and we should have a body that specifically reaches out and looks for medical providers to put a facility in a place that has a determined need?

MR. TIERNEY: Representative Lang, I certainly agree that there is room for the health planning process in the state. I do believe we need to share data, need to -- the state has perhaps the responsibility to collect data and to share data with hospitals or others, physicians,

and anyone interested in improving access to care in the state, and I guess I do see a role for the Department of Public Health to do that.

CO-CHAIR GARRETT: Jim, what kind of data are you talking about that we should be collecting?

MR. TIERNEY: Well, I think it should be population data, population shifts. You know, certainly some of that is collected by the Health Facilities Planning Board in making their determinations on CON approval or disapproval.

I think you need to also collect data on the incidence of disease, and probably other demographic information with respect to age of populations because certainly as -- you know, we all know as our population grows older, that more health care services are needed.

So in those particular areas of the state where the average age is relatively higher, you can probably assume you're going to need more health care facilities and physicians.

So, yeah, I think there is a role and a need for that.

MEMBER LANG: Well, Jim, I was going

beyond just putting together numbers and statistics. I was going to a place where even if we do away with much of the process, and we let what Senator Brady would call free enterprise determine who would build what and where, I'm wondering if you would agree with the assertion that there ought to be a body out there that not only takes these statistics, but actually affirmatively makes public statements or affirmatively looks for providers who are willing to build in an area of need.

MR. TIERNEY: I think that's a proper role as well. Yeah, I think that's an appropriate function for a state agency.

MEMBER LANG: Well, would it have to be a state agency or at least would it have to be one of your current ones? Would there be a role for a separate agency that deals with planning, if not the Health Care Facilities Planning Board, some other kind of planning board regardless of how it would be appointed, or do you think the appropriate place would be within the confines of a state agency?

MR. TIERNEY: I suppose it could be

either/or, Representative Lang. I don't -- you know, as long as the information is valid, as long as it's collected appropriately, as long as it's shared with everyone, whether it's a state agency or a nonstate agency, I suppose it doesn't make much difference.

MEMBER LANG: The next area, do you see a difference relative to this process relative to physicians or hospitals or nursing homes, or do you see that this process ought to be eliminated and effectively curtailed for all?

MR. TIERNEY: Well, we would suggest it would be -- first of all, most physician offices are not subjected to any type of certificate of need process, and we certainly would oppose the extension of CON into physician offices under any circumstances.

Other than that, I would think that we would recommend repealing CON for every health care facility. That would be our recommendation.

MEMBER LANG: The last area, I wanted just to comment, I heard Senator Brady suggest to you that perhaps your desire on the CON won't happen, that you should perhaps propose a backup

plan, ways that you think the current process should be improved, streamlined, or amended if you don't get everything you want.

I would concur. Not only would I suggest that you do that, but I would suggest that other witnesses do as well, if not today, sometime in the future.

I know that, for instance, the Hospital Association is going to propose to keep the same system, but change it. I would suggest to them looking on the other side of this.

I think all witnesses ought to not just take one point of view because we don't know where we're going. I would suggest that witnesses give us options in all directions so that the task force has the benefit of your wisdom.

Does that make sense?

MR. TIERNEY: I get the message.

MEMBER LANG: Thank you.

MR. TIERNEY: Thank you.

CO-CHAIR GARRETT: Any questions from people on the telephone?

ON THE PHONE: No. No.

CO-CHAIR GARRETT: Okay. Gary, did

you have a question?

MR. DeWEESE: I have a question.

CO-CHAIR GARRETT: Oh, I'm sorry. Go ahead.

MR. DeWEESE: Kurt DeWeese. I wonder if there could be further explanation about the cherry-picking solution, I guess, is the way it's being addressed, the DRG system. I don't think I quite understand what the impact of that would be, or whether it's for real, whether it really has the potential for really affecting these kinds of decisions in comparison to CON.

MS. NALLEY: You know, I don't have the document in front of me, but as I stated, this was an issue that was addressed with the Department of Health and Human Services and CMS, and they are implementing changes to the DRG payment system based on more accurate measures that would reform the classification system and adjust reimbursements to more closely reflect accurate health status upon admission.

Any further details I would be happy to get to you. I don't have them in front of me right now.

MR. DeWEESE: I guess that was part of my question. The DRG payments or the DRG-based payments seem to have a pretty limited impact on most of these systems, and whether you're dealing with hospitals or nursing homes or other types of health facilities, I just wasn't sure whether that was a real potential for addressing the same issues of the CON.

The other question I had was, where the CON process does not exist, there have been other for-profit developments. Do we have any information as to how much of that is really physician-owned or just investor-owned sort of corporate-sponsored development?

My understanding is that these aren't just necessarily Illinois physicians who are interested in coming into this state, but there are corporations similar to what's going on in the nursing home industry, with investor-owned groups who are kind of chomping at the bit to get to the Illinois market.

I'm wondering if we have any understanding as to whether or not this is really a physician-driven process or some other process that we could

look forward to.

MS. NALLEY: I don't have the statistics on how many physician -- or specialty hospitals are physician-owned or joint ventures. I did quote Physician Hospitals of America. They provided me with statistics that 52 percent are joint ventures with acute care hospitals. I don't know the breakdown beyond that.

Also the 2003 GAO study that I quoted looked and said that 30 percent are not physician investors, and that those -- half of those remaining are actually only 2 percent -- physician investment is only 2 percent.

So I'd be happy to try to get more statistics on that as well for you.

CO-CHAIR GARRETT: I just want to add to that because I think what happens is you've got investors coming in who put down sort of the down payment, and then gradually it goes into, depending on how well the ASTCs and the physicians are able to buy in and become more of an equal partner and make that payment, and it's phased out eventually. I'm sure they're structured in different ways. That's the way I understand it.

It's a partnership in many cases.

We should look into that, though.

MR. DeWEESE: The only other question or actually comment is that one of the outcomes of the East St. Louis facility as I now understand it is that there were some contingencies put on the system that is now relocating itself to another hospital development, that there would be some basic emergency room capacity and perhaps other services that were going to be retained.

So where there was a decision to close, scale back the East St. Louis facility, it seems that there is a commitment on the part of that system to retain some kind of community asset.

I think that probably the CON process may be the only way that you could leverage that if there are systems -- even in the SSM case at St. Mary's where the assertion is that they're -- that they might have wanted to go to another community or they may want to build in Wisconsin, and then, you know, starve the Blue Island facility.

I don't know that there would have been a commitment for them to retain or an ability on the part of the CON process to retain a basic capacity

where they are in Blue Island.

It just seems as though those kinds of contingencies could possibly only exist in the CON process where you have a decision to relocate or to reallocate services within those systems.

CO-CHAIR GARRETT: We're going to have to move on. So nobody on the phone has any questions.

Oh, Gary, I'm sorry.

MEMBER BARNETT: That's okay.

CO-CHAIR GARRETT: Are you sure? Okay.

Thank you very much.

MR. TIERNEY: Thank you.

CO-CHAIR GARRETT: We appreciate your testimony, and you'll get back to us maybe with some proposals. Okay. Thanks.

I think we have our minutes of our last meeting coming around. While she's passing the minutes around, for those who have read and looked into the minutes in a very comprehensive way, did you find any parts of the minutes that need to be changed? Are there any changes at all from committee members? Paul.

MEMBER GAYNOR: In the March 10th -- I'm not saying that this isn't an accurate reflection of what happened, but we may want to talk about it briefly. With regard to the ethics officer from my office, it talks about it, and I can't remember where it is in here.

CO-CHAIR GARRETT: Maybe the first page at the very bottom.

MEMBER GAYNOR: Yes.

CO-CHAIR GARRETT: Okay.

MEMBER GAYNOR: It was talked about that the ethics -- any ethical issues would be brought to the Chairs, and then the Chairs in turn would bring it to the ethics officer.

That's probably not the best way to proceed. If people want to consult the ethics officer, they should feel free to directly contact the ethics officer. I just wanted to make that clear.

CO-CHAIR GARRETT: I agree with that. Do the other members also agree and on the phone and in Springfield? We don't want an intermediary. So if the minutes next month could certainly reflect that, that would be a step in the right direction.

MR. CARVALHO: The minutes are correct.

CO-CHAIR GARRETT: Yes.

MR. CARVALHO: If you want to make -- on the record, if you want to do it differently.

CO-CHAIR GARRETT: Yes.

MEMBER LYNE: I move for approval subject --

CO-CHAIR GARRETT: Is there a second?

MEMBER GAYNOR: Second.

CO-CHAIR GARRETT: All in favor. Any opposed?

(No response.)

CO-CHAIR GARRETT: We will proceed accordingly with that motion.

Okay. Any other changes or recommendations in the minutes?

If not, then is there a motion to approve the minutes with the change?

MEMBER RUDDICK: Do you capture all the questions and dialogue in the minutes or just some? I'm looking for the exchange on the slide we just talked about, about the safety net hospitals with Mr. Dobson, and I didn't see it in

here. Do you think you have captured everything?

MR. CARVALHO: They're intended to be summary minutes. There was a transcript because that was a meeting where there were witnesses. It is always a problem in a summary that it doesn't necessarily capture everything.

I think I was the one who engaged with Dobson on that, so I didn't leave it out for that reason.

MEMBER RUDDICK: I think you did and Paul and me, and I think Ken did as well.

MR. CARVALHO: It's all out?

MEMBER RUDDICK: Well, I guess it's touched on.

MR. CARVALHO: I remember certainly looking up how to spell endogenous, or I think he used the word endogenation, turning it into a noun.

MEMBER RUDDICK: I just wanted to make -- I think there were a few more points made on that, and I wanted to make sure it's all in there because people keep going back and citing that aspect of the Lewin Report, and I think we have pointed out a lot of things that were not --

you know, on that one slide that were not well-argued or well-thought --

CO-CHAIR GARRETT: Well, maybe what we can do is take out the testimony of the transcript and attach it to the next minutes that we get next month, this month's minutes. Does that make sense? We'll just attach it for the next go-around.

MR. CARVALHO: I should tell you, I don't think it's quite ready to go live, but certainly before your next meeting, at our Web site we will have all approved minutes and all the transcripts of the task force. So it will be something that can be consulted by everybody on the task force as well as the public.

CO-CHAIR GARRETT: Do we need a motion to add the testimony to this meeting's minutes that will be given to us for next month?

MEMBER ROBBINS: I like the idea of having them available, but it seems like Dave is saying they will be available. So to save a few trees, I wonder if --

CO-CHAIR GARRETT: I'm thinking the testimony -- I want to add the testimony.

MEMBER ROBBINS: Yes, that's what he said.

CO-CHAIR GARRETT: But I'm wondering if we need a motion to do that. That's all.

MR. CARVALHO: Sure. You could have a motion that says, for example, that transcripts of hearings shall be attached.

CO-CHAIR GARRETT: No, this is the specific testimony that Hal brought up.

MR. CARVALHO: Okay. Mr. Dobson.

CO-CHAIR GARRETT: Yeah.

MR. CARVALHO: Okay.

CO-CHAIR GARRETT: Mr. Dobson's testimony would be excerpted from the testimony and attached to the minutes, today's minutes that we will receive next month.

MR. CARVALHO: Yes.

CO-CHAIR GARRETT: Okay. Do we need a motion to do that?

MR. CARVALHO: You don't. If you ask me to do it, we'll do it.

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

MEMBER LYNE: So moved.

CO-CHAIR GARRETT: So moved.

MEMBER GAYNOR: Second.

CO-CHAIR GARRETT: Second by Paul. There being no -- everybody is in favor of this one. Against? Okay. Then the next motion shall pass.

All right. So let's have the -- I'll get my agenda here.

Mark Newton, who is vice president of the Association of Safety Net Hospitals.

Thank you for coming.

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

CO-CHAIR GARRETT: I'm just going to ask you to speak as loudly as you possibly can.

MR. NEWTON: Yes.

CO-CHAIR GARRETT: Thank you.

MR. NEWTON: I have a short prepared statement if that's okay.

Good morning. My name is Mark Newton. I am the president and chief executive officer of Swedish Covenant Hospital, which is located on the north side of Chicago.

I am also co-chair of the Association of

Safety Net Community Hospitals, which is an organization of 10 safety net hospitals located in urban Chicago, and we represent over 1,600 hospital beds. I am also a board member of the Illinois Hospital Association. But I come to you today to provide testimony from the perspective of a safety net provider.

Thank you for the opportunity to share what I think is a unique perspective, and my comments, I believe, will resonate with some of the perspectives that you had offered -- that have been offered by yourselves earlier today.

In my past and current positions, I have been directly involved for over 20 years in numerous certificate of need processes, task forces, and I certainly recognize the tremendous impact that this process has in assuring that safety net hospitals maintain some stopgaps that protect access to health care services, particularly for underserved populations.

As the president and chief executive officer of an urban, federally designated disproportionate share hospital -- and I think those are key terms. I think that's truly the definition of a safety

net hospital is what is the percentage of Medicaid and population you're serving.

The MIUR, the Medicaid inpatient utilization rate for my institution is in the mid-40s. 40 percent of the days are covered in some fashion by Medicaid.

In this position, I'm no stranger to responding to community health risks. I'm no stranger to responding to competitive market changes, to the malpractice crisis in Illinois, to nurse staffing shortages, and to the ever threatening possibilities of revenue cuts to Medicare and Medicaid programs.

Currently, as a side point, we're also dealing now with the significant financial impact of refinancing debt due to the failed bond market on Wall Street. But interestingly, safety net hospitals have found a way to be challenged, but also to respond to these risks while continuing to hopefully expand our infrastructure and advancing quality outcomes.

Let me share some details of our story particular to Swedish Covenant, and through these comments, you'll get a perspective of where I come

from in terms of certificate of need.

I have been at Swedish since the year 2000, and during that period of time, two hospitals within a few miles have closed. One has stopped obstetrical services. 900 mothers have no place to deliver their children. Another has announced plans to close obstetrical services leaving 500 more mothers with no place to deliver, and yet others are for sale or struggling.

This translates into the loss of approximately 500 hospital beds and 3,000 good paying jobs. Swedish Covenant Hospital's best response to our community during the last eight years has been investing over $140 million into new facilities, services, technologies, and staff, all the while being challenged by an increasing competitive environment.

We are surrounded by ASTCs. We are surrounded by imaging freestanding diagnostic centers, and they are a competitive force in our community.

Our sense of mission, however, tells us that we have to provide both respectful and efficient health care to vulnerable people regardless of

their economic standing, and that is a moral theme that I will come back to.

There needs to be a sense that in the provider community, that organizations that are licensed by the State of Illinois, that license comes with an obligation to strategically invest in the long-term health of the community that they serve.

The Lewin Report suggests that without the certificate of need process, safety net hospitals will be at great risk. CON goes beyond protecting safety net hospitals.

The report also suggests that the goals of CON can be achieved through appropriate financing and by curtailing physician self-referral to centers that they own.

Capital costs and access to capital is restricted by the nature of our low reimbursement. You've heard that before. Capital is restricted by the price of technology, and it's also restricted by increased regulatory burdens.

We must invest as safety net hospitals. If we do not invest, we will be vulnerable; and therefore, the key premise of my testimony is to

say that do not ask us to invest in a medical arms race, especially a medical arms race that could set us against better capitalized competitors.

Access to care is closely associated with the financial strength of safety net hospitals, which may be affected by the number of specialty competitors, ambulatory surgical treatment centers, and freestanding imaging, diagnostic, and rehabilitation centers that can choose to enter lucrative parts of the market and are not obligated to serve the total community.

By definition and function, ambulatory surgical treatment centers concentrate on such areas as ophthalmology, orthopedics, gastroenterology, general surgical and female care treatments.

Because these specialty surgical centers tap into more profitable areas of care, primarily ones that generate higher reimbursement, they siphon funds from a revenue base that general hospitals use to subsidize the charity care they provide in emergency rooms for Medicaid underinsured and uninsured populations.

In addition, physicians who have private

interests in freestanding surgery centers pose a threat to hospitals because it allows physicians to direct premium patients to their own surgery facilities while leaving uninsured and underinsured patients for hospitals to care for. The ability of ASTCs to, quote, cherry-pick, unquote, is particularly devastating to, intercity, safety net hospitals. We need the CON process to mitigate this risk.

I have two stories to tell you. One story relates to a patient call that I received, who was complaining that his physician who does endoscopies in their office demanded an $800 cash payment because he had a high-deductible health insurance plan. This is a high-insured individual. The individual did not have $800 of cash.

The physician sent him over to the hospital and said let the hospital take care of you because they'll figure out a way to either write it off or to provide the care for free even though you're insured. It happens every day.

I have been -- a second story, I have been involved in some discussions over the years with

physicians and for-profit investors looking at ASTCs as a business and as a market opportunity.

One component that has not come out is that the economic level of investment, the barrier, if you will, or the level of return is 100-percent cash-on-cash. So if a physician puts $50,000 into an ASTC, the typical return is 100 percent of that cash within the first year or two. So the standard of economic investment is 100-percent cash-on-cash return. Certainly as a charity hospital, I wish I could get a 100-percent cash-on-cash return for investment.

ASCs and freestanding rehab and diagnostic centers, and I tend to lump those somewhat collectively, but they are distinct parts of the market. You've heard testimony today that deals with surgery centers. Diagnostic centers and rehabilitation centers are also part of this competitive landscape.

Our view of safety net hospitals is that they should partner with us and provide a like level of Medicaid services as do safety net hospitals.

My hospital experienced in the last few

years the relocation of thousands of outpatient surgical cases to exclusively physician-owned centers, and I use the word "thousands," while continuing to have these same physicians refer self-pay or Medicaid surgeries to the hospital.

This is a story line that's being played out daily. The result is a slow and steady drain on the financial stamina of safety net providers.

I'd like to give a story of a success of certificate of need.

Even though it's very anxious, and for the last 20 years I have been presenting in front of the certificate of need board, it is certainly an anxious moment for anyone that sits in front of the board because we are asking the board for approval. It's different than providing my comments to you today.

What I wanted to share with you is the way that we worked with the CON board to open a cardiac surgery program in the year 2000.

Since the program opened in July of 2000, Swedish Covenant performed -- has performed over 1,100 surgeries, and we have less than a 2-percent mortality rate. That is better than the

state-wide average by far.

We started with a conditional permit and progressed to a full permit. The planning board trusted Swedish Covenant, they worked with us, and the result is a stronger hospital and a healthier population. If the open heart program had not been approved, I think the long-term future of my institution would have been called into jeopardy.

This strength would be eroded if a specialty heart hospital were to be allowed to open under a certificate of need that would compete with my institution.

In past legislative action, we supported Senate Bill 244 that allowed for the creation of this task force to complete its work and make recommendations to fix the shortcomings of the CON process and program.

I have some additional comments and suggestions.

One, Illinois needs an effective health facilities planning process to promote access to health care for Illinois. We do need and support the continuation of the program.

Second, industry representatives should be

part of the planning board. I'm well aware of the history of the planning board. It's my view that when I am presenting to the planning board, having people on the board and of service with a perspective of being a provider is a good thing. Greater questions of greater depth are asked and answered.

The third point, we need open communication with the staff. The existing ex-parte rules and mentality work against this goal, frankly.

Four, set standards for Medicaid, for levels of Medicaid that will be provided by freestanding facilities, the ASCS, the diagnostic centers, the rehab centers. The standard level of care should be equal to that of the average of the two closest hospitals' outpatient services.

In other words, if the landscape is open, then those centers should be required to achieve a level of Medicaid participation that's equal to the average of two hospitals nearby.

Next point, many services would simply be unavailable if limited service providers who care for the best uninsured -- excuse me, the best insured and least complex patients were allowed to

proliferate unnecessarily, leaving hospitals with the sickest and poorest patients.

The CON process needs to be structured in a way to protect those providers interested in expanding safety net services, while restraining those providers interested in targeting their geographic expansion efforts to those who can afford to pay.

Next, if CON were to be eliminated, Illinois would be the target for specialty investor-owned hospitals and other limited service providers as has occurred in non-CON states. Hospitals in communities across Illinois would find it harder to function as safety net providers.

The program needs to be made permanent with oversight of major health care capital expenditures, construction of new facilities, and service changes.

A point to the legislators on the panel, safety net hospitals are in desperate need of new sources of capital to rebuild our physical facilities. Continuing the provider assessment program long-term is a critical source of funding to maintain our hospitals.

Safety net hospitals are a dichotomy which must be allowed to grow and to be strengthened, but also protected from better capitalized competitors who are not required to fully accept our sense of mission and who can capitalize a service model which targets well-paying patients.

In a free market, an economist would argue that the market will operate based on supply, demand, and efficiency. In reality, health care markets do not operate in a free manner, with existing regulations allowing for gaps to be exploited by for-profit enterprises. Certificate of need is the most fair and efficient method to close those gaps while strengthening the existing frail safety net.

I want to thank the committee for the opportunity to discuss this important topic and would welcome any questions.

CO-CHAIR GARRETT: Any questions from the committee members?

I have a question.

I think it was in 2002 -- I have talked to Dave Carvalho about this -- we actually passed legislation that put together a hospital report

card, and this hospital report card would basically evaluate hospitals on a set of criteria.

Are you familiar with that?

MR. NEWTON: I am familiar with the Act, yes.

CO-CHAIR GARRETT: And maybe Dave can explain the legislation. Do you want to explain that, because I think there's this -- what I'm trying to get at, what I'm trying to present is that both the safety net hospitals and the other hospitals, if they want to expand or be protected or whatever it is, that criteria needs to come out.

You know, we need to not just look at the demographics and the population shifts, but also how healthy the hospitals are and maybe then, you know, the competition would make some sense.

So I don't know, Dave, do you want to talk about that?

MR. CARVALHO: Real short, there are two quality measurement pieces of legislation that will be implemented later this year. One is the Hospital Report Card Act, which will share information for all hospitals regarding, A, their

nurse staffing ratios, and B, their hospital acquired infection rates in certain categories.

The second Act is the Consumer Guide to Health. That will share quality and pricing information, charging information for hospitals focusing upon their 30 or more procedures with the greatest disparities in quality and pricing, but it will probably be more than 30.

CO-CHAIR GARRETT: And that will be significant, I think, because for the first time, once these two Acts are implemented, we'll be able to understand how effective all of these hospitals are that either want to be protected or want to expand.

So I'm just wondering, what's your opinion on that? I mean, do you think that makes sense? Would you like to see something like that have sort of a huge impact on how we address the certificate of need process?

MR. NEWTON: Unfortunately, it's going to be a very inexact science.

CO-CHAIR GARRETT: Why do you say that?

MR. NEWTON: Well, the perspective I

would offer is this: I start from the standpoint that every hospital wants to do the right thing. Every hospital wants to be a top 100. Every hospital wants to have the best nursing staff ratios. The issue has been how one pays for that.

There is no question in my mind that any hospital CEO strives to be the absolute best they can be. When you're dealing with years of under-investment or a burden in which others have been able to benefit from a more lucrative part of the market, you find yourself trying to make up so much territory.

But I think you'll -- one will find from this is that even in spite of that, safety net hospitals do a remarkable job, but it is -- I think the data needs to be taken with a grain of salt in the sense of let's understand the gap that needs to be made up that historically has developed over the last 10 or 15 years.

MEMBER BRADY: If I heard your comments correctly, you suggested that CON should not be approved unless the facility is willing to accept the same disproportionate charity, Medicaid, Medicare, or under full reimbursement as

the two closest facilities?

MR. NEWTON: My suggestion is that a freestanding surgery center, diagnostic treatment center, rehab center be required to take a level of Medicaid that is consistent with the average of the hospitals in that service area in order to get approved. There should be --

MEMBER BRADY: Why just those?

MR. NEWTON: Well, it could be hospitals as well, but I do --

MEMBER BRADY: So you're saying any expansion ought to take their fair share?

MR. NEWTON: Yes.

MEMBER BRADY: So nothing should be approved unless that were the case. How would you -- does anyone do that? How would you do that?

MR. NEWTON: You take the two hospitals --

MEMBER BRADY: If you don't have emergency rooms -- we can't make anybody take a fair share, as far as I know, unless they've got an emergency room.

MR. NEWTON: They can have outpatient

surgeries, as an example. So if someone is asking for approval for an ASC that's going to deal with three different types of surgeries, they should be also willing to say we will treat a level of Medicaid that is commensurate with the outpatient services of the nearest competitive hospitals.

MEMBER BRADY: How would you -- does anyone do that?

MR. NEWTON: Not that I know of.

MEMBER BRADY: In any state?

MR. NEWTON: Not that I know of.

MEMBER BRADY: In your opinion, why do people go to the surgery centers rather than go to a traditional hospital?

MR. NEWTON: In my view, the reason they go is because that's where their physician directs them.

MEMBER BRADY: Why --

MR. NEWTON: That's it.

MEMBER BRADY: Why does the physician direct them in your opinion?

MR. NEWTON: The physician will direct them because of a couple issues. One, they have -- they do find that they are efficient, that

they can move -- they can do four or five or six cases in sequence. So there's an efficiency issue for them, but there is also an economic motivation, and the two go hand in hand.

MEMBER BRADY: The economic motivation is ownership?

MR. NEWTON: Yes.

CO-CHAIR GARRETT: Is there evidence of that? I mean, these are pretty broad statements. I just --

MR. NEWTON: Well, I'm giving my evidence, my experience over the last 20 years of seeing how physicians behave and listening to hundreds of stories of patients and in conversations with physicians, those are the two primary motivations: efficiency and economic return in terms of why they will move cases.

When I have an ophthalmologist that says, I used to do 50 cases a month in the outpatient center in the hospital; but now because I've got an opportunity to own my own place, I'm going to move those 50 cases out of the hospital. When I talk to him, it's efficiency, and I'm going to get an economic return.

MEMBER SCHAPS: David read this to us earlier.

MR. CARVALHO: There was a report in the Journal of Health Affairs, which is the journal for health policy, and the findings -- it was a study. It wasn't an opinion piece. It was a study. It said the findings indicate that physicians of physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid to hospital outpatient clinics.

As I stated, it was a national study, but our data are very similar to that. In fact, at the last facilities planning board meeting there was an applicant whose historical information showed zero Medicaid patients and zero charity care patients, and I had already elicited by questioning, do your physicians -- are they also on staff at neighboring hospitals, and do those neighboring hospitals do Medicaid and charity care?

So clearly, zero would be done at the ASTC, whereas Medicaid and charity care was being done at the surrounding hospitals.

MEMBER BRADY: Do you know of any studies where we find that the fees charged at ASTCs are less than those at safety net hospitals?

MR. NEWTON: You know, I don't have immediate access on the top of my head about those studies.

MEMBER BRADY: You compete though with safety net hospitals -- I mean, with ASTCs.

MR. NEWTON: Yeah. What I may be more familiar with is what the medical insurers do, and they tend to force down hospital reimbursements to -- and they through economic incentives redirect patients to ASCs.

MEMBER BRADY: So the insurers are finding the ASTCs are charging less, and in some cases are directing their insured there.

MR. NEWTON: Well, they may -- again, they may be charging less, but again, the physician also has the economic benefit of the technical fee as well as the professional fee, and I would tell you also that I don't have -- I would find it difficult as a CEO of a safety net hospital to have a great deal of sympathy for a lot of the insurance companies. Now, I say that

with some risk, obviously.

MEMBER BRADY: Although if you have any, they're the ones that are subsidizing your Medicaid rates.

MR. NEWTON: No, actually as a safety net --

MEMBER BRADY: Oh, really, they aren't paying you more than on Medicaid?

MR. NEWTON: No. You know, actually Medicaid is a great payor for us because of --

MEMBER BRADY: Timely?

MR. NEWTON: Pardon me?

MEMBER BRADY: Timely?

MR. NEWTON: For us as a safety net hospital, it is, yes.

So I would not -- I actually find --

MEMBER BRADY: You're saying your Medicaid rate is a higher rate of reimbursement than your insurance rates?

MR. NEWTON: Let me explain in one key service area, and that's in obstetrics. It is a better payor than commercial insurance, but it is a better payor only because of the additional payments that we get through the Department.

So because we have invested in providing those OB services, the Department has responded to us and has supported our reimbursement on obstetrics.

I would tell you that on chest X-rays --

MEMBER BRADY: How much higher?

MR. NEWTON: -- it's not the case.

MEMBER BRADY: How much higher is that rate than private patients?

MR. NEWTON: It's about equivalent.

MEMBER BRADY: It's the same as insured, Blue Cross/Blue Shield or whatever?

MR. NEWTON: I don't want to get too much into rates, but there's -- I find that in obstetrical services, HMO reimbursement is a comfortable level to Medicaid. They're on par.

CO-CHAIR GARRETT: Go ahead.

MEMBER LENNHOFF: Okay. My name is Claudia Lennhoff, and I'm with the Champaign County Health Care Consumers, and I wanted to thank you for your testimony and also for your recommendation. I had a question, but I also want to explain why I'm asking this question.

When you talked about your proposal about

the standard level of care for another entity applying for status should be comparable to the two closest hospitals for Medicaid and so on, I'm wondering whether you would also include the percent of uninsured served in there as well.

I just wanted to give some comment about why I'm asking that. In Champaign County, we've had a massive health care access crisis because the physicians who are organized into two large physician clinics have refused to serve people with Medicaid and people who are uninsured.

Our estimates are that 40 percent of the population has been affected. This has been going on for five years, and there's over 70,000 people who don't have access to health care. I work with them every single day.

They do have access through the hospital emergency room, yes; but for the kinds of services that are needed, they can only get surgeries and so on if their situation rises to the level of an emergency.

I've had a lot of clients who clearly need a surgery or something else done, and they can't get in through a physician; and then they can't get

their surgery until it rises to the level of an emergency. This, of course, means that they are sicker and perhaps lost their job because they haven't been able to function and all of those things.

Now, in our community at the same time that this was going on, Christie Clinic wanted to build an ASTC. They came to my organization looking for our support on that, and the question that I asked them directly was along the lines of what you're suggesting.

You know, we might consider lending our support to that if they could guarantee a certain level of access to care to people with Medicaid and also people who are uninsured, mind you the very same people they have been turning away from physician services. They refused to guarantee that.

Anyway, that was our situation. So I share very much the same concerns that you do, but my question is, when you consider commitment to serve Medicaid population, do you also consider commitment to serve uninsured?

MR. NEWTON: A couple of points: one,

there's a logical consistency to saying that it should be both Medicaid and uninsured. So on a logical basis, I would have to say that direction is correct.

The challenge, however, is not -- one size does not fit all, and the rationale for saying that at least look at that micro community where the experience in that community is that hospital providers which are both caring for the uninsured and underinsured and Medicaid are providing to a certain level. They're performing at that certain level.

There is consistency in my view to say that you could set -- you could say that that should also be considered. The challenge is trying to put it to a number that tries to force everybody into the same size because it's just not the way health care tends to operate.

So I think my comments are much more on the Medicaid side, but logic would say that you could extend that to the uninsured as well.

MEMBER GAYNOR: One of the witnesses we had a couple of meetings ago from the Association of Health Care Planning Board or

Health Facilities Planning Board, Paul Parker, I had asked him the question about are there any states that, you know, the CON process looks at the charity care level when they're considering approving the project.

He said Virginia looks at the median level of charity care in the region in which they're located; and if you are below the median, they ask you to ratchet up your service to the median. So that's not a one size fits all, rather it looks at the actual region that you're located in.

I'm wondering to address your one size fits all concern, would that alleviate that concern?

MR. NEWTON: I think that's consistent with what my testimony is. And, again, I would say that this is very much of a micro environment.

In my world, I essentially look at a 5-mile circumference, and that's our world.

MEMBER GAYNOR: Right.

MR. NEWTON: So I'm not looking at regional planning areas that -- you know, when I get a request from a hospital in Elgin for me to comment on whether they should expand or add services, I don't think that's appropriate.

MEMBER GAYNOR: Right.

CO-CHAIR GARRETT: Dave.

MR. CARVALHO: One thing that you mentioned in your testimony was a recommendation regarding categorical membership. I want to ask you something about that.

I started working with the board in August of 2003. It had just gone from categorical membership to noncategorical membership, where there wasn't, you know, a representative of a hospital and a nursing home and all that.

One of the things that I did to prepare for the first meeting because I hadn't been to a facilities planning board meeting in 12 years was to go back and read the transcripts for the prior year. I do not recommend that to anybody, but I thought it would be a good thing to do.

MR. NEWTON: There are pharmaceuticals for that problem.

MR. CARVALHO: And one of the things that became clear to me as I read those over the course of the year is, I could almost draft the transcript after reading two or three meetings because the nursing home person was always going

to make the same comment, and the minority contracting person was always going to make the same comment, and the union person was always going to make the same comment, and the hospital people were always going to make the same comment about the types of applications.

So rather than looking like a deliberative judicial body, it looked more like a debating society or a legislature really where people represented this county or that county.

One of the things that I have observed with the current board, which is not categorical, is that you don't have that. You have people looking more like judges, but it isn't to state that there is not expertise.

Mr. Mark used to work at a hospital. I used to work at a hospital. Chairman Lopatka used to work at a hospital. The ex-officio member from HFS used to run a hospital. The physician member used to practice at a hospital. So between all of those folks, they have knowledge and experience about hospitals, but none of them are there representing a hospital.

If you had categorical membership, wouldn't

you fall back into a situation where people were there, in effect, representing an interest group rather than just bringing expertise?

MR. NEWTON: Well, I think it is a perspective in terms of the role of governance and the quality of leadership that people bring to it. My view is that people with experience are more important in this endeavor than people without experience.

Now, in the area of categorical membership, you know, in 20 years, I could certainly agree with your comment that, you know, people get lock-step to represent a certain constituency, and that's what they represent.

I think we're better than that. I think we have an opportunity to be better than that, and the real key is the nature of the people that are vetted and brought forward into the board, and perhaps that's a way of addressing that is to open up the vetting process and open up the nominating process and bring people with experience to the table.

I don't believe I said categorical membership. I think I said people with experience

or industry experience, and so if I need to refine my statement, let me say that that's more important than pure categorical membership.

The challenge with that is there are too many constituencies in the state, and we'll end up with a planning board that will have 50 different entities being represented. So I would amend if I was not clear that it should be heavy on the experience.

CO-CHAIR GARRETT: Any other members have --

MEMBER RUDDICK: Hal Ruddick, SEIU. You won't be surprised, based on my comments with the previous presenter, that I very much appreciate your perspective and what you're bringing.

I wanted to ask you, you described a pretty dire situation in terms of hospitals closing and downsizing. So obviously, the system that we have now is not working effectively enough to preserve the safety net system. These trends continue over the course.

So you've mentioned one example which is the regulations on the ASTCs. Are there other areas

that you can think of that would strengthen the role of the planning board in protecting safety net hospitals? If you can't think of them today, I would be interested if you would have a chance to review and submit some additional ideas as we go forward.

MR. NEWTON: I noted some in my testimony. One in particular I'll amplify, take the opportunity to amplify my response a little bit, and that is on freestanding diagnostic centers.

Here's what happens. There will be an MRI or a CT scanner that's owned by a physician or a freestanding oncology treatment center, and what do you think happens? There is movement of referral directly to those entities.

They are -- often, they fly under the radar because they can -- as long as they get licensed, they may not be, if they're under the equipment threshold or if it's a category of service that is not reviewable, they would not be captured in the net; but yet they are licensed by the state, and the licensing process of the state does not have a requirement that they provide a certain level of

service or serve a certain reimbursement level.

So that's one of the gaps that exists in the system today. The licensing act does not catch up to what the CON may be trying to address.

MR. MARK: A point of correction, I believe it's accurate to say that freestanding diagnostic centers do not require any sort of license, other than perhaps nuclear regulatory license.

MR. NEWTON: Yes, thank you. That's my point.

MEMBER RUDDICK: They do not go through the CON process?

MR. MARK: No, they do not.

MEMBER RUDDICK: So that's kind of an open field.

MR. NEWTON: But they do have permission by the State of Illinois to operate.

MEMBER RUDDICK: Okay.

MR. NEWTON: They have a business license.

MR. MARK: Yes.

MEMBER RUDDICK: You mentioned also the access to capital in the current assessment,

but are there broader things that should be considered in the planning process in terms of ensuring access to capital for the safety net hospitals?

I know that -- I mean, part of the issue is whether it's a nonprofit or a for-profit, some of the larger hospitals may have more access to capital than the safety net hospital.

MR. NEWTON: You know, I'm not sure, and I'd have to give a little bit more thought to that. I'm not sure that the planning board is the right vehicle, frankly, to be the overseer of capital access in the state. I also do not feel that the planning board should be the overseer of quality in the state.

CO-CHAIR GARRETT: You don't think the State should oversee quality?

MR. NEWTON: My own personal opinion is, I think that there is a requirement to say you've got to be a quality provider, but the challenge that we're going to find in this state is, and really in the country is, what is a quality provider? My opinion might be somewhat controversial, but I do not feel that the planning

board -- there are so --

CO-CHAIR GARRETT: We talked about the hospital report card and --

MR. NEWTON: Right.

CO-CHAIR GARRETT: -- consumer -- yeah.

MR. NEWTON: Frankly, there are so many organizations.

CO-CHAIR GARRETT: That's something that I think is really missing in some of this process is that a lot of these decisions are arbitrary, and we don't have any real data on the real progress and the health of the hospital.

MR. NEWTON: I wish I could -- I wish I could give an easy answer on this one.

CO-CHAIR GARRETT: Yeah.

MR. NEWTON: But the quality of health care is -- I think as a society, we're going to find it immensely difficult for people really to understand what is quality health care.

I went through a process in my institution where I looked at every quality organization which is trying to weigh in on what should be a quality provider, and then I crosswalked it to all of the

matrix that people look at, and you could easily come up with hundreds of measures on what makes a quality hospital or a quality provider, and we have not -- there is not an easy way to say that.

And frankly, people don't understand the numbers and what lies behind the numbers; and so as a society, as we give people numbers, they're going to struggle with what does that mean, and we're already starting to see that.

So I don't think it's -- I just don't think it's going to get solved by publishing a whole lot of numbers, and I don't think trying to regulate capital expenditure and add services into vulnerable communities, it's going to be easy to determine that based on quality matrix.

CO-CHAIR GARRETT: Well, we can talk about capital expenditures based on quality.

Let me just move it along because I'm worried we're not going to get to the Hospital Association.

Are there any other questions from Springfield? Lou?

MEMBER LANG: This is Lou Lang. I have a question, and perhaps -- perhaps I'm not

picking up on something, and everyone else will roll their eyes when I ask this question, but I'll ask it anyway.

Mr. Newton, I'm having trouble understanding why the relationship of other facilities that are near the disproportionate share or safety net hospital and their relationship to the CON process affects you? Maybe you can give me a primer in how that filters down to you and why public policymakers ought to care.

MR. NEWTON: Well, the longer-term view and why you should care about it is that I come from the perspective that health care is a social right, and we have to improve and allow for access to people in this community and all communities to get access to health care, and if --

MEMBER LANG: Well, let me stop you there. Clearly we agree with that.

MR. NEWTON: Okay.

MEMBER LANG: That wasn't the question I was asking. I don't want you to think I don't care about health care or don't care about the disproportionate share hospitals.

My question relates to your comment that when there are, let's say, freestanding clinics around you that are picking up the self pays or the insurance pays, that does add to additional access to health care.

If your only comment is that when there are more of those, then there are less people being self paying at your facilities, and it cuts into your numbers, then that would be a clear answer, but other than that, I don't understand you.

MR. NEWTON: That's at the heart of it. That's what happens -- my point is that when these providers are there and have a different playing field than what is required of hospitals, then there is a tendency where the higher-pay patients end up being directed to those centers in which there is an economic interest.

In the long term what that does is it erodes and it cuts into the ability of hospital providers to remain viable in their community.

That's the essence of it.

MR. CARVALHO: I think I can help here. Some folks have proposed that various categories of facilities have a threshold of

charity care or a threshold of Medicaid, one size fits all across the state.

And what you are saying was you're looking on a much more focused basis. You expect a provider who comes into northwest DuPage to meet the northwest DuPage standard for Medicaid and charity care versus folks who are coming into southeast Chicago to meet the southeast Chicago standard.

So you're looking at the micro level rather than saying one size fits all across the state --

MR. NEWTON: That's fair.

MR. CARVALHO: -- and a standard based on the area.

MR. NEWTON: Yes.

CO-CHAIR GARRETT: Lou, are you done?

MEMBER LANG: Well, I'm not sure if I'm done.

CO-CHAIR GARRETT: Okay.

MEMBER LANG: So let me pursue this just briefly.

Let's presume for the moment, Mr. Newton, that we did away with the CON process and the Health Facilities Planning Board. I'm assuming

that you wouldn't like that, but let me ask this question, and if you don't have an answer to it now, that's fine, maybe you could give us one.

Let's presume we end the process, but you have this concern about the cherry-picking of self pays and insurance pays. Perhaps you could provide to us your comment as to if that happened, what we should do to protect you.

MR. NEWTON: My answer is really within my testimony. One, we want to see continued -- you know, if the supposition is it goes away, I don't feel that there is an adequate process that's going to be in place that would protect us.

Because the essence of CON allows for entry and exit into marketplaces and into communities. So I think it's -- unfortunately, I think it's a nonstarter to take it away.

MEMBER LANG: Well, except that wasn't my question.

So just as Representative Brady asked the previous witness and I reiterated to the previous witness, we want to hear from witnesses as to not just, well, it's my way or the highway. We want

to hear from witnesses as to other options, so we've got a lot of different directions we can go with this -- with a proposal that we might make at the end of our testimony, and we hear what you say about your preference.

Now we'd like to hear what you have to say if you don't get your preference. What else could be done? If it goes exactly the opposite way to what you would request, then what can be done to protect the safety net hospitals, and how should we do it? Whatever that is, we want to hear that from you.

MR. NEWTON: Okay.

MEMBER LANG: Let's assume that tomorrow we pass legislation ending this entire process, and then you go back to your office all ticked off that we ended the process and, oh, woe is us, and that's fine, and perhaps you should.

But then you would come to us at some point in the future and say, well, wait, this has really badly impacted us, and now State of Illinois, this is what you need to do so that the safety net hospitals remain in place. That's what we want to hear from you before we put the proposal in place.

MR. NEWTON: I can give just an initial response to that, and then I'm more than willing on behalf of the association to give some further thought on it.

My answer is going to be related to reimbursement, and the reason why safety nets truly struggle is because we cannot recapitalize our facilities, and it's related to the level of reimbursement.

So anything that -- if CON went away, the response I believe that our association would provide is, you need to take care of us financially.

MEMBER LANG: Well, fine, we assume that that would be the answer, sir. I'm really not trying to be difficult or annoying. I would like you to at some point tell us what that means.

MR. NEWTON: Okay.

MEMBER LANG: What specific legislative proposals would you throw on my desk in six months to say, okay, Representative Lang, you sponsored a bill to do away with the entire CON process and the entire board, this is what you have done to us; and therefore, here is another

piece of paper saying this is what you need to do to protect us. I want to know what that is.

MR. NEWTON: Okay.

MEMBER LANG: I don't expect that answer now, but throughout the course of these deliberations, it would be helpful for me and I assume other people on the task force to find out what you're saying you would do if the -- if the point of view prevails that we should just let the free market determine where all health facilities go in the State of Illinois, and I don't know if it will or it won't, but then we would like to hear from you as to, well, this is really nasty for our hospitals. Here is what we need to do to protect us.

It isn't just saying give us more money. It's saying, how much more money? It's saying, what regulatory or substantive legislation do we need to put in place to deal with this problem?

In addition, we'd like to hear from you not just simply protect this process in place, but ask you some ideas even if the current process stays in place as to how to beautify it, if you will, or how to make it better, how to make it work better

for your facilities and for other facilities.

So I know this is a big undertaking, but this task force is in the middle of a big undertaking.

MR. NEWTON: I would be glad to provide some additional comments.

CO-CHAIR GARRETT: Can you do that in a written form then?

MR. NEWTON: Uh-huh.

CO-CHAIR GARRETT: Okay. Thank you.

Any other questions from our phone?

(No response.)

CO-CHAIR GARRETT: Are you guys still there on the phone?

ON THE PHONE: Yes, we are.

CO-CHAIR GARRETT: Just checking.

MEMBER GAYNOR: I was just asking if the court reporter needs to take a break.

CO-CHAIR GARRETT: Okay. I think that's all for Mark, and we'll bring up the next Mark, if that's okay.

MR. NEWTON: Thank you.

CO-CHAIR GARRETT: Thank you very much for your testimony.

So we have Mark Mayo from the Ambulatory Surgical Center Association.

CO-CHAIR GARRETT: Okay. Mark Mayo.

MR. MAYO: I would like to say that I'm pleased to be here, but I'm not sure about that. So let me start. I will tell you that our association wants to thank you for the opportunity to submit comments to the task force and to talk about possible reforms in the health planning process.

There are some 110 ambulatory surgery centers located throughout the State of Illinois. They provide surgical services to approximately 340,000 patients. Our centers employ some 2,000 staff, and collectively, we have over 4,500 surgeons on staff, as members of our medical staff at the various surgery centers.

There is some overlap because, as Mr. Carvalho and I talked about last week, not only are our physicians required at surgery centers to be on staff at a licensed Illinois hospital, but many physicians who work in one surgery center may be on staff at another surgery center, and I'm going to address some of that in a

little bit because there were several comments that came out before.

My thoughts are based on, unfortunately, 30 years in health care planning and health care delivery in the State of Illinois.

I happen --

MEMBER LYNE: Did you say unfortunately?

MR. MAYO: I happen to be old, Sister, that I was here in the 1970s when we actually had a health planning process in addition to a certificate of need process, and I was involved in that federal/state health care planning process where we developed area-wide health plans and certificate of need standards.

I served as the director of project review for the health systems agency that served Kane, Lake, and McHenry counties. So I conducted the analysis of certificate of need from the federal health planning side and sat many times to the right of state agency staff in making recommendations to the Illinois Health Facilities Planning Board about the merits of particular projects.

I have also served as the administrator of an ambulatory surgery center starting in the late 1980s, and I have been the executive director of the ASC Association of Illinois since 1988. I have served locally. I have served on a national board of ambulatory surgery centers. I have served for a national for-profit corporation that at one time owned 65 surgery centers.

I currently work for a group that has three surgery centers in the Chicago metropolitan area, and I also continue to serve as the consulting editor for one of the national outpatient surgery newsletters.

I only tell you about my past perspective not just to champion surgery centers, but to also tell you that I am personally and soundly committed to health planning in the state and to a coordinated system of health care delivery.

I speak as someone who is very familiar with the certificate of need process and the evolution of that process over some 30 years.

I need to tell you that our association has gone on record before, and we sit before you this morning, to tell you that we support the

continuation of the certificate of need process and the existence of the Illinois Health Facilities Planning Board.

Believe me, this is not a universally accepted position in my field. I believe that our state is the only state-wide association of ambulatory surgery centers that continues to support certificate of need, and I've had that comment thrown at me several times at national meetings.

We recognize the need for health planning, and we recognize the need for a strong health care delivery network. We recognize the need and the role in our community for community hospitals. We also recognize that hospitals are not the only provider of health care services.

Hospitals with their current high utilization of surgical suites could not meet the needs of the Illinois community as evidenced by the 340,000 cases that are performed in ambulatory surgery centers and a growing number of minor surgical procedures that are actually performed in physician offices and never see a surgery center or a hospital for those cases.

The federal centers for Medicare and Medicaid have developed a system for paying hospitals, surgery centers, and physicians differing rates for performing essentially the same service, but in different service settings. So it becomes a site-of-service differential payment system on the federal Medicare program.

Decisions made on ways to perform an outpatient surgical procedure are made by doctors in consultation with their patients. Many factors influence that decision, including the quality of the entire team, cost, both provider charges and the patient coinsurance out-of-pocket payment charges.

You have heard testimony today about the efficiency of surgery centers which usually translates to surgical turnover time and throughput for physicians, the idea of specialization and convenience.

Our association does not think that community hospitals or surgery centers have any special right to be protected through the certificate of need program. Instead they must earn and maintain the respect and continue to meet

the needs and the demands of the physicians in the community and the patients that we each serve because it is the physician that drives both the hospital and the surgery center networks.

We continue to support not only the certificate of need process, but also the data collection efforts of the Illinois Department of Public Health.

We're convinced that a fair and equitable collection and distribution of outcome-based data will better allow consumers to choose where they elect to have elective outpatient surgical procedures performed.

I have several recommendations for the task force specific to the certificate of need process.

We suggest that the role of the Health Facilities Planning Board should focus on CON activities that include the establishment of new facilities, new categories of service, and the discontinuation of existing facilities and existing categories of service.

We believe that the Department of Public Health, separate from the role of the certificate of need board, should through its licensing

processes be better equipped to handle the more administrative matters such as change in ownership applications.

We support a process of health planning. Years ago, facilities were required to publish facility plans that outlined their goals for continued service and for new services to be provided. Hospitals actually had a health planner, rather than a director of development and whatever other terms they're called now.

We do not however support a 10-year planning cycle and would suggest that a five-year cycle is more realistic, and it is more in tune with the type of information that you're looking for with very specific details about Year 1, meaning next year, less specific about Year 2, more general about Year 3, 4, and 5.

We believe that the CON process should give greater due consideration to public hearing testimony.

We had a great deal of testimony provided at a meeting last week regarding a downstate hospital in the Alton area closing, and busloads of people attended a meeting that they had no ability to

present anything other than their physical presence, which I think was sufficient enough to make a good point before the Health Facilities Planning Board, but I have seen where the process of collecting public hearing testimony becomes one pile, there's a state report, and then there's a third pile with an application, and all of the three of them need to be combined into a more effective state report.

I would suggest that this is more like the legislative and regulatory process where people specifically comment on rules, and there is actually a state response, or that those comments are somehow incorporated into a summary of testimony and also incorporated into state agency reports, and I know that's a greater challenge for the state staff, but we believe that to be the case.

We believe that there should be better cooperation between the CON process and the licensure division of the Illinois Department of Public Health. We have talked to both the Department and the facilities board about this. I'll give you an example.

An ambulatory surgery center may come into a community, they may apply for and be approved as a single specialty orthopedic surgery center, but they'll receive the same ASTC license that any other surgery center will receive.

And we feel that at a minimum, licensure and certificate of need, or CON first and then licensure should coordinate so that you have defined single-specialty, limited-specialty, and multi-specialty licenses that correspond to the actual certificate of need activity that occurred in the state planning process.

We believe that hospitals as well as surgery centers need to earn the trust and the business of the physicians that we serve and that neither should be accorded any right to exclusive referral by physicians.

There may be very legitimate reasons, such as quality, efficiency, outcomes, and cost, why some physicians prefer to perform certain cases in one setting over another.

The notion that hospitals deserve protection that they do not earn or maintain by inadequately meeting the needs of their own surgeons is

inherently unsound and undermines the value of competition.

If this were not the case, then all surgeries would be performed at hospitals, and the benefits of competition resulting from lower cost ambulatory surgery centers and physician-owned clinics would significantly increase the cost of health care delivery both in terms of new or expanded facilities needed by hospitals to, in fact, perform the 340,000 cases that are today being performed outside of the hospital and in the charges associated with the higher cost hospital settings.

On the Medicare program, the federal government determined that surgery centers' costs were 84 percent that of a hospital to perform the exact same surgical procedure on the exact same type of intensity patient. A 68-year-old cataract patient is a 68-year-old cataract if they have the same co-morbidity issues and intensity issues.

The federal government pays a hospital more for performing that case. They pay a surgery center less, and by the way, it's not 84 percent. It's now gone down to 65 percent of the hospital

outpatient rate for that same procedure, and that was just a function of cost -- budget neutrality rather than any other constraint, but the figure was 84 percent.

Similarly, for certain GI or other procedures, a site-of-service differential incentivizes certain doctors to bypass both the hospital and the surgery center and to perform the case in their physician offices.

We think that the CON decision should be clearly supported by information included within the record where the state board makes decisions or determinations that are contrary to staff recommendations which come in something called a state agency report.

We feel that the state board has a particular obligation to develop its own findings of fact, conclusions of law, or regulation, and to issue its report back to the applicant in writing because in many cases the applicant is being granted or given an intent to deny and will appear before the board again.

Such a step would allow an applicant to focus clearly upon the stated concerns of the

state board. I have been in that room many times where I've heard the Chair say, intent to deny, you've heard the concerns of the board and talk to our staff and come back and see us at a later date; and the applicant is sitting there dumbfounded because they don't know what just ran them over, and they're really not clear until they step back or maybe get a transcript to find out what additional information it is that they may have to provide to the state agency.

We also feel that this is a step forward in transparency in the review process so that everybody is crystal clear as to what has happened and why, and we think it would also help restore confidence in the state board's decision-making process.

Finally, something that we haven't heard today, but I know you all know it, but we want to go on record is to say that this task force has really several significant tasks before it. One of them is how you might reform a system or replace it, and the other is how this task force will be viewed to help restore public confidence and provider confidence in our health care

planning and certificate of need process.

Past and current exposes and stories of undue influence peddling has hurt the credibility of that process. There are many providers who believe that if you have the right person and the right contact, you have a project that would be better approved.

I used to strongly believe and for the most part still continue to believe that a good project, well-presented, factual, will bear the review and will eventually receive approval from the state board.

So working up-front with the provider community is going to be important, and there are many ways that we hope that can be done. I think the state board has taken some steps, and I think this task force and the general assembly have taken some steps, and we need to be cognizant of this because I think it's incumbent to restore that type of faith.

Our association wants to thank you, and I'm just more than pleased to open myself for questions.

CO-CHAIR GARRETT: Margie, do you want

to go first?

MEMBER SCHAPS: Thank you very much. I think you raised some interesting and important issues. I wonder how your association would respond to the previous witness, Mr. Newton's notion about looking at the regional or your areas' Medicaid rates or uncompensated care and having the surgery centers --

MR. MAYO: We had hoped to actually have an opportunity to provide some additional information before the Health Facilities Planning Board, and Mrs. Lopatka had suggested that that might be an appropriate thing to do, and we're waiting for an invitation from the board to do that.

With regard to charity care, the first thing that needs to be realized is that our cases come to us from physicians. I think you're going to be surprised to hear that in my experience, over half of the physicians who are on medical staff at a licensed ambulatory surgery center have no financial interest as a limited partner, a general partner, distributive partner, shareholder, and receive no remuneration at the end of the year for

sending cases to that --

MEMBER BRADY: Do you have that census information?

MR. MAYO: I have information from three facilities, four facilities that I have operated at.

MEMBER BRADY: Can you survey your membership and give us that information?

MR. MAYO: I can survey my membership and get information on that.

What's surprising about that is why those physicians still come to a surgery center and bring cases, and it is, as the last speaker talked about, it is the efficiency. It's the ability to do three, four, five cases and get back to their office by 11:00 o'clock, instead of 2:00 o'clock, instead of, you know -- and having patients waiting for them in their office.

It is the physician that brings the patient to the surgery center. If physicians in our surgery centers wish to do charity care cases, uncompensated care cases, and I'll address public aid in a minute, they're welcome to do so because we feel on balance that they're bringing two or

three cases. We can afford to take a loss on one, make a little bit of profit on another, and if it's a well-insured patient or private pay, make more money off of those patients.

MEMBER SCHAPS: I guess my question is more about requiring, rather than having people voluntarily say, here, I'll do charity care.

MR. MAYO: Here's several problems that go with it. First of all, our physicians, as Mr. Tierney talked to you about this morning, already are providing community care and uncompensated care as physicians.

Surgery centers by the federal government are viewed as an extension of the physicians' office. So if they're willing to bring the cases to our surgery centers, we should be willing to do them.

However, up until a few years ago, the Illinois public aid program would not allow ambulatory surgery centers to participate, and there is some legislative history that goes into that that I don't think we need to discuss at this forum, but there was a reason for it.

Our association actually had to go back and

ask for that right to participate in the Medicaid program. So a number of surgery centers who received a certificate of need and opened prior to five years ago didn't even have a requirement or any access to it.

From a health planning standpoint, I think it's appropriate that everybody does their part. I also think what you need to look at is not uncompensated care, charity care, public aid going through the emergency room, labor and delivery and other services that surgery centers don't provide.

So let's look at on a comparative basis outpatient surgery, which in many cases is an elective procedure that is performed not rising to the level that you talked about in Champaign where it's elevating, it's a quality-of-life issue, but it's not an emergent issue. So we do this -- public aid is not going to pay for plastic surgery. Public aid is not going to pay for certain procedures.

We've had managed care companies that refused to pay for procedures in a surgery center because they think it's more appropriate to be performed in a physician's office. I got into a

lot of trouble by challenging that once. We won. I won't tell you how, but we won with that insurance company by stressing to them that that's a decision that really needs to be made by the physician and the patient as to where the patient should go, needless to say, if there is a level there.

The other thing is that community hospitals, for all that they do, they receive some community benefit, and they provide some community benefit.

We don't get tax breaks on our real estate taxes. We don't have an endowment for our capital equipment requirements, our facility costs, our development costs. Those are all borne by in most cases physicians, in some cases joint ventures. There are a number of surgery centers in this state, folks, that are joint ventures between hospitals and ambulatory surgery centers. So it's not just the doctor alone.

The last thing I want to point out about that is that because of state requirements that all surgeons who perform surgery in an ambulatory surgery center must be on staff at a licensed Illinois hospital and perform skilled equivalent

practice privileges at their hospital, there has got to be a reason that that doc walked out the front of the hospital for 10 percent of his cases, 20 percent of his cases.

We didn't go out and grab somebody from Alaska and plop them down and say, let's compete with the local hospital. It's our local hospital's community doctors who still have a need for and continue to utilize that community hospital. So we're still members of that community, and we need to continue to do that.

So yeah, I agree that we need to provide some level. I don't know what it is, and I don't know what the tradeoff is for that.

CO-CHAIR GARRETT: Do you have more questions? I'm just trying to expedite this.

MR. CARVALHO: Mark, one of the things that you recommended is that when the board denies something, that there be a written record, and like many of these ideas, there's pluses and minuses. I just want to make sure everybody has thought through and any insights you might have on what -- my initial reaction on one of the minuses is, as you know, the board meets every six weeks.

So sitting as a board, if they have a conversation that leads them to a vote that says intent to deny, which is just an initial denial, it comes back later, if something is to be drafted that reflects that conversation and collectively agreed upon, it's not going to happen right then. It's going to be drafted by staff later for consideration by the board at their next meeting six weeks later when they look at that written document and say, yes, that is exactly what we intended, and the applicant will get it then, and then they'll have another six weeks.

So is it worth the six-week delay, or do you have an idea on how that could be avoided?

MR. MAYO: Where the problem comes in is where there's a written staff finding and there is no specific corresponding state agency adoption or state board adoption of that finding, or it's totally turned around. So there has to be sometimes a process to afford the applicant the opportunity to have clearly laid out in front of them what the objection was.

MEMBER BRADY: Are you saying that you want the minutes approved and at the point

disseminated?

MR. CARVALHO: No, not minutes. I think what Mark has suggested was rather than the board simply saying for all the reasons we have discussed at this meeting, you will get a letter of an intent to deny, and the letter will come from the office. It will say at the last meeting the board denied -- you know, issued an intent to deny. Under the intent to deny, you have an opportunity to come back with more information or proposals or whatever, and the time line is laid out.

I think what Mark suggested was, he would like rather than them say for all the reasons we discussed today, to actually convey something in writing that identifies --

MR. MAYO: To have a finding.

MR. CARVALHO: Right.

MR. MAYO: It's very similar, Senator to --

MEMBER BRADY: Now, why do you have to wait six weeks? Why couldn't you do it in a week?

MR. CARVALHO: But who would do it? In other words, let's say, for example, you all

were board --

MEMBER BRADY: Well, who would do it if it was six weeks?

MR. MAYO: Usually staff anyway.

MR. CARVALHO: But then would it go out by the staff without any further --

MEMBER BRADY: Who would do it if it was six weeks?

MR. CARVALHO: Staff would draft it and bring it back to the board and say --

MEMBER BRADY: Why doesn't the staff draft it in a week and send it to the board for a proxy approval?

MR. CARVALHO: Well, under the Open Meetings Act, we don't have proxy approvals. That's why I'm saying --

MEMBER BRADY: For minutes?

MR. CARVALHO: No, nothing, everything is done in an open meeting with a quorum present and public available. The board doesn't do anything off-line.

If you're proposing that, I mean, that's the proposal. I'm just saying we need to build into your proposal something to ensure that there's not

a delay or accept the fact that the tradeoff is worth it. So you're going to have the delay and have it in writing.

MEMBER BRADY: One request I'd make of staff is that we've asked for a lot of recommendations beyond continue or not. Thank you for giving us yours.

I'd like a matrix kept of testimony, and I'd actually ask that you include the Senate Republican Task Force recommendation some time ago and start keeping us up-to-date on these recommendations as we see them by matrix.

Do you want to answer his questions?

MR. MAYO: Again, I agree with you it has to be the staff, and it's how you get that document out, and it's problematic, but in cases where it's not clear, it really is -- the burden is on the applicant to try to figure out again which way the truck was going that hit them.

CO-CHAIR GARRETT: But I think what --

MR. MAYO: I know.

CO-CHAIR GARRETT: -- proposals coming, reforms, that might be something we would definitely consider. So without trying to figure

it out now, I think that's something we're going to be looking at, but it's a good recommendation.

MEMBER BRADY: You also suggested that one of the two problems is the confidence level of the board decision making in the eyes of the applicant and the public.

MR. MAYO: Yes.

MEMBER BRADY: I don't recall you giving recommendations on how to handle that.

MR. MAYO: I think -- personally, I think that's coming out of this public vetting process and the reforms that will come out of this system to instill greater confidence in the provider community in particular.

CO-CHAIR GARRETT: So let me go to that point because the last meeting that you had, I think two days, so -- or one day, I thought it was two, but X number of hospitals come before the board. Instead of doing all of them you did, let's say, five, six, maybe make it fewer at one time, and then you can get more input from the general public just to make it more --

MR. MAYO: Unfortunately, Senator, the process is there's a public hearing that's held a

month or so ago.

CO-CHAIR GARRETT: Yes.

MR. MAYO: And there's an application that came in three months ago. There is a staff report that got written last Friday, and somebody gets it Friday morning, and they've got until Tuesday to write an answer. So it's like doing your taxes last weekend. You hurry up and try to respond.

So because of that process, I think that -- and, again, this is my old health planning background, but I think that the public's -- the weight to public comment needs to be elevated.

I have seldom seen public comment incorporated into a state report. It's usually you've got three stacks. You've got the application and in the case of the two hospitals in Lake County substantial volumes of data. You have got a state agency report, and you may have reams of transcribed data and letters from the public.

Where there's some substance to those issues rather than, you know, not in my backyard or something, they need to be incorporated and

referenced or at a minimum summarized so that the public has a feeling that they've been heard.

CO-CHAIR GARRETT: Okay. Let me just pick up, they need to be incorporated. Could they be incorporated when the staff makes its recommendation to the board?

MR. MAYO: Yes.

CO-CHAIR GARRETT: Okay. So that's what you're saying, not necessarily having people selectively come forward and testify, or would you say both? I mean, something has to be delineated.

MR. MAYO: I wish that would work --

CO-CHAIR GARRETT: Okay.

MR. MAYO: -- but it's actually too late in the deliberative process to allow it.

CO-CHAIR GARRETT: So if there are comments that really could have an impact positive, negative, that stand out from not in my backyard, you would ask that the staff incorporate that into the proposal or at least acknowledge that.

MR. MAYO: Summarize it, respond to it, just as you do with JCAR or somebody coming through, a real process.

CO-CHAIR GARRETT: Any other comments from committee members?

I'm wondering if we could have a copy of your testimony today?

MR. MAYO: I brought copies, yes.

CO-CHAIR GARRETT: Lou, are you --

MEMBER LANG: Senator, yeah, I just have one.

Mr. Mayo, I heard your testimony regarding the public hearing process and that you would agree with many who say that just having staff there and not having a member of the board there is not a good idea. I heard you say that you think at least one board member ought to be there.

Let me just throw out an idea. What about the notion that all board members be at public hearings? Let's assume that we made it worth their while by giving board members a salary that was worthy of the time they would expend, would you then think it would be a good idea to have all the board members at all public hearings?

MR. MAYO: I don't think it's practical. I did see a process where the board did a dog and pony show around the state to

receive comment on previous revisions of the certificate of need process several years ago.

I don't think you're going to enable all board members to be there. That's why I'm stressing that the staff should be able to summarize proponents, opponents, you know, factual data and present it.

It's also very difficult I think for the board members to try to read through every single page and every single letter.

MEMBER LANG: In fact, I don't think they do. We heard at our very first hearing that sometimes there's 10,000 pages in a report, and I don't think we should -- anyone believes that all board members read all 10,000 pages.

But I did hear you say that it would be appropriate in your opinion to have at least somebody who is sitting on the board at every public hearing; is that correct?

MR. MAYO: I actually didn't say that, and I feel that staff can do an adequate job, but the role of a hearing officer at a public hearing now changes, and they're not just simply there to be a clerk of the court and receive a document.

MEMBER LANG: So you would say it should at least be more than a procedure where the witnesses all just speak into the air, and there's no one listening.

MR. MAYO: And I'm not -- I'm not suggesting that that always happens, but I get concerned where you have a very sensitive issue such as the closure of a hospital in Alton or the creation of two new hospitals in Lake County. There's a lot of passion that goes into that, and some facts come out of that, too.

MEMBER LANG: Thank you.

CO-CHAIR GARRETT: I have one more question. You talked about the planning process and how it used to be and it doesn't really exist anymore. We have talked a little bit about this hospital report card and qualifiers when evaluating.

Do you think that the evaluation process that's currently used is relevant?

MR. MAYO: We think it's going to be.

CO-CHAIR GARRETT: Well, that's not my question. My question is, do you -- let me just restate that.

Do you think that the current process in place, the CON process, you know, without taking into consideration any planning and some of the other things that you put out, is relevant?

MR. MAYO: Not without planning. The data collection effort by the state is going to expand.

CO-CHAIR GARRETT: Do you think that it's important to evaluate the health of hospitals when making a decision whether or not that hospital has the right to expand, and I'll just use Lake County as an example?

MR. MAYO: I think it always happens, yes. I don't know that that's a sole determinant.

CO-CHAIR GARRETT: If that was agreed upon, do you think that would make it a more fair and relevant process?

MR. MAYO: I think that the health planning process should be expanded to include data more than just existing beds, existing referral patterns, and I know they try with in-migration, you know.

CO-CHAIR GARRETT: How about our telephone members, do you guys have any questions?

Are you still there?

MS. SULLIVAN: Yes. This is Myrtis Sullivan, I'm still here. I'm just listening. I'm listening to the comments, and I don't have any questions about the protocol.

CO-CHAIR GARRETT: Okay.

MEMBER KOSEL: This is Renee Kosel. I'm still here, and, no, I don't have any additional questions now.

MEMBER BRADY: Did you say you were waiting to be called in to talk about acceptance of Medicaid?

MR. MAYO: We had a discussion with the board chairman, Mr. Mark, and someone else about the value of our association doing a presentation before the Health Facilities Planning Board and to give them some factual information, and I'm waiting for that invitation to become formal.

MEMBER BRADY: Are you prepared to give it now?

MR. MAYO: I gave some of it already, but I --

MEMBER BRADY: Do you want to give --

is there more you'd like to share with us?

MR. MAYO: No, we would bring in someone on a national level, but we think it's an appropriate thing because we're a significant player at the table.

CO-CHAIR GARRETT: Why would you bring it to the Health Facilities Planning Board? I mean, it seems to me like it would be legislative.

MR. MARK: If I may clarify, Mr. Mayo. The Health Facilities Planning Board over the last year or so has requested basically in-service educational talks as part of the various industries, and we have had a session on -- from the critical access hospital, Critical Access Hospital Association. We have had a couple others. I don't recall offhand. So we've been discussing having the ASTC industry, ERSD industry -- these are inservice education.

CO-CHAIR GARRETT: It seems to -- and I think that Senator Brady would agree with me, that this is a huge step. It's a huge component of what you all do. How long have you been waiting for the invitation?

MR. MAYO: Three months.

MEMBER BRADY: I would request the chairman to make a presentation to us, just kill it all in one.

No, I'm talking to Mark about the presentation you said you're ready to make and you would bring national people in.

MR. MAYO: If you would like us to come back, we would be willing to.

CO-CHAIR GARRETT: I think it's a good idea as we evaluate the impact of your organization and what that means in Illinois. I mean, it's the first time I heard that there is even an opportunity that's lingering out there to address the Medicaid patients. I'm just -- you know, I guess I assumed that it was already happening.

MEMBER SCHAPS: What's the presentation?

MEMBER ROBBINS: I'm not sure I understand what's happening.

MEMBER BRADY: As I understand it, he suggested that they're in a position to make a presentation about charity and Medicaid --

CO-CHAIR GARRETT: Reimbursement.

MEMBER BRADY: -- work that they do, that everyone is under the assumption that they only take -- they only pick the cherries.

CO-CHAIR GARRETT: Do you know -- is that your presentation?

MR. MAYO: That's part of it, yes.

CO-CHAIR GARRETT: Do your facilities, do they get reimbursement for Medicaid now?

MR. MAYO: Some do.

MEMBER BRADY: But not all under the law?

MR. MAYO: But not all do.

MEMBER BRADY: Would you support legislation that would allow them all to get it?

MR. MAYO: We've already got it. We've already been permitted.

MEMBER BRADY: Okay.

MR. MAYO: We actually had to go and ask for that right, and now it's a two-way education street.

MEMBER ROBBINS: Mark, am I fair to -- do I understand it correctly that you have to apply to be a Medicaid provider?

MR. MAYO: Correct.

MEMBER ROBBINS: And some of your facilities have done so and some have not.

MR. MAYO: Correct. We also have --

CO-CHAIR GARRETT: With the state or with the feds?

MR. MAYO: With the state.

CO-CHAIR GARRETT: With the state.

MR. MAYO: I have also talked to Mr. Carvalho that the one IT software program that's used by a majority of surgery centers in the state doesn't readily collect charity care, uncompensated care. It's either -- it falls into certain categories, or it wasn't paid, and we need to work on that on a national level so that we have more accurate data.

MR. CARVALHO: The issue is whether our data that we share with you that shows a very low level of charity care, Mark is concerned that it may be a function of their software not accurately picking up the data so then when their software then turns around and gives it to us, it may be under-counting.

MEMBER BRADY: How many facilities do we have licensed in the state?

MR. MAYO: I think it's about 100 and --

MR. MARK: 112.

MEMBER BRADY: Hospitals and everything?

MR. MARK: There are 12-, 1400 --

MEMBER BRADY: Earlier we had asked for a map that would show the safety net and disproportionate -- I don't know what that -- I'd like the definition as well, but I also think it would be nice to have in that all hospitals as well as all the licensed facilities identified by color or whatever. Particularly along the lines, I'd like to know in the last 25 years how many emergency rooms have been opened on that map.

MEMBER ROBBINS: You mean hospitals?

MEMBER BRADY: No. As I understand it, we have emergency rooms without hospitals.

CO-CHAIR GARRETT: Yes.

MR. MAYO: Freestanding emergency rooms.

MR. MARK: A very limited number.

MEMBER ROBBINS: One, maybe two.

MEMBER SCHAPS: But then you might

want to see the emergency rooms that have closed, too.

MEMBER BRADY: Yes.

MR. CARVALHO: Okay. It works both ways. Hospitals can't close its emergency room, but it can reduce it to the lowest of the three levels.

MEMBER ROBBINS: It can't be a hospital without having an emergency room.

MR. CARVALHO: Yeah, there's sort of a one-for-one almost going on here. Namely, you have an emergency room that's part of a hospital except one or two examples; and if you have a hospital, it has an emergency room with probably no --

MEMBER BRADY: I think just start defining it as best you can, and we can then see --

MR. MAYO: And the state may have some data that would help you, for example, in ownership categories of surgery centers. There are a number of centers that are joint ventures owned with hospitals.

MEMBER BRADY: When it comes to these,

I'd like to know which ones have -- by color, again, which ones have applied for Medicaid reimbursement and which ones have not.

MEMBER ROBBINS: That's the question I was going to ask. What percent of the ASTCs in the state have actually -- are actually participating in the Medicaid program?

MR. MAYO: I'd have to go back. It was low, but it was growing.

MR. CARVALHO: One other thing. It's been referenced several times about the ownership structure of ASTCs. Just a reminder, ASTCs came into full bloom in the 90s, and the rules for the planning board recognized that there was this potential impact on hospitals; but if you look through the rules, the rules treat an application that comes in as a joint venture with a hospital differently under certain criteria, evaluation, than if you come in on your own.

So the fact that there are a number of joint ventures out there, the pathway to getting an ASTC if you're a joint venture with a hospital is easier.

MR. MARK: Slightly more favorable

with a hospital joint venture.

MR. CARVALHO: Yes. You have already built in -- the board has already built into -- the statute permitted the board to build in something to steer people in that direction in part because of this concern.

MR. MAYO: I'll give you a crazy --

MR. DeWEESE: Isn't there also an instance where the physician gets reimbursed for the care that they are providing at the ASTC, but the ASTC doesn't get the payment, the Medicaid payments; they're just directed to the physician in that case?

MR. MAYO: Usually that's done in a physician's office. The surgery center would have one of two choices. If they're in the public aid program, they would submit a facility fee and at least recapture some of their tray and supply cost, or they'd just write it off as charity care and don't submit it to anybody, just do it as free care.

MR. DeWEESE: I know that in Medicare a physician can get their professional services or their professional charges reimbursed even if the

facility does not.

MR. MAYO: In the Medicare system, you're absolutely correct because in some cases they'll actually pay the physician more to not perform the case in a hospital or a surgery center, but do it in their office.

CO-CHAIR GARRETT: I'm going to -- any other questions from committee members?

Okay. Thank you very much, Mark.

MR. MAYO: Thank you.

CO-CHAIR GARRETT: If you would provide each of us with your testimony, that would be great.

MR. MAYO: I will.

CO-CHAIR GARRETT: Next, I think we have the Illinois Hospital Association. We are now at the end of our meeting. We can stay and go through the Hospital Association, or we can defer the presentation either to a separate meeting or the next meeting. Ken.

MEMBER ROBBINS: I think we have probably already begun to lose some people.

CO-CHAIR GARRETT: Yeah.

MEMBER ROBBINS: My preference would

be that we have that testimony be at the next scheduled meeting.

CO-CHAIR GARRETT: Okay.

MEMBER BRADY: So moved.

MEMBER SCHAPS: Second.

CO-CHAIR GARRETT: Everybody is in agreement with that. Okay. We will do that.

Having said that, I think we will officially adjourn the Health Planning Board Task Force meeting.

(Which were all of the proceedings had in the above-entitled matter ending at 12:10 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.