Illinois Task Force on Health Planning Reform
Wednesday, October 8, 2008
10am-2pm

Illinois Dept. of Human Services
1112 S. Wabash Ave., 3rd floor
Directors Conference Room
Chicago, Illinois

SIUE School of Nursing
Springfield Campus
409 Calhoun
Springfield, Illinois

Task Force Members Present:
Chicago: Senator Susan Garrett, Paul Gaynor, Gary Barnett, Rep. Lou Lang, Hal Ruddick, Senator Bill Brady, Heather O'Donnell, Sister Sheila Lyne, William McNary, Margie Schaps, Rep. Lisa Dugan, Senator Pam Althoff, Kenneth Robbins
By phone: Rep. Renee Kosel

Ex Officio Members Present: David Carvalho/IDPH, Jeff Mark/IHFPB, Myrtis Sullivan (for Carol Adams)/IDHS, Mike Jones (for Barry Maram)/IHFS

Staff Present:
Illinois Public Health Institute Staff - Chicago: Kathy Tipton, Elissa Bassler, Mairita Smiltars
Illinois Public Health Institute Staff- Springfield: Laurie Call
Legislative Staff- Chicago: Greg Cox
Legislative Staff- Springfield: Kurt DeWeese, Melissa Black, Clayton Klenke

Public:
Chicago: Ann Guild/IHA, Susana Lopatka/IHFPB, Patrick Keenan Devlin/SEIU, Jack Axel,
Springfield: Howard Peters/IHA,

Facilitator: Laura McAlpine, McAlpine Consulting for Growth

Call to Order: 10:06am

Action: Approval of 9-15-08 Minutes
Rep Lou Lang motioned to approve the 9/15 minutes, seconded by ____. Senator Brady abstains from voting as he has not seen or read the minutes yet. Motion approved.

Discussion – Edward Hospital
Rep. Kosel: The Edward Hospital report is being handed out. Edward Hospital would like the Task Force to review the migration factor used in the CON approval process.

- Garrett: I think it would be good to have Edward come in to testify at some point, but I leave it up to the Task Force Members to decide.
- Mark: Edward Hospital wants to make changes to the CON rules regarding migration. The Illinois legislature did amend the minimum level of migration in the Health Facilities Planning Act. It seems as though this party (Edward) does not think the change was enough. The board elected, based on the law, to adopt a 50% migration factor.

- Senator Brady- I think when we get down to the nitty gritty of how the Board will operate, and if this case applies to the function of the Board, this will fall under our recommendations to the legislature regarding the CON rule-making process.
- Lang: Based on emails and phone calls I've received from folks surrounding this issue, it seems like there is an interesting story to tell, but it is not the Task Force's place to decide whether Edward Hospital is right or wrong. Some of their testimony might be relevant to us to learn how a proposal goes through the review process, so we can identify the speed bumps and problems with the process. It is not right for us to listen to the merits of their case- this is not our province. Their testimony should be limited to process only.
- Robbins: I agree, especially if their testimony does not ask the Task Force to decide about merits.
- Lyne: If we allow Edward to testify, what about other hospitals that may want to then come in?
- Robbins: I frankly don't feel at all confident as to whether a migration factor should be 50%, 80%, etc. I only want to hear about an example from Edward of a process issue, and I feel that type of testimony could be educational.
- Brady: In many cases the subjectivity of Board's decisions are far too loose. At the end of the day, the legislature has to give the Board more guidelines in order to remove subjectivity. I think that we as a Task Force should make recommendations to remove subjectivity from the decision making process.
- Garrett: Have them contact me or Rep Dugan if they would like to testify.
- Kosel: I will let them know.

Facilitated Discussion: Key Questions

McAlpine reviews the written materials in the binder as well as other supporting documents on the IHFPB Statutory Authority and Administrative Rules. McAlpine will provide Task Force members the opportunity to answer the discussion questions, and will call on ex-officio and public participants upon agreement by the Task Force members.

The three questions for today are:

1. How should the CON process be changed?
2. How should statewide health planning be done by the State of Illinois?
3. Should the IHFPB be re-structured, and, if so, how?

Group Agreements for the Discussion

- Speak one at a time
- Be open to new ideas
- Step Up Step Back
- Speak to new ideas, avoid repeating previous remarks
- Allow the facilitator to move the conversation along
- Try to stay in the conversation as much as you can (Limit side conversations, email, etc.)

McAlpine noted that we are using these key questions to gather information for recommendations to the legislature. There is one more meeting scheduled on Oct 30th, which may conclude the facilitated discussions.

First question: How should the CON process be changed?

McAlpine: The statute is asking you to consider the following reforms and recommendations for the CON process: focusing project review efforts; evaluating specialty provider applications, including impact of specialty providers on access to services and community and Safety Net hospitals; impact of all project on access to "safety net" services, possible impact statement; changes for predictable, transparent and efficient process; establishing separate criteria for long-term care vs. acute care facilities; changes to enforcement and compliance. Given those points to follow, how should the CON process be changed?

- Robbins: There are many ways we could streamline the process. For example:
    - Conduct full substantive 120-day review only for new or replacement facilities or new categories of service, the addition of beds beyond 20 or 10% of bed capacity (whichever is greater), any free- standing medical facilities offered by any provider if that service is regulated in a hospital setting (i.e. cardiac catheterization, and proton therapy).
    - Conduct 60-day non-substantive reviews for discontinuations and major construction projects
    - Increase the total project cost threshold to $15 million
    - Eliminate projects under same financing considered interrelated and thus considered under same CON application
    - Focus the financial review on individual project cost not overall cost
- Garrett: The question also asks what we would we eliminate?
- Mark: The only thing that Robbins is shifting from substantive to non-substantive is large scale construction projects.
- Carvalho: What about closures?
- Mark: Closures are non-substantive right now. (Sister Sheila asks about a Mercy Hospital application.) According to Ken's proposal, your application would fall into a non-substantive category.
- Garrett: I disagree with the $15 million cap. The cap should be struck completely. Why do health facilities have a cap on their building costs? I don't know of any other industry that does that. Why do hospitals have this cap- is there a reason?
- Lyne: Even if you do away with the cap, one would still have to come before the board to get permission.
- Garrett: If a hospital wants to buy 3 MRI's, why should they have to come before a board to get approved to improve their infrastructure?
- Schaps: What if they don't need 3 MRIs?
- Garrett: Well, I don't think hospitals are buying things they don't need or can't afford. They have their own Boards that approve these things.
- Jones: Back in the 70's, the thought on this cap was to control costs.
- Barnett: Back in the 70's there was cost reimbursement. But now facilities don't buy things if they can't afford it because there is no longer cost reimbursement.
- Lyne: I think we need to first discuss statewide health planning to figure out how we should change the CON process.
- McAlpine: The idea for today was to start with discussion on this topic and then go back to statewide health planning.
- Brady: It's like the chicken before the egg. Why does the CON board exist? What do we want it to regulate? What purpose does it exist for? What is its scope? The more limited the better.

We first have to come to the scope of the CON Board's authority before we determine how it operates. Maybe planning comes first, or maybe first scope and then planning.

- Schaps: We need a plan that says we need X number of MRIs in this county or region. Without planning we can get over bedded and over equipmented. I would not be in favor of eliminating the dollar cap.
- Lang: I agree with Sister that the most important thing is the planning process. I understand why we would allow hospitals to buy anything out of their own pocket, however if those costs are then passed on to the customers, then that goes back to the planning board. Maybe we state what items do and do not need to be approved by the Board.
- Robbins: What kinds of things do need a CON within an existing hospital?
- Mark: We just created a checklist which I can distribute. Briefly, that list includes:
    - Capital expenditures over $8.5 million (dollar amount adjusted annually)
    - Establishing a facility or category of service
    - Facility opens or closes a category of service
    - Bed service- add more than 10 or 10%
    - Imaging equipment does not come under this. Anyone can buy 10 MRI machines for under $8.5 million, so that would not come under the CON process.
- Ruddick: What is the purpose we are trying to accomplish with the Board? We need a frame work before we can assess what things should come under the CON process. We need to determine what the process is before we can determine if there should be a cap to spending.
- Garrett: Ok let's just go back to talking about planning.

Statewide Health Planning Discussion

McAlpine: Discussion Question: "How should the State of Illinois conduct statewide Health Planning, and for what purpose?" Group instructed to follow the statutory language establishing the Task Force as well as the notes from the September 15, 2008 discussion. Reforms and recommendations from the statutory language include: overall impact (essential and accessible services; prevention of unnecessary duplication; improvement in efficiency; support of quality care; economic use of resources); more active role in health planning to provide guidance in the development of services for health care needs and special needs; coordination with other health planning laws and activities.

- Brady: Using a sports metaphor, I think of it like offense and defense. On the offensive, services and access to care are initiated. On the defensive the only reason we would keep the CON process is to prevent the Safety Net services from going out of business. At least, that is the only reason I can think of.
- Robbins: The CON process clearly protects Safety Net services and prevents cherry picking. It is harder to contemplate how the offensive strategy plays out. Here is hypothetical situation. Say there is a shortage of in-patient psych services in central IL. If it turns out that Medicaid payments prevent these services from happening here, what do we do?
- Brady: On the offensive, we need to see if there are too many services in certain areas – eliminate duplication- and also make sure things are properly specialized. Offensive is not only about adding services, but also eliminating.
- Carvalho: The other sort of cherry picking comes from within. In other words, if you have a hospital serving a community and that hospital wants to eliminate a service, it currently has to go through the CON board. If you have a state plan that ensures services, you also want to regulate the stopping and starting of services.

- Brady: Philosophically the only reason a hospital would want to discontinue a specialization is because the State isn't funding it well enough. Should we focus on offense or defense?
- Lyne: Offense. What should it look like so that everyone in IL has access to services?
- Brady: Is it reasonable to talk about offense only in terms of facilities?
- O'Donnell: Maybe the planning process should identify the areas that the State does not reimburse well enough.
- McAlpine: You spent a lot of time in the last meeting talking about inventory. As a group, you covered it and now the question is what do you do with that information? Are there other things that would logically come out of that health planning?
- Robbins: Health planning is not only about facilities. It is about doctors, nurses, techs, etc. IT is about meeting the unmet needs of the population anywhere in the state.
- O'Donnell: There should be a plan for health facilities access in the state.
- Garrett: Ok so if we did a health plan that determined where there are ample services, and where there are insured consumers, then we could focus on areas where there is neglect. The planning board could recommend to the General Assembly the areas in IL that need more facilities and services. But we don't really have a situation analysis like this right now. So we don't know.
- Lyne: It seems to me that there is a semblance of that plan in the IHFPB.
- Mark: We have a plan but it is limited to projection of service need based on facilities. We don't take into consideration manpower or clinical. Our plan focuses on bed need projections and ESRD projections.
- Garrett: That's really limited. My worry is that the planning process is bureaucratic and works against access to healthcare. It would be refreshing to reinvent the planning process and make it simpler.
- Brady: If we try to handle shortages of workers, financing, and facilities, we will never accomplish everything. We should focus on facilities in IL. The other two are very important but we need to focus our efforts.
- Barnett: We have a time pressure, but planning needs to go beyond facilities to consider staffing and finances. Planning is more than just facilities.
- Lang: It is clear that the low-hanging fruit would be to plan just for facilities and call it a day, but that is not our only role here. We have agreed that the HFPB is not planning, but healthcare in IL demands a plan that includes how to bring doctors back to Illinois, and how to incentivize people to build facilities in areas of need. This isn't just about bricks and mortar and capital expenditures.
- Brady: There are many important issues, but I do think we should focus on one rather than the all at the moment. I don't want to confuse all the topics together and go in circles. There needs to be comprehensive thought to this. Focus on each issue one at a time.
- O'Donnell: We are not doing the planning, we are just making recommendations. We need to make recommendations for all areas.
- Brady: I didn't say we only had to give recommendation in just one area. We should just choose one to focus on first.
- Garrett: I've often thought we could regionalize planning. Northern, Central, Southern Illinois.
- Carvalho: Everything you've talked about in IL health planning, each of those have a current governmental role. The threshold question for you is- Do you leave pieces of health planning in the various places they currently are and ask the planning board to be a part of it? A lot of what you are talking about is being done by the government or not done at all. Do you assign new things to the planning board?

- Garrett: I think that the IPHI could be a good entity to do that planning. Could you explain a little bit about the structure of IPHI?
- Bassler: IPHI is a public-private partnership. We work with state agencies, local public health departments, and private health entities and non-profits. We have done some other health planning- namely the State Health Improvement Plan (SHIP), under contract with IDPH. We are a private entity. We could step in to a role that you need as a non-public body to provide research and support for a statewide health plan.
- Dugan: There seems to be health planning going on in many places in the state. Shouldn't it be brought all together somewhere? Wouldn't that be in the best interest of the state?
- Carvalho: That sounds good. But you are almost creating a 4th branch of government by coordinating all that planning. "Everything" includes workforce, reimbursement, etc. Do you want to create something that tries to coordinate all these elements?
- Garrett: The coordinating body would not make decisions, just gather all the information for the decision making body.
- Lyne: When IPHI completes a job for whomever you contract with, do you help with fulfillment of it? Or do you move on? And who pays attention?
- Bassler: With SHIP, we did help with fulfillment. For instance, SHIP identified workforce issues as important. Currently there is no comprehensive workforce planning in the state of IL and this would be a really good idea and is something that IPHI is working towards creating. Historically, with SHIP, IPHI is looking at coordinating a few projects that grew out of the original project.
- Carvalho: The legislature charged IDPH and SBOH to come up with a state health improvement plan. IDPH contracted with IPHI as a vendor to work on the SHIP.
- Barnett: I don't think it is our responsibility to decide what vendor to use. Can't we decide what work needs to be done and then further details can be worked out?
- Schaps: I have great respect for IPHI, but to me, government does health planning.
- Ruddick: Margie made my point. Government can contract with whomever they'd like to write reports and does research, but government should hold the overall function.
- O'Donnell: I don't think the planning board should do the planning. The plan should facilitate the board decisions. IDPH is the most appropriate agency to do the plan, and if they need to contract some work out, that's fine.
- Garrett: That's where I am going. But I think the planning needs to be separate from where it is currently housed because it doesn't seem to be working now. If we don't identify something now, we will just go back to the way it is.
- Lang: Planning should be a separate entity, separate from Governor's office. Planning is too important to be done within government.
- Garrett: How would the plan be utilized if it is done outside of a government agency?
- Brady: We are not giving up legislative authority or executive authority on health planning. We (legislature/governor) need to decide on the recommendations. A governing body needs to decide on recommendations.
- Lang: Government should have role in the process. I am not suggesting that government has nothing to do with the planning entity, but the planning entity can't just be a group that issues a report and disbands. The planning committee puts a plan together and has significant power. The planning group can provide incentives to build in areas of need.
- Brady: The market can take care of it if we have a need. We don't need an incentive program.
- Lang: That's not true- that market hasn't taken care of it yet.
- Brady: I envision the planning group having a middle role like the auditor general.

- Barnett: The plan should be instructive. If the legislature looks at the plan, and there is an area in need, and the market is not taking care of it, do we have to decide now as part of this process that we need to create a mandate to consolidate or add services?
- Garrett: The recommendation is to define goals and objectives of a planning entity that will report back to the GA on a quarterly basis about health need in IL. Then the GA could target the needs through legislation or appropriations. But right now we are powerless, because we don't have that information.
- Barnett: How directive do you want to be?
- Gaynor: Whatever body develops a plan, the plan needs to take away the subjectivity. The plan takes out the subjectivity. So when the "health whatever we name it" board assesses an application before them, they review it with the health plan in mind as well as keeping in mind any legislation imparted on behalf of the plan.
- Althoff: I concur with one small caveat. We need latitude to update the plan on a timely basis and sharing with GA regularly.
- McNary: These are the questions that I want this health plan to answer.
    - How can the healthcare planning process more effectively control health care costs for the consumer and tax payer?
    - How can quality healthcare be given to everyone?
    - How can planning process compensate institutions that serve underinsured/uninsured?
    - How can we make sure that all hospitals provide adequate levels of charity care?
- Robbins: I agree that whatever the entity created to design or improve capital spending and facility creation should be done within the framework of a larger plan. If an application put forward violates what the plan calls for, it should not be approved. The plan should not go as far as to say that certain levels of expenditures need scrutiny or no scrutiny. It should be a plan but it shouldn't be narrowly descriptive.
- Garrett: Could the planning be done regionally?
- Schaps: There is some regional planning done in IL now.
- Dugan: One concern- I think charity care needs to be looked at- and we need to determine what an adequate level of charity care is. It depends on the region as to what is adequate. Not one size fits all. And we need to find out what exactly is causing the problems in Safety Net hospitals regarding quality care- I know we say Medicaid reimbursement, but we do need to find out.
- Brady: I hope we give the Board a limited scope to determine decisions on applications based on the health plan. The legislature will have to decide.
- Robbins: Before you can design an answer, you need to ask the right question. If you have a class of hospitals in financial jeopardy, why? Is it the populations they are asked to serve, or they do serve because of location, paucity of commercially insured patients, etc. What is the best way to continue the financial viability of these hospitals? Answers are not automatic; they vary based on the institution.
- McAlpine: We headed towards discussing CON again. Are we done for a moment with health planning? Have we discussed health planning enough? Process wise, people have different ideas. We don't have complete consensus. How can we come to consensus and make decisions, and do we need to determine that right now?
- Garrett: We need some consensus on what the planning process should look like. And I think that there is more consensus than not.
- DeWeese: In an article in the Springfield newspaper, 13 downstate critical access hospitals appealed to a different task force about financial issues, and asked the task force to advocate to get them more solvent. Congress recognizes these hospitals as a special class of hospitals. They

have applications before the IHFPB for capital expenditures now. The planning process could identify special class of hospitals that get enhanced reimbursement. This is a way that the process can develop.

- Barnett: I too feel there is a lot of consensus.
- McAlpine: (Synthesis) The focus is on access to care and protecting safety net services, and understanding the relationship between reimbursement levels and ability to offer charity care. Planning- coordinate, comprehensive? Recommendations side: would doing an assessment of the void automatically result in an incentive program? Those are the big picture ideas.
- Barnett: You've synthesized the ideas. Who would do planning and how much authority would they have to create change?
- Lyne: Comprehensive services – address broad range of services.
- Schaps: Include long-term care.
- Robbins: Shortage of primary care physicians. Any health plan needs to include workforce.
- McNary: Access and quality. End health disparities.
- Schaps: Talk about regional planning too. That can better deal with specialties.
- McAlpine: You are in agreement in big picture ideas.
- Garrett: Outline of potential structure: planning entity gives quarterly recommendations to the GA, IDPH and a decision-making body. I am not saying if the planning body needs to be non-governmental or not. But don't leave the GA out of it.
- Carvalho: The decision making body on any application is the CON board. Maybe we should just call the IHFPB the CON board since that is what they do now. A lot of the information you need for a health plan is already collected at various state agencies and departments; it's just not integrated into a plan used by the HFPB. Right now there are objective rules that applicants file under and the applications are usually out of whack on one or more of those rules. The Board's subjectivity comes into play only when it decides to approve an application when the application is out of whack on the rules. I don't know of any instance when the board did not approve an application that was consistent with all the rules. So when you're talking about eliminating subjectivity, keep in mind your basically saying that more applications should be denied.
    - Health Systems Agencies (HSA) used to be the super planning agency. The CON process was much longer when they first had to go through the HSA for approval. Local regional planning that flows into something else is a model that has been done and has worked.
- Robbins: What is the cost to do that?
- Carvalho: We can see what it cost in the past.
- Garrett: Well, the application process generates revenue, as do fines.
- Carvalho: You should develop costs first, and then figure out if the revenue stream is sufficient.
- Peters: I don't want to argue against planning, but planning identifies service gaps and access barriers. Don't overburden planning by having it decide CON applications. Planning is limited in saying whether hospitals needs to improve facility infrastructure. You have to think about planning as separate from decision making in CON.
- Garrett: We agree with that.
- Althoff: He is indicating that the collected application fees won't be adequate to fund a health plan for the whole state.
- Carvalho: Facilities planning funds come from the IDPH general health planning fund. IDPH does not have a separate appropriation for health facilities planning. Some IDPH staff outside of the IHFPB staff do work on creating stats and plans for the IHFPB.
- Brady: We need a document that is a plan that gives direction. What is difference between this doc and the one that IDPH produces?

- Carvalho: Take SHIP for example. In IDPH, much of what we do is targeted to population health- broad measures, public education. Health Care is more on an individual basis. SHIP, a 4 year doc, is done on the broad big picture basis, not the micro-level health care basis. SBOH is charged with developing the SHIP, and the IDPH Director also appoints a health planning team.
- Brady: We either need to expand on that or eliminate it.
- Carvalho: The SHIP plan is at 30,000 feet and informs work done at a lower level, but it won't dictate things at a lower level- like what area of the state needs what.
- Dugan: What was SHIP for?
- Carvalho: The purpose of SHIP was at the population level- a consensus document for the principal health needs of the IL population. We came up with obesity, etc. It was first completed in 2007, another updated version is coming in 2009, and then we are on a 4-year cycle.
- Garrett: We need a planning entity and we need to give it goals and objectives. Take some dollars away from areas that are less relevant to the state, and put them towards a planning entity. IPHI, what were your costs for SHIP?
- Bassler: About $300,000, but a plan you are talking about would need much more detailed data collection and analysis, so it would be far more expensive.
- Garrett: Isn't it just about paying salaries for people to collect the data and analyze it?
- Robbins: There were about 20 HSAs around the state. If that is the type of plan you are talking about, that would be really expensive. I thought there would be some regional planning aspects.
- Garrett: Is there consensus to have this overall plan? Maybe 4-5 employees working on this full time?
- Schaps: I don't think that will do it.
- Garrett: We don't want to create a whole new bureaucracy, but we may need to.
- O'Donnell: Is there another state that does this where they have an overall planning entity? Could we find this out and use them for an example?
- Lang: This body does not have to decide about the cost. Let the GA decide. We should just create the plan we want to create.
- McAlpine: Does the group feel comfortable now? Can we break for lunch and shift to a CON discussion?
- Garrett: I think we need to hammer out goals and objectives and can talk while we eat.
- Dugan: We can't drill down to everything today, and I think we do need to talk about CON.
- McAlpine: Let's agree on broad issues today, then we create a document in the interim between meetings, leaving us time to talk about CON this afternoon.

Afternoon Discussion: How should the CON process be changed?

McAlpine: Regarding the statewide health planning conversation, Senator Garrett and Rep. Dugan will take the information from this morning's conversation as well as at the September 15th meeting, and we will put together a document that you can look at before October 30th, for further discussion. The rest of the conversation today will be on the CON process.

- Lang: We have heard about streamlining the process. To me that means setting up guidelines, and if the applicant is within the guidelines, they are given a perfunctory approval (staff could do the approval). Don't add unnecessary hoops. Have a quorum of the board at every public hearing. Automatic appeals with public hearing.
- McAlpine: There is a set of guidelines that applicants are currently judged against. Would they be similar or different?

- Lang: They could be the same, but I just feel that applicants shouldn't have to go through a lengthy procedure if they fit right into the criteria.
- Lyne: The agency coming for CON approval would be aware of that automatic approval rule, and I think they would all try to argue that they fit the guidelines. But I do think that applications are quite lengthy. I also want to sneak in some consideration for Safety Net hospitals.
- Schaps: If we have a serious planning process, we have to revisit the criteria. Elements from planning could be laid into the new criteria, and I would like some criteria on Safety Net services.
- Lyne: What do they pay for their application- what are the fees? What is the cost to the applicant?
- Carvalho: IDPH charges a fee and then there are consultants.
- Mark: The application fee is two tenths of one percent of construction costs, to a maximum of $100,000 dollars.
- Axel: Over the past three years, my average charges for CON (and I do 10-15 a year) is in the neighborhood of $40,000 to $50,000. And some of those projects cost well over 100 million dollars.
- Garrett: Well some people said they spent close to half a million dollars in fees.
- Axel: I think those fees were inflated.
- Brady: What does it matter? We aren't regulating consultants.
- Lyne: I was trying to get a percentage of the cost for Safety Net services.
- Barnett: To streamline the process, guidelines would need to change. I agree that I am comfortable that guidelines are established and staff can assess whether they are met or not met.
- Carvalho: If there was automatic approval, people would work to stay within the guidelines.
- Ruddick: In the revised guidelines, increase a focus on the impact to the Safety Net and provision of charity care, and decrease focus on dollars spent per square foot. One of guidelines could be for the applicant to document what charity care they do now and agree to pay into a fund if they do not meet a certain level.
- Brady: The only justifiable reason to continue CON is to protect Safety Net. So don't worry about the total costs of building. Eliminate that as a criterion. But we need to identify what SN services we want to protect. When you protect the SN, you also could hurt the community (over protection of monopolies).
- Mark: There are SN facilities, but more important are SN services. I endorse the concept of identifying services. Within the current statute, we have a limited list of services the board officially deals with- bed services, cardiac catheterization, and cardiac services. We don't look at surgery, radiology, etc. One reason the dollar threshold exists is that is serves as a catch-all. For instance, we had no criteria for CON proton therapy and the only reason they came under CON was for the dollar amount. There will always be unknowns and new services, and if there is no catch-all then they will not come under the purview of the board.
- Carvalho: I want to remind everyone that you talked about planning first because jurisdiction of the CON board would come from planning criteria.
- Barnett: Sounds like the right idea to identify SN services. For many people, Safety Net services encompass everything that is provided locally and would negatively affect the community were they to disappear.
- Robbins: There are various types of SN hospitals – both small rural hospitals and struggling inner-city hospitals.

- McAlpine: Will the health planning group have to define what a Safety Net service is?
- Garrett: We have an overall plan and it says that in the northern part of the state there are medical facility shortages. So a hospital comes in and sees a perfect fit to build a new hospital. But this new hospital will not be serving SN clients, and to offset that, they would have to pay into a fund.
- Robbins: But would this new hospital take away insured patients from the existing hospitals?
- Garrett: The criteria should be that, using the Medicaid formula, if there is a Safety Net service shortage at a facility, then they should pay into a fund. The fund would go back to SN services in the region where the new hospital is being built.
- Robbins: What if you were in Rockford- would you pay into a fund for Waukegan?
- Garrett: I don't know that right now. We can't afford to have the haves and have not's in health care.
- McAlpine: To clarify, Senator Garrett is suggesting to use a Medicaid formula to flow funds to SN services affected by CON approval.
- Peters: If the planning authority realizes a value in meeting the healthcare needs of a certain community, and a provider steps forward to make the investment, why should they pay a penalty to meet the needs of that community?
- Garrett: Those needs could be based on population.
- Peters: I understand, but there is a value in meeting any health care need of any population.
- Lyne: Most times hospitals see an opportunity and, if they have the money, they decide to build. It is not like hospitals are pursued and asked to open a hospital in a poorer community. But Howard, hospitals go into new areas and open to increase their bottom line, not because they want to offer a lot of charity care. Provider tax.
- Barnett: Redistribution of wealth is a role of government, typically through a tax on all of us. If we do it through CON, only certain entities will contribute.
- Garrett: Gives an example of 3 Lake County hospitals that donate $166,000 each year for SN services in her area.
- Dugan: Wasn't the question "How should we change the CON?" Currently, charity care is not a formal guideline for CON approval but it is discussed during the application process. Maybe we should focus on things we want to change or remove and then talk about things we could add, like charity care. The first goal of our Task Force creation was to deal with the current CON issues that people feel aren't working. The charity care issue is that there are not established level of adequate charity care.
- Gaynor: To move the conversation along, can people give their opinion if charity care should be a criteria in any way in the CON process?
- Robbins: I don't know if it should be a criteria, but maybe it should be a consideration.
- Althoff: I do not want charity care as a criteria of CON process. Do I want it talked about and considered ?– yes. Do I want an application to be denied on that basis?- No. We don't even have a definition of charity care.
- DeWeese: Pull ASTCs into charity care.
- Gaynor: Everyone says that we don't know what charity is and what it includes. The courts have said what can be considered charity care, but not what the percentage requirements are. I am willing to start with what the courts said and build out. Ken is right when the courts determine it as free services given to people who cannot pay. Forgiveness of debt is not included in charity care because the hospital is supposed to determine ability to pay at the time of rendering of service. People have suggested that Medicaid shortfall should be included and I

think that is right even though the courts haven't said it. If a hospital gives a donation to another facility that provides charity care, they should get credit for that too.

- Barnett: No to both criteria and consideration. Concern is about cherry picking.
- Ruddick- Criteria. And it should apply to everything that comes before the CON board. Charity care should be narrowly defined, but more generous than the court definition. Charity care should not include general community benefit because that is recovered in general tax exempt status.
- Lyne: Consideration. Make sure it's on the table.
- O'Donnell: Some minimum level of charity care should be offered, and if hospitals don't meet it they should have to pay in to a fund. No denials should be based on charity care. So it is a criterion/requirement.
- Lang: Should be a criteria only if the GA determines what the criterion should be. Problems with determining what should be included. Forgiveness of debt is one of the issues. I think it should count, AG doesn't agree with me. This group shouldn't define it.
- Lyne: We need to have the discussion here and give the GA our best guess.
- Carvalho: The Task Force has to give recommendations to the GA, so why wouldn't this count?
- Dugan: Yes we need to give recommendations for action, but not specific language.
- Garrett: No I think we do include specific language.
- Schaps: The most specific we get, the more likely it will get through the GA.
- Gaynor: Criteria- broader than court definition.
- Garrett: Criteria- fund $$ spelled out, across all facilities.
- Schaps: Institute of Medicine has a definition of SN hospital.
- Dugan: Consideration, because everyone needs access to healthcare. I want to protect the SN and protect people who need health care, but I think we need to define it.
- McNary: A criteria of the CON process should be to look at the needs of community through the needs of charity care. How can we deal with charity care if it isn't even on a list to consider? Wouldn't say that an application could be denied based on charity care. Criteria.
- Althoff: Is CON the process we want to use to protect Charity care?
- Schaps: Criteria, and CON is the place to put it, and it should be considered beyond what the courts have said.
- Brady: No, neither a consideration nor criteria. Charity care needs to be considered on a broader state basis.
- Althoff: My dilemma is that I have a hospital in my rather affluent area, but I still have many constituents without insurance or access to health care. I can't go back to my hospital and tell them to pay into a charity care fund to pay for charity care outside of our area when we have people of need in our backyard.
- Sullivan: I think charity care should be a criteria because SN hospitals are providing a service and providing access to a service.
- Carvalho: Both a criteria and a consideration. Criteria would be "Do you have a charity care policy that you abide by? Do you provide services to patients without the ability to pay?" Consideration would be the level offered. Criteria is minimum standard that must be met to be approved, and the consideration could be a bonus to the application.
- DeWeese: You could get a credit for meeting a charity care need.
- McAlpine: You can turf charity care and have myself and Garrett and Dugan to work on it for the next meeting.
- Garrett: Let's talk about other things we like or don't like about the CON process.

- McAlpine: Ok let's set aside charity care and go back to what Ken started talking about this morning.
- Garrett: Technical assistance- an applicant can make an appointment with HFPB staff to talk about technical application issues. I have a lot of issues with this. What is the point of having closed door meetings? I want to make these meetings public if they are at all needed.
- Barnett: The IHFPB is an agency we applicants deal with just like any other agency. It is helpful to go to the experts to have discussions.
- Garrett: Yes, but they should be public meetings with minutes and open to public and publicized. Make sure everyone is aware of what is going on. I don't want to take away assistance, but I want it to be more transparent.
- Ruddick: Meetings should be fully disclosed, but I agree that the need for them is critical.
- Mark: To clarify- the staff of the board follows rule in the statute that says that any technical assistance meeting is documented by both parties which is put in the public record which is available to anyone at any time.
- Garrett: I have items faxed from your office, and in all but one case, the minutes were taken by the applicant or a consultant.
- Mark: Should we advertise technical assistance meetings?
- Brady: (to Garrett) Would it satisfy your concerns to post these meetings on the internet? Would it satisfy your needs if both the applicant and state agency did take minutes?
- Garrett: I guess if it gets done.
- Carvalho: We would be happy to not do any more technical assistance meetings, but it would hurt the applicants to not have access to that knowledge. Applicants bring in big vision documents because they need to ask if they need to include that information as part of their application.
- Robbins: Even the IRS will let you come in to ask questions.
- Garrett: This is a bit more than the IRS helping you with your taxes.
- Robbins: I would say not.
- Garrett: What happens at the board meetings then? I am not against the technical assistance meetings, I just want more transparency.
- Robbins: If it is only about transparency, I have no problem with that.
- Gaynor: Do you think the technical assistance meetings are abused?
- Carvalho: I have sat in fewer meetings than Jeff, and I have been asked by applicants what board members want to see, and I don't answer that.
- Mark: There has been a repeated theme about transparency and what the staff does. Our instructions are that everything we do is public information except for compliance and legal issues. If you want we could put everything from all applications on the internet.
- Garrett: This technical assistance meetings process can lead to asking non-relevant questions.
- Carvalho: When did we ever have problems with staff and ex parte? In the past we only had issues with 2 corrupt board members. It would be easier for us to not have technical assistance meetings. I guess we could do them as open meetings- post a notice.
- Garrett: Put a tape recorder in the room.

Next Steps

McAlpine: Senator Garrett and Rep. Dugan will create a summary of the two discussions from September 15 and October 8th prior to the October 30th meeting. We will have proposed language on statewide health planning, and potentially the CON process. Our focus will be on the areas where there is no consensus among Task Force members.

- DeWeese: I expect there will be a collaborative document from the nursing home people soon.
- Next meeting, Thursday October 30th, 10am-2pm, JRTC 100 W. Randolph, 2nd floor, Room 2-025.

Adjournment: 1:59pm

Minutes respectfully submitted by Mairita Smiltars.