Illinois Task Force on Health Planning Reform
May 12, 2008
9am-3pm

James R. Thompson Center
100 W. Randolph, Room 9-040
Chicago, Illinois

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

Task Force Members Present:
***Chicago*:** Senator Susan Garrett, Mr. Paul Gaynor, Ms. Margie Schaps, Mr. Kenneth Robbins, Sister Sheila Lyne, Mr. Gary Barnett, Mr. Patrick Keenan Devlin, Mr. Hal Ruddick, Senator Pam Althoff, Ms. Heather O'Donnell
Springfield: Rich Johnson, Rep. Lou Lang, Senator Bill Brady
Via Phone: Rep. Lisa Dugan, Rep. Renee Kosel

Ex officio Members Present:
Chicago: Mr. Jeffery Mark/HFPB, Mr. David Carvalho/IDPH, Mr. Mike Jones/HFS, Mr. Barry Maram/HFS

Staff Present:
Illinois Public Health Institute (Chicago): Ms. Kathy Tipton, Ms. Mairita Smiltars, Ms. Laura McAlpine
Legislative Staff (Springfield): Mr. Kurt DeWeese, Ms. Melissa Black
HFPB (Springfield): Ms. Jan Rutledge

Court Reporter: Joanne Ely

Call to Order: 9:10am

Action: Approval of 4-14 Minutes
Sister Sheila Lyne moves approval, Mr. Barnett seconds the motion.
Motion Passed- minutes approved.

Presentation by Ms. Ann Guild, Illinois Hospital Association (IHA)

- Presented recommendations from the IHA Task Force on CON.
    - The IHA developed these recommendations with a lot of hospital membership input.
    - 30 members on the Policy Council Board developed these recommendations. Ultimately the recs were approved by the IHA board, which is another 30 people.
- Recommendations:
    - CON process can and should be streamlined
    - Streamline decision-making and admin processes
    - Make the process accountable and predictable
    - Consider access to safety net services
    - HFP Board should be diverse – reconfigure Board size and composition
- Ms. Guild- IHA Recommendations to streamline the CON process:
    - Goal is to limit the number of projects under substantive review - the full 120-day review process should be limited to the following instances:
        - New or Replacement facilities (to ensure that there is not duplication of facilities)
        - Establish a new service
        - Adding more bed flexibility (more than 20 beds or 10% of total every 2 years)
        - Freestanding services by any provider if regulated for hospitals (e.g. proton therapy- hospitals have to go through full CON process, therefore free –standing

medical centers that offer proton therapy should also have to complete the full review process)
- Same standards for regulation for a service if you are a hospital or freestanding center

- Evaluate categories of services reviewed
  - Make sure that review benefits the public by constraining unnecessary duplication
  - Develop current criteria for services that are regulated
- Clarify definition of "non-clinical" and therefore not subject to review
  - Not directly for diagnosis, treatment, rehab
  - List of infrastructure and other improvements
  - Non-clinical review seems to be creeping towards expansion, so clarify what non-clinical means

Question from Mr. Carvalho- if a hospital wanted to build a ward for VIP patients, is that clinical or non-clinical? What about a restaurant?

- Ms. Guild replied they are non-clinical.
- HFPB regulates land acquisition- there are lots of things that HFPB doesn't regulate. The HFPB needs to get back to basics on regulation.
- Example- redoing ICU's, and there are different standards for air exchanges, or the dept has found that the air ducts aren't clean enough- IHA views that as non-clinical. It can be expensive to fix the infrastructure. Regulating infrastructure improvement is not the purpose of CON. IHA members are less concerned with what people are doing within their own hospitals.

Senator Garrett responded that it is up to the hospital to improve the infrastructure of the hospital (expansion not included). It seems like that should be "hands off" to the HFPB. What is the gray part?

- Mr. Mark gave examples of non-clinical service areas- parking garages, HVAC, computer systems. If a hospital puts in a PAC system, according to the statutory definition it is non- reviewable. That can be a $10-30 million project which he thinks should be reviewable.
- Senator Garrett stated that if a hospital is going to expend a lot of money to buy imaging equip, why should that be questioned/reviewed? New equipment is good for the patients.
- Mr. Mark replied that it goes back to the original act- avoiding duplication.
- Senator Garrett replied that adding new equipment is not an expansion, and so why should it be regulated?
- Ms. Guild stated that the HFPB used to regulate computer systems, and they stopped because there was not expertise on the Board in that area. She further stated that she doesn't think we should try to fix problems that do not exist.

Question from Mr. Gaynor- Can you describe the Safety Net hospital role in IHA's process of developing these recommendations?

- Ms. Guild replied that all of IHA's councils/groups are diverse- they had almost an entire meeting to discuss Safety Net options- and there was a strong value system to say that it was important- however there was another sense that while we need to find a way to incorporate concerns about Safety Net into the CON process, we shouldn't add additional bureaucracy that isn't needed. Things could be built into existing process to address that.

Comment from Mr. DeWeese- when the clinical vs. non-clinical discussion took place a few years back, there was a fundamental question between what is clinical vs. non-clinical. The goal of the HFBP is cost containment to eliminate unnecessary capital expenditures that go into the bottom line of the hospital. Mr. DeWeese thinks there is still a question about

some things that are considered to be non-clinical but contribute to the overall financial viability of a hospital or tie directly in to the use of that facility like parking, entrance, etc.

- Ms. Guild replied that we can debate more, but IHA members think that the HFPB should not have a goal of cost-containment but the goal should be unnecessary duplication. Ms. Guild can't recall a hospital project being denied on financial grounds. A hospital doesn't go before the HFPB board with a $30 million project and no way to finance it, and this is a form of self-regulation.
- If projects are inter-related, they have to be considered as one project. We also don't think that projects should be considered inter-related just because they are under one financial debt instrument. Eliminate this provision. You can use one debt instrument to redo your roof and improve your ob/gyn ward. Doesn't make sense to count two very different projects like that as related just because of financing.

Question from Senator Garrett: they've never been denied on financial basis?

- Ms. Guild- Projects get denied, but I can't recall a hospital project that was denied due to financing.

Question from Senator Garrett: what are the costs to apply to the HFBP?

- Ms. Guild- I would have to go back and review the State documents. It can be expensive with consultants, design costs, etc.
- Senator Garrett replied that hospitals don't want to spend a lot of money to apply to do infrastructure improvements
- Ms. Guild replied that the more you can simplify the application process, the more money is saved.
- Ms. Guild further stated that the project review itself should be streamlined. Questions should be asked such as: Is it needed? Is the size of the project necessary for review? Look at the big picture instead of micromanaging the details. HFPB members and staff won't need to review things that have been reviewed in detail at the hospital level if the process is streamlined.
- Ms. Guild further stated that it should be required that only the hospital is to be applicant. The hospital is the licensed entity- so let the hospital be the applicant- not everyone needs to be dragged into the review process.

Question from Mr. Devlin- Provident Hospital is part of Cook County Health System- but they should be able to apply on their own?

- Ms. Guild- yes, but if the hospital is getting funding from a health system, that should be reviewed in the financials part of the application.

Question from Mr. Ruddick- Say a new hospital is being built by health system.

- Ms. Guild- the system would have to apply, but as soon as the hospital is a licensed entity, they would have to apply on their own.
- Mr. Ruddick asked if IHA doesn't think it's important to see what the rest of the health system is doing to fund this expansion or new project?
- Ms. Guild- the HFPB needs to consider if this new project is necessary and relevant. HFPB is already sensitive to who the applicant is. The planning board will ask questions related to the system and that is what the meetings are for. We think that is the appropriate forum for it- but don't increase paperwork. The HFPB can ask the applicants to submit extra information if there are special considerations- case by case.
- Mr. Ruddick responded that IHA wouldn't preclude the HFPB to ask for extra information?
- Ms. Guild replied no. IHA would hope that the ultimate decision would be based on if the project is needed and does the applicant make the case for it.

- Ms. O'Donnell commented that we should be focusing on the hospital, but the flip side is accountability for costs.

Senator Garrett presented a scenario where a big system has 15 hospitals, and they want to improve one suburban hospital at the expense of an urban Safety Net hospital. How does IHA feel about that?

- Ms. Guild replied that she understands the concern, but hospital systems have capital plans that determine what they will spend on each hospital in their system.
- Senator Garrett replied that the overall plan may be that the system won't put enough money into the Safety Net hospitals. Should the HFPB review that? Should we be concerned about it?
- Ms. Guild replied that if it is part of a broader discussion, then it should be considered as a factor. I can't imagine how the HFPB could decide how to allocate funds within a system.

Question from Senator Garrett: I think a hospital should be able to upgrade their diagnostics without review. What if one hospital has new diagnostics, but another hospital has outdated diagnostics- what do you think about that?

- Ms. Guild replied that she doesn't think the HFPB can regulate that. Financing is an issue, but not something that the HFPB can deal with. You can't standardize financing across the board, so I don't think it should be a consideration.

Question from Senator Garrett: Safety Net hospitals can't necessarily improve their infrastructure, but other hospitals have more resources to improve infrastructure. Cost containment is a factor, but there should be some balance too. Should the HFPB have role in determining balance in quality of hospital resources across the board?

- Ms. Guild replied what exactly would be the role?
- Senator Garrett replied that right now the HFPB reviews cost containment. So if a system is investing heavily on the suburbs, but let's urban hospital standards lag, should the HFPB review that?
- Ms. Guild replied that the scenario is a simplification. Within a system, hospitals will offer different services- more primary care vs. tertiary care. I think that should be left to the system to determine.
- Mr. Carvalho replied that the HFPB is not a debating society. It determines things on statutory criteria. So the HFPB has to be mandated to consider things- "balance can't just be in the "back of their mind".
- Ms. Guild replied that she would say no, that it shouldn't be a mandated consideration.

Question from Mr. Gaynor- Poorest 25% of private non-profit hospitals held less than 1% of the debt of all IL non-profit hospitals. Cash richest 25% of IL non-profit hospitals held 82% of cash and investments of all IL non-profit hospital. In order to preserve access to Safety Net hospitals, how will cost containment deal with that?

- Mr. Robbins replied that those are troubling statistics. Most Safety Net hospitals are not part of larger health systems and they do have desperate capital needs. Nothing the HFBP can do will directly affect the capital funds of these hospitals. If IL legislature wanted to mandate a state mechanism to help fund the capital needs of these Safety Net hospitals, I think that should be given serious consideration. I don't think capital funding is in the scope of the HFPB.
- There may be unintended consequences of preventing a project to happen unless a lesser-funded hospital is worked into the application.
    - Less incentive to keep safety net hospitals in the system
    - Leeway to make capital expenditures in order to fund the safety net hospitals

Sister Sheila Lyne commented on whether in our society health care is a public good or a marketable commodity. She believes that right now it is a marketable commodity and that is why there is not a transfer of funds from cash rich to cash poor hospitals in a system. How can the HFP board fix a marketable good? If healthcare was a public good, then we wouldn't be in the fix we are in. I think that CON process could include a question on what a hospital will do to fund Safety Net hospitals if their project is approved.

- Mr. Mark replied that currently there is no formal criteria on Safety Net funding

Senator Garrett commented that this is a dilemma because we believe in Safety Net systems, but we believe hospitals shouldn't be held back when they want to make infrastructure improvements. You also don't want to create a medical arms race, where there are different standards for different regions- make it fair across the board without making in cumbersome for the hospitals.

- Mr. Barnett replied that this is related to planning. We have a HFPB without a plan.
- Ms. O'Donnell commented that this is the time for planning to happen
- Mr. Barnett replied that the HFPB is trying to make rational decisions without a planning tool. How do you redistribute wealth so that there is a basic and reasonable level of access for everyone? Capitalistic society means that some people will always have more access. Without a plan, we will waste lots of money.
- Ms. Schaps commented that Mr. Barnett is right. At our first meeting, we talked about this as an issue. We have to grapple with what the role of planning is and do we want to bring it back into this process.
- Ms. O'Donnell commented that the purpose of CON is to contain costs and protect the Safety Net but without a plan it is hard to do that.
- Mr. Robbins commented that meeting health care needs, cost containment, and health care access are the tenets of CON. CON does not do a good job of containing cost, but they do a good job on eliminating duplication which may help to contain cost. Be realistic about what can be done within the framework of the CON / HFPB process.
- Senator Garrett commented that ultimately what comes out of the taskforce is more planning on long-term health care in Illinois. Some hospitals can contain cost but some hospitals can't even think of that.
- Mr. Robbins stated that the taskforce should recommend what we think can be done realistically through CON process, but also make recommendations on other items that should be addressed but that can't be done through CON process.
- Ms. O'Donnell stated that she feels the taskforce should take the CON process to the next level and challenge ourselves in this process- that is how change happens.
- Mr. Robbins stated that there is a lack of access to capital for Safety Net hospitals- I don't think there is a way for us in this reform process to deal with that, but we can put it in the report that it is a critical problem that should be addressed elsewhere.
- Senator Garrett replied that the Taskforce needs to address it here or there will be never-ending discussions.
- Mr. Gaynor commented that the Taskforce should figure out a mechanism to transfer funds from the haves to the have-nots. Concerned that streamlining means ignoring some huge issues.
- Mr. Barnett commented that if we are concerned about some citizens not having access to health care and Safety Net hospitals not having capital, it is inefficient to say that if a rich hospital comes before the HFP Board, they need to help a Safety Net hospital. Inefficient. If we want to do something for poor people in the state, then we need to tax citizens.

        - Senator Garrett stated that this is a messy debate, and not everyone will be happy. No one has determined how the Safety Net will get money.

    Senator Brady clarified that the Attorney General office didn't see voluminous evidence that there is delay in the CON process

        - Mr. Mark stated that there are three (3) types of applications
            - an exemption process with 30 day review process.
            - CON substitute project- 60 day review max, upon completion of review it goes to the board
            - CON substantive project- 120 max review, after which it goes to the board
            - All of these review times are observed and practiced

    Senator Brady responded that he understands that, but it is not what he is talking about. In the past 4 years, how long did it take for a project to get through the system for whatever reason? Given a list of projects in the last year, how long did it take to get approval. I hear from people that there are millions of dollars ready for healthcare improvements but the HFPB strangles the ability to spend the money.

    - Mr. Carvalho reported that he will create a map and send out a PDF to everyone to note where the safety net hospitals are located in IL.

- Ms. Guild continued her presentation- IHA Recommendations to Simplify Decision-Making
    - Allow limited executive secretary approvals for projects that meet all criteria and are unopposed
    - IHA is uncomfortable with current criteria and oppose having the staff make decisions
    - Review criteria are getting more complex and more projects are being opposed. Symptom of more constrained resources that more projects are being opposed, especially new buildings.
    - HFP Staff could approve requests for extensions and alterations.
- Ms. Guild- IHA Recommendations to Simplify Admin Processes
    - Eliminate Letter of Intent (LOI)
    - Staff comments should be included with the state agency report (SAR)
    - Eliminate 50% reduction in service reports
    - Require only annual progress and final costs reports.
    - Timely agency responses- 2 parts of the same agency (IDPH) shouldn't hold things up.
    - Limit new information after SAR. Unintended consequences of this unnecessarily delays the process. Revisit.
    - Require timely notice to applicants on the agenda- people don't know if they have to come before the board. People with expertise (physicians, etc) need to come as well and their schedules should be considered.
        - Senator Garrett asked what the notice is now?
        - Ms. Guild responded that it depends. You should have at least 7 days notice in advance, but people have been notified very close to the date of a meeting.
        - Mr. Mark responded that the HFP staff publish a draft agenda 14 days before a meeting. They refine the agenda until 48 hours before to wait for withdrawals, public comments, etc. Everyone is tentatively scheduled for a meeting months in advance. Occasionally the Board will review applications over 2 days and people want to know if they are being reviewed the 1st or 2nd day and HFP staff may tell them too late.
        - Ms. Guild stated that people will call and ask her if they are on the agenda or not and she refers them to the HFPB.

        - Mr. Mark added that the agenda is posted online 14 days in advance, and we say what applicants are expected to be reviewed at which meeting online.
    - Mr. Carvalho stated that in March, he distributed the document "Historical CON Caseload Summary" which addressed the question you had on the length of time of the CON process. Currently the average is 112 days. Ms. Kathy Tipton from IPHI will redistribute this document to Task Force members.
- Ms. Guild- IHA Recommendations on Predictability and Accountability
    - Allow applicants to have open communication with staff as they are not the decision makers. Applicants would like more open dialogue with staff to assist them getting through the process. No application dialogue with board members who are the decision makers. Ms. Guild encourages people to know a lot about their project before going to the HFPB staff for technical assistance.
    - Compliance issues and settlement- there was a sense that IHA members needed more data. More transparency so that applicants have hard data to change their applications to be compliant- don't just provide anecdotal information.
    - Senator Garrett asked if there is a simple report on these settlement agreements- a short summary on the final agreement?
        - Mr. Mark stated that they have internal reports and there is no reason not to create a public report at the appropriate legal time.
        - Rep. Kosel asked when is the appropriate legal time?
        - Mr. Frank Urso stated that the final order is signed off and approved by board, and then that settlement becomes a public document and you can call and ask for it.
        - Senator Garrett stated that it should be more transparent. Post the reports online as people shouldn't have to call.
        - Mr. Urso replied that there is not a set amount of time for this settlement process, depends on complexity of the case.
    - Senator Garrett stated that the funds are confusing. It took me and my staff weeks to understand how everything works- committees and sub agencies- where does the money go and where does the money get spent?
        - Ms. Guild replied that hospitals pay fees to have their CON reviewed. At the end of the year, those funds have been swept. Hospitals want to know if the application fees are reasonable.
        - Senator Garrett asked what do you mean by swept?
        - Ms. Guild replied that the funds are swept by IDPH. Hospitals want the fees to support an adequate review. If there is money left over at the end of the year, why is that? Has it even been audited?
        - Mr. Carvalho responded that the HFPB funding has been audited as part of the department.
        - Senator Garrett stated that she doesn't see oversight or accountability to the spending.
        - Ms. Guild replied that what goes into the planning fund, should come out.
        - Rep. Lang asked what dollars have been swept over the past few years?
        - Mr. Carvalho responded that the last sweep was several years ago and board members have indicated some displeasure. It is not up to the board or the department if funds are swept. HFPB is an independent board.
        - Rep. Lang asked why don't you take steps to stop the governor from taking your money?
        - Mr. Carvalho responded that the board has been given independence to review applications, but it does not control its' budget. The budget is controlled by OMBUD.

        - Rep. Lang asked that if the board were to continue, to retain complete independence should you have complete independence from the Governor's office?
        - Mr. Carvalho replied that as far as he knows the governors authority to sweep funds is a legislative issue. Mandated by legislation.
        - Rep. Lang replied that if you don't think that the funds should be swept, shouldn't you let the legislative body know that?
        - Mr. Carvalho responded that the sweeps don't go below the appropriations level
        - Rep. Lang replied that in that case, why are the hospitals paying so much then?
        - Mr. Carvalho responded that fees are assessed based on the dollar amount of the project. New hospitals pay the max and there has been a big influx of funds into the HPFB because of the recent growth of new hospitals. If new growth were to drop off, the fee intake would take go back to historical levels.
        - Rep. Lang requested the transcripts that show the board upset with sweeps. He wants to know what relationship exists between board and governor. More independence from Governor's office.
        - Senator Garrett stated that she doesn't disagree with that. She thinks the issue is even deeper and needs more transparency.
        - Mr. Mark added that the HFPB fund is audited every 2 years.
        - Senator Garrett replied that she'd like to see a copy of that.
        - Mr. Mark replied that he doesn't think it is a stand-alone audit.
        - Senator Garrett responded that is the problem. She wants to know how and why the dollars are being spent.
        - Mr. Carvalho clarified that the consultants that are referred to are the contract staff. Jeff hires the consultants and IDPH pays for it. Decisions to buy chairs and hire people on contract are firstly made by Jeff, he does the internal paperwork, Mr. Carvalho's office processes it through HR, then Jeff signs off, and Mr. Carvalho signs off on it. HFPB has $1.7 million dollars but really this isn't a lot of money. In comparison, my rural health fund has $20 million dollars.
        - Senator Garrett states that there needs to be more checks and balances for Jeff to make consultant decisions without a review process. The Task force should address oversight issues.
- Ms. Guild-IHA Recommendations on IHFPB Size and composition
    - At least 9 members
    - Categorical appointments- people who know what they are doing and the dynamics should be on the board. Hospital administrators are great on the board. They understand the issues. Adds to richness of the decision making.
    - Improve conflict of interest provisions and apply to Board members, not staff
- Mr. Devlin requested that Ms. Guild review her Safety Net slide
- Ms. Guild- IHA Recommendations on Safety Net
    - Requirement for Safety Net Impact Statement (SNIS) when applicants propose new facilities- IHA determined that the SNIS could be appropriate for a new facility proposal.
    - <u>Senator Garrett</u> asked what a SNIS would look like.
        - Ms. Guild replied that we are still determining that.
    - <u>Ms. Schaps asked</u> why would a SNIS be required only with new facilities?
        - Ms. Guild responded because new facilities are the ones that people are most worried about. People don't worry about what hospitals do in their own facility.
    - <u>Ms. Schaps stated</u> that she doesn't think Safety Net hospitals would agree with that.
        - Ms. Guild responded that the statement should be based on a broad definition of Safety Net services.

- <u>Mr. Gaynor asked</u> what should the board do with the statement?
  - Ms. Guild stated that part of the reason for having a board is to deal with individual situations. The board can't have a standard response to the SNIS.
  - Ms. Guild further stated that when there is intent to deny, the applicant realizes there is something they need to do to fill in the gaps to be approved. In the case of each applicant, weigh the pros and cons.
- <u>Mr. Carvalho gave the example of Bethany hospital</u>- full service hospital owned by Advocate. Applied with HPFB to close obstetrics and psychiatric services. Fully compliant for those 2 services. Bethany's plan was to convert a full service acute-care community hospital to a long-term care facility. Lots of community interest was raised, there was a lot of community opposition. HFP Board wanted to know the bigger picture issues to the community if these services were closed. Board ultimately gave the project intent to deny. Board raised many questions which the applicant addressed. Board approved it on the second review in open public discussion because the applicant created a $17 million fund for healthcare services in the area.
  - Mr. Carvalho stated that there is follow-up report on how they spent the money and we can give Task Force members a copy of that.
  - Mr. Devlin asked if this would this substantiate a need for a system to apply versus a hospital?
  - Mr. Mark replied that the board has requirement for whole applicants. If the hospital is to apply but they are owned by someone else, the owner should be a co-applicant.
  - Senator Garrett inquired into the $17 million. Who paid it? Was it a lump sum?
  - Mr. Mark responded that Advocate raised the money and a community board reviewed proposals.
  - Senator Garrett asked about the status of the money?
  - Mr. Mark responded that, as Mr. Carvalho said, the board has submitted a report to the IHFPB, but offhand I don't know how much money has been distributed.
  - Senator Garrett asked if there was a provision in place in order for the CON to approve their application if they created the fund.
  - Mr. Mark stated that the fund creation was a voluntary thing by the applicant
  - Senator Garrett asked how did they determine the $17 million was adequate or fair?
  - Mr. Mark responded that he doesn't know. We can invite someone from Advocate to testify.
  - Mr. Carvalho replied that the initial application from Advocate met all criteria. But the board was concerned about Safety Net and so turned the application down, which the Tribune blasted. The applicant developed something on their own to help the community and came back to the Board.
  - Senator Garrett stated that you can't have an impact statement without action steps. Need to incorporate action steps.
  - Ms. Guild stated that impact statements codify in some way the impact of the CON application
  - Senator Garrett suggested that we create a formula. If X hospital wants to expand and will create X impact, the application owes X amount to the Safety Net hospital.
  - Mr. Mark stated that originally the HFPB focused on expansion. Equally important today is to address closure of facilities and services.
  - Mr. Ruddick added that the SNIS should apply to closures as well
  - Ms. Guild replied that SNIS is a new process. While we work on that new process, there is already a process in place to address these concerns. Is there a role for a

SNIS? Let's start with new facilities. But that doesn't mean that anyone in the public has access to the public comment process.

- Senator Garrett discussed bringing equality to the process. Ambulatory surgical centers should have some accountability too. The hospitals shouldn't be stuck with all the burden of providing for the Safety Net.
- Ms. Guild stated that if an ASTC comes into a community, it means they were able to prove a need.
- Rep. Lang stated that the HFPB currently doesn't do any planning- they do paperwork. If we do planning and provide incentives for hospitals to move into areas of needs, and disincentives to move into areas with little need, that would help the Safety Net. The IHA has Safety Net hospitals as members, but doesn't have clear recommendations to protect these members. The Safety Net hospitals themselves should have some ideas about how we should protect them.

- General discussion on Ms. Guild Guild's testimony:
  Rep. Lang asked a question about ex-parte communication between applicants and staff. In some ways, I agree with you that applicants should be able to talk with staff, but, from the testimony and inferences, we have gathered that staff and staff reports have a strong impact on decision –makers. How do you deal with a statement that communication with staff is equal to communication with board members?
    - Ms. Guild stated that the SAR describes criteria and whether or not the hospital met it. No matter who writes the report, the applicant needs to meet the criteria. These rather simple reports go to the Board members. The SAR is like the computer report- not unduly influencing board members. I think if you had a larger board with more expertise, the staff would have less influence. Originally, the board makes complicated decisions on rules that were foreign to them.
    - Mr. Robbins asked Ms. Guild to give some examples of appropriate communication.
    - Ms. Guild stated that many hospitals would like to sit down with staff and say we're not meeting this criterion, so what should we do about it?
    - Rep. Lang stated that he can conjure up many ways to have appropriate communication with staff, but I can also conjure up many inappropriate ways. How do we set up the criteria for appropriate vs. inappropriate? Don't want lobbying to happen.
    - Rep. Lang asked what types of communication IHA wants the Task Force to allow?
    - Ms. Guild responded that anything relating to the application itself that gets translated to the SAR, is fair game. The staff should not use that discussion to influence the board- that is inappropriate.
    - Senator Garrett stated that the work is done by consultants hired by the staff.
    - Mr. Mark replied that the term" consultants" is used in lieu of a staff person. In his 4 years as executive secretary, he has not been able to hire full-time staff. If they need additional resources, it needs to be done under contract. Most recently, the personal services contracts are not being renewed. Don Jones is here with one of the personal services contractors, and they can speak as to how they review the applications. *(Note: Mr. Jones' testimony was later rescheduled for the June meeting.)*
- Rep. Lang asked for what Mr. Newton promised us (??)
- Rep. Lang asked about IHA's recommendation to eliminate reporting requirements if there is more than a 50% reduction. He understands the need behind that but if we are doing better planning, how do these two things work together?
    - Ms. Guild replied that, as Jeff said, no one is currently reporting because no one understands the requirements. This started as a simple request because the

legislator didn't know what was going on in his local hospital. Rules came back with more complicated criteria. Since this legislation was based on one anecdote, and it doesn't seem to be solving any problems, it should be eliminated.
    - Mr. Carvalho clarified that Rep. Washington from Waukegan was concerned that a hospital doesn't have to come to HFPB if they are going to reduce a service by 98% (not completely eliminated), and so he spearheaded this legislation.
    - Rep. Lang asked Ms. Guild if IHA would like to eliminate the reporting requirement?
    - Ms. Guild responded yes.
    - Rep. Lang asked what would happen if a hospital then dramatically curtails their services?
    - Ms. Guild responded that it's unusual that a service would be reduced by 98%, but at some level, bed reporting provides some accountability.
    - Mr. Mark clarified that currently facilities just report reduced services unless it is temporary reduction and then they do ongoing reporting.
- Rep. Lang asked Ms. Guild to discuss the hearing process- some have suggested that board members be at the hearing?
    - Ms. Guild replied that she has never been to a hearing and IHA is not able to have opinions on the applications. It is good for the public to have a time to give comments and have the board members receive these comments. IHA does not have an opinion as to whether the board members should be at the hearing. We don't have a problem with them just reading the comments. Hearings are held in the community where the project is. You can't expect that a board member will attend every public hearing across the state. You can revisit this proposal when the board is larger.
- Senator Garrett asked- What if there is a local arm of the board that can then attend the public hearings? Like a county board?
    - Ms. Guild responded that IHA has not talked about that with any of our members. I can see pros and cons to that. Health Systems agency-used to make a lot of decisions.
    - Mr. Carvalho stated that Illinois used to have regional HSAs. Applicants first when to Regional HAS and then the HFPB. Do you know how long the process took under this old system? Right now it is 120 days.
    - Ms. Guild responded that as she recalls it took a long time but now she still feels that the process takes a long time.
    - Mr. Robbins stated that this also assumes that each county board is equally efficient.
    - Senator Garrett stated that she is not arguing for regional planning, but we have to consider all options. A regional planning board might help us grapple with these issues of accountability.
- Senator Brady asked Ms. Guild about the five (5) criteria- help me understand what you mean by "SN Service".
    - Ms. Guild responded that it could be a Level One Trauma service that not every facility provides but is available to all who enter that facility
    - Senator Brady asked if SN Services are economically aligned?
    - Ms. Guild stated that is one possibility- but it is also defined by what the people need in that community.
- Senator Brady stated that there is no area of the state that HFPB reform doesn't affect and it is not objective enough for a computer to do it. How do we prepare good guidelines and eliminate corruption? How do you get rid of corruption when you get the government

involved in this subjective issue? We could let the free market decide- survival of the fittest.

    - Ms. Guild replied that there is not a problem with the current board. There have been problems in the past. There are review criteria- they are in the application. There are already things that are somewhat objective.

- Senator Brady stated that IHA hasn't given him a good reason to believe that the free market couldn't regulate this system better than CON
    - Mr. Robbins responded for IHA, saying that if we are to make changes to the CON process, and if attention is to be paid to preserving Safety Net services, and if we are to work with this Task Force to put more detail to it or leave it to the rule making process, IHA can come up with words to create a standard. I think the rule making process is where the detail can come into play.
    - Senator Brady responded that if we are going to keep this thing, we need statutory criteria. The last recommendation in the legislation was to consider elimination. I don't think we can trust government to not be corrupt.
    - Ms. Schaps stated that she thinks it goes back to the point that we need planning and then we will have criteria against which to judge. I think I would be for regional planning. Not county planning because you need to look a bit broader than that. If we knew the needs, we can set goals against which to judge applications. That is the way to get a rational system.
    - Mr. Devlin added that he doesn't think we as a task force should restrict ourselves to come up with our own subjective criteria.
    - Rep Dugan stated she is still concerned that none of the entities have addressed actual health care planning. Rep. Dugan is worried we will come to the end of this task force- what will we base the criteria on if we don't know what is out there or what we need? How do we put criteria down if we as a state don't know what we need or want?
    - Ms. Guild responded that it makes sense to her. Criteria exist if you want to build a new hospital, but they aren't totally up to date. IHA members have a strong sense that state data used to establish criteria could be more sophisticated. What do transportation planners and school boards and housing developers use? More resources to increase sophistication.
    - Rep. Dugan replied that when the Task Force asked Dr. Poshard how he made his CON decisions, it was very subjective.
    - Sister Sheila Lyne stated that we need to reinforce planning- CON never started out to protect Safety Net. Started out to contain cost and assure there are services in all communities. Lot of work to be done as to who sits on the board and what the criteria should be. We don't have clear rules and regulations.
    - Rep. Dugan added that we don't truly have the strictest criteria available that all board members base their decisions on, period.
    - Senator Garrett summarized that she thinks there has been a shift in how the Task Force is looking at establishing a new process or building or subtracting from the current process. Emphasis on planning and creation of strong criteria. I think it is incumbent on us to come up with clear directives and bring them to the legislative body. I don't want to leave the making of directives up to the legislative body.
- Senator Garrett thanked Ms. Guild for her testimony and her time.
- Ms. Guild replied that she will be happy to answer any questions during this Task Force process.

Presentation by CON Applicants

- Senator Garrett asked each member to introduce themselves, and mention a few points relating to their experience with the CON process. Questions will be held until all panelists have had a chance to speak.
  - Mr. Ralph Weber- Northwestern Memorial Hospital
    - At one point in the process, he couldn't contract with an architect because it would trip one of the permits
    - Northwestern views itself as gov't agency and also helping the process along
  - Mr. Thomas Manak- Provena Health
    - Recently had 2 big CON applications
    - First application was for bed expansion-first had dialogue to determine the right size of the project and the appropriate request of the board.
    - Second application was to discontinue a service
    - Pleased with working relationship with HFPB staff
    - Because of system, we had to provide additional information to complete the application
    - The system at times makes it more difficult, but the planning process is important
    - CON should be continued long term. The year-to-year extension is problematic.
  - Ms. Kathy Yosko- Marianjoy Rehabilitation Hospital
    - Chair of Nat'l Rehab Providers Assoc
    - Not a difficult CON process for Marianjoy- uncontested
    - Concern of Rehab institute- only 3 in IL. CMS is looking to establish a site neutral payment system by 2011. Concern about money being spent in post acute care. How we look at these hospitals and allocate beds will be an issue that comes into this new payment system.
    - 75% rule- enforce a rule that has been in place for 18 years that needed updating
  - Mr. K. Jeffrey Hill- Galena-Strauss Hospital
    - 25 beds, only hospital in county, small facility
    - Replaced facility- older facility was 45 years old
    - Have adult daycare and assisted level facility and 57 bed nursing home
    - New hospital was going to be outside of hospital district, so dissolved hospital district and started new 501C3. Had to do that by going through CON board.
    - 2nd CON process to start new hospital. It worked but it was expensive- had to hire consultants and attorneys.
    - We had to establish a new license for the nursing home- 3rd CON process
    - Expensive and cumbersome for a small hospital
    - Change of ownership process- public hearing called by one person – a disgruntled employee. At hearing there was overwhelming positive support. Had to spend a lot of money on that.
    - Would have liked to have all 3 streamlined into one CON application, whereby eliminating expense
    - Good experience with HFPB staff
  - Ms. Margaret Gustafson- Kewanee Hospital
    - Small rural hospital- critical access hospital
    - 1917 original hospital was built, CON application for full replacement facility
    - Very good process, but cumbersome and scary for someone with no expertise, had to engage consultants and legal counsel.
    - We think of our hospital as Safety Net- 30,000 in greater community
    - Elderly and indigent patients.
    - Need future planning to stay viable

        - Hospital offers primary care to many community members
        - Referrals go to Peoria- 50 miles away
        - We do need helicopter and ambulances for heart attack and stroke and other trauma and larger-needs cases
        - Interested in regional concept
    - Senator Garrett asked when each speaker was invited to come testify before the Task Force.
        - Various panelists answered last Tuesday, Wed, Thurs
        - Senator Garrett responded that she is sorry about that and she wished they would have been notified sooner
    - Senator Garrett asked how did each panelist determine who to hire as a consultant?
        - Mr. Hill replied that there are a handful of consultants with a good success record in getting projects approved and we were recommended a few by other hospitals
    - Senator Garrett asked each panelist about fees for attorneys and consultants.
        - Mr. Hill replied that he spent about $500,000 dollars, not including internal costs. Consultant charged per job- it cost us $100,000 total. Consultant was Pat Sweitzer, Hinshaw and Culbertson.
        - Ms. Gustafson replied that she spent $300,000 and that was to appear before the board once. $40,000 consultant, $100,000 application fee and legal counsel made up the balance. Legal counsel put us in touch with a consultant. Prizm, Draker & Biddle were attorneys. Would have appreciated technical assistance.
        - Mr. Weber replied that Northwestern has had 50 appearances before the board so we don't use outside consultants or legal counsel.
            - Senator Garrett asked about the number of full time staff dedicated to CON process?
            - Mr. Weber replied that they have 2 FTE who use 1/3 time on CON, and Mr. Weber spends time writing application. Hard to separate out the CON work from other job tasks. Fees to apply ranges from $25,000 to $70,000.
            - Senator Garrett asked if they break down what you spend on CON?
            - Mr. Weber replied no, CON spending is incorporated into our department budget. In 1992, Northwestern did hire outside expertise for expansion to main hospital from the firm Hopkins and Sutter.
        - Ms. Yosko replied that Schwab used Skinner for something. 2 CON while at Marianjoy. 1st project we needed technical advice so we used a consultant, Jeff Axel, for $70,000. Technical advice under $10,000.
        - Mr. Manak stated he used to be a consultant to hospitals for CON.
    - Mr. Robbins stated that critical access hospitals serving a large percentage of uninsured and Medicare patients get reimbursement at a cost basis. How important was it for you to have reimbursement levels you enjoyed when you decided to build a replacement hospital? How key was reimbursement rate in your decision to have a replacement hospital?
        - Ms. Gustafson stated that reimbursement was the key factor. Once we became a critical access hospital, we were able to save money to put equity in the project and attract lower interest rate.
        - Mr. Hill stated that he had a similar experience with an increase in the bond line through critical access determination.
    - Mr. Carvalho referred to the chart of numbers for Medicaid, self-pay and charity care. Not what you would expect. Galena actually has lower Medicaid, Self-pay and charity care numbers than many others but they are critical access hospital.
        - Critical access is also about being the only facility around for miles and miles
    - Mr. Weber stated that we've lost the planning base that CON started out with. CON is reactive. Planning is proactive and much harder to do. Developing a plan for community health

development is difficult and can't be done with the resources available right now, especially if governor is sweeping funds.

  - o Mr. Carvalho replied that from the IDPH perspective, we have no problem with planning. Part of not planning is a resource issue, as planning is intense, involved, and expensive. And do you all want to live with a plan?
  - o Mr. Weber replied that you have to look at what's needed and how the plan will be used. Look at outpatient and community outreach as well as inpatient services
  - o Mr. Manak stated that a plan shouldn't be stagnant. Have a standing planning committee to review the plan on an ongoing process. Current economic circumstances can change things in the short-term. The plan should be forward looking but also able to change with current pressing issues.

- o Senator Garrett mentioned the Hospital Report Card
  - o Mr. Carvalho described the Consumer Guide to Health and Hospital Report Card.
  - o Senator Garrett asked if it would make sense to you if the hospital report card on how healthy a hospital is was taken into consideration in a CON application process?
    - ▪ Mr. Hill replied that data could be skewed for smaller hospitals. I am in support of using the Hospital report card because we are doing a lot of quality improvements, but I would want the data to not be skewed based on hospital size.
    - ▪ Mr. Carvalho replied that in some cases, data from smaller hospitals won't even be used because of the small cell issue- not a large enough sample size
    - ▪ Ms. Yosko responded that the Hospital Report Card is not always applicable to post acute care
- o Senator Garrett asked everyone's opinion on bigger hospitals having to pay some funds into a community health foundation
  - o Mr. Weber stated that he is not opposed to it. Take a close look at what hospitals do and don't do regarding charity care/Safety Net care. Some things that large hospitals do for Safety Net may not fit into a neat definition of charity care. Funding for many things are skewed- schools, churches, etc. etc. How do you make broader decisions about resource allocation? What role does health care have in that discussion? Hospitals should be given the opportunity to document how they pay their share of charity care.
  - o Mr. Manak stated that attention should be paid to services hospitals provide that they are not reimbursed for. More specifically, in a trauma center everyone has to be cared for regardless of ability to pay. Another example is the flagship- Provena St. Joseph Joliet- we need to protect that hospital because it subsidizes other hospitals and other programs. The "system-ness" makes the HFPB job more difficult because you can't look at one hospital.
- o Ms. Schaps asked the panelists that when they apply for CON, would you like to have the hospital apply or the whole system?
  - o Mr. Manak responded that all of our hospitals are in a single corporation so when we've applied we do it as a system. It would be simpler to apply as a single entity. But I think some things might be missed if you are a single entity applying.
  - o Mr. Carvalho mentioned unintended consequences, an example of which is the cancer registry- hospitals need to submit their cancer data in order to submit a CON. If the whole system needs to apply, then we know if there is any outstanding cancer data we need. If the whole system does not need to apply, then we could miss out on an opportunity to get data compliance.

    - Mr. Hill stated that it would be lots of work to get this done- critical access hospitals are satisfied with the status quo and provide a basic level of services- taking on a new hospital in a small community is huge undertaking
  - Senator Garrett asked if ASTC's should they pay a certain percentage into the Safety Net system, instead of taking the cream off the top, how would you feel about that?
    - Mr. Manak responded that if an ASTC opened in Urbana, it would have taken 60% of the business away from Provena in Urbana. That 60% would have been the insured patients, thereby crippling the hospital.
    - Mr. Weber responded that if there is a need in the area, I would hope existing providers would be on it.
    - Senator Garrett replied that in many cases, the existing providers can't respond to community needs.
    - Mr. Weber then stated that the playing field should be leveled. ASTC's need to go through the same CON application process.
    - Ms. Gustafson stated that in Kewanee, they have a new hospital and as long as they pay for it and keep up good services, then they are fine. They are focused on finding good physicians. Doctors don't want to practice here because there are not enough paying patients. Mostly Medicare and Medicaid patients. The greatest need in our community is for dental services. Our community will get older and poorer. We need to manage what we have- not looking to grow. But we need physicians to help us with that.
    - Sister Sheila Lyne mentioned the U of C Medical example
    - Ms. Yosko- role of consultant is very important for a small facility like Marianjoy-
      - Senator Garrett replied that yes it is important, but it is heavy handed for a small hospital to spend half a million dollars to apply. The process shouldn't be so expensive that facilities have to hire consultants. If you pay $100,000 to apply, that should come with some technical assistance.

<u>Presentation by Attorneys and Consultant Advisors</u>

- **Mr. Dan Lawler** is with **Bell, Boyd & Lloyd** and they have practiced in front of the HFPB since 1985. Involved in more relations with HFPB than anyone around. Very often, we are on the same side as the board. Sometimes adverse. Current no pending litigation in front of the board. In the last 15-20 years, it has become a more adversarial process to apply. Public hearing is most often called by a competitor who is against the application. The public usually wants expanded or new facilities. A proposal to discontinue a facility has much more public interest. The planning board has become a battle ground between competitors. That is why there has been much more litigation.
- **Mr. Joe Ourth, Arnstein and Lehr,** has done this for about 20 years, about 100 cases. Not speaking for any particular client today. Good thing about the planning board is that they have a lot of discretion to make decisions on projects, but that is also a bad thing. No determination as to whether HFP board members exercise too much or not enough discretion. So we have ended up with a lot of rules. Streamlining the process will allow for more discretion. More rules equals less discretion. Important to know the integrity of the situation right now. The current battle is not about a present problem with integrity. The HFPB is really being done on the straight and up-and-up right now. One comment about Lewin report, it said that maybe the planning process isn't helpful because so many projects are approved anyway. That overlooks the fact that I tell about 1/3 of potential clients that they don't really have a case. Before the project ever sees the planning board, they have had legal counsel to let them know whether or not it is a viable project.
- **Ms. Anne Murphy** , **Holland and Knight**, appreciated the opportunity to provide her perspective. Has been a generalized health care attorney since 1980's. In the last several years, I have been extensively involved in IL CON process. Complexity of CON process- heavily regulated industry.

Advise clients in the complicated regulatory, enforcement, or reimbursement issues. Unusually technical and complex process that demands the need for assistance. August 2003- general counsel to IDPH and then general counsel to the HFPB to 2005. Then worked in Attorney General's office and then returned to private practice. Complexity and capital investment and dollar value of these projects make consultants and counsel more necessary especially in this competitive environment.

- **Mr. Jack Axel, Axel and Associates** is the only non-attorney on panel. Involved on 250 projects since 1984. About 60% of projects that he is contacted about never make it before the board. Represented range of hospitals and ASCs. Identified issues related to IL CON program:
  - Size of the planning board- too small right now- increase it
  - Length of review process should be shortened. Right now it is 6.5 months. Inflation during that waiting period is over a million dollars.
  - Inflation needs to be incorporated into the project review.
  - Size of review staff needs to be expanded
  - Accommodations need to be made to providers operating at high utilization levels even if there are nearby medical facilities. High utilization means they are doing well. Also accommodate hospitals that are providing high levels of charity care, Medicaid care.
  - Re-evaluate the distance between medical facilities. 1.5 hours is too far for acute, and 45 minutes is too far for ob.
  - Unstaffed beds in hospital- low utilization, convert double to singles- the unstaffed beds shouldn't skew the stats of bed need
- **Ms. Clare Ranalli, Hinshaw and Culbertson** stated that despite cost and frustration associated with the process, all clients want the board and process to remain in place. Key themes-
  - delay, longer now that it was 10 years ago, address this critical point
  - board should be larger, ideally 9-13 people. Agree with complexity statements about board.
  - Rules and regs being changed. Process not being streamlined- it is becoming more complex. Not the way to go. There are opportunities to streamline that would take burden off staff that would move process along. Appropriate for system or owner to be co-application to licensed facility. But ensure that parent corporation information is necessary to the application.
- <u>Senator Garrett stated</u> there is a financial burden to hiring consultants. Appears that hospitals that have in-house staff have a more direct relationship with the HFPB staff.
  - Mr. Axel replied that all of us have professional relationships with staff consistent with ex-parte. We can call them for technical assistance.
  - Senator Garrett asked for an example
  - Mr. Axel gave an example: if I am trying to project utilization, I can call staff to ask which source they are familiar with and which they would prefer me to use.
- <u>Senator Garrett asked</u> if a hospital that can't afford you is at a disadvantage
  - Mr. Axel disagreed. I think the staff fully understand when they are talking to one of us who works with clients very often vs. someone who is newer to the process
- <u>Senator Garrett wondered</u> if applicants should be given guidelines, training, or staff time for a $100,000 application fee?
  - Ms. Murphy stated that as counsel to staff and in private practice, I see that staff go to great lengths to answer questions, but they are under procedural constraints when answering technical assistance questions. To some degree, hiring a consultant is the prerogative of the client.
- <u>Senator Garrett asked</u> if there should be a more formal process of staff helping the applicant.
  - Mr. Axel responded that he thinks we are all in support of that. Fee paid to HFPB is 2/10 of 1% of the project cost (building costs) to maximum of $100,000. $50 million dollar project

pays $100,000. When a consultant is working on the project, the consultant can help get it in front of the board faster to prevent inflation.
        - Mr. Mark stated that anytime an applicant calls with a question, we always say that we are happy to sit down with them and help them with questions. Steep learning curve, especially if you don't do this often or ever. John Fiyet- in Harris IL did an application himself. Most people choose to hire outside expertise to navigate the process.
        - Senator Garrett stated that it is not clear what is expected of an applicant who doesn't have the right attorney or consultant and what services the HFPB staff can offer. Expensive process and I have a problem with that. Maybe there should be a list of consultants published somewhere.
    - <u>Mr. Robbins asked</u> why there is more litigation now? Because of absence of rules or too many rules?
        - Mr. Lawler responded that it is difficult to challenge a decision – you have to prove the Board misapplied a criterion. Market is much more competitive now, and that creates litigation.
    - <u>Mr. Robbins asked</u> how much subjectivity is appropriate? Is it reasonably applied?
        - Mr. Lawler responded that as an attorney counseling a client, you can tell them to do this or not do that with consistent application. Without consistent application, you can't guide your client as well.
        - Ms. Murphy said needs assessment and regional planning. A substantial portion of the act addresses regional planning. Create a set of standards against which an application is assessed- a touchstone. Right now there are technical rules but not a set of standards. Board uses a lot of discretion now.
        - Mr. Axel stated that there needs to be subjectivity for the board- they are taking a set of rules and applying them to hospitals with 350 beds in Chicago to 25 beds in Galena
    - <u>Mr. Barnett asked</u> Mr. Axel to clarify what he said about sending away 60% of his potential clients.
        - Mr. Axel replied that the vast majority were groups of physicians who wanted to develop a dialysis facility or ASTC, and I do believe most of them could have written checks to cover the cost. I don't believe there would have been a significant improvement in healthcare delivery had that 60% of clients gone before the board. People would be using less gas because there would be more free-standing centers.
    - <u>Mr. DeWeese asked</u> him to elaborate on why they didn't get to the board
        - Mr. Axel- for the most part, because I told them they'd be wasting money and time. They had a project where you can't prove need. Some of them sought other counsel. Clearly consultants can act as deterrents.
        - Mr. Ourth stated that his fees range from less than $10,000 to over $100,000, given the counsel that is needed. Tension on staff- projects I am involved in are more contentious. At what point is staff helpful and not too much of an ally? They have to be aware of that.
    - Mr. Lawler stated that once upon a time, an applicant could send in a draft application and have staff review it with comments.
        - Senator Garrett asked him how he feels about that? For $100,000, I feel like you should get some review.
        - Mr. Axel stated that the review staff was a lot larger then.
        - Senator Garrett stated that the government shouldn't be making money hand over fist and not provide any services. It is a deterrent.
    - Ms. Murphy stated that $100,000 is a large fee to pay any form of government. Having a process that is accessible to all who need to avail themselves of it is a fair part of the bargain. The staffing resources and ability of the HFPB to bring in more staff to offer guidance would have to be reviewed. Understaffed right now, and they are doing the best they can with the staff they have.

There needs to be meaningful dialogue between applicants who don't understand ex-parte with staff who can outline what they can and cannot discuss with applicants.

- Senator Garrett commented that she is baffled by the HFPB being understaffed. The revenues that come in should cover staff. Why can't you hire people?
  - Mr. Carvalho replied that there are personal services consultants and the outside world would not know the different between staff and a consultant
- Mr. Mark stated that reviewers can refer applicants to him or their supervisor to ask questions about communication and technical assistance. Conversations are documented.
- Senator Garrett asked do you get many calls from applicants who are in this for the first time?
  - Mr. Mark stated that if they are coming into the process for the first time, I suggest they meet with staff to go over the application line by line.
  - Ms. Ranalli replied that if the communication is part of the record, then there isn't a problem.
  - Mr. Axel commented that we would all benefit from a less structured process if ex-parte were relaxed.
- Ms. Schaps commented on Ms. Murphy's comment that the restrictions came about for a reason- so there have been problems before
  - Ms. Murphy replied that procedural and technical assistance are exceptions to broad prohibition to contact between applicants and HFPB staff. Current staff has high standards. Documentation creates an element of transparency because you know what is covered. Maybe the documentation can create a chilling effect on the communication.
- Mr. Gaynor asked how you document these calls? Is it a basic "so and so called" or "she said this, I said that"?
  - Mr. Mark replied that both the applicant and staff must document communication. If Mr. Axel were to call and ask for this application, what rules should be addressed, I would document he called and what we discussed and it goes into the project record which the board reviews and goes into public record.
- Senator Garrett questioned the fees again. If you collect $100,000 for an application, how can there not be enough staff?
  - Mr. Carvalho responded that appropriations for HFPB have been stagnant for 10 years
- Mr. Robbins asks for the context of ex parte rules? Is there history that we are unaware of that relates to staff members?
  - Ms. Murphy replied that staff have always been consistent and diligent in not behaving inappropriately. My real point is that staff is potentially put in a challenging position. Resource limitations. Staff work very hard to cover a lot of ground quickly. Cognizant of the fact that they need to comply with principles of objectively and prohibitions of ex-parte. My point is not that I believe that communication with staff should remain unchanged, but it is important for the Task Force to ask their perspective on communicating with applicants.
  - Mr. Carvalho asked do you want to loosen the rules for the applicants or for the world? And everyone is saying that everything is running smoothly with communication now, so we want to loosen the rules. And where will be in 10 more years? Back with needing ex parte.
  - Mr. Ourth stated that we'd love to be able to talk more with HFPB staff and communicate our enthusiasm for our projects
  - Mr. Gaynor reiterated that staff provide information to the board- they are the main conduit
  - Mr. Carvalho- State Agency Report (SAR) states here is the criteria and here is how the application stacks against the criteria- there is no opinion or merits in the SAR.

- Mr. Ruddick commented that it is hard to look at details of the rules when we don't have the big picture in mind yet.

Discussion on New Business- Task Force Consultants

- Senator Garrett stated that she has talked with a friend, a consultant, Dave Englehart at Deloitte. We need to put together a framework – a catalyst to get this process moving- so she talked to Dave about the budget. Deloitte could do something like this but she doesn't have cost framework yet.
- Mr. Carvalho stated that there are procurement issues. You cannot just go to Deloitte and ask for a bid unless it is under $20,000. We would have to open it up to an RFA. About $125,000 left in the Task Force budget to work with.
- Senator Garrett urged the Task Force on the need to craft Final recommendations for legislation- here are our recommendations, and proposals, and their impact- the good, bad, and ugly. These final recommendations would be developed after there is an agreement on the Task Force. Need a framework. We could take testimony for months and months and the sunset would expire and we are back to square one.
- Mr. DeWeese stated that LTC and Dialysis centers would like to testify. Rehab facilities. We do still need one more hearing for testimony.
- Senator Garrett replied that she is not trying to cut the process off, but wants to have an end game and a goal, and framework to get there.
- Mr. Carvalho stated that the RFP process is lengthy so we need to start now even if there are several more meetings of testimony
- Mr. DeWeese asked about the Task Force's status in FY09 budget appropriations?
    - Mr. Carvalho replied that this year FY08, the Task Force was appropriated $250,000. The unspent monies would carry over and be re-appropriated.
- Mr. Barnett asked if the Task Force would need a facilitator to guide the process or someone with expertise to develop a written paper?
    - Senator Garrett said both.
- Ms. Schaps seconded a motion to start RFP process, and have us think of other consultants.
- Mr. Carvalho reiterated that it is not a trivial process to develop an RFP. Do you want to spend some time now so that we can start to draft what we want from a facilitator?
- Mr. Barnett is interested in a facilitator. He doesn't want to go out and look for someone to tell us what to recommend. He doesn't want an expert. He wants someone who can help us come to a decision within this body.
- Mr. DeWeese stated that if you were going to have someone or some group do additional work, they could compile testimony and compare it to the charge of the Task Force and classify or list the recommendations from the witnesses.
- Mr. Carvalho asked the Task Force what they want an outside consulting expertise to help you analyze? How do you want to spend $125,000 remaining in the budget?
- Senator Garrett commented that the consulting work could cost a lot less than $125,000.
- Senator Brady suggested that a consultant compile a list of issues and pros/cons. Create a matrix. Or IDPH staff could do that.
- Senator Garrett stated that to get that point, we can have a facilitator or a retreat for Task Force members to have a chance to discuss issues brought up.
- Ms. O'Donnell commented that the Task Force has heard a lot of testimony. Need a chance to discuss and digest all the information we've heard.
- Senator Garrett suggested that the consultant could be more like a facilitator.
- Mr. Carvalho reiterated that they RFP process for Hospital Report Card has taMr. Robbins about 2 months with very clear objectives. Since the Task Force does not have clear objectives about what they want right now, the process could take longer.

- Ms. Schaps suggested that the Task Force have a special meeting where we discuss what we want to make recommendations around.
- Rep. Kosel asked if the Task Force was accepting written testimony?
- Mr. Gaynor stated that we will have more witnesses in the next few hearings.
- Senator Garrett replied that the Task Force has hearings scheduled through October
- Mr. Robbins stated that so far this has been a hospital centric discussion. Need to hear from other providers before we start to develop recommendations.
- Senator Garrett stressed that we just need to think long-term. Don't want this Task Force to think of 100 ideas, and not implement one of them. She wants to make a difference.
- Mr. DeWeese commented that it shouldn't be too difficult to list all the things the Task Force would like to consider and we could fill in other things that have come up. Wouldn't be too hard to outline the general topics. Getting to specifics will be the tough part.
- Senator Garrett asked if Mr. Carvalho should start an RFP together with all the topics there will be?
- Senator Brady asked how many Task Force members can meet without violating the Open meetings act?
- Senator Garrett and Mr. Carvalho responded 5 people.
- Senator Brady suggested that a subcommittee of 5 members could meet with staff to determine what Mr. DeWeese was talking about.
- Mr. Carvalho was uncertain about that suggestion.
- Mr. Mark stated that an unofficial committee of 5 might be ok.
- Ms. Schaps asked if we could hire a consultant to review the minutes before the next meeting and compile a list of topics to consider. This would be work for less than $20,000 so no RFP.
- Senator Garrett stated that we need someone who has expertise on facilitating and someone with expertise/knowledge of CON across the United States. Two different roles.
- Mr. Gaynor suggested that the Task Force not be presumptuous with IDPH/HFPB staff time.
- Mr. Carvalho stated that he can hire someone if it is less than $20,000. Laura McAlpine is staff to this project now, and she has done both meeting facilitation and report writing for IDPH.
- Mr. Gaynor stated that a facilitator would force us to focus and come to a decision.
- Senator Garrett suggested that maybe we should get 3 resumes to review for a facilitator role.
- Mr. Carvalho stated that at upcoming meeting there will be testimony from the Attorney General, Labor, LTC/Nursing Homes, dialysis centers, etc.
- Senator Garrett stated that we need to decide when testimony should end and then schedule a time with a facilitator
- <u>Senator Garrett stated</u> the Motion to receive three facilitator resumes at next meeting and plan out next steps, and then have a future meeting with a facilitator.
    - ***Motion approved.***
- Mr. Gaynor suggested that at the next meeting, we can take Mr. Robbins's recommendation to schedule more meetings beyond what we have if we feel that is necessary.
- Senator Garrett said that we can ask staff to plan a timeline of when all proposed people will come to speak and then decide if we need more meetings

<u>Adjourn- 2:59pm</u>

Minutes respectfully submitted by Mairita Smiltars.