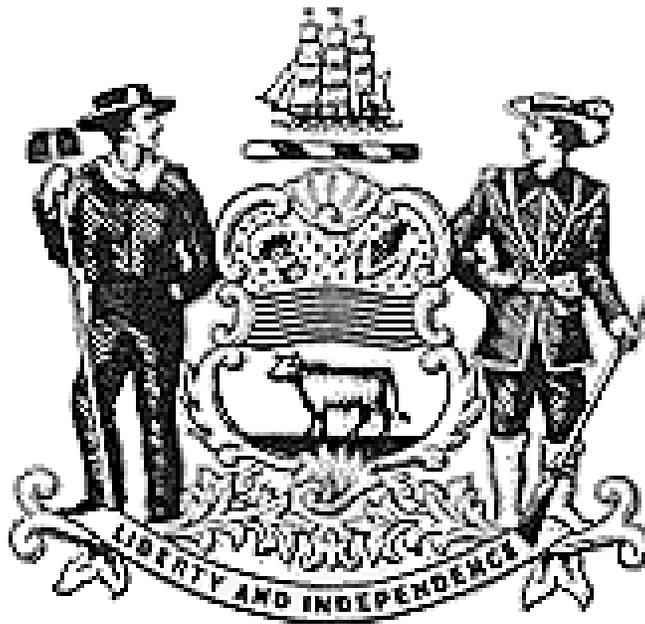


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# Joint Sunset Committee 2012 Final Report



## Delaware Health Resources Board

*A Report to the Governor  
and the  
146<sup>th</sup> General Assembly of the State of Delaware*

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May 2012

## 2012 Joint Sunset Committee Members

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Rep. E. Bradford Bennett

Rep. Edward S. Osienski  
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The Sunset Law in Delaware, Chapter 102 of Title 29, enacted in 1979, provides for the periodic legislative review of state agencies, boards and commissions. The purpose of sunset review is to determine if there is a public need for an agency, board or commission and, if so, to determine if it is effectively performing to meet that need. Typically, agencies are reviewed once every six (6) years.

The Joint Sunset Committee (JSC) is responsible for guiding the sunset review process. The JSC is a bipartisan committee comprised of ten legislators. Five senators are appointed to serve on the Committee by the Senate President Pro Tempore and five representatives are appointed to serve by the Speaker of the House.

Sunset reviews are generally conducted over a ten month period commencing in July. A comprehensive review of each agency, based on statutory criteria, is performed by the JSC analyst, who subsequently prepares a preliminary report for use by the Committee members during the public hearings, which take place in February each year. Public hearings serve as a critical component of this process, as they provide an opportunity for the JSC to best determine if the agency is protecting the public's health, safety and welfare.

At the conclusion of a sunset review, the JSC may recommend the continuance, consolidation, reorganization, transfer, or termination (sunset) of an agency, board, or commission. Although the JSC has sunset several agencies since its first reviews in 1980, the more common approach has been for the Committee to work with the entity under review to formalize specific statutory and non-statutory recommendations, with the goal of improving the entity's overall performance and government accountability.

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## **2012 Final Recommendations: Delaware Health Resources Board**

The Joint Sunset Committee recommends the Delaware Health Resources Board be continued, provided the Board is meeting certain conditions and/or making certain modifications as identified below.

1. For administrative and budgetary purposes only, the Delaware Health Resources Board shall be relocated to the Office of the Secretary, Department of Health and Social Services. The Delaware Health Resources Board shall function in cooperation with the Delaware Health Care Commission, as well as other state health policy activities.
2. Amend 16 Del. C. § 9303 (c) as follows: The Delaware Health Care Commission and the Office of the Secretary, DHSS will be responsible for the administration and staffing for the Delaware Health Resources Board.
3. The total composition of the Delaware Health Resources Board shall be reduced from 21 members to 15 members. The membership shall be representative of all counties in the State. The remaining positions will be as follows: 4 members to represent the public at large; public members may include, but not be limited to, representatives from business, educational and non-profit organizations; 1 rep from DHSS recommended by the Secretary of DHSS; 1 rep of labor; 1 rep of a provider group other than hospitals, nursing homes or physicians; 1 rep involved in purchasing health care coverage on behalf of state employees; 1 rep involved in purchasing health care coverage for employers with more than 200 employees; 1 rep licensed to practice medicine in Delaware; 1 rep with knowledge and professional experience in health care administration; 1 rep with knowledge and professional experience in long-term care administration; 1 rep of the Delaware Health Care Commission; and 1 rep of the health insurance industry. The Chair shall be an at large position and shall be appointed by and serve at the pleasure of the Governor. The Governor shall designate a Vice Chair from among the members of the Board who shall serve in this capacity at the pleasure of the Governor. Members are appointed for 3 year terms, provided that the terms of newly appointed members will be staggered so that no more than 5 appointments shall expire annually. The Governor may appoint members for terms of less than 3 years to ensure that the Board members' terms expire on a staggered basis. The Delaware Healthcare Association, the Medical Society of Delaware, the Delaware Health Care Facilities Association, the Delaware State Chamber of Commerce, and other interested organizations may submit nonbinding recommendations to aid the Governor in making appointments to the Board.
4. Amend 16 Del. C. § 9303 (d) (1) to require that when revising the Health Resources Management Plan, the Board shall conduct a public hearing and shall establish rules and regulations published in accordance with the procedures specified in the Administrative Procedures Act (29 Del C. c. 101) for reviewing Certificate of Public Review applications.

5. Amend 16 Del. C. § 9903 (d) (1) to reflect that the Health Resources Management Plan should be reviewed and approved by the Delaware Health Care Commission prior to submission to the Secretary of DHSS for final written approval.
6. Amend 16 Del. C. § 9304 (1) to clarify that only for-profit acquisitions of a nonprofit health care facility are subject to the Certificate of Public Review process. Not-for-profit acquisitions of another nonprofit health care facility would not require a review.
7. Amend 16 Del. C. § 9303 to include a section as follows: The Governor may at any time, after notice and hearing, remove any Board member for gross inefficiency, neglect of duty, malfeasance, misfeasance or nonfeasance in office. A member shall be deemed in neglect of duty if they are absent from 3 consecutive Board meetings without good cause or if they attend less than 50% of Board meetings in a calendar year.
8. The Delaware Health Resources Board, with assistance provided by DHSS and the Delaware Health Care Commission, shall conduct a comprehensive review of 16 Del. C. c. 93 and the Certificate of Public Review program. The focus of this government efficiency review should be aimed at streamlining operations, increasing efficiency, simplifying the application process and updating the categories for review. This review shall include, but is not limited to, the following: activities subject to a review; criteria considered during a review; procedures to review; timelines/deadlines for a review; feasibility of quarterly Board meetings; documents used by the Board; application fees and fee structure; strengthening the charity care requirements; consider publishing the list of equipment triggering a review through the regulatory process; consider adding assisted living communities to CPR process; consider IT capabilities and an increased online presence. The Delaware Health Resources Board shall report the key findings identified and make recommendations to the Joint Sunset Committee by January 1, 2013.
9. The Delaware Health Resources Board shall review, and revise as needed, the conflict of interest definition enumerated in the by-laws. The Board shall develop guidelines for members to use when identifying and evaluating potential conflicts of interest. Additionally, the Board shall provide its members with the opportunity to participate in a Public Integrity Commission training session no less than once per year.
10. The Delaware Health Resources Board, with assistance provided by the Delaware Health Care Commission, shall undertake a comprehensive review of the Health Resources Management Plan and shall update the Plan to ensure that it supports the development of health services that are cost effective, consistent with meeting consumer needs and choice, and that the standards for a Certificate of Public Review are appropriate. Public hearings and forums should be held to solicit comment from all interested stakeholders and the public at large.
11. The Delaware Health Resources Board shall review and revise the current by-laws governing the Board to ensure consistency with 16 Del. C. c. 93; by-laws shall be updated accordingly.

**12.** The Delaware Health Resources Board shall develop a toolkit for the CPR process. The toolkit should include, but not be limited to, the Board by-laws, the revised CPR applications, an overview of the CPR process outlining what applicants can expect at each step in the process, the options available for applications to be reconsidered if denied, as well as a general timeline detailing the average time needed to complete each step in the process for applications to be approved or denied by the Board. Upon completion of the toolkit, the Board shall make these documents available to the public on the Board's website.

## Agency History

In 1966, the federal government created the Comprehensive Health Planning Program through the enactment of Public Law (P.L.) 89-749. This legislation authorized federal support for health planning at both the state and local levels in an attempt to control unnecessary or duplicate hospital investment in plant and equipment. In 1972, the federal government subsequently enacted P.L. 92-603, commonly referred to as Section 1122, which amended the Social Security Act to include the Certificate of Need (CON) concept for reimbursing capital expenditures due to the increase in costs of Medicaid, Medicare, and other health service programs.<sup>1</sup>

The inadequacies of the Comprehensive Health Planning Program as well as the ineffectiveness of Section 1122 provisions combined with the redundancy of other federally funded programs consequently led Congress to develop a consolidated planning program that required each state to establish a mandatory CON process. This legislation, P.L. 93-641, passed in the latter part of 1974 and established a national system of local and state planning agencies that required a majority of members to be consumers.<sup>2</sup>

The 1980 presidential election saw a change in administration, which ultimately resulted in limited funding for the CON program through continuing resolutions. Eventually all financial support was stopped, effectively abolishing the program in 1986 in favor of competition in the health care market place.<sup>3</sup>

Following the demise of the federal law and with the renewed interest in local health planning and volunteerism in some states, the 1985 recommendations of the Health Care Cost Management Commission, which was created pursuant to an executive order issued by then Governor Michael Castle, were enacted through Senate Bill 132 and became law on July 2, 1987. This legislation established the state-only CON program with the Health Resources Management Council (HRMC).<sup>4</sup>

In 1993 the Sunset Committee sunset the HRMC, allowing a year to wrap up business before June 30, 2004. This period was extended by epilogue language until September 20, 1994. House Bill 331 enacted in September 1994, established the Delaware Health Resources Board (HRB) and provided a June 30, 1996 sunset date. Following the review of the CON program by the Delaware Health Care Commission (DHCC) in July 1996, House Bill 640 was enacted which provided for the phase out of CON and a sunset date of June 30, 1999. House Bill 640 also increased the threshold which would require a review.<sup>5</sup>

Senate Bill 74, enacted on June 24, 1999, replaced CON with Certificate of Public Review (CPR) and delayed the sunset date until June 30, 2002. SB 74 also eliminated several categories of providers from the process of review, permitted members of the HRB to serve for more than two consecutive terms, required reviews for all acquisitions of a nonprofit health care facilities,

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<sup>1</sup> JSC Questionnaire, Pg. 8

<sup>2</sup> JSC Questionnaire, Pg. 8

<sup>3</sup> JSC Questionnaire, Pg. 8

<sup>4</sup> JSC Questionnaire, Pg. 8

<sup>5</sup> JSC Questionnaire, Pg. 8

and added language to make explicit that a failure to comply with conditions which may be placed on the Board's approval of an application is grounds for revocation.

In 2002, the sunset provision was extended to 2005. In accordance with the May 31, 2005 Final Report by the Joint Sunset Committee, the sunset date was further extended to June 30, 2009.

On July 8, 2009, Senate Bill 181 was signed into law, removing the sunset provision on the Delaware Health Resources Board-Certificate of Public Review program.

### **Joint Sunset Committee Review History**

The Joint Sunset Committee (JSC) commenced a review of the HRMC in 1992. The JSC concluded in its 1993 Final Report that there was a need to develop a comprehensive health planning process and that the various commissions, councils and boards responsible for health planning should be brought under one umbrella for the purpose of centralizing health planning decisions. To date, this recommendation has not been implemented.

The JSC further agreed that the CON program and a regionally based health care planning process should be part of the state's comprehensive health plan. It therefore sunset the HRMC and with the passage of House Bill 331, initiated an overhaul of the CON program. Specifically, House Bill 331 established the HRB to assume the functions of the HRMC as the state's overseer of the CON process and made changes to CON policies. It vested the final CON decision making power solely with the Board rather than the previous policy in which the Bureau of Health Planning and Resources Management made final decisions based on HRMC recommendations. Additionally, the bill abolished the CON Appeals Board.

The JSC in its May 31, 2005 HRB Final Report made a number of recommendations, some of which were implemented through Senate Bill 181 and others which were implemented by Bureau of Health Planning and Resources Management staff. For example, Senate Bill 181 increased the dollar amount that triggers a review from \$5 million to \$5.8 million and provided the HRB with the authority to establish a charity care requirement. Staff carried out JSC recommendations to create and maintain a CPR website to facilitate public access to agendas, minutes, the CPR application and procedures.

The JSC also recommended that the HRB comply with the statutory requirement to coordinate health planning activities with the Delaware Health Care Commission (DHCC), DHSS and other health care organizations. This is partly achieved by Bureau of Health Planning and Resources Management staff attendance at DHCC meetings, and DHSS Office of Health Facilities Licensing and Certification staff attendance at HRB meetings. More importantly, coordination of HRB work with the DHCC, DHSS and other health care organizations is achieved through membership on the HRB. In early May 2011, in recognition of the need to coordinate health planning activities, Governor Markell appointed the chairperson of DHCC, the Director of the Division of Services for Aging and Adults with Physical Disabilities, as well as individuals representing hospice and the nursing profession to serve on the HRB.

## **Composition of the Health Resources Board**

The HRB consists of 21 members appointed by the Governor. Members are appointed for three year terms and shall represent all three counties. Members appointed to a position which has been vacated prior to the end of the previous member's term shall be appointed to serve the remaining portion of the unexpired term.

The membership structure of the HRB is intended to facilitate communication among various interest groups and state agencies.<sup>6</sup> Ten (10) Board members represent the public at large and cannot be involved in the delivery of health care, health care insurance or the purchasing of health care coverage for an employer with more than 200 employees.<sup>7</sup>

The statute stipulates that the remaining eleven (11) members represent the following:<sup>8</sup>

- 1 representative designated by the DHCC
- 1 representative designated by the Secretary of DHSS
- 1 representative of organized labor
- 1 representative of the health insurance industry
- 1 representative designated by the Delaware Healthcare Association
- 1 representative designated by the Medical Society of Delaware
- 1 representative designated by the Delaware Health Care Facilities Association
- 1 representative of a provider group other than hospitals, nursing homes, or physicians
- 1 representative designated by the State Chamber of Commerce
- 1 representative involved in purchasing health care coverage on behalf of state employees
- 1 representative involved in purchasing health care coverage for employers with more than 200 employees.

### **Chairperson and Other Officers**

The Governor designates a Chair and Vice Chair for the Board from among those members representing the public at large.

The Director of the Bureau of Health Planning and Resources Management in the Division of Public Health (DPH) serves as both the Secretary to the Board and Chief Administrative Officer.<sup>9</sup>

### **Removal of Members**

The statute does not have express language in regards to removing members from the HRB. A member can resign their position or request not to be reappointed upon the expiration of their term. The Governor can also decline to reappoint a member whose term has expired.

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<sup>6</sup> JSC Questionnaire, Pg. 17

<sup>7</sup> 16 Del. Code, § 9303(b)

<sup>8</sup> 16 Del. Code, § 9303(b)

<sup>9</sup> 16 Del. Code, § 9303 (c)

The Board's bylaws state that the HRB may request that the Governor declare a vacancy for any member who is absent from four consecutive meetings upon the recommendation of the membership.<sup>10</sup>

### **Compensation and Training**

Members may be reimbursed for mileage associated with their duties as Board members.<sup>11</sup> HRB members receive no additional compensation for their service.

Board members do not receive any special training opportunities; however, a survey of the HRB members was conducted in September 2011 to identify assets on the Board, with the intent to provide programmatic opportunities in which members' knowledge and expertise are shared for overall development.<sup>12</sup>

### **Health Resources Board Membership Roster**

<b>Name County/Party</b>	<b>Appointment Date</b>	<b>Term</b>	<b>Expiration Date</b>	<b>Qualification/Occupation</b>
Veronica F. Rempusheski, PhD, RN, FAAN, FGSA- New Castle/	05/02/2011	1	05/02/2014	Chair- Public At Large/ Professor, Chair of Nursing Science & Coordinator, College of Health Sciences, U of D
Harold Stafford Kent/Democrat	07/01/2011	1	07/01/2014	Vice Chair- Public At Large rep/ CEO at Stafford Firm; Former DOL Secretary
Bettina Riveros New Castle/Democrat	05/02/2011	1	05/02/2014	Health Care Commission rep/ Chair DHCC, Advisor to Governor
William Love New Castle/	05/21/2011	1	12/31/2011	DHSS rep/ Director, Division of Services for Aging & Adults with Physical Disabilities
David Hollen New Castle/ Democrat	10/28/2011	1	12/31/2011	Organized labor rep/ Red Zone Properties, LLC
<b><i>Vacant</i></b>				<b><i>Health Insurance Industry rep</i></b>
Suzanne Raab-Long New Castle/Independent	04/19/2004	2	11/13/2010	DE Healthcare Association rep/ Executive Vice President, DHA

<sup>10</sup> Bylaws of the Delaware Health Resources Board, Article IV, Section 7

<sup>11</sup> JSC Questionnaire, Pg. 29

<sup>12</sup> JSC Questionnaire, Pg. 29

Yrene Waldron New Castle/	05/13/1999	3	12/31/2011	DE Health Facilities Association rep/ Executive Director, DHFA
Sheila Grant New Castle/ Democrat	05/02/2011	1	05/02/2014	Provider Group rep (i.e. not hospitals, nursing homes or physician)/ Hospice Nurse Educator & VP of Hospice & Palliative Care of DE
Mark Thompson Kent/Republican	09/13/2011	1	12/31/2011	Medical Society of DE rep/ Manager of Community Relations & External Affairs Officer
Faith Rentz Kent/Democrat	04/25/2008	1	08/30/2008	State Employee Coverage rep/ Senior Health Policy Advisor, OMB
Brian Posey New Castle/Republican	05/26/2011	1	05/26/2014	Chamber of Commerce @ Large rep/ Associate State Director, AARP DE
Bedford Bruno Kent/Independent	07/05/2011	1	07/05/2014	Coverage for employers with more than 200 employees rep/ Director, Personal Care Products, Playtex at Energizes
John Walsh Sussex/Democrat	05/02/2011	1	05/02/2014	Public at Large rep/ VP, DE Manufactured Home Owners Association
Carolyn Casey New Castle/Democrat	07/01/2011	1	07/01/2014	Public at Large rep/ Director, Community Development & Housing Division NCC
Kyle Hodges New Castle/Democrat	09/13/2011	1	12/31/2011	Public at Large rep/ Director, State Council for Persons with Disabilities
Brenda Heckert Sussex/Republican	10/28/2011	1	01/05/2012	Public at Large rep/ Improvisational Performer
Gina Ward New Castle/Democrat	01/05/2012	1	05/02/2014	Public at Large rep/ St. Francis Hospital Board of Directors
Sarah Noonan New Castle/Democrat	10/26/2007	1	10/26/2010	Public at Large rep/ Deputy Director, Westside Family Healthcare

<i>Vacant</i>				<i>Public at Large rep</i>
<i>Vacant</i>				<i>Public at Large rep</i>

There are currently 3 vacancies on the Board for the following positions:<sup>13</sup>

- Health Insurance Industry representative: Vacated 04/30/09
- Public at Large representative: HRB staff is unsure when position was vacated
- Public at Large representative: HRB staff is unsure when position was vacated

In recent years, the HRB has averaged approximately six (6) vacant positions at any given time. These vacancies have included both the designated positions and the public at large representatives. Historically, there have been very few issues with members appointed to the Board who do not regularly attend the meetings, as absences usually occurred due to a Board member’s illness.<sup>14</sup>

**Health Resources Board Meetings and Subcommittees**

Per Article IV, Section 2 of the HRB bylaws, regular meetings of the Board will usually be held once a month; however, if there is no business to be conducted by the Board during a particular month the chairperson may cancel or postpone a meeting, provided the HRB will meet no less than four (4) times per year.<sup>15</sup>

Article IV, Section 3 of the bylaws stipulates that the chairperson may call a special meeting at any time. Also, a special meeting shall be called by the chairperson upon the written request of any eleven (11) HRB members.<sup>16</sup>

The Board also has the authority to create committees, task forces and work groups as outlined in Article 5, Section I in the HRB’s bylaws. Members of these committees, task forces and work groups shall be appointed by the chair and may include persons who are not members of the HRB.<sup>17</sup>

**Freedom of Information Act (FOIA) Compliance**

The Health Resources Board is FOIA compliant. All meetings are open to the public and agendas include time for public comment. Meeting agendas are distributed by email to interested parties via a distribution list which is maintained by the Bureau of Health Planning and Resources Management. Agendas are also posted on the HRB website and the state’s online Public Meeting Calendar. Tentative agendas are posted one week before each monthly meeting, with a disclaimer that they are subject to change. Minutes are developed by the staff of the Bureau of Health Planning and Resources Management and are available to the public on the web and by request as soon as they are approved by the Board. The public also has access to a variety of

<sup>13</sup> JSC Questionnaire, Pg. 26  
<sup>14</sup> Email from Judy Chaconas, received 12-7-11  
<sup>15</sup> Bylaws of the Delaware Health Resources Board, Article IV, Section 2  
<sup>16</sup> Bylaws of the Delaware Health Resources Board, Article IV, Section 3  
<sup>17</sup> Bylaws of the Delaware Health Resources Board, Article V, Section 1

materials posted on the HRB website, including a description of the program, the governing statute, guiding principles, relevant reports, agency membership, the application kit, monthly activity reports and various other materials.

The Bureau of Health Planning and Resources Management within DPH promptly responds to all FOIA requests on behalf of the HRB. All documents delivered to or created by the Board are considered public information, with the exception of legal advice that is provided by the Department of Justice and is considered attorney-client privileged information.<sup>18</sup>

The Board has entered in to executive session one time during the past three years; however, the Board does not deliberate in closed sessions. On September 16, 2011, in accordance with 29 Del. Code, §10004 (b)(4), the Board entered into executive session to receive legal advice from the Deputy Attorney General on the matter of the HRB being listed as appellee in the Notice of Appeal of the Board's decision on the application from HealthSouth Corporation.<sup>19</sup>

### **Administrative Procedures Act Compliance**

The HRB is not expressly covered by the Administrative Procedures Act (APA), as it is not listed in 29 Del. C. § 10161 (a). However, the HRB is statutorily required to implement the APA through its regulation changes as required pursuant to 29 Del. C. § 10161(b). Nonetheless, the HRB follows the APA guidelines for hearings and case decisions and the assigned Deputy Attorney General provides guidance on these processes.<sup>20</sup>

### **Public Integrity Act Compliance**

Every meeting agenda includes a "Conflict of Interest" item, at which time HRB members are asked to declare any conflict of interest that they may have with respect to the business scheduled to be heard and/or discussed by the Board at that particular meeting.

Article IV, Section 8 of the Board's bylaws defines conflicts of interest, with specific provisions regarding financial benefits for HRB members and/or their immediate family. If a HRB member and/or their immediate family could benefit financially from participating in the consideration of certain business before the Board, that member has an obligation to recuse themselves from those proceedings.

Janet Wright, Executive Director of the Public Integrity Commission (PIC) made a presentation and led discussion at the Board's November 12, 2009 meeting. At that time, the members were instructed on how to comply with Public Integrity Act outlined in 29 Del. Code, Chapter 58. Additionally, members of the HRB have had individual consultations with the PIC's Executive Director and a Board member recently sought an official opinion from the PIC regarding a potential conflict of interest.<sup>21</sup>

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<sup>18</sup> JSC Questionnaire, Pg. 14

<sup>19</sup> JSC Questionnaire, Pg. 14

<sup>20</sup> JSC Questionnaire, Pg. 13

<sup>21</sup> JSC Questionnaire, Pg. 15

Conflicts of interest do not usually hinder the ability for action to be taken on applications under consideration by the Board. However, two (2) HRB members have regularly expressed uncertainty as to what constitutes a conflict of interest.<sup>22</sup> One (1) member sought advice from the Executive Director of the PIC, and subsequently requested a formal opinion from the PIC on the same matter. The second HRB member has remained uncertain as to if/when they have a conflict and has asked for another presentation by the PIC before the Board. Ultimately, HRB staff anticipates that questions regarding conflicts of interest will likely re-occur in the future.<sup>23</sup>

There have been two (2) instances in the past three (3) years when the declaration of a conflict of interest prevented action from being taken on application that was scheduled to be heard at a specific meeting. Both instances were during the meeting held June 23, 2011, and were in regards to the HealthSouth application. As a result, two (2) votes were taken during the course of the meeting which resulted in a tie, with seven (7) members supporting the application and seven (7) members opposing. Later the PIC ruled that one HRB member, who had recused themselves from participating in the consideration of the HealthSouth application and whose request for a formal opinion from the PIC was pending at that time, could have voted on the application; however, the advice previously given by the PIC Executive Director on this issue differed from the subsequent ruling by the PIC. It is possible that had the other HRB member who had also recused themselves in regards to the HealthSouth application sought a ruling from the PIC, that member also could have voted. However, because of the uncertainty, and to err on the side of caution, neither voted during the June 23, 2011 meeting.<sup>24</sup>

### **Health Resources Board Staff**

Staff support for the HRB is provided by the Bureau of Health Planning and Resources Management in the Division of Public Health.

#### **Public Health Administrator I (FT merit employee)**

The public health administrator functions as the Director of the Bureau of Health Planning and Resources Management and, hence, Secretary and Administrative Officer to the Health Resources Board. This position ensures that HRB records and activities are recorded and filed, minutes and agendas are prepared, pertinent materials are distributed to committee members, etc. The position directs the review of applications, provides staff expertise on the CPR process, and ensures accuracy of the program mechanics. This position is funded with 100% federal appropriations received through a primary care grant.<sup>25</sup>

#### **Management Analyst III (FT merit employee)**

The full-time management analyst reviews applications for technical completeness, collects information from applicants needed to assure applications are complete prior to review by the Board, staffs review committee and Board meetings, helps prepare minutes, conducts research for use by the Board in evaluating applications and prepares review committee reports. The

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<sup>22</sup> Email from Judy Chaconas, received 12-7-11

<sup>23</sup> Email from Judy Chaconas, received 12-7-11

<sup>24</sup> Email from Judy Chaconas, received 12-7-11

<sup>25</sup> JSC Questionnaire, Pg. 32

position provides staff expertise on the CPR process and helps ensure accuracy of the program mechanics.<sup>26</sup>

### **Management Analyst III (PT casual seasonal employee)**

The casual seasonal management analyst tracks the approximately \$35,000 allocated for the program using revenue funds generated by fees collected by DPH. These funds are used for meeting refreshments, transcriptions services when needed, production of annual utilization statistical reports on Delaware nursing homes, assisted living facilities, rest residential facilities, mileage reimbursements, and other incidental costs.<sup>27</sup>

### **Administrative Assistant I (FT merit employee)**

The administrative assistant is responsible for maintaining files and tracking the multiple processes and deadlines associated with Board activities. This position is also responsible for working with Board members and the public to identify dates/locations for review committee meetings and board meetings, as well as other logistical arrangements.<sup>28</sup>

The effectiveness of the HRB has been hampered by a lack of staff assistance as the program has been downsized significantly over the years.<sup>29</sup> Program staff members routinely communicate about three issues:<sup>30</sup>

- 1) Insufficient resources to ensure that HRB-CPR activities are appropriately recorded and managed.
- 2) Difficulty in conducting analytical research to aid the Board's decision making.
- 3) Use of federal primary care and rural health grant funds to support staff assigned to the HRB; this is not within the scope of services for which these funds are appropriated to Delaware and it diminishes the ability to focus on improving primary care and rural health.

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<sup>26</sup> JSC Questionnaire, Pg. 31

<sup>27</sup> JSC Questionnaire, Pg. 31-32

<sup>28</sup> JSC Questionnaire, Pg. 32

<sup>29</sup> JSC Questionnaire, Pg. 32

<sup>30</sup> JSC Questionnaire, Pg. 32

## Fiscal Information

Total operating costs for the HRB were \$170,174 in FY 2009, \$166,055 in FY 2010, and \$170,165 in FY 2011. Expected costs for FY 2012 are \$175,250.<sup>31</sup> Expenditures by line item for FY 2012, FY 2011 and FY 2010 are provided in the table below.<sup>32</sup>

<b>FY 2012 Expenditures (Budgeted)</b>		<b>FY 2011 Expenditures (Actual)</b>		<b>FY 2010 Expenditures (Actual)</b>	
Salaries/Fringe	\$72,738	Salaries/Fringe	\$72,063	Salaries/Fringe	\$70,079
Mileage	\$1400	Mileage	\$1297	Mileage	\$874
Other Prof Services	\$6000	Other Prof Services	\$626	Other Prof Services	\$0
Postage	\$600	Postage	\$462	Postage	\$490
Phone	\$1980	Phone	\$1980	Phone	\$1970
Computer	\$480	Computer	\$480	Computer	\$480
Advertising	\$1500	Advertising	\$1348	Advertising	\$114
Food	\$550	Food	\$812	Food	\$950
Subscription	\$638	Subscription	\$638	Subscription	\$138
<b>Total:</b>	<b>\$85,886</b>	<b>Total:</b>	<b>\$79,706</b>	<b>Total:</b>	<b>\$75,095</b>

Revenue is generated through the collection of filing fees for capital expenditure applications. All filing fees collected are deposited into the General Fund. Within five (5) working days of determining that an application is complete, the Bureau will notify the applicant of any filing fee due. Filing fees are due 30 days after the notification date for the beginning of the review and may be extended up to ten (10) additional days at the discretion of the Bureau. Applications for which the filing fee has not been paid within this timeframe are considered to be withdrawn. Below is a table outlining the capital expenditure application filing fees, for which the current fee amounts have been in place for more than 23 years.<sup>33</sup>

<b>Capital Expenditures</b>	<b>Filing Fee</b>
Less than \$500,000	\$100
\$500,000 to \$999,999	\$750
\$1,000,000 to \$4,999,999	\$3,000
\$5,000,000 to \$9,999,999	\$7,500
\$10,000,000 and over	\$10,000

The total revenue generated from the filing fees was \$10,000 in FY 2009, \$17,500 in FY 2010 and \$45,000 in FY 2011. The projected revenue for FY 2012 is \$6,000, and includes one actual fee in the amount of \$3,000, as well as an anticipated fee of \$3,000 related to a letter of intent. Further projection is not feasible due to the lack of correlation between past and future submission of applications.<sup>34</sup>

The *Evaluation of Delaware's Certificate of Public Review Program* conducted in November 2008 found that Delaware's revenue from CPR application fees significantly lags behind that of

<sup>31</sup> JSC Questionnaire, Pg. 34

<sup>32</sup> JSC Questionnaire, Pg. 34-35

<sup>33</sup> 16 Del. Code, § 9305 (10)

<sup>34</sup> JSC Questionnaire, Pg. 36

other states. Upon the completion of that evaluation, the HRB was presented with several options to revise the fees; however the Board took no action at that time. In 2010, the Board reviewed another proposal to increase the fees and again did not take any action on this issue.<sup>35</sup>

Per information provided by the HRB, the fee amount and structure needs to be updated and revised. The fees should be increased to cover the cost of operations, including staff positions and contractual needs. Legislative involvement and approval is necessary to revise the fees.<sup>36</sup>

### **Purpose, Goals and Organization**

As stated in 16 Del. Code, §9301, the purpose of the HRB is to assure that there is continued public scrutiny of certain health care developments which could negatively affect the quality of health care or threaten the ability of health care facilities to provide services to the medically indigent. This public scrutiny is to be focused on balancing concerns for cost, access and quality.

The goal of the HRB is to foster the cost-effective and efficient use of health care resources and the availability of and access to high quality and appropriate health care services.<sup>37</sup> Pursuant to 16 Del. Code, §9303 (c), HRB is constituted as an independent public instrumentality and is housed within the Bureau of Health Planning and Resources Management in DHSS for administrative and budgetary purposes only. However, effective November 1, 2011, the Bureau of Health Planning and Resources Management moved to the Director's Office in DPH. DPH Director Dr. Karyl T. Rattay, in announcing the change on October 13, 2011, wanted to help bring greater visibility and direction to one of the strategic priorities of the Division, health reform. While a new mission and vision for this Bureau is under development, it will likely include the promotion of prevention in the delivery of health care services, as well as coordinating health reform initiatives that are occurring elsewhere in the Division.<sup>38</sup>

### **Duties and Responsibilities**

The duties and responsibilities of the HRB, pursuant to 16 Del. Code, § 9903 (d) (1) – (6), are listed in italics below, with detailed information immediately following in regards to how the Board is meeting each of the statutorily mandated duties and responsibilities:<sup>39</sup>

- 1) Develop a Health Resources Management Plan which shall address the supply of health care resources, particularly facilities and medical technologies, and the need for such resources.*

HRB maintains a Health Resources Management Plan, last updated March 6, 2010, which includes the current supply and projected need for hospital beds and nursing home beds. It also includes a formula for determining the need for freestanding surgery centers. The methodology

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<sup>35</sup> JSC Questionnaire, Pg. 38

<sup>36</sup> JSC Questionnaire, Pg. 38

<sup>37</sup> JSC Questionnaire, Pg. 16

<sup>38</sup> JSC Questionnaire, Pg. 6

<sup>39</sup> JSC Questionnaire, Pg. 20-21

used is largely based on the state's bed-to-population ratio and takes into account age-specific utilization rates, occupancy rates and predicted future population growth. The Board has identified new areas to be addressed in the Health Resources Management Plan and provides an opportunity for and consideration of public comment through the conduct of a public meeting. The statute requires the plan to then be submitted to the DHCC for review. Finally, it is sent to the Secretary of DHSS upon whose signature the Plan becomes effective.

- 2) ***Review Certificate of Public Review applications filed pursuant to this Chapter and make decisions on same. Decisions shall reflect the importance of assuring that health care developments do not negatively affect the quality of health care or threaten the ability of health care facilities to provide services to the medically indigent.***

The CPR is a document issued to a successful applicant authorizing the proposer organization/individual to undertake the project that has been determined to be in the best interest of the community. Per the information provided by the HRB, CPRs are necessary in order to control the increase in health care costs while striving to ensure the availability of and access to high quality and appropriate health care services.<sup>40</sup>

- 3) ***Gather and analyze data and information needed to carry out the Board's responsibilities. Identify the kinds of data which are not available so that efforts can be made to assure that legitimate data needs can be met in the future.***

This work is done by Bureau staff for the Board or by Board members.

- 4) ***Address specific health care issues as requested by the Governor or the General Assembly.***

To date, the Board has not received any requests to address specific health care issues from the Governor or the General Assembly.

- 5) ***Adopt bylaws as necessary for conducting its affairs.***

The Board has bylaws for conducting its business and operates in compliance with both the provisions set forth in 29 Del. C. c. 58 and 29 Del. C. c. 100. The bylaws were last updated June 28, 1999.

- 6) ***Coordinate activities with the Delaware Health Care Commission, the Department of Health and Social Services and other groups as appropriate.***

Prior to the adoption of the Health Resources Management Plan, the Board coordinated with the DHCC. The Board sends the Health Resources Management Plan to DHSS for approval before adoption by the Board. The Board coordinates activities with other groups such as the Delaware Health Care Association, informally and through its membership structure.

Changes to the bylaws and the governing statute have not officially been proposed at this time; however, the bylaws should be reviewed to ensure consistency with the statute. For example, the

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<sup>40</sup> JSC Questionnaire, Pg. 20-21

bylaws currently limit the number of terms a member can serve, while term limitations are not addressed in the governing statute.<sup>41</sup>

There is an on-going conversation about the need to either discontinue or make significant changes to the HRB - CPR program. If continued, the Health Resources Management Plan should also be reviewed and updated along with other relevant documents (application kit, statutorily set list of health facilities subject to review, the review criteria and process of review, fee structure, etc.).<sup>42</sup>

DHSS believes the HRB and the CPR process should be components of a comprehensive health planning system in Delaware. DHSS is interested in working with the HRB to review the current Health Resources Management Plan to determine if the plan supports the development of health services that are cost effective and are consistent with meeting consumer needs and choice (e.g. the growing consumer demand for home-based services).<sup>43</sup>

Per the information provided in the JSC questionnaire, the Governor also recognizes the need to make sure the HRB has all its members appointed and that the Board needs to retain its vitality over time. Consistent with this, the Governor has recently made several new appointments, which will bring new ideas and skills the Board needs.<sup>44</sup>

### **CPR Review Process**

A CPR is required for the following activities:<sup>45</sup>

- The construction, acquisition, development, or other establishment of a health care facility or the acquisition of a nonprofit care facility.
- Any expenditure by or on behalf of a health care facility, not including a medical office building, in excess of \$5,800,000, which is considered a capital expenditure. Expenditures in excess of \$5,800,000 may be exempt from review if they are necessary to maintain the physical structure of a facility and are not directly related to patient care.
- A change in bed capacity of a health care facility which increases the total number of beds (or distributes beds among various categories, or relocates such beds from one physical or site to another) by more than 10 beds or is more than 10% of total licensed bed capacity, whichever is less, over a 2-year period.
- The acquisition of major medical equipment; does not include the replacement of major medical equipment nor major medical equipment acquired by a business or industrial establishment for a dispensary or first aid station, for use by students, employees of a school or university or by inmates and employees of a prison.

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<sup>41</sup> JSC Questionnaire, Pg. 10

<sup>42</sup> JSC Questionnaire, Pg. 10

<sup>43</sup> JSC Questionnaire, Pg. 10

<sup>44</sup> JSC Questionnaire, Pg. 10

<sup>45</sup> JSC Questionnaire, Pg. 39

### **Notice of Intent/Applications for Review**

At least 30 days prior to submitting an application, applicants are required to submit a notice of intent in regards to the scope and nature of the project to the Bureau of Health Planning and Resources Management. Applications can be submitted less than 30 days from the submission of the notice, with the written approval by the HRB. A notice of intent expires if an application is not received within 180 days.<sup>46</sup>

### **Deadlines and Time Limitations**

Upon receipt of an application, the Bureau has a maximum of fifteen (15) days to notify the applicant as to whether or not their application is considered complete.<sup>47</sup> If incomplete, applicant will be notified as such and will be advised of the additional information that is required to complete the application.<sup>48</sup>

### **Agency Review/Notification**

Within five (5) working days after determining an application is complete, the Bureau will provide written notification of the beginning of a review. Notification shall be sent directly to all health care facilities and all others who request direct notification. A notice is also placed in the newspaper which also serves as both the public notice and the official date of notification.<sup>49</sup> Applications are required to be reviewed within 90 days of notification. If a public hearing is requested, the review period is extended to 120 days. The HRB may also extend the review period up to 180 days to allow for the development of appropriate review criteria or to facilitate the simultaneous review of similar applications. The maximum review period can be extended as mutually agreed to in writing by the Board and the applicant.<sup>50</sup>

In conducting reviews, the Board considers the following:<sup>51</sup>

- (1) The relationship of the proposal to the Health Resources Management Plan.
- (2) The need of the population for the proposed project.
- (3) The availability of less costly and/or more effective alternatives to the proposal.
- (4) Including alternatives involving the use of resources located outside the state.
- (5) The relationship of the proposal to the existing health care delivery system.
- (6) The immediate and long-term viability of the proposal in terms of the applicant's access to financial, management and other necessary resources.
- (7) The anticipated effect of the proposal on the costs of and charges for health care.
- (8) The anticipated effect of the proposal on the quality of health care.

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<sup>46</sup> 16 Del. Code, § 9305 (1)

<sup>47</sup> 16 Del. Code, § 9305 (3)

<sup>48</sup> 16 Del. Code, § 9305 (3)

<sup>49</sup> 16 Del. Code, § 9305 (4)

<sup>50</sup> 16 Del. Code, § 9305 (3)

<sup>51</sup> 16 Del. Code, § 9306

With respect to applications submitted to address an emergent situation, the Chair or Vice Chair of the HRB is authorized to render a decision stating if the application is a true emergency and if the application will or will not be approved. The Chair or Vice Chair shall have discretion with respect to the decision making process and is required to render a decision within 72 hours.<sup>52</sup>

### **Public Hearing in the Course of a Review**

Within ten (10) days after the date of notification, a public hearing can be requested by any person in writing. A public hearing notice will be published in the newspaper, and the hearing will take place within fourteen (14) days of the publication. Any person is permitted to speak at the public hearing.<sup>53</sup>

### **Findings**

Upon the completion of an application review, the Bureau shall notify the applicants and other interested parties in writing regarding the HRB's decision, including the basis on which the decision was made. Decisions can be conditional (e.g. requirements for a charity care policy, participation in the Delaware Medicaid Program, sliding fee scale for indigent uninsured patients, etc.) but the conditions must be related to the specific project in question.<sup>54</sup>

### **Administrative Reconsideration/Appeal**

Requests for administrative reconsideration must be received within ten (10) days of the Board's decision and any hearing for the purposes of reconsideration must commence within 45 days of the request. In order for an administrative hearing to be granted, a person must show there is new evidence to consider that previously was not available which significantly changes the factors the Board relied upon to render its decision, or prove that the Board did not follow the established protocol set forth in the governing statute or bylaws.<sup>55</sup>

A decision by the HRB following the review of an application may be appealed within 30 days to Superior Court. Such appeal shall be on the record. As currently written, and upheld by the courts, the statute limits the right of appeal to the applicant.<sup>56</sup>

### **CPR-Period of Effectiveness**

A CPR shall be valid for one (1) year from the date such approval was granted. At least 30 days prior to the expiration of the CPR, the applicant shall inform the Board in writing of the project's status. The Board will determine if sufficient progress has been made for the CPR to continue in effect. If sufficient progress has not been made, the applicant may submit a request in writing to the Board for a six (6) month extension. The HRB shall either allow the certificate to expire or grant such extension.<sup>57</sup> A decision by the Board to deny an extension may be appealed pursuant to 16 Del. Code, § 9305(8).

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<sup>52</sup> 16 Del. Code, § 9305 (3)

<sup>53</sup> 16 Del. Code, § 9305 (6)

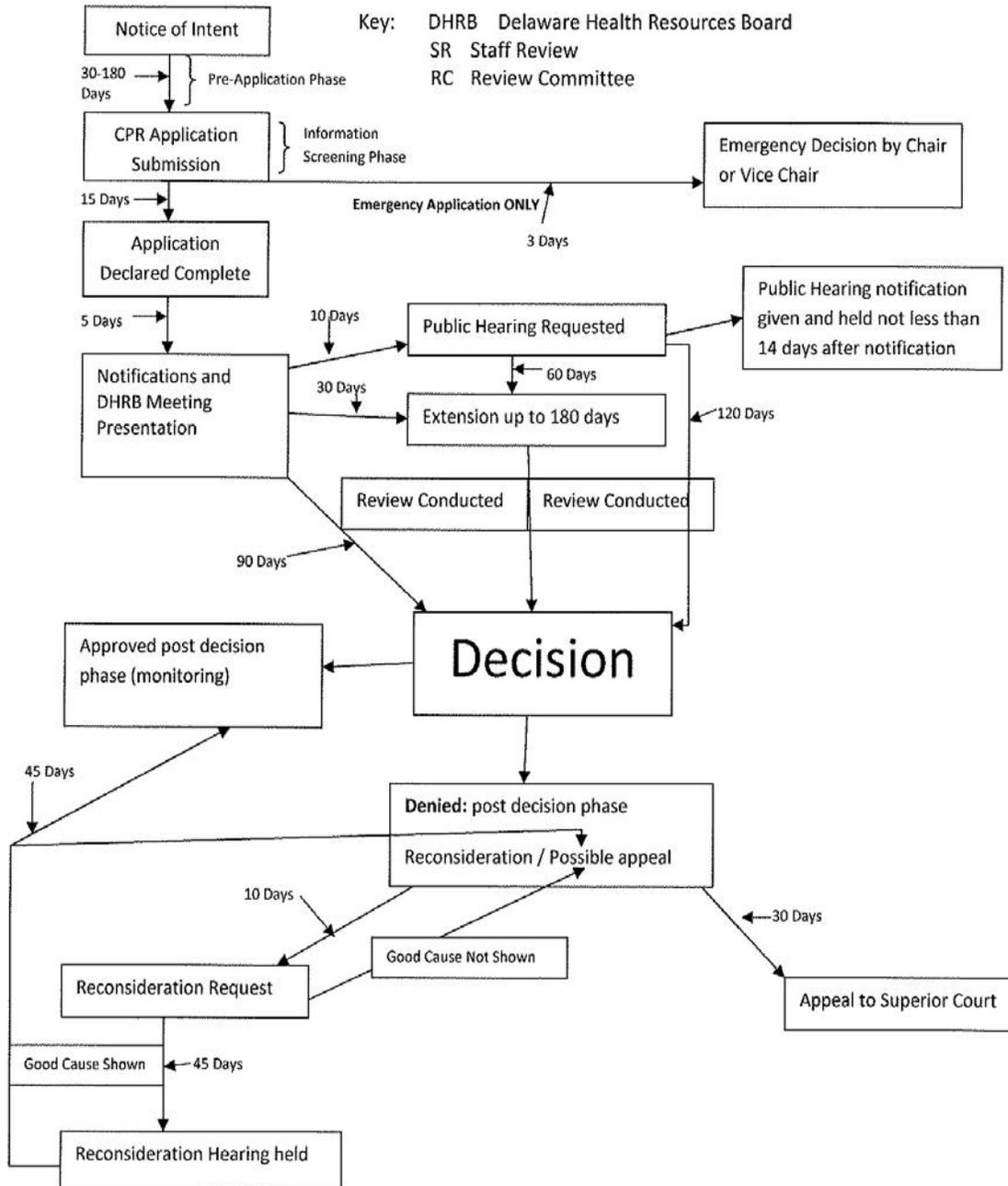
<sup>54</sup> 16 Del. Code, § 9305 (5)

<sup>55</sup> 16 Del. Code, § 9305 (7)

<sup>56</sup> JSC Questionnaire, Pg. 42

<sup>57</sup> JSC Questionnaire, Pg. 41

# CPR Review Process



## CPR Program Data

	2008	2009	2010	2011
<b>Notice of Intent Letters Received</b>				
Construction, development or other establishment of health care facility	0	2	2	1
Acquisition of a nonprofit health care facility	0	0	1	0
Capital Expenditures in excess of \$5.8 million	1	1	0	1
Change in bed capacity	0	2	2	3
Acquisition of major medical equipment	1	0	2	1
<b>Applications Received</b>				
Construction, development or other establishment of health care facility	0	1	1	2
Acquisition of a nonprofit health care facility	0	0	0	0
Capital Expenditures in excess of \$5.8 million	1	1	0	1
Change in bed capacity	0	0	2	3
Acquisition of major medical equipment	1	0	1	0
<b>Public Hearings Requested</b>				
Construction, development or other establishment of health care facility	0	0	0	1
Acquisition of a nonprofit health care facility	0	0	0	0
Capital Expenditures in excess of \$5.8 million	0	0	0	0
Change in bed capacity	0	0	0	0
Acquisition of major medical equipment	0	0	0	0
<b>Applications Approved</b>				
Construction, development or other establishment of health care facility	0	0	2	2
Acquisition of a nonprofit health care facility	0	0	1	0
Capital Expenditures in excess of \$5.8 million	1	1	0	0
Change in bed capacity	0	0	2	1
Acquisition of major medical equipment	1	0	1	0
<b>Applications Denied</b>				
Construction, development or other establishment of health care facility	0	0	0	0
Acquisition of a nonprofit health care facility	0	0	0	0
Capital Expenditures in excess of \$5.8 million	0	0	0	0
Change in bed capacity	0	0	0	0
Acquisition of major medical equipment	0	0	0	0
<b>Requests for Administrative Reconsideration</b>				
Construction, development or other establishment of health care facility	0	0	0	1
Acquisition of a nonprofit health care facility	0	0	0	0
Capital Expenditures in excess of \$5.8 million	0	0	0	0
Change in bed capacity	0	0	0	0
Acquisition of major medical equipment	0	0	0	0
<b>Appeals filed in Superior Court</b>				
Construction, development or other establishment of health care facility	0	0	0	1
Acquisition of a nonprofit health care facility	0	0	0	0
Capital Expenditures in excess of \$5.8 million	0	0	0	0
Change in bed capacity	0	0	0	0
Acquisition of major medical equipment	0	0	0	0

## CON/CPR Programs in Other States

Currently, there are 14 states without and 36 states with a CON/CPR program. The states without a CON/CPR program rely on the free market as well as licensure and regulations to ensure quality. Business entities establish new facilities, expand existing ones and purchase medical equipment at their own risk. Licensing does slow growth, as it can take months and sometimes years to be surveyed, pass inspection and become licensed. In Idaho, it can take up to two (2)

years before a new nursing home is inspected and Minnesota currently has a moratorium on nursing homes.<sup>58</sup> If there is a critical need for a certain type of facility in a particular location, such a facility may float to the top of the inspection list, which is part of the licensure process, while others wait in line. Some states issue a Request for Applications when there is a critical need for a particular type of facility.<sup>59</sup>

In Pennsylvania, CON activities were transferred to the state's licensure and regulations divisions in 1996; however licensure and regulations divisions do not get involved in need analysis. Instead, the hope is that entities have evaluated how they are going to secure enough patients to be successful.

In the state of Washington, the Ninth Circuit Court of Appeals has lent some credibility to a lawsuit filed by a hospital against the state's Department of Health. The lawsuit alleges that a CON regulation unreasonably burdens interstate commerce and so violates the Constitution's "dormant" Commerce Clause, which grants Congress authority to regulate interstate commerce, thereby limiting the ability of states to do so. In the decision issued August 22, 2011, the court of appeals ruled state certificate of need regulations will be struck down as unconstitutional if they impose more than an incidental burden on interstate commerce. After the ruling, the case was sent back to district court where the hospital will have the burden of proving that the state's disputed CON regulation imposes a burden on interstate commerce that is clearly excessive in relation to the putative local benefits of such regulation.<sup>60</sup>

A research brief released in May 2011 found that various stakeholders from states with CON programs across the country thought their state's program tended to be influenced heavily by political relationships. This held true for every state, with the exception of Michigan. Respondents from Michigan cited several elements of the state's CON apparatus that contribute to greater objectivity and transparency. Michigan divides responsibility for setting CON review standards and the actual review of CON applications between an appointed commission and the State Department of Community Health, respectively. The commission members include representatives of hospitals, physicians, health care providers, employers and labor. Researchers also cited Michigan with having the most systematic approach to evaluating and updating CON requirements. The appointed CON commission evaluates the review standards for modification on a three-year rotating schedule and has the authority to recommend revisions to the list of covered clinical services subject to CON review. Finally, Michigan recently shifted to an electronic filing system, and the response to this was overwhelmingly positive because of increased transparency and efficiency of the process overall.<sup>61</sup>

### **Reviews/Audits of Delaware's CON/CPR Process**

In 1996, the DHCC put forth a recommendation, which resulted from the *Evaluation of Certificate of Need and Other Health Planning Mechanisms* report by the Cost Containment Committee, to eliminate the CON program in gradual phases. The review concluded that

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<sup>58</sup> JSC Questionnaire, Pg. 46

<sup>59</sup> JSC Questionnaire, Pg. 46

<sup>60</sup> *Court Holds Certificate of Need Laws May Be Unconstitutional* by Douglas Ross & Charles White, 8/23/11

<sup>61</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?* By Tracy Yee, Lucy Stark, Amelia Bond, Emily Carrier- May 2011

sufficient evidence did not exist to demonstrate that CON contains costs. The effort to eliminate the CON process failed, as the hospital association lobbied for its continuation. Instead, legislation was passed that changed the program from a CON to a CPR and increased the dollar amount threshold that triggers a CPR from \$750,000 to \$5.8 million. Additionally, the activities subject to review were somewhat reduced as well.<sup>62</sup>

The *Delaware Certificate of Public Review Policy Options Review*, dated November 2008, provided information needed by DPH in the formation of an opinion to share with the JSC on how to manage the impending sunset of the CPR program. The following abbreviated list of recommendations is the product of the 2008 review:<sup>63</sup>

- Recommendation 1: DHSS should propose legislation that allows for a two year review of health planning systems for the purpose of devising a plan for a fully coordinated and comprehensive health planning process.
- Recommendation 2 (Option A): If CPR is to be continued, it is recommended that a mechanism for determining system costs be devised. Lowering thresholds for CPR is one way to move toward this goal.
- Recommendation 2 (Option B): If CPR is discontinued, some mechanism needs to be devised for assuring consumer access to medical health care “goods” and that some procedures should be rendered in high-volume environment should be considered.
- Recommendation 3: If CPR is maintained, consider extending CPR to services, not facilities and technology, and add assisted living as a reviewed service.

Secondary Recommendations included:<sup>64</sup>

- Recommendation 5: Close the loop-hole which allows for adding other specialties on to a single specialty certificate.
- Recommendation 6: Mandate annual updates to Health Resource Board Plan with population trends, inpatient and outpatient utilization data, and cost analyses.
- Recommendation 7: A sub-group should immediately be convened to study nursing home capacity and make recommendations to stimulate capacity so that consumer choice and quality is more likely to occur.

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<sup>62</sup> JSC Questionnaire, Pg. 47

<sup>63</sup> JSC Questionnaire, Pg. 23

<sup>64</sup> JSC Questionnaire, Pg. 23-24

## CON/CPR Programs: Pro vs. Con

<ul style="list-style-type: none"> <li>➤ Some believe that health care is not like other businesses that can be regulated by market forces alone. A large portion of health care services are paid for by the government. The government does not pay market prices and not every line of health care services is profitable, thus market forces alone do not always allocate health resources appropriately or equitably.<sup>65</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Others believe that market competition will have a positive influence on containing costs and improving the quality of care. There is a move toward consumers purchasing health savings accounts with larger deductibles, leading to increased price awareness and sensitivity, as well as an interest in improved transparency of health care costs.<sup>66</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ There is a general perception that the CPR Program may have a “sentinel effect” by discouraging new service providers who might otherwise be tempted to build health care facilities in Delaware if they knew they did not have to undergo the CPR process and the agency’s scrutiny.<sup>67</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ The CPR Program has a history of approving almost every application that comes before it. In the past five years there have been no denials.<sup>68</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ Some believe that the CPR Program could be used as a tool to limit the number of nursing homes in the state of Delaware.<sup>69</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Elimination of the agency would have a positive impact on the ability of the DHSS/Division of Public Health to carryout activities designed to improve the delivery of preventive and primary care and focus on health system change, including the development of medical homes.<sup>70</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ For-profit acquisitions of not-for-profit health care facilities also may be discouraged by the CPR Program’s existence.<sup>71</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Staff assigned to the CPR Program would be able to devote their time to working on health care reform, primary care and prevention.<sup>72</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ Very recently, the Board has begun using the CPR Program to make significant changes to the health system by attaching conditions to the approval of applications (e.g. charitable care requirements, coordinated outreach, etc.).<sup>73</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ It has long been known that the fees do not cover the salary of staff designated to support the Board nor do they cover the cost of contractual research that could be provided, if funds were available, to inform Board decisions.<sup>74</sup></li> </ul>

<sup>65</sup> JSC Questionnaire, Pg. 45

<sup>66</sup> JSC Questionnaire, Pg. 45

<sup>67</sup> JSC Questionnaire, Pg. 45

<sup>68</sup> JSC Questionnaire, Pg. 47

<sup>69</sup> JSC Questionnaire, Pg. 46

<sup>70</sup> JSC Questionnaire, Pg. 51

<sup>71</sup> JSC Questionnaire, Pg. 47

<sup>72</sup> JSC Questionnaire, Pg. 51

<sup>73</sup> JSC Questionnaire, Pg. 47

<sup>74</sup> JSC Questionnaire, Pg. 38

<ul style="list-style-type: none"> <li>➤ The CPR process provides an opportunity for the public to become aware of and weigh in on major health care developments. This is particularly evident during the review of contested applications (e.g. the establishment of a surgery center in Seaford and an inpatient rehabilitation hospital in Middletown.).<sup>75</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ In 1996, the DHCC’s Cost Containment Committee reviewed the Delaware CON Program and recommended that the program be phased out. The review concluded that sufficient evidence does not exist to demonstrate that CON contains costs.<sup>76</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ There is concern that elimination of CON would result in a surge of new health facilities, including freestanding surgery centers, and that Delaware hospitals would face increased competition from for profit hospitals.<sup>77</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Research conducted in regards to the success of CON/CPR Programs has been inconclusive, and often produced disparate findings.<sup>78</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ There is research evidence that the death rate among patients who have cardiac surgery is higher in states without certificate of need. This is because the certificate of need process can help to keep such procedures in high volume hospitals.<sup>79</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ CON Programs tend to be influenced heavily by political relationships, such as provider’s clout, organizational size, or overall wealth and resources, rather than policy objectives.<sup>80</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ Some experts have concluded that CON/CPR regulations do protect access to safety net hospitals and access to care in rural communities.<sup>81</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Hospitals typically view CON/CPR regulations opportunistically and are more likely to use this process to block competitors.<sup>82</sup></li> </ul>
<ul style="list-style-type: none"> <li>➤ CON Programs set standards for project planning, which helps to ensure access to care and quality standards.<sup>83</sup></li> </ul>	<ul style="list-style-type: none"> <li>➤ Most physicians likely view the CON process as overly restrictive, delaying access to the most advanced equipment and making it difficult to recruit top-tier specialists.<sup>84</sup></li> </ul>

## **Complaints**

A formal complaint would be presented in the form of an appeal of a decision by the Board. Appeals are managed by the Department of Justice and the courts. In the last three years, the Board has not received any written complaints from applicants or members of the public.<sup>85</sup>

Recently, an attorney for an applicant shared their concerns that the CPR program, including the process for having an application deemed complete and the review process itself, required too much detail and was too lengthy.<sup>86</sup>

<sup>75</sup> JSC Questionnaire, Pg. 50

<sup>76</sup> JSC Questionnaire, Pg. 24

<sup>77</sup> JSC Questionnaire, Pg. 50

<sup>78</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 2

<sup>79</sup> JSC Questionnaire, Pg. 45

<sup>80</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 2

<sup>81</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 6

<sup>82</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 4

<sup>83</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 7

<sup>84</sup> *Health Care Certificate-of-Need Laws: Policy or Politics?*, Pg. 5

<sup>85</sup> JSC Questionnaire, Pg. 44

<sup>86</sup> JSC Questionnaire, Pg. 44

In addition, the ruling on voting on an application that resulted in two (2) tie votes generated confusion and complaints. Using a “new standard” for achieving a quorum (majority of 21 statutory members, as opposed to appointed members) has also resulted in verbal complaints, from an applicant and Board members.

### **Accomplishments**

Per the HRB, below is a list of the three most significant accomplishments of the Board:<sup>87</sup>

- HRB historically has taken pride in its ability to review and make decisions on detailed applications within timelines set forth in the statute with the intent of achieving the best possible outcomes for Delawareans. The process is often very difficult as the Board must review not only the information provided by the applicants but also conduct its own independent research so as to assess the full impact of a proposed project on the broader effort to ensure access to a high quality, cost efficient health care system.
- Development of a Charity Care Policy and Charity Care Implementation Requirements for freestanding health care facilities and incorporation of these materials into the Health Resources Management Plan.
- Development of Freestanding Surgery Center “need” criteria, and incorporation of such into the Health Resources Management Plan.

### **Challenges**

Per the HRB, below is a list of the top challenges the Board is currently facing:<sup>88</sup>

- The statute calls for the Director of the Bureau of Health Planning and Resources Management to function as the Secretary to the Board and its Chief Administrative Officer. The individual in this position is funded 100% with federal funds through the Primary Care Services Resource Coordination and Development Grant. Ideally, this individual would spend the bulk of their time working on activities to improve the delivery of primary care and on health prevention activities. Instead, 85-90% of her time is consumed by activities to support the CPR program and the HRB. Similarly, the administrative specialist assigned to the Board is fully funded with federal grant funds provided to Delaware for other purposes. More staff and/or funding are also needed to develop analytic reports, develop methodology to determine need and perform other activities for the Board to inform its decision making.
- As a statutory Board of 21 members, achieving a quorum requires 11 members. Recusals do not count toward a quorum. The Board’s bylaws state that the “presence of at least 50 percent of the members of the Board shall constitute a quorum,” and the Board has

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<sup>87</sup> JSC Questionnaire, Pg. 17- 18

<sup>88</sup> JSC Questionnaire, Pg. 18-19

interpreted this to mean 50 percent of appointed members. Decisions on applications in the past have been made using the definition of quorum in the bylaws; however, a recent opinion by the Deputy Attorney General clarified that a majority of the statutory members is needed to meet the quorum requirement.

- The statute lists a minimum of seven (7) factors that must be considered during the review of an application. In some cases the items are difficult to assess. For example, Review Criteria #6 is the “anticipated effect of the proposal on the costs of and charges for health care.” This is of critical importance given the present cost of health care; however it is challenging to gauge and there is much debate over whether the establishment of a health service will increase the demand for a service, and thereby increase health care costs and charges. There is also significant discussion regarding the role of competition in the marketplace. Review Criteria #7 requires the Board to consider the “anticipated effect of the proposal on the quality of health care”, which is also difficult to gauge and ideally is assessed through licensure, inspection and accreditation.
- 16 Del. Code §9305 (8) has been interpreted by the courts to mean that only an applicant can appeal a Board decision.
- There is a technical error in 16 Del. Code, §9304 (1), which lists the type of activities subject to review including “the acquisition of a nonprofit health care facility.” The historical purpose of this clause was to assure that for-profit acquisitions of not-for-profit facilities were reviewed, but not not-for-profit acquisitions of another not-for-profit. The thinking behind this was that for-profit facilities are mostly interested in making a profit and may not be as focused on charitable care or community benefit as a not-for-profit. However, several years ago it was determined by a Deputy Attorney General that technically all acquisitions of not-for-profits were subject to review.

### **Opportunities for Improvement**

Per the HRB, below is a list of possible opportunities for improvement:<sup>89</sup>

- Additional staff resources are needed to meet the responsibilities of the Board, including the need to develop analytic reports for the Board to inform its decision making. Also, effort should be made to identify staff persons whose budget positions are funded by General Funds or increase application filing fees to cover the operations which include the salaries of staff positions that support the CPR program and the Board. The fees have never been increased and pursuant to 16 Del. Code §9305 (10), all filing fees are deposited into the General Fund.
- Evaluate the purposes of the CPR program, the activities that are subject to review and the review criteria considered during the course of a review. Revise as necessary to assure that the CPR program supports and is in synch with the state’s health policy goals.

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<sup>89</sup> JSC Questionnaire, Pg. 19

- Appoint members to fill the vacancies on the Board. There has been discussion about reducing the size of the HRB; however, it has also been noted that the current composition set forth in statute is carefully balanced, with eleven (11) members designated by organizations and ten (10) members representing the public at large.
- Revise the timelines and deadlines in the statute to enable the Board to meet quarterly instead of monthly. Procedures to review, including deadlines and time limitations in the statute, currently require the HRB to meet monthly in order to conduct business in a manner that is in compliance with the law.