The Illinois Task Force on Health Planning Reform

Pursuant to
Public Act 095-0005

Co-chairs:
Senator Susan Garrett, *Co-Chair*
Representative Lisa Dugan, *Co-Chair*

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Illinois Task Force on Health Planning Reform Members

Committee Members

Member	Affiliation
Sen. Susan Garrett, Co-Chair	State Senate (D)
Rep. Lisa Dugan, Co-Chair	State House of Representatives (D)
Gary Barnett	Sara Bush Lincoln Health Center
Kenneth Robbins	Illinois Hospital Association
Jay Doherty	City Club of Chicago
Sister Sheila Lyne	Mercy Hospital and Medical Center
Hal Ruddick	SEIU Local #4
Donna Thompson	Access Community Health Network
Sen. Pamela Althoff	State Senate (R)
Sen. Bill Brady	State Senate (R)
Rep. Louis Lang	State House of Representatives (D)
Rep. Brent Hassert	State House of Representatives (R)
Rep. Renée Kosel	State House of Representatives (R)
Claudia Lenhoff	Champaign County Health Care Consumers
William McNary	Citizen Action Illinois
Heather O'Donnell	Center for Tax and Budget Accountability
Margie Schaps	Health and Medicine Policy Research Group
Lisa Madigan represented by Paul Gaynor	Office of the Attorney General
Vacancy	State Senate (D)

Ex-Officio Members

Member	Affiliation
Secretary Carol Adams represented by Dr. Myrtis Sullivan	Illinois Department of Human Services
Director Damon T. Arnold represented by David Carvalho	Illinois Department of Public Health
Director Barry Maram, and designee Mike Jones	Illinois Department of Healthcare and Family Services
Executive Secretary Jeffrey S. Mark	Illinois Health Facilities Planning Board
Ginger Ostro	Governor's Office of Management and Budget

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Memorandum

December 31, 2008

to: Members, Illinois House of Representative
Members, Illinois Senate

from: Senator Susan Garrett, *Co-Chair*
Representative Lisa Dugan, *Co-Chair*

re: **Illinois Task Force on Health Planning Reform**

This document is the final report of the **Task Force on Health Planning Reform** ("Task Force") required by Senate Bill 244 (PA 95-0005) of the 95th General Assembly. Senate Bill 244 amended the Illinois Health Facilities Planning Act to create a 19-member Task Force to evaluate the current "Certificate of Need" (CON) program and recommend changes to the structure and function of both the Illinois Health Facilities Planning Board and the Illinois Department of Public Health (IDPH) in the review of applications to establish, expand, or modify health facilities and related capital expenditures.

The Task Force met 14 times to meet our goals, with the final 3 meetings focused on developing a consensus on the recommendations. On December 19, 2008, the Task Force voted 12 to 1 to approve the attached final recommendations. With one dissenting opinion, a minority report has been provided to the Task Force (see Appendix A).

The Task Force determined its main reform goal as follows:

> The State of Illinois will promote the distribution of health care services and improve the healthcare delivery system in Illinois by establishing a statewide comprehensive plan and ensuring a predictable, transparent and efficient CON process.

In order to meet this goal, the Task Force recommends the establishment of a Statewide Comprehensive Health Plan, as well as reforms to the Illinois Health Facilities Planning Board, in order to increase the efficiency and effectiveness of both overall health planning and the CON process. The Comprehensive Health Plan will comprehensively address health and mental health services, to specifically focus on identifying health disparities, identifying state-level and regional needs, and determining the impact of market forces on access to high quality services for uninsured and underinsured residents. Cost containment and support for safety net services will continue to be tenets of the CON process. The process will lead to evidence-based assessments, projections and decisions applied to capacity, quality, value and equity in health care delivery. Further, the CON Process will result in written and consistent decisions based on the Comprehensive Health Plan, as well as other plans recommended by the Center for Comprehensive Health Planning, a new unit to be established under IDPH. In addition, the integrity of the CON Process will be insured through revised structure and policies, including the introduction of a Special Nomination Panel for the CON Board membership, along with improved ethics and communications procedures.

The **Illinois Health Facilities Planning Act** (20 ILCS 3960, et seq.) became effective in 1974. It created a 13-member **Illinois Health Facilities Planning Board** ("CON Board") to review the

necessity of capital expenditures for the establishment or modification of health facilities and the procurement of medical equipment. Both the 93rd and 94th General Assemblies restructured the Board, after extensive debates about the history and performance of the Board, and in response to proposals for its complete elimination. Additionally, illegal activity in 2004, involving conflicts of interest and criminal indictments of a board member for influence peddling, kickbacks, and other corrupt actions by parties involved in applications subject to review, prompted the Governor and General Assembly to reduce the size and makeup of the board, and to impose more strict membership requirements.

In response, the 95th General Assembly enacted House Resolution 1497, which required the Legislative Commission on Government Forecasting & Accountability to conduct a comprehensive evaluation of the Illinois Health Facilities Planning Act, including a review of the performance of the Illinois Health Facilities Planning Board. The Commission contracted with the Lewin Group to conduct the evaluation. Their subsequent report, entitled "An Evaluation of Illinois' 'Certificate of Need' Program" was submitted in February 2007 and had 6 main recommendations, including "the Illinois legislature continue the 'Certificate-of-Need' program with an abundance of caution."

The Lewin Group recommendations were the catalyst for the creation of this Task Force, which began a long and deliberative process on January 31, 2008. The Task Force engaged in a course of action to review the health planning process in an open and impartial fashion. As testimony was received and discussed, it became evident that Illinois needed the safeguards in place which are afforded by the regulated health facility planning process, and an initial decision was made to maintain the CON process. From then on, the Task Force focused on how to re-structure the process. The principle findings outlined in this report stem from the intent of the Task Force to streamline the CON process, take significant steps toward transparency, and unite comprehensive health planning and health facility efforts for statewide gains.

The Task Force urges the General Assembly to implement its recommendations to establish and implement a Statewide Comprehensive Health Plan, as well as to reform the Certificate of Needs process. We believe that the overall changes included in the recommendations will have the effect of rejuvenating and insulating the Illinois Health Facilities Planning Board. Our work concluded on December 31, 2008 and any proposed reforms are due to be implemented by July 1, 2009, which corresponds to the sunset date for the CON program in House Bill 5017. The Task Force expects to be available to the 96th General Assembly for the legislative implementation of these recommendations. A complete record of the Task Force activities is available on the Illinois Department of Public Health website.

Signers,

Susan Garrett
Illinois State Senator

Lisa Dugan
Illinois State Representative

Introduction

This document is the final report of the **Task Force on Health Planning Reform** ("Task Force") required by Senate Bill 244 (PA 95-0005) of the 95th General Assembly. Senate Bill 244 amended the Illinois Health Facilities Planning Act to create a 19-member Task Force to evaluate the current "Certificate of Need" (CON) program and recommend changes to the structure and function of both the Illinois Health Facilities Planning Board and the Illinois Department of Public Health (IDPH) in the review of applications to establish, expand, or modify health facilities and related capital expenditures. The Task Force concluded its work on December 31, 2008 and any proposed reforms are due to be implemented by July 1, 2009. A complete record of the Task Force activities is available on the Illinois Department of Public Health website (see Appendix C for further information).

Background

The **Illinois Health Facilities Planning Act** (20 ILCS 3960, et seq.) became effective in 1974. It created a 13-member **Illinois Health Facilities Planning Board** ("CON Board") to review the necessity of capital expenditures for the establishment or modification of health facilities and the procurement of medical equipment. Entities subject to the Act include licensed and state-operated: hospitals; long-term care facilities; dialysis centers; ambulatory surgery centers; and alternative health care delivery models. Facilities operated by the federal government are exempt. Transactions requiring a permit now include any: construction or modification by or on behalf of a health care facility exceeding the expenditure minimum ($8,850,717); substantial increase in a facility's bed capacity; substantial change in the scope or functional operation of a facility; and, proposed establishment or discontinuation of a facility or category of service. In addition, the acquisition of major medical equipment (valued at more than $8,850,717) or health and fitness centers (valued at more than $4,231,660) must obtain a permit or exemption. These thresholds are updated annually for inflation[1].

Proposals to repeal the Illinois Health Facilities Planning Act have not been enacted, but there has been a substantial reorganization of the CON Board. Proponents have successfully argued that although the CON Board has not historically denied many projects, the review process requires applicants to more carefully develop and scale their projects to established criteria and standards of need. Many existing hospitals and the communities they serve have generally supported the "Certificate of Need" law, because elimination could jeopardize their economic vitality by a radical proliferation or expansion of unnecessary facilities.

Both the 93rd and 94th General Assemblies restructured the CON Board after extensive debates about the history and performance of the Board, and in response to proposals for its complete elimination. Additionally, illegal activity in 2004, involving conflicts of interest and criminal indictments of a board member for influence peddling, kickbacks, and other corrupt actions by parties involved in applications subject to review, prompted the Governor and General Assembly to reduce the size and makeup of the board, and to impose more strict membership requirements.

The 94th General Assembly subsequently enacted Senate Bill 2436 (P.A. 94-0983) that extended the "Sunset" date to April 1, 2007, so that the status of the Board and the "Certificate of Need" program would be subject to further and more intensive evaluation, given the acceleration of health facility capital expenditures, the national trends of such health care regulation, continuing concerns about increasing health care costs, the need for more effective cost containment, and the controversial history of Illinois' current system.

[1] Figures from the Illinois Health Facilities Planning Board, Memo dated June 18, 2008

House Resolution 1497, enacted by the 95th General Assembly, required the Legislative Commission on Government Forecasting & Accountability to conduct a comprehensive evaluation of the Illinois Health Facilities Planning Act. This included a review of the performance of the Illinois Health Facilities Planning Board to determine if it was meeting the goals and objectives that were originally intended, as well as meeting the goals of subsequent amendments and revised Board policies.

The Commission contracted with the Lewin Group to conduct the evaluation. Their subsequent report, entitled "An Evaluation of Illinois' 'Certificate of Need' Program" was submitted in February 2007, and recommended "the Illinois legislature continue the 'Certificate-of-Need' program with an abundance of caution." Specifically, six main recommendations of the Lewin Group report were as follows: 1) the CON program be extended for 3 years; 2) other policies which support safety-net hospitals be evaluated; 3) a more proactive Charter for the Health Facilities Planning Board be considered; 4) CON Board size and composition be modified; 5) CON Board member compensation be considered; and 6) the workload of the CON Board be focused on reviewing new facilities, as well as monitoring the viability of safety net hospitals. The Lewin Group also found that given the potential for harm to specific critical elements of the health care system, non-traditional rationales for maintaining "Certificate-of-Need" laws deserve consideration, until further study is conducted on the impact that specialty providers and ambulatory surgery centers may have on safety-net providers. Explicit transfers of funds to safety-net hospitals may also be more direct policy tools for their protection.

In response to the Lewin Group analysis and additional concerns regarding health planning in Illinois, the 95th General Assembly enacted Senate Bill 611 (Public Act 95-0001) that extended the "sunset" date of the Illinois Health Facilities Planning Act from April 1, 2007 to May 31, 2007 so that interested parties could agree on a strategy to further extend the "sunset" date, and develop a more comprehensive reform agenda.

Subsequently, the 95th General Assembly enacted Senate Bill 244 (PA 95-0005) which created the Task Force on Health Planning Reform. House Bill 5017 extended the conclusion of the Task Force to December 31, 2008 and the sunset for the CON program to July 1, 2009.

Task Force Activities

The Task Force on Health Planning Reform began a long and deliberative process on January 31, 2008 and engaged in a review of the health planning process in an open and impartial fashion.

The 19 member Task Force was co-chaired by Senator Susan Garrett and Representative Lisa Dugan (for further detail on members see page 3). The Task Force was designed to include:

- 6 persons appointed by the Director of IDPH;
- 2 appointed by the President of the Senate (1 as co-chair);
- 2 appointed by the Senate Minority Leader;
- 2 appointed by the Speaker of the House of Representatives (1 as co-chair);
- 2 appointed by the House Minority Leader;
- 1 The Attorney General, or designee; and
- 4 appointed by the Attorney General representing health care consumers.

A vote of 12 appointed Task Force members is required to adopt recommendations for the Governor and General Assembly, as well as for the final report.

In accordance with Senate Bill 244 (PA 95-0005), the Task Force gathered information and heard testimony concerning:

1. The impact of health planning on the provision of essential and accessible health care services, including; prevention of duplication of facilities and services; improved efficiency of the health care system; maintenance of an environment in the health care system that supports quality care; economic use of resources; and the effect of repealing the Act.
2. Reform of the Illinois Health Facilities Planning Board, including identifying and recommending initiatives to meet special needs.
3. Reforms to ensure that health planning under the Illinois Health Facilities Planning Act is coordinated with other health planning laws and activities of the State.
4. Reforms to enable the Planning Board to focus its review efforts on CON applications involving new facilities, discontinuation of services, major expansions, and volume-sensitive services, and to expedite review of other projects to the maximum extent possible.
5. Reforms to enable the Planning Board to determine how procedures should be amended to give special attention to the impact of those projects on traditional community hospitals.
6. Implementation of policies and procedures which give special consideration to the impact of the projects it reviews on access to "safety net" services.
7. Changes to make the planning policies and procedures predictable, transparent, and as efficient as possible.
8. Reforms which ensure that patient access to new and modernized services are not delayed during a transition period.
9. Identification of necessary resources to support the work of the Agency and the Board.

The legislation also directed the Task Force to recommend reforms regarding:

1. Size and membership of the Illinois Health Facilities Planning Board.
2. Changes in the state's long-range health facilities plan (10-year scope, to be updated every year).
3. Changes in regulations that establish separate criteria, standards and procedures when necessary to adjust for structural, functional, and operational differences between long-term care facilities and acute care facilities.
4. Changes in policies and procedures which ensure that the planning board updates standards and criteria on a regular basis and proposes standards to keep pace with the health care system.
5. Expediting the review and approval of projects and determining their impact on "safety net" services.
6. Revisions of enforcement processes and compliance standards to ensure fairness and consistency with the severity of the violations.
7. Conflict-of-interest standards and increases in penalties for violations.
8. Other changes determined necessary to improve the administration of this Act.

The Illinois Department of Public Health was required to provide staff support services. The Department, as directed by the Task Force, was authorized to hire staff or consultants and incur other expenditures from appropriated funds. The Department received assistance from the Illinois Public Health Institute and contracted for technical assistance from Laura McAlpine (McAlpine Consulting for Growth).

The Task Force conducted public hearings from January to December 2008 in Chicago and Springfield with video conferencing. The initial meeting focused on review of the statutory requirements and determination of future meetings dates. In the February meetings, the Task Force agreed on changes to the timeline, organized the work plan, reviewed the current

structure of the CON process and evaluated the Lewin Group study. Although the Act originally abolished the Task Force on March 1, 2008, the Task Force requested an extension to their deadline to December 31, 2008 during their February 8th meeting. During subsequent public hearings, the Task Force heard from fifty expert witnesses and interested parties, including representatives of unions, health facilities, the Justice Department, the Federal Trade Commission, health professionals, as well as previous and current representatives of the CON Board (for a detailed list of presenters and website information on their testimony see Appendix B and Appendix C). Presentations varied from clarification and analysis of the current CON process to specific recommendations on Safety Net Hospitals. One of the initial decisions of the Task Force members was to maintain the CON process. Moving forward, the Task Force focused on recommendations to improve and re-structure the CON process.

Final Recommendations:

Overview

The Task Force began extensive deliberations on September 15, 2008 with the assistance of a facilitator in order to allow all Task Force members to participate in the discussion. These deliberations, using a draft Blueprint document of recommendations and a draft organizational chart, continued on October 8th, October 30th, and December 8th, concluding on December 19th with a vote of 12 to 1 on the final Blueprint recommendations[2]. A minority report is attached in Appendix A.

As testimony was received and discussed, it became evident that Illinois should continue with the safeguards in place, which are afforded by the regulated health facility planning process. The principle findings outlined in this report stem from the intent of the Task Force to streamline the process, take significant steps toward transparency, and to unite comprehensive health planning and health facility efforts for statewide gains.

The Task Force determined its main reform goal as follows:

> The State of Illinois will promote the distribution of health care services and improve the healthcare delivery system in Illinois by establishing a statewide comprehensive plan and ensuring a predictable, transparent and efficient CON process.

In order to meet this goal, the Task Force recommends the establishment of a comprehensive health planning agency charged with creating a plan, which will allow for a stronger CON process. At present, the statewide health planning efforts have been fragmented at best, with no single source for health planning in a global sense. The inability of the current CON Board to conduct sufficient planning was determined by the Task Force as a major deficit in its functioning. Significant reforms are also being recommended for the CON process. Implementation of these recommendations will increase the efficiency and effectiveness of both overall health planning and the CON process.

The objectives of the Comprehensive Health Plan are to assess existing community resources and determine health care needs, to support safety net services for the uninsured and underinsured residents, to promote adequate financing for health care services, and to recognize and respond to changes in community health care needs. To this end, strategies include conducting a biennial comprehensive assessment of health resources and service needs, conducting needs assessments, collecting and analyzing relevant, objective and

[2] Aye: Chicago - Garrett, Dugan, Althoff, Gaynor, Lyne, McNary, Robbins, Ruddick, Schaps; Phone – Barnett, Kosel, Lenhoff
Nay: Chicago - Brady

accurate data, identifying issues related to health care financing, evaluating the findings of the inventory/needs assessment and annually reporting to the General Assembly and the public. The Comprehensive Health Plan will comprehensively address health and mental health services, specifically focus on identifying health disparities, identify state-level and regional needs, and determine the impact of market forces on access to high quality services for uninsured and underinsured residents.

The existing objectives of the current Certificate of Need Process include improving the financial ability of the public to obtain necessary health services, establishing an orderly and comprehensive health care delivery system, maintaining and improving the provision of essential health care services, increasing the accessibility of these services, assuring the reduction and closure of health care services and/or facilities is performed in an orderly and timely manner while considering the public interest, and assessing the financial burden patients experience as a result of unnecessary health care construction and modification.

In order to reform the CON process and better meet the existing objectives, the Task Force recommends applying the findings from the Comprehensive Health Plan and the establishment of mechanisms to support adequate financing of the health care delivery system. Cost containment and support for safety net services will continue to be tenets of the CON process. The process will lead to evidence-based assessments, projections and decisions applied to capacity, quality, value and equity in health care delivery. Further, the CON Process will result in written and consistent decisions based on the Comprehensive Health Plan, as well as other plans recommended by the Center for Comprehensive Health Planning, a new unit to be established under IDPH.

Restructuring the Illinois Health Facilities Planning Board is a principal element of the recommendations, based upon consideration of the Lewin Report and testimony gathered by the Task Force. We recommend the CON Board be made up of 9 paid members, with a Chairman as the principal officer of the Board, and the elimination of the Executive Secretary position. The duties of the Executive Secretary, to the greatest extent possible, will be assumed by the Chairman. This board will continue to be located at IDPH with operational support. The Task Force suggests reviewing the compensation levels paid to the members of the Election Board for comparable salaries.

Recommendations to streamline the application process include the elimination of the letter of intent. Additional recommendations to refocus and streamline the CON process include a separate cost threshold for hospital and non-hospital applications, as well as the removal of the application of common financing as a test for whether projects are inter-related. In order to increase support for safety net services, recommendations drafted jointly by the Attorney General's Office and the Illinois Hospital Association were accepted. Charity care and safety net service recommendations include, but are not limited to, the following: 1) reasonable conditions or stipulations agreed to by the applicant that address health resource needs; 2) special consideration to the impact of the project on access to safety net services; 3) definitions of safety net services and charity care; and, 4) establishment of a review standard requiring a 'Safety Net Impact Statement' with CON applications, including a mechanism for public comment on such statements.

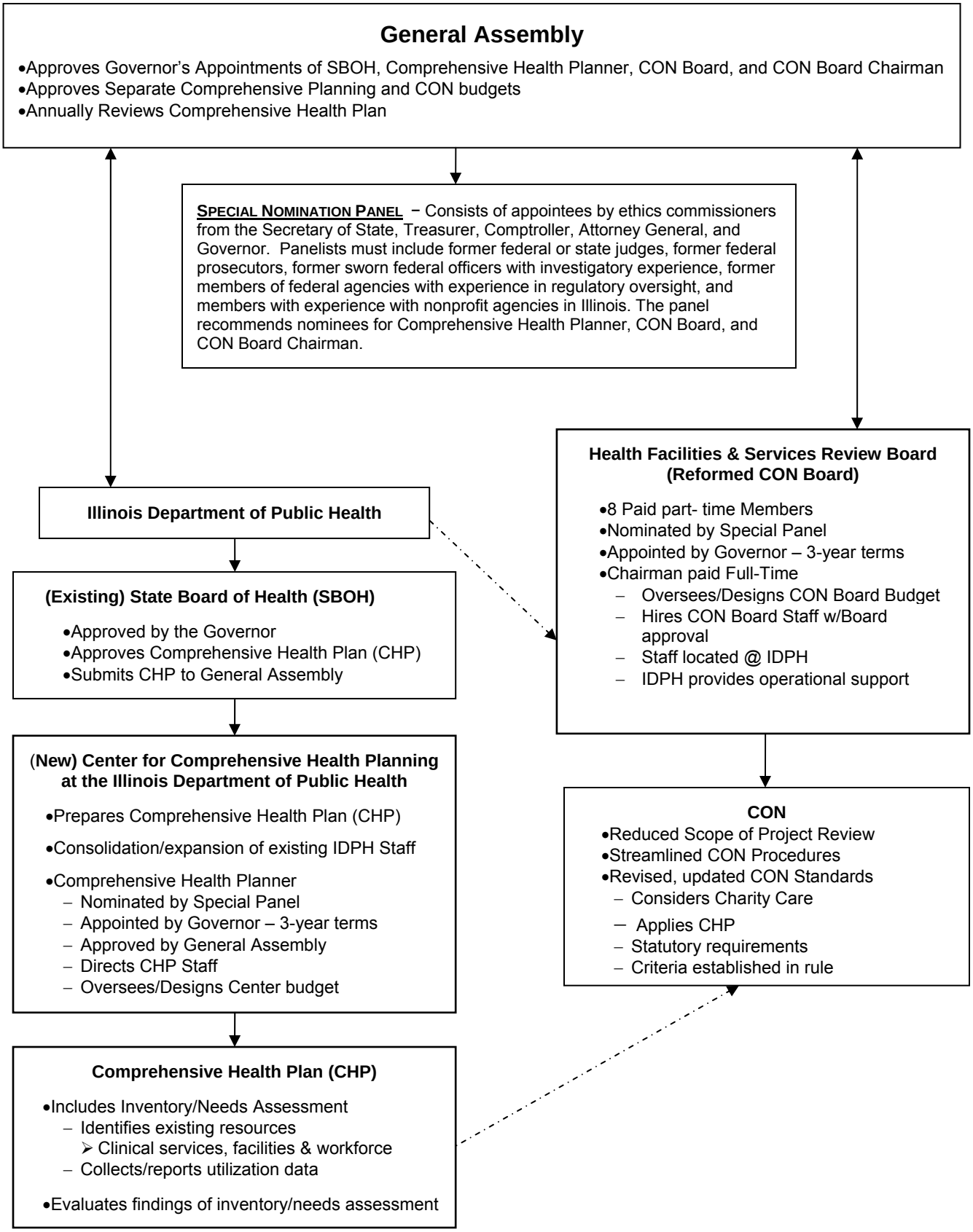
The Task Force is also making recommendations to ensure the integrity of the CON Board and its activities. These include the use of a Special Nomination Panel to provide some independence in the appointment of Board members, clarifying limits on ex parte communication, and a renewed emphasis on ethics for CON Board and staff. The composition

and qualifications of this new Nomination Panel may be revised to ensure its timely formation and effectiveness. This, and oversight of the Panel, will be addressed during the drafting of legislation.

Given the important nature of the work coming before the CON Board, we are recommending an orderly, acceptable and timely transition process that preserves the existing authority of the CON Board while adjustments are made to comply with new rules formulated from legislation. Further, the Task Force also recommends that the “sunset” of the existing law be extended for at least 10 years, in order to provide stability and continuity to the process.

The following sections provide the following: a) Organizational Chart of the proposed reorganization of the CON Board and the implementation of the Center for Comprehensive Health Planning; b) Blueprint of the Task Force recommendations; and c) Financial estimates on the cost of establishing the Center for Comprehensive Health Planning, as well as the reorganization of the CON Board.

Proposed Reorganization for Illinois Health Facilities Planning Board



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TASK FORCE ON HEALTH PLANNING REFORM

BLUEPRINT

Reform Goal and Objectives

A. Reform Goal

The State of Illinois will promote the distribution of health care services and improve the healthcare delivery system in Illinois by establishing a statewide comprehensive health plan and ensuring a predictable, transparent and efficient CON process.

B. Statewide Comprehensive Health Plan

Objectives

1) To assess existing community resources and determine health care needs
2) To support safety net services for uninsured and underinsured residents
3) To promote adequate financing for health care services
4) To recognize and respond to changes in community health care needs, including public health emergencies and natural disasters

Implementation Strategies

1) Conduct a biennial (every 2 years) comprehensive assessment of health resources and service needs, including but not limited to facilities, clinical services and workforce
2) Conduct needs assessments using key indicators of population health status and determinations of potential benefit that could occur with certain changes in the health care delivery system
3) Collect and analyze relevant, objective and accurate data, including health care utilization data
4) Identify issues related to health care financing (such as revenue streams, federal opportunities, better utilization of existing resources, development of resources and incentives for new resource development)
5) Evaluate findings of inventory/needs assessment
6) Annually report to the General Assembly and the public

Comprehensive Health Planning Principles

1) Health and mental health services will be assessed comprehensively
2) Assessment of need will include a special focus on identifying health disparities
3) State-level and regional needs will be identified
4) Findings shall identify the impact of market forces on the access to high quality services for uninsured and underinsured residents.

C. Certificate of Need Process

Objectives

1) To improve the financial ability of the public to obtain necessary health services
2) To establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public
3) To maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent
4) To assure that the reduction and closure of health care services and/or facilities is performed in an orderly and timely manner, and that these actions are deemed to be in the best interests of the public
5) To assess the financial burden to patients caused by unnecessary health care construction and modification

Implementation Strategies

1) Apply the findings from the Comprehensive Health Plan to update review standards and criteria, as well as better identify needs and evaluate applications
2) Establish mechanisms to support adequate financing of the health care delivery system in Illinois, for the development and preservation of safety net services

CON Process Principles

1) Written and consistent decisions will be required that are based on the findings from the Comprehensive Health Plan, as well as other issue or subject specific plans, recommended by the Center for Comprehensive Health Planning. Established policies/procedures, which include criteria and standards for plan variations/deviations, will be updated.
2) Evidence-based assessments, projections, and decisions will be applied regarding capacity, quality, value and equity in the delivery of health care services in Illinois.
3) Integrity of the 'Certificate of Need' process will be insured through implementation of a special panel for nominations of the CON Board, as well as revised ethics and communications procedures.
4) Cost containment and support for safety net services will continue to be central tenets of the CON process.

Comprehensive Health Planning - Functions

1) The State of Illinois shall undertake a more active role in comprehensive health planning to guide the development of clinical services, facilities and workforce that will meet the health and mental health care needs of Illinois.

2) A newly formed **Center for Comprehensive Health Planning** at the Illinois Department of Public Health shall be charged with developing a long range **Comprehensive Health Plan** (5-to-10 years) to be updated biennially, with the ability to update annually if needed.

3) The plan will incorporate an inventory to map the state for growth, population shifts, and utilization of available healthcare resources, using both state-level and regionally defined areas. The plan will also evaluate health service needs, addressing gaps, over-supply and continuity of care. This evaluation will include an assessment of existing safety net services. The Center for Comprehensive Health Planning will identify unmet health needs, and assist in any inter-agency state planning for health resource development.

4) The inventory of state's health facilities infrastructure includes regulated facilities and services, as well as facilities and services that are not currently regulated, as determined by the Agency.

5) In developing the plan, the Center for Comprehensive Health Planning shall consider health plans and other related publications that have been developed both in Illinois and nationally.

6) In developing the plan, the need to ensure development and maintenance of access to care, especially for "safety net" services, including rural and medically underserved communities, shall be included.

7) The Center for Comprehensive Health Planning may establish priorities and recommend methods for meeting identified health service, facilities and workforce needs. This includes proposing legislation, policy and/or administrative rule adjustments, ways to incentivize providers or educational facilities to assist in resource development. Further, recommendations should be short term, mid-term, and long range in nature.

8) Health planning for clinical services, facilities and workforce under the Illinois Health Facilities Planning Act shall be integrated with other health planning laws and activities of the State, where appropriate. These include, but are not limited to the State Health Improvement Plan, the *Illinois Rural/Downstate Health Ac*t and related activities of the Office of Rural Health of the Illinois Department of Public Health, and the recommendations of the (2006) *Joint (House/Senate) Task Force on Rural Health & Medically Underserved Areas*.

9) The Center for Comprehensive Health Planning may consider health resource development projects or information on methods by which a community may receive benefit, that are consistent with health resource needs identified through the comprehensive health planning process, which contribute to the development of appropriate and necessary services and facilities. The Center for Comprehensive Health Planning established by this reform may recognize such "community benefit" or "charity care" project as meeting an identified need.

10) The Center must also work cooperatively with a reorganized Illinois Health Facilities Planning Board, to become known as the "**Health Facilities and Services Review Board**" ("CON" Board). The plan may include recommendations that will be integrated into and applied to any relevant "CON" criteria, standards and procedures. Not all service needs that are identified in the comprehensive health planning process would be subject to "CON" regulation.

11) The (existing) **State Board of Health** (SBOH) must, within 60 days of receipt from the Center for Comprehensive Health Planning, review and comment on the final Comprehensive Health Plan and must submit the plan to the Illinois General Assembly on a biennial basis, by March 1 of the year. The initiation of the Center for Comprehensive Health Planning will commence with the signing of legislation, and the first comprehensive health plan will be submitted to the SBOH within one year of hiring the Comprehensive Health Planner. The SBOH will also review any policy change recommendations. The SBOH shall adopt and follow the *Illinois Governmental Ethics Act* (5 ILCS 420/).

12) This new Center will also be charged with making comprehensive health planning data available to interested parties. This data should be kept current and made available to the public, including publication on an accessible agency website. Information about the funding of the Center should also be made available.

13) The Center for Comprehensive Health Planning and the State Board of Health shall hold public hearings on the plan and its updates. There shall be a mechanism for the public to request that the plan be updated more frequently to address emerging population and demographic trends.

14) The components of the plan shall be outlined in state statute, with reasonable detail to limit administrative rule-making.

Comprehensive Health Planning - Organizational Structure

15) A Center for Comprehensive Health Planning shall be created as a new and separate subdivision of the Illinois Department of Public Health, which will develop a Comprehensive Health Plan.

16) The new Center for Comprehensive Health Planning shall manage its own professional staff dedicated to the development of the Comprehensive State Health Plan. Staff of the Illinois Department of Public Health currently dedicated to health planning duties may be realigned or consolidated under the new Center. Staff shall also provide technical assistance to the CON Board in terms of the application of the components of the comprehensive health plan for the CON Board's usage.

17) The (new) Center for Comprehensive Health Planning will be supervised by a **Comprehensive Health Planner** appointed by the Governor by a ***Special Nomination Panel*** (See Attachment for the Special Nomination Panel), with the advice and consent of the Illinois Senate. The Planner will serve as the chief of staff responsible for the operations of the Center for Comprehensive Health Planning and its staff. This appointment is subject to review and approval every 3 years. The Director shall be paid a salary in accordance with the top salary range for a Senior Public Service Administrator.

18) The Comprehensive Health Planner shall prepare and submit a separate and distinct budget for the Center for Comprehensive Health Planning for review and approval by the Illinois General Assembly. To promote transparency of the process, this information shall be made available as part of an annual report that is available on the IDPH website.

Reform of the Illinois Health Facilities Planning Board – Functions

CON Process and Scope of Reforms

19) Reform of the CON Board shall focus "Certificate of Need" project review efforts on applications involving new or replacement facilities, new services (including those for freestanding facilities, such as proton therapy and cardiac catheterization, that are regulated under CON for only some providers, or regulated under different standards), discontinuation of services, major expansions, the addition of 20 or more beds or 10% of a facility's bed capacity (whichever is greater), and major changes in volume-sensitive services, and to expedite review of other projects to the maximum extent possible. The financial review would focus the overall project cost rather than on individual line items. Replacement facilities on the same site that are below the capital expenditure threshold would not be subject to a substantive full scope review. Because applications for discontinuation are not complicated, they should continue to be reviewed under a 60-day timetable. The public would continue to have an opportunity to request a public hearing.

20) There will continue to be three categories of permit requests as currently defined by rules – emergency, non-substantive, and substantive. There will also be an exemption to permit category. The Staff review timeframes will continue to be as follows (with current extensions when a public hearing is requested):
    - 30 days for exemptions from permits
    - 60 days for non-substantive projects
    - 120 days for substantive projects

21) The CON Board shall use the Comprehensive Health Plan to determine whether to reclassify the types of projects that fall into the various categories of review, with special consideration given to opportunities to streamline the process.

22) The CON Board shall create a mechanism for the public to request changes to the rules, including standards and criteria. The public will be allowed an opportunity to comment on any proposed rule and standard changes.

23) Assess the cost of the capital expenditures for all projects in relation to the cost of care.

24) For projects that are reviewed solely because of cost and not because they propose to establish a new facility or service, the capital expenditure shall be statutorily updated to $11.5 million (based on 2008 dollars) for hospitals. The rate for all other projects will be set at $3 million. These rates should be adjusted for inflation every year in the same fashion and on the same schedule as currently required by rule. This will allow applicants to upgrade existing facilities without adding unnecessary costs and delaying access to modernized facilities for the community. In calculating cost components to be included in relation to the capital expenditure threshold, consideration would be given to whether the components are programmatically related and whether a component could be completed independently of the other components. Regional differences in cost may also be

considered. Common financing of components would not automatically result in components being considered interrelated.

25) To expedite project approval, particularly for less complex projects, the CON Board, in conjunction with its staff, and industry experts and consumers, should promulgate regulations to be applied by the Staff in determining whether a project is in compliance with the review standards.

26) "Letters of Intent" will no longer be required. Limitations on *ex parte* communication will apply at the point that the application is formally filed and noted by staff as complete.

27) At least one public hearing is required for any project for which a hearing has been requested subject to full CON Board review, at which at least one of the members of the CON Board must participate. The CON Board shall implement public information campaigns, in addition to the current practices of website notice and legal notice, to regularly inform the general public about the public hearing requirement and the standards and procedures ensuring public access to and participation in the hearings.

28) All rights to due process in appeals of CON Board final decisions remain in effect.

29) Permit holders would be required to submit annual progress reports and final cost reports as the mechanism to enable the CON Board and Staff to know that projects are proceeding with due diligence. These reports are public information.

CON Board Responsibilities

30) The CON Board will continue to have responsibility for decision-making on applications. Standards shall be clear and detailed to the extent that the staff and CON Board determine compliance on an objective and consistent basis. Decisions must be consistent with appropriate standards. Written decisions shall be issued upon request. There must be clear and documented criteria and procedures for any variation from standards.

31) Standards and criteria must be updated to better identify needs and evaluate applications on a regular basis (at least every 2 years), using the inventory and recommendations of the Comprehensive Health Plan for guidance. These updates shall be adopted by the CON Board to keep pace with the evolving health care delivery system. Certain standards shall be stipulated in statute, with provisions that allow for modification by rules adopted under the Illinois Administrative Procedures Act.

32) The CON Board shall also periodically re-evaluate categories of service that are subject to review, including provisions related to structural, functional, and operational differences between long- term care facilities and acute care facilities and that allow routine changes of ownership, facility sales, and closure requests to be processed on a timely basis. There should be flexibility in the standards to allow for facilities to modernize, expand, or convert to alternative uses that are in accord with health planning standards. As necessary, the CON Board may appoint temporary advisory committees to assist in the development of revisions to standards and criteria, including experts with professional competence in the subject matter of the proposed standards or criteria that are to be developed.

33) The Board shall issue reports on a monthly basis, to be posted on the Board's website. Reports should include the status of applications and recommendations regarding updates to the standards, criteria, or the health plan as appropriate.

34) The CON Board shall publish an annual report of all fines, fees and other revenue collected, as well as expenses incurred with respect to the CON process.

35) The CON Board shall meet at least every 45 days. A quorum of the appointed members is only required for matters upon which a formal vote is required.

CON Board Chairman Responsibilities

36) The Chairman of the CON Board is authorized to approve emergency applications, consistent with the current regulations. Emergency projects can be approved orally but must be followed by a written application that summarizes the nature of the problem and the anticipated cost of the project. Emergency projects are defined as those projects that are necessary because of imminent threat to the structural integrity of the building or because of an imminent threat to the safe operation and functioning of the mechanical, electrical, or comparable systems of the building.

37) The Chairman is also authorized, as provided under the current rules, to approve applications for exemption. These exemptions are not discretionary. If applicants do not meet specific criteria that are set forth in the CON Board's rules, they must go through the full "Certificate of Need" process. The Chairman also may refer any application for exemption to the full CON Board for its consideration.

38) In addition, the CON Board, after analyzing data on previous applications, should consider adopting rules that would authorize the Chairman to approve other applications that meet all of the review criteria and are unopposed. For the limited applications that the Chairman is authorized to approve, the Chairman also has the authority to refer them to the full CON Board. The Chairman will still be authorized to approve certain administrative changes such as extensions and some alterations, as is currently allowed under the rules.

39) After the public hearing and review of applications that will be considered at a meeting of the CON Board, the Chairman may request that some applications be considered as part of a consent agenda that will be voted on at the beginning of the Board meeting. There will be an opportunity for CON Board members to raise questions about applications on the consent agenda and they may request that the applications be considered on the regular agenda if there are significant issues that warrant full discussion.

Staff Responsibilities

40) All staff will be required to meet minimum professional qualifications, and all staff and their immediate family members (parents, spouses, children and siblings) shall be subject to the pertinent provisions of the **Illinois Governmental Ethics Act (5 ILCS 420/).**

41) The CON Board staff may provide technical assistance to applicants in the development of their applications in strict accordance of with Section 4.2 of the Illinois Health Facilities Planning Act, as amended to clarify pre-application communications (See Attachment below concerning Ex Parte communication.) This could include consultation at any time prior to the actual filing of an application. In addition, the staff may communicate with the

applicant to clarify or verify information provided in the application as it prepares the Staff Report on the application. A written record of such consultation must be made by the staff, and made part of the public record for any active application. These consultations are not considered *ex parte* since staff are not the decision-makers on applications. Communications occurring during administrative reconsideration shall be made a part of the formal public record using a prescribed, standardized format that is included in the application file.

42) Staff will establish short timeframes for responding to requests about the applicability of rules and will communicate to applicants in a timely manner regarding whether or not their project is to be considered at an upcoming meeting.

43) Staff must prepare reports showing the degree to which an application conforms to the CON Board's review standards. Any additional information that Staff wants to communicate would be included in the Staff Report. The public will have an opportunity to comment up until 14 days prior to the CON Board meeting regarding facts set forth in staff reports. These reports would be posted on the Boards' web site and should include summations of relevant public testimony. All information related to any application shall be public information (except those required by law to be confidential). The CON Board shall make such information immediately available for public inspection, which may include access on the agency website.

Predictability and Accountability

44) Policies and procedures of the (reformed) Illinois health facilities planning process shall ensure that it is predictable, transparent, and as efficient as possible. The staff and the CON shall provide timely and appropriate explanations of its decisions and establish more effective procedures to enable public review and comment on facts set forth in Staff analyses of project applications prior to the issuance of final decisions on each project.

45) The enforcement processes and compliance standards must be fair and consistent with the severity of the violation.

46) Policies and procedures shall ensure that patient access to new and modernized services will not be delayed during a transition period under any proposed system reform, including the appointment of members. The transition to a reformed system should minimize disruption of the process for current applicants.

47) The Auditor General should conduct a performance audit of the Center for Comprehensive Health Planning, the CON Board and the "Certificate of Need" process to commence 18 months after the initial appointment of the 9 members. Section 19.5 of the Act providing for a special audit should be revised accordingly.

Charity Care and "Safety Net" Services

48) In addition to other requirements or conditions that may be applied to the approval of applications, the CON Board may include reasonable conditions or stipulations agreed to by the applicant that are directly related to the application being considered and that address health resource needs identified through the comprehensive health planning process to be established under the reform. These may include the establishment of time

frames for compliance with such conditions and the establishment of reporting requirements.

49) Policies and procedures of the CON Board shall take into consideration the priorities and needs of medically underserved areas and other health care services identified through the comprehensive health planning process, giving special consideration to the impact of the projects it reviews on access to “safety net” services.

50) “Safety net services” should be defined as services provided by organizations that deliver health care services to persons with barriers to mainstream health care due to factors such as lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation.

51) Composition of the safety net varies by community, but has regional and statewide factors. Safety net services can be provided by hospitals and private practice physicians that provide charity care, school-based health centers, migrant health clinics, rural health clinics, federally qualified health centers, community health centers, public health departments, community mental health centers and others.

52) CON review standards must include a requirement for applicants to provide a "Safety Net Impact Statement,” which shall be filed with an application for a certificate of need and shall be considered with “general review criteria” within the meaning of Section 1110.230 of the current rules promulgated by IHFPB. This Statement shall describe the project's potential impact on safety net services in the community, to the extent feasible. Safety Net Impact Statements should be filed by all applicants which are “health care facilities” as defined under Section 3 of the Act (20 ILCS 3960/3), when they are proposing a substantive project or when they are proposing to discontinue a category of service. This requirement does not apply to skilled and intermediate long term care facilities licensed under the Nursing Home Care Act.

53) Upon the filing of an application for a certificate of need and accompanying Safety Net Impact Statement with the IHFPB, the Agency shall provide notice of such filing by publishing a notice in a newspaper having general circulation within the area affected by the application. If no such newspaper has a general circulation within the area, then the notice shall appear in a newspaper having general circulation within the county and by posting such notice in 5 conspicuous places within the proposed area.

54) Any person, community organization, provider or health system or other entity wishing to comment upon or oppose the application for certificate of need may file a “Safety Net Impact Statement Response” with the IHFPB which provides additional information concerning the project's impact on safety net services in the community.

55) The applicant shall have an opportunity to reply to any Safety Net Impact Statement Responses that are submitted.

56) Safety Net Impact Statements, as developed by the applicant, should describe what material impact, if any, a proposed facility or service may have on essential safety net services, including the impact of a project on the ability of another provider or health system to cross-subsidize safety net services and the impact of the discontinuation of a facility or service on the remaining safety net providers in a given community.

57) Since “charity care” is currently defined as “care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer” under Section 3 of the Act (20 ILCS 3960/3), Safety Net Impact Statements should include a certification for the three fiscal years prior to the application to the Illinois Health Facilities Planning Board of the amount of charity care provided by the applicant. Such amounts should be calculated by hospital applicants in accordance with the reporting requirements for charity care set forth in Section 20 (a)(3) of the Community Benefits Act, 210 ILCS 76/20 (a)(3), i.e., the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services. Non-hospital applicants should also report charity care at cost rather than charges in accordance with an appropriate methodology specified by IHFPB.

58) Safety Net Impact Statements should include a certification for the three fiscal years prior to the application to the Illinois Health Facilities Planning Board of the amount of care provided to Medicaid patients. Such amounts should be reported by hospital and non-hospital applicants by providing the information reported each year to the Illinois Department of Public Health regarding “Inpatients and Outpatients Served by Payor Source” and “Inpatient and Outpatient Net Revenue by Payor Source” and published by IDPH in the Annual Hospital Profile.

59) In addition to data provided on charity care and care provided to Medicaid patients, the applicant may provide in its Safety Net Impact Statement information regarding teaching, research and any other service provided by the applicant that it believes is directly relevant to the safety net.

60) The State Agency Report shall include a statement as to whether a Safety Net Impact Statement was filed by the applicant and whether it included the information described in paragraphs 57, 58 and 59 above, the names of the parties submitting Responses and the number of Responses and Replies, if any, that were filed.

Long Term Care

61) Require the Center for Comprehensive Health Planning to conduct a special analysis regarding the availability of long term care resources throughout the state, taking into consideration data and plans developed under the Older Adult Services Act, to adjust existing bed-need criteria and standards for changes in utilization of both institutional and non-institutional care, with special consideration of the availability of least-restrictive care options, when appropriate and in accordance with the needs and preferences of the persons requiring long term care.

62) Establish a separate set of rules and guidelines for long term care that recognize that nursing homes are a different business line and service model. In the revision of planning criteria and standards consider the fact that nursing homes have a significant number of open beds, as well as the transitional nature of Medicare skilled clientele. An open and transparent process should be developed that looks at the following: how skilled nursing fits into the continuum of care; other care providers who are licensed under the skilled nursing criteria; encouraging modernization, more private rooms and development of alternative services; and current trends (such as resident focused care) in the provision of long-term care services.

63) Adopt language under the CON process that allows for Continuing Care Retirement Communities (CCRC) to have CON application fees apply only to the licensed sections of the campus, not the unlicensed portions.

Reform of the Illinois Health Facilities Planning Board – Organizational Structure

64) In order to transition to a new focus on health planning and setting new criteria and standards by which CON projects are evaluated, the (reformed) CON Board – the Illinois Health Facilities and Services Review Board -- membership shall be increased from 5 to 9 members appointed by the Governor from a list of 3 nominees per office developed by the Special Nomination Panel. Appointments to the Board shall be subject to the advice and consent of the Illinois Senate. (See Attachment for the Special Nomination Panel.)

65) All members to be appointed shall have a reasonable knowledge of the practice, procedures and principles of the health care delivery system in Illinois. At least five (5) of the members of the CON Board should have knowledge about health care delivery systems, health systems planning, finance, or the management of health care facilities that are currently regulated under the Illinois Health Facilities Planning Act. At least one (1) of the members shall be a representative of a non-profit health care consumer advocacy organization. Each member shall be a resident of Illinois. At least 4 members shall reside outside of the Chicago Metropolitan Statistical Area. Appointments should reflect the ethnic, cultural and geographic diversity of the State of Illinois.

66) No more than 5 members of the CON Board may be from the same political party at the time of appointment.

67) The Special Nomination Panel shall nominate 3 nominees to Chair the CON Board on a full-time basis who will receive an annual salary to be determined. The Chair must have expertise in health care delivery system planning, finance or management of health care facilities that are regulated under the Illinois Health Facilities Planning Act. This appointment shall also be subject to the advice and consent of the Illinois Senate.

68) CON Board members (other than the Chair) shall be paid a part-time salary at a rate to be determined, and the Chairman shall be paid an additional amount to be determined per year to compensate for the additional duties required of that full-time position. Additional duties for the Chair include review of Board member performance on an annual basis. The Board shall report on the attendance record of members annually to the General Assembly. Each unexcused absence from a scheduled meeting of the full Board will result in a $500 deduction from the annual salaries, which may be pro-rated over the period of 4 regularly-scheduled pay periods.

69) Five members of the CON Board will constitute a quorum. The affirmative vote of 5 appointed members is required for approval of a project application. Terms of new CON Board members will be staggered. Four (4) of the initial appointments will be for two year terms, and 5 will be appointed for 3-year terms. After the initial terms, all members may serve for three year terms. Members cannot serve for more than 3 terms. Members whose terms have expired may only serve up to 6 additional months or until a successor has been appointed and qualified, whichever comes first.

70) The CON Board shall also be subject to strict ethics requirements – See Attachment.

71) No person who has been convicted or pled to a felony shall be nominated, appointed to the CON Board or hired as staff.

72) Spouses or other members of the immediate family of the Board cannot be an employee, agent or under contract with services or facilities subject to the Act. Prior to appointment and in the course of service on the Board, members of the Board shall disclose the employment or other financial interest of any other relative of the member, if known, in services or facilities subject to the Act, and members of the Board shall declare any conflict-of-interest that may exist with respect to the status of those relatives and recuse themselves from voting on any issue for which a conflict-of-interest is declared.

73) Any member may be removed for neglect of duty, misfeasance, malfeasance, or nonfeasance in office of for engaging in any political activity – i.e., activity in support of or in connection with any political organization, in accordance with state law and regulation. Board members must formally disclose any potential conflicts of interest, which must be filed with the Special Nomination Panel.

74) Within a separate and distinct budget approved by the General Assembly for such purposes, the CON Board, through the Chairman, shall have expressed independent authority to hire and supervise its own staff responsible for processing and reviewing CON project applications.

75) The CON Board may also contract for expertise related to specific health services or facilities, and create technical advisory panels to assist in the development of criteria, standards and procedures and the evaluation of projects that may require special attention.

76) The Illinois Department of Public Health shall, through inter-agency agreements and from the specific appropriations for such purposes, provide operational support to the CON Board, including the provision of office space, supplies and services, clerical services, financial and accounting services, etc.

Transition/Re-Organization

77) Establish a “saving” provision to allow for an orderly, acceptable and timely Board reorganization, which preserves the existing authority of the Board, and adjusts for pending applications during the re-organization and transition to the new CON process. Prospective applicants shall be given adequate notice regarding the effective date of the new Board and any related changes in standards and procedures.

78) Extend the “sunset” of the existing law for at least 10 years.

PROPOSED LEGISLATION

Sec. ____ . **Special Nomination Panel**. (Based on HA#4 to SB 2595 of the 95th General Assembly)

(a) The Nomination Panel is established to provide a list of candidates to the Governor for appointment to the Illinois Health Facilities and Services Review Board (the "Board"), the position of Chairman of the Board, and the Comprehensive Health Planner. Members of the Nomination Panel shall be appointed by a majority vote of the following appointing authorities: (1) the Executive Ethics Commissioner appointed by the Secretary of State; (2) the Executive Ethics Commissioner appointed by the Treasurer; (3) the Executive Ethics Commissioner appointed by the Comptroller; (4) the Executive Ethics Commissioner appointed by the Attorney General; and (5) the Executive Ethics Commissioner appointed to serve as the first Chairman of the Executive Ethics Commission, or, upon his disqualification, refusal to serve, or resignation, the longest-serving Executive Ethics Commissioner appointed by the Governor. However, the appointing authorities as of the effective date of this amendatory Act of the 95th General Assembly shall remain empowered to fill vacancies on the Nomination Panel until all members of the new Board, the Chairman of the Board, and the Comprehensive Health Planner have been appointed and qualified, regardless of whether such appointing authorities remain members of the Executive Ethics Commission. In the event of such appointing authority's disqualification, resignation, or refusal to serve as an appointing authority, the Constitutional officer that appointed the Executive Ethics Commissioner may name a designee to serve as an appointing authority for the Nomination Panel. The appointing authorities may hold so many public or non-public meetings as is required to fulfill their duties, and may utilize the staff and budget of the Executive Ethics Commission in carrying out their duties; provided, however, that a final vote on appointees to the Nomination Panel shall take place in a meeting governed by the Open Meetings Act. Any ex parte communications regarding the Nomination Panel must be made a part of the record at the next public meeting and part of a written record. The appointing authorities shall file a list of members of the Nomination Panel with the Secretary of State within 60 days after the effective date of this amendatory Act of the 95th General Assembly. A vacancy on the Nomination Panel due to disqualification or resignation must be filled within 60 days of a vacancy and the appointing authorities must file the name of the new appointee with the Secretary of State.

(b) The Nomination Panel shall consist of the following members: (i) 2 members shall be former federal or State judges from Illinois, (ii) 2 members shall be former federal prosecutors from Illinois, (iii) one member shall be a former sworn federal officer with investigatory experience with a federal agency, including but not limited to the Federal Bureau of Investigation, the Internal Revenue Service, the Securities and Exchange Commission, the Drug Enforcement Administration, the Bureau of Alcohol, Tobacco, Firearms and Explosives, or any other federal agency, (iv) 2 members shall be former members of federal agencies with experience in regulatory oversight, and (v) 2 members shall have at least 5 years of experience with nonprofit agencies in Illinois committed to public-interest advocacy for which the appointing authorities shall solicit recommendations from the Campaign for Political Reform, the Better Government Association, the Chicago Crime Commission, the League of Women Voters, the Urban League, the Mexican American Legal Defense and Educational Fund, and any other source deemed appropriate. Members shall submit statements of economic interest to the Secretary of State. Each member of the Nomination Panel shall receive $300 for each day the Nomination Panel meets. The Executive Ethics Commission shall provide staff and support to the Nomination Panel pursuant to appropriations available for those purposes.

(c) Candidates for nomination to the Illinois Health Facilities and Services Review Board, Chairman of the Board, or the position of Comprehensive Health Planner may apply or be nominated. All candidates must fill out a written application and submit to a background investigation to be eligible for consideration. The written application must include, at a minimum, a sworn statement disclosing any communications that the applicant has engaged in with a constitutional officer, a member of the General Assembly, a special government agent (as that term is defined in Section 4A-101 of the Illinois Governmental Ethics Act), a member of the Board or the Nomination Panel, a director, secretary, or other employee of the executive branch of the State, or an employee of the legislative branch of the State related to the regulation of health facilities and services within the last year. A person who knowingly provides false or misleading information on the application or knowingly fails to disclose a communication required to be disclosed in the sworn statement under this Section is guilty of a Class 4 felony.

(d) Once an application is submitted to the Nomination Panel and until (1) the nominee is rejected by the Nomination Panel, (2) the nominee is rejected by the Governor, (3) the candidate is rejected by the Senate, or (4) the candidate is confirmed by the Senate, whichever is applicable, a candidate may not engage in ex parte communications, as that term is defined in Section 5.7 of this Act.

(e) The Nomination Panel shall conduct a background investigation on candidates eligible for nomination to the Board, Chairman of the Board, or the position of Comprehensive Health Planner. For the purpose of making the initial nominations after the effective date of this amendatory Act of the 95th General Assembly, the Nomination Panel shall request the assistance of the Federal Bureau of Investigation to conduct background investigations. If the Federal Bureau of Investigation does not agree to conduct background investigations, or the Federal Bureau of Investigations cannot conduct the background investigations within 120 days after the request is made, the Nomination Panel may contract with an independent agency that specializes in conducting personal investigations. The Nomination Panel may not engage the services or enter into any contract with State or local law enforcement agencies for the conduct of background investigations.

(f) The Nomination Panel must review written applications, determine eligibility for oral interviews, confirm satisfactory background investigations, and hold public hearings on qualifications of candidates. Initial interviews of candidates need not be held in meetings subject to the Open Meetings Act; members or staff may arrange for informal interviews. Prior to recommendation, however, the Nomination Panel must question candidates in a meeting subject to the Open Meetings Act under oath.

(g) The Nomination Panel must recommend candidates for nomination to the Board, the Chairman of the Board, and the position of Comprehensive Health Planner. The Nomination Panel shall recommend 3 candidates for every open position and prepare a memorandum detailing the candidates' qualifications. The names and the memorandum must be delivered to the Governor and filed with the Secretary of State. The Governor may choose only from the recommendations of the Nomination Panel and must nominate a candidate for every open position within 30 days of receiving the recommendations. The Governor shall file the names of his nominees with the Secretary of the Senate and the Secretary of State. If the Governor does not name a nominee for every open position, then the Nomination Panel may select the remaining nominees for the Board, Chairman of the Board, or the position of Comprehensive Health Planner. For the purpose of making the initial recommendations after the effective date of this amendatory Act of the 95th General Assembly, the Nomination Panel shall make recommendations to the Governor no later than 150 days after appointment of all members of

the Nomination Panel. For the purpose of filling subsequent vacancies, the Nomination Panel shall make recommendations to the Governor within 90 days of a vacancy in office.

(h) Selections by the Governor must receive the advice and consent of the Illinois Senate by record vote of at least two-thirds of the members elected.

Sec. ____ **Ethics**. (New)

Members of the Health Facilities and Services Review Board (the "Board"), members of the Special Nomination Panel, the Comprehensive Health Planner, and employees will follow the rules outlined in 5 ILCS 430/ General Provisions, State Officials and Employees Ethics Act.

Sec. ___. **Ex parte communications**. (Suggested revisions noted in **bold**)
(Amends 20 ILCS 3960/4.2, Illinois Health Facilities Planning Act)
(Section scheduled to be repealed on July 1, 2009)

Sec. 4.2. Ex parte communications.

(a) Except in the disposition of matters that agencies are authorized by law to entertain or dispose of on an ex parte basis including, but not limited to rule making, the State Board, any State Board member, employee, or a hearing officer shall not engage in ex parte communication in connection with the substance of any pending **~~or impending~~** application for a permit with any person or party or the representative of any party. This subsection (a) applies when the Board, member, employee, or hearing officer knows, or should know upon reasonable inquiry, that the application is pending **~~or impending~~**.

(b) A State Board member or employee may communicate with other members or employees and any State Board member or hearing officer may have the aid and advice of one or more personal assistants.

(c) An ex parte communication received by the State Board, any State Board member, employee, or a hearing officer shall be made a part of the record of the matter, including all written communications, all written responses to the communications, and a memorandum stating the substance of all oral communications and all responses made and the identity of each person from whom the ex parte communication was received.

(d) "Ex parte communication" means a communication between a person who is not a State Board member or employee and a State Board member or employee that reflects on the substance of a pending or impending State Board proceeding and that takes place outside the record of the proceeding. Communications regarding matters of procedure and practice, such as the format of pleading, number of copies required, manner of service, and status of proceedings, are not considered ex parte communications. Technical assistance with respect to an application, not intended to influence any decision on the application, may be provided by employees to the applicant. Any assistance shall be documented in writing by the applicant and employees within 10 business days after the assistance is provided.

(e) For purposes of this Section, "employee" means a person the State Board or the Agency employs on a full-time, part-time, contract, or intern basis.

(f) The State Board, State Board member, or hearing examiner presiding over the proceeding, in the event of a violation of this Section, must take whatever action is necessary to ensure that the violation does not prejudice any party or adversely affect the fairness of the proceedings.

(g) Nothing in this Section shall be construed to prevent the State Board or any member of the State Board from consulting with the attorney for the State Board.
(Source: P.A. 93-889, eff. 8-9-04.)

COMPENSATION. (New)

Sec. ___ . Each Member of the Board shall receive a part-time salary to be determined. The Chairman of the Board shall receive a full-time salary to be determined. Board members will be reviewed annually for their performance, and may be removed pursuant to provisions of related bylaws adopted by the Illinois Health Facilities Board for not executing their duties.

Sec. ___. The Comprehensive Health Planner shall be paid a full-time salary to be determined, or such amount as set by the Compensation Review Board.

Cost Estimates

Proposed Reorganization for Illinois Health Facilities Planning Board
CON Board Inside Illinois Dept of Public Health

Center for Comprehensive Health Planning Inside Illinois Dept Public Health
Estimated Annual Budget Summary

Expenditure Details	Annual Estimates	
1- Senior Public Service Administrator	120,000	Division Manager
1- Public Service Administrator Opt 1	78,000	Data Manager
3- Public Service Administrator Opt 6	165,000	Health System Planners
1- Senior Public Service Administrator	81,000	Health Care Economist
4- Management Operations Analyst	294,000	Analysts
1- Public Service Administrator Opt 1	55,000	Community Coordinator
.5- Legal Counsel	30,000	Legal
1- Administrative Assistant Opt 1	50,000	Clerical Support
1- Office Associate	34,000	Clerical Support
Total Personal Services (13.5 FTE)	907,000	
Fringe	541,415	
Contractual	100,000	
Travel	5,200	
Supplies	910	
Equipment	1,040	
Lease (Rent & Utilities Included)	3,900	
Telecommunications	2,860	
Estimated Annual Expenses	1,562,325	

Health Facilities & Services Review Board
(Reformed CON Board)
Estimated Budget Summary

Expenditure Details **Certificate of Need Board**	**Annual Estimates**	
1- Chairman **	90,000	
8- Board Members **	520,000	
1- Administrative Assistant Opt 2	62,000	Board Support
Review Section		
1 - Public Service Administrator Opt 1	59,000	Senior Reviewer
3 - Public Service Administrator Opt 6	142,000	Reviewers
Compliance		
1 - Public Service Administrator Opt 6	81,000	Compliance Manager
1 - Administrative Assistant Opt 1	62,000	Compliance Reseacher
1 - Executive 2	59,000	Compliance Assistant
Administrative		
1- Public Service Administrator Opt 2 (.2)	12,000	Fiscal Manager
1- Public Service Administrator Opt 1 (.2)	12,000	HR/Procurement Manager
1- Senior Public Service Administrator (.15)	11,400	Assistant Deputy Director
Clerical		
1- Office Specialist	38,000	Clerical Support
1- Administrative Assistant Opt 1	50,000	Clerical Support
1- Administrative Assistant Opt 2	56,000	Clerical Support
Rules		
1 -Public Service Administrator Opt 1	76,000	Rules Manager
Legal		
1- Chief Legal	96,000	Chief Legal
1- Attorney	60,000	Attorney
Total Personal Services ***(14.55 FTE & 9 Board Members)**	1,486,400	
Fringe	909,950	
Contractual	188,000	
Travel	23,672	
Supplies	3,980	
Equipment	10,000	
Lease (includes Rent & Utilities)	-	
Telecommunications	11,022	
Estimated Annual Expenses	2,633,024	

* This FTE total does not include the 9 Board Members
** Board Salary Rates are per the Task Force on Health Planning Reform Blueprint

Conclusion

The Task Force on Health Planning Reform urges the General Assembly to implement its recommendations to establish and implement a Statewide Comprehensive Health Plan, as well as reform the Certificate of Needs process. We believe that the overall changes included in the recommendations will have the effect of rejuvenating and insulating the Illinois Health Facilities Planning Board, as well as increasing the ability of all state agencies to use sound health planning to guide their work.

The Task Force has proceeded cautiously and deliberately, as was recommended by the Lewin Group, and examined in minute detail all of the aspects and opinions about overall health planning and the health facilities planning process, in order to present these recommendations. Given the important nature of the CON process, which promotes the distribution of needed health care services, this Task Force concluded that reforms, rather than dissolution, is the best course of action. Especially in the current economy, it is important to maintain the framework of the process.

Our work concluded on December 31, 2008 and any proposed reforms are due to be implemented by July 1, 2009, which corresponds to the sunset date for the CON program in House Bill 5017. The Task Force expects to be available to the 96th General Assembly for the legislative implementation of these recommendations. A complete record of the Task Force activities is available on the Illinois Department of Public Health website.

Signers

Susan Garrett
Illinois State Senator

Lisa Dugan
Illinois State Representative

Pam Althoff
Illinois State Senator

Gary Barnett
Sarah Bush Lincoln Health Center

Paul Gaynor
Office of the Attorney General

Renee Kosel
Illinois State Representative

Claudia Lenhoff
Champaign County Health Care Consumers

Sister Sheila Lyne
Mercy Hospital and Medical Center

William McNary
Citizen Action Illinois

Ken Robbins
Illinois Hospital Association

Hal Ruddick
SEIU Local #4

Margie Schaps
Health & Medicine Policy Research Group

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APPENDIX A

MINORITY REPORT:

In Dissent from the Majority Recommendations of the Task Force on Health Planning Reform

Senator Bill Brady does hereby dissent from the majority which has approved recommendations to be presented to the General Assembly on behalf of the Task Force.

Bill Brady
Illinois State Senator

SUMMARY

The vast majority of the recommendations being submitted by the Task Force on Health Planning Reform have unanimous support from the members of the Task Force. However, there are a few critical points of disagreement. The points of dissent are briefly outlined in this introduction and are discussed in greater detail in the body of this report.

Points of Dissent:

- **Independence of the CON Board from the Executive Branch:**
  Concern over ethical Board conduct was a centerpiece of Task Force deliberations. A recommendation to establish an independent Certificate of Need Board (CON Board) was put before the members of the Task Force but rejected when representatives from the Department of Public Health estimated that an independent Board would cost roughly $300,000 more to operate than a CON Board that resided within the Executive Branch of government. The Department's cost projections are grossly exaggerated; subsequently there is disagreement with the majority's decision to place the CON Board under the control of the Department of Public Health. A

CON Board should operate independent of the Executive Branch of government and should therefore not come under the administrative umbrella of the Department of Public Health.

- **CON Board & Charity Care**

  The recommendations of the Task Force to the General Assembly include a section on "Charity Care and Safety Net Services". The value of a Safety Net Impact Statement to the certificate of need process is not contested. However, a stipulation allowing the CON Board to include "reasonable conditions or stipulations" concerning charity care as a factor in certificate of need determination is not an acceptable proposition. Only one other state in the union (Virginia) considers charity care in the deliberations of certificate of need applications. This state has a defined and structured process that incorporates charity care in the certificate of need process. The Task Force recommendations, by contrast, leave any charity care stipulations and definitions entirely to the discretion of the CON Board. The CON Board should not be bestowed with this power.

- **Capital Threshold for non-hospital providers**

  The current threshold that a project must exceed to trigger the requirement for a certificate of need based solely on capital expenditures is $8.9 million. This means that a project that is not otherwise required to come in for a certificate of need is compelled to do so if its capital expenditure exceeds the $8.9 million threshold. The Task Force increased this threshold for hospitals to $11.5 million. The Task Force also inexplicably lowered this threshold for all other providers to $4.2 million. It is not possible to agree with this position of the majority Task Force members.

- **Nursing Home exclusions**

  A coalition of organizations representing the nursing home industries testified before the Task Force and was asked to submit recommendations. One recommendation that was rejected by the majority in the Task Force would allow for the sale of excess and unused bed capacity in one facility to a facility that is seeking to expand capacity. This measure is used in other states and does not add to the number of allowable beds in a given service area. However, the stipulation would encourage modernization that would lead to less restrictive living conditions and more personal

independence within the nursing home environment. This provision would enable seniors to have more choice in their long term care living environment and should have been supported by the Task Force.

- **Constitutionality of Nominating Panel**

  Article V, Section 9 of the Illinois Constitution dictates that the Executive Branch of government retains the duty and obligation to nominate and appoint executive offices. The Nominating Panel, as it is conceived in the Task Force report, would allow a newly created panel to limit the Governor's ability to nominate and appoint executive officials. The constitutionality of this provision is questionable, especially if the reformed CON Board is to remain under the administrative umbrella of the Department of Public Health.

- **Re-evaluating services requiring a certificate of need**

  Despite the lengthy deliberations of the Task Force, a comprehensive review of services that require a certificate of need was not conducted. The continuation of this exercise is necessary, at minimum dialysis should be removed from the list of health care services that requires a certificate of need.

- **Consideration given to high population growth areas**

  Special consideration needs to be given to areas of high population growth, particularly those with high levels of patient migration to other planning areas. It is the hope of the Task Force that high growth areas will be addressed through the newly established planning process, however, no specific recommendations or guidance is given by the Task Force on how this is to occur. Rules governing the CON process should include special consideration for high population growth areas and that those rules should be reviewed and updated at least annually.

- **Legislative input needed for greater clarity**

  Many recommendations received the support of the legislators serving on the Task Force but were not supported by the other members of the Task Force. The greatest example of this dichotomy was the decision to house the CON Board at the Department of Public Health. Other issues that need to be addressed more fully by members of the General Assembly include; the salary and compensation of CON

Board members, reinstating categorical Board membership and tasking the Comprehensive Planning Agency or CON Board with recommending public healthcare financing solutions.

CON Board Independence

The independence of the Board from the Executive Branch of government was the single most important issue before the Task Force. Placing the CON Board under the umbrella of the Executive Branch lends itself to a continued pattern of corruption that has plagued the Health Facilities Planning Board in recent years. If the CON Board is dependent on an executive agency for its survival then the threat of pay-to-play scandals is always present. To neutralize that threat, an independent CON Board should be created.

The evidence that persuaded the members of the Task Force to continue executive control of the CON Board was an inflated cost estimate provided by staff from the Department of Public Health. This cost estimate is unnecessarily overstated. If the cost estimate for an independent CON Board is reduced by approximately 10% then it would be the same (or even less) than the cost estimate approved by the majority members of the Task Force. If the cost estimates for an independent CON Board are equal to, or less than, a CON Board within the Department of Public Health, there is no reason not to have an independent CON Board.

The independent CON Board cost projection could be adjusted as follows:

Department's projected cost of independent CON Board	**$3,003,931**
Adjustments	
Office Lease - The Department is currently required to pay CMS for office space yet this is not included in the cost estimate. The independent Board could also be housed in existing state space with no greater costs to the state than if it were under the umbrella of DPH	(120,000)
2nd Attorney - there is currently only 1 attorney serving the Board with no need for an additional lawyer.	(60,000)
HR/Procurement Manager - many small agencies combine the fiscal officer, human resource and procurement functions. The new Board should be able to fill this role for around $70,000 thus saving about $50,000 from the Department's estimated costs.	(50,000)

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Fiscal Assistant - this position is unnecessary.	(37,000)
Office Associate - The Department's model has 5 support staff which represents over a quarter of the entire staff. This is excessive. The Board can function with one less support staffer.	(34,000)
Fringe benefits - with 4 fewer staff, the Board will save on fringe benefits (group health insurance, pension and social security costs).	(87,000)
Total Savings	**($388,000)**
Adjusted cost projection for independent CON Board	**$2,615,931**
Department's cost estimate for executive branch CON Board	$2,633,024

Charity Care

Another issue of vital importance discussed by the Task Force was the issue of the amount of charity care provided by a facility seeking certificate of need approval. The Task Force heard testimony on this topic at more than one meeting and the subject dominated much of the Task Force's discussion. Despite the inordinate amount of time dedicated by the Task Force to the topic of charity care, the majority members of the Task Force settled on a vague and speculative compromise to the charity care issue.

The charity care provisions of the new CON Board are detailed in articles 49 through 61 of the Task Force Report. The ability to include "reasonable conditions or stipulations" (Article 49 of the Task Force Report) in their consideration of a certificate of need application enables the CON Board to define what are "reasonable conditions or stipulations". This power should be bestowed on the CON Board. Any charity care conditions or stipulations should be defined in statute by the people's representatives in the General Assembly. CON Board members are not elected officials and they should not be making important policy decisions. It is the responsibility of the CON Board members to execute the law as written by the legislature. The legislature should not forfeit their ability to legislate to the CON Board. To that end, the recommendations of the Task Force concerning charity care be taken into consideration as the

debate on the provision of charity care continues within its proper venue; the Illinois General Assembly.

A more stringent review of the only state to require charity care provisions in its certificate of need process is recommended. Virginia is the only state that considers charity care in reviewing certificate of need applications.

Capital Threshold

The majority of Task Force members approved an amendment to Article 24 of the Task Force Report at the December 19th meeting. This change increased the capital threshold for hospital construction projects from $8.9 million to $11.5 million. While there is agreement among Task Force members for increasing the capital threshold for hospitals, the Task Force also approved lowering the capital threshold for all other healthcare providers in the same motion from $8.9 million to $4.2 million. It is not possible to agree with this recommendation.

The capital threshold for the certificate of need is only applicable to projects that are not otherwise required to seek a certificate of need. Discussion on lowering this threshold for other healthcare providers (including dialysis centers, nursing homes, surgical centers, etc.) was brief and may not have been fully understood by all of the voting members of the Task Force. This is a significant change from the current certificate of need process and was done rather hastily and with little, if any, testimony by those impacted the most. It is essential extreme caution be taken in dealing with this issue, and to emphasize the point that the reduced threshold contained in the Task Force Report is not preferred.

Nursing Homes

A coalition of organizations representing the nursing home industries testified before the Task Force and was asked to submit recommendations. One recommendation that was rejected by the majority in the Task Force would allow for the sale of excess and unused bed capacity in one facility to a facility that is seeking to expand capacity. This measure is used in other states and does not add to the number of allowable beds in a given service area. However, the stipulation would encourage modernization that would lead to less restrictive living conditions

and more personal independence within the nursing home environment. In addition, this provision would enable seniors to have more choice in their long term care living environment.

This measure would also be a positive step that adds competition into a certificate of need process that is often exploited by health care providers to repel competitors. If an arrangement were to be adopted that permitted the sale of unused capacity it would be more difficult for providers to "hoard" unused bed capacity and prevent a competitor from demonstrating need before the CON Board. Few, if any, measures encouraging competition are contained in the Task Force Report. This measure was unanimously proposed by those representing the long term care industry. This could be a valuable experiment in transforming the CON in the future to a process that encourages responsible competition rather than stifling competitive growth.

Nominating Panel Constitutionality

Article V, Section 9 of the Illinois Constitution dictates that the Executive Branch of government retains the duty and obligation to nominate and appoint executive offices. The Nominating Panel, as it is conceived in the Task Force report, would allow a newly created panel to limit the Governor's ability to nominate and appoint executive officials by permitting anyone to submit a request to the Nominating Panel to be considered for appointment. The power to select potential nominees for appointment clearly resides with the Governor according to the Illinois Constitution. The Nominating Panel concept may be more clear and appropriate if the Governor retained the sole responsibility to select potential candidates and he/she alone would be the only entity to submit names of potential nominees to the Panel. The Panel could then vet the Governor's nominees and give him/her a choice of three vetted candidates that could be put before the Senate for confirmation.

There is dire need for reform in selecting ethical members of the CON Board, but the constitutionality of the Nominating Panel provision as it exists in the Task Force recommendations is questionable. Further investigation of this construct is warranted during the course of the legislative process.

Dialysis

Despite the lengthy deliberations of the Task Force, a comprehensive review of services that require a certificate of need was not conducted. Dr. Gordon Lang testified that the CON process lowered the quality of dialysis services and that long travel times required by the CON process jeopardized the health of dialysis patients. Future discussion on this issue is warranted. Further, dialysis should be removed from the list of health care services that requires a certificate of need. This action would be especially timely if the reduced threshold of $4.2 million is adopted by the members of the General Assembly.

High Growth Consideration

Special consideration should be given to areas of high population growth, particularly those with high levels of patient migration to other planning areas. It is the hope of the Task Force that high growth areas will be addressed through the newly established planning process, however, no specific recommendations or guidance is given by the Task Force on how this is to occur. Rules governing the CON process should include special consideration for high population growth areas and that those rules should be reviewed and updated at least annually. The CON Board should convene a special sub-committee to create and review these rules and have public hearings to establish and revise the rules.

Greater Legislative Input

Some key components of the CON process were not clarified in the deliberations of the Task Force. Among these are; the salaries of CON Board members, categorical membership on the CON Board and the ability of the Comprehensive Planning Agency or CON Board to recommend public healthcare financing solutions. CON Board members should be paid equitably with other independent boards and commissions; using them as a guideline. The CON Board should be a professional board and the salaries of board members should be able to attract qualified and ethical candidates.

Categorical membership on the CON Board should be reinstituted. Never has the Board experienced ethical problems with the categorical membership. Categorical membership offers

the Board access to expertise that it cannot obtain through other means. Life experience is important to the process and should be recognized and utilized.

Finally, any and all references to the CON Board or the Comprehensive Planning Agency's ability to make recommendations on public healthcare financing are inappropriate and should be stricken. Neither entity is in a position to recommend changes to the State's publicly financed healthcare system (Medicaid) as neither will retain expertise in these programs. Attempting to mandate either entities participation in discussions of public healthcare financing would dilute both entities efforts at their true purpose and would likely yield few, if any, plausible recommendations.

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APPENDIX B:

Illinois Task Force on Health Planning Reform Testimony

Name	Date of Testimony	Affiliation
Paul Parker	March 3, 2008	American Health Planning Association
Al Dobson	March 3, 2008	Lewin Group
Dr. Kyusuk Chung	March 3, 2008	Governor's State University
Jeffery Mark	March 3, 2008	Illinois Health Facilities Planning Board
Mark Silberman & Frank Urso	March 3, 2008	Illinois Department of Public Health
Dr. Glenn Poshard	March 12, 2008	Southern Illinois University
Barry Maram	March 12, 2008	HFS
James Tierney	April 14, 2008	Illinois Medical Society
Janet Nally	April 14, 2008	American Medical Association
Mark Newton	April 14, 2008	Association of Safety Net Hospitals
Mark Mayo	April 14, 2008	Ambulatory Surgical Center Association
Ann Guild	May 12, 2008	Illinois Hospital Association
Ralph Weber	May 12, 2008	Northwestern Memorial Hospital
Thomas Manak	May 12, 2008	Provena Health
Kathy Yosko	May 12, 2008	Rehabilitation Hospital
Jeffrey Hill	May 12, 2008	Galena-Straus Hospital
Margaret Gustafson	May 12, 2008	Kewanee Hospital
Dan Lawler	May 12, 2008	Bell, Boyd & Lloyd
Joe Ourth	May 12, 2008	Arnstein and Lehr
Ann Murphy	May 12, 2008	Holland and Knight
Jack Axel	May 12, 2008	Axel and Associates
Clare Ranalli	May 12, 2008	Hinshaw and Culbertson
Ralph Martire	June 9, 2008	Center for Tax and Budget Accountability
David Buysse	June 9, 2008	Office of the Attorney General Lisa Madigan
Coleen Muldoon & Lori Wright	June 9, 2008	Fresenius Medical Care
Sumantata Ray & Keith Kelleher	July 14, 2008	SEIU
David Dranove	July 14, 2008	Northwestern University
Dennis Bozzi	July, 14, 2008	Life Services Network
Judy Amiano	July, 14, 2008	Riverside Health Care
Billie Paige	July, 14, 2008	Shea, Paige, Rogal and Associates
Pam Comstock & Terry Sullivan	July, 14, 2008	Health Care Council of Illinois / Illinois Counsel on Long Term Care
Jeffery DeMint	July, 14, 2008	Village of Plainfield
Susana Loptaka	Aug 15, 2008	Health Facilities Planning Board
James Burden	Aug 15, 2008	Health Facilities Planning Board
Courtney Avery	Aug 15, 2008	Health Facilities Planning Board
Claire Burman	Aug 15, 2008	Health Facilities Planning Board
Fred Benjamin	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Clarence Nagelvoort	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Michael Copelin	Aug 15, 2008	Formerly of the Health Facilities Planning

		Board
Michael Gonzalez	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Joyce Washington	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Pat Sweitzer	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Ray Passeri	Aug 15, 2008	Formerly of the Health Facilities Planning Board
Joseph Miller	Sept 15, 2008	U.S. Department of Justice, Anti-Trust Division
Dr. Gordon Lang	Sept 15, 2008	Illinois State Medical Society
Annette Kennedy	Oct 30, 2008	Edward Health Services Corporation

APPENDIX C:

Illinois Task Force on Health Planning Reform Documents

For information on the Illinois Health Facilities Planning Board, see the Illinois Department of Public Health's Health Facilities Planning Board website: http://www.idph.state.il.us/about/hfpb.htm.

The following documents concerning the Task Force on Health Planning Reform are available through the Illinois Department of Public Health's Task Force on Health Planning Reform website: http://www.idph.state.il.us/tfhpr/index.htm.

General:

- Statutory Authority
- Bylaws
- Members
- Meetings
- Financial Reports
- Matrix of CON programs by state
- Illinois Health Facilities Planning Act

Financial Reports:

- HFPB FY 88 to FY 08 Revenue Detail
- HFPB FY 88 to FY 08 History of Revenues, Appropriations and Expenditures
- HFPB FY 88 to FY 08 Expenditure Detail
- Vendor Contracts FY 06
- Vendor Contracts FY 07
- Vendor Contract FY 08
- Illinois Health Facilities Payor Mix - 2006

Agendas for the following Meetings:

- Feb 11, 2008
- March 10, 2008
- April 14, 2008
- June 9, 2008
- July 14, 2008
- Aug 15, 2008
- Sept 2, 2008
- Sept 5, 2008
- Sept 15, 2008
- Oct 8, 2008
- Oct 30, 2008
- Dec 8, 2008
- Dec 19, 2008

Minutes of the following Meetings:

- Jan 31, 2008
- Feb 11, 2008

- March 10, 2008
- March 12, 2008
- April 14, 2008
- May 12, 2008
- June 9, 2008
- July 14, 2008
- Aug 15, 2008
- Sept 15, 2008
- Oct 8, 2008
- Oct 30, 2008
- Dec 8, 2008
- Dec 19, 2008

Transcripts of the following Meetings:

- March 10, 2008
- March 12, 2008
- April 14, 2008
- June 9, 2008
- July 14, 2008
- Aug 15, 2008
- Sept 15, 2008
- Oct 30, 2008

Written Testimony / Documents Submitted:

Date	Title
March 10, 2008	Certificate of Need Regulation – A National Overview by Paul E. Parker, American Health Planning Association
March 10, 2008	Study by Lewin Group by Al Dobson
March 10, 2008	Supplemental Information to Study by Lewin Group submitted by Jeffrey Mark & Frank Urso
March 10, 2008	Presentation by Kyusuk Chung, Ph. D
March 10, 2008	Illinois Health Facilities Planning Fund Summary by Illinois Health Facilities Planning Board
April 14, 2008	Illinois Hospital Association Recommendations to Reform Certificate of Need by Ann Guild
June 9, 2008	The Role of Non-Profit Hospital Charity Care in Illinois' Publicly-Funded Health Care Safety-Net by Ralph Martire
June 9, 2008	Illinois Health Planning Reform: Competition, Certificates of Need and Charity Care by David Buysse
June 9, 2008	Testimony before Legislative Task Force on Health Planning Reform, Fresenius
June 9, 2008	"America's Health Care Safety Net, Intact but Endangered" – Carvalho handout
June 9, 2008	Map of Illinois Hospitals
July 14, 2008	Healthcare on the Brink: An Integrated Solution to Illinois' Health Care Crisis by David Dranove
July 14, 2008	Center for Tax and Budget Accountability – Charity Care Study, prepared by Heather O'Donnell & Ralph Martire
July 14, 2008	CON Task Force Presentation

July 14, 2008	SEIU Position Paper
Aug 15, 2008	Formal Remarks before the Task Force on Health Planning Reform by Susana Loptaka
Aug 15, 2008	Rules Development – Open Meetings Document
Aug 15, 2008	Rulemaking – Status Report
Aug 15, 2008	Comparative Assessment of Program Fees
Aug 15, 2008 Sept 15, 2008	Framework for Discussion and Recommendation
Sept 15, 2008	Summary of Testimony Feb to Aug 2008
Sept 15, 2008	IHA Position on a Charity Care Mandate as Part of Certificate of Need
Sept 15, 2008	Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform
Sept 15, 2008	Testimony by Dr. Gordon Lange
Oct 8, 2008	Summary of Facilitated Discussion
Oct 8, 2008	Summary of Testimony Feb to Sept 2008
Oct 8, 2008	Discussion Questions
Oct 8, 2008	Discussion Framework
Oct 8, 2008	Health Facilities Planning Board statutory authority
Oct 30, 2008	Comprehensive Health Planning Chart
Oct 30, 2008	Draft Blueprint
Oct 30, 2008	Summary of facilitated discussion, Oct 8, 2008
Oct 30, 2008	Edward Hospital Testimony by Annette Kenney
Oct 30, 2008	Long-term care policy statement
Dec 8, 2008	Charity Care and Safety Net Services Draft
Dec 8, 2008	THFPR Proposed Blueprint Draft
Dec 8, 2008	HCCI Long-Term Care Comments
Dec 8, 2008	Health Facilities Planning Act – Proposed Amendments
Dec 8, 2008	Chart – Reorganization CON Board inside IDPH
Dec 8, 2008	Chart – Reorganization CON Board outside IDPH
Dec 8, 2008	TFHPR Survey Results
Dec 8, 2008	Matrix – CON Programs by State
Dec 19, 2008	Chart – CON Review
Dec 19, 2008	Certificate of Need or Exemption to Permit Assessment of Applicability
Dec 19, 2008	Health Facilities & Services Review Board Estimated Budget Summary
Dec 19, 2008	Revised Chart – Reorganization CON Board Inside IDPH
Dec 19, 2008	Revised Chart – Reorganization CON Board Outside IDPH
Dec 19, 2008	TFHPR Revised Blueprint
Dec 31, 2008	TFHPR Final Report
Dec 31, 2008	5 ILCS 430/General Provisions, State Officials and Employees Ethics Act

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