Illinois Task Force on Health Planning Reform
Summary of Testimony
February 2008 to August 2008

This document is a summary of the testimony that occurred at public meetings of the Task Force on Health Planning Reform between February 2008 and August 2008. The statutory requirements have been used to create a framework for this summary, which was compiled from the meeting minutes and written testimony. In some cases, testimony is applicable to more than one area of statutory language, so there are places where bulleted information is repeated.

Notes on formatting:

- The bold indicates statutory language.
- Testimony is noted by the testifier's name and affiliation, and a summary of their comments that relate to the statutory language.
- The italicized paragraphs reflect an overall summary of the bulleted testimony.

OVERALL IMPACT

The Task Force shall gather information and make recommendations relating to at least the following topics in relation to the Illinois Health Facilities Planning Act:

- **The impact of health planning on the provision of essential and accessible health care services**
    - Paul Parker/American Health Planning Association (AHPA) – most states do not devote enough resources to health facilities planning and analysis.
    - Dr. Glenn Poshard/Past Chair, Illinois Health Facilities Planning Board (IHFPB) -- comprehensive health care planning should be done as part of the work of the Board, but not sure how they can do that given the large time commitment already needed to review applications. A state health plan is essential to making objective, rather than subjective, decisions about applications.
    - Susana Lopatka/Chair, IHFPB -- Board exists to do health planning as well as review 'Certificate of Need' (CON) applications. Current size of board prevents most health planning.
    - Ray Passeri/Former Executive Secretary, IHFPB-- reiterated that this was called a "Planning Act" for a purpose, and there should be a connection between the planning and regulatory aspects of the CON process.
    - Current and past IHFBP members who testified on August 15 spoke to the need to have a clear vision to direct the Board's activities. Part of this clear vision will come from a health planning component.
    - Joseph Miller/US DoJ –
        - Incumbent hospitals argue that they should be protected against additional competition so that they can continue to offer services to the uninsured or underinsured.
        - The imposition of regulatory barriers to entry as an indirect means to fund charity care may impose costs on all health care consumers.

- If the goal in IL is to preserve the Safety Net, there are other less costly solutions that CON for doing this
- It is also possible that CON laws do not actually advance the goal of maintaining charity care. Specialty hospitals generally open in areas of high population growth, and do not siphon off the patients that use Safety Net hospitals.

- *Overall, testifiers believe that the there should be statewide health planning. Some testified that the IHFPB should provide this function with the help of additional staff resources. Others suggested that another entity (separate but linked to the IHFPB) could conduct statewide health planning. Some testified that the absence of a statewide health plan increased the likelihood of subjectivity in the IHFPB decisions. However, few recommendations were given on the specifics of how the statewide planning should be done (regional basis, etc), how often (10 years?), who should do it, how it should be funded, etc. The statute outlines several points for the Task Force to consider with regards to health planning, and that language begins on page 15 of this document.*

- **Prevention of unnecessary duplication of facilities and services**
  - Paul Parker/AHPA – CON certainly impacts the pattern of health facilities development
  - David Buysee/Office of the Attorney General Lisa Madigan (AG) – cited a 2008 Illinois Hospital Association (IHA) report that stated that the primary purpose of CON should be to prevent unnecessary duplication in order to preserve access to the Safety Net.
  - Keith Kelleher/Service Employee International Union Healthcare IL & IN (SEIU) - the IHFBP does prevent duplication.
  - Joseph Miller/US DoJ – stated that CON laws impede the efficient performance of health care markets by creating barriers to entry and expansion to the detriment of health care competition and consumers. Market forces tend to improve the quality and lower the costs of health care goods and services.
  - Dr. Gordon Lang – CON regulations prevent the opening of necessary dialysis centers within a certain distance of each other. Dr. Lang argues that these centers are necessary because dialysis patients do not want to drive far for treatment.
- *One of the original stated goals of CON was to prevent unnecessary duplication of health facilities to contain healthcare costs and improve access and quality. While most testifiers cannot agree on whether CON improves quality and access, nor on whether it lowers healthcare costs, most agree that CON does its job of preventing duplication of healthcare facilities and services.*

- **Improvement in the efficiency of the health care system**
  - Joseph Miller/US DoJ – stated that CON laws impede the efficient performance of health care markets by creating barriers to entry and expansion to the detriment of health care competition and consumers. market forces tend to improve the quality and lower the costs of health care goods and services. CONs undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs.

- *There is not sufficient testimony to summarize whether or not the CON process improves the efficiency of the health care system.*

- **Maintenance of an environment in the health care system that supports quality care**
    - Paul Parker/AHPA – some evidence that CON regulation benefits quality for some types of services, but this is not a totally resolved question
    - Al Dobson/Lewin Group -
        - CON impacts the quality of care due to fewer service providers. Higher volume per facility= more practice= better quality
        - Quality measures could be rewarded by higher reimbursement from insurance, not through CON planning
    - Janet Nally/American Medical Association (AMA) - CON is not an effective quality improvement mechanism
    - Joseph Miller/ USDoJ – Market forces tend to improve the quality and lower the costs of health care goods and services. CON laws stifle competition that could encourage community hospitals to improve their performance.
    - Dr. Gordon Lang – CON hurts quality. The fewer dialysis centers allowed to open means each center must treat a high number of patients, which lowers quality.
- *There is conflicting testimony as to whether or not the CON process maintains quality care.*

- **The most economic use of available resources**
    - Paul Parker/AHPA – not much difference in health care costs between states with and without CON
    - Al Dobson/Lewin Group- not much change in healthcare costs when CON is removed in a state
    - Janet Nally/AMA – some studies have concluded that CON programs actually increase health care costs
    - Ann Guild/IHA - not the task of the IHFPB to standardize financing of healthcare facilities or determine balance in quality of hospital resources across the board
    - David Buysse/AG –
        - Cited a report by the Federal Trade Commission that stated that CON programs are not successful in containing healthcare costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits
        - Cited a 2005 AHPA report that argued for the value of CON as a market balancing tool to help protect the Safety Net
        - Cited a 2008 IHA report that stated that CON is weak with regards to containing costs so that should be a secondary role of the IHFPB.
    - Joseph Miller/ USDoJ –
        - Market forces tend to improve the quality and lower the costs of health care goods and services. CONs undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs.

    - Government regulations concerning health care reimbursement have changed in a way that eliminates the original justification for CON programs.
    - CON laws impose additional costs and may facilitate anti-competitive behavior
  - Dr. Gordon Lang- CON is counterproductive and anti-competitive. Let the free market do its work.
- *There is not a clear answer among testifiers as to whether or not the CON process allows for the most economic use of available resources. Some people are of the opinion that the CON process unduly restricts competition and the free market should sort out which health facilities prosper, while others believe that CON should restrict competition to protect the Safety Net. Many testifiers believe it should not be within the scope of the IHFPB to contain costs within a healthcare facility or balance costs between healthcare facilities.*

- **The effect of repealing this Act.**
  - NO, do not repeal Act
    - Dr. Glenn Poshard/Past Chair, IHFPB - eliminate Sunset statute or extend the repeal date
    - Mark Mayo/Ambulatory Surgical Center Association (ASCA) - only statewide group of ASTC's that continues to support CON
    - Al Dobson/Lewin Group- keep CON for 3 years under certain restrictions
    - Mark Newton/Association of Safety Net Hospitals (ASNH) - keep CON as it increases access to care in Safety Net hospitals
    - Ann Guild/IHA- keep CON, protect the Safety Net, but don't add additional bureaucracy
    - Clare Ranalli/Attorney to CON applicants - stated that none of her clients wanted to repeal CON
    - Ralph Martire/Center for Tax & Budget Accountability (CTBA)- Keep CON because it protects the Safety Net
    - Coleen Muldoon & Lori Wright/Fresenius - keep CON
    - David Buysse/AG - believes that the CON process and protection offered to health facilities should continue to further the original purposes of the Illinois Health Facilities Planning Act. Protecting access to necessary health services should be the major focus of CON and unnecessary duplication should remain as a goal but not the focus.
    - Keith Kelleher/SEIU - does not want the Act repealed as it protects Safety Net services and should be kept permanently
    - Susana Lopatka, Courtney Avery, and James Burden/current IHFPB members – keep IHFPB
    - Fred Benjamin, Clarence Naglevoort, Michael Copelin, Michael Gonzalez, Joyce Washington, Pat Sweitzer, Ray Passeri/former IHFPB members and staff -- the Sunset cripples the Board. Eliminate the Sunset and keep the Board permanently.
  - YES, repeal the Act
    - Janet Nally/AMA – CON does not improve access to care
    - James Tierney/IL State Medical Society (ISMS) – end CON, do not expand into physician offices

- Joseph Miller/USDoJ – Task Force members should consider if CON achieves its stated goals. Is there another way to achieve CON goal without restricting competition?
- Dr. Gordon Lang – yes, repeal CON for dialysis centers.

- *The vast majority of testifiers do not want the Act repealed. They believe in the CON process, yet most think the process should be improved in various ways.*

REFORMATIONS

- **Reform of the Illinois Health Facilities Planning Board to enable it to undertake a more active role in health planning to provide guidance in the development of services to meet the health care needs of Illinois, including identifying and recommending initiatives to meet special needs.**
  - Susana Lopatka and other current and former IHPPB members recommended increasing the number of board members which would allow for subcommittees, one of which would do health planning.
- *Overall, most testifiers would like the IHFPB to do health planning, though it is not clear how the Board members would have time to participate in that given the large amount of time it takes to review applications. The statute outlines several points for the Task Force to consider with regards to health planning, and that language begins on page 15 of this document. No recommendations were given about initiatives to meet special needs.*

- **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.**
  - Mark Newton/ASNH – advised against the idea that a facility should only be allowed to expand if they have high marks in the Hospital Report Card and Consumer Guide to Health. Newton stated that every hospital wants to do the right thing and get the high marks, but not every hospital can afford to do this.
  - Mark Mayo/ASCA - recommends that IDPH licensure and the IHFBP should work more closely together for single specialty or multi-specialty licenses that relate to CON applications.
- *There has not been much discussion on this topic.*

- **Reforms that will enable the Illinois Health Facilities Planning Board to focus most of its project review efforts on "Certificate-of-Need" 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.**
  - Mark Mayo/ASCA
    - Recommends that CON only be used for approving new facilities in existing categories of services, or to approve facility closing. Change of ownership should be done through IDPH, not HFPB.
    - IHFPB should develop its own findings and issue those back to the applicant so that the applicant can focus clearly on the state's concerns for refusing an application.

- Kyusuk Chung/Governors State University-- adopt batch processing (comparative review) instead of current first come-first serve policy
- Ann Guild/IHA - CON process can and should be streamlined
  - Limit number of projects under substantive review
  - Full 120-day review process should be limited to the following instances:
    1. New or replacement facilities (to ensure no duplication)
    2. Establishment of new service
    3. Adding more beds (more than 10% of total every 2 years)
    4. Freestanding services by any provider if same service is regulated in a hospital setting (same standards for hospitals and other facilities)
  - Evaluate categories of services reviewed to ensure that it benefits the public by preventing unnecessary duplication
  - Develop current criteria for services that are regulated
  - Clarify definition of "non-clinical" (i.e. not subject to review). Get back to basics on regulation. No need to regulate infrastructure improvements.
  - If projects are inter-related, they have to be considered as one project.
  - Do not count 2 separate projects as inter-related because they are being financed by the same debt instrument.
  - The more the CON application process can be simplified, the less costly it becomes for the applicant.
  - Not the task of the HFPB to standardize financing of healthcare facilities or determine balance in quality of hospital resources across the board
  - Allow limited executive secretary approvals for projects that meet all criteria and are unopposed
  - HFP staff could approve requests for extensions and alterations.
  - Eliminate letter of intent
  - Staff comments should be included with the State Agency Report
  - Eliminate 50% reduction in service reports
  - Require only annual progress and final cost reports
  - Timely agency response- 2 separate departments of IDPH should not hold things up
  - Limit new information after release of state agency report as it can unnecessarily delay the process
  - Require timely notice to applicants on the HFBP meeting agendas
  - When denied, applicants need more hard data on why they were rejected, not just anecdotal information.
- Dr. Glenn Poshard/Past Chair, IHFPB
  - Does not agree with narrowing the scope of regulated activities that must apply for CON to those projects where the most dollars will be spent in order to make the Board's work load more manageable. He testified that Ambulatory Surgical Treatment Centers (ASTC's) need to be regulated along with hospitals.
  - Disagrees with the suggestion to change the CON process so that applicants are assumed approved, and the Board must formally state reasons why they deny an application. Dr. Poshard feels this change could create wasteful healthcare spending if applicants assume approval

and there is nothing in their application that merits their denial but their facility is not needed.

- Jack Axel/CON application consultant from Axel & Associates
  - Review process should be shortened as the inflation costs of waiting 6 months are over a million dollars.
  - Accommodate highly utilized providers even if there are other nearby medical facilities
  - Accommodate facilities that provide high levels of Medicaid and charity care
  - Re-evaluate distance between medical facilities. 1.5 hours is too far for acute, and 45 minutes too far for OB
  - Unstaffed beds at a hospital should not count in the stats of bed need
- Joe Ourth/attorney- streamlining the review process will eliminate rules, and elimination of rules means that board members will have more discretion in what is now a heavily regulated process
- Clare Ranalli/attorney –something needs to be done to streamline the process as it is taking much longer than it used to. Right now the process is going in the opposite direction- becoming more complex and rules-based.
- Attorney panel- incorporate a more formal process for IHFPB staff to help the applicant
- Anne Murphy/attorney- create a set of standards against which an application is assessed. Right now there are technical rules, but not a set of standards. Board uses a lot of discretion now. Health planning would help this.
- Coleen Muldoon & Lori Wright/Fresenius:
  - Eliminate application of the financial review criteria for projects that fall under the capital expenditure threshold, which would eliminate most dialysis projects
  - Eliminate CON review process for changes in ownership for dialysis facilities. Make changes of ownership for dialysis centers subject to the exemption process only, with an allowance for approval by the Board Chair.
  - Allow Board Chair to approve a CON for relocation of a facility within the same neighborhood if it meets all requirements, is not adding any stations, and there has been no public opposition.
- Dave Buysse/AG - when streamlining the CON process, do not forget to include measures that increase access and protect the Safety Net
- Keith Kelleher/SEIU- IHFPB should continue to review dialysis, ASTC's and reinstate the power to review nursing home changes of ownership when at least 3 facilities are sold to the same entity
- Susana Lopatka/IHFPB Chair- reinstate power to review nursing home changes of ownership
- Dennis Bozzi/Life Services Network (LTC) -
  - Fee assessed for CON applications in an issue for LTC because they pay for the non-medical part of the project
  - Raise square footage maximum for LTCs
  - Revise bed-need methodology for LTCs
- Judy Amiano/Riverside Health Care (LTC)

- Amend process based on scope of project. Existing facility expansions should not have to go through the same process as a new facility application. Implement "fast track" or shortened review.
- Increase price per square footage maximum for LTCs
- More frequent updates to rules
- More contemporary methodology for computing need
- LTCs should only have to pay an application fee that is a percentage of the cost of skilled nursing beds. Should not have to pay a percentage of the total project cost.

- Billie Paige/Attorney for LTC applicants -
  - Limit criteria for LTC applicants to need, financial viability/feasibility, and quality issues
  - Reconfigure the LTC bed need formula so that it does not include the distance from one LTC facility to another
  - Misdistribution of LTC beds can be solved by allowing an underutilized facility to sell beds to another facility that needs to increase capacity
  - LTCs should only have to pay an application fee that is a percentage of the cost of skilled nursing beds. Should not have to pay a percentage of the total project cost
- Pat Comstock, HealthCare Council of IL & Terry Sullivan, IL Counsel on LTC
  - Nursing homes should have a separate planning act due to the differences between this industry and hospitals
  - Bed need formula for nursing homes should reflect market impact
  - Bed need formula should be updated annually
  - Replacement, modernization, conversion, or service changes of existing beds that does not involve increasing the # of beds should be a streamlined (60 day) process
  - Square footage maximums for LTC beds should be eliminated to reflect market-driven trends to private rooms
  - Facilities should be able to sell or buy existing beds from one facility to another within a local planning area
- Jeffery DeMint/Village of Plainfield
  - Task force should look at how facilities are distributed in high growth areas of the state
  - Public testimony should be heard by board members. Village has held 6 hearings for public testimony and no board members have attended any of the hearings. Village feels like the testimony is not heard by board members.
  - CON should be a clearer process. In 6 years, the Village has gone through 3 applications with the same facility to bring a hospital to the area.
- Dr. Gordon Lang- Eliminate CON for dialysis centers.

- *Many testifiers expressed dissatisfaction with the length of time of the CON review process and feel that the entire process should be more streamlined. Some feel that there are too many rules that guide the process and bog it down. In addition to the above recommendations, some testifiers believe that the IHFPB needs more review staff to expedite the process and provide more technical assistance to applicants. Some testifiers also recommend changes for facilities other than hospitals.*

- **Reforms that will enable the Illinois Health Facilities Planning Board to determine how criteria, standards, and procedures for evaluating project applications involving specialty providers, ambulatory surgical facilities, and other alternative health care models should be amended to give special attention to the impact of those projects on traditional community hospitals to assure the availability and access to essential quality medical care in those communities.**
    - Janet Nally/AMA- best evidence indicates that specialty hospitals have had no negative effect on competing general hospitals and their ability to provide services
    - Mark Newton/ASNH- Medicaid levels provided at ASTCs should be equal to that of the two nearest hospitals. CON process needs to be structured in a way to protect Safety Net hospitals who want to expand while preventing free-standing facilities from expanding without regulation.
    - Joseph Miller/US DoJ - It is also possible that CON laws do not actually advance the goal of maintaining charity care. Specialty hospitals generally open in areas of high population growth, and do not siphon off the patients that use Safety Net hospitals.
    - Dr. Gordon Lang – eliminate CON for dialysis centers.
- *This reform has been touched upon by some testifiers. More recommendations were given below, for the protection of Safety Net services. The general consensus with most testifiers to date has been that ASTCs can potentially "cherry pick" the insured populations that would otherwise use traditional hospitals, thereby harming the funding base of that hospital.*

- **Implementation of policies and procedures necessary for the Illinois Health Facilities Planning Board to give special consideration to the impact of the projects it reviews on access to "safety net" services.**
    - Mark Newton/ASNH –
        - Any ASTC or similar facility needs to provide a level of Medicaid care that is equal to the average of the 2 nearest hospitals. No other state has implemented this.
        - Recommends that free-standing diagnostic centers should have to apply for CON (right now they just need a license)
    - Mark Mayo/ASCA - does not support protection for Safety Net hospitals--undermines competition
    - Paul Parker/AHPA-
        - Most states do not require minimum levels of charity care.
        - No programs directly tie building expenditure levels to charity care
        - Maryland example- charity care policy gives standards of how quickly a facility will give people and answer to how much they will have to pay
        - Virginia example- looks at median level of charity care in the region in which an applicant is located, and you must raise your levels of charity care if you fall below the median. Or, you can give money to primary care clinics instead of offering more charity care.
    - Al Dobson/Lewin Group- Safety Net hospitals do worse in CON states- which is counterintuitive, but perhaps competition works. No evidence that CON

saves the Safety Net, so Safety Net should be unbundled from CON. IL has other programs to protect the Safety Net, and if you adequately fund those programs, you can examine getting rid of CON.

- Dr. Glenn Poshard/Past Chair, IHFPB - states that if a hospital system makes a lot of money in a certain area, they should be mandated to re-invest some of that profit into their facilities in lower-income areas, instead of just shelving their less profitable facilities. It is important to maintain balance- keep the Safety Net going and also allow hospital systems to make some money
- Ann Guild/IHA
  - It is not the IHFPB's place to intervene in funding issues. Legislature would have to go about getting higher Medicaid reimbursements.
  - Safety Net Impact Statement would be appropriate for a new facility proposal
- Coleen Muldoon & Lori Wright/Fresenius- a portion of the application fee should be directed to public health initiatives. If necessary, increase the fees.
- Ralph Martire/CTBA
  - A major rationale for the CON process is to protect and preserve the safety-net services and providers. All providers that play a role in the Safety Net should be fulfilling that role to the fullest extent. Charity care accountability measures that are fair and financially sustainable should be part of the CON process in IL.
  - Non-profit hospitals should identify charity care patients on the front-end of the process rather than through the collection process. In this way, 50% of bad debt costs could qualify as charity care. Under this scenario, the non-profit hospitals could eliminate over 40% of the gap between the value of the tax exemptions they receive and the value of the charity care they provide, at no additional cost to the hospital.
- David Buysse/AG - the CON process and protection it offers to health facilities should continue to further the original purposes of the IHFP Act. Since "access to necessary health services" remains an unfilled goal (in comparison to unnecessary duplication), the reform of the CON process should mandate specific criteria for health facilities to increase accessibility to necessary health services to IL residents whose access to such services remains deficient. There is a clear connection between health planning (CON) and increased accessibility to health services for indigent residents. (Examples from SC, NJ, FL, VA)

  Task Force should consider policies including:

  - Specific minimum requirements regarding the provision of charity care by the classes of health facilities under the Act
  - Specific requirements regarding the provision of care to Medicaid recipients by the classes of health facilities under the purview of the Act
  - Specific criteria for CON applications regarding the provision of charity care and care to Medicaid recipients
  - Specific annual reporting requirements concerning the provision of such care

        - Flexibility in the manner in which such requirements and criteria can be satisfied
    - Dr. David Dranove/Northwestern University- Tie CON approval to charity care. CON approval is a license to prosper as it limits competition, so these approved facilities have an obligation to support the Safety Net. Providers should give back in the following ways:
        - One-time obligation based on a percentage of the capital costs of the project
        - Annual obligation based on total revenue
        - Exemptions can be obtained based on Medicaid level and charity care provided
        - Applies to all CON applicants, not just hospitals
        - Floor and Trade System - Providers need to meet a minimum standard of charity care. If that minimum is not met, the provider can form a financial partnership with a designated Safety Net hospital (preferred) or the provider can pay a certain amount into a Safety Net account that will be dispersed to needy hospitals (less preferred by Dranove due to increased bureaucracy).
        - With Floor and Trade, the hospital or other medical facility provides a certain level of charity care or pays another entity to do it.
    - Joseph Miller/US DoJ – If the goal in Illinois is to preserve the Safety Net, there are other less costly solutions besides CON for doing this.
- *The majority of testifiers believe that reforms could be implemented within the CON process to protect Safety Net hospitals. A minority of testifiers do not believe that CON protects the Safety Net and/or feel that the IHFPB is not the appropriate place for the Safety Net to be protected. Most testifiers alluded to regulation of ASTCs as an important component of protecting the Safety Net. If Safety Net protection were not to happen through CON, it could happen by making health insurance more affordable to all citizens and/or through increasing Medicaid reimbursement levels.*

- **Changes in policies and procedures to make the Illinois health facilities planning process predictable, transparent, and as efficient as possible; requiring the State Agency (the Illinois Department of Public Health) and the Illinois Health Facilities Planning Board to provide timely and appropriate explanations of its decisions and establish more effective procedures to enable public review and comment on facts set forth in State Agency staff analyses of project applications prior to the issuance of final decisions on each project.**
    - Mark Mayo/ASCA
        - IHFPB should develop its own findings and issue those back to the applicant so that the applicant can focus clearly on the state's concerns for refusing an application.
        - CON process should give greater consideration to public testimony
    - Kyusuk Chung/Governor State- adopt batch processing (comparative review) instead of current first come-first serve policy
    - Ann Guild/IHA
        - CON process can and should be streamlined
        - Limit number of projects under substantive review

- Full 120-day review process should be limited to the following instances:
    1. New or replacement facilities (to ensure no duplication)
    2. Establishment of new service
    3. Adding more beds (more than 10% of total every 2 years)
    4. Freestanding services by any provider if same service is regulated in a hospital setting (same standards for hospitals and other facilities)
- Evaluate categories of services reviewed to ensure that it benefits the public by preventing unnecessary duplication
- Develop current criteria for services that are regulated
- Clarify definition of "non-clinical" (i.e. not subject to review). Get back to basics on regulation. No need to regulate infrastructure improvements.
- If projects are inter-related, they have to be considered as one project.
- Do not count 2 separate projects as inter-related because they are being financed by the same debt instrument.
- The more the CON application process can be simplified, the less costly it becomes for the applicant.
- Not the task of the HFPB to standardize financing of healthcare facilities or determine balance in quality of hospital resources across the board
- Allow limited executive secretary approvals for projects that meet all criteria and are unopposed
- HFP staff could approve requests for extensions and alterations.
- Eliminate letter of intent
- Staff comments should be included with the State Agency Report
- Eliminate 50% reduction in service reports
- Require only annual progress and final cost reports
- Timely agency response- 2 separate departments of IDPH should not hold things up
- Limit new information after release of state agency report, as it can unnecessarily delay the process
- Require timely notice to applicants on the HFBP meeting agendas
- When denied, applicants need more hard data on why they were rejected, not just anecdotal information

- Dr. Glenn Poshard/Past Chair, IHFPB - it would be great for the Board members to attend public testimony but time restrictions prevent this from happening. How to fix this?
- Coleen Muldoon & Lori Wright/Fresenius -
    - Eliminate LOI requirement- it is only a delay mechanism, takes up staff time. Adds delays when a site or applicant changes and the LOI has to be resubmitted. LOI submission, without then submitting an application, can discourage other healthcare providers from applying in that area
    - Dedicate project reviewers for particular application types
    - Eliminate application of the financial review criteria for projects that fall under the capital expenditure threshold, which would eliminate most dialysis projects
    - Eliminate CON review process for changes in ownership for dialysis facilities. Make changes of ownership for dialysis centers subject to the

exemption process only, with an allowance for approval by the Board Chair.
    - Allow Board Chair to approve a CON for relocation of a facility within the same health service area if it meets all requirements, is not adding any stations, and there has been no public opposition.
    - Mandate that the Board consider independent travel studies relating to drive times between existing facilities. Dialysis centers are supposed to be 30 minutes apart and the Board uses MapQuest to determine that which tends to be the fastest measurement.
    - Abolish legislation allowing a comment period on the State Agency Report up to 2 days before a Board meeting. Causes frequent deferrals of applicants, and wastes time and money. (Do keep the ability to notify the IHFP staff if factual errors are contained in the SAR without worrying about ex parte)
    - Give 6 months notice when staff changes the interpretation of a rule.
- David Buysse/AG - when streamlining the CON process, do not forget to include measures that increase access and protect the Safety Net
- Keith Kelleher/SEIU - CON creates a place for the public to weigh in on public healthcare decisions. Every board meeting should have time for public comment- public review is of utmost importance.
- Billie Paige/Attorney - Ex parte should be loosened so that applicants can speak with staff members when developing an application.
- Susana Lopatka/Chair, IHFPB-
    - Public should not be allowed to make comments at the board meetings. There are ample times for public comment before a board meeting, and times for written public comment after a board meeting. Nor should board members be required to attend public testimonies. She reads the testimony and gets more out of it than if she were to attend the public hearing.
    - Eliminate 48 hour rule whereby applicants can submit important information right before a board meeting. This often causes deferrals of application approval as the board has to consider new information.
- Jeffery DeMint/Village of Plainfield
    - Task force should look at how facilities are distributed in high growth areas of the state
    - Public testimony should be heard by board members. Village has held 6 hearings for public testimony and no board members have attended any of the hearings. Village feels like the testimony is not heard by board members.
    - CON should be a clearer process. In 6 years, the Village has gone through 3 applications with the same facility to bring a hospital to the area.

- *Many testifiers expressed dissatisfaction with the length of time of the CON review process and feel that the entire process should be more streamlined and efficient. In particular, there should be a timely and clear explanation process when an application is denied. Some testifiers recommended that the IHFPB provide a written explanation with an "intent to deny". No recommendations have been given on how the Board could provide a better explanation of denial in a more timely manner.*

Some testifiers also feel that ex parte should be relaxed between applicants and staff members in order to better facilitate technical assistance. Additionally, some testifiers would like more assurance that public comments are being heard by the IHFPB members, and some would like more space for public comment throughout the CON process.

- **Reforms to ensure that patient access to new and modernized services will not be delayed during a transition period under any proposed system reform, and that the transition should minimize disruption of the process for current applicants.**
- *We have not heard any recommendations on this topic.*

- **Identification of the resources necessary to support the work of the Agency and the Board.**
    - Several testifiers, including Courtney Avery, Susana Lopatka, Pat Sweitzer, and Jack Axel, noted that the IHFPB should have the ability to hire more staff. There were more staff in the past, but some have left due to looming sunsets.
    - Coleen Muldoon & Lori Wright/Fresenius- portion of the application fee should be directed to public health initiatives and fees could be raised for this purpose. Perhaps there could be a fund dedicated to provide appropriate staffing for health planning from experts in the subject matter.
- *Several comments were made between Task Force members and Ex-officio Task Force members with regards to IHFPB resources. While this is not testimony, the discussion does offer some interesting information. Specifically, IHFPB appropriations have been frozen for 10 years, preventing the hiring of additional FT staff. Many testifiers believe that it would be beneficial for the review process if more staff were hired. A separate issue is the concern that the IHFPB may be charging too much for application fees if the governor's office can sweep funds at the end of the year. (Currently, application fees are .2 of 1% of total project cost up to $100,000.) Finally, if there is a decision to pay Board members for their time and effort, that would need to be funded, but no recommendations have been presented for where that funding will come from.*

RECOMMENDATIONS

The Task Force shall recommend reforms regarding the following:

1) **The size and membership of current Illinois Health Facilities Planning Board. Review and make recommendations on the reorganization of the structure and function of the Illinois Health Facilities Planning Board and the State Agency responsible for health planning (the Illinois Department of Public Health), giving consideration to various options for reassigning the primary responsibility for the review, approval, and denial of project applications between the Board and the State Agency, so that the "Certificate-of-Need" process is administered in the most effective, efficient, and consistent manner possible in accordance with the objectives referenced above.**
    - Jeff Mark/Executive Secretary of IHFPB –
        - Current IHFPB staff has 7 FTE, several part time-contractual employees

  - Current IHFP Board Membership = 5 individuals
- Jack Axel/Consultant to applicants-
  - Increase size of review staff. Other attorneys voiced opinions that staff is doing the best they can, but they are under-resourced and there are not enough of them do to the work. Need to hire more staff and then they could be more helpful during the application process.
  - Increase number of board members
- Claire Ranalli/Attorney- Raise the number of Board members to 9-13
- Dr. Glenn Poshard/Past Chair, IHFPB –
  - Increase the number of Board members to 7-11
  - Board member selection should be based on knowledge of healthcare and location in the state
  - Politicians should not serve on the Board at all unless they have expertise in healthcare
- Ann Guild/IHA-
  - Increase board to at least 9 members
  - People who know what they are doing should be on the board
- Coleen Muldoon & Lori Wright/Fresenius-
  - Recommend increasing size of the board
  - Have Board members be individuals who are familiar with a wider array of the different healthcare services that are required to seek CON approval
- Al Dobson/Lewin Group - IHFPB members need to be knowledgeable
- Mark Newton/ASNH - IHFPB should include healthcare industry reps that are better informed and ask better questions
- Keith Kelleher/SEIU-
  - Keep board at 5 members.
  - Continue non-categorical membership/appointments
- Billie Paige/Attorney
  - Need at least 9 members on board.
  - Need 4 reps from industry-regulated agencies and 5 consumers. Need a majority consumer board.
  - Should be time limit on how long a Board seat should be open before it is filled.
- Susana Lopatka/Chair, IHFPB –
  - Need 7-9 board members. A larger board could have subcommittees, one of which could be for health planning. A larger board could also allow for "experts" in the various healthcare fields that CON approves- LTC, ASTC, Hospital, ESRDs. Larger board also puts less pressure on members when making important healthcare decisions.
  - Board should be composed of people who have a strong healthcare background. One doctor, one RN, one with administration background. Members should reflect geography and diversity of IL. Not in favor of categorical membership.
  - Executive Secretary, Executive Counsel, and Chief of Review should not be gubernatorial appointments (insulated from politics.)
  - Does not recommend compensation for Chairperson and Board members. Serving on this board is public service, and receiving a stipend could negatively affect the independent functioning of the Board.

- Courtney Avery/Current IHFPB Board member
  - Board should be 8-9 or even 11 members.
  - Need diverse board.
  - Need term limits for Board chairperson.
  - Recommends a stipend for Chairperson and Board members to compensate them for their time (in addition to existing travel reimbursements)
  - Board should have specialized educational retreats
- Fred Benjamin/Past Chair of IHFPB - increase number of board members. Too much to do for a 3-member board.
- Michael Gonzalez/past IHFPB member - as a member of a 13 and then 9 member board, he was able to learn from the questions and expertise of his other board members
- Joyce Washington/past IHFPB member - increase # of board members
- Michael Copelin/former staff to IHFPB - increase # of board members
- Pat Sweitzer/former Executive Secretary to IHFPB –
  - Increase # of board members.
  - Lift restrictions against healthcare related individuals to be part of the board.
- *Most testifiers agree that the number of Board members should be increased from 5 to 7-13 members. The board members should have an in-depth knowledge of the health care field. In general, testifiers are not asking for categorical membership, just that Board members are qualified to participate in some way.*
- *Many recommendations have been given on how the rules could be changed to make the CON process more efficient, but there has not been much discussion about how the current responsibilities of the Board and staff could be re-assigned to create a more efficient CON process.*

2) **Changes in policies and procedures that will charge the Illinois Health Facilities Planning Board with developing a long-range health facilities plan (10 years) to be updated at least every 2 years, so that it is a rolling 10-year plan based upon data no older than 2 years.**
   - **The plan should incorporate an inventory of the State's health facilities infrastructure including both facilities and services regulated under this Act, as well as facilities and services that are not currently regulated under this Act, as determined by the Board.**
   - **The planning criteria and standards should be adjusted to take into consideration services that are regulated under the Act, but are also offered by non-regulated providers.**
   - **The Illinois Department of Public Health bed inventory should be updated each year using the most recent utilization data for both hospitals and long-term care facilities including 2003, 2004, 2005 and subsequent-year inpatient discharges and days. This revised bed supply should be used as the bed supply input for all Planning Area bed-need calculations.**
   - **Ten-year population projection data should be incorporated into the plan.**
   - **Plan updates may include redrawing planning area boundaries to reflect population changes.**

- **The Task Force shall consider whether the inventory formula should use migration factors for the medical/surgical, pediatrics, obstetrics, and other categories of service, and if so, what those migration factors should be.**
- **The Board should hold public hearings on the plan and its updates.**
- **There should be a mechanism for the public to request that the plan be updated more frequently to address emerging population and demographic trends.**
- **In developing the plan, the Board should consider health plans and other related publications that have been developed both in Illinois and nationally.**
- **In developing the plan, the need to ensure access to care, especially for "safety net" services, including rural and medically underserved communities, should be included.**
    - Paul Parker/American Health Planning Association (AHPA) – most states do not devote enough resources to health facilities planning and analysis.
    - Dr. Glenn Poshard/Past Chair, Illinois Health Facilities Planning Board (IHFPB) -- comprehensive health care planning should be done as part of the work of the Board, but not sure how they can do that given the large time commitment already needed to review applications. A state health plan is essential to making objective, rather than subjective, decisions about applications.
    - Susana Lopatka/Chair, IHFPB -- Board exists to do health planning as well as review 'Certificate of Need' (CON) applications. Current size of board prevents most health planning.
    - Ray Passeri/Former Executive Secretary, IHFPB-- reiterated that this was called a "Planning Act" for a purpose, and there should be a connection between the planning and regulatory aspects of the CON process.
    - Current and past IHFBP members who testified on August 15 spoke to the need to have a clear vision to direct the Board's activities. Part of this clear vision will come from a health planning component.
    - Mark Mayo/ASCA– support 5 year, not 10 year, planning cycle
    - Ralph Weber/Northwestern and Thomas Manak/Provena (CON applicants) - stated they were supportive of health planning and think that it should not be stagnant- plan should look forward 10 years but also change with any current pressing issues
    - Anne Murphy/Attorney- HFBP needs to do regional planning.
    - Coleen Muldoon & Lori Wright/Fresenius - suggested funding the work of health planning through the application fees- funneling a portion of those fees into a special fund.
    - Kyusuk Chung/Governors State - spoke to migration factors- IL adopted a 50% migration factor. IL has a lot of migration between planning areas. Not clear what the appropriate migration factor is.
- *Overall, testifiers believe that the there should be statewide health planning and that the absence of a comprehensive statewide health plan leaves the Board members a lot of room to make subjective decisions. However, there were not many recommendations given on the specifics of how the statewide planning should be done (regional basis, etc), how often (10 years?), who should do it, how it should be funded, etc.*

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 and that allow routine changes of ownership, facility sales, and closure requests to be processed on a timely basis. Consider rules to allow flexibility for facilities to modernize, expand, or convert to alternative uses that are in accord with health planning standards.**
    - Ann Guild/IHA - recommends a full 120-day review for freestanding services by any provider if same service is regulated in a hospital setting (same standards for hospitals and other facilities)
    - Dr. Glenn Poshard/Past Chair, IHFPB- Does not agree with narrowing the scope of regulated activities that must apply for CON to those projects where the most dollars will be spent in order to make the Board's work load more manageable. He testified that ASTC's need to be regulated along with hospitals.
    - Coleen Muldoon & Lori Wright/Fresenius:
        - Would like to present an educational session to Board members to educate them about how the utilization and operation of dialysis clinics differs from other healthcare providers.
        - Eliminate application of the financial review criteria for projects that fall under the capital expenditure threshold, which would eliminate most dialysis projects.
        - Eliminate CON review process for changes in ownership for dialysis facilities. Make changes of ownership for dialysis centers subject to the exemption process only, with an allowance for approval by the Board Chair.
        - Allow Board Chair to approve a CON for relocation of a facility within the same neighborhood if it meets all requirements, is not adding any stations, and there has been no public opposition.
        - Mandate that the Board consider independent travel studies relating to drive times between existing facilities. Dialysis centers are supposed to be 30 minutes apart and the Board uses MapQuest to determine that which tends to be the fastest measurement.
    - Susana Lopatka/Chair, IHFPB-
        - Reinstate Board ability to approve change of ownership in nursing homes
    - Keith Kelleher/SEIU-
        - Reinstate Board ability to approve changes of ownership when at least 3 nursing home facilities are sold to one entity
        - IHFPB should continue to review dialysis, ASTC's and reinstate the power to review nursing home changes of ownership when at least 3 facilities are sold to the same entity
    - Dennis Bozzi/Life Services Network (LTC)
        - Fee assessed for CON applications is an issue for LTC because they pay for the non-medical part of the project
        - Raise square footage maximum for LTCs
        - Revise bed-need methodology for LTCs
    - Judy Amiano/Riverside Health Care (LTC)

- Amend process based on scope of project. Existing facility expansions should not have to go through the same process as a new facility application. Implement "fast track" or shortened review.
- Increase price per square footage maximum for LTCs
- More frequent updates to rules
- More contemporary methodology for computing need
- LTCs should only have to pay an application fee that is a percentage of the cost of skilled nursing beds. Should not have to pay a percentage of the total project cost. (Paige agrees.)

- Billie Page/Attorney for LTC applicants-
  - Limit criteria for LTC applicants to need, financial viability/feasibility, and quality issues
  - Reconfigure the LTC bed need formula so that it does NOT include the distance from one LTC facility to another
  - Misdistribution of LTC beds can be solved by allowing an underutilized facility to sell beds to another facility that needs to increase capacity
- Pat Comstock, HealthCare Council of IL & Terry Sullivan, IL Counsel on LTC
  - Nursing homes should have a separate planning act due to the differences between this industry and hospitals
  - Bed need formula for nursing homes should reflect market impact
  - Bed need formula should be updated annually
  - Replacement, modernization, conversion, or service changes of existing beds that does not involve increasing the # of beds should be a streamlined (60 day) process
  - Square footage maximums for LTC beds should be eliminated to reflect market-driven trends to private rooms
  - Facilities should be able to sell or buy existing beds from one facility to another within a local planning area
- Dr. Gordon Lang – eliminate CON for dialysis centers

- *Testifiers from Long-term Care and Dialysis facilities spoke to their unique needs. Most of the representatives from the LTC and Dialysis facilities felt that the CON process is focused on hospital facilities, and these representatives gave several recommendations on how the process could be amended to better fit their special needs.*

4) **Changes in policies and procedures so that the Illinois Health Facilities Planning Board updates the standards and criteria on a regular basis and proposes new standards to keep pace with the evolving health care delivery system. Proton Therapy and Treatment is an example of a new, cutting-edge procedure that may require the Board to immediately develop criteria, standards, and procedures for that type of facility. Temporary advisory committees may be appointed to assist in the development of revisions to the Board's standards and criteria, including experts with professional competence in the subject matter of the proposed standards or criteria that are to be developed.**
   - Claire Burman's testimony gave an overview of the current process for rules update.

- *We have not heard testimony or recommendations on policies and procedures that would allow the IHFPB to immediately develop standards and criteria for cutting-edge/emerging medical technology. The general sense of the discussion on writing rules is that it is a fairly time and labor intensive process.*

5) Changes in policies and procedures to expedite project approval, particularly for less complex projects, including standards for determining whether a project is in "substantial compliance" with the Board's review standards.

- Dr. Glenn Poshard/Past Chair, IHFPB
  - Does not agree with narrowing the scope of regulated activities that must apply for CON to those projects where the most dollars will be spent in order to make the Board's work load more manageable. He testified that Ambulatory Surgical Treatment Centers (ASTC's) need to be regulated along with hospitals.
  - Disagrees with the suggestion to change the CON process so that applicants are assumed approved, and the Board must formally state reasons why they deny an application. Dr. Poshard feels this change could create wasteful healthcare spending if applicants assume approval and there is nothing in their application that merits their denial but their facility is not needed.
- Ann Guild/IHA- CON process can and should be streamlined
  - Limit number of projects under substantive review
  - Full 120-day review process should be limited to the following instances:
    1. New or replacement facilities (to ensure no duplication)
    2. Establishment of new service
    3. Adding more beds (more than 10% of total every 2 years)
    4. Freestanding services by any provider if same service is regulated in a hospital setting (same standards for hospitals and other facilities)
  - Evaluate categories of services reviewed to ensure that it benefits the public by preventing unnecessary duplication
  - Develop current criteria for services that are regulated
  - Clarify definition of "non-clinical" (i.e. not subject to review). Get back to basics on regulation. No need to regulate infrastructure improvements.
  - If projects are inter-related, they have to be considered as one project.
  - Do not count 2 separate projects as inter-related because they are being financed by the same debt instrument.
  - The more the CON application process can be simplified, the less costly it becomes for the applicant.
  - HFPB can ask for extra information on a case-by-case basis for special cases. Don't increase standard application paperwork in order to cover all the special cases.
  - Not the task of the HFPB to standardize financing of healthcare facilities or determine balance in quality of hospital resources across the board
  - Allow limited executive secretary approvals for projects that meet all criteria and are unopposed
  - HFP staff could approve requests for extensions and alterations.
  - Eliminate letter of intent

- Staff comments should be included with the State Agency Report
- Eliminate 50% reduction in service reports
- Require only annual progress and final cost reports
- Timely agency response- 2 separate departments of IDPH should not hold things up
- Limit new information after release of state agency report as it can unnecessarily delay the process
- Require timely notice to applicants on the HFBP meeting agendas
- When denied, applicants need more hard data on why they were rejected, not just anecdotal information

- Jack Axel/Consultant to CON Applicants
  - Review process should be shortened as the inflation costs of waiting 6 months are over a million dollars.
  - Accommodate highly utilized providers even if there are other nearby medical facilities
  - Accommodate facilities that provide high levels of Medicaid and charity care
  - Re-evaluate distance between medical facilities. 1.5 hours is too far for acute, and 45 minutes too far for OB
  - Unstaffed beds at a hospital should not count in the stats of bed need
- Joe Ourth/Attorney- streamlining the review process will eliminate rules and elimination of rules means that board members will have more discretion in what is now a heavily regulated process
- Clare Ranalli/Attorney – something needs to be done to streamline the process as it is taking much longer than it used to. Right now the process is going in the opposite direction- becoming more complex and rules-based.
- Attorney panel- incorporate more formal process of HFP staff helping the applicant
- Anne Murphy/Attorney- create a set of standards against which an application is assessed. Right now there are technical rules, but not a set of standards. Board uses a lot of discretion now. Health planning would help this.
- Mark Mayo/ASCA –
  - Recommended that CON only be used for approving new facilities in existing categories of services, or to approve facility closing. Change of ownership should be done through IDPH, not IHFPB.
  - IHFPB should develop its own findings and issue those back to the applicant so that the applicant can focus clearly on the state's concerns for refusing an application.
- Kyusuk Chung/Governors State University- adopt batch processing (comparative review) instead of current first come-first serve policy
- Ray Passeri/former Executive Secretary for IHFPB- also recommends batch processing/comparative review.
- Coleen Muldoon & Lori Wright/Fresenius:
  - Eliminate LOI requirement- it is only a delay mechanism, takes up staff time. Adds delays when a site or applicant changes and the LOI has to be resubmitted. LOI submission, without then submitting an application, can discourage other healthcare providers from applying in that area

- Dedicate project reviewers for particular application types
- Eliminate application of the financial review criteria for projects that fall under the capital expenditure threshold, which would eliminate most dialysis projects
- Eliminate CON review process for changes in ownership for dialysis facilities. Make changes of ownership for dialysis centers subject to the exemption process only, with an allowance for approval by the Board Chair.
- Allow Board Chair to approve a CON for relocation of a facility within the same HAS if it meets all requirements, is not adding any stations, and there has been no public opposition.
- Mandate that the Board consider independent travel studies relating to drive times between existing facilities. Dialysis centers are supposed to be 30 minutes apart and the Board uses MapQuest to determine that which tends to be the fastest measurement.
- Abolish legislation allowing a comment period on the State Agency Report up to 2 days before a Board meeting. Causes frequent deferrals of applicants, and wastes time and money. (Do keep the ability to notify the IHFP staff if factual errors are contained in the SAR without worrying about ex parte)
- Give 6 months notice when staff changes the interpretation of a rule.

- Keith Kelleher/SEIU- CON approval criteria should consider:
  - The entire health system, not just individual facilities
  - Increased community input
  - Patient care
  - Charity care
  - Impact study- the impact the project will have on workers, patients and the community.
- Dr. David Dranove/Northwestern University - recommendations:
  - Increase monetary threshold for CON review. Small projects unlikely to cause harm to systems
  - Eliminate burdensome aspects of review process such as financial projection requirements
  - Re-evaluate computation of utilization and bed need projections
  - Eliminate micromanagement of facility construction

- *Many testifiers expressed dissatisfaction with the length of time of the CON review process and feel that the entire process should be more streamlined and efficient. Many recommendations were presented that could make the process more efficient and expedite approvals.*

The review standards must include a requirement for applicants to include a "Safety Net" Impact Statement. This Statement shall describe the project's impact on safety net services in the community. The State Agency Report shall include an assessment of the Statement.

- Paul Parker/AHPA-
  - Most states do not require minimum levels of charity care.
  - No programs directly tie building expenditure levels to charity care

- Ann Guild/IHA- Safety Net Impact Statement would be appropriate for a new facility proposal
- Keith Kelleher/SEIU- recommends that future approval criteria should consider charity care

- *Most testifiers would like Safety Net services to be protected, but did not comment specifically on the requirement for inclusion of a Safety Net Impact Statement. See Page 8 of this document for other recommended policies on how the IHFPB could give special consideration to the impact of projects on access to Safety Net services.*

6) Changes to enforcement processes and compliance standards to ensure they are fair and consistent with the severity of the violation.

- Frank Urso/Counsel to IHFPB-
  - Majority of compliance issues arise when someone has violated the Act or Code. Fines are issued or permits can be revoked. Often, compliance issues are resolved through in-kind services as well as fining.
  - Need to revise statutory schedule that provides guidance on how to levy fines for non-compliance
  - Nothing in the statute specifically authorizes compliance matters to be settled with in-kind services.
- Billie Paige, Attorney- the IHFPB has far too many fines and they are too high. In the past, the fines were not applied to the maximum amount as much as they are now.

- *The IHFPB attorneys have spoken specifically to compliance standards and explained how fines are levied. One testifier in particular raised the issue that the current fine structure is not appropriate.*

7) Revisions in policies and procedures to prevent conflicts of interest by members of the Illinois Health Facilities Planning Board and State Agency staff, including increasing the penalties for violations.

- Dr. Glenn Poshard/Former Chair, IHFPB
  - Keep ex parte
  - Eliminate mandate that IHFPB members cannot have an immediate family member in the healthcare industry. As healthcare is a major industry in Southern IL, you will disqualify a number of great potential board members.
  - Board members should be able to discuss applications with IHFPB staff and ask for staff opinions. These opinions would only better inform that board in their decisions.
- Mark Silberman/IHFPB attorney - Ex parte and the Open Meetings Act can be unwieldy with a board of only 5 people.
- Susana Lopatka/Chair, IHFPB - IHFPB Executive Secretary should be appointed by IDPH Director, not Governor.
- Mark Newton/ASNH - Applicants need open communication with staff and ex parte works against this
- Ann Guild/IHA –
  - Applicants would like more open dialogue with staff to assist them with getting through the process. No dialogue between applicants and Board members.

    - Improve Conflict of Interest provisions and apply to board members, not staff
- Jack Axel/Consultant to CON applicants – Ex parte creates a highly structured review process. Relaxing ex parte would create a more beneficial review process, especially in communication between applicants and staff.
- Coleen Muldoon & Lori Wright/Fresenius -recommends that the ex parte rule not apply to staff. Relationships between staff and people who appear before the board should be encouraged to decrease costs and lessen delays. To eliminate undue influence of the staff on the Board, you should increase the number of board members and disallow questions from staff to applicants at Board meetings. Staff would still be a resource for Board members.
- Susana Lopatka/Chair, IHFPB - is comfortable with where ex parte currently is- where the change in Open Meetings Act has allowed 2 board members to discuss applications outside of a board meeting.
- Clarence Naglevoort/Former Staff to IHFPB - recommends having a watchdog group of 2-3 people who review Board meeting transcripts and look for the "out of character" comments that might allude to conflicts of interest or corruption

- *There was much discussion among testifiers and Task Force members about Ex parte and the Open Meetings Act, what those regulations include, and the practical application of those regulations on the communication of the IHFPB. Ex parte and the Open Meetings Act were enacted to prevent conflicts of interest and corruption. A consequence of this rigid structure has made communication between applicants and staff more challenging, and has also led Board members to make CON decisions in isolation of staff opinions. Positive and negative consequences of loosening Ex Parte and the Open Meetings Act have been given, with all sides noting the importance of balancing the communication with applicants against the dangers of corruption.*

8) **Other changes determined necessary to improve the administration of this Act**.