STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PERFORMANCE AUDIT OF THE

CENTER FOR COMPREHENSIVE HEALTH PLANNING AND HEALTH FACILITIES AND SERVICES REVIEW BOARD

MAY 2014

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AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the performance audit of the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board, and the Certificate of Need processes.

The audit was conducted pursuant to Public Act 96-0031 which amended the Health Facilities Planning Act and added a requirement that an audit be performed 24 months after the final member of the Board was appointed. The final member was appointed in June 2011 and our audit work began in June 2013. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
May 2014

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
William G. Holland, Auditor General

SUMMARY REPORT DIGEST

CENTER FOR COMPREHENSIVE HEALTH PLANNING AND HEALTH FACILITIES AND SERVICES REVIEW BOARD

PERFORMANCE AUDIT
Release Date: May 2014

SYNOPSIS

Public Act 96-0031, effective June 30, 2009, amended the Health Facilities Planning Act (Planning Act) and directed the Auditor General to conduct a performance audit of the Center for Comprehensive Health Planning (Center), Health Facilities and Services Review Board (Board), and the Certificate of Need (CON) processes. The Public Act required the performance audit to be commenced 24 months after the final member of the Board had been appointed. The final member was appointed to the Board in June 2011 and our audit work began in June 2013. Our audit found the following:

- The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning as required by Public Act 96-0031, effective June 30, 2009.
- The Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031, effective June 30, 2009.
- As a result of the lack of a Comprehensive Health Planner and the lack of a Center for Comprehensive Health Planning, no progress had been made to develop a Comprehensive Health Plan.
- According to an annual report to the General Assembly and Governor from the Department of Public Health, the fiscal year 2014 budget appropriated $900,000 from the Health Facilities Planning Fund to the Department to fund the start-up of the Center for Comprehensive Health Planning. This appropriation amount appears reasonable, however, the adequacy of funding for the Center for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan.
- Of the 77 settlement agreements finalized in fiscal years 2009 through 2013, 5 settlements were uncollectable (totaling $474,000) and 5 settlements were in a non-compliant status ($4,500 plus outstanding reports).
- While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule. The negotiated value of settlements for fiscal years 2012 and 2013 totaled approximately $2.1 million, of which $1.7 million was "in-kind" services and the remaining $425,000 was fines.
- The Board was not timely in identifying violations and moving through the violation process. Overall, the violation process took 3.5 years on average from the date of the violation to the date when there was a signed resolution to the issue. Seven settlements took longer than 4 years, the longest taking almost 10 years.
- While we found it difficult to make a comparison due to the many factors influencing the final value of the settlement, we concluded that, given their respective circumstances, the settlements did not appear unreasonable.
- Since 2009, there have been several changes to the Health Facilities and Services Review Board and the certificate of need process. We determined that most of these changes have been implemented. Changes not implemented include: the Board did not post on its website an annual accounting of revenues and expenses for fiscal years 2011, 2012, and 2013; and the Board's Chairman did not conduct annual reviews of Board member performance or report attendance records to the General Assembly as required by the Planning Act.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

Public Act 96-0031, effective June 30, 2009, amended the Health Facilities Planning Act (Planning Act) and directed the Auditor General to conduct a performance audit of the Center for Comprehensive Health Planning (Center), Health Facilities and Services Review Board (Board), and the Certificate of Need processes. The Public Act required the performance audit to be commenced 24 months after the final member of the Board had been appointed. The final member was appointed to the Board in June 2011 and our audit work began in June 2013. (pages 4-5)

The Planning Act lays out in significant detail the process for the Board to approve or deny applications for a certificate of need. The Board also has detailed rules that deal with operations, criteria for project need, and criteria for financial and economic feasibility. Although there have been several changes to the Planning Act, the general process for an applicant has remained fairly similar for the last several years. A health care facility applies for a certificate of need (CON) permit by submitting an application and paying the initial application fee of $2,500 to the Illinois Health Facilities and Services Review Board. The total application fee is assessed based on the cost of the project and ranges between $2,500 and $100,000. The application is reviewed by the Board staff, and the application fee is deposited into the Health Facilities Planning Fund. (pages 10-13, 26)

The Health Facilities and Services Review Board is funded by the Illinois Health Facilities Planning Fund (Fund). The Fund receives all fees and fines collected by the Board pursuant to the Illinois Health Facilities Planning Act. Although the Board operates in cooperation with the Department of Public Health, and Public Health provides operational support to the Board through an interagency agreement, the Planning Act requires the Board to have a separate and distinct budget approved by the General Assembly. (pages 7-9)

Comprehensive Health Planner and the Center for Comprehensive Health Planning

The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning as required by Public Act 96-0031.

The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning. Public Act 96-0031, effective June 30, 2009, required that the Governor appoint a Comprehensive Health Planner, with the advice and consent of the Senate, to

supervise the Center and its staff (20 ILCS 2310/2310-217(b)(2)). (page 18)

The Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031.

Furthermore, the Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031. The Public Act states that Public Health shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan (20 ILCS 2310/2310-217). In addition to developing a Comprehensive Health Plan, the Center has the following responsibilities and duties: providing technical assistance to the Health Facilities and Services Review Board to permit the Board to apply relevant components of the Comprehensive Health Plan in its deliberations; attempting to identify unmet health needs; and establishing priorities and recommending methods for meeting identified health service, facilities, and workforce needs. (pages 18-20)

As a result of the lack of a Comprehensive Health Planner and the lack of a Center for Comprehensive Health Planning, no progress had been made to develop a Comprehensive Health Plan. State statutes require that the Center develop a long-range Comprehensive Health Plan to guide the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State (20 ILCS 2310/2310-217(a)). (pages 21-22)

For four fiscal years, from July 1, 2009, through June 30, 2013, no appropriations or funding were provided for the Comprehensive Health Planner or the Center for Comprehensive Health Planning. However, according to an annual report to the General Assembly and Governor from the Department of Public Health, the fiscal year 2014 budget appropriated $900,000 from the Health Facilities Planning Fund to the Department of Public Health for establishment of the Center. This annual report noted concerns about the viability of financially supporting both the Board and a fully staffed Center in the long run utilizing only the Health Facilities Planning Fund.

While a $900,000 appropriation for fiscal year 2014 appears reasonable to fund the start-up of the Center for Comprehensive Health Planning, the adequacy of funding for the Center for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan.

Public Act 96-0031 required the Auditor General to determine whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning. The $900,000 appropriation for initial establishment of the Center appears reasonable. However, the adequacy of funding for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan. (pages 20-21)

Certificate of Need Process

Since 2009, there have been several changes to the certificate of need (CON) process through Public Acts amending the Health Facilities Planning Act. Through discussions with Health Facilities and Services Review Board staff, an examination of Board rules, and testing samples of Board reports and settlement agreements, we determined that most of these changes have been implemented. Public Act 96-0031, effective June 30, 2009, made the most substantive changes to the Planning Act. However, as noted above, the Board cannot implement statutory provisions related to the Comprehensive Health Plan because the entity responsible for creating the Plan (Center for Comprehensive Health Planning) has not yet been established.

Other changes not implemented include: the Board did not post on its website an annual accounting of revenues and expenses for fiscal years 2011, 2012, and 2013; and the Chairman of the Board did not conduct annual reviews of Board member performance or report attendance records to the General Assembly as required by the Planning Act. (pages 30-34)

We tested a sample of 43 applications acted upon by the Board to test general compliance with the Planning Act, particularly recent changes made to the Planning Act and the administrative rules. Our population included all applications acted upon by the Board from FY10 through FY13 to construct a new hospital (9 applications) or long-term care facility (28 applications). Our testing also included one application to establish a facility from each of the following categories: end stage renal dialysis, ambulatory surgical treatment centers, freestanding emergency centers, medical office buildings, rehabilitation centers, and cancer centers.

We found that Board staff was generally in compliance with Planning Act requirements pertaining to the timeliness of application review and public hearings. Five projects in our sample contained ex-parte communications. We tested the ex-parte documentation for these five applications and found that Board staff complied with the Planning Act requirements. However, we found that the Board staff had not posted these reports of ex-parte communications to the Board's website as required by its administrative rules (2 Ill. Adm. Code 1925.293(e)). (pages 34-35, 41)

The Board has implemented the Safety Net Impact Statement required by the Health Facilities Planning Act (20 ILCS 3960/5.4). Safety net services are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or

cultural characteristics, or geographic isolation. The revised Planning Act requires that general review criteria include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

Our testing of 43 projects reviewed by the Board found that all nine projects which required a Safety Net Impact Statement included one; however, there were three projects for which the Safety Net Impact Statement was lacking one of the requirements laid out by the Planning Act.

Our testing of 43 projects reviewed by the Board included 9 projects which required a Safety Net Impact Statement. Our testing found that all nine projects included a Safety Net Impact Statement as required; however, there were three projects for which the Safety Net Impact Statement was lacking one of the requirements laid out by the revised Planning Act.

We also tested whether the Board published a notice in a newspaper, as required by the Planning Act, for the nine projects requiring a Safety Net Impact Statement. We found one case which did not have a published notice that an application containing a Safety Net Impact Statement was received. (pages 35-37)

We looked at two categories of hospitals which could be considered safety net providers: Critical Access Hospitals and Disproportionate Share Hospitals. Both categories of hospitals generally had their projects approved by the Board for fiscal years 2010 through 2013. We concluded that Public Act 96-0031 has had little impact on safety net hospitals. (page 40)

Fines and Settlements

Of the 77 settlement agreements, 5 settlements were uncollectable (totaling $474,000) and 5 settlements were in a non-compliant status ($4,500 plus outstanding reports).

During fiscal years 2009 through 2013, there were a total of 77 settlement agreements executed. Of the 77 settlement agreements, 5 settlements' fines were uncollectable (totaling $474,000) and 5 settlements had a non-compliant status ($4,500 plus outstanding reports). However, the remainder of the fine and "in-kind" service agreements were noted as either fulfilled or were in a compliant status (e.g., had submitted reports as required, but still has future reports to submit).

"In-kind" services or a combination of "in-kind" services and a fine were used in 30 of 77 settlement agreements.

In 47 of 77 settlement agreements (61%), the facility opted to pay a fine to resolve compliance issues. Fine amounts are mandated by State statute; however, if a facility proves that the amount of the levied fine may cause a financial hardship, the facility could make a counter offer which would then be considered by the Board. "In-kind" services or a combination of "in-kind" services and a fine were used in the remaining 30 settlement agreements.

Digest Exhibit 1 summarizes both fines and "in-kind" settlements which were negotiated with health care providers

for the fiscal years noted. The exhibit shows that negotiated "in-kind" service amounts have been larger than negotiated fines and a significant portion of the settlement amounts four of the last five fiscal years. (pages 46-47)

Digest Exhibit 1
FINES AND "IN-KIND" SETTLEMENT AGREEMENT AMOUNTS
Fiscal Years 2009 through 2013

	Fines	"In-Kind"	Total
Fiscal Year 2009	$583,978	$7,975,000	$8,558,978
Fiscal Year 2010	$437,500	$841,479	$1,278,979
Fiscal Year 2011	$165,000	$308,240	$473,240
Fiscal Year 2012	$146,800	$60,525	$207,325
Fiscal Year 2013	$278,250	$1,612,721	$1,890,971
Total	$1,611,528	$10,797,965	$12,409,493

Source: Health Facilities and Services Review Board data summarized by OAG.

We tested the 26 settlement agreements with a final order (effective) date in fiscal year 2012 or 2013. According to the Board's General Counsel, the practice is to start with the maximum possible fine and negotiate down from there. Our testing indicated that many settlements end up being significantly discounted from the proposed maximum fine amount. The settlement files contained documentation of "in-kind" settlement compliance reporting. (pages 47-48)

While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule.

According to the Board's General Counsel, the Board has authorized staff to use "in-kind" services in settlement negotiations. While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule. The negotiated value of settlements for fiscal years 2012 and 2013 totaled approximately $2.1 million, of which $1.7 million was "in-kind" services and the remaining $425,000 was fines. Given the frequent use of "in-kind" services and to ensure the Board is not violating the intent of the State statute, the Board should seek a legislative change in State statute and/or update its administrative rules to specifically authorize the use of "in-kind" settlements.

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Public Act 96-0031 asks us to determine whether fines and settlements are fair, consistent, and in proportion to the degree of violations. We compared settlement agreements within the same category and for similar violations to test for consistency and whether the settlements were in relative proportion to the degree of the violation. While we found it difficult to make a comparison due to the many factors influencing the final value

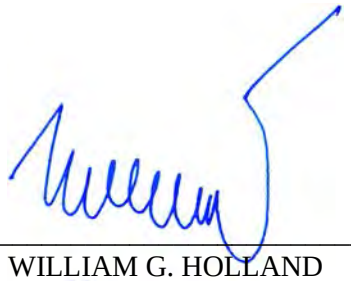
The Health Facilities and Services Review Board was not timely in identifying violations and moving through the violation process.

of the settlement, we concluded that, given their respective circumstances, the settlements did not appear unreasonable.

The Health Facilities and Services Review Board was not timely in identifying violations and moving through the violation process. Overall, the violation process took 3.5 years on average to move from the date of the violation to the date when there was a signed resolution to the issue. Seven settlements took longer than four years, the longest taking almost 10 years. Taking a significant amount of time to identify violations and initiate the fines process could decrease the likelihood of collecting fines, especially in the case of facility closures. (pages 49-50)

RECOMMENDATIONS

The audit report contains seven recommendations, five directed to the Health Facilities and Services Review Board and its staff, one directed to the Department of Public Health, and one directed to the Governor's Office. The Board, the Department of Public Health, and the Governor's Office agreed with all seven recommendations. Appendix E to the report contains the agency responses.



WILLIAM G. HOLLAND
Auditor General

WGH:TEW

AUDITORS ASSIGNED: This Performance Audit was performed by the Office of the Auditor General's staff.

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

Public Act 96-0031, effective June 30, 2009, amended the Health Facilities Planning Act (Planning Act) and directed the Auditor General to conduct a performance audit of the Center for Comprehensive Health Planning (Center), Health Facilities and Services Review Board (Board), and the Certificate of Need processes. The Public Act required the performance audit to be commenced 24 months after the final member of the Board had been appointed. The final member was appointed to the Board in June 2011 and our audit work began in June 2013.

The Planning Act lays out in significant detail the process for the Board to approve or deny applications for a certificate of need. The Board also has detailed rules that deal with operations, criteria for project need, and criteria for financial and economic feasibility. Although there have been several changes to the Planning Act, the general process for an applicant has remained fairly similar for the last several years.

The Health Facilities and Services Review Board is funded by the Illinois Health Facilities Planning Fund (Fund). The Fund receives all fees and fines collected by the Board pursuant to the Illinois Health Facilities Planning Act. Although the Board operates in cooperation with the Department of Public Health, and Public Health provides operational support to the Board through an interagency agreement, the Planning Act requires the Board to have a separate and distinct budget approved by the General Assembly.

Comprehensive Health Planner and the Center for Comprehensive Health Planning

The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning. Public Act 96-0031, effective June 30, 2009, required that the Governor appoint a Comprehensive Health Planner, with the advice and consent of the Senate, to supervise the Center and its staff (20 ILCS 2310/2310-217(b)(2)).

Furthermore, the Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031. The Public Act states that Public Health shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan (20 ILCS 2310/2310-217). In addition to developing a Comprehensive Health Plan, the Center has the following responsibilities and duties: providing technical assistance to the Health Facilities and Services Review Board to permit the Board to apply relevant components of the Comprehensive Health Plan in its deliberations; attempting to identify unmet health needs; and establishing priorities and recommending methods for meeting identified health service, facilities, and workforce needs.

As a result of the lack of a Comprehensive Health Planner and the lack of a Center for Comprehensive Health Planning, no progress had been made to develop a Comprehensive Health Plan. State statutes require that the Center develop a long-range Comprehensive Health Plan to guide the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State (20 ILCS 2310/2310-217(a)).

For four fiscal years, from July 1, 2009, through June 30, 2013, no appropriations or funding were provided for the Comprehensive Health Planner or the Center for Comprehensive Health Planning. However, according to an annual report to the General Assembly and Governor from the Department of Public Health, the fiscal year 2014 budget appropriated $900,000 from the Health Facilities Planning Fund to the Department of Public Health for establishment of the Center. This annual report noted concerns about the viability of financially supporting both the Board and a fully staffed Center in the long run utilizing only the Health Facilities Planning Fund.

Public Act 96-0031 required the Auditor General to determine whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning. The $900,000 appropriation for initial establishment of the Center appears reasonable. However, the adequacy of funding for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan.

Certificate of Need Process

Since 2009, there have been several changes to the certificate of need (CON) process through Public Acts amending the Health Facilities Planning Act. Through discussions with Health Facilities and Services Review Board staff, an examination of Board rules, and testing samples of Board reports and settlement agreements, we determined that most of these changes have been implemented. Public Act 96-0031, effective June 30, 2009, made the most substantive changes to the Planning Act. However, as noted above, the Board cannot implement statutory provisions related to the Comprehensive Health Plan because the entity responsible for creating the Plan (Center for Comprehensive Health Planning) has not yet been established.

Other changes not implemented include: the Board did not post on its website an annual accounting of revenues and expenses for fiscal years 2011, 2012, and 2013; and the Chairman of the Board did not conduct annual reviews of Board member performance or report attendance records to the General Assembly as required by the Planning Act.

We tested a sample of 43 applications acted upon by the Board to test general compliance with the Planning Act, particularly recent changes made to the Planning Act and the administrative rules. Our population included all applications acted upon by the Board from FY10 through FY13 to construct a new hospital (9 applications) or long-term care facility (28 applications). Our testing also included one application to establish a facility from each of the following categories: end stage renal dialysis, ambulatory surgical treatment centers, freestanding emergency centers, medical office buildings, rehabilitation centers, and cancer centers.

We found that Board staff was generally in compliance with Planning Act requirements pertaining to the timeliness of application review and public hearings. Reports of ex-parte communications prepared by Board staff identified five projects in our sample which contained ex-parte communications. We tested the ex-parte documentation for these five applications and found that Board staff complied with the Planning Act requirements. However, we found that the Board staff had not posted these reports of ex-parte communications to the Board's website as required by its administrative rules (2 Ill. Adm. Code 1925.293(e)).

The Board has implemented the Safety Net Impact Statement required by the Health Facilities Planning Act (20 ILCS 3960/5.4). Safety net services are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. The revised Planning Act requires that general review criteria include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

Our testing of 43 projects reviewed by the Board included 9 projects which required a Safety Net Impact Statement. Our testing found that all nine projects included a Safety Net Impact Statement as required; however, there were three projects for which the Safety Net Impact Statement was lacking one of the requirements laid out by the revised Planning Act.

We also tested whether the Board published a notice in a newspaper, as required by the Planning Act, for the nine projects requiring a Safety Net Impact Statement. We found one case which did not have a published notice that an application containing a Safety Net Impact Statement was received.

We looked at two categories of hospitals which could be considered safety net providers: Critical Access Hospitals and Disproportionate Share Hospitals. Both categories of hospitals generally had their projects approved by the Board for fiscal years 2010 through 2013.

The Planning Act asked us to determine whether changes to the certificate of need processes have had any impact on access to safety net services. Based on our Safety Net Impact Statement testing for projects in our sample, a discussion with the Association of Safety Net Community Hospitals, and looking into the outcome of Critical Access and Disproportionate Share Hospital projects, we concluded that Public Act 96-0031 has had little impact on safety net hospitals.

Fines and Settlements

During fiscal years 2009 through 2013, there were a total of 77 settlement agreements executed. Of the 77 settlement agreements, 5 settlements' fines were uncollectable (totaling $474,000) and 5 settlements had a non-compliant status ($4,500 plus outstanding reports). However, the remainder of the fine and "in-kind" service agreements were noted as either

fulfilled or were in a compliant status (for example, had submitted reports as required, but still has future reports to submit).

In 47 of 77 settlement agreements (61%), the facility opted to pay a fine to resolve compliance issues. Fine amounts are mandated by State statute; however, if a facility proves that the amount of the levied fine may cause a financial hardship, the facility could make a counter offer which would then be considered by the Board. "In-kind" services or a combination of "in-kind" services and a fine were used in the remaining 30 settlement agreements.

We tested the 26 settlement agreements with a final order (effective) date in fiscal year 2012 or 2013. According to the Board's General Counsel, the practice is to start with the maximum possible fine and negotiate down from there. Our testing indicated that many settlements end up being significantly discounted from the proposed maximum fine amount. To decrease the fine amount, many facilities also chose to provide "in-kind" services. The settlement files contained documentation of "in-kind" settlement compliance reporting.

According to the Board's General Counsel, the Board has authorized staff to use "in-kind" services in settlement negotiations. While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule. Negotiated "in-kind" service amounts have been larger than negotiated fines and a significant portion of the settlement amounts four of the last five fiscal years. The negotiated value of settlements for fiscal years 2012 and 2013 totaled approximately $2.1 million, of which $1.7 million was "in-kind" services and the remaining $425,000 was fines. Given the frequent use of "in-kind" services and to ensure the Board is not violating the intent of the State statute, the Board should seek a legislative change in State statute and/or update its administrative rules to specifically authorize the use of "in-kind" settlements.

Public Act 96-0031 asks us to determine whether fines and settlements are fair, consistent, and in proportion to the degree of violations. We compared settlement agreements within the same category and for similar violations to test for consistency and whether the settlements were in relative proportion to the degree of the violation. While we found it difficult to make a comparison due to the many factors influencing the final value of the settlement, we concluded that, given their respective circumstances, the settlements did not appear unreasonable.

The Health Facilities and Services Review Board was not timely in identifying violations and moving through the violation process. Overall, the violation process took 3.5 years on average to move from the date of the violation to the date when there was a signed resolution to the issue. Seven settlements took longer than four years, the longest taking almost 10 years. Taking a significant amount of time to identify violations and initiate the fines process could decrease the likelihood of collecting fines, especially in the case of facility closures.

BACKGROUND

The General Assembly passed, and the Governor signed, Public Act 96-0031, which made several changes to the Health Facilities Planning Act (Planning Act) and the Health

Facilities and Services Review Board. Among the changes to the Planning Act was the addition of a provision that 24 months after the final member of the Health Facilities and Services Review Board (Board) had been appointed, the Auditor General was to commence a performance audit of the Center for Comprehensive Health Planning, Health Facilities and Services Review Board, and the Certificate of Need processes. The final member was appointed to the Board in June 2011. We began our audit work in June 2013. The audit is to determine:

1. Whether progress is being made to develop a Comprehensive Health Plan and whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning;

2. Whether changes to the Certificate of Need processes are being implemented effectively, as well as their impact, if any, on access to safety net services; and

3. Whether fines and settlements are fair, consistent, and in proportion to the degree of violations.

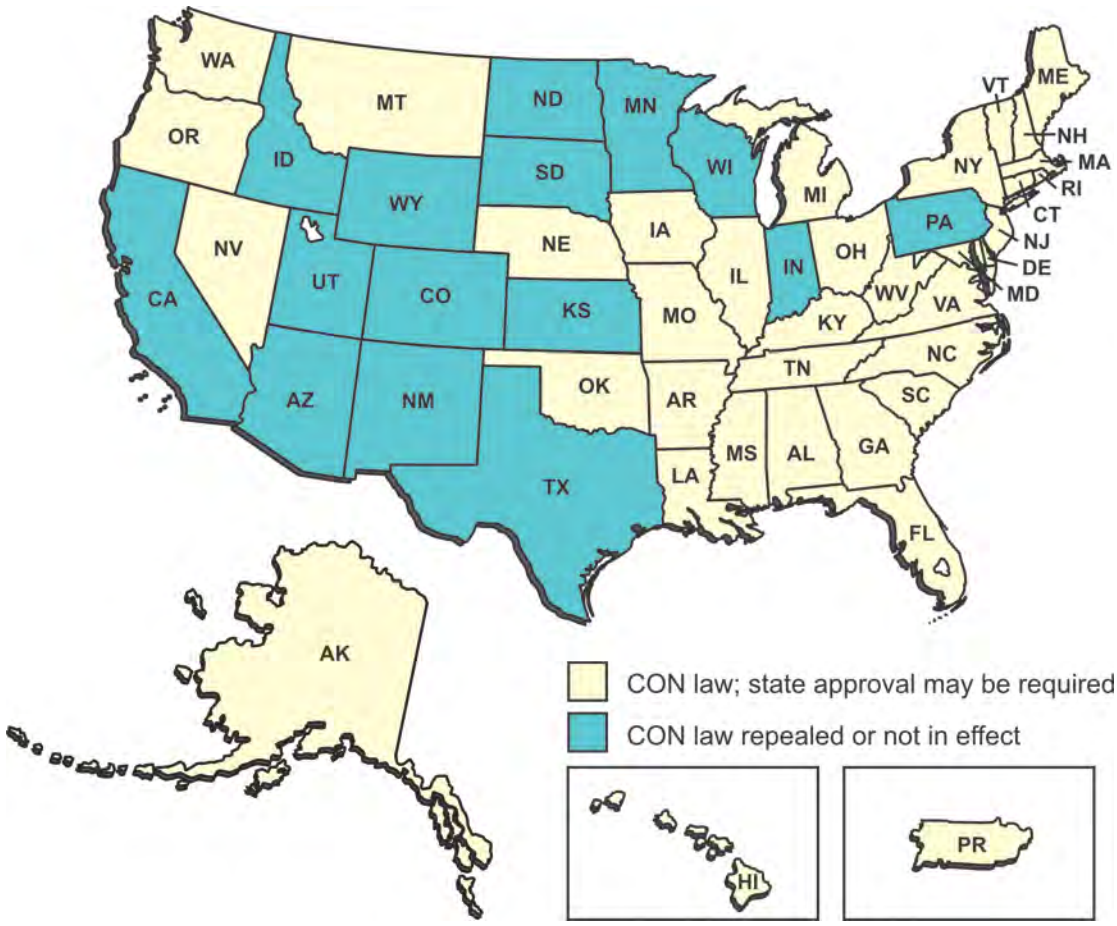
Public Act 96-0031 was effective June 30, 2009. The section from Public Act 96-0031 requiring the audit is included as Appendix A.

CERTIFICATE OF NEED

The Health Facilities Planning Act (20 ILCS 3960) created the Illinois certificate of need (CON) program in 1974. The first CON program was created in New York in 1964. That program became the model for health care capital expenditure regulation used in other states and the federal government. The federal government mandated CON in 1974 and by 1980 all states except Louisiana had adopted some form of CON regulation. Support for health planning at the federal level had waned by the early 1980s and, in 1986, the federal government repealed national health planning requirements, including federal certificate of need.

Currently there are 15 states where CON programs have been repealed or are no longer in effect. Exhibit 1-1 shows those states based on an analysis by the National Conference of State Legislatures (NCSL). The Office of the Auditor General released an audit of the Health Facilities Planning Board in 2001. Since that audit of the Illinois certificate of need program, only one state, Wisconsin, eliminated its program in 2011. Wisconsin had a program, eliminated it in 1987, recreated it in 1993, and now has eliminated it again.

Exhibit 1-1
STATE CERTIFICATE OF NEED HEALTH LAWS



Source: Compiled by the National Conference of State Legislatures based on data from the American Health Planning Association. Updated by OAG to reflect a change in Wisconsin.

HEALTH FACILITIES PLANNING IN ILLINOIS

Illinois' certificate of need program's purpose is laid out in the Health Facilities Planning Act (20 ILCS 3960/2). Its general purpose is noted in the following numbered bullets which have remained similar for many years, although recent changes related to comprehensive health planning are shown in italics. The program is intended to establish a procedure that:

1. Requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community;

2. Promotes, through the process of *comprehensive health planning*, the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities;

3. Promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs; and

4. Carries out these purposes in coordination with the *Center for Comprehensive Health Planning and the Comprehensive Health Plan developed by that Center*.

Public Act 96-0031 added to the purpose section of the Planning Act noted above.

The health facilities planning process in Illinois has gone through a number of revisions since the OAG's 2001 audit. The number of Board members was fifteen in our last audit. After some ethical issues were uncovered after the last audit, the number of Board members was reduced to five and then with Public Act 96-0031, the number of Board members was increased to nine. Exhibit 1-2 shows the Board members including ex-officio members as of January 2014.

Changes to the Planning Act make the Board somewhat independent of the Department of Public Health. The Board is independent in that they are required, through the Chairman, to have a separate and distinct budget approved by the General Assembly. The Board operates in cooperation with the Department of Public Health. Public Health provides operational support to the Board which is formalized through an interagency agreement and typically updated annually. However, there was no interagency agreement from July 1, 2013, to January 15, 2014. On January 16, 2014, the Board and Public Health executed an interagency agreement. The agreement was retroactive to July 1, 2013, and is in effect through December 31, 2014.

As of July 2013, the Board had six employees: an administrator, a general counsel, a compliance/legislative affairs manager, a health systems data manager, a rules coordinator, and an administrative assistant. As of March 2014, the compliance/legislative affairs manager position was vacant, the compliance reviewer position was filled with a contractual employee and a legislative affairs assistant had been hired.

In addition to the Board staff, there are four Public Health staff who work full time on Board functions. This includes two employees who perform the reviews of applications and two administrative assistants. Appendix C provides an organizational chart for the Board and for the related Public Health division for the four Public Health employees that work full time on Board functions. In Fiscal Year 2013, an additional seven Public Health employees spent some time on Board activities including the Deputy Director of Policy, Planning and Statistics who is Public Health's ex-officio member of the Board.

Exhibit 1-2
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
Voting Members as of January 2014

Kathryn J. Olson **Chair** **Independent** Rochelle **First Appointed:** June 2, 2011 **Reappointed:** October 26, 2012 **Term Expires:** July 1, 2015	**John Hayes** **Vice Chair** **Democrat** Indian Head Park **First Appointed:** December 10, 2009 **Reappointed:** March 1, 2010 & September 20, 2013 **Term Expires:** July 1, 2016	**Philip Bradley** **Member** **Republican** Springfield **First Appointed:** October 26, 2012 **Term Expires:** July 1, 2015
James J. Burden, M.D. **Member** **Independent** Glenview **First Appointed*:** November 5, 2007 **Reappointed:** July 2, 2011 **Term Expires:** July 1, 2014	**Deanna J. Demuzio** **Member** **Democrat** Carlinville **First Appointed:** August 31, 2012 **Term Expires:** July 1, 2014	**Justice Alan Greiman** **Member** **Democrat** Wilmette **First Appointed:** March 1, 2010 **Reappointed:** September 20, 2013 **Term Expires:** July 1, 2016
David Penn **Member** **Democrat** Bloomington **First Appointed*:** June 3, 2008 **Reappointed:** July 2, 2011 **Term Expires:** July 1, 2014	**Richard H. Sewell** **Member** **Democrat** Chicago **First Appointed:** June 2, 2011 **Term Expires:** July 1, 2014	**Dale Galassie** **Member (former Chair)** **Republican** Lake Forest **First Appointed:** December 16, 2009 **Reappointed:** September 20, 2013 **Term Expires:** July 1, 2016

Note: All members have been appointed by Governor Quinn.
Two members* were originally appointed by Governor Blagojevich

Ex-Officio Non-Voting Members

David Carvalho, Deputy Director of Policy, Planning and Statistics - Illinois Department of Public Health

Matt Hammoudeh, Assistant Secretary of Operations - Illinois Department of Human Services

Michael Jones, Special Assistant to the Director of Healthcare Policy - Illinois Department of Healthcare and Family Services

Illinois Health Facilities and Services Review Board Administrator: Courtney R. Avery

Source: Health Facilities and Services Review Board and Governor's Appointment websites.

The Health Facilities and Services Review Board is funded by the Illinois Health Facilities Planning Fund. The Fund receives all fees and fines collected pursuant to the Illinois Health Facilities Planning Act. Exhibit 1-3 provides details for the Board's expenditures for fiscal year 2013. Exhibit 1-4 summarizes revenues, expenditures, and appropriations for the Fund for fiscal years 2009 through 2013. The appropriations represent amounts appropriated to the Department of Public Health for expenses of the Board and Department expenses in support of the Board.

Exhibit 1-3
EXPENDITURES DETAIL FOR THE HEALTH FACILITIES AND SERVICES REVIEW BOARD
Fiscal Year 2013

Salaries	$859,258
Fringe	$558,155
Contractual	$209,844
Travel	$31,977
Telecom	$11,841
Equipment	$4,554
Total Expenditures	$1,675,629

Source: Comptroller data summarized by OAG.

Exhibit 1-4
REVENUES, EXPENDITURES, AND APPROPRIATIONS FOR THE ILLINOIS HEALTH FACILITIES PLANNING FUND
Fiscal Years 2009 through 2013

	Revenue	Expenditures	Appropriation
FY 2009	$2,445,965	$1,741,896	$2,200,000
FY 2010	$2,147,979	$1,406,057	$2,200,000
FY 2011	$2,244,818	$1,369,338	$2,800,000
FY 2012	$3,515,827	$1,774,714	$2,800,000
FY 2013	$2,226,221	$1,675,629	$2,800,000

Source: Board data, Comptroller reports, and Illinois Public Acts.

THE CENTER FOR COMPREHENSIVE HEALTH PLANNING

The Center for Comprehensive Health Planning is authorized in State statute (20 ILCS 2310/2310-217). The law includes a section that states that Public Health shall establish a Center for Comprehensive Health Planning. The section and the requirement were added by Public Act 96-0031, the same Public Act that required this audit. That Public Act was effective June 30, 2009. As of March 2014, the Department of Public Health had not established a Center for Comprehensive Health Planning.

The purpose of the Center for Comprehensive Health Planning is established in State statute (20 ILCS 2310/2310-217). Responsibilities and duties of the Center include, among other things: providing technical assistance to the Health Facilities and Services Review Board to permit the Board to apply relevant components of the Comprehensive Health Plan in its

deliberations; attempting to identify unmet health needs; establishing priorities and recommending methods for meeting identified health service, facilities, and workforce needs; and conducting an analysis regarding the availability of long-term care resources throughout the State.

Comprehensive Health Planner

Public Act 96-0031 (20 ILCS 2310/2310-217(b)(2)) provides that a Comprehensive Health Planner shall be appointed by the Governor, with the advice and consent of the Senate, to supervise the Center and its staff for a paid 3-year term, subject to review and re-approval every 3 years. The Planner shall receive an annual salary of $120,000, or an amount set by the Compensation Review Board, whichever is greater. The Planner shall prepare a budget for review and approval by the Illinois General Assembly, which shall become part of the annual report available on the Department website. The Governor has not appointed a Comprehensive Health Planner. Chapter Two discusses the Center for Comprehensive Health Planning and the Comprehensive Health Planner in more detail.

HEALTH FACILITIES AND SERVICES REVIEW BOARD

Illinois' Health Facilities and Services Review Board and the certificate of need program were both established in 1974 by the Illinois Health Facilities Planning Act (20 ILCS 3960 *et seq.*). The Planning Act lays out in significant detail the process for the Board to approve or deny requests to construct or make changes to health facilities and services. Changes made to the Planning Act under Public Act 96-0031, effective June 30, 2009, were intended to accomplish the following objectives:

- Improve the financial ability of the public to obtain necessary health services;
- Establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public;
- Maintain and improve the provision of essential health care services and increase the accessibility of those services to the medically underserved and indigent;
- Assure that the reduction and closure of health care services 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; and
- Assess the financial burden to patients caused by unnecessary health care construction and modification.

To achieve these objectives, the Board would be working closely with the Center for Comprehensive Health Planning; however, a Center has not yet been established. The Center for Comprehensive Health Planning is discussed in Chapter Two of this report. Public Act 96-0031 required other changes to the Board's processes and rules. Some of the more important changes to the Planning Act include:

- Changing the name to the Health Facilities and Services Review Board and changing the number of Board members from five to nine.

- Making the Board more independent, including noting that the Board shall have a separate budget and appropriation.

- Adjusting the Capital Expenditure Minimums for hospitals, long-term care facilities, and other projects to be covered by the Board's CON process.

- Adding a requirement that most applicants, except long-term care facilities, shall include a Safety Net Impact Statement.

- Requiring that the Board's policies and procedures consider priorities and needs of medically underserved areas identified through the comprehensive health planning process.

- Noting specifically that cost containment and support for safety net services must continue to be central tenets of the certificate of need process.

- Setting a limit of 10 days before a Board meeting for members of the public to submit any written response concerning the Board staff's written review of applicants.

- Clarifying what should be considered substantive projects for the CON review process.

- Establishing that parties adversely affected by a final decision of the Board may request a written decision within 30 days of the meeting at which the decision was made.
- Noting that the Board shall establish a separate set of rules and guidelines for long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities.
- Requiring the creation of a Long-Term Care Facility Advisory Subcommittee to develop and make recommendations for Board rules. The Subcommittee is appointed by the Board Chair.

These requirements, and changes made to the process to reflect them, are discussed further in Chapter Three of this report.

Safety Net Impact Statement

The revised Planning Act requires that general review criteria include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

Safety net services are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic

isolation. Safety net service providers include, but are not limited to, 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, and community mental health centers.

The Board staff is to publish a notice in a newspaper having general circulation within the area affected by the application that an application accompanied by a Safety Net Impact Statement has been filed. If a response to a Safety Net Impact Statement is filed with the Board, applicants are provided an opportunity to submit a reply. Safety Net Impact Statements are discussed in more detail in Chapter Three of this report.

Capital Expenditure Minimum

The revised Planning Act changed the capital expenditure minimum which requires a health facilities project to be reviewed by the Board. The thresholds were changed from a single threshold of $6 million for all applicants to $11,500,000 for projects by hospital applicants, $6,500,000 for applicants for projects related to skilled and intermediate care long-term care facilities licensed under the Nursing Home Care Act, and $3,000,000 for projects by all other applicants (e.g., end stage renal dialysis, ambulatory surgical treatment centers, etc.). The thresholds are to be adjusted annually to reflect the increase in construction costs due to inflation, for major medical equipment, and for all other capital expenditures. As of July 1, 2013, the capital expenditure thresholds for review were adjusted to $12,495,668 for hospitals, $7,062,768 for long-term care, and $3,259,740 for all other applicants.

Administrative Rules

The Board has lengthy and detailed rules that deal with operations, criteria for project need, and criteria for financial and economic feasibility. Most of the rules are contained in Title 77 of the Illinois Administrative Code which relates to Public Health and are found within a chapter for the Health Facilities and Services Review Board. The following bullets show administrative rules parts that deal with different components of the process:

- Narrative and Planning Policies - Part 1100
- Processing, Classification Policies and Review Criteria - Part 1110
- Health Facilities and Services Financial and Economic Feasibility Review - Part 1120
- Long-Term Care - Part 1125
- Health Facilities and Services Review Operational Rules - Part 1130
- Health Care Worker Self-Referral - Part 1235
- Appropriateness Review - Part 1250
- State Board Policy Statement Regarding Reserve Bed Capacity - Part 1260

Title 2 of the Illinois Administrative Code also contains a part that pertains to the Board. Part 1925 provides rules related to public information, rulemaking, and organization, most notably, rules related to ex-parte communications.

The Certificate of Need Process

Although there have been several changes to the Board's rules and statutes, including changes to review criteria, dollar thresholds, and the types of projects subject to review, the general process for an applicant has remained fairly similar for the last several years.

An application is submitted and reviewed by board staff for completeness and compared to established criteria. Board staff prepare a State Board Staff Report that describes the project and how it compares to criteria in statute and rules. The Board considers the project and either approves it or issues an intent to deny. If a project is denied, the applicant can make changes to its proposal or provide additional supporting information. If the applicant does this, the Board considers the project again for a second time and again may approve the project or issue an initial denial. If the project is denied this second time, the applicant can still request a review through administrative hearing and, if applicable, may appeal the denial to the courts. A more complete description of the certificate of need process is included in Chapter Three of this report.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The objectives of the audit were identified in Public Act 96-0031 which required the Auditor General's Office to conduct a performance audit of the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board, and the Certificate of Need processes. Appendix A provides the applicable section from Public Act 96-0031. Initial audit work began in June 2013, 24 months after the final member of the new Health Facilities and Services Review Board had been appointed (June 2011), as required by the Public Act. Fieldwork was concluded in February 2014.

We reviewed risk and internal controls related to the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board, the certificate of need process, and other issues related to the audit's objectives. We also reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the Department of Public Health and reviewed the Auditor General's 2001 program audit of the Health Facilities Planning Board. This included reviewing applicable findings and background information. A risk assessment was conducted to identify audit areas that needed closer

examination. This audit identified some weaknesses in those controls and some issues of noncompliance which are discussed in this report.

To fulfill the audit's objectives, we interviewed representatives of the Health Facilities and Services Review Board and the Department of Public Health. These interviews included discussions of the Center for Comprehensive Health Planning, the certificate of need process, as well as fines and settlements of the Board. We contacted the Governor's Office to discuss the status of the Comprehensive Health Planner appointment. To assess the impact on access to safety net services, as required by Public Act 96-0031, we interviewed two representatives of the Association of Safety Net Community Hospitals.

We tested projects for compliance with State statutes and administrative rules. We selected 43 projects to sample from a population of 107 projects which submitted an application for permit during fiscal years 2010 through 2013 to construct a new facility. We sampled all long-term care and hospital projects that proposed to construct a new facility. These two categories represent the bulk of facility construction projects and project dollars. We also randomly chose one project from each of the following categories: end stage renal dialysis, cancer centers, freestanding emergency centers, ambulatory surgical treatment centers, rehabilitation centers, and medical office buildings.

For our sample of 43, we reviewed the State Board Staff Reports associated with each application for completeness and accuracy, including proper application of the rules cited and whether or not the project was classified properly according to the requirements within the rules and Planning Act. We also reviewed, when applicable: the Safety Net Impact Statements and if the Board published notice as required; if a public hearing was requested and held; and any ex-parte communications. We found that the Board was generally in compliance with the applicable State statutes and administrative rules regarding certificate of need projects submitted. However, there were instances of noncompliance which are discussed in this report. Results from this testing are presented in Chapter Three.

We also reviewed all 26 settlement agreements that were finalized during fiscal years 2012 and 2013. We found that there was a wide variation in the type, size, and violations covered by these settlement agreements, making a direct comparison between settlement agreements complicated. However, given their respective circumstances, we determined that the settlements did not appear unreasonable based upon our review of the available information. Results from this testing are presented in Chapter Four.

We also analyzed additional projects and issues. To analyze what impact statutory changes made by Public Act 96-0031 have had on access to safety net services, we considered rules, procedures, and process elements used by the Board to consider safety net services. We analyzed annual hospital questionnaire data which includes data on Medicaid and charity care services provided. Additionally, we reviewed the outcome of projects brought before the Board by hospitals which could be considered safety net service providers (i.e., Critical Access Hospitals and Disproportionate Share Hospitals). We also analyzed projects that had both a denial and an approval; projects with conditions or stipulations; and projects with deferrals.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- Chapter Two – Center for Comprehensive Health Planning;
- Chapter Three – Certificate of Need Process; and
- Chapter Four – Fines and Settlements.

Chapter Two

CENTER FOR COMPREHENSIVE HEALTH PLANNING

CHAPTER CONCLUSIONS

The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning. Public Act 96-0031, effective June 30, 2009, required that the Governor appoint a Comprehensive Health Planner, with the advice and consent of the Senate, to supervise the Center and its staff (20 ILCS 2310/2310-217(b)(2)).

Furthermore, the Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031. The Public Act states that Public Health "shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan" (20 ILCS 2310/2310-217). In addition to developing a Comprehensive Health Plan, the Center has the following responsibilities and duties: providing technical assistance to the Health Facilities and Services Review Board (Board) to permit the Board to apply relevant components of the Comprehensive Health Plan in its deliberations; attempting to identify unmet health needs; and establishing priorities and recommending methods for meeting identified health service, facilities, and workforce needs.

As a result of the lack of a Comprehensive Health Planner and the lack of a Center for Comprehensive Health Planning, no progress had been made to develop a Comprehensive Health Plan. State statutes require that the Center develop a long-range Comprehensive Health Plan to guide the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State (20 ILCS 2310/2310-217(a)).

For four fiscal years, from July 1, 2009, through June 30, 2013, no appropriations or funding were provided for the Comprehensive Health Planner or the Center for Comprehensive Health Planning. However, according to an annual report to the General Assembly and Governor from the Department of Public Health, the fiscal year 2014 budget appropriated $900,000 from the Health Facilities Planning Fund to the Department of Public Health for establishment of the Center. This annual report noted concerns about the viability of financially supporting both the Board and a fully staffed Center in the long run utilizing only the Health Facilities Planning Fund.

Public Act 96-0031 required the Auditor General to determine whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning. The $900,000 appropriation for initial establishment of the Center appears reasonable. However, the adequacy of funding for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan.

THE COMPREHENSIVE HEALTH PLANNER

The Governor has not appointed a Comprehensive Health Planner to lead the Center for Comprehensive Health Planning. Public Act 96-0031, effective June 30, 2009, required that the Governor appoint a Comprehensive Health Planner, with the advice and consent of the Senate, to supervise the Center and its staff (20 ILCS 2310/2310-217(b)(2)).

The Comprehensive Health Planner is to supervise the Center and its staff for a paid 3-year term, subject to review and re-approval every 3 years. The statute provides that the Planner is to receive an annual salary of $120,000, or an amount set by the Compensation Review Board, whichever is greater. The Planner is to prepare a budget for review and approval by the Illinois General Assembly, which shall become part of the annual report available on the Department of Public Health's website.

The first Comprehensive Health Plan is to be submitted to the State Board of Health within one year after hiring the Comprehensive Health Planner. According to a Department of Public Health official, there will be no hiring of staff or any work done until the Comprehensive Health Planner is appointed by the Governor.

The failure to appoint a Comprehensive Health Planner results in non-compliance with State law and negatively impacts the health facilities planning process. We inquired of the Governor's Office regarding the status of the Comprehensive Health Planner position. A Governor's Office official responded that, as of April 30, 2014, they did not yet have an appointment to announce; however, they are seeking a candidate for the position.

COMPREHENSIVE HEALTH PLANNER	
RECOMMENDATION NUMBER **1**	***The Governor should appoint a Comprehensive Health Planner as required by State statute (20 ILCS 2310/2310-217(b)(2)).***
Governor's Office Response	The Office of the Governor concurs in the recommendation. Actions are in progress to secure a quality appointment.

THE CENTER FOR COMPREHENSIVE HEALTH PLANNING

The Department of Public Health has not established a Center for Comprehensive Health Planning as required by Public Act 96-0031. The Public Act states that Public Health "shall establish a Center for Comprehensive Health Planning to develop a long-range Comprehensive Health Plan" which guides the development of clinical services, facilities, and workforce that meet the health and mental health care needs of this State (20 ILCS 2310/2310-217). According to a Department of Public Health official, there will be no hiring of staff or any work done until the Comprehensive Health Planner is appointed by the Governor.

The Center for Comprehensive Health Planning (Center) was created by Public Act 96-0031 (effective June 30, 2009) to 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 certificate of need process under the Illinois Health Facilities Planning Act. The statute requires the Center to:

- Comprehensively assess health and mental health services;
- Assess health needs with a special focus on the identification of health disparities;
- Identify State-level and regional needs; and
- Make findings that identify the impact of market forces on the access to high quality services for uninsured and underinsured residents.

The Center is also to conduct a biennial comprehensive assessment of health resources and service needs, including, but not limited to, facilities, clinical services, and workforce; conduct needs assessments using key indicators of population health status and determinations of potential benefits that could occur with certain changes in the health care delivery system; collect and analyze relevant, objective, and accurate data, including health care utilization data; 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; evaluate findings by the needs assessments; and annually report to the General Assembly and the public. These requirements for the Center are all located in State statute (20 ILCS 2310/2310-217(a)).

The Center for Comprehensive Health Planning also has the following responsibilities and duties established in the statute (20 ILCS 2310/2310-217(b)):

- Providing technical assistance to the Health Facilities and Services Review Board to permit the Board to apply relevant components of the Comprehensive Health Plan in its deliberations;
- Attempting to identify unmet health needs and assisting in any inter-agency State planning for health resource development;
- Considering health plans and other related publications that have been developed in Illinois and nationally;
- Establishing priorities and recommending methods for meeting identified health service, facilities, and workforce needs. Plan recommendations shall be short-term, mid-term, and long-range;
- Conducting an analysis regarding the availability of long-term care resources throughout the State, using data and plans developed under the Illinois Older Adult Services Act, to adjust existing bed need criteria and standards under the Health Facilities Planning Act

for changes in utilization of institutional and non-institutional care options, with special consideration of the availability of the least-restrictive options in accordance with the needs and preferences of persons requiring long-term care; and

- Considering and recognizing 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.

Funding for the Center

For four fiscal years, from July 1, 2009, through June 30, 2013, no appropriations or funding were specifically provided for the Comprehensive Health Planner or the Center for Comprehensive Health Planning. Public Act 96-0031 required the Auditor General to determine whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning. The Department of Public Health stated in a report to the Governor and General Assembly (dated March 2014) that the $2.5 million appropriation to Public Health from the Health Facilities Planning Fund for Department expenses in support of the Board for fiscal year 2014 included $900,000 for the initial establishment of the Center. This amount appears reasonable; however, the adequacy of funding for subsequent years is difficult to assess given the absence of a Comprehensive Health Planner and lack of a Comprehensive Health Plan.

In the statutorily required annual report to the Governor and General Assembly on the progress of the Center dated January 2013, the Department of Public Health reported that no specific appropriation had been enacted that would allow the creation of the Center. Although no specific appropriation had been made, the statute does not provide that the Center is to be established only if specific or additional appropriations were provided. **A Public Health official told us that no specific appropriation request relating to the Center had been made for any of the four fiscal years since the mandate was effective** (i.e. fiscal years 2010, 2011, 2012, or 2013).

In fiscal year 2014, the Department of Public Health was appropriated $3.7 million from the Health Facilities Planning Fund which was comprised of $1.2 million for Board expenses and $2.5 million for Department expenses in support of the Board. According to the Department's annual report on the progress of the Center, filed in March 2014, the $2.5 million included about $900,000 for the Center. As can be seen in Exhibit 2-1, there was a $900,000 increase in Public Health's appropriation from the Illinois Health Facilities Planning Fund. Even though the funding for the establishment of the Center was provided for in the fiscal year 2014 budget, as of March 2014, no Center had been established.

According to Department of Public Health estimates, $900,000 should be sufficient to provide for a minimum of operations at the new Center. The annual report states, "The Department estimates that an appropriation of $900,000 would allow for the establishment of a center with five staff, four professional and one support . . . which would provide for a minimum of operations at the new Center." The report also states that a fully staffed Center is projected to include eleven professional staff and two support staff at an annual cost of approximately $1.5 million.

The Director of Public Health noted concerns about the ability of the Health Facilities Planning Fund to sustain both the Board and the Center for more than several years without an increase in the fees that populate the fund. At fully staffed levels, the Fund is projected to be spending more than $700,000 annually over receipts.

Money in the Illinois Health Facilities Planning Fund comes from fees and fines charged to health facilities that apply or have approved projects. Monies in the fund, subject to appropriation, are to be used for expenses incurred to administer the Health Facilities Planning Act, historically, the certificate of need program and the operations of the Board.

The March 2014 report notes that the imbalance of expenses and revenues is manageable in the early years as the Center is developed, but it cannot be sustained over the long term. The report includes estimated revenues and expenses and projections for the Fund through 2020 and notes that by the fourth year of a mature Center, the Fund would be diminished by half and, without an additional mechanism for funding the Center, only a few years from insolvency. However, the report notes that the Fund currently has a healthy balance and the time is right to move ahead with the development of the Center. Appendix D contains the most recent annual report filed in March 2014.

Exhibit 2-1
APPROPRIATIONS AND FUND BALANCES FOR THE ILLINOIS HEALTH FACILITIES PLANNING FUND
Fiscal Years 2009 through 2014

	Appropriation	Year End Fund Balance
FY 2009	$2,200,000	$3,847,758
FY 2010	$2,200,000	$3,002,673
FY 2011	$2,800,000	$1,406,260
FY 2012	$2,800,000	$5,129,589
FY 2013	$2,800,000	$6,242,385
FY 2014	$3,700,000	N/A

Source: Illinois Public Acts, Comptroller reports, and Department of Public Health data.

Exhibit 2-1 shows appropriations and year end fund balances for the Illinois Health Facilities Planning Fund for fiscal years 2009 through 2014 as taken from Illinois Public Acts, Comptroller reports, and Department of Public Health data. The appropriations represent amounts appropriated to the Department of Public Health for expenses of the Board and Department expenses in support of the Board. As shown in the exhibit, the balance of the Fund can vary. According to the Board's Administrator, the general fluctuation in the balance is based on the number of projects, total project costs (i.e., more projects and projects for a larger dollar amount equate to more applications fees which are deposited into the Fund), and an appropriation to entities such as the Center for Comprehensive Health Planning. According to the Board's Administrator, the dip in the Fund balance (from fiscal year 2010 to 2011) can be attributed to interfund borrowing of approximately $2.4 million. The increase from fiscal year 2011 to 2012 is attributed to the repayment of the interfund borrowing and an increase in the number and scope of projects.

The Comprehensive Health Plan

No progress had been made to develop a Comprehensive Health Plan. The statute requires that the Center develop a long-range Comprehensive Health Plan to guide the development of clinical services, facilities, and workforce that meet the health and mental health

care needs of this State (20 ILCS 2310/2310-217(a)). The first Comprehensive Health Plan is to be submitted to the State Board of Health within one year after hiring the Comprehensive Health Planner. The Plan is to be submitted to the General Assembly by the following March 1. However, the Governor has not appointed a Comprehensive Health Planner. According to a Department of Public Health official, there will be no hiring of staff or any work done until the Comprehensive Health Planner is appointed.

The objectives of the Comprehensive Health Plan include:

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

According to the State statute (20 ILCS 2310/2310-217(c)), the Comprehensive Health Plan shall be developed with a 5 to 10 year range, and updated every 2 years, or annually, if needed. Components of the Plan are to include:

- An inventory to map the State for growth, population shifts, and utilization of available healthcare resources, using both State-level and regionally defined areas;
- An evaluation of health service needs, addressing gaps in service, over-supply, and continuity of care, including an assessment of existing safety net services;
- An inventory of health care facility infrastructure, including regulated facilities and services, and unregulated facilities and services, as determined by the Center;
- Recommendations on ensuring access to care, especially for safety net services, including rural and medically underserved communities; and
- An integration between health planning for clinical services, facilities and workforce under the Illinois Health Facilities Planning Act and other health planning laws and activities of the State.

The statute states that components of the Plan may include recommendations that will be integrated into any relevant certificate of need review criteria, standards, and procedures. The Planning Act requires the Board apply the findings from the Comprehensive Health Plan, not only to update review standards and criteria, but also to better identify needs and evaluate applications and to establish mechanisms to support adequate financing of the health care system in Illinois to ensure the development and preservation of safety net services. Without the Center and the Comprehensive Health Plan, certificate of need reform intended by changes to State statutes will not be fully implemented.

CENTER FOR COMPREHENSIVE HEALTH PLANNING	
RECOMMENDATION NUMBER **2**	***The Department of Public Health should work to establish the Center for Comprehensive Health Planning as required by State statute (20 ILCS 2310/2310-217). The Center and the Comprehensive Health Planner should develop the required Plan.***
Department of Public Health Response	The Department concurs in the finding and recommendation. Steps are being taken to implement 20 ILCS 2310/2310-217. Draft organizational charts have been created and draft position descriptions are being developed. The Department is also engaging the Department of Central Management Services about establishing positions for the new Center.

Chapter Three

CERTIFICATE OF NEED PROCESS

CHAPTER CONCLUSIONS

Since 2009, there have been several changes to the certificate of need (CON) process through Public Acts amending the Health Facilities Planning Act (Planning Act). Through discussions with Health Facilities and Services Review Board (Board) staff, an examination of Board rules, and testing samples of Board reports and settlement agreements, we determined that most of these changes have been implemented. Public Act 96-0031, effective June 30, 2009, made the most substantive changes to the Planning Act. However, the Board cannot implement statutory provisions related to the Comprehensive Health Plan because the entity responsible for creating the Plan (Center for Comprehensive Health Planning) has not yet been established.

Other changes not implemented include: the Board did not post on its website an annual accounting of revenues and expenses for fiscal years 2011, 2012, and 2013; and the Chairman of the Board did not conduct annual reviews of Board member performance or report attendance records to the General Assembly as required by the Planning Act.

We tested a sample of 43 applications acted upon by the Board to test general compliance with the Planning Act, particularly recent changes made to the Planning Act and the administrative rules. Our population included all applications acted upon by the Board from FY10 through FY13 to construct a new hospital (9 applications) or long-term care facility (28 applications). Our testing also included one application to establish a new facility from each of the following categories: end stage renal dialysis, ambulatory surgical treatment centers, freestanding emergency centers, medical office buildings, rehabilitation centers, and cancer centers.

We found that Board staff was generally in compliance with Planning Act requirements pertaining to the timeliness of application review and public hearings. Reports of ex-parte communications prepared by Board staff identified five projects in our sample which contained ex-parte communications. We tested the ex-parte documentation for these five applications and found that Board staff complied with the Planning Act requirements. However, we found that the Board staff had not posted these reports of ex-parte communications to the Board's website as required by its administrative rules (2 Ill. Adm. Code 1925.293(e)).

The Board has implemented the Safety Net Impact Statement required by the Planning Act (20 ILCS 3960/5.4). Safety net services are services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. The revised Planning Act requires that general review criteria include a

requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service.

Our testing of 43 projects reviewed by the Board included 9 projects which required a Safety Net Impact Statement. Our testing found that all nine projects included a Safety Net Impact Statement as required; however, there were three projects for which the Safety Net Impact Statement was lacking one of the requirements laid out by the revised Planning Act.

We also tested whether the Board published a notice in a newspaper, as required by the Planning Act, for the nine projects requiring a Safety Net Impact Statement. We found one case which did not have a published notice that an application containing a Safety Net Impact Statement was received.

We looked at two categories of hospitals which could be considered safety net providers: Critical Access Hospitals and Disproportionate Share Hospitals. Both categories of hospitals generally had their projects approved by the Board for fiscal years 2010 through 2013.

The Planning Act asked us to determine whether changes to the certificate of need processes have had any impact on access to safety net services. Based on our Safety Net Impact Statement testing for projects in our sample, a discussion with the Association of Safety Net Community Hospitals, and looking into the outcome of Critical Access and Disproportionate Share Hospital projects, we concluded that Public Act 96-0031 has had little impact on safety net hospitals.

CERTIFICATE OF NEED APPLICATION PROCESS

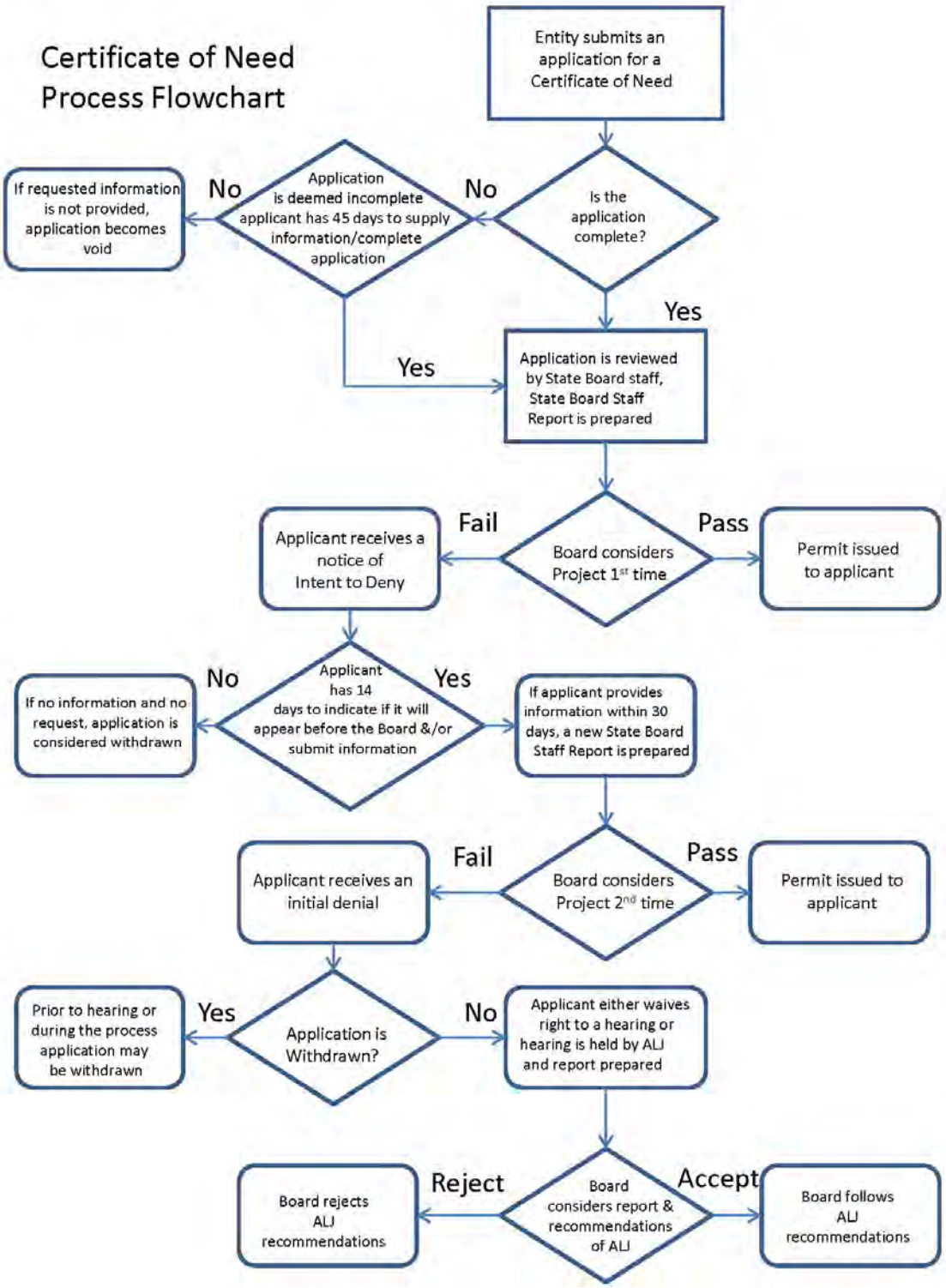
A health care facility applies for a certificate of need (CON) permit by submitting an application and paying the initial application fee of $2,500 to the Illinois Health Facilities and Services Review Board (Board). The total application fee is assessed based on the cost of the project and ranges between $2,500 and $100,000. The application is reviewed by the Board staff, and the application fee is deposited into the Health Facilities Planning Fund. Exhibit 3-1 provides a flowchart of the certificate of need application process.

Completeness Review

Ten working days are allowed for Board staff to perform a **completeness review** on the application for permit. If the application is incomplete, the applicant receives notice from the Board staff and is given 45 days to provide additional information to complete the application. If the applicant does not provide the requested information within this timeframe, the application becomes void. If the additional information is provided to complete the application, the applicant receives notice and a hearing date is scheduled with the Board.

A completeness review requires the Board staff to determine if the applicant has substantially addressed all relevant criteria for the proposed project. As part of this completeness

Exhibit 3-1
HEALTH FACILITIES AND SERVICES REVIEW BOARD FLOWCHART



Source: Health Facilities and Services Review Board.

review, the applicant must have submitted all required reports for all outstanding permits, addressed all facility survey information required by Public Health, be in compliance with Illinois Department of Public Health Cancer Registry and the Adverse Pregnancy Outcomes Reporting System, and not have any outstanding legal issues with the Board.

Opportunity for Public Hearing

Once an application is deemed complete and before the project is considered by the Board, there is an opportunity for a public hearing. Notice for an opportunity for a public hearing and written comment (public notice) is published in a general circulation newspaper in the area or community to be affected and on the Board's website. Interested parties have 15 days to request a public hearing from the date the application is published. If a public hearing is requested, it shall be held at least 15 days but no more than 30 days after the date of publication of the legal notice in the community in which the facility is located. The hearing shall be held in a place of reasonable size and accessibility and a full and complete written transcript of the proceedings is made. A Board member is required to attend all public hearings that are requested. For all substantive projects or projects proposing to discontinue a category of service, (long-term care facilities licensed under the Nursing Home Care Act are exempted from submitting a Safety Net Impact Statement), the public notice must contain a statement that a Safety Net Impact Statement was included in the application for permit.

Application Review

The CON application review is completed by Board staff. An analysis is done to determine whether the facility meets or does not meet the various criteria set forth in the Board's administrative rules. Staff prepares an analysis referred to as the **State Board Staff Report** which addresses the individual criteria.

Projects are classified as either substantive or non-substantive. The two categories of **substantive** projects and their maximum review period (120 or 60 days) are described in the adjacent box. All other projects are considered **non-substantive** and have a maximum 60-day review period. All projects must have, at a minimum, a 30-day review. After the application review process is completed, a copy of the State Board Staff Report, complete application, opposition and support letters, public hearing transcript, and written comments are sent to the Board members.

Substantive Projects

1. *Construction of a new or replacement facility located on a new site, or a replacement facility that exceeds the capital expenditure minimum.*

   Maximum review period: 120 days

2. *A new service or a discontinuation of a service or a project proposing a change in bed capacity greater than the lesser of 20 beds or 10% of the facilities total bed count.*

   Maximum review period: 60 days

Fourteen days before the Board meeting, the State Board Staff Report is published on the Board's website. Individuals and members of the public have up to ten days before the Board meeting to submit any written response to the staff review and findings. If errors are identified in the State Board Staff Report,

that information is forwarded to the Board members for review. Approval and inclusion of the comments to the State Board Staff Report are done at the Board meeting.

The Board meeting is subject to the Open Meetings Act and a period of time is set aside at each Board meeting to accommodate individuals wanting to provide public testimony at the Board meeting. All applications for permits are forwarded to the Board for review. Projects that meet all applicable criteria and for which there is no opposition can be approved by the Chairman. However, because the Open Meetings Act allows an opportunity to comment on any item before the Board, these projects are currently forwarded to the Board members for approval.

Project's Initial Board Meeting Consideration

At the Board meeting with the applicant present, the Board considers the project and votes on whether it should be approved. A motion is made to approve a project and five affirmative votes are needed to issue a permit. If the project is approved, the CON permit is issued to the applicant. Failure of the project to meet one or more review criteria does not prohibit members of the Board from voting for approval. During the Board consideration process, there are provisions to allow consideration of the application to be deferred.

If the project fails to receive five votes, the applicant receives a notice of intent to deny. After the notice, the applicant has 14 working days to request to appear before the Board or submit additional information. If the applicant waives the right to appeal the intent to deny or takes no action, the application is considered withdrawn. However, if the applicant elects to appear before the Board, the Board will reconsider the application. If the applicant wants to submit additional information for the Board to consider, it has 60 days to provide the information. Upon receiving the information, Board staff has 60 days to review the information and prepare a supplemental report.

Project's Second Board Meeting Consideration

If on second consideration, the Board approves the application, the CON permit is issued to the applicant. If the application is denied a second time, the applicant will be issued a denial of an application for permit.

The applicant has 30 days to request an **administrative hearing** at which an Administrative Law Judge considers the case and issues a recommendation. After the hearing, the Board will vote and issue its **final decision.** Once a final decision has been issued, any adversely affected party or the applicant may request a **written decision** within 30 days of the meeting at which the

Written Decision: An adversely affected party or the applicant may request a written decision of the Health Facilities and Services Review Board decision. The Board has 30 days in which to issue this written decision.

The written decision shall identify the applicable criteria and factors that were taken into consideration by the Board when coming to the final decision. If the Board denies or fails to approve a project, the Board is required to include in the final decision a detailed explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill.

decision was made. If the Board issues a final denial, the only option left for the applicant is to appeal the decision in the Circuit Court.

Application for Exemption

Exemptions are allowed under the Planning Act (20 ILCS 3960/6(b)) and are reviewed under the Board's administrative rules. Most exemptions involve the change of ownership of a health care facility.

Certain applicants qualify for an exemption from obtaining a certificate of need, most of which involve a health care facility change of ownership. However, before an applicant can submit an application for exemption to the certificate of need for a change of ownership, an applicant must have a bond rating of "A" or better or meet the Board's financial standards. If the applicant meets this qualification, an application for exemption to certificate of need for change of ownership is submitted, and the applicant pays an application fee of $2,500 to the Illinois Health Facilities and Services Review Board. The application is reviewed by the Board staff, and the application fee is deposited into the Health Facilities Planning Fund.

The Board staff has 30 days to determine if the exemption applicant has provided all of the information required by Board administrative rules. If all the information has been provided, a Notice of an Opportunity for a Public Hearing and Written Comment is published in a newspaper of general circulation for 3 consecutive days (and a newspaper of limited circulation for an application for a facility located in a Metropolitan Statistical Area) and posted on the website. Notice is sent to the Representatives and Senators representing the legislative district where the health care facility is located, notifying them of the change of ownership of the health care facility.

Once an exemption has been determined to meet all Board requirements, a State Board Staff Report is prepared. Because of the Open Meetings Act, all exemption applications are forwarded to the Board for approval to allow for public comment on the change of ownership at the Board meeting. An exemption shall be approved when information required by Board administrative rules is submitted. There is no right to a rehearing of the Board's decision. The Board shall be notified within 24 months of the completion of the change of ownership.

CHANGES TO THE PLANNING ACT AND THEIR IMPLEMENTATION

Since 2009, there have been several changes to the CON process through Public Acts amending the Health Facilities Planning Act. Through discussions with Board staff, an examination of Board rules, and testing samples of State Board Staff Reports and settlement agreements, we determined whether the changes to the Planning Act had been implemented. Many of these changes have been implemented. Below we summarize the most substantive changes to the Planning Act, the Public Act that required them, and whether the changes have been implemented.

Changes Required by Public Act 96-0031

Public Act 96-0031, effective June 30, 2009, made the most substantive changes to the Planning Act. We found that many of these changes have been implemented. Below is a summary of the most substantive changes that have been implemented.

- The Public Act added cardiac catheterization, open heart surgery, and major medical equipment used in the direct clinical diagnosis or treatment of patients as services that are included in the definition of "health care facilities" under review. While Public Act 96-0031 specifically included these categories of service in the Planning Act, this was not a new requirement; this was already contained in and required by the Board's administrative rules.

- The Public Act set a higher "capital expenditure minimum" for hospitals and skilled and intermediate care long-term care facilities ($11.5 million and $6.5 million respectively) and established a lower capital expenditure minimum for all other applicants ($3.0 million). Previously, the capital expenditure minimum which required a review was $6.0 million for all health facilities projects requiring a certificate of need review. The administrative rules reflect the new capital expenditure thresholds, adjusted for inflation. Also, as noted in the administrative rules, the thresholds are posted on the Board's website.

- The Public Act changed Board composition from five to nine members, established standards of knowledge for members, and delineated certain exclusions for Board member eligibility. In June 2011, the last of the appointments was made to bring the total number of members to nine. All Board members appear eligible based on their backgrounds and experience.

- The Public Act established a Long-Term Care Facility Advisory Subcommittee. The Long-Term Care Facility Advisory Subcommittee has met regularly since September 2010.

- The Public Act required that health care facility applicants, with the exclusion of skilled and intermediate long-term care facilities licensed under the Nursing Home Care Act, must submit a Safety Net Impact Statement with an application for a substantive project or when an application proposed to discontinue a category of service. All nine projects in our sample that required a Safety Net Impact Statement contained one. Safety Net Impact Statements are addressed in more detail later in this Chapter.

- The Public Act required that, upon request of the applicant or an adversely affected party, the Board will issue a written decision of a final decision. This has been added to the administrative rules. According to Board staff, a written final decision has been requested for one project. The written decision was provided to the parties requesting it and also posted on the Board's website.

- The Public Act required the Board to establish a separate set of rules and guidelines for long-term care. Long-term care rules are now a separate section of the Administrative Code (Section 1125 of 77 Ill. Adm. Code).

- The Public Act required the Board to put in place a mechanism for the public to comment on, and request changes to, draft rules and standards. A section was added to the Board's administrative rules requiring the Board to conduct public hearings on all proposed rules and provide notice of public hearings. We have observed various postings and opportunities for the public to comment on and request changes to draft rules and standards on the Board's website.

- The Public Act required the Board to publish various reports on its website including staff reports, monthly application status reports, and annual reports of settlement agreements entered into by the facilities and the Board that resolve alleged instances of facility noncompliance. We have observed these various reports posted on the Board's website. The website contains all staff reports for projects being considered at each respective Board meeting, applications acted upon by the by the Board, and a list of applications received and pending. For our sample of 43 projects, we verified access to the application, staff report, and various other project related documents. Additionally, we checked the settlement reports posted on the Board's website for accuracy as part of our settlement testing.

- The Public Act required ex-parte communications to be made part of the public record, using a prescribed, standardized format, and be included in the application file. Five files in our sample contained ex-parte communications. These communications were dealt with appropriately and in accordance with the Planning Act.

There are several substantive changes that have not been implemented completely or effectively:

- Various changes cannot be accomplished until the Center for Comprehensive Health Planning is established, including the Board providing written and consistent decisions that are based on findings from the Center's Comprehensive Health Plan, as well as other issues recommended by the Center. This was discussed in more detail in Chapter 2 – see Recommendation 2.

- The Board staff is required to publish, in a newspaper having general circulation within the affected area, a notice that an application containing a Safety Net Impact Statement has been received. Our testing identified one of nine projects which required, but did not have a published notice. This is discussed in more detail later in this Chapter – see Recommendation 3.

- An annual accounting of revenues and expenses incurred by the Board is required to be included on the Board's website. This is discussed in more detail later in this Chapter – see Recommendation 4.

- Annual reviews of Board member performance are to be conducted and a report of attendance of each Board member is required to be provided to the General Assembly. Although one year's evaluation was done and attendance records were available, these were not reported to the General Assembly. This is discussed in more detail later in this Chapter – see Recommendation 5.

Changes Required by Public Act 97-1115

Public Act 97-1115, effective August 27, 2012, also made some significant changes to the Planning Act. Listed below are the most substantive changes, most of which were implemented.

- Facility reporting requirements and expenditure commitment regulations/deadlines were added. The administrative rules were updated, effective June 1, 2013, to reflect events causing a permit to become invalid; among those events are the failure on the part of the facility to submit expenditure commitment reports, annual progress reports, and final cost reports.

- Regarding the facts set forth in the review or findings of the Board staff, members of the public shall have until 10 days before the meeting of the Board to submit any written response concerning the Board staff's written review or findings. The administrative rules were updated to include the language from the Planning Act.

- Processing deadlines for review of permits and public hearings were changed and/or added. Applicants are required to be notified within 10 days of application completeness. Board staff review is to be completed within 120 days. The Board was required to "adopt reasonable rules and regulations governing the procedure and conduct of the hearings." The administrative rules were updated, effective June 1, 2013, to include procedures for public hearings on applications for permit. While Public Act 97-1115 added the 120-day application review period to the Planning Act, this was not a new requirement; this was already contained in and required by the Board's administrative rules.

- Board staff are using a five-year projection for need formulas as required by Public Act 97-1115 as opposed to the previous ten-year projection requirement. Effective February 1, 2014, the administrative rules for all categories of service except long-term care have been updated to reflect the five-year projection requirement.

- When a written decision is requested by an applicant or an adversely affected party, the Board must include in the written decision an explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill. According to Board staff, only one written decision has been requested. The written decision was provided to the parties requesting it and also posted on the Board's website. This written decision contained the necessary information.

- Public Act 97-1115 added a specific fine category for failure to comply with the post-permit and reporting requirements to impose fines more appropriate to the offense. Not complying with post-permit reporting requirements was fined previously under a higher

fine structure. According to Board staff, this new fine category was established to avoid giving a large fine for a violation such as not submitting a report and stated that the new fine is more appropriate to the violation.

APPLICATIONS ACTED UPON BY THE BOARD

We tested a sample of 43 applications acted upon by the Board to test general compliance with the Planning Act, particularly recent changes made to the Planning Act and the administrative rules. Our population included all applications acted upon by the Board from FY10 through FY13 to establish a new hospital (9 applications) or long-term care facility (28 applications). Our testing also included one application from each of the following categories: end stage renal dialysis, ambulatory surgical treatment centers, freestanding emergency centers, medical office buildings, rehabilitation centers, and cancer centers.

We reviewed the State Board Staff Reports associated with each application for completeness and accuracy, including proper application of the rules cited and whether or not the project was classified properly according to the requirements within the rules and Planning Act. We also reviewed, when applicable, the Safety Net Impact Statements, if a public hearing was requested and held, and any ex-parte communications.

We found instances where the statutory review period was exceeded. Six of the 43 applications we tested exceeded the 120 or 60 day review period (substantive and non-substantive, respectively). However, five of the six exceeded the review period by 3 days or less. One application exceeded the review period by 62 days; however, there was a modification to the application which required Board staff to give notice of and hold a public hearing.

We also tested timeliness of public hearings. Board staff are required to, upon request by the applicant or an interested person, hold a public hearing within a reasonable amount of time, but not to exceed 90 days after receipt of the complete application. Public hearings were held for 11 of the 43 applications. Ten of the 11 were held within 90 days as required. The one application which exceeded the 90-day deadline was the application discussed above; there was a modification to the application which required Board staff to give notice of and hold a public hearing. After the modification created the need for a public hearing, Board staff held the public hearing in a timely manner.

We also tested applications in our sample for which there were documented ex-parte communications. Per the Planning Act, ex-parte communications related to a formally filed application are to 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. Reports of ex-parte communications prepared by Board staff identified five projects in our sample which contained ex-parte communications. We tested the ex-parte documentation for these five applications and found that Board staff complied with the Planning Act requirements. However, we found that the Board staff had not posted these reports of ex-parte communications to the Board's website as

required by administrative rule. This is discussed in more detail later in this Chapter – see Recommendation 4.

IMPACT ON ACCESS TO SAFETY NET SERVICES

The Planning Act which requires this audit asked us to determine whether changes to the Certificate of Need processes have had any impact on access to safety net services. The changes discussed previously require the Board to consider safety net services in the course of its work. Safety net services are considered by the Board through information required and submitted with the application, transcripts of public hearings (if requested), written responses to Safety Net Impact Statements, and summary reports prepared by the Board staff.

Also, the Center for Comprehensive Health Planning is charged with responsibilities related to safety net services. One of the objectives of the Center is to support safety net services for uninsured and underinsured residents. The Center is also required to develop a Comprehensive Health Plan which assesses existing safety net services and makes "recommendations on ensuring access to care, especially for safety net services, including rural and medically underserved communities." The Center was to consider facilities and services reviewed by the Board, but was also to consider facilities and services not regulated by the Board. Those unregulated services could include the health centers and clinics included in the Planning Act's definition of safety net services.

The Health Facilities Planning Act defines safety net services as:

> *. . . services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. Safety net service providers include, but are not limited to, 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, and community mental health centers.*

Safety Net Impact Statement

The Health Facilities and Services Review Board has implemented the Safety Net Impact Statement required by the Planning Act (20 ILCS 3960/5.4). The revised Planning Act requires that general review criteria include a requirement that all health care facilities, with the exception of skilled and intermediate long-term care facilities, provide a Safety Net Impact Statement, which shall be filed with an application for a substantive project or when the application proposes to discontinue a category of service. The required Safety Net Impact Statement is to include all of the following:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

4. For the three fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

5. For the three fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health.

6. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

The Board staff are to publish a notice in a newspaper having general circulation within the area affected by the application that an application accompanied by a Safety Net Impact Statement has been filed. Our results from testing this requirement are presented in a following section. If a response to a Safety Net Impact Statement is filed, applicants are provided an opportunity to submit a reply.

Association of Safety Net Community Hospitals

We spoke with representatives of the Association of Safety Net Community Hospitals to discuss the impact of Public Act 96-0031 on safety net hospitals. According to the representatives, they were unaware of any impact on safety net hospitals or any cases where the safety net language had been tested (as of January 2014). They noted that there have been no problems, grievances, or concerns that they are aware of from members of their Association.

Safety Net Impact Statement Testing

Our testing of 43 projects reviewed by the Board included 9 projects which required a Safety Net Impact Statement. Our testing found that all nine projects included a Safety Net Impact Statement as required; however, there were three projects for which the Safety Net Impact Statement was lacking one of the requirements laid out by the revised Planning Act. Two projects provided information on the amount of charity care and Medicaid only, but did not address the project’s material impact on the essential safety net services in the community or the impact on the ability of another provider or health care system to cross-subsidize safety net services. The third project did not provide the number of charity care or Medicaid patients. Without all required safety net information, the Board staff is not complying with the Planning Act and puts the Board at a disadvantage when trying to evaluate that project’s impact on safety net services.

Of the nine projects filing a Safety Net Impact Statement, two of these projects were denied. We reviewed the denial letters, State Board Staff Reports, and the meeting transcripts for these projects. While impact on other facilities was discussed, there was not any mention of these being safety net service providers nor of an impact on safety net services.

We also reviewed the remaining seven projects which were approved. In several cases, the applicant was a safety net provider and noted an improvement in access to safety net services. We saw no evidence of opposition for three of the seven projects. There was opposition for four of the projects; however, in only one project did the opposition discuss an impact on safety net service providers in the area. It is important to note that this project was denied twice by the Board. The applicant requested an administrative hearing to contest the project denial and received approval after the Board adopted the Administrative Law Judge's recommendations and reconsidered and approved the project.

We also tested whether the Board published notice in a newspaper for the nine projects requiring a Safety Net Impact Statement. Board staff are required to publish a notice that an application accompanied by a Safety Net Impact Statement has been filed. The notice is to be published in a newspaper having general circulation within the area affected by the application. A notice was published for eight of the nine applications as required; however, we found one case which did not have a published notice that an application containing a Safety Net Impact Statement was received. According to the Board's Administrator, the project was for the establishment of a hospital and should have been identified in the legal notice which was published; however, it was not identified. If notice of receipt of a Safety Net Impact Statement is not published, then the public could be unaware of the project and might miss an opportunity afforded to them to respond to the Safety Net Impact Statement and provide additional information concerning a project's impact on safety net services in the community.

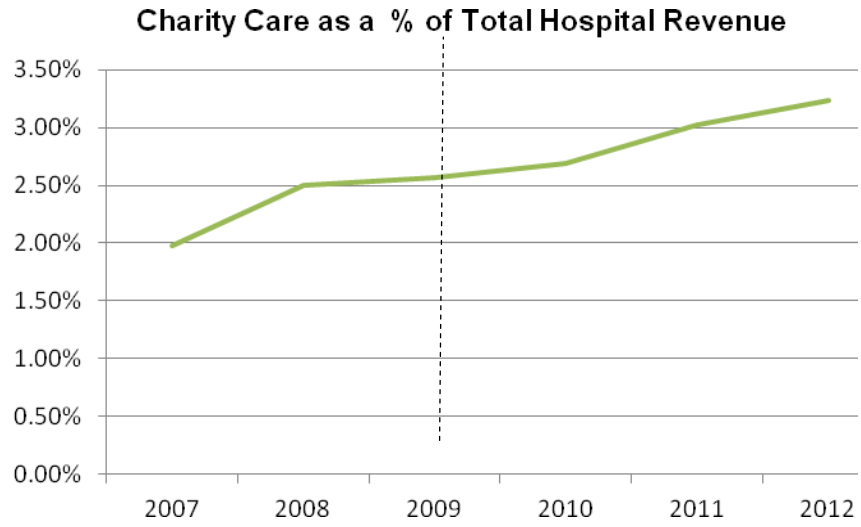
SAFETY NET IMPACT STATEMENTS	
RECOMMENDATION NUMBER **3**	***The staff of the Health Facilities and Services Review Board should ensure that Safety Net Impact Statements contain all elements required by the Health Facilities Planning Act (20 ILCS 3960/5.4). Additionally, a notice should be published, in a newspaper having general circulation within the area affected by the application, for all projects for which an application accompanied by a Safety Net Impact Statement has been filed.***
Health Facilities and Services Review Board Response	In accordance with the Health Facilities Planning Act (20 ILCS 3960/5.4) HFSRB will ensure that safety net impact statements contain all elements required and the notice should be published, in a newspaper having general circulation within the area affected by the application, for all projects for which an application accompanied by a safety net impact statement has been filed.

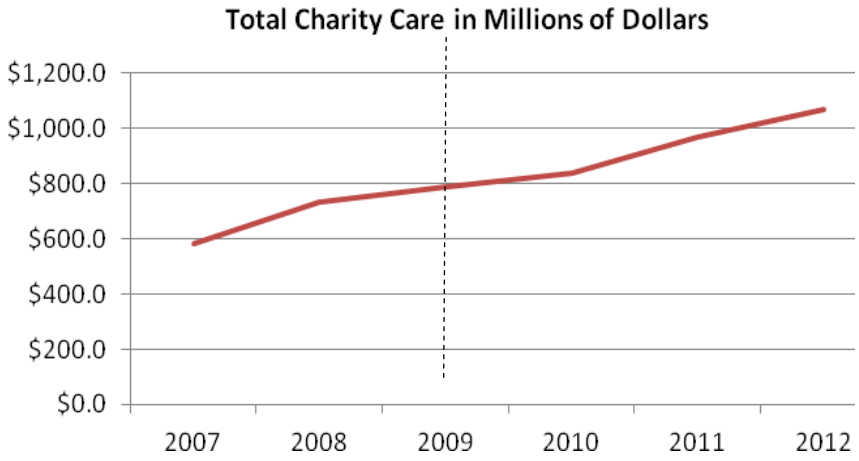
Measuring Impact on Safety Net Services

The Department of Public Health captures data to measure the number of hospitals that provide charity care including both number of patients and revenue that relate to charity care. Using Public Health data, we summarized hospital charity care for the State including one graph showing charity care as a percentage of total revenue and one showing total dollars for charity care (see Exhibit 3-2).

Both graphs include data from calendar years 2007 through 2012. Both the cost of charity care and the proportion of charity care have increased over the years, but the changes in the Health Facilities Planning Act on June 30, 2009, show no discernible impact in the graphs.

Exhibit 3-2
HOSPITAL CHARITY CARE FOR ILLINOIS SHOWN AS:
PERCENT OF TOTAL REVENUE AND DOLLARS
Calendar Years 2007 through 2012 (dollars in millions)





Effective date of PA 96-0031

Source: Illinois Department of Public Health data summarized by OAG.

Effect on Critical Access Hospital and Disproportionate Share Hospital Projects

We looked at two categories of hospitals which could be considered safety net providers. The changes that require consideration of safety net services were not effective until June 30, 2009. Both categories of hospitals generally had their projects approved by the Board for fiscal years 2010 through 2013.

The first category is Critical Access Hospitals which are licensed acute care hospitals with 25 inpatient beds or less, that maintain an average length of stay of no more than four days, and provide 24/7 emergency services. In addition, these hospitals must be located in a designated rural area and certified by the Medicare program. These conditions for being designated a Critical Access Hospital are laid out in federal statute (42 CFR 485 Subpart F). In Illinois there are 52 Critical Access Hospitals. Since the change in the law, the Board has acted upon 22 applications related to projects submitted by Critical Access Hospitals. These applications include change of ownership; permit renewals; and hospital additions, discontinuations, and modernizations. All 22 applications have been approved; however, there was one item which was considered by the Board and denied. It related to a county hospital whose ownership was changing to a not for profit company and they asked that the application fee be reduced from $41,000 to the minimum fee of $2,500. The Board approved the change of ownership, but did not reduce the fee.

The second category is Disproportionate Share Hospitals which are located in inner-city neighborhoods and rural communities where few health care professionals practice. Federal statutes provide specific criteria for classification as a Disproportionate Share Hospital (42 CFR 412.106). These Disproportionate Share Hospitals receive payment adjustments, in addition to regular Medicaid payments, to help keep these providers operational so they can continue to fulfill their mission of caring for communities. The Illinois Department of Healthcare and Family Services is responsible for determining payment adjustments in accordance with the Public Aid Code and federal regulations. In Illinois there are 76 Disproportionate Share Hospitals. Since the change in the law, the Board has acted upon 53 applications related to projects submitted by Disproportionate Share Hospitals. These applications include change of ownership; permit renewals and alterations; and hospital additions, discontinuations, and modernizations. All 53 applications considered for Disproportionate Share Hospitals have been approved since the change in the law.

Based on our Safety Net Impact Statement testing for projects in our sample, a discussion with the Association of Safety Net Community Hospitals, and looking into the outcome of Critical Access and Disproportionate Share Hospital projects, we concluded that Public Act 96-0031 has had little impact on safety net hospitals.

OTHER BOARD REQUIREMENTS

There are other requirements which are included in the Health Facilities Planning Act (20 ILCS 3960) and the Board's administrative rules (2 Ill. Adm. Code Section 1925) which had not

been performed. This includes requirements of the Health Facilities and Services Review Board, its staff, and its Chairman. The requirements are detailed in the following sections.

Required Board Website Reports

The Board did not post on its website all of the reports required by the Planning Act (20 ILCS 3960/12.2(2.1)(A)) and its administrative rules. In particular, the Board did not post an annual accounting of fees, fines, and other revenues as well as expenses incurred in the administration of the Planning Act for fiscal years 2011, 2012, and 2013, as well as a report of ex-parte communications.

Public Act 96-0031 required the following reports be included on the Board's website:

- An annual accounting, aggregated by category and with names of parties redacted, of fees, fines, and other revenue collected as well as expenses incurred, in the administration of the Planning Act. No revenue and expenditure reports for fiscal years 2011 thru 2013 had been posted as of February 3, 2014.

- An annual report, with names of the parties redacted, that summarizes all settlement agreements entered into with the Board that resolve an alleged instance of noncompliance with Board requirements under the Planning Act. We found that an annual report of settlement agreements has been posted on the web page.

- A monthly report that includes the status of applications and recommendations regarding updates to the standard, criteria, or the health plan as appropriate. We found that a web report is available that shows the status of applications which is updated when status changes.

- Board reports showing the degree to which an application conforms to the review standards, a summation of relevant public testimony, and any additional information that staff wants to communicate. We found that State Board Staff Reports and many other applicable documents are posted on the Board's website.

The required reports on revenue and expenditures are the only web reports required by the Planning Act that had not been included. When we asked Board staff why the fiscal year 2011 through 2013 reports had not been posted on the website, the Board's Administrator attributed it to an oversight and posted the FY11 and FY12 reports immediately.

The Board also did not post a report of prohibited (ex-parte) communications as required by its administrative rules (2 Ill. Adm. Code 1925.293(e)). The Board's administrative rules require ex-parte communications be reported to the General Assembly and incorporated on the Board's website. The reports were filed with the General Assembly as required; however, the reports were not on the Board's website until we inquired about them. The reports for calendar years 2009, 2010, 2011, and 2013 were posted shortly thereafter. According to the Board's Administrator, there were no ex-parte communications in 2012.

REQUIRED WEB REPORTS	
RECOMMENDATION NUMBER 4	***The staff of the Health Facilities and Services Review Board should post all required web reports on its website as required by the Health Facilities Planning Act (20 ILCS 3960/12.2) and its administrative rules (2 Ill. Adm. Code 1925.293(e)) to ensure the transparency intended by the State statute.***
Health Facilities and Services Review Board Response	In accordance with the Health Facilities Planning Act (20 ILCS 3960/12.2) and the Illinois Administrative Code 1925.293 (e), all required web reports will be posted at www.hfsrb.illinois.gov.

Required Board Member Performance Reviews

The Chairman of the Health Facilities and Services Review Board had conducted only one annual review of Board members' performance. This review was performed in May of 2011. Four fiscal years have passed since the annual requirement was added to the Health Facilities Planning Act (20 ILCS 3960/4(f)) effective June 30, 2009. The statute also requires that attendance records of Board members be provided to the General Assembly. Although one year's evaluation was done and attendance records were available, they were not provided to the General Assembly.

When we asked about these submissions, the Board's Administrator responded that annual performance reviews and attendance records of the Board members have not been reported to the General Assembly. She noted that the information would be submitted as required. Failure to perform reviews and provide information to the General Assembly results in non-compliance and limits General Assembly oversight information.

REQUIRED BOARD MEMBER PERFORMANCE REVIEWS	
RECOMMENDATION NUMBER 5	***The Chairman of the Health Facilities and Services Review Board should conduct annual reviews of Board members' performance and submit them to the General Assembly along with required attendance records as required by the Health Facilities Planning Act (20 ILCS 3960/4(f)).***
Health Facilities and Services Review Board Response	In accordance with the Health Facilities Planning Act (20 ILCS 3960/4(f)), the Chairperson of the Health Facilities and Services Review Board will conduct annual reviews of Board members' performance and submit the reports to the General Assembly along with required attendance records. Please note that for calendar year 2014 HFSRB is in full compliance with this recommendation.

Chapter Four

FINES AND SETTLEMENTS

CHAPTER CONCLUSIONS

During fiscal years 2009 through 2013, the Health Facilities and Services Review Board (Board) executed a total of 77 settlement agreements. Of the 77 settlement agreements, 5 settlements' fines were uncollectable (totaling $474,000) and 5 settlements had a non-compliant status ($4,500 plus outstanding reports). However, the remainder of the fine and "in-kind" service agreements were noted as either fulfilled or were in a compliant status (e.g., had submitted reports as required, but still has future reports to submit).

In 47 of 77 settlement agreements (61%), the facility opted to pay a fine to resolve compliance issues. Fine amounts are mandated by State statute; however, if a facility proves that the amount of the levied fine may cause a financial hardship, the facility could make a counter offer which would then be considered by the Board. "In-kind" services or a combination of "in-kind" services and a fine were used in the remaining 30 settlement agreements.

We tested the 26 settlement agreements with a final order (effective) date in fiscal year 2012 or 2013. According to the Board's General Counsel, the practice is to start with the maximum possible fine and negotiate down from there. Our testing indicated that many fines end up being significantly discounted from the proposed maximum fine amount. To decrease the fine amount, many facilities also chose to provide "in-kind" services. The settlement files contained documentation of "in-kind" settlement compliance reporting.

According to the Board's General Counsel, the Board has authorized staff to use "in-kind" services in settlement negotiations. While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule. Negotiated "in-kind" service amounts have been larger than negotiated fines and a significant portion of the settlement amounts four of the last five fiscal years. The negotiated value of settlements for fiscal years 2012 and 2013 totaled approximately $2.1 million, of which $1.7 million was "in-kind" services and the remaining $425,000 was fines. Given the frequent use of "in-kind" services and to ensure the Board is not violating the intent of the State statute, the Board should seek a legislative change in State statute and/or update its administrative rules to specifically authorize the use of "in-kind" settlements.

Public Act 96-0031 asks us to determine whether fines and settlements are fair, consistent, and in proportion to the degree of violations. We compared settlement agreements within the same category and for similar violations to test for consistency and whether the settlements were in relative proportion to the degree of the violation. While we found it difficult to make a comparison due to the many factors influencing the final value of the settlement, we concluded that, given their respective circumstances, the settlements did not appear unreasonable.

The Health Facilities and Services Review Board was not timely in identifying violations and moving through the violation process. Overall, the violation process took 3.5 years on average to move from the date of the violation to the date when there was a signed resolution to the issue. Seven settlements took longer than four years, the longest taking almost 10 years. Taking a significant amount of time to identify violations and initiate the fines process could decrease the likelihood of collecting fines, especially in the case of facility closures.

FINES AND SETTLEMENTS

The audit requirement from Public Act 96-0031 asks us to determine whether fines and settlements are fair, consistent, and in proportion to the degree of violations. In 1974, a provision was added to the Health Facilities Planning Act granting the Board the authority to issue fines for constructing, modifying, or establishing a health care facility without a permit. This fine has increased over time. In 1993, additional fines and the amounts were established and have remained the same since then, with one exception. One new category of fines was added recently: failure to comply with post-permit and reporting requirements. As discussed later, fines were previously issued for these violations under a different section which required a larger fine.

Posting a report that summarizes all settlement agreements entered into with the Board is required by the Planning Act (20 ILCS 3960/12.2). The Board's web page contains listings of settlement agreements in fiscal years 2009 through 2013. There were a total of 77 settlement agreements executed during these five fiscal years.

Exhibit 4-1 shows fines that are established in the Planning Act and also provides a breakdown of violations for the 77 settlement agreements. As shown in Exhibit 4-1, 41 of the violations levied over the last five fiscal years were for failure to maintain a valid permit.

Until February 2013, the failure to maintain a valid permit category captured violations for failure to submit post-permit reports, such as annual progress reports and final cost reports. The fine for failure to maintain a permit is up to 1 percent of the approved project amount with no established maximum. According to Board officials, they instituted a new category (failure to comply with the post-permit and reporting requirements), with a maximum fine of $10,000, to capture these post-permit reporting violations to keep the fines from being so large in relation to the violation. This new fine category is in effect only for applications filed after August 27, 2012.

Exhibit 4-1
FINES DELINEATED IN THE HEALTH FACILITIES PLANNING ACT
Fiscal Years 2009 through 2013

Violation	Statutory Fine	# of Violations
Change of ownership without a permit (20 ILCS 3960/14.1(b)(4))	Fine up to $25,000, plus $25,000 for each 30-day period	2
Failure to maintain a valid permit (20 ILCS 3960/14.1(b)(1))	Fine up to 1% of the approved permit amount, plus 1% for each 30-day period	41
Unauthorized alteration of scope or size without Board approval (20 ILCS 3960/14.1(b)(2))	The lesser of $25,000 or 2% of the permit amount, plus an additional $20,000 for each additional million	11
Failure to comply with the post-permit and reporting requirements (20 ILCS 3960/14.1(b)(2.5))	Fine up to $10,000 for each category of service established, plus $10,000 for each 30-day period [Effective 2/27/13 for applications filed after 8/27/12]	0
Acquiring major medical equipment, or a new category of service without a permit (20 ILCS 3960/14.1(b)(3))	Fine up to $10,000 for each acquisition, plus $10,000 for each 30-day period	0
Constructing, modifying, or establishing a health care facility without a permit (20 ILCS 3960/14.1(b)(4))	Fine up to $25,000, plus $25,000 for each 30-day period	2
Discontinuation without a permit (20 ILCS 3960/14.1(b)(5))	Fine up to $10,000, plus $10,000 for each 30-day period	12
Failure to provide requested information within 30 days (formally requested in writing) (20 ILCS 3960/14.1(b)(6))	Fine up to $1,000, plus $1,000 for each 30-day period	17
Failure to pay any fine imposed within 30 days (20 ILCS 3960/14.1(a)(5))	Other sanctions permitted by the Planning Act as the Board deems appropriate	0

Note: The exhibit violation totals more than 77 because some settlements trigger two violation categories.

Source: Health Facilities Planning Act, related administrative rules, and Health Facilities and Services Review Board data summarized by OAG.

Exhibit 4-2 summarizes both fines and "in-kind" settlements which were negotiated with health care providers for the fiscal years noted. The exhibit shows that negotiated "in-kind" service amounts have been larger than negotiated fines and a significant portion of the settlement amounts four of the last five fiscal years.

Exhibit 4-2
FINES AND "IN-KIND" SETTLEMENT AGREEMENT AMOUNTS
Fiscal Years 2009 through 2013

	Fines	"In-Kind"	Total
Fiscal Year 2009	$583,978	$7,975,000	$8,558,978
Fiscal Year 2010	$437,500	$841,479	$1,278,979
Fiscal Year 2011	$165,000	$308,240	$473,240
Fiscal Year 2012	$146,800	$60,525	$207,325
Fiscal Year 2013	$278,250	$1,612,721	$1,890,971
Total	$1,611,528	$10,797,965	$12,409,493

Source: Health Facilities and Services Review Board data summarized by OAG.

Process for Negotiating Settlements

Unless a facility chooses to contest and litigate a compliance issue, settlements are used to resolve compliance issues. According to the Board's General Counsel, litigation is rare. Once a facility is informed of its options and it chooses to settle, it is up to the facility to develop a settlement proposal. According to the Board's General Counsel, the Board authorizes the staff to negotiate either a fine or a fine and "in-kind" settlement. Once that proposal is agreed upon by the Board staff and legal counsel, then the initial proposal is presented to the Board and the Board votes on whether to accept the offer. According to the Board's General Counsel, sometimes the Board does not accept the original settlement. The Board can and may suggest changes to the proposal. After the Board accepts the settlement proposal, a written consent agreement is drawn up and sent to the facility. After the written agreement is approved by the facility, a final order is approved by the Board, signed by the Board chair, and becomes final and effective.

Monitoring of Settlement Status

According to Board officials, compliance staff monitor all settlements to ensure facilities are complying with the terms of the settlement. Settlements include fines and "in-kind" services/"in-kind" service reporting requirements. The Board's staff uses a spreadsheet to track settlement compliance.

We reviewed the tracking spreadsheet the Board's staff uses to track fines and "in-kind" settlements. The spreadsheet contained 77 agreements for fiscal years 2009 through 2013. Of the 77 settlement agreements, 5 settlements' fines were uncollectable and 5 settlements had a non-compliant status; however, the remainder of the fine and "in-kind" service agreements were

noted as either fulfilled or were in a compliant status (e.g., had submitted reports as required, but still has future reports to submit).

The facilities responsible for the five uncollectable fines totaling $474,000 appear to have gone out of business. Documentation noted that three of the five fines (totaling $282,000) were uncollectable despite the Board's General Counsel requesting help from the Attorney General's office in collecting the fine.

Five settlements were listed as non-compliant. Three of the five non-compliant settlements were due to unpaid fine payments (totaling $4,500) and the other two were due to reports not being filed in accordance with the settlement agreements (no monetary amount).

In 47 of 77 settlement agreements (61%), the facility opted to pay a fine to resolve compliance issues. As noted previously, fine amounts are mandated by State statute; however, if a facility proves that the amount of the levied fine may cause a financial hardship, the facility could make a counter offer which would then be considered by the Board.

"In-kind" services or a combination of "in-kind" services and a fine were used in the remaining 30 settlement agreements. "In-kind" services are a way for services to be provided back to the community in lieu of, or to decrease, a fine. Examples of "in-kind" services included: *services-in-kind program for community outreach and seminars* or *services-in-kind program to substantially expand suicide prevention training at Chicago Public Schools.* According to the Board's Administrator, when "in-kind" services are offered, the facility is asked to work with at least the local and state health departments to ensure that the offered services are indeed needed and do not have an adverse impact on the community or are not a duplication of existing services.

Fines and Settlements Testing

The audit requirement from Public Act 96-0031 asks us to determine whether fines and settlements are fair, consistent, and in proportion to the degree of violations. We tested all settlement agreements with a final order (effective) date in fiscal year 2012 or 2013. This encompassed 26 of 77 settlement agreements.

Exhibit 4-3 provides a breakdown of the violations tested and the value of the settlements. Sixteen of the 26 violations fell into a failure to maintain a valid permit category. Several of these were related to post-permit reporting violations and would fall into the new violation category (20 ILCS 3960/14.1(b)(2.5)). However, the applications associated with these 16 projects were filed before August 27, 2012; therefore, this new category was not yet in effect. According to Board officials, they instituted this new category with a lower fee structure and maximum fine of $10,000, to capture these post-permit reporting violations to keep the fines from being so large in relation to the violation.

Exhibit 4-3
FINES AND "IN-KIND" SETTLEMENT TESTING
Fiscal Years 2012 and 2013

Violation	# of Violations	Total
Change of ownership without a permit	1	$75,000
Failure to maintain a valid permit	16	$1,571,180
Unauthorized alteration of scope or size without Board approval	2	$165,755
Failure to comply with the post-permit and reporting requirements [Effective 2/27/13 for applications filed after 8/27/12]	0	$0
Acquiring major medical equipment, or a new category of service without a permit	0	$0
Constructing, modifying, or establishing a health care facility without a permit	2	$175,525
Discontinuation without a permit	4	$109,836
Failure to provide requested information within 30 days (formally requested in writing)	1	$1,000
Failure to pay any fine imposed within 30 days	0	$0

Source: OAG analysis of Board data.

The initial proposed fines were based on statutory maximums and well documented in the Board staff's administrative settlement files. According to the Board's General Counsel, the practice is to start with the maximum possible fine; however the fine is often negotiated down from there. Our testing indicated that many fines end up being significantly discounted from the proposed maximum fine amount. Many files contained documentation of communications regarding the settlement amount.

To decrease the fine amount, many facilities also chose to provide "in-kind" services. Board officials said that until recently, the staff could negotiate an entirely "in-kind" services settlement, but that option is no longer available. The Board's Administrator said the Board became concerned about the solvency of the Health Facilities Planning Fund after money was directed from the fund to the Department of Public Health to fund the Center for Comprehensive Health Planning and therefore made a decision to collect more fines. Negotiated "in-kind" service amounts have been larger than negotiated fines and a significant portion of the settlement amounts in four of the last five fiscal years. The negotiated value of settlements for fiscal years

2012 and 2013 totaled $2.1 million, with nearly $1.7 million in "in-kind" services and $425,000 in levied fines.

Our testing of settlement agreements indicated "in-kind" service agreements include reporting requirements. The settlement files contained documentation of "in-kind" settlement compliance reporting. Examples of reporting include annual reports or charity care reports of services provided. However, it was difficult to determine if the "in-kind" services were done specifically in response to the settlement agreement or if the "in-kind" services were already planned to be provided as part of the facility's normal charity care plan. This could lead to facilities avoiding fines, not providing the community with any services beyond their normal plans, and circumventing the Board's violation process altogether.

According to the Board's General Counsel, the Board has authorized staff to use "in-kind" services in settlement negotiations. While fines are specifically authorized and prescribed by the Planning Act, the use of "in-kind" services in settlement agreements is not specifically authorized or addressed in statute or rule. Additionally, fines are one of only two funding mechanisms established by the General Assembly for the Health Facilities Planning Fund (application fees being the other funding mechanism). The Board's administrative rules on penalties, fines, and sanctions (77 Ill. Adm. Code 1130.790) were updated effective June 1, 2013, but essentially quote the statute and do not discuss nor mention the use of "in-kind" services to reduce cash fines.

Given the frequent use of "in-kind" services and to ensure the Board is not violating the intent of the State statute, the use of "in-kind" services should be authorized in statute or rule.

AUTHORIZATION OF THE USE OF "IN-KIND" SERVICES	
RECOMMENDATION NUMBER 6	***The Health Facilities and Services Review Board should seek legislative change in statute and/or update its administrative rules to specifically authorize the use of "in-kind" services to reduce fines in the negotiation of settlements.***
Health Facilities and Services Review Board Response	The Board staff will discuss the possibility of this recommendation with HFSRB members.

Comparison of Fines and Settlements

We compared settlement agreements within the same category and for similar violations to test for consistency and whether the settlements were in relative proportion to the degree of the violation. We found it difficult to make a comparison due to the many factors influencing the final value of the settlement including: did the facility negotiate, were there financial hardships to consider, are there special "in-kind" services that could be beneficial to a particular community, and did the settlement include more than one violation and/or project. Also complicating the comparison was the fact that projects within the same violation categories also varied in size ($326 million dollar projects vs. $3.5 million dollar projects) and facility type

(hospital vs. long-term care facility vs. ambulatory surgical treatment center), and scope of services provided. We compared the settlements to the extent possible and further looked into the outliers (e.g., settlements that seemed high in proportion to the other settlements). We found that, given their respective circumstances, the settlements did not appear unreasonable.

Timeliness of Identification of Violation

Board staff was not timely in identifying violations and moving through the violation process. Overall, the violation process took 3.5 years on average to move from the date of the violation to the date when there was a signed resolution to the issue. Seven settlements took longer than four years, the longest taking almost 10 years.

Board staff did not move from violation to notice of intent to impose a fine in a timely manner. Facilities in violation of one of the Board's requirements receive a notice of intent to impose a fine and are given the opportunity for an administrative hearing to show cause as to why they should not be fined. For the 15 agreements for which violation date and a notice of intent to impose a fine date were available, it took an average of 2 years, from the time of the violation, to send a notice of intent to the violating facilities. Four took longer than 2 years to have a notice of intent to impose a fine sent to the facility. For example, one project did not submit various post-permit reports (i.e., annual report, final cost report) in late 2003 and early 2004 as required; however, the compliance matter was not referred to legal until May 2007 and a notice of intent to impose a fine was not delivered to the facility until July 2010. Another six took between one and two years before the notice was sent to the facility. Prolonging these settlements delays "in-kind" services that could be benefiting the community or fines that could be collected by the Board.

On average, it took about a year to have a signed final order (finalized settlement agreement) after the notice of intent to impose a fine went out. During this time, there is often negotiating between the facility and the Board's staff and General Counsel. The settlement agreement also has to be approved by the Board. According to the Board's General Counsel, sometimes the Board does not accept the original settlement. The Board can and may suggest changes to the proposal. After the Board and the facility come to an agreement, a final order is approved by the Board, signed by the Board chair, and becomes final and effective.

Taking a significant amount of time to identify violations and initiate the fines process could decrease the likelihood of collecting the fine, especially in the case of facility closures. In contrast, identifying violations and beginning the fines process could make fines collection easier or more probable. Additionally, if "in-kind" services are used as part of the settlement, needed services will be delivered to the community sooner.

TIMELINESS OF VIOLATION IDENTIFICATION	
RECOMMENDATION NUMBER 7	***The staff of the Health Facilities and Services Review Board should identify violations and initiate and complete the fines process in a timely manner.***
Health Facilities and Services Review Board Response	Board staff will strive to identify violations and initiate and complete the fines process in a timely manner. It should be noted that no time frames or guidance is provided in the Health Facilities Planning Act (20 ILCS 3960) or the Board's Administrative Rules regarding the timeliness of the fines process.

APPENDICES

APPENDIX A

Applicable Section from Public Act 96-0031 Requiring Audit

Public Act 096-0031

(20 ILCS 3960/19.5)

(Section scheduled to be repealed on December 31, 2019 and as provided internally)

Sec. 19.5. Audit. Twenty-four months after the last member of the 9-member Board is appointed, as required under this amendatory Act of the 96th General Assembly, and 36 months thereafter, the Auditor General shall commence a performance audit of the Center for Comprehensive Health Planning, State Board, and the Certificate of Need processes to determine:

(1) whether progress is being made to develop a Comprehensive Health Plan and whether resources are sufficient to meet the goals of the Center for Comprehensive Health Planning;

(2) whether changes to the Certificate of Need processes are being implemented effectively, as well as their impact, if any, on access to safety net services; and

(3) whether fines and settlements are fair, consistent, and in proportion to the degree of violations.

The Auditor General must report on the results of the audit to the General Assembly.

This Section is repealed when the Auditor General files his or her report with the General Assembly.

Effective date: 6/30/2009

APPENDIX B
Audit Methodology

Appendix B

AUDIT METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The objectives of the audit were identified in Public Act 96-0031 which required the Auditor General's Office to conduct a performance audit of the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board (Board), and the Certificate of Need processes. Appendix A provides the applicable section from Public Act 96-0031. As required by the Public Act, initial work began 24 months after the final member of the new Health Facilities and Services Review Board had been appointed, in June 2013, and fieldwork was concluded in February 2014.

We reviewed risk and internal controls related to the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board, the certificate of need process, and related issues as they related to the audit's objectives. We also reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the Department of Public Health and reviewed the Auditor General's 2001 program audit of the Health Facilities Planning Board. This included reviewing applicable findings and background information. A risk assessment was conducted to identify audit areas that needed closer examination. This audit identified some weaknesses in those controls and some issues of noncompliance which are discussed in this report.

To fulfill the audit's objectives, we interviewed representatives of the Health Facilities and Services Review Board and the Department of Public Health. These interviews included discussions of the Center for Comprehensive Health Planning, the certificate of need process, as well as fines and settlements of the Board. We contacted the Governor's Office to discuss the status of the Comprehensive Health Planner appointment. We also attended and observed Board meetings. To assess the impact on access to safety net services, as required by Public Act 96-0031, we interviewed two representatives of the Association of Safety Net Community Hospitals.

We tested projects for compliance with statutes and administrative rules. We selected 43 projects to sample from a population of 107 projects which submitted an application for permit during fiscal years 2010 through 2013 to construct a new facility. We sampled all long-term care and hospital projects that proposed to construct a new facility. These are typically the largest projects from a monetary standpoint. Because we sampled all long-term care and hospital applications that proposed to construct a new facility, these results can be projected to the population. We also randomly chose one application to establish a facility from each of the following categories: end stage renal dialysis, cancer centers, freestanding emergency centers, ambulatory surgical treatment centers, rehabilitation centers, and medical office buildings. The

random samples were not chosen using a statistically valid method utilizing confidence intervals and confidence levels. Therefore, results from the randomly chosen samples in this audit have not been, and should not be, projected to the population.

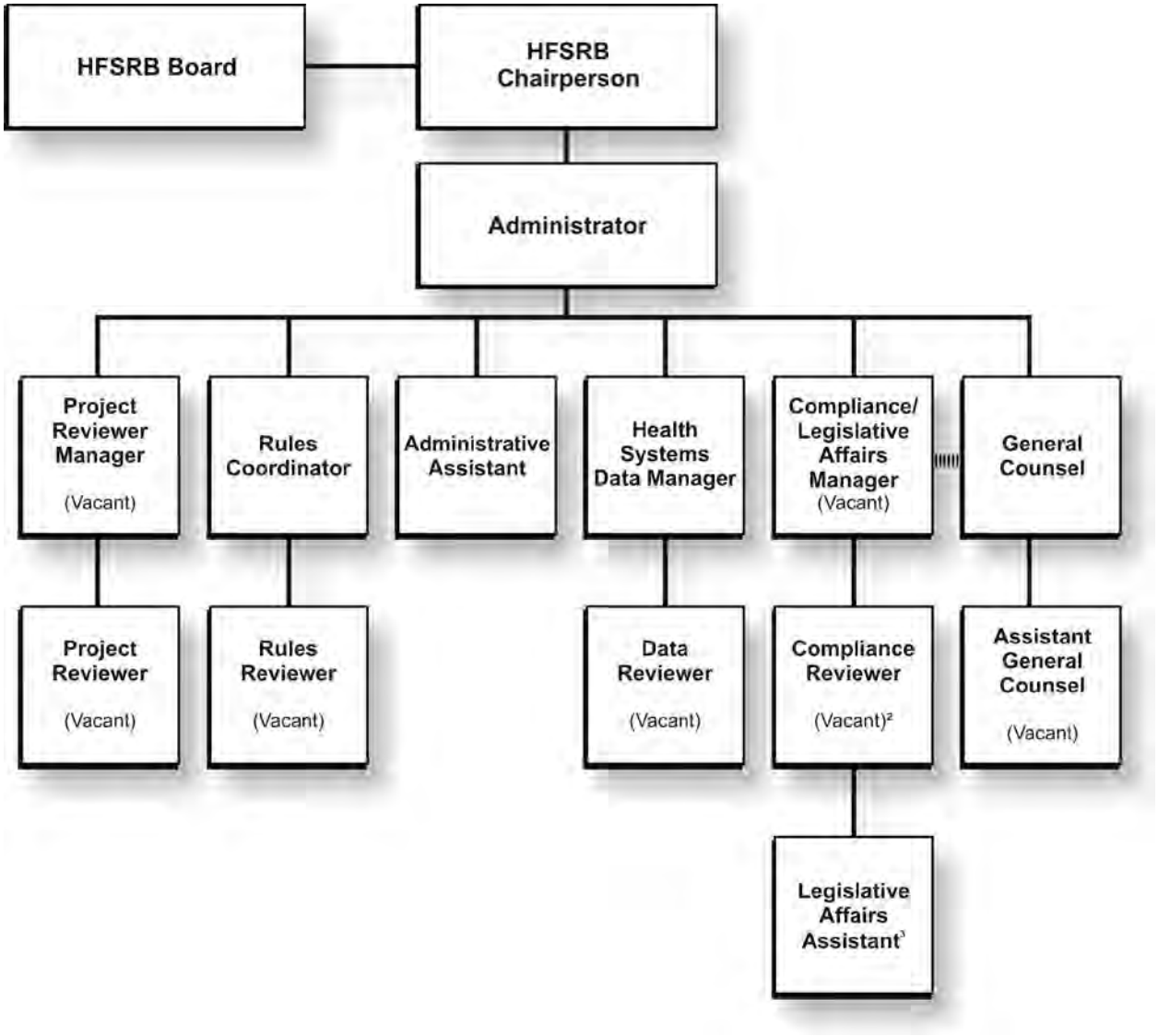
For our sample of 43, we reviewed the State Board Staff Reports associated with each application for completeness and accuracy, including proper application of the rules cited and whether or not the project was classified properly according to the requirements within the rules and the Health Facilities Planning Act. We also reviewed, when applicable: the Safety Net Impact Statements and if the Board published notice as required; if a public hearing was requested and held; and, any ex-parte communications. We found that the Board was generally in compliance with the applicable statutes and administrative rules regarding certificate of need projects submitted. However, there were instances of noncompliance which are discussed in this report. Results from this testing are presented in Chapter Three.

We also reviewed all 26 settlement agreements that were finalized during fiscal years 2012 and 2013. We found that there was a wide variation in the type, size, and violations covered by these settlement agreements, making a direct comparison between settlement agreements complicated. However, given their respective circumstances, we determined that the settlements do not appear to be unreasonable based upon our review of the available information. Results from this testing are presented in Chapter Four.

We also analyzed additional projects and issues. To analyze what impact statutory changes made by Public Act 96-0031 have had on access to safety net services, we considered rules, procedures, and process elements used by the Board to consider safety net services. We analyzed annual hospital questionnaire data which includes data on Medicaid and charity care services provided. Additionally, we reviewed the outcome of projects brought before the Board by hospitals which could be considered safety net service providers (i.e., Critical Access Hospitals and Disproportionate Share Hospitals). We also analyzed projects that had both a denial and an approval; projects with conditions or stipulations; and projects with deferrals.

APPENDIX C
Organizational Charts Related to the Health Facilities and Services Review Board

Health Facilities and Services Review Board (HFSRB) Organizational Chart[1]
As of March 2014



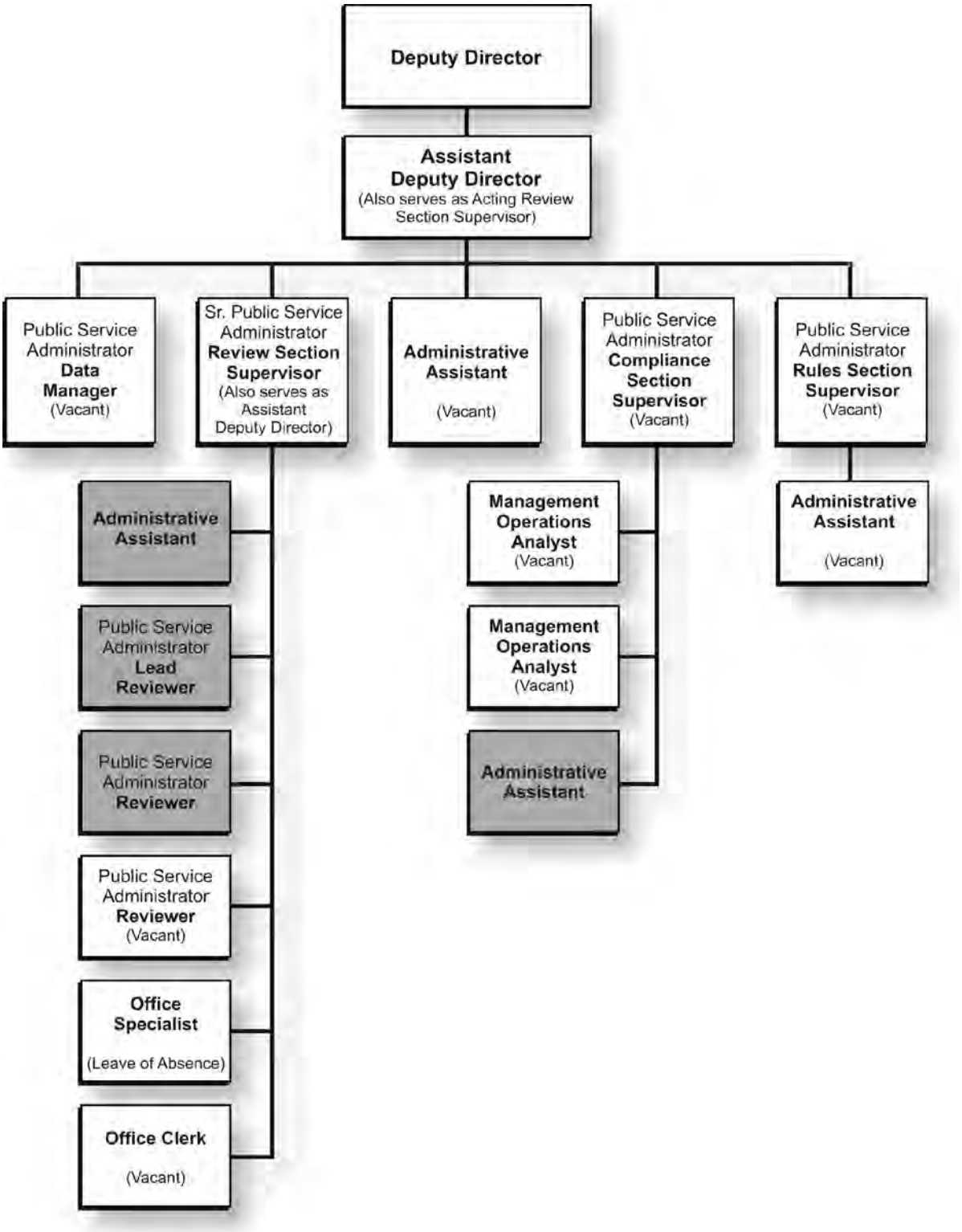
Notes:

1 Four Illinois Department of Public Health (IDPH) employees (two administrative assistants and two reviewers) work full-time on Board activities (see next page).

2 A former employee started a 75-day contract on January 2, 2014, to handle compliance matters until a new Compliance Manager could be hired.

3 A Legislative Affairs Assistant began January 2, 2014.

IDPH Division of Health Systems Development Organizational Chart
As of March 2014



Note: The highlighted employees work full-time on Health Facilities and Services Review Board activities.

Source: OAG analysis of Health Facilities and Services Review Board and IDPH organizational charts.

APPENDIX D
2013 IDPH Report on the Center for Comprehensive Health Planning
(Filed March 2014)

Illinois Department of
PUBLIC
HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

2013 Report on the Center for Comprehensive Health Planning

To the Honorable Pat Quinn, Governor
And Members of the Illinois General Assembly:

Pursuant to Section 12 of the Health Facilities Planning Act, Powers and Duties of the State Board (20 ILCS 3960(5)), the Department presents this report regarding the development of the Center for Comprehensive Health Planning (Center) within the Illinois Department of Public Health. Provisions calling for the creation of the Center for Comprehensive Health Planning were approved in Public Act 96-31. The purpose of this Center is to improve the health care delivery system in Illinois by establishing a statewide Comprehensive Health Plan and ensuring a predictable, transparent, and efficient Certificate of Need process under the Illinois Health Facilities Planning Act.

In the fiscal year 2014 budget, the Department of Public Health was appropriated $2.5 million from the Health Facilities Planning Fund (fund # 238) for Department expenses in support of the Health Facilities and Services Review Board (HFSRB), including about $900,000 for the Center. The Center and the HFSRB are to coordinate on issues affecting health care facilities including the distribution of health care services. The 2008 report from the Illinois Task Force on Health Planning Reform recommended the Center as a key measure to increase the efficiency and effectiveness of the Certificate of Need Process.

The Department estimates that an appropriation of $900,000 would allow for the establishment of a center with five staff, four professional and one support. This would provide for a minimum of operations at the new Center. A fully staffed Center is projected to include eleven professional staff and two support staff at an annual cost of approximately $1.5 million. The draft organizational chart of this basic unit is shown as figure A while the draft organization of a fully staffed center is depicted in figure B.

Figure A. "Base" Center for Comprehensive Health Planning (draft)

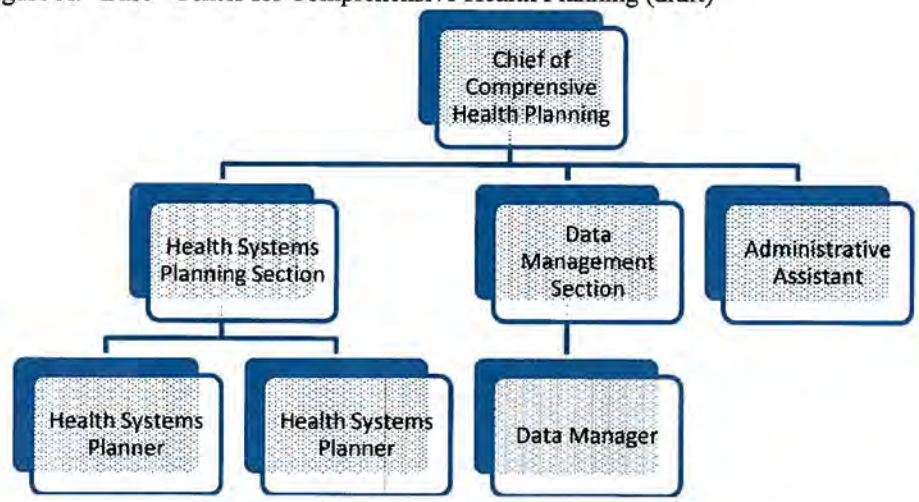
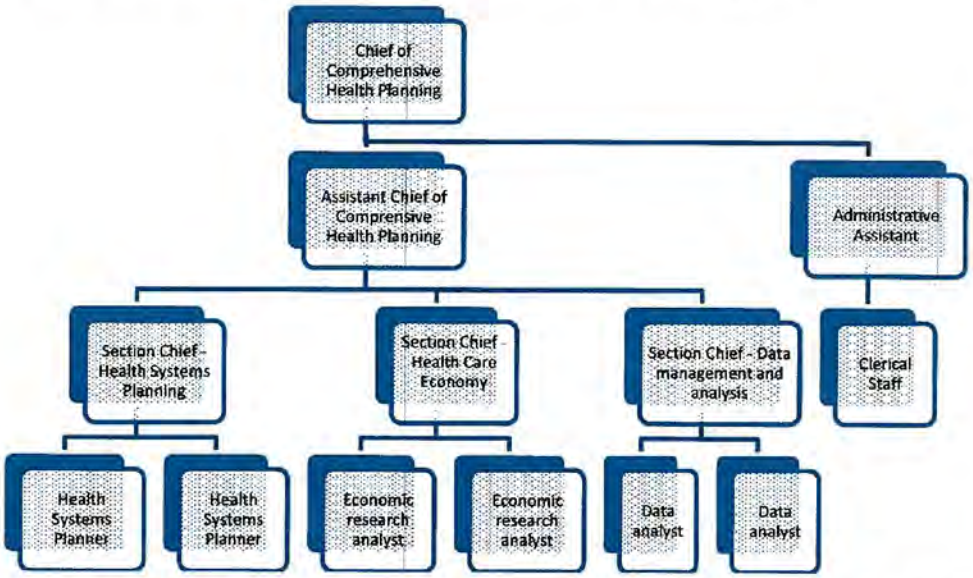


Figure B. "Fully staffed" Center for Comprehensive Health Planning (draft)



Receipts into the Health Facilities Planning Fund in an average year are about $2.3 million while expenses for current activities of the HFSRB required under the Act are approximately $1.6 million annually. Since the combined expenses of the HFSRB and the Center will exceed revenues, the Department has proceeded carefully in establishing the Center.

The balance in the Health Facilities Planning Fund had grown to just over $6.2 million at the start of FY14 (see Figure C). Once the Center reaches mature staffing levels, the Fund is

projected to be spending more than $700,000 annually over receipts. The imbalance of expenses and revenues is manageable in the early years as the Center is developed, but it cannot be sustained over the long term. By the fourth year of a mature Center, the Fund would be diminished by half and, absent other changes, only a few years from insolvency. The latest financial projections depicting these conclusions are shown as figure D. Accordingly, once the Center is up and running, a mechanism for funding the costs of the Center that includes more than the revenues currently flowing into the Health Facilities Planning Fund will need to be identified and established.

Figure C. Balance of the Health Facilities Planning Fund

	Beginning Balance at July 1
FY 09	4,009,335
FY 10	3,847,758
FY 11	3,002,673
FY 12*	3,869,660
FY 13	5,129,589
FY 14	6,242,385
* balance includes FY11 interfund borrowing of $2,463,400	

Figure D. Estimates and Projections for Health Facilities Planning Fund (fund #238)

		Balance		HFSRB	CCHP	Expenses	Revenue less
Year	7/1/2013	6,242,385	Revenues	Expenses	Expenses	Combined	Combined Expense
1	7/1/2014	6,806,385	2,289,000	1,575,000	150,000	1,725,000	564,000
2	7/1/2015	6,644,070	2,370,488	1,632,803	900,000	2,532,803	-162,314
3	7/1/2016	6,306,222	2,454,878	1,692,726	1,100,000	2,792,726	-337,849
4	7/1/2017	5,593,644	2,542,271	1,754,849	1,500,000	3,254,849	-712,578
5	7/1/2018	4,852,118	2,632,776	1,819,252	1,555,050	3,374,302	-741,526
6	7/1/2019	4,080,482	2,726,503	1,886,019	1,612,120	3,498,139	-771,636
7	7/1/2020	3,277,527	2,823,567	1,955,236	1,671,285	3,626,521	-802,954

Assumes revenue grows at 3.56% per year based on the average of three year moving averages from 1992 to present.

Assumes expenses increase at 3.67% per year based on the average of three year moving averages from 1992 to present for HFSRB expenses; the rate is also applied to CCHP expenses beginning in FY18.

Since Illinois' economic recovery is continuing at a modest pace and the 238 fund has a healthy current balance, the time is right to move ahead with the development of the Center for Comprehensive Health Planning. I look forward to continuing our collaborations on health care, population health and public safety issues.

Sincerely,

LaMar Hasbrouck, MD, MPH
Director

cc: Ms. Kathryn Olson, Chair, HFSRB
Courtney Avery, Administrator, HFSRB

APPENDIX E
Agency Responses

STATE OF ILLINOIS
HEALTH FACILITIES AND SERVICES REVIEW BOARD

525 WEST JEFFERSON ST. • SPRINGFIELD, ILLINOIS 62761 • (217) 782-3516 • FAX: (217) 785-4111

Tricia Wagner
Audit Manager
Office Of The Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, Illinois 62703-3154

Ms. Tricia Wagner:

Please find attached the Health Facilities and Services Review Board (HFSRB) response to the performance audit.

On behalf of the Board, please accept our sincere thanks to you, Patrick and Paul for your professionalism and input during this process.

Should you have any questions or require additional information, please feel free to contact me.

Sincerely,

Courtney Avery

Courtney Avery,
Administrator

Cc: Kathy Olson, Chairperson
Frank Urso, General Counsel

Recommendation Number 3: The staff of the Health Facilities and Services Review Board should ensure that safety net impact statements contain all elements required by the Health Facilities Planning Act (20 ILCS 3960/5.4).

Additionally, a notice should be published, in a newspaper having general circulation within the area affected by the application, for all projects for which an application accompanied by a safety net impact statement has been filed.

HFSRB Response: In accordance with the Health Facilities Planning Act (20 ILCS 3960/5.4) HFSRB will ensure that safety net impact statements contain all elements required and the notice should be published, in a newspaper having general circulation within the area affected by the application, for all projects for which an application accompanied by a safety net impact statement has been filed.

Recommendation Number 4: The staff of the Health Facilities and Services Review Board should post all required web reports on its website as requires by the Health Facilities Planning Act (20 ILCS 3960/12.2) and its administrative rules (2 Illinois Administrative Code 1925.293 (e)) to ensure the transparency intended by the State statute.

HFSRB Response: In accordance with the Health Facilities Planning Act (20 ILCS 3960/12.2) and the Illinois Administrative Code 1925.293 (e), all required web reports will be posted at www.hfsrb.illinois.gov.

Recommendation Number 5: The Chairman of the Health Facilities and Services Review Board should conduct annual reviews of Board members' performance and submit them to the General Assembly along with required attendance records as required by the Health Facilities Planning Act (20ILCS 3960/4(f)).

HFSRB Response: In accordance with the Health Facilities Planning Act (20ILCS 3960/4(f)), the Chairperson of the Health Facilities and Services Review Board will conduct annual reviews of Board members' performance and submit the reports to the General Assembly along with required attendance records.

Please note that for calendar year 2014 HSFRB is in full compliance with this recommendation.

Recommendation Number 6: The Health Facilities and Services Review Board should seek legislative change to address in statute and/or update its administrative rules to specifically authorize the use of in-kind services to reduce fines in the negotiation of settlements.

HFSRB Response: The Board staff will discuss the possibility of this recommendation with HFSRB members.

Recommendation Number 7: The staff of the Health Facilities and Services Review Board should identify violations and initiate and complete the fines process in a timely manner.

HFSRB Response: Board staff will strive to identify violations and initiate and complete the fines process in a timely manner. It should be noted that no time frames or guidance is provided in the Health Facilities Planning Act (20 ILCS 3960) or the Board's Administrative Rules regarding the timeliness of the fines process.

Illinois Department of
PUBLIC
HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

122 S. Michigan Ave., Suite 2009 • Chicago, Illinois 60603-6152 • www.idph.state.il.us

VIA ELECTRONIC MAIL

May 8, 2014

The Honorable William Holland
Auditor General for the State of Illinois
740 East Ash Street
Springfield, IL 62703-3154

Re: Performance audit per Public Act 96-0031

Dear Auditor General Holland:

The Illinois Department of Public Health (IDPH) appreciates the work performed by your staff in conducting the audit of the Center for Comprehensive Health Planning, the Health Facilities and Services Review Board (HFSRB) and the Certificate of Need process.

Please see below the responses to recommendations one and two of the performance audit. I understand that the HFSRB, as a quasi-independent body, will respond separately.

Recommendation Number 1: The Governor should appoint a Comprehensive Health Planner as required by State statute (20 ILCS 2310/2310-217(b)(2)).

Agency response: The Office of the Governor concurs in the recommendation. Actions are in progress to secure a quality appointment.

Recommendation Number 2: The Department of Public Health should work to establish the Center for Comprehensive Health Planning as required by State statute (20 ILCS 2310/2310-217). The Center and the Comprehensive Health Planner should develop the required Plan.

Agency response: The Department concurs in the finding and recommendation. Steps are being taken to implement 20 ILCS 2310/2310-217. Draft organizational charts have been created and draft position descriptions are being developed. The Department is also engaging the Department of Central Management Services about establishing positions for the new Center.

If you have questions or comments about these responses, please let me know.

Sincerely,

David N. Carvalho

David N. Carvalho
Deputy Director

cc: Michael Gelder, Governor's Office