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.

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.

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