State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need

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INTRODUCTION

Beginning in the 1960s, federal and state legislators recognized a pattern of escalating health care costs in this country. Governmental action was deemed necessary in order to respond to the unique structure of the health care marketplace. In an attempt to address the rising cost of health care, laws were passed at both national and state levels with the specific purpose of controlling costs by regulating supply. One specific method of regulating supply was the enactment of laws which sought to eliminate the unnecessary duplication and inequitable distribution of health care facilities and services. Pursuant to these laws, a health care provider seeking to establish or improve a facility or seeking to provide new or substantially different services was required to receive government...
authorization before proceeding.\textsuperscript{3} Theoretically, permission to expand would not be issued by the appropriate regulating agency unless and until the agency determined that community need warranted the expansion.\textsuperscript{4} Community need for additional health services was determined by criteria set forth in individual state statutes.\textsuperscript{5} A governmental finding of community need was evidenced by the state issuance of a "certificate of need" (CON).

Part I of this paper discusses the historical perspective of CON laws, tracking state and federal action. Part II addresses the workings of the Illinois health facility planning system. Part III summarizes typical judicial treatment of Illinois health facility planning agency decisions, demonstrating judicial deference to state agency findings. Part IV explores the role of politics in the Illinois health facility planning system, raising the question of whether political involvement has so tainted the CON system that it ought to be eliminated. This paper concludes with the author's comments regarding the future of CON regulations.

\section*{PART I: HISTORICAL PERSPECTIVE ON CERTIFICATE OF NEED LAWS}

\textbf{Market Forces and the Health Care Marketplace}

Regulators believe state regulation of health facility growth is necessary in order to control the health care marketplace.\textsuperscript{6} Commentators have argued that institutional health care facilities are economically induced to manipulate or increase supply by overinvesting in technology, beds and services without regard to actual need or demand.\textsuperscript{7} Increased health care supply encourages increased demand which, in turn, leads to increased costs. The traditional economic market forces of supply and demand need governmental intervention due to the unique dynamics of the American health care system.

For example, a grocery store and a consumer illustrate a classic

\begin{itemize}
\item \textsuperscript{3}See id. at 145.
\item \textsuperscript{4}See id. at 144.
\item \textsuperscript{5}See id. at 145.
\item \textsuperscript{6}Mark E. Kaplan, Comment: An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change, 19 Fl. St. U. L. Rev. 475 (Fall 1991).
\item \textsuperscript{7}Id.
\end{itemize}
supply and demand marketplace. The grocery store supplies goods in relation to the demand of the consumer. If the consumer demands more or better goods, then the grocery store may increase the quantity or quality of goods so that supply meets demand. If the grocery store increases costs to the consumer, then the consumer must choose whether to pay the cost of supply, or reject the cost and take demand elsewhere, perhaps to the competing grocery store on the other side of town. The consumer’s decision will determine the grocery store’s adjustment of supply. As consumer’s demand determines supply, the cost of supply determines demand. This delicate check and balance is prevalent throughout our economy.

Conversely, the health care marketplace has a more intricate field of players and traditional components of this health care field skew the classic supply and demand dichotomy. First, the traditional health care marketplace has experienced little competition. It is difficult for patients to hold providers accountable for cost comparisons because of the scarcity of price information. Second, unlike the consumer expert in food consumption, the average patient is not equipped for decision-making. Patients lack the necessary expert knowledge to make informed decisions about the quality and necessity of health care services; therefore, patients rely on their physicians to recommend or arrange for these services. Unchecked providers and uninformed consumers create demand which leads to unwarranted and irresponsible supply. Third, health care costs are primarily paid by third-party payers, usually insurance companies, which then pass costs along indirectly by allocating costs to and among all insureds. This payment arrangement insulates a patient from concern regarding direct payment for services. Because neither providers nor patients face direct medical cost payments under this system, only the insurers have the incentive to control costs.

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8Dean M. Harris, State Action Immunity Form Antitrust Law For Public Hospitals: The Hidden Time Bomb for Health Care Reform, 44 KAN. L. REV. 459, 466 n.24 (May 1996) (citing In re Hospital Corp. of Am., 106 F.T.C. 361, 479 (1985), aff’d, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987)).

9Ibid. at 467.

10See id.

11See id. at 466 n.25 (citing CONGRESSIONAL BUDGET OFFICE, RISING HEALTH CARE COSTS: CAUSES, IMPLICATIONS, AND STRATEGIES 9 (1991)).

12Maja Campbell-Eaton, Note, Antitrust and Certificate of Need: A Doubtful Prognosis, 69
The premise that unchecked supply creates unwarranted demand is a concept historically recognized by the United States Congress as it has addressed health care issues in the United States. This theory, as argued by former U. S. Sen. Patrick Moynihan on the floor of Congress, explains the unnecessary escalation of health care costs in this country:

And it was put to me in terms of that ancient economic conundrum, if you could use it that way, what is called Says' law -- a Frenchman named Says -- who propounded in the 18th century that supply creates demand. Now economists have never, the best I understand, never quite liked that because they prefer the proposition that demand creates supply. But it noted that supply creates demand.

It is important to note, however, that this general premise of supply creating demand, thereby contributing to needless and escalating health costs is not supported by conclusive studies. "Although increased competition ordinarily will reduce prices in most industries, the empirical evidence is inconclusive as to whether increased competition in the health care field decreases or increases the prices charged to patients and their third-party payers." In *United States v. Rockford Memorial Corp.*, Judge Posner stated,

We would like to see more effort put into studying the actual effect of concentration on price in the hospital industry as in other industries. If the government is right in these cases, then, other things being equal, hospital prices should be higher in markets with fewer hospitals. This is a studiable hypothesis, by modern methods of multivariate statistical analysis, and some studies have been conducted correlating prices and concentration

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IDA. L. REV. 1451, 1458 (July 1984).

Id. at 1459.

13 Id. at 1459.


16898 F.2d 1278 (7th Cir. 1990), cert. denied, 498 U.S. 920 (1990).
State Regulation of Health Facility Planning

In the hospital industry.... Unfortunately, this literature is at an early and inconclusive stage....

In recent years, Judge Posner's "hospital industry" has become more competitive. Today, the growing trend towards managed care has placed an emphasis on cost containment and has diminished supply to the displeasure of many patients who wish for untethered consumerism. This financially conservative trend, however, did not exist post-World War II at the onset of the hospital boom. To understand the economic dynamic of today's health care market, it is necessary to examine its World War II origins.

Post-World War II

During the Great Depression and World War II, the economic realities of the times affected the availability of health care in the United States. Few American hospitals were built, and many became obsolete. Existing hospitals were unevenly allocated among and within the states. By the mid-1940s, local communities called for hospital development.

The Hospital Survey and Construction Act of 1946, also known as the Hill-Burton Act, was enacted in response to this grassroots groundswell. The Hill-Burton Act provided federal subsidies to hospitals that participated in voluntary community planning of hospital expansion. The purpose of community planning was to identify, prioritize, and meet community need. Government agencies helped identify and meet the most urgent health needs, while also curbing a hospital's excess spending. However, the Hill-Burton Act had limited impact on health

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17 Id.
18 See id.
19 Id. at 145 (citing Campbell-Eaton, supra note 12, at 1453).
21 See id. at 1149.
22 See id. at 1143, 1149 (1973), cited in McGinley, supra note 1, at 147.
23 See id.
facility planning financed by private funding, which was not influenced by or dependent upon federal subsidies. These private entities did not participate in governmental health facility planning. This pattern of non-regulated hospital expansion based on private funding limited the effectiveness of the Hill-Burton Act. Federal monetary incentives and voluntary participation in health facility planning did not cure marketplace failures.

State Action
Eventually, certain states recognized the need for mandatory governmental oversight and passed CON laws requiring state regulation of health facility expansion. In 1964, New York became the first state to require a governmental finding of community need before a hospital or nursing home could be constructed. By 1968, the American Hospital Association publicly supported CON laws and began lobbying efforts to encourage the enactment of these laws in every state across the country. Within ten years, thirty-six states had enacted CON laws. Ironically, many of these state laws were brought about by the lobbying efforts of hospitals, which profited from state regulations and limited access to the marketplace.

Where certificate-of-need laws limit resources effectively, the owners of existing facilities are in a seller's market. They can charge inflated prices for their facilities, making it impossible for [the newcomer] to develop or expand. Certificate-of-need laws will continue to raise health care costs by restricting the entry of cost-effective providers into the market.

\[\text{\textsuperscript{28}} \text{See id. at 1150.} \]
\[\text{\textsuperscript{29}} \text{See id.} \]
\[\text{\textsuperscript{30}} \text{McGinley, supra note 1, at 147.} \]
\[\text{\textsuperscript{31}} \text{See id.} \]
\[\text{\textsuperscript{32}} \text{See id.} \]
\[\text{\textsuperscript{33}} \text{See id.} \]
\[\text{\textsuperscript{34}} \text{See id.} \]
\[\text{\textsuperscript{35}} \text{McGinley, supra note 1, at 166.} \]
The National Health Planning and Resources Development Act of 1974

In 1974, Congress followed the lead of individual states and enacted the National Health Planning and Resources Development Act (National Health Planning Act). 36 Like state CON laws, the National Health Planning Act was passed as an effort to avoid duplication of health services while providing equal access to quality health care. 37 The primary purpose of the legislation was to save money by controlling out-of-control health costs. 38

At the time the National Health Planning Act was being considered, the health care system in America was in crisis. The consumer price index was rising annually at 13.7%, 39 but medical care prices were rising at a rate of 16.6% annually. 40 More dramatically, hospital charges were rising at a rate of 18.7% annually. 41 "The average cost of a single day in the hospital rose from nearly $16.00 in 1950, to almost $45.00 in 1965, and then to about $128.00 in 1974." 42 Congress believed the cause of this health care cost crisis was the absence of cost containment in the marketplace. 43

The National Health Planning Act was intended to correct the marketplace failures and the inequitable distribution of health care facilities. 44 The Senate committee which drafted the National Health Planning Act discovered that the need for additional hospital facilities, measured by the need for hospital beds, 45 had almost disappeared. 46 "As of 1974, 20,000 beds were unused, labeled as ‘surplus’ in this country, and the number of surplus beds was expected to hit 67,000 by 1975." 47

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37 McGinley, supra note 1, at 147.
38 See id. at 147 n.41.
39 See id. at 147.
40 See id. at 149.
41 See id.
42 McGinley, supra note 1, at 149.
43 See id.
44 See id. at 150 (citing 42 U.S.C. § 300k(a)(3)(B) (2000)).
45 See id. (explaining that health care planners identify services by referring to the number of hospital beds available for patient usage).
47 McGinley, supra note 1, at 150.
Senate committee reported that "[t]here is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost services exists." Regulators believed market failures in the health care industry caused hospitals to overinvest in unneeded services, thus artificially raising costs. The cost of this excess supply was passed along to third-party purchasers, such as insurance companies and the government, which ultimately passed this cost along in higher premiums and other costs to health care consumers. Health care consumers were overpaying for services because they were required to compensate for services available but not consumed.

"The Federal Planning Act's legislative history confirms that the Act was conceived of as creating a planning system to totally displace free market allocation of resources." The Senate Committee Report on the 1974 Act states: "In the view of the Committee the health care industry does not respond to classic marketplace forces. The highly technical nature of medical services together with growth of third-party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services."

Free enterprise and supply and demand were not working in the health care arena.

1979 Amendments

The National Health Planning Act was amended in 1979. According to the legislative notes, "the critical provision in the 1979 Amendments for determining Congress's purpose was section 1502(b)." This section contains "extensive findings concerning competitive allocation of

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48 Campbell-Eaton, supra note 12, at 1453.
49 Kaplan, supra note 6, at 479 (defining a market failure as "some imperfection that causes a market to operate in other than an economically ideal way, deviating from our notions of how businesses should react to certain economic conditions").
50 See id. at 479 n.28.
51 McGinley, supra note 1, at 150.
54 See id. at 334 n.94 (citing C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 125, 143 (1981)).
resources in the health services industry. The essence of the section is that health services should be divided into two categories -- those for which competition does and those for which competition does not serve as a reliable allocation mechanism.\textsuperscript{55} "The Senate Committee report on the 1979 Amendments illuminated Congress's intent with respect to the role of competition in health planning. It revised the above-quoted statement from the Senate Committee report on the 1974 Act to read: 'The health care industry has not responded to classic marketplace forces.'\textsuperscript{56}

National Planning Act Results

Early governmental studies purported to show success in the reduction of hospital expenditures.\textsuperscript{57} Private sector studies, however, did not show the same result.\textsuperscript{58} A prominent study of CON effectiveness, published in 1979, found that although the rate of hospital bed growth slowed between 1968 and 1972, the average cost of each patient-day rose.\textsuperscript{59} In 1983, the U.S. Department of Health and Human Services reported that the country's 1982 medical bill reached $332 billion, which was 10.5% of the gross national product.\textsuperscript{60} This figure represented the first time health care

\textsuperscript{55}See id. (citing C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 125, 146 (1981) (stating this provision has been codified as 42 U.S.C. §§ 300k-2(b) (1976 & Supp. III 1970))).

\textsuperscript{56}Section 300k-2(b) states: (1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services. 42 U.S.C. §§ 300k-2(b).

\textsuperscript{57}See id. at 336 n.99 (citing S. REP. NO. 96-96 CONG., 1\textsuperscript{st} Sess. 53 (1979), reprinted in C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION 125, 148 (1981)).

\textsuperscript{58}Campbell-Eaton, supra note 12, at 1459 n.74 (citing S. REP. NO. 96, 96\textsuperscript{th} CONG., 1\textsuperscript{st} Sess. 38, reprinted in 1979 U.S.C.C.A.N. 1306, 1343.

\textsuperscript{59}See id. (citing Blumstein & Sloan, Health Planning and Regulation Through Certificate of Need: An Overview, UTAH L. REV. 3, 23, 24 (1978)).

\textsuperscript{60}See id. at 1459 (citing D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE-OF-NEED CONTROLS: IMPACT ON INVESTMENT, COST, AND USE (1979); F. Sloan & B. Steinwald, Effects of Regulation on Hospital Costs and Input Use, 23 J.L. & ECON. 81, 105 (1980) (suggesting regulatory programs did not contain hospital costs during first half of 1970's)).

\textsuperscript{61}See id. at 1451 n. 1 (citing DES MOINES REG., July 17, 1983, at 10A).
costs had exceeded 10% of the country’s total production.\textsuperscript{61}

The federal CON law was viewed as a failure, since the law had not reduced health care costs as expected.\textsuperscript{62} The cost of American health care had continued to rise.\textsuperscript{63} By some calculations, high medical costs were shown to be especially severe in areas controlled by CON laws.\textsuperscript{64} “In one comparison of health care prices and expenses, it was shown that such prices and expenses [were] actually higher in areas with CON regulations than they are in areas without CON.”\textsuperscript{65} Even if measuring the success of CON laws by the decrease, rather than the total eradication, of health care inflation, CON laws still caused disappointment, as evidenced by the constant high percentage held by health care costs in the nation’s gross national product.\textsuperscript{66}

The result of CON regulation has been debated for years. Many health care experts have expressed disdain for the CON process: “CON ‘has elicited a remarkable evaluative consensus--that it does not work.’”\textsuperscript{67} Congress, the origin of much CON regulation, has expressed disappointment in CON results. In the words of U. S. Rep. Thomas DeLay of Texas:

The Health Planning Amendments of 1985 [and] the National Health Planning and Resources Development Act required States to institute certificate-of-need laws providing for review and approval or disapproval of such proposals if expenditures exceeded specified limits. Congress intended this review process to prevent inappropriate investment in the health care industry and thus keep cost down.

Obviously, the program was not a success. The health systems agencies, which review proposed investment, are a hindrance to flexible response by health care providers. The process of seeking approval from such an agency is burdensome, costly and

\textsuperscript{61}See id.
\textsuperscript{62}McGinley, supra note 1, at 156 (describing the goal of Congress as reduction of health care costs).
\textsuperscript{63}See id. at 157.
\textsuperscript{64}See id.
\textsuperscript{65}See id.
\textsuperscript{66}See id.
\textsuperscript{67}McGinley, supra note 1, at 157.
causes needless delays. As a Texas legislator I worked to dismantle the Texas Health Facilities Commission. Clearly to abolish the Federal portion of this flawed program is a positive step.\textsuperscript{68}

This view was reinforced by U.S. Rep. David Dreier of California in remarks inserted into the Congressional Record: "The Certificate of Need Program is one more example of how stifling Government regulation is preventing the marketplace from providing badly needed health care services."\textsuperscript{69}

Representative Dreier’s remarks served as an introduction to the Congressional testimony of health planning expert Dr. Bedford H. Berrey, Medical Director, National Alliance of Senior Citizens. Dr. Berrey, a former Deputy Assistant Chief Medical Director of the Veterans Administration and former Health Director of the Virginia Department of Health, has experience in the CON process as both a member of a governmental entity conducting internal reviews and as a hearing officer.\textsuperscript{70} Dr. Berrey testified that the CON program actually increased costs by requiring government approval of provider expansion.\textsuperscript{71} This increase in costs, in turn, stifled the flow of resources.\textsuperscript{72} Dr. Berrey testified that the CON process is unfair due to the lack of public policy resulting from the closed nature of the process, the rigid standards, and the program’s limitation to a large-scale protection system.\textsuperscript{73} Dr. Berrey concluded that the closed nature\textsuperscript{74} of the regulated CON process, as well as the rigid standards and the program’s limitation to a large-scale protection system\textsuperscript{75} led to unfair governmental intervention devoid of public policy.\textsuperscript{76}

In 1986, the National Health Planning Act was repealed.\textsuperscript{77} Forty-two states and the District of Columbia had CON programs when Congress

\textsuperscript{68}132 CONG. REC. 1460 (1986).
\textsuperscript{69}133 CONG. REC. 20104 (1987).
\textsuperscript{70}See id.
\textsuperscript{71}See id.
\textsuperscript{72}See id.
\textsuperscript{73}133 CONG. REC. 20105 (1987).
\textsuperscript{74}See id.
\textsuperscript{75}See id.
\textsuperscript{76}See id.
\textsuperscript{77}McGinley, supra note 1, at 156.
repealed federal requirements. Although states were not prohibited from continuing local CON programs, the federal government would no longer fund these programs. This decision was due in part to the “...Reagan Administration’s desire to decrease both federal funding for and regulation of many government programs and because of the mounting empirical evidence that CON cost containment objectives were not being realized.”

**State Repeal of CON Laws**

Following the lead of Congress, many states repealed their CON laws. Since 1983, the repeal of state CON laws includes: Idaho in 1983; Minnesota and Utah in 1984; Arizona, Kansas, New Mexico, Texas and Wyoming in 1985; California and Colorado in 1987; South Dakota in 1988; and Ohio in 1995.

Some commentators contend that these states have experienced a post-repeal failure to control health care costs: “Those states that abandoned CON shortly after the federal government removed the incentives for these programs did seem to experience at least a short-term increase in investment and some costs.” CON proponents argue these states have experienced alarming health facility growth leading to a vast waste of resources and spiraling costs. On the floor of Congress, U.S. Rep. Fortney “Pete” Stark spoke in favor of continued state regulation of capital expenditures, targeting his home state of California as an example of wasted resources resulting from excess capacity:

California currently has 119 separate cardiovascular surgery programs. Twenty-five of these were added after the State abandoned its certificate-of-need [CON] program. One might inquire that while the post-CON expansion was great, was it excessive? A clear answer to this question is provided by a quick [comparison] of Canada and the former West Germany with the United States. The United State[s] has twice as many open-heart surgical units per million persons as does Canada and nearly five times as many as West Germany. And the ratio in California? It

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78 Kaplan, supra note 6, at 478.
79 See id.
81 Kaplan, supra note 6, at n.8.
exceeds the national average. The startup costs for each of these programs are between $6 and $13 million. Annual operating costs average $7 to $10 million at each location. For each open-heart surgery center that is not needed and not created, millions of dollars can be saved each year.8

Illinois and Health Care Facility Planning
Unlike California and other states which have repealed their CON laws, Illinois has not yet completely repealed its CON laws. In fact, state regulation of health care planning is currently a volatile issue in Illinois. This paper will address the workings of the Illinois health facility planning system and will discuss in particular a case recently before the Illinois Health Facilities Planning Board: the Case of Proposed Project No. 99-080, The Heart Hospital, as a reflection of state health care planning across the county. This proposed project represented the cutting edge of health care planning. It involved a hospital included in the top one percent of fastest growing hospitals in the United States83 -- the only hospital in the nation’s twelfth fastest growing community84 -- and its attempt to expand by establishing The Heart Hospital. The proposal was met with loud opposition from other hospitals in the Chicagoland area.

PART II: A CASE STUDY - PROPOSED PROJECT NO. 99-080
THE HEART HOSPITAL

The Illinois Health Facilities Planning Act
Illinois’ current CON statutes are known as the Illinois Health Facilities

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83Pam Davis, Chief Executive Officer, Edward Health Service Corp., Transcript of State of Illinois Health Facilities Planning Board Proceedings, 99-080, January 15, 2000, at 16. “Naperville has consistently been listed in the nation’s top ten fastest growing communities. This is one of the reasons why Edward Hospital is among the top 1 percent fastest growing hospitals in the United States.” Id.
84Id. at 11.
“Naperville is the 12th fastest growing city in the United States. The population of Naperville is also projected to continue to grow at a very rapid rate, culminating in about 165,000 individuals. Additionally, we are the only hospital located in this town. And in several of the towns bordering us, there is also extreme growth with no hospitals in those towns. Plainfield, Lisle, Bolingbrook, and the Fox Valley area.”

Id.
Planning Act (State Planning Act). Mirroring the public policy rationale behind the National Health Planning Act of 1974, the purpose of the State Planning Act is to address uncontrolled health care costs by limiting unnecessary growth.

The purpose of this Act is to establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. Such procedure shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public.

By limiting unneeded expansion of health care facilities, Illinois seeks to eliminate the cost of excess services. The State Planning Act thus attempts to limit health care cost inflation by prohibiting unnecessary growth. “The Act shall establish a procedure...that promotes through the process of recognized local and area wide health facilities planning, the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities;....”

The Illinois Health Facilities Planning Board
The Illinois Health Facilities Planning Board (State Planning Board) administers the State Planning Act. The composition of the State Planning Board is mandated by statute:

The State Board shall consist of 15 voting members, including: 8 consumer members; one member representing the commercial health insurance industry in Illinois; one member representing proprietary hospitals in Illinois; one member who is actively engaged in the field of hospital management; one member who is a professional registered nurse in Illinois; one member who is

85 20 ILL. COMP. STAT. 3960 (2000).
86 20 ILL. COMP. STAT. 3960/2 (2000).
87 Id.
88 Id.
a physician in active private practice licensed in Illinois to practice medicine in all of its branches; one member who is actively engaged in the field of skilled nursing or intermediate care facility management; and one member who is actively engaged in the administration of an ambulatory surgical treatment center licensed under the Ambulatory Surgical Treatment Center Act.¹⁹

Members of the State Planning Board are appointed by the Governor, with the advice and consent of the Illinois Senate, and in consideration of recommendations made by professional organizations.²⁰ Members serve terms of three years.²¹ Currently, there is no limit on the number of terms board members are allowed to serve.²² Members of the State Planning Board possess great power. No health care facility may be constructed, established, or substantially modified in Illinois without first obtaining a permit or exemption from the State Planning Board.²³ No health care facility may acquire major medical equipment without permission from the State Planning Board.²⁴ Failure to obtain a CON permit, or proceeding in non-compliance with an issued CON permit, may result in penalties, fines, sanctions, or revocation of permit.²⁵

CON Application No. 99-080: The Heart Hospital
Edward Hospital is located in Naperville, Illinois, a community located approximately 30 miles west of Chicago. Edward Hospital is an acute care hospital currently licensed for 124 medical/surgical beds, 7 pediatric beds, 25 obstetric beds, 15 intensive care beds, and 14 skilled nursing beds.²⁶ As such, Edward Hospital qualifies under Illinois regulations as a "general hospital," defined as a "facility which offers an integrated variety of categories of service and which offers and performs scheduled surgical

²¹ Id.
²² Id.
²³ Id.
²⁴ 20 ILL. COMP. STAT. 3960/5 (2000).
²⁵ Id.
²⁷ Written Statement to the State Planning Board, 99-080, August 24, 1999, at 4 [hereinafter Written Statement to the State Planning Board].
procedures on an inpatient basis."  

The city of Naperville is in the midst of a rapidly expanding suburban area of Chicago, as explained by the president of Naperville Development Partnership:

The cities of Naperville and Aurora lead the State in residential growth. These two communities rank among the largest cities in Illinois, with a combined population of over a quarter of a million people. Projected growth estimates for Naperville and the surrounding communities, the total population, at approximately half a million people by the year 2020[sic]. As an example, northeastern Illinois in its entirety is expected to grow in population between 1990 and 2001 at a rate of 24.5 percent, while the Naperville area is expected to grow at a rate of 76.8 percent, more than triple the northern region as a whole.  

In June of 1999, a coalition of business entities led by Edward Hospital submitted a CON application to the State Planning Board, requesting permission for the construction of a for-profit, five-story "specialty" hospital. Illinois law defines a "special or specialized" hospital as a "facility which offers, primarily, a special or particular category of service." The proposed five-story facility, devoted exclusively to cardiac care, would be named Heart Hospital, LLC. Heart Hospital was originally proposed to have 56 Medical/Surgical beds, 15 Intensive Care beds, 2 Operating Rooms, and 3 Cardiac Catheterization Labs, as well as Diagnostic Cardiology and Cardiac Rehabilitation Departments, and 14,410 square feet of leased physicians' offices. The

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97ILL. ADMIN. CODE tit. 77 § 1100.220 (2000).
99CON Application, 99-080, Heart Hospital, LLC, June 1999, at 3-4 [hereinafter CON Application]. (The applicants were as follows: Edward Hospital, Edward Cardiovascular Institute, Heart Hospital, LLC, Edward Health Services Corp. and Physicians, LLC, all entities located at 801 South Washington, Naperville, Illinois. Id.
100A White Paper Opposing the Establishment of the Heart Hospital, LLC, 99-080, August 1999, at 1 [hereinafter White Paper].
102CON Application, supra note 99, at 2.
103See id. at 7, 15.
estimated project costs were $92,391,587.\textsuperscript{104} The site for Heart Hospital was proposed as adjacent to Edward Hospital itself.\textsuperscript{105}

Request for Permission to Modernize

Heart Hospital was proposed as a modernization of an existing, licensed hospital, rather than the establishment of a new hospital. The proposal called for the modernization of Linden Oaks Hospital, a psychiatric hospital owned by Edward Health Ventures and located approximately .5 miles from Edward Hospital.\textsuperscript{106} At the time of the application, Linden Oaks Hospital (Linden Oaks) was licensed\textsuperscript{107} for 110 acute mental illness beds.\textsuperscript{108} The Heart Hospital application proposed a "modernization"\textsuperscript{109} of Linden Oaks Hospital by which Heart Hospital would assume the license of Linden Oaks.

The first step of this modernization plan consisted of discontinuing the use of 50 psychiatric beds at Linden Oaks, which would have reduced the psychiatric beds from 110 beds to 60 beds.\textsuperscript{110} The second step was the transfer of the remaining 60 psychiatric beds to Edward Hospital.\textsuperscript{111} The third step involved changing the name of Linden Oaks Hospital to Heart Hospital\textsuperscript{112} and moving Heart Hospital from an area .5 miles from Edward Hospital to a newly constructed building, physically abutting Edward Hospital itself.\textsuperscript{113} The final step in this modernization plan was the sale of Edward Hospital's existing not-for-profit Cardiac Catheterization and Open Heart Surgery Services to the for-profit Heart Hospital.\textsuperscript{114}

As the CON applicant,\textsuperscript{115} Edward Hospital had the burden of proof

\begin{footnotes}
104 See id. at 9.
105 See id. at 2, 5.
106 Written Statement to the State Planning Board, supra note 96, at 5.
107 Ill. Comp. Stat. 85/1 et seg. (2000). Illinois hospitals are regulated, in part, by the Hospital Licensing Act, which states no hospital may be opened, conducted, operated or maintained without first obtaining a license from the Illinois Department of Public Health.
108 Written Statement to the State Planning Board, supra note 96, at 4.
109 CON Application, supra note 99, at 7.
110 See id.
111 See id.
112 See id.
113 See id.
114 CON Application, supra note 99, at 7.
115 Ill. Admin. Code tit. 77 § 1180.40(c) (2000). "An applicant is the person required by the Illinois Health Facilities Planning Act to obtain a permit from the State Board who files an application with the State Board."
\end{footnotes}
on all application issues. This burden included establishing that Heart Hospital "was consistent with the standards, criteria or plans adopted by the State Board." For example, Edward Hospital was required to document that Heart Hospital was the "most effective or least costly alternative" and that the project was needed. Proof of need could have been documented by: area studies evaluating population trends, "calculation of need based upon models of estimating need for the service," "historical high utilization of other providers in the area," and "identification of individuals likely to use the project." The applicant was also required to demonstrate that, except for a few exceptions, the size of the proposed project did not exceed the norms for projects of this size, that the size of the project was appropriate and "that in the second year of operation the annual utilization of the beds or service will meet or exceed the target utilization."

The Heart Hospital CON application was subject to hearing requirements in place at the time under the State Planning Act. Upon review of an application for permit, an opportunity for a hearing was provided. All hearings were open to the public. The public hearing was required to take place within a reasonable time, not to exceed 90 days after receipt of the application, and notice of opportunity for public hearing and the opportunity to participate in the public hearing was afforded to all "affected persons". A hearing officer, appointed by the

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116 See id. § 1130.130(a).
117 See id. § 1180.120(e).
118 See id. § 1110.230(c).
119 See id. § 1110.230(d)(2)(A).
121 See id. § 1110.230(d)(2)(C).
122 See id. § 1110.230(d)(2)(D).
123 See id. § 1110.230(e)(1)(A-D).
124 See id. § 1110.230(e)(1).
125 ILL. ADM. CODE tit. 77 § 1110.230(e) (2000).
126 See id. § 1110.230(e)(2).
127 See id. § 1130.100.
128 See id. § 1140.20(a).
129 See id. § 1180.120(a).
130 ILL. ADM. CODE tit. 77 § 1140.20(a) (2000).
131 Formerly 77 ILL. ADM. CODE § 1200.20(b) (1999). See also former 77 ILL. ADM. CODE § 1200.30(c) (1999) (defining "affected persons" as the applicant, as well as the State Health Planning Development Agency or area wide health planning organization, any contiguous area wide health planning organizations located in the same Standard Metropolitan Statistical Area that
State Planning Board, conducted all hearings. Any party to the proceeding was allowed to appear at the hearing and was allowed representation by an Illinois licensed attorney. All parties at the hearing had the right to give testimony, produce evidence, cross-examine adverse witnesses, and present arguments.

The Heart Hospital Public Hearing: August 24, 1999

On August 24, 1999, the State Planning Board conducted a public hearing on the issue of the Heart Hospital proposal. The hearing officer announced the purpose of the hearing:

As you know this Public Hearing is held pursuant to the [State Planning Act] to allow you, the public, an opportunity to present verbal and/or written testimony...So all we’re going to do is be the conduit to get the information to the [State] Planning Board. Obviously, we had no idea how many people were going to show up. I’ve had none. I’ve had 10. I’ve had 50. I’ve never had 300 plus, and we’re thrilled to have you here.

The Heart Hospital Proposal

At the August 1999 public hearing, Heart Hospital proponents presented arguments supporting the need for expansion to serve the growing demands of the Naperville community. The sizable increase in population and hospital staff was not complimented by an equivalent increase in patient beds. In specific instances, bed shortages forced area hospitals to hold patients in the emergency department or ambulatory areas until an inpatient bed became available. The projected increase in the number of future inpatients would increase the strain of an institution already...
stretched beyond capacity. The voices of Heart Hospital proponents were consistent in their message at the public hearing, but theirs were not the only voices heard that day.

Opposition to Heart Hospital: The Alliance
A group of charitable, not-for-profit hospitals from DuPage, Kane and Cook Counties (Chicagoland counties) opposed the Heart Hospital CON Application. This group of hospitals called itself "The Alliance for Governmental Action" (Alliance) and included Central DuPage Hospital, Good Samaritan Hospital, Hinsdale Hospital, LaGrange Memorial Hospital, Loyola University Medical Center, Provena Mercy Center, and Provena St. Joseph Medical Center. Under Illinois law, members of the Alliance were allowed to participate in proceedings before the State Planning Board as "interveners." Alliance concerns were voiced at the August 24, 1999 public hearing and also in the Alliance's "White Paper" brief filed with the State Planning Board. Alliance opposition to the CON was organized into four basic allegations: (1) CON deficiencies and inaccuracies; (2) potential misuse of charitable assets; (3) fraud and abuse and physician self-referral concerns; and (4) threats to health planning and the orderly delivery of health care.

CON Deficiencies and Inaccuracies
The Alliance objected to the CON application as fundamentally misleading, and argued the Heart Hospital proposal was not a modernization of an existing hospital at all, but rather, the construction of a new hospital at a location separate from the Linden Oaks facility. The Alliance argued that the characterization of this CON proposal as a

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139See id. at 12.
140Written Statement to the State Planning Board, supra note 96, at 1.
141110. ADM. CODE tit. 77 § 1180.40(e) (2000) (defining interveners as "adversely affected persons" granted the right to be parties to proceedings before the State Board. Interveners include: "(5) health care facilities located in the health service area in which the project is proposed which provide services similar to the services of the applicant; and/or (6) health care facilities which have formally indicated an intention to provide similar services in the future.").
142Written Statement to the State Planning Board, supra note 96, at 1.
"modernization of Linden Oaks" was misleading, as no modernization of psychiatric services was proposed. Psychiatric services would be reduced and transferred, not modernized.

An argued defect of the CON application involved the issue of hospital licensing and the proponents' plan for Heart Hospital to inherit the hospital license of Linden Oaks. Although Linden Oaks had been operating under a duly granted license, hospital licenses in Illinois are issued for specific categories of service and a specific number of beds, and are valid only for the premises and persons named in the CON application. Heart Hospital would be neither a psychiatric hospital, nor located in the same building as Linden Oaks. The Alliance argued that a change in the legal identity of a hospital licensee constituted the establishment of a new hospital contrary to Illinois regulations, which hold a hospital license is not transferable. The Alliance argued Heart Hospital should not be allowed to assume the license of Linden Oaks in an effort to "modernize" that facility into the Heart Hospital.

Furthermore, the Alliance argued, the proposed reduction in psychiatric beds was not consistent with a recent, prior representation of Linden Oaks. In 1998, Linden Oaks had filed a request with the State Planning Board to increase its mental health service to the community through the addition of 10 psychiatric beds. Theoretically, this request was based upon community need for additional services. The State Planning Board granted the request. After the grant of 10 additional beds, Linden Oaks made another request of the State Planning Board. On June 11, 1999, Linden Oaks filed a Certificate of Exemption (COE) application requesting permission to complete a change in ownership of Linden Oaks to Edward Health Ventures. The COE application stated in part, "There will be no changes in bed capacity or scope of services provided at Linden

144Id.
145See id.
146White Paper, supra note 100, at 1.
147210 ILL. COMP. STAT. 85/6(a) (2000).
148White Paper, supra note 100, at 5.
149See id. at 1, 9, 10.
150210 ILL. COMP. STAT. 85/6(a) (2000).
151White Paper, supra note 100, at 1.
152Written Statement to the State Planning Board, supra note 96, at 2.
153See id.
Oaks Hospital as a result of this transaction." Less than one year after the State Planning Board responded to the request for additional beds, Edward Health Ventures, through Edward Hospital, filed the Heart Hospital CON application, which requested a decrease in psychiatric beds and cited a decrease of 45% in the community’s need for mental health services. The Alliance cited the pending CON proposal to reduce psychiatric services as a clear signal of imminent changes in psychiatric care offered to the Edward community in direct contradiction of earlier representations made to the State Planning Board.

**Potential Misuse of Charitable Assets**

The Alliance contended that approval of the CON application would usurp community health dollars, dollars which should be safeguarded by the State Planning Board. The proposal involved the transfer of cardiac services from a community not-for-profit entity to a new, for-profit joint venture. This transfer would draw not-for-profit funds away from a community hospital while adding no new cardiac services. Heart Hospital, the Alliance argued, was devoid of community benefit.

Edward Hospital is a not-for-profit community hospital. As a community hospital, Edward Hospital’s assets are community assets that exist solely for the benefit of the community. All revenues generated by hospital services are returned to the community through the subsidization of other health services. These community assets include the not-for-profit monies generated by most of the cardiac care services currently in operation at Edward Hospital. If the Heart Hospital were approved and Edward Hospital’s cardiac care services sold, the Alliance charged, then the not-for-profit Edward Hospital would be, in effect, subsidizing private physician investment in the for-profit Heart

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154 See id. at 11, 16.
155 See id. at 2.
156 See id.
157 Written Statement to the State Planning Board, supra note 96, at 1.
158 See id.
159 See id. at 3.
160 See id.
161 See id.
162 Written Statement to the State Planning Board, supra note 96, at 3.
Heart Hospital was projected to lose more than $20 million in its first three years of operation, which could impact Edward Hospital’s finances.\footnote{See id.} Illinois Attorney General Jim Ryan began evaluating whether Edward Hospital’s not-for-profit hospital’s charitable funds should be used toward the 71-bed for-profit Heart Hospital.\footnote{Id.} Floyd Perkins, an attorney in the charitable trusts division of Ryan’s office, stated: “We want to know, from a financial point of view, whether the venture is fair to the charity, in this case being (Edward) hospital.”\footnote{See id.} Perkins further asked: “Should the charity do it and is it being done at arm’s length? Does this make sense for Edward to be making this kind of arrangement?”\footnote{Id.}

To understand the Alliance’s argument on this point, it is important to note the lucrative aspect of cardiac care in relation to other health services. “General hospitals often derive more than a third of their margins from cardiology and cardiovascular surgery services, with such services typically being the most profitable programs a hospital operates.”\footnote{Written Statement to the State Planning Board, supra note 96, at 3.} Revenue generated from cardiology and cardiovascular surgery services often is applied to other vital but fiscally draining hospital services, such as trauma services, psychiatric services, and indigent care.\footnote{See id.} This balancing of profitable and nonprofitable services allows a not-for-profit to carry out its mission to provide for all those who present themselves for care, including the medically indigent.

If the CON application were approved, argued the Alliance, then Edward’s cardiac services and the community monies generated by these services would be sold to the Heart Hospital.\footnote{White Paper, supra note 100, at 1, 26; See also Written Statement to the State Planning Board, supra note 96, at 3.} Ownership of the cardiac services would be divided between Edward Hospital, which would hold 50.1% interest, and private investor/physicians, who would hold 49.9% interest.\footnote{State Agency Report, Project No. 99-080, Heart Hospital, LLC, at 2 [hereinafter State} Thus, Edward Hospital’s share of cardiac profits would be
reduced from 100% to 51%.\textsuperscript{172} And, the 51% of profit share would be for-profit income instead of not-for-profit monies.\textsuperscript{173} The remaining 49% of cardiac care profit, previously a charitable community asset, would be diverted to private investors/physicians.\textsuperscript{174}

The proposal affected not only community funds in Naperville, but in adjoining areas as well. The not-for-profit institutions in the involved planning areas had invested hundreds of millions of dollars to meet charitable community health care needs.\textsuperscript{175} These funds, and the resultant benefit to their communities, were now endangered. The Alliance voiced the following opposition at the public hearing:

Taking not-for-profit medicine, which has as its foundation, altruism, that is the interests of communities and patients, and replacing it with a for-profit health care, the primary purpose of which is generating earnings for stakeholders is a distortion of health care, in our opinion, and a potential source of harm to patients.\textsuperscript{176}

This loss in not-for-profit status would cause Medicaid patients and underinsured patients in the service area to experience a decrease in cardiac care, particularly in procedures such as bypass surgery, angioplasty, or angiography.\textsuperscript{177}

Representatives for Alliance Hospital Provena Mercy Center explained the connection between cardiac services and charitable assets at the public hearing:

Cardiac services, as you’ve heard, are the centerpiece of most hospitals’ strategies, a service with very high consumer visibility and demand, and a main driver of hospitals’ profit margins,

\textsuperscript{172}White Paper, supra note 100, at 26; See also Written Statement to the State Planning Board, supra note 96, at 3.
\textsuperscript{173}Id.
\textsuperscript{174}Id.
\textsuperscript{175}White Paper, supra note 100, at 16.
\textsuperscript{176}Dr. Anthony Barbato, President and Chief Executive Officer of Loyola University Medical Center and Health System, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 41 (copy on file with author).
\textsuperscript{177}Written Statement to the State Planning Board, supra note 96, at 7.
whether for-profit or not-for-profit.\textsuperscript{178}

The cardiovascular program at Mercy Center is one of the hospital's most financially viable programs, and its bottom line allows Provena Mercy Center to continue its work and its dedication to the mission. If the volume decreases, as is anticipated by shift to the new for-profit entity known as the Heart Hospital, cost per procedure at Mercy will increase and the Program will not survive [sic].\textsuperscript{179}

In the past Mercy Center has reduced beds as part of a CON.\textsuperscript{180} In the past 24 months alone, Mercy has written off 5.6 million dollars in charity care, in addition to significant dollars for bad debt.\textsuperscript{181} ... Mercy serves a very broad geographic market, much of which overlaps the market identified in the new for-profit hospital.\textsuperscript{182}

Provena Mercy Center is a longstanding mission-focused community hospital and it will be put in jeopardy so that the investors in the new Heart Hospital will benefit financially. That is unconscionable.\textsuperscript{183}

Representatives of Loyola University Medical Center summarized the value of not-for-profit, charitable health care:

The Catholic Church has had a long tradition of delivery of medical services. We know from principle, as others are learning from experience, that for-profit hospitals give rise to the question of whether or not they can deliver quality-appropriate service to the broad public in need of medical service.\textsuperscript{184}

\textsuperscript{178}Steve Davis, Regional Vice-President of Adventist Health Systems, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 98.

\textsuperscript{179}Mary Sheahen, then-President and Chief Executive Officer of Provena Mercy Center, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 91.

\textsuperscript{180}Id. at 90.

\textsuperscript{181}See id.

\textsuperscript{182}See id.

\textsuperscript{183}See id. at 91.

\textsuperscript{184}Michael Sharon, Chief Financial Officer and Treasurer of Loyola University Medical Center, reading a letter from the Most Rev. Edward M. Conway, Auxiliary Bishop of Chicago,
Some speakers, such as Dr. Austin Gibbons, past President of the Medical Staff at Alliance Hospital Good Samaritan Hospital, were more direct: "I see this as a form of skimming which will pose a threat to the financial underpinning of the not-for-profit hospitals. Dollars which now help to underwrite charitable care and the treatment of unprofitable diseases will instead go to investors."\(^\text{185}\)

The Alliance argued that Edward Hospital’s proposal constituted a loss of not-for-profit revenue to the community, a loss which should be a focus of the State Planning Board.\(^\text{186}\)

**Fraud and Abuse and Physician Self-Referral Concerns**

The third concern voiced by the Alliance was the impact that Heart Hospital physician investment and self-referral would have on cardiology and cardiovascular costs in the community.\(^\text{187}\) The CON application expressed the intent of fourteen cardiologists and cardiovascular surgeons, allegedly future investors,\(^\text{188}\) to refer a substantial number of patients to Heart Hospital.\(^\text{189}\) These referrals were to be made regardless of the physicians’ long associations with other area hospitals that had highly reputable cardiology and cardiovascular surgery programs,\(^\text{190}\) hospitals which would suffer the utilization loss of existing cardiac facilities. Why, the Alliance argued, had Heart Hospital become the hospital of choice? What did Heart Hospital offer which the existing community hospitals and medical centers did not? The answer, according to the Alliance, was the existence of physician investment and profit.\(^\text{191}\)

Issues regarding physician self-referral have been the subject of national interest long before the Heart Hospital proposal. In an attempt to

\(^{187}\)Dr. Austin Gibbons, Immediate Past President of Medical Staff of Good Samaritan Hospital, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 113-14.
\(^{189}\)Written Statement to the Planning Board, *Supra* note 96, at 4.
\(^{189}\)See *id.*
\(^{190}\)See *id.* (noting a commitment to refer 2,977 cardiology cases and 1,363 cardiac surgery cases in 2004).
\(^{191}\)See *id.*
control rising health costs, the Health Care Financing Administration and the Office of the Inspector General (OIG) implement and enforce Medicare rules and regulations. These rules and regulations include the Anti-Kickback Statutes, Stark I and Stark II, which restrict physicians in their use and ownership of health care facilities and services. Such regulations are based on the premise that physician investors who refer patients for costly services may be swayed from what is best for the patient's health to what is best for the physician's personal finances, thereby raising health costs unnecessarily.

In a Special Advisory Bulletin of July 7, 1999, the OIG announced it would be looking closely at physician ownership of specialty hospitals to determine whether such arrangements are within the Anti-Kickback guidelines which prohibit physicians from being paid for patient referrals. U.S. Rep. Fortney "Pete" Stark, the sponsor of Stark I and II, believes even if physician ownership of specialty hospitals complies with the letter of the law, such arrangements violate the spirit of the law. Stark has stated, "My suspicion is that this is a watered-down lawyer's way to pay doctors kickbacks for the patients they refer." Stark has also articulated concerns about physician-owned services and has said, "I don't think the physicians ought to be investing in the hospitals...It troubles me as a patient, as an individual. I would like for my physician to have no incentive one way or the other to send me to the hospital or choose which hospital I go to."

The Alliance argument raised the distinction between profit and not-for-profit health care entities: a perceived distinction, real or not, found in the mission of a hospital and the motivation of physicians. This distinction was articulated by Patrick Fahey, Chairman, Department of Medicine, Loyola University Medical Center: "[A] for-profit physician investor program calls into question the fundamental expectations that patients

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192 Written Statement to the State Planning Board, supra note 96, at 4 (noting a commitment to refer 2,977 cardiology cases and 1,363 cardiac surgery cases in 2004).
193 See id.
194 See id.
195 See id.
196 See id.
197 Written Statement to the State Planning Board, supra note 96, at 4, 5 (citing to Hospitals & Health Networks, 72(7): 24-26, 28-30 (April 5, 1998).).
198 See id. at 5.
have of their physicians. Patients rely on physicians to always work in their best interests, independent of the physician’s financial investments. For-profit health care systems have a very, very different motivation.’’

The Alliance concluded that, “The Edward Heart Hospital places a burden on physicians that should not exist by making them investors.”

**Threats to Health Planning and the Orderly Delivery of Health Care Services**

The final objection levied by the Alliance against the CON application was the threat to area-wide health planning and “the orderly delivery of health care services.”

Under Illinois regulations, an applicant proposing the establishment or expansion of a health facility must document that the primary purpose of the project will be to provide care to the residents of the planning area in which the project will be physically located. The applicant must also prove that the location will not create a maldistribution of beds and services.

Because some cardiologists and cardiovascular surgeons on staff at Alliance hospitals were members of physician groups who would be investing the required 46 million dollar physician share in Heart Hospital, the Alliance was concerned about the redirection of patients away from communities already served by Alliance hospitals. Such redirection would have a direct impact on Alliance hospitals. A reduction in the number of patients at Alliance hospitals would lead to increased costs for remaining Alliance patients, due to fewer patients being available to defray cost of cardiology staff, equipment, and facilities. As explained by Jack Barto, President of Provena Hospitals: “The projected volume of

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199 Patrick Fahey, Chairman, Dept. of Medicine, Loyola University Medical Center, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 105.

200 Dr. Steven Slogoff, Chairman, Dept. of Anesthesiology, Stritch School of Medicine and Loyola University Medical Center, Chairman of Loyola University Physician Foundation, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 103.

201 Written Statement to the Planning Board, supra note 96, at 5.


203 Id. § 1110.230(a)(2) (emphasis added).

204 David Fox, President of Central DuPage Hospital, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-080, August 24, 1999, at 77.

205 Id. at 78.
increased referrals to the Heart Hospital represents projected volume declines at other area hospitals which could have serious results. Redirection would reverse years of successful area-wide health planning for cardiac services. The Alliance argued:

These Heart Hospital physicians who will profit by performing more surgical and invasive procedures at that facility, will be incented to move patients from existing hospital settings to the proposed Heart Hospital. That shift of patients will have significant impact on several local community hospitals and on Loyola University Medical Center, not on the basis of improved services to patient, but, instead, on a new dynamic influencing patient referral.

Alliance witnesses described the impact redirection would have on Alliance hospitals and their ability to care for remaining patients and argued that the area had ample cardiac services available for the population. Alliance members stressed that the endangerment of cardiac services in other areas was being brought about by greed, not necessity, and cited several examples where bed need was already being met by existing cardiac services.

In addition to the issue of new beds, the Alliance raised the issue of new services. According to the Alliance, Heart Hospital mandated great cost but offered no new services:

None of the services in the new facility offer anything new to the patients or the community.

The programs of services described in the Heart Hospital’s application do not differ to any degree from those that already exist. Actually, what people in our communities are getting are no new service, but less accessibility and significantly greater accessibility.

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205 Barto, supra note 186, at 176.
207 Fox, supra note 204, at 79.
208 Barbato, supra note 176, at 41.
210 Barbato, supra note 176, at 45.
211 Barto, supra note 186, at 174.
Alliance speakers were incredulous at what they saw as an enormous misallocation of health care dollars: “At a time when health care costs continue to rise, to spend more than 91 million to create an unnecessary entity is beyond the comprehension of most fiscally responsible health care executives and physicians.”

Yet, Alliance officials predicted, an approval of the Heart Hospital application would create a Pandora’s Box of health care planning, as other hospitals in the area pursued similar proposals in an effort to compete with a specialty hospital. The threat to the orderly delivery of health care services would have only just begun.

Responses From Heart Hospital Investors
Heart Hospital proponents also spoke at the August 24, 1999 public hearing. Dr. Louis McKeever, Chairman of the Board, Midwest Heart Specialists, a projected Heart Hospital physician/investor, responded to the Alliance’s charge that a for-profit Heart Hospital would practice a lower standard of care and also detrimentally impact care at Alliance hospitals:

Midwest Heart Specialists has been the leading provider of cardiology care in DuPage County for over 20 years.... We’ve always sought to make all of the institutions that we’ve been a part of the best that they can be, and that will not change with this new proposal....We...do not share the same concerns of the competing hospitals that you’ve heard today. In fact, two of the competing hospitals that have spoken against this are places that we practice and have a major preference. Our commitment to them will not change....And yet, we feel that the Heart Hospital proposal is an idea that is right for our time. It’s right for our patients. And in particular, it’s right for the community of

213 Sheahen, supra note 179, at 91-92.
214 Davis, supra note 178, at 99.
Naperville, given the demographics that you've already been told.\(^{215}\)

Dr. Mark Goodwin, another projected Heart Hospital physician, responded to the allegation of inappropriate physician self-referral and health planning:

Our group, Midwest Heart Specialists, has founded a program at Good Samaritan Hospital and currently is the predominant provider of care there. So when you hear people talking about their wonderful programs, that wonderful program is us....We're the predominant provider to both Elmhurst and Good Samaritan Hospital. And a large provider of care at Central DuPage Hospital and, previously, at Loyola....Our group has served all these hospitals for the past 25 years, and as of yet, have not, to this date, moved cases from one site to another.\(^{216}\)

**Illinois State Planning Agency Report**

After the public hearing, the Heart Hospital CON request, like all CON applications, was reviewed and evaluated by the State Planning Board staff for compliance with general review criterion\(^{217}\) set out in the Illinois regulations.\(^{218}\) The purpose of the criteria and standards is to establish a basis for evaluating a project.\(^{219}\) Review considerations include (1) cost effectiveness;\(^{220}\) (2) availability of services;\(^{221}\) (3) accessibility of services based on geographic, social, financial and other considerations;\(^{222}\) (4) quality of services delivered;\(^{223}\) (5) needs of the population;\(^{224}\) and (6)

\(^{215}\)Dr. Louis McKeever, Chairman of the Board, Midwest Heart Specialists, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-030, August 24, 1999, at 130.

\(^{216}\)Dr. Mark Goodwin, Midwest Heart Specialists, Member of Edward Hospital Board of Directors, Transcript of State of Illinois Health Facilities Planning Board Public Hearing, 99-030, August 24, 1999, at 154.

\(^{217}\)Ill. Adm. Code tit. 77 § 1110.30(b) (2000).

\(^{218}\)See id. § 1250.110(a).

\(^{219}\)See id. § 1250.1320(a).

\(^{220}\)See id. § 1250.1320(a)(1).

\(^{221}\)See id. § 1250.1320(a)(2).


\(^{223}\)See id. § 1250.1320(a)(4) (noting further that quality is often broken down into three components: quality of input resources (i.e. certification/training of providers); quality of process of service delivery and quality of outcome of service use (actual improvement in condition or reduction of harmful effects)).
financial viability of the health care institution. By adhering to established, published criteria, the analysis and evaluation of CON projects is a public and consistent process.

All evidence submitted on an application is considered in the determination of whether the application is in compliance or noncompliance with the review criteria. The State Planning Agency staff then issues its findings in a report known as the State Agency Report (SAR).

State Agency Report Evaluating Heart Hospital
Staff personnel from the State Planning Agency reviewed the Heart Hospital CON application and issued a SAR. The SAR found the proposed project did not meet certain criteria. Findings of deficiency in the Heart Hospital CON application echoed Alliance arguments presented at the August 1999 public hearing. The SAR found a lack of evidence supporting each of the following criterion: the basis for discontinuation of mental health services at Linden Oaks; establishment of mental health services at Edward Hospital; unmet community need for cardiac services; unmet community need for beds; and economic feasibility. An in-depth discussion of each criterion found unmet is beyond the scope of this article. However, in order to understand the CON application process in general, a review of the State Planning Agency’s analysis of some criterion is necessary.

Discontinuation and Establishment of Services Analysis
Based on Edward Hospital’s plans to discontinue acute mental illness care at Linden Oaks, the SAR used a Discontinuation of Services analysis in reviewing the Heart Hospital application. However, Edward Hospital had not seen the proposal as involving a discontinuation of services but, rather, a transfer and modernization of services. The Hospital had argued the acute mental illness beds and services at Linden Oaks Hospital would be

\[^{224}\text{See id. } \S 1250.1320(a)(5).\]
\[^{225}\text{See id. } \S 1250.1320(a)(6).\]
\[^{226}\text{See id. } \S 1130.620(d)(4).\]
\[^{227}\text{State Agency Report, supra note 171, at 3-10.}\]
\[^{228}\text{Id.}\]
\[^{229}\text{See id.}\]
\[^{230}\text{See id.}\]
reestablished in a separate building at Edward Hospital, and therefore would not be discontinued. Thus, Edward Hospital had not addressed discontinuation criteria in the CON application. Edward Hospital's failure to address the discontinuation of services criterion led to a SAR finding that the proposal did not appear to be in conformance with this criterion.

Contrary to the analysis under Discontinuation of Services, the SAR used Establishment criteria to evaluate Linden Oaks as an existing cardiac facility, rather than a discontinued mental illness facility. One criterion applied by the SAR states:

The applicant must document that a minimum of 200 open heart surgical procedures will be performed during the second year of operation or that 750 cardiac catheterizations were performed in the latest 12 months for which data is available. Anticipated open heart surgical volume must be documented by historical referral volume of at least 200 patients directly referred following catheterization at the applicant facility for open heart surgery for each of the last two years.

Because the SAR reviewed the past and current cardiac services at Linden Oaks, rather than Edward Hospital, and because Linden Oaks/Heart Hospital had not offered current cardiac catheterization services, it could not meet the requirements of this section. Therefore, the SAR found that the proposed project did not appear to be in conformance with this criterion.

Allocation of Bed Analysis
Consistent with basic CON concerns regarding duplication of services, bed need is a standard analysis brought to proposals requesting the establishment or addition of hospital beds. If the regulating entity reviews the proposal as a request to establish an additional hospital, then the applicant must also document that access to services will be improved by the project. Such documentation must consist of proof of one of the

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231 See id.
233 See id. at 10.
234 See id. at 11.
235 ILL. ADM. CODE tit. 77 § 1110.320(b) (2000) (emphasis added).
following facts: (1) the proposed service is not available within the area;\textsuperscript{236} 
(2) existing facilities have restrictive admission policies resulting in access limitations;\textsuperscript{237} 
(3) existing providers are experiencing occupancy levels beyond target levels;\textsuperscript{238} 
or (4) the travel time to existing providers is excessive (exceeds 45 minutes).\textsuperscript{239} 

If the state agency reviews the request as permission to add beds to an existing facility, then the applicant must prove the need for additional beds.\textsuperscript{240} 
Proof includes documentation that: (A) existing inpatient beds over the latest 12 month period have been used at the target occupancy or higher;\textsuperscript{241} 
or (B) when occupancy levels over that period fall below the target occupancy, affected services cannot be converted to provide needed bed space.\textsuperscript{242} 

Edward Hospital had not addressed this criterion and had asserted that this criterion was not relevant to the project.\textsuperscript{243} 
The SAR, however, found this criterion was relevant and noted that both Linden Oaks/Heart Hospital and Edward Hospital were proposing the establishment of one or more categories of service involving the addition of beds.\textsuperscript{244} 
Under the proposal, Edward Hospital would add acute mental illness beds and Linden Oaks/Heart Hospital would add intensive care unit and medical/surgical beds.\textsuperscript{245} 
Therefore, the SAR found the proposed project did not appear to be in conformance with this criterion.\textsuperscript{246} 

\textbf{Duplication of Services Analysis} 
The study of duplication of services and a project’s impact on services at other facilities is a traditional CON analysis. Unnecessary duplication of open heart services is analyzed by the following criterion:

\textsuperscript{236} See id. § 1110.320(b)(1).  
\textsuperscript{237} See id. § 1110.320(b)(2).  
\textsuperscript{238} See id. § 1110.320(b)(3).  
\textsuperscript{239} See id. § 1110.320(b)(4).  
\textsuperscript{240} ILL. ADM. CODE tit. 77 § 1110.320(c) (2000).  
\textsuperscript{241} See id. § 1110.320(c)(1)(A).  
\textsuperscript{242} See id. § 1110.320(c)(1)(B).  
\textsuperscript{243} State Agency Report, supra note 171, at 6.  
\textsuperscript{244} See id.  
\textsuperscript{245} See id.  
\textsuperscript{246} See id.
The applicant must document that the volume of any existing service within 90 minutes travel time from the applicant will not be reduced below 350 procedures annually for adults and 75 procedures annually for pediatrics. Documentation will consist of proof of contact of all facilities within 90 minutes travel time currently providing open heart surgery to determine the projected impact the project will have on existing open heart surgery volume.\textsuperscript{247}

Because Edward Hospital had not addressed this Criterion, the SAR found that the proposed project did not appear to be in conformance with this regulation.\textsuperscript{248}

Unnecessary duplication of services in cardiac catheterization is another example of criteria not addressed by the CON application, but found relevant by the SAR. This criteria states:

Any application proposing to establish cardiac catheterization services must indicate if it will reduce the volume of existing facilities below 200 catheterizations. Any applicant proposing the establishment of cardiac catheterization services must contact all facilities currently providing the service to determine the impact the project will have on the patient volume as existing services.\textsuperscript{249}

The SAR stated Edward Hospital had not addressed this criterion either and found that the proposed project did not appear to be in conformance with this regulation criterion.\textsuperscript{250}

In sum, the SAR found that the proposed project did not appear to be in conformance with 18 criteria.\textsuperscript{251}

**Hearing Before State Planning Board - January 13, 2000**

After issuance of the SAR, the State Planning Board convened another public hearing. At the January 13, 2000 hearing of the State Planning

\begin{footnotes}
\footnotetext[247]{See id. at 11.}
\footnotetext[248]{See id.}
\footnotetext[249]{State Agency Report, supra note 171, at 13.}
\footnotetext[250]{See id.}
\footnotetext[251]{See id. at 2.}
\end{footnotes}
Board, Edward representatives responded to the SAR and to concerns of State Planning Board members: “The negatives that are in the Staff Report are addressed,...11 of the 18 as I count them, by our legal theory or our legal position, and...the rest by testimony from our witnesses.”

Response to Discontinuation and Establishment Analysis
The Heart Hospital proponents argued that the SAR inappropriately used discontinuation and establishment criteria and ignored the relationship of the proposed Heart Hospital to its parent corporate entity, Edward Health Ventures:

Definition of ‘existing healthcare facility’ requires the State Planning Board to look at the whole enterprise, not at pieces or entities that the lawyers might create and might present as partial pieces of the situation.....‘Existing healthcare facility’ is defined as ‘any healthcare facility or any person or organization that owns or operates a healthcare facility.’...In this fact situation, it goes up to EHSC, Edward Health Service Corp., which is the ultimate parent.

Under this correct interpretation, proponents reasoned, the entire Edward Hospital campus must be seen as one location.

Notwithstanding this view of the law, the SAR, we think erroneously, rejects the restructuring within this group as transfers among, in effect, separate entities. And we don’t think that that squares with your definition in the rules of modernization, which means, and I’m quoting again, ‘modification’ of an existing healthcare facility by means of building, alteration, reconstruction, remodeling, replacement, the erection of new buildings or the acquisition, alteration, or replacement of equipment.

The definition of ‘establishment’ puts you under another set of criteria, which were the ones that the SAR relied upon. But

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253 Id.
254 See id. at 12.
'establishment' means much of these same things on another site. That's Rule 1130.140. And the key words there are 'on another site', and we're not on another site. This is all being done at 80 South Washington, the site that the Edward facilities exist on.\textsuperscript{255}

\textbf{Response to Bed Analysis}

Heart Hospital proponents responded vigorously to other criteria concerns, including Bed Analysis Criteria.

We've had patients backlog in our emergency department more than 40 times in 1999. We've exceeded occupancy to more than 100 percent on 25 days last October alone. We've had occupancies as high as 128 percent. And in fact, today, we have patients backlogged in our emergency department, and elective cases have been canceled.\textsuperscript{256}

There are other indicators of overcrowding. In fact, a significant one comes from Dr. John Lumpkin, the Department of Public Health, in memorandums dated December 29 and January 7. I quote, 'In response to a significant pattern of hospitals reaching capacity, exceeding their ability to provide monitored beds in their intensive care units and other units, and going on bypass, the Illinois Dept. of Public Health has sought the counsel involvement of the IHHA and MCHC. These issues have been an annual concern. They have gotten worse each year. Because of this, Task Force have been put together in order to help hospitals deal with overcrowding and try to determine ways not to go on bypass.'\textsuperscript{257}

Additionally, a September 1999 memorandum from the Chief of Staff at Foster G. McGaw Hospital from Loyola states that 'Loyola Hospital has a bed crunch and requests that physicians help avoid overcrowding by immediately discharging their patients.'\textsuperscript{258} 

\textsuperscript{255}See id.

\textsuperscript{256}Davis, \textit{supra} note 83, at 17.

\textsuperscript{257}See id. at 17, 18.

\textsuperscript{258}See id. at 18.
occupancy rates, which are averaged over a year.\(^{259}\)

**Response to Duplication of Services Analysis**

The Heart Hospital response to the SAR's Duplication of Services analysis was clear and well-reasoned.

In 1998, Edward performed 325 bypass surgeries out of a total in our marketplace of 1792. That’s a market share of 18 percent. As seen from the chart, when you take a look at the year 2004, we are projecting that we will perform 612 bypass surgeries out of a total of 3,239, at a market share of 19 percent....We are less than 10% of the total surgeries performed by these existing institutions now, and in the year 2004, we will continue to be less than 10 percent of the total number of bypass surgeries performed by these nine existing institutions. We will not be hurting these programs. Rather, we will be meeting the needs of our existing patients and recognizing the growth in aging of the communities that we currently serve.\(^{260}\)

The Heart Hospital forecasts an 88 percent increase in CABG procedures between 1998 and 2004. This increase is based on forecasts of growing medical need in the community and does not assume any cannibalization....The Heart Hospital does not need to cannibalize other facilities to meet its growth target.\(^{261}\)

**Board Member Inquiries**

During the January public hearing, Board Members expressed frustration at the proponent's interpretation of underlying data and queried the alleged improvement in patient care and services to be derived from the 90 million-dollar Heart Hospital. Heart Hospital proponents were asked these questions and gave this answer:

Q: Dr. Buffalino, would you give a brief summary of how this is going to improve patient care?\(^{262}\)

\(^{259}\)See id.(emphasis added).

\(^{260}\)See id. at 23-24.

\(^{261}\)Dr. David Dranove of Northwestern University, Transcript of State of Illinois Health Facilities Planning Board Proceedings, 99-080, January 13, 2000, at 38.

\(^{262}\)Dr. William Marshall, Planning Board Member, Transcript of State of Illinois Health
Q: As you're speaking now, Doctor, about quality, just promise me something, how are you going to measure that?...You say you are going to do it. How are you going to measure that?263

Q: How is the new proposed program going to improve that particular part of your...your measurement part?264

Q: I asked - you know, that was a part of my first question - the targets you set for improvement?265

Q: Well, see where I'm struggling is,...when I ask, 'Well what's the next level that you're going to take it to in terms of quality of care, to kind of pay back the [90] million dollars?'...In business school, if somebody came to you..., the board is going to say, 'Show me the numbers before you get the money.'265

A: (I)t appears from the forecast that one can justify the investment purely on the basis of current need and current quality.267

At least one Board Member expressed skepticism over Edward Hospital’s continuing refusal to address what the Board considered as relevant criteria. Yet Edward Hospital continued to assert its own interpretation of required documentation:

Q: Earlier in the testimony was also the need for beds, because there’s people waiting to get in a bed. But when I look at Mike’s report under ‘Addition of Beds, Allocation of Additional Beds’, and I get down to the bottom and it says, ‘The applicant has chosen not to address this criteria.’263


263Id.


265Id.

266See id. at 77.

267Dranove, supra note 261, at 78.

A: But the situation is that the reason why those were not evaluated was because the project was addressed as an additional bed to Edward’s Hospital, which is not what was proposed. They’re proposing to establish those beds as category of service in another distinctly licensed facility, and that doesn’t work.\(^{269}\)

In an effort to sway votes, Board Members themselves engaged in the art of persuasion. Board Member Stuart Levine, who would ultimately cast votes in favor of the Heart Hospital CON, stated at the conclusion of the January hearing:

And, I think, that the reality is that this—this Board has to regard this project as an existing facility, and not a new facility. And the fact that this project is being built at the same site is the fact that there is not establishment of a new facility.\(^{270}\)

This interpretation, however, did not carry the entire State Planning Board.

**State Planning Board Decision**

In making its determination whether to approve the Heart Hospital proposal, the State Planning Board was required to consider the CON application, the SAR, the public hearing testimony, and any other information coming before it.\(^{271}\) The approval of an application and the issuance of a CON requires eight affirmative votes by the State Planning Board.\(^{272}\) The vote taken at the Heart Hospital public hearing on January 13, 2000 found only three votes in favor of the Heart Hospital.\(^{273}\) Because the application failed to receive the necessary affirmative votes,\(^{274}\) the


\(^{272}\) Id. (establishing that the failure of an application to meet the review criteria does not necessarily prohibit the issuance of a permit).

\(^{273}\) See id.

\(^{274}\) See id. § 1130.670(a).
State Planning Board voted an Intent-to-Deny the CON application.\(^{275}\)

As required under Illinois law,\(^{276}\) the Intent-to-Deny gave Edward Hospital notice of another opportunity to appear before the State Planning Board and the opportunity to submit additional information in support of the project.\(^{277}\) Edward Hospital had 30 days\(^{278}\) within receipt of the Notice of Intent-to-Deny to notify the State Planning Board in writing whether it intended to appear before the State Planning Board\(^{279}\) and/or submit additional information.\(^{280}\) If Edward Hospital indicated that no additional information would be submitted, then the State Planning Board would take action on the application at its next meeting.\(^{281}\) If the State Planning Board did not receive a written response within ten days, or if Edward Hospital waived the right to appear before the State Planning Board, then the application for permit would have been considered withdrawn.\(^{282}\) But Edward Hospital was not about to give up the fight.

**Edward Hospital’s Modified Petition**

On March 13, 2000, while continuing to defend its original plan,\(^{283}\) Edward Hospital submitted a new proposal to the State Planning Board. In an effort to increase its chances of receiving permission to expand,\(^{284}\) Edward Hospital’s new plan reduced the scale of its previous proposal by


\(^{276}\)720 ILL. COMP. STAT. 3960/10 (2000).

\(^{277}\)ILL. ADM. CODE tit. 77 § 1130.670(a) (2000).

\(^{278}\)720 ILL. COMP. STAT. 3960/10 (2000).

\(^{279}\)ILL. ADM. CODE tit. 77 § 1130.670(b)(1) (2000).

\(^{280}\)See id. § 1130.670(b)(2).

\(^{281}\)See id. § 1130.670(c)(2).

\(^{282}\)See id. § 1130.670(c)(1).

\(^{283}\)PR NEWSWIRE, Edward Health Services Modifies Heart Hospital Proposal in Preparation For Subsequent State Agency Hearing, PR NEWSWIRE ASS’N, March 13, 2000 (statement of Vincent Bufalino, Medical Director of Cardio-Vascular Services at Edward Hospital) ("The mission of Heart Hospital remains the same...Our original plan was solid, but the Board had issues about its scope.").

\(^{284}\)Bruce Japsen, Edward Hospital Shrinks Heart Plan; 43 Beds, Not 71, For New Faculty, CHI. TRIB., Mar. 14, 2000 (Business Section) at 3 (statement of Hospital Spokesman Brian Davis) ("By modifying our proposal, we believe we are giving ourselves a better chance."). See also, Susan Stevens, Edward Officials Submit Proposal For A Smaller Heart Hospital, CHI. DAILY HERALD, Mar. 14, 2000 (Neighbor Section), at 1 (statement of Edward Hospital Spokesman Brian Davis) ("We took a hard look at the amount of beds and the cost and decided we’d have a better chance of getting the concept approved by scaling back.").
approximately twenty percent. The cost reduction in this proposal from over $90 million to approximately $70 million was based on a number of things, including the removal of the purchase price of Linden Oaks from the proposal and a reduction in the original bed request from 71 additional beds to 43 beds (28 medical/surgical beds and 15 intensive care beds).

Pamela Meyer Davis, President and CEO of Edward Hospital, summarized Edward Hospital’s view of the second proposal:

With these revisions, we’re sending a clear message to [the State Planning Board] and the Department of Public Health staff that we’ve carefully considered, and now have addressed, specific issues raised at the January meeting....We’ve been working with the Department of Public Health staff to better understand their concerns. We’re encouraged by the progress in our discussions and believe that the changes we’ve made may satisfy their concerns.

The size of the new proposal was considered “still quite grandiose” by the Alliance. Speaking for the Alliance, Thomas Fahey noted, “There’s still an excess capacity of beds in the region.” Maintaining the Alliance’s objections to the proposal as modified, Mr. Fahey stated, “[The new proposal] certainly continues to pose a dimension of the project that is very threatening.”

A hearing on the amended proposal was held June 1, 2000, and again the State Planning Board denied Edward Hospital’s request for a Heart Hospital CON. The proposal received only five of eight necessary votes.

**Administrative Review**

Upon final receipt of the decision of the State Planning Board, Edward Hospital had further options. Illinois law provides for administrative

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285 *Id.*
286 *See id.*
287 PR NEWSWIRE, *supra* note 283.
289 Stevens, *supra* note 284, at 1.
290 Japsen, *supra* note 284, at 3.
291 Japsen, *Board Again Rejects Heart Hospital*, CHI. TRIB., June 2, 2000, (Business Section), at 1.
review of decisions of the State Planning Board.\textsuperscript{292} At the conclusion of the administrative hearing, a final administrative decision is made, with findings of fact and conclusions of law.\textsuperscript{293} Under Illinois law, any person or entity found adversely affected by the final decision of the State Planning Board may have the decision judicially reviewed.\textsuperscript{294} Despite the expenditure of time, expertise and funds, Edward Hospital did not petition the state court for review. An understanding of Illinois court decisions explains why health care entities may be reluctant to do so.

**PART III: ILLINOIS STATE COURT DEFERENCE TO STATE PLANNING**

In Illinois, there is virtual judicial abstention from oversight of the State Planning Board, which results in a grant of great power to the State Planning Board. A review of typical Illinois decisions shows this to be true.

In *Cathedral Rock of Granite City, Inc. v. Illinois Health Facilities Planning Board*,\textsuperscript{295} the State Planning Board granted a CON to defendants Rosewood and HSM Development, allowing Rosewood to build an 80-bed, long-term care nursing facility in Granite City. A competing nursing facility, Cathedral Rock, appealed the decision to the circuit court pursuant to Section 11 of the Planning Act.\textsuperscript{296} The circuit court affirmed.

There had been great opposition to the plan at the public hearing. Opponents said the proposed nursing home would take all the private paying patients, leaving the Medicare patients for other homes in the area, and that no need for the new home was shown because of the high number of empty beds in the existing homes.\textsuperscript{297} The State Agency opposed the CON, finding three criteria were not met: allocation of additional beds, location, and alternatives.\textsuperscript{298} As the opponents said, Rosewood did not

\textsuperscript{292}20 ILL. COMP. STAT. 3960/11 (2000).
\textsuperscript{293}ILL. ADM. CODE tit. 77 § 1130.680(c) (1999).
\textsuperscript{296}20 ILL. COMP. STAT. 3690/11 (2000) (incorporating the Administrative Review Act).
\textsuperscript{297}Cathedral Rock, 720 N.E.2d at 1117.
\textsuperscript{298}See id.
prove its project would improve access to the nursing home service. The SAR concluded the additional facility would be an unnecessary duplication of existing services.

Even though the State Planning Agency reviewed and investigated the application and issued the SAR, the State Planning Board was not bound by the State Agency’s findings. Initially, the State Planning Board denied approval. But the State Planning Board held a second hearing, where it determined the bed utilization rate based on licensed capacity was not a true number, and that it should consider the lower number of actual beds. The State Planning Board reconsidered its decision and voted to approve the project.

Upon review, the court held Cathedral Rock, as a competing health facility, did not have a protectible property interest that was implicated by the State Planning Board proceeding. This finding defeated Cathedral’s procedural due process claims arising out of notice and no opportunity to be heard contentions. That is: “The purpose of the Planning Act and the public hearing is not to provide protection to competitors from an imposition on their market shares.” Rather, “...the purpose of the Planning Act is to ‘establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modifications of health care facilities.’” While Cathedral had no due process claim, it could, as a party adversely affected by the State Planning Board’s final decision, seek judicial review under the Administrative Review Act.

Finally, the court held the State Planning Board’s decision was neither against the manifest weight of the evidence, nor arbitrary and capricious. It was not against the manifest weight of the evidence because an opposite conclusion was not clearly evident. The court found sufficient evidence was presented that: the applicant was fit, willing and

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299 See id.
300 See id.
301 See id. at 1118.
302 Cathedral Rock, 720 N.E.2d at 1118.
303 See id. at 1119.
304 See id. at 1121.
305 See id.
306 See id.
307 Cathedral Rock, 720 N.E.2d at 1124.
able to provide a proper standard of health care for the community; the project was economically feasible; the project was in the public interest; and the project was consistent with the orderly and economic development of such facilities and is in accord with the standards promulgated by the State Planning Board. Specifically, the court held failure of the project to meet one or more review criteria did not bar issuance of a CON. The State Planning Board was free to use its expertise to determine what information was relevant.

*Crystal Lake v. Planning Board*, an unpublished Rule 23 opinion, has no precedential value under Illinois law; however, it is instructive in its discussion of General Review Criteria and economic judgments. The case involved the State Planning Board’s denial of Crystal Lake’s request for a permit to build an ambulatory surgical treatment center. The circuit court, on administrative review, reversed the State Planning Board. The appellate court reversed the circuit court and affirmed the State Planning Board.

The SAR had recommended denial and the State Planning Board had agreed, even after more reports and more hearings. The primary reason for denial was Crystal Lake’s failure to show the facility would generally result in a substantial cost savings to patients in the planning area. There also were concerns about the project’s financial viability. The appellate court held that the administrative decision of the State Planning Board merited court deference unless its power had been used in an arbitrary and capricious manner and, finding no evidence of such abuse, upheld the State Planning Board’s decision.

The court discussed general review criteria and economic judgments. It found evidence in the record supporting the State Planning Board’s concern regarding cost savings, specifically, support for

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305 See id.
309 See id.
311 See id. at 1.
312 See id. at 2.
313 See id. at 5.
314 See id. at 7.
315 See id. at 11, 22.
316 See id. at 12-21.
the State Planning Board’s conclusions that Crystal Lake’s proposal would duplicate existing services and cause a negative impact on delivery of low-cost services in the area. Limiting review to the manifest weight of the evidence, the appellate court would not second-guess the State Planning Board.

*Springwood Associates v. Planning Board* is one of those rare cases where the court reverses the State Planning Board by finding the State Planning Board did not follow its own rules and regulations. The State Planning Board had approved First CareAmerica’s application for a CON to add 28 skilled nursing beds to its Collinsville Care Center -- a 122-bed skilled nursing facility in Collinsville. The challenger, Springwood Associates, operated the Elmwood Health Care Center in Maryville. Both were in Madison County.

A public hearing was conducted. Springwood and other competing facilities claimed the additional beds were not needed because of excess beds available in surrounding counties. At the hearing, the State Agency recommended approval on the basis the proposed project was in accord with review criteria established by State Agency regulations. The State Planning Board approved the project.

On administrative review, the circuit court affirmed the State Planning Board, but the appellate court held the State Planning Board’s approval was arbitrary and capricious. The Court found the State Planning Board’s approval was contrary to the State Agency’s duly promulgated regulations. Why? The regulations require “market studies of the area indicating the characteristics of the population to be

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317 See id.
318 See id. at 10.
320 See id.
321 See id. at 1375.
322 See id.
323 See id.
324 Springwood Associates, 646 N.E.2d at 1375.
325 See id. at 1376.
326 See id.
served," and First CareAmerica failed to do that; specifically, First CareAmerica’s application failed to meet the staffing review criterion required by the regulations. Regulations require letters of verification from other health facilities and organizations in the area regarding the supply of manpower, and there was no evidence 20 percent of the area facilities had been cited for staffing deficiencies over the past two years, nor was there any documentation that required staffing levels would be met.

There was some evidence on these matters, but the court held the evidence was not sufficient. The court cited to “the numerous differences between the documentation required by the regulations and that which the State Planning Board requested in its application, and upon which its approval of First CareAmerica’s application was based....” Because of these “differences,” the State Planning Board’s action was arbitrary and capricious.

This appears to be a case where the court abandons the usual standard of review and second-guesses its way to reversal. The court apparently made up its mind that excess beds were available in surrounding counties; therefore, the application did not do as the State Planning Act requires. “The Act establishes a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities."

In Highland Park Convalescent Center v. Planning Board, the State Planning Board denied Highland Park’s application to build a nursing home facility in Lake County. The SAR recommended denial. After the applicant submitted additional information, the State Planning Board denied the application. Highland Park asked for a hearing. At the hearing, the hearing officer recommended approval of the application. Again, the State Planning Board denied it. On administrative review in

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327 See id.
328 See id.
329 Springwood Associates, 646 N.E.2d at 1376.
330 See id. at 1377.
331 See id. at 1375.
333 Id. at 93.
334 See id.
the circuit court, the denial was affirmed. The appellate court affirmed, finding: (1) The State Planning Board is not required to follow the hearing officer’s judgment. It must make its own decision; (2) The State Planning Board’s finding that the proposed facility would be in an area (Lake County) that already had a significant number of nursing homes, still leaving other areas of the county inadequately served, was not against the manifest weight of the evidence. The proposed nursing home would be a “maldistribution” as that term is used in the State Planning Board’s review criteria; and (3) The State Planning Board did not use an unpublished rule to deny the application and therefore did not deny the applicant due process.

In Charter Medical of Cook County v. HCA Health Services, the State Planning Board awarded CONs to three applicants who wanted to build psychiatric hospitals in the same planning area. One of the successful applicants, Charter Medical, claimed the other two should not have received the CONs because they would produce more beds than the projected bed need. The CONs provided for a total of 280 beds. The state bed need for acute mental illness beds in the planning area was 154. At a public hearing, Charter asserted that one of the projects failed to comply with the rule that requires additional or new beds be added to existing hospitals.

The court held that nothing in the rules indicates the State Planning

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335 See id.
336 See id. at 94.
338 Id. at 84.
339 See id. at 85.
340 See id.
341 See id. at 83.
Board is without authority to award more beds than the state need. The State Planning Board has "discretion, judgment, and expertise required for a balanced consideration of all statutory and regulatory criteria." The court stated substantial compliance. The decision was not against the manifest weight of the evidence.

It is interesting to compare this case with *Springwood*. Here, the State Planning Board did not scrupulously follow the rules and regulations, but it came close. That was enough for the reviewing court. Strict compliance was not required.

Conclusions Regarding Court Deference
General conclusions may be drawn from a reading of Illinois cases:

(1) Because the State Planning Board is made up of people who have expertise in the area, its factual findings are given great deference by the courts, yet they are not immune from reversal when a court is persuaded they are against the manifest weight of the evidence or are arbitrary or capricious. At the same time, there is no consistent judicial policy. Some courts hold the State Planning Board strictly to its rules and regulations, while others require only substantial compliance and give the State Planning Board a good measure of discretion.

(2) The courts understand the bottom line is consumer interest. The cost of health care and the ability to get to it easily are prime factors in judicial thinking.

(3) The State Planning Board makes independent judgments, and is not controlled by the Illinois Department of Public Health, SARs, or hearing officers.

(4) The State Planning Board is willing to change its mind when an

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342 *Charter Medical*, 542 N.E.2d at 85.
343 See *id.*
applicant or an opponent offers persuasive additional evidence after a preliminary finding.

(5) The Planning Act and the State Planning Agency’s rules and regulations create a complex, fact-intensive system for reviewing applications. It can be a long and costly process, as reports are studied, experts testify, and lawyers advocate.

PART IV: THE ROLE OF POLITICS

Understanding the great deference granted to the State Planning Board by the Illinois courts and experiencing the State Planning Board’s almost unlimited power to decide the futures of providers and health care planning in Illinois, members of the health community have focused attention on the complex nature of the CON application process. Hospitals and market players have accused the State Planning Board of being politically influenced and inconsistent in applying board rules and suggest the State Planning Board is influenced by lobbyists rather than health care needs.344

Illinois is not the only CON playing field in which CON approval is seen as a political battle. This allegation has long been a criticism leveled in the CON national debate. According to critics, the process of obtaining a CON has become an enterprise in itself “...becom[ing] so lucrative that it attract[s] many politicians and former politicians who successfully [use] their influence to weight the process for those who [employ] their services.”345

The Heart Hospital proposal is an example of the political weight which can be seen in these cases. Loyola University Medical Center, one of the Alliance hospitals, hired former Illinois Republican Governor James Thompson to lobby the State Planning Board, while Edward Hospital hired former Illinois House Republican leader Sam Vinson.346 At least six of the fifteen State Planning Board Members have been on the State Planning Board.

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346Wisniewski, supra note 344, at 3.
Planning Board for a decade or more and Board Chair Pam Taylor has served on the State Planning Board for more than twenty years.\textsuperscript{347} Referring to the long service of State Planning Board members, Illinois State Senator Doris Karpiel stated, "To have members be on the [State Planning Board] so long and be so political and disregard their own rules is really a terrible thing for the state because it means a great deal of money to all of these interests and ultimately to patients."\textsuperscript{345} Additional concerns expressed by legislators include assertions that: the CON process is onerous and burdensome\textsuperscript{349} (requiring applicants to incur substantial legal fees in the preparation of any petition); almost all projects are denied; and the use of expensive consultants is essential to complete an application.\textsuperscript{350}

In response to these legislative inquiries, the State Planning Agency conducted an analysis of calendar year 1997 CON applications in Illinois\textsuperscript{351} and issued a report named The State of Illinois Health Facilities Planning Board Report for Fiscal Year 1998\textsuperscript{352} (Fiscal Report). Rejecting claims of political considerations within a deliberately complex process, the Fiscal Report contends that the State Planning Board's goal is the approval of 100% of CON applications tendered.\textsuperscript{353} According to the Fiscal Report, approximately 88% of all CON applications were approved upon initial consideration and 96% of all applications were eventually approved.\textsuperscript{354}

\textsuperscript{347}Japsen, Proposal Would Limit Terms of Health Board, CHI TRIB., Feb. 22, 2000, (Business Section), at 4.
\textsuperscript{348}\textit{Id.}
\textsuperscript{349}\textit{Id.}
\textsuperscript{350}\textit{id.}
\textsuperscript{352}\textit{Id.}
\textsuperscript{353}\textit{Id.}
\textsuperscript{354}\textit{Id.}
\textsuperscript{355}\textit{1998 Fiscal Report, supra note 349, at 5.}
TABLE A: Summary of Planning Board Actions on Permit Applications - FY 92-98

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<th>Fiscal Year</th>
<th>Applications Processed</th>
<th>Applications Approved</th>
<th>Amount Proposed</th>
<th>Amount Approved</th>
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<td>95</td>
<td>190</td>
<td>157</td>
<td>1,600,581,731</td>
<td>1,312,336,807</td>
<td>18%</td>
</tr>
<tr>
<td>96</td>
<td>110</td>
<td>74</td>
<td>593,283,137</td>
<td>524,803,694</td>
<td>12%</td>
</tr>
<tr>
<td>97</td>
<td>103</td>
<td>88</td>
<td>482,889,041</td>
<td>425,306,004</td>
<td>12%</td>
</tr>
<tr>
<td>98</td>
<td>147</td>
<td>129</td>
<td>1,022,832,533</td>
<td>757,911,815</td>
<td>26%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>1,054</td>
<td>885</td>
<td>$6,423,312,144</td>
<td>$5,394,594,149</td>
<td>16%</td>
</tr>
</tbody>
</table>

Addressing criticism regarding the cost of applications and outside experts, the Fiscal Report found outcomes for CON applicants "were virtually identical" for applications that were prepared by health facility in-house counsel and those prepared by outside consultants. Additionally, "there was no indication" that the 74% of projects which used consulting services received more favorable consideration than projects which did not use consultants. Notably, "[o]f applications receiving an intent to deny, 25% did not use consultants while 75% did use consultants."

Arguing on behalf of the effectiveness of the Illinois CON program, the Fiscal Report notes "the State Planning Board has disallowed nearly $1 billion in proposed capital expenditures since [fiscal year 1992]," saving billions of dollars (current and future dollars) on behalf of the

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355 See id.
356 See id.
357 See id.
358 See id.
Comparing Illinois to states where CON laws have been repealed, the Fiscal Report indicates that “states which have abolished CON programs experienced substantial development or expansion of facilities and services with no assurance or evidence that cost containment, quality of care, and access to services has been maintained.”

Despite the efforts of the State Planning Agency, the controversy regarding the role and power of State Planning Board members led to legislative action. Illinois Senate Bill 807 is an example of many bills which were introduced in the Illinois General Assembly in recent years which sought to amend the State Planning Act, thereby decreasing the power of the State Planning Board. Where other bills failed, however, Senate Bill 807 succeeded. The Bill, as introduced by Sen. Karpiel on February 24, 1999, was designed to limit the number of terms State Planning Board members may serve, and to limit State Planning Board review to projects of $2.7 million or more. In February 2000, Senate Bill 807 was amended by the Senate Executive Committee. One amendment limited State Planning Board review to clinical projects only, thus eliminating the requirement of State Planning Board approval for non-clinical developments, such as hospital parking lots. Another amendment raised the threshold of State Planning Board approval to projects estimated to cost $7 million or more, far more than the original bill adjustment of $2.7 million. A third amendment clarified the status of State Planning Board members as governmental officials accountable to the public under ethics regulations, including the Open Meetings Act (requiring, with exceptions, public notice and public access to all meetings at which official business is discussed) and the State Gift Ban Act (restricting contributions and gifts to public officials). Most importantly,

360 See id.
362 Wisniewski, supra note 344, at 3.
364 Id.
365 Id.
366 5 ILL. COMP. STAT. 120/1, et seq. (2000).
367 5 ILL. COMP. STAT. 425/1, et seq. (2000).
Senate Bill 807 included a sunset provision to eliminate the State Planning Board completely by July 1, 2003 unless additional legislative action is taken before that date. Thomas Schafer, a spokesman for the Illinois Department of Public Health, which opposed the bill, stated: “We believe [the State Planning Board] [provides] oversight to the health care industry and helps control costs.” State Planning Board Member William Marovitz spoke on behalf of the necessity of a regulatory agency. “I think health care costs will escalate. People are going to rue the day. The power of hospitals is getting out of hand.”

Legislators did not find these statements persuasive. On February 25, 2000, Senate Bill 807 passed the Illinois Senate and was sent to the Illinois House of Representatives for consideration where it was passed with amendment by the House and returned to the Senate for concurrence. The Senate concurred in the House amendments and passed Bill 807 on April 12, 2000. Bill 807 was signed by Illinois Governor George Ryan on June 9, 2000. In anticipation of legislative review of the sunset provision and the continuing controversy regarding state regulation of health facility planning, the CON debate rages on.

CONCLUSION: THE FUTURE OF CONS

An analysis of CON theory and practices clearly shows that important public health decisions are being made by an entrenched group of men and women, virtually unknown and accountable to no one. The necessity of state health facility planning is being questioned nationally. Regardless of its eventual outcome, the Heart Hospital battle in Illinois demonstrates a need for change.

First, states which have CON laws must immediately conduct studies analyzing the premise that CON laws control rising health costs, prevent unnecessary duplication of services, and allocate beds and services

368 Wisniewski, supra note 344, at 3.
369 See id.
370 Bruce Japson and Christi Parsons, Curbs Gain on Health Planning Board, CHI. TRIB., Apr. 13, 2000, (Business Section), at 1, 3.
372 Id.
373 Id.
374 Id.
equitably. Hard data must replace general public policy theory and anecdotal evidence. Only current and thorough data can respond to the argument that the historical basis for CONs no longer exists in the new world of managed care and cost consciousness.

Second, if CON procedures continue, these procedures must be limited in scope to health facility actions of some relevance and significant cost. Ordinary, non-clinical modifications such as expansion of health facility parking lots and renovation of hospital cafeterias should be outside the control of state regulation, regardless of cost. Additionally, the CON process must be limited to actions of some financial magnitude, taking into account today's health care economy, with thresholds or minimums adjusted yearly according to inflation.

Third, CON procedures must be streamlined and clarified to make the process more open and fair. A governmental administrative procedure which is so complicated that it requires an expertise exercised by only a few legal specialists in a state cannot hope to survive allegations of cronyism and unfairness.

Finally, the political process of representation and lobbying must be limited in order to avoid the appearance of impropriety. Whether real or imagined, the appearance of secret deals, hidden agendas, and undue influence corrupts public confidence in the governmental system. Once a state agency loses the confidence of the public and, particularly, the health care entities it seeks to regulate, it cannot serve the public interest.