Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*

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"Each certificate of need proceeding is an exercise in the inherently inexact science of determining how society's scarce health care resources might best be allocated."[1]

I. Introduction

Certificate of need (CON) programs are federally-funded, state-administered regulatory mechanisms providing for review and approval by health planning agencies of capital expenditures and service capacity expansion by hospitals and other health care facilities. Their primary purpose is to discourage unnecessary investment in health care facilities and to channel investment into socially desirable uses. At the beginning of 1986, forty-two states and the District of Columbia had statutes authorizing such programs, and four of the eight states without certificate of need statutes operated similar programs authorized under the Social Security Act.[2] A majority of states have administered such programs for over a decade.

State certificate of need programs generally operate in the following manner. A health care facility covered by the program must submit a permit application to an official state health planning agency before undertaking those capital expenditures and other projects subject to review. The average proposed expenditure is $1.7 million, and states review an average of 127 applications each year.[3] The state agency transfers the application for initial review to a local health planning organization, comprised of consumers and medical care providers in the

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[1]Kansas Dep't of Health & Env't v. Banks, 230 Kan. 169, 170-71, 630 P.2d 1131, 1133 (1981).

[2]State laws relating to health planning and certificate of need are frequently amended. Except as otherwise indicated, the information on state certificate of need programs presented in this article is current as of January 1, 1986.

[3]Office of Health Planning, U.S. Dep't of Health & Human Services, Status Report on State Certificate of Need Programs 9-10 (1985).

community to be served by the proposed project. Review criteria include consideration of community need, financial feasibility, expected quality of care, less costly alternatives, and accessibility of the project to underserved and indigent populations. The local organization conducts a public meeting at which interested persons may comment on the proposal. It then conveys its recommendation to approve or deny the project to the state health planning agency. The state agency conducts an administrative adjudicatory hearing on the application and renders a formal decision as to the need for the project. Administrative and judicial appeals may follow, and often do when multiple applicants compete to serve an identified community need. The ultimately successful applicant is awarded a "certificate of need" entitling it to proceed with its project.

A. Federal Involvement

Over the years, federal control over state health planning and certificates of need has waxed and waned. In the late 1960's, the federal government financed voluntary, non-regulatory health service planning programs at the local community and state levels. In 1972, Congress adopted section 1122 of the Social Security Act, providing for review, by states choosing to participate, of proposed capital expenditures by health care facilities reimbursed under Medicare and Medicaid.[4] Most states have participated in section 1122 at some time.[5] In 1975, Congress passed the National Health Planning and Resources Development Act of 1974[6] (NHPRDA or Act). The Act provided substantial funding for state and local health planning activities and effectively required states to adopt certificate of need laws conforming to federal standards.

After the passage of NHPRDA, states without certificate of need began to adopt statutes complying with the Act. States with pre-existing statutes took steps to comply with the federal requirements, which mandated a certificate of need program of extremely broad regulatory scope, subjecting a wide range of health care facilities and projects to a complex review and approval process. In a few years most states had programs resembling the federal model.[7]

With the advent of the Reagan administration in 1980, federal support for certificate of need fell on hard times. The administration entered office with an anti-regulatory platform and a strong interest in using

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[4]Social Security Amendments of 1972, § 221(a), 86 Stat. 1386 (codified as amended at 42 U.S.C. § 1320a-1 (1982 & Supp. I 1983)).

[5]*See infra* note 73 and accompanying text.

[6]Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified as amended at 42 U.S.C. §§ 300k-300n-6 (1982)).

[7]*See* Cohodes, *The State Experience with Capital Management and Capital Expenditure Review Programs*, in BUREAU OF HEALTH FACILITIES, U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CAPITAL ISSUES 87-88 (DHHS Pub. No. (HRA) 81-14531 (1980)).

market incentives rather than regulatory controls to restrain the rising costs of health programs. It proposed to delete funding under NHPRDA, and although Congress did not fully concur, funding for health planning dropped sharply.[8] At the same time, however, the prescriptive terms under which the federal government awarded monies to states for certificate of need programs were greatly relaxed.[9]

Consequently, state certificate of need programs have begun to diverge from the federal model and from each other. Some states have entirely repealed their certificate of need laws.[10] Others have increased the scope and forcefulness of their regulatory controls.[11] The vast majority of states have modified their programs in recent years by streamlining the review process and narrowing the range of health care facilities and projects subject to review. In doing so, they appear to have shifted the goals of their certificate of need programs from systematic management of all institutional health care delivery to several more narrowly conceived purposes.

This Article describes changes in state certificate of need programs from their origins to the present. It concentrates on the types of health care facilities and categories of projects that have been subject to certificate of need review, because scope of coverage is the aspect of certificate of need that has changed the most over the years in response to changing state and federal regulatory policies.

A number of recent studies have considered procedural aspects of state certificate of need programs.[12] Several have attempted to evaluate the impact of such programs on health care expenditures.[13] Evaluations

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[8]In fiscal year 1982, annual NHPRDA funding was reduced by one half to $64.4 million. H.R. Rep. No. 218, 98th Cong., 1st Sess. 10 (1983). It has remained at that level ever since.

[9]*See infra* note 166 and accompanying text.

[10]*See infra* Table 1 and text accompanying note 192.

[11]*See infra* Table 2; noets 194-245 and accompanying text.

[12]Brown, *Common Sense Meets Implementation: Certificate of Need Regulation in the States*, 8 J. Health Pol. Pol'y & L. 480 (1983); Cohodes, *supra* note 7, at 68; Consedine, Jekel, & Dunaye, *Certificate of Need and the Pitfalls of Due Process*, 17 Inquiry 348 (1980); Nutt & Hurley, *Factors That Influence Capital Expenditure Review Decisions*, 18 Inquiry 151 (1981); *see, e.g.*, Colby & Begley, *The Effects of Implementation Problems on Certificate of Need Decisions in Illinois*, 3 Health Pol'y Educ. 303 (1983).

[13]*E.g.*, Ashby, *The Impact of Hospital Regulatory Programs on Per Capita Costs, Utilization, and Capital Investment*, 21 Inquiry 45 (1984); Howell, *Evaluating the Impact of Certificate of Need Regulation Using Measures of Ultimate Outcome: Some Cautions from Experience in Massachusetts*, 19 Health Services Reg. 587 (1984); Joskow, *The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital*, 11 Bell J. Econ. 421 (1980); Sloan, *Rate Regulation as a Strategy for Hospital Cost Control: Evidence for the Last Decade*, 61 Milbank Mem. Fund Q. 195 (1983); Sloan & Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 J. Law & Econ. 81 (1980). A survey and critique of other, unpublished studies may be found in Congressional Budget Office, Health Planning: Issues for Reauthorization 19-30, 57-64 (1982).

of the regulatory "toughness" of state certificate of need programs and variations in performance have also been undertaken.[14] However, there have been no recent reports examining in detail project coverage under certificate of need programs.[15]

II. Purposes of Certificate of Need

States undertake certificate of need programs to achieve various goals, which may differ from state to state and from one type of covered project to another. The major premise underlying certificate of need is that the market for institutional health services contains incentives to excess capital investment for which certificate of need programs are intended to compensate by limiting entry to facilities and services found to be medically necessary and affordable.[16] Every state certificate of need

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[14]*E.g.*, Policy Analysis, Inc. and Urban Systems Research & Engineering, Inc., Evaluation of the Effects of Certificate of Need Programs - A Report on Twelve State C/N Programs (1981) (Report prepared for Health Resources Administration, U.S. Dep't of Health & Human Services under Contract No. 231-77-0114); Begley, Schoeman & Traxler, *Factors That May Explain Interstate Differences in Certificate-of-Need Decisions*, 1982 Health Care Fin. Rev. 87.

[15]Surveys comparing certificate of need expenditure thresholds are distributed from time to time. *E.g.*, Division of Regulatory Activities, Office of Health Planning, U.S. Dep't of Health & Human Services, Status Report on State Certificate of Need Programs (1985), distributed in Office of Health Planning, U.S. Dep't of Health & Human Services, Program Information Letter 85-34 (1985) (expenditure thresholds as of July, 1984); Congressional Budget Office, Health Planning: Issues for Reauthorization (1982) (expenditure thresholds as of March, 1982). However, published reports identifying health care facilities and types of projects subject to certificate of need review date back several years. *See* Chayet & Sonnenreich, P.C., Certificate of Need: An Expanding Regulatory Concept 5 (1978) (survey of certificate of need and section 1122 coverage through approximately January, 1978); Cohodes, *supra* note 7 (survey of certificate of need coverage as of October, 1978); Curran, *A National Survey and Analysis of State Certificate-of-Need Laws for Health Facilities*, in Regulating Health Facilities Construction 88-89 (1974) (CON coverage as of the end of 1972 state legislative sessions); Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 Va. L. Rev. 1143 (1973) (CON coverage as of 1973).

[16]Proponents of certificate of need programs cite several reasons for market failure in institutional health care. *See, e.g.*, 42 U.S.C. § 300k-2 (1982) (market failure rationale for implementation of NHPRDA certificate of need function). First, such care is covered by private insurance or governmental benefit programs for most consumers, making them indifferent to the choice between treatments of differing costs and equal benefit, and in favor of all treatments with any marginal benefit, regardless of cost. Second, federal and state tax subsidies encourage individual consumers and employees, when bargaining collectively, to purchase more health insurance than they otherwise would, exacerbating the "moral hazard" of insurance coverage. Third, the prevailing methods by which insurers and government benefit programs pay for institutional health services discourage attention to costs and price competition by providers. Fourth, medical care delivery is organized in a manner that tends to allocate and expend resources without regard to cost. Hospitals, in particular, are organized so that a physician, acting as an insured patient's agent and

program implicitly incorporates this idea by providing for issuance of certificates on the basis of community "need." Some also contain express findings of market failure or of excess capacity in the health sector.[17]

The second major rationale for certificate of need is to protect public health by preserving and improving the quality of institutional health care. Many state certificate of need statutes include the preservation of quality of care as an express justification for their adoption.[18] In addition, quality of care considerations appear in many states' certificate of need review criteria as factors to be taken into account in approving or denying applications. For example, eight state certificate of need statutes expressly identify quality of care in existing facilities (either those of the applicant or other health care providers) as a review criterion.[19] Six certificate of need statutes explicitly require consideration of the expected

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lacking an independent incentive to limit volume or costliness of care, decides what services the patient receives. Fifth, there has traditionally been little competition among health insurance companies of the sort that would lead them to bargain with institutional health care providers over price and volume controls.

The foregoing characteristics cause institutional health care to exhibit excess demand for and consumption of medical technologies, high rates of introduction of new technologies and low rates of introduction of cost-reducing innovations, duplication of facilities and services with consequent unused capacity and failure to exploit economies of scale, and general organizational slack and inefficiency. Certificate of need programs are intended to prevent facility duplication and excessive rates of introduction of new technologies and services. They are not targeted at the underlying causes of market failure, nor are they designed to affect directly the demand for existing services or to improve efficiency and reduce operating costs in health care facilities. *See generally* P. JOSKOW, CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATION 56-88 (1981).

[17]*E.g.*, COLO. REV. STAT. § 25-3-502 (1982); FLA. STAT. ANN. § 381.493(2) (Supp. 1985); ILL. ANN. STAT. ch. 111-1/2 ¶ 1152 (Smith-Hurd Supp. 1985); KY. REV. STAT. § 216B.010 (Supp. 1982); NEB. REV. STAT. § 71-5802 (Supp. 1984); N.H. REV. STAT. ANN. § 151-c:1 (Supp. 1983); N.C. GEN. STAT. § 131E-175 (Supp. 1983); OR. REV. STAT. § 442.025(2) (Supp. 1983); PA. CONS. STAT. ANN. § 448.102 (Purdon Supp. 1985); S.D. CODIFIED LAWS ANN. § 34-7A-22 (Supp. 1985); VT. STAT. ANN. tit. 18, § 2400 (1983); WASH. REV. CODE ANN. § 70-38-015 (Supp. 1986); W. VA. CODE §§ 16-2D-5(c), (d) (1985).

[18]*See, e.g.*, COLO. REV. STAT. § 25-3-502(4)(a) (1982); 1977 Hawaii Sess. Laws Ch. 178, § 1 (1977); KY. REV. STAT. § 216B.010 (Supp. 1982); MD. HEALTH-GENERAL CODE ANN. § 19-102(a) (Supp. 1985); NEB. REV. STAT. § 71-5802 (Supp. 1984); N.H. REV. STAT. ANN. § 151-c:1 (Supp. 1983); N.J. STAT. ANN. § 26:2H-1 (West Supp. 1985); N.Y. PUB. HEALTH LAW § 2800 (McKinney 1985); N.C. GEN. STAT. § 131E-175 (Supp. 1983); OR. REV. STAT. § 442.025(1) (Supp. 1983); 35 PA. CONS. STAT. ANN. § 448.102 (Purdon Supp. 1985); VT. STAT. ANN. tit. 18, § 2400 (1983).

[19]ALASKA STAT. § 18.07.041 (Supp. 1984); D.C. CODE ANN. § 32-304(a) (1981) (incorporating by reference 42 C.F.R. § 123.412(a)(18) (1985)); FLA. STAT. ANN. § 381.494(6)(c)(2) (Supp. 1985); MONT. CODE ANN. § 50-5-304(d) (1985), § 50-5-304(h) (1985) (incorporating by reference 42 C.F.R. § 123.412(a)(18) (1985)); S.D. CODIFIED LAWS ANN. § 34-7A-38(12) (Supp. 1984); WASH. REV. CODE ANN. § 70-38-115(2)(j) (Supp. 1985); W. VA. CODE § 16-2D-6(a)(22) (1985); WIS. STAT. ANN. § 150.39(10) (West Supp. 1985) (nursing homes).

quality of care in proposed facilities and services.[20] Most other states include quality of care considerations in their certificate of need regulations, often by incorporation of NHPRDA past quality standards.[21]

The quality protective function of certificate of need may be merged with its cost containment role. A number of epidemiological studies have demonstrated an association between volume of services provided in health facilities and reduced mortality rates, suggesting that as well as controlling costs, preventing excess, underutilized capacity improves quality of care.[22] The optimum service size standards found in certificate of need review criteria are based on these quality considerations.[23]

Third, certificate of need programs may be used to achieve a uniform geographic distribution of health services[24] or an equitable distribution

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[20]ARK. STAT. ANN. § 82-2311(d) (Supp. 1985); FLA. STAT. ANN. § 381.494(6)(c)(3) (Supp. 1985); GA. CODE ANN. § 31-6-42(a)(13) (1985); KY. REV. STAT. § 216B.040(2)(a)(2)(e) (Supp. 1982); ME. REV. STAT. ANN. tit. 22, § 309(1)(A) (Supp. 1985); R.I. GEN. LAWS § 23-15-4(d)(7) (1985).

[21]*See* 42 U.S.C. § 300n-1(c)(14) (1982); 42 C.F.R. § 123.412(a)(18) (1985).

[22]*See, e.g.*, Flood, Scott & Ewy, *Does Practice Make Perfect? Part I: The Relation Between Hospital Volume and Outcomes for Selected Diagnostic Categories*, 22 MED. CARE 98 (1984); Flood, Scott & Ewy, *Does Practice Make Perfect? Part II: The Relation Between Volume and Outcomes and Other Hospital Characteristics*, 22 MED. CARE 115 (1984); Luft, *The Relations Between Surgical Volume and Mortality: An Exploration of Causal Factors and Alternative Models*, 18 MED. CARE 940 (1980); Luft, Bunker & Enthoven, *Should Operations Be Regionalized: The Empirical Relation Between Surgical Volume and Mortality*, 301 NEW ENG. J. MED. 1364 (1970). It is postulated that increased volume is associated with diminished mortality rates because of a "learning curve" effect. Flood, Scott & Ewy, *supra*, at 123.

[23]*E.g.*, OR. ADMIN. R. 409-03-010(13)(b) (1985) (quality of care of proposed projects measured by sufficiency of expected volume to maintain staff skills); *see also* Humana, Inc. v. Department of Health & Rehabilitative Servs., 469 So. 2d 889 (Fla. Dist. Ct. App. 1985) (quality concerns justified criterion basing need for new facilities on full utilization of existing facilities); National Guidelines for Health Planning (a set of national "need" standards required to be considered by all state and local health planning agencies) regarding neonatal special care units, open heart surgery, cardiac catheterization, and radiation therapy, 42 C.F.R. §§ 121.204, .205, .207, .209 (1985). Each specifies a minimum volume of services identified by medical authorities as necessary to maintain quality of care.

[24]Standards for acceptable patient travel time to health facilities and acceptable risks of queuing at the facility are incorporated into states' criteria for identifying community need for new projects. *E.g.*, ALA. CODE § 22-21-264(4)(f) (1984) (certificate of need criterion of "evidence of the locational appropriateness of the proposed facility or service such as transportation accessibility . . ."); IOWA CODE ANN. § 135.64(1)(8) (West Supp. 1985); MONT. CODE ANN. § 50-5-304(1)(m) (1985) (CON criteria of distance, convenience, cost of transportation, and accessibility of health services for persons living outside urban areas); VA. CODE § 32.1-102.3(B)(6) (1985) (certificate of need criteria of topography and highway facilities in area proposed to be served); *see also* 42 C.F.R. § 121.201(b) (1985) (National Guidelines for Health Planning recommended 30 minute travel time to the nearest hospital for general acute care).

of health services among social and economic groups.[25] In such cases,

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[25]The foremost example is the use of certificate of need programs to encourage and protect health care facilities that internally subsidize socially desirable but unprofitable lines of business. For reasons of legal obligation or conscience, facilities may offer emergency or routine services to persons unable to pay, or accept Medicaid or other public program beneficiaries for whom reimbursement is less than cost or less generous than private payer reimbursement. Presumably, such facilities price other services or charge other payers above cost to recover their losses. When they do, it creates an opportunity for other facilities not so charitably inclined to undercut their prices and capture the paying market. Certificate of need programs can protect charitable subsidizers from cream skimmers by denying cream skimmers entry into the marketplace. *See, e.g.*, Collier Medical Center v. Department of Health and Rehabilitative Servs., 462 So. 2d 83 (Fla. Dist. Ct. App. 1985) (new hospital's certificate of need application denied to protect existing hospitals with high indigent patient loads from loss of paying patients, needed to subsidize indigent care, to new hospital). NHPRDA requires state programs to use several criteria designed to achieve this effect by expressing a preference for health care facilities that serve low-income and other "medically underserved" patients. 42 C.F.R. § 123.412(a)(6) (1985). *See also* 42 C.F.R. §§ 123.412(a)(5); 123.413 (1985). Numerous state certificate of need statutes also have medically-underserved access criteria. *E.g.*, CAL. HEALTH & SAFETY CODE §§ 437.11(b)(4)(c), 437.116 (Deering Supp. 1985) (certificate of need exemptions for facilities participating in Medicaid or providing certain volume of free care); D.C. CODE ANN. § 32-305(a)(2) (Supp. 1984) (certificate of need requirement that facilities provide a reasonable volume of uncompensated care); FLA. STAT. ANN. § 381.494(6)(c)(8) (Supp. 1985); GA. CODE ANN. § 31-6-42(a)(7), (c) (1985) (waiver of strict adherence to certificate of need criteria for minority administered hospital facilities serving socially and economically disadvantaged urban populations); MICH. COMP. LAWS ANN. § 333.22131(1)(j), (e) (Supp. 1985) (certificate of need criteria of access to residents and physicians, nondiscrimination in employment, patient admission or care, room assignment, training programs, and medical staff membership); NEB. REV. STAT. § 71-5853(1), (3) (Supp. 1985); 1985 N.H. Laws ch. 378, § 6 (to be codified at N.H. REV. STAT. ANN. § 51-C:7(III)) (certificate of need criterion of degree to which proposed facility is accessible to medically underserviced, including handicapped and indigent); N.C. GEN. STAT. § 131E-183(3), (3a), (13) (Supp. 1983); N.D. CENT. CODE § 23-17.2-05 (Supp. 1983) (incorporating by reference NHPRDA access review criteria); OKLA. STAT. ANN. tit. 63, § 2652.1(B)(3)(e), (6) (West 1984); PA. CONS. STAT. ANN. § 448.707(a)(9), (19) (Purdon Supp. 1985); VA. CODE § 32.1-102.3(B)(5) (1985); WASH. REV. CODE ANN. §§ 70.38.115(2)(e), (k) (Supp. 1986) (certificate of need criterion of hospital meeting or exceeding regional average level of charity care); W. VA. CODE § 16-2D-6(a)(4), (14), (18), (25) (1979); Executive Budget Bill, Act 29, 1985 Wis. Legis. Serv. 391 (West) (to be codified at WIS. STAT. § 150.69(13) (certificate of need requirement of acceptable plan for provision of health care to indigent); *see also* IDAHO ADMIN. CODE § 02.11400.01(a)(v) (1983) (Idaho section 1122 regulations); N.J. ADMIN. CODE tit. 8, § 33-2.1(a), (b) (1985) (prohibition on issuance of certificate of need to any facility that fails to provide or contractually commit itself to provide services to medically underserved populations residing or working in its service area as adjusted for indications of need). For court decisions upholding certificate of need decisions based on the performance in assuring access to medical care to the indigent or medically underserved, see *Collier*, 462 So. 2d 83 (Fla. Dist. Ct. App. 1985); Doctors Hosp. of Prince George's County v. Maryland Health Res. Plan Comm'n, 501 A.2d 1324 (Md. Spec. App. 1986) (hospital's record of lower Medicaid and indigent patient load than other area hospitals supported denial of its certificate of need application); Chambery v. Axelrod, 101 A.D.2d 610, 474 N.Y.S.2d 865 (1984) (certificate of need preference for facilities participating in

certificate of need regulation finds its justification not in market failure, but in compensation for undesirable consequences of market functioning.

Fourth, states may adopt certificate of need programs to limit public outlays for benefit programs, primarily Medicaid, or as adjuncts to state programs regulating health facility operating expenses.[26] For example, states have used certificate of need to control or to limit the supply of nursing home beds in order to limit Medicaid outlays for nursing home care.[27]

Fifth, certificate of need laws may be adopted to assure public participation in decision-making respecting major health facility projects and, by extension, in the overall configuration of institutional health care delivery. For example, the Maryland health planning statute provides that "The citizens of this State have a fundamental interest in planning the development of quality health services . . . ."[28] It establishes local health planning agencies and a consumer-dominated state health planning commission, and gives the local agencies and the general public roles in certificate of need review.[29] NHPRDA's provisions for local health planning agencies evince similar purposes.[30]

Medicaid upheld). The ultimate effect of employing certificate of need in this fashion is to tax indirectly the private paying patients of charitable health care facilities and to shield public budgets from the full costs of socially desirable services.

[26]*See* Mahler, *Barriers to Coordinating Health Services Regulatory Programs*, 6 J. HEALTH POL. POL'Y & L. 528 (1981).

[27]ME. REV. STAT. ANN. tit. 22, § 307(6-A) (Supp. 1985) (comparative review of new nursing home bed addition projects based on availability of legislative appropriations); MICH. COMP. LAWS ANN. § 333.22131(2)(f) (Supp. 1985) (certificate of need criterion, for nursing home bed addition, of consideration of Medicaid agency plans); MONT. CODE ANN. § 50-5-430(2) (1985) (authority to condition nursing home bed additions on availability of Medicaid funding); 1985 N.H. Laws Ch. 378, § 378:6 (to be codified at N.H. REV. STAT. ANN. § 151-C:5(II)(b)) (coverage of all health facility transfers of ownership except those subject to federal restrictions on asset revaluation for Medicare/Medicaid reimbursement purposes); PA. CONS. STAT. ANN. § 448.707(c)(7) (Purdon Supp. 1985) (nursing home bed addition criterion of consistency with Medicaid agency plans); VT. STAT. ANN. tit. 18, § 2406(a)(4) (Supp. 1985) (certificate of need criterion for nursing home bed addition of consideration of Medicaid agency plans); WIS. STAT. ANN. § 150.39 (West Supp. 1985) (nursing home project criteria of sufficient Medicaid funds appropriated to reimburse for care to be provided, and statutory ceiling on approveable nursing home beds to enable the state to accurately establish Medicaid budget); 1985 Wisc. Legis. Serv. Act 29, § 1975 (West) (to be codified at WIS. STAT. ANN. § 150.31). *See generally* Feder & Scanlan, *Regulating The Bed Supply in Nursing Homes*, 58 MILBANK MEM. FUND Q. 54 (1980).

[28]MD. HEALTH-GENERAL CODE ANN. § 19-102(a)(2) (Supp. 1985).

[29]*Id.* at (b)(5), 19-114, 19-118.

[30]42 U.S.C. §§ 300*l*-1,2, 300n-1 (1982) (establishment of consumer-dominated "health systems agencies" with formal role in certificate of need review); *see also* DEL. CODE ANN. tit. 16, § 9301 (1984); FLA. STAT. ANN. § 381.493(2) (Supp. 1985); 1975 Hawaii Sess. Laws ch. 178, Sec. 1; MICH. COMP. LAWS ANN. § 333.22131(1)(m) (Supp. 1985) (certificate of need criterion of non-profit health facility governance by body composed of a majority consumer membership broadly representative of the population served);

Until recently, another purpose for certificate of need in a few states was to avoid financial penalties threatened by the federal government if the state failed to adopt a certificate of need statute. From 1975 through 1982, NHPRDA required states to adopt certificate of need laws complying with its model provisions in order to receive funding under the Act and to avoid severe financial penalties.[31] Several certificate of need laws passed after 1975 cite NHPRDA compliance and avoidance of financial penalties as a reason for their adoption.[32]

III. Certificate of Need Before NHPRDA

A. Early Federal Support for Health Planning

Federal support for non-regulatory governmental planning of hospital and other health facility services began with the Hospital Survey and Construction Act of 1946, popularly known as the Hill-Burton Act.[33] During its three decades of operation, the Hill-Burton Act provided grants in participating states for construction and modernization of hospital and other health care facilities. A state Hill-Burton agency was required to prepare a medical facilities plan setting forth the number of facilities of various kinds in the state, the relative need for new facilities, and their appropriate distribution. In turn, construction grant applicants had to conform to the plan and were required to secure the approval of the Hill-Burton agency. When first enacted, Hill-Burton provided grants only to hospitals and public health centers.[34] The list of eligible facilities expanded over the years to include, at one time or another, nursing homes, rehabilitation facilities, chronic disease hospitals, diagnostic or treatment centers,[35] outpatient facilities, hospital-related

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Wash. Rev. Code Ann. § 70.38.015(1) (Supp. 1986) (state policy to encourage consumer and provider involvement in health planning);W. Va. Code § 16-2D-6(a)(26) (1985) (certificate of need criterion of existence of a mechanism for soliciting consumer input into the health care facilities decision-making process).

[31] *See infra* note 81 and accompanying text.

[32] 1975 Hawaii Sess. Laws ch. 178, Sec. 1 (purpose of certificate of need legislation is to conform to NHPRDA requirement); N.C. Gen. Stat. § 131E-175(5) (Supp. 1983) (legislative finding that failure to adopt certificate of need law would cause state to lose in excess of $55 million in federal funds); Tex. Rev. Civ. Stat. Ann. art. 4418h, § 1.01 (1976) (repealed 1985) (purpose of certificate of need statute is to meet requirements of NHPRDA). *Cf.* Colo. Rev. Stat. § 25-3-502(6) (1982) (legislative finding that certificate of need provisions differ from federal requirements, but advance state's own goals of quality assurance, access, and cost-effectiveness).

[33] Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. § 291-2910-1 (1982)).

[34] Pub. L. No. 79-725 § 2, 60 Stat. 1040 (1946).

[35] Pub. L. No. 83-482, 68 Stat. 461 (1954).

extended care facilities and home health services, equipment acquisitions, and emergency rooms.[36] In later years, authority for grants to voluntary local health planning agencies to assist in the process of planning for community needs was incorporated into Hill-Burton.[37]

In 1966, Congress authorized new funding for state and local public or non-profit planning agencies to perform "comprehensive health planning," an activity with broader implications than disbursement of construction funds.[38] The state agencies identified public and private facilities, services, and personnel required both to meet the health needs of the state's population and to encourage cooperative efforts among health, education, welfare, and rehabilitation providers and agencies. Local agencies developed comprehensive regional or metropolitan plans for coordination of existing and projected services. In 1967, the comprehensive health planning laws were amended to require the state comprehensive health planning agency to assist health care facilities in developing individual programs for capital expenditures consistent with an overall state plan, and to provide for periodic state review of the facilities' capital expenditure programs.[39] The comprehensive health planning agencies were expected to provide consultation, not to control or regulate facility expenditures.[40] Nevertheless, the amendment clearly authorized, through the health planning process, official oversight of health facility expenditures and projects not financed with Hill-Burton or other federal funds. In this sense, this change was the progenitor of federal requirements for health planning regulation through certificate of need.

Regulations implementing the 1967 amendments listed the health care facilities whose capital expenditures were subject to review to include:

> All hospitals, sanitariums, nursing homes, and other facilities for the inpatient care of the sick, injured, or disabled, which are licensed or formally approved for such purposes by an officially designated state standards-setting authority, and all public or private non-profit clinics, health centers, and other facilities a major purpose of which is to provide diagnostic,

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[36]Pub. L. No. 91-296, 84 Stat. 336 (1970).

[37]Pub. L. No. 88-443, § 2, 78 Stat. 447 (1964).

[38]Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, 80 Stat. 1180 (codified as amended at 42 U.S.C. § 246 (1982)).

[39]Partnership for Health Amendments of 1967, Pub. L. No. 90-174, 81 Stat. 533.

[40]*See* S. REP. No. 724, 90th Cong., 1st Sess., *reprinted in* 1967 U.S. CODE CONG. & ADMIN. NEWS 2076, 2078 ("This new requirement is intended to provide for assistance in the planning activities of health-care facilities, but is not intended to serve as a vehicle for control of the capital expenditure plans of any institution. The paragraph is designed to aid health care facilities in providing for more orderly planning so as to aid them in eliminating duplications and overlaps between the services they provide and the services provided by other facilities serving the same general area.").

> preventive, or therapeutic outpatient health care by or under the supervision of doctors of medicine, osteopathy, or dentistry; provided, that such term shall not include facilities operated by religious groups relying solely on spiritual means through prayer and healing and in which health care by or under the supervision of doctors of medicine, osteopathy, and dentistry is not provided.[41]

The regulations also provided that the expenditures subject to review would include all capital expenditures of any amount for "replacement, modernization, or expansion."[42]

These provisions drew virtually every type of institutional health care provider and expenditure within the purview of comprehensive health planning. Their inclusivity arose out of comprehensive health planning's origin in Hill-Burton planning (the scope of which naturally encompassed all the facilities and services Hill-Burton would fund) and out of a desire on the part of the federal government and the health planning community to oversee every aspect of health service delivery.[43] This viewpoint was, in turn, an outgrowth of the widely-held expectation among health policymakers at the time that prevailing economic and social forces would lead to centralized control of health services delivery in the United States along the lines of the national health services or universal health insurance systems of western European countries.[44] If such developments were inevitable, comprehensive health planning with very broad jurisdiction and built-in input from local communities seemed to be a logical prelude to their implementation in an American setting.[45]

Notably absent from these early federal ventures into health planning is any evidence of concern with distortions in the health care marketplace that might lead to excess capacity. The Hill-Burton program was intended to solve the opposite problem—insufficent private investment in health facilities. The comprehensive health planning legislation speaks of encouraging efficiency and economy through planning, but in the sense of rational resource management rather than of compensation for market defects.[46]

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[41] 42 C.F.R. § 51.4(i) (1969) (repealed 1976).

[42] *Id.*

[43] Applicable regulations defined the scope of comprehensive health planning to encompass the "health services, facilities and manpower to meet the physical, mental, and environmental health needs [of the populace] and the financial and organizational resources through which these needs may be met . . ." 42 C.F.R. § 51.4(c)(1) (1967) (repealed 1976).

[44] *See generally* THE REGIONALIZATION OF PERSONAL HEALTH SERVICES (E. Saward ed. 1976).

[45] *See* M. ROEMER, COMPARATIVE NATIONAL POLICIES ON HEALTH CARE 202 (1977).

[46] *See* Comprehensive Health Planning and Public Health Services Amendments of 1966, Pub. L. No. 89-749, § 2, 80 Stat. 1180 (legislative findings and declaration of purpose to promote health through public/private partnership planning for health services, manpower, and facilities).

However, a concern for preservation of quality of care and assurance of geographic and income-related access is evident in these programs.[47]

B. *Adoption of Certificate of Need Laws by the States*

While voluntary health planning agencies were appearing in the states and beginning to receive federal funding, several states had adopted certificate of need laws. The first was New York, which enacted its statute in 1966 after promoting regional voluntary planning since 1946.[48] Converting voluntary health planning into a regulatory mechanism appealed to other states.[49] In the next six years, twenty states adopted some kind of certificate of need program.[50] By the end of the 1973 legislative sessions, four more states had added certificate of need requirements and a total of twenty-three states had such programs.[51] Administrative responsibility for certificate of need programs was often

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[47]The Hill-Burton Act conditioned the receipt of grant funds on a health facility's agreement to provide a reasonable volume of uncompensated services and to make its facilities available to all persons residing in the area without discrimination on account of race, creed, or color. Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). *See generally* Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975); Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C.L. REV. 577 (1982). The Act also mandated minimum maintenance and operation standards for funded projects, and prompted many states first to adopt health facility licensure programs. *See* A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 118-32 (1969). The comprehensive health planning program combined these concerns in its announced goal of assuring "comprehensive health services of high quality for every person." *Id.*

[48]*Hearings on H.R. 6084 Before the Subcomm. on Health and Environment of the House Comm. on Energy and Commerce*, 97th Cong., 2d Sess. 58 (1982) (testimony of James R. Tallon, Jr., Chairman, Committee on Health, New York State Assembly).

[49]Differing opinions as to the reason states adopted certificate of need laws have been offered. According to Curran, state legislators grafted CON programs onto voluntary health planning programs in response to public concern for rising hospital and health insurance costs. Curran, *supra* note 15, at 88-90. Havighurst suggests that certificate of need laws were adopted to strengthen voluntary health planning and, in some states, to limit proprietary hospital expansion. Havighurst, *supra* note 15, at 1148-50. Payton and Powsner attribute the passage of CON legislation to the efforts of the voluntary hospital establishment to forestall rate regulation and solidify its dominance of the hospital market. Payton & Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate of Need*, 17 MICH. L. REV. 203 (1980). Certificate of need legislation was supported by the health planning establishment, the American Hospital Association, Blue Cross, state insurance commissioners, and various business and labor groups, and opposed by medical professional organizations, proprietary hospitals, and nursing home operators. Curran, *supra* note 15, at 90. The legislatures themselves appear to have been motivated by multiple concerns for cost containment, quality preservation, access assurance, and public participation in health facility decision-making. See *supra* notes 16-30 and accompanying text.

[50]Curran, *supra* note 15, at 85.

[51]Havighurst, *supra* note 15, at 1143-44.

assigned to comprehensive health planning agencies, which were often instrumental in securing passage of the certificate of need laws.[52]

Certificate of need programs adopted at this time varied considerably in their scope of coverage. They generally covered a narrower range of facilities and projects than were to be covered under subsequent federal regulatory health planning initiatives. A contemporary survey reported that nineteen programs subjected hospitals and nursing homes to regulation.[53] One state (Oklahoma) covered nursing homes, but not hospitals.[54] Three states (Michigan, Oregon, and Rhode Island) covered hospitals, but not nursing homes.[55] About half subjected freestanding outpatient facilities to review. None extended coverage to individual physician's offices.

Under project coverage, most states reviewed "capital expenditures" or similarly-labeled expansions of physical plants. Virtually all states had expenditure "thresholds," dollar amounts below which capital expenditures by health facilities were not subject to review. The expenditure thresholds varied widely from $25,000 to $350,000.[56] Over half of the states expressly covered increases in bed supply whether or not associated with a capital expenditure. All appeared to cover substantial expansion in services, sometimes without regard to expenditure thresholds. Acquisitions of medical equipment were expressly subjected to review in about half of the states, frequently with expenditure thresholds. However, several states exempted replacement of equipment. Finally, ten states covered both reductions in bed supply and/or termination of services.[57]

C. Section 1122

Congressional concern with the costs of institutional health services rose as the costs of the Medicare and Medicaid programs, established in 1965, increased. Among the reasons for increasing Medicare and Medicaid costs was the programs' open-ended payment to providers on the basis of costs incurred in the provision of services to beneficiaries.[58] In addition to paying for reasonable costs directly associated with patient care, Medicare and Medicaid paid for "capital costs," i.e., actual costs of interest on capital indebtedness, an allowance for depreciation on capital assets, and a fixed rate of return on equity capital used by

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[52]H.R. REP. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. CODE CONG. & ADMIN. NEWS 4989, 5065-66.

[53]Havighurst, *supra* note 15, at 1144.

[54]*Id.* at 1145.

[55]*Id.* at 1146 n.10.

[56]*Id.* at 1146 n.9.

[57]*Id.* at 1145-47.

[58]*See* Kinney & Lefkowitz, *Capital Cost Reimbursement to Community Hospitals Under Federal Health Insurance Programs*, 7 J. HEALTH POL. POL'Y & L. 648 (1982).

proprietary health facilities for patient care.[59] The Social Security Amendments of 1972 contained several measures designed to restrain Medicare and Medicaid program cost increases caused by incurred-cost reimbursement. They included mandatory utilization review, ceilings on payment for routine hospital inpatient costs, and the so-called "section 1122" program.[60] Section 1122 authorized the Secretary of Health, Education and Welfare to contract with individual states for a review and recommendation to the Secretary on the community need for capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations.[61] State recommendations were to be based on state health plans, including those adopted by comprehensive health planning and Hill-Burton agencies. A negative state recommendation usually would lead to withholding by the Secretary of payment under Medicare and Medicaid for capital costs associated with the project.[62] Although section 1122's enforcement sanction—denial of federal program reimbursement—differed from that of state certificate of need programs, its purpose was similarly to deter unnecessary capital investment by health facilities. An additional purpose was to assure that Medicare and Medicaid reimbursement supported state health planning programs.[63]

1. Section 1122 Coverage.—Despite its origin in congressional concern over distorted incentives in Medicare and Medicaid reimbursement, as implemented by the Department of Health Education and Welfare, the section 1122 program extended the federal government's practice, begun under the comprehensive health planning program, of imposing extensive review requirements on virtually all categories of health facilities. Health care facilities subject to review under the Department's regulations encompassed the following: hospitals, psychiatric hospitals, and tuberculosis hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, providers of outpatient physical therapy services (including speech pathology services), kidney disease treatment centers (including freestanding hemodialysis units), and organized ambulatory care facilities such as health centers, family planning clinics, and surgicenters, which are not part of a hospital but are organized and operated to provide medical care to outpatients.[64]

In addition to health care facilities, health maintenance organizations were subject to review.[65] Projects were subject to review when undertaken

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[59] *Id.*

[60] Social Security Amendments of 1972, Pub. L. No. 92-603, § 221, 86 Stat. 1329 (codified as amended at 42 U.S.C. § 1320a-1 (Supp. I 1983)).

[61] *See generally* 42 C.F.R. §§ 100.101-100.109 (1985).

[62] 42 U.S.C. § 1320a-1(d) (1982).

[63] 42 U.S.C. § 1320a-1(a) (1982).

[64] 42 C.F.R. § 100.103(a)(1) (1974).

[65] 42 C.F.R. § 100.103 (1974).

by or on behalf of health care facilities or health maintenance organizations and when they involved capital expenditures that: (1) exceeded $100,000; (2) changed the bed capacity of the facility with respect to which such expenditures were made; or (3) substantially changed the services of the facility with respect to which such expenditures were made.[66] Capital expenditures that changed bed capacity and substantially changed services were defined by the Department of Health, Education, and Welfare in the following manner:

> [A] Capital expenditure that "changes the bed capacity" of a facility means a capital expenditure that results in any increase or decrease in licensed capacity under applicable state or local law, or, if there is no such law, the number of beds in a given facility as of January 1, 1973, as determined by the designated planning agency.
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> [B] Capital expenditure that "substantially changes the services" of a facility means a capital expenditure that results in the addition of a clinically related (i.e., diagnostic, curative, or rehabilitative) service not previously provided in the facility or the termination of such a service that had previously been provided in the facility.[67]

The extreme breadth of section 1122 coverage may have been justified from a comprehensive health planning perspective, but the connection between section 1122's broad coverage and the cost containment concerns that led to the program's adoption was difficult to identify.[68] The list of health care facilities covered under section 1122 seems to have been taken from the list of institutional providers eligible to participate in Medicare or Medicaid.[69] However, excessive capital investment of acquisition of costly new technology had never been associated with several of these providers, including home health agencies, outpatient physical therapy providers, or ambulatory care facilities. In fact, such providers were eligible for Medicare reimbursement in part because they offered less capital-intensive, lower-cost substitutes for hospital or nursing facility care.[70] It

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[66]42 U.S.C. § 1320a-1 (Supp. II 1972).

[67]42 C.F.R. §§ 100.103(a)(2)(iii),(iv) (1974).

[68]Reflecting the linkage of the two programs, the original section 1122 regulations also amended the comprehensive health planning regulations to conform their definitions of covered health care facilities. 38 Fed. Reg. 31,281 (1973) (amending 42 C.F.R. § 51.4(i)(4) (repealed 1976)).

[69]The list duplicated the list of Medicare-eligible providers in large part, and repeated the facility definitions in Medicare or Medicaid regulations.

[70]The Department of Health and Human Services eventually revised its interpretation of the purposes of section 1122 with regard to service and bed terminations. In 1983, it

would have been more consistent with Medicare and Medicaid cost control concerns to have exempted these facilities from section 1122 in order to channel investment toward them and away from institutional providers. Similarly, health maintenance organizations were a then-unusual form of organized health care delivery favored by the federal government because they appeared to operate with internal incentives for cost containment and reduced investment. They would also have been likely candidates for exemption from section 1122 coverage.

The Department's interpretation of the statutory phrases "substantial change in services" and "change in bed capacity" to include decreases as well as increases in bed capacity and to include terminations of services as well as service additions seems clearly inconsistent with the role of the section 1122 program to compensate for distorted Medicare incentives to excess capacity. The purpose for covering terminations of beds and services is presumably to maintain existing services, not to reduce capacity. Like the decision to cover a very broad array of non-institutional facilities, the Department's decision to cover terminations probably arose out of the perception that section 1122 was comprehensive health planning's successor, with the same broad purposes.[71]

D. Pre-NHPRDA State Participation in Capital Expenditure Review

State participation in the section 1122 program was optional.[72] By the beginning of 1975, thirty-nine states and two territories, many of which already had certificate of need programs, had agreed to enter the program.[73] The states' willingness to do so may have been due in part to the fact that section 1122 regulations and policy guidelines offered a means by which a state could participate in section 1122, but waive review of some of the exceedingly broad range of health care facilities and projects covered by section 1122. A state was permitted to "elect

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proposed to amend the section 1122 regulations to delete coverage of decreases in bed capacity and termination of services that are not associated with capital expenditures in excess of the current expenditure threshold. 48 Fed. Reg. 36,395 (to be codified at 42 C.F.R. §§ 3125.102(a),(b) (1983)). The preamble to the proposed regulations stated that such a deletion would be "consistent with Section 1122's central purpose of assuring that Medicare and Medicaid funds are not used to pay higher health care costs that result from duplication or irrational growth of health care facilities, while at the same time advancing the policy of the new Medicare prospective payment system, which provides health care facilities with incentives to eliminate inefficient services." *Id.* at 36,391.

[71] *Id.*

[72] 42 U.S.C. § 1320a-1(6)(1982).

[73] LEWIN & ASSOCS., INC., THE EXPERIENCE WITH THE SECTION 1122 CAPITAL EXPENDITURE REVIEW PROGRAM 14-15 (1985) (report prepared for Office of Health Planning and Evaluation, Office of the Assistant Secretary for Health, U.S. Dep't of Health & Human Services, under Contract No. 282-83-0072) distributed in OFFICE OF HEALTH PLANNING, U.S. DEP'T OF HEALTH & HUMAN SERVICES, PROGRAM INFORMATION LETTER 85-17 (1985).

not to review" categories or classes of projects identified in advance.[74] Although the extent to which states elected not to review in order to avoid the broad requirements of section 1122 prior to the passage of NHPRDA is not known, states' frequent election after NHPRDA suggests that states did resort to this provision to limit review scope.[75]

Twenty-six states had certificate of need programs, and seventeen states had both certificate of need and 1122 in early 1975.[76] By the end of 1975, every state except West Virginia and the District of Columbia had either a certificate of need or section 1122 program.[77] In short, well before the adoption of the NHPRDA, the vast majority of states had chosen to implement certificate of need or capital expenditure review. Their programs were generally more limited in scope than the broad programs favored by the federal government at the time. All these states later accepted NHPRDA funding, obliging themselves to conform to its requirements. However, for most states, the initial choice to adopt certificate of need or participate in section 1122 was independent of federal requirements.

IV. Certificate of Need Requirements of NHPRDA

Although regulatory health planning through certificates of need began in the states, it became fully established as national policy with the passage of NHPRDA. As originally adopted, NHPRDA embodied the ideal of comprehensive health planning: management of the health care delivery system by publicly-controlled, decentralized planning organizations. It was designed to induce every state to adopt a certificate of need law conforming to federal requirements; to give local planning agencies an official role in state planning and certificate of need review; and to enhance the regulatory toughness of state programs by improving the plans, criteria, and methodologies on which certificate of need decisions were based and providing for a more skilled professional staff for planning agencies.[78]

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[74]Bureau of Health Planning, U.S. Dep't of Health & Human Services, Election Not to Review Under the Section 1122 Program, Program Information Letter 82-04 (1981); Division of Comprehensive Health Planning, U.S. Dep't of Health, Education & Welfare, DPA Manual: Guidance and Procedures for Designated Planning Agencies in Administering Section 1122 of the Social Security Act 13 (1974). In August 1983, the Department proposed to codify this policy in amended section 1122 regulations. *See* 48 Fed.Reg. 36,396 (1983) (to be codified at 42 C.F.R. § 125.03).

[75]*E.g.*, Ga. Admin. Comp. § 272-3-.03 (1984); Iowa Admin. Code § 470-201.9 (1982) (election not to review under section 1122 all projects not required to be reviewed by certificate of need program).

[76]Chayet & Sonnenreich, P.C., *supra* note 15, at 5-6.

[77]*Id.*

[78]A good account of the adoption of NHPRDA is B. Lefkowitz, Health Planning: Lessons for the Future (1983).

NHPRDA's local health planning agencies, denominated Health Systems Agencies (HSA's), replaced voluntary local health planning boards. Elaborate requirements for public participation on HSA governing boards were established to assure that HSA's would be consumer-controlled and representative of all segments of the population.[79] HSA's had the task of providing community based health planning for specified geographical areas. Typically, there were three or four such health service areas, each served by an HSA, within each state. HSA's also were required to be allowed to participate in state certificate of need reviews by conducting a public meeting on proposed projects and submitting recommended findings with respect to projects.

NHPRDA provided for designation of state agencies, denominated State Health Planning and Development Agencies (SHPDA's), to develop a state health plan incorporating HSA plans and to administer certificate of need programs. A state advisory panel made up of HSA representatives was mandated. Certificate of need programs were required to provide for review of capital expenditures, substantial changes in services, and additions of beds by health care facilities. NHPRDA also prescribed detailed review procedure requirements and a laundry list of criteria for evaluating certificate of need applications. As the first of many attempts over the years to merge the two programs, a state participating in section 1122 was required to designate its SHPDA as the agency to perform section 1122 reviews.

NHPRDA did not literally compel states to adopt certificate of need programs consistent with its provisions.[80] Instead, it offered financial inducements to do so, in the form of federal funding for SHPDA's, and penalties for failure to do so. The penalties initially announced were severe. If a state did not have a certificate of need program in compliance with NHPRDA by a specified date, grants and contracts under numerous other federal health programs to state, local, and private entities in the state would be abruptly cancelled.[81] The funding at risk could amount to tens or even hundreds of millions of dollars in some states.[82] Because the funding at risk benefitted such diverse groups as community health

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[79]Pub. L. No. 93-641, § 3, 88 Stat. 2225, 2232-35 (1975) (current version at 42 U.S.C. § 300*l*-1 (1982)).

[80]North Carolina *ex rel.* Morrow v. Califano, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978).

[81]*See Health Planning and Resources Development Amendments of 1979: Hearings on H.R. 3041 and 3167 Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 96th Cong., 1st Sess. 108 (1979) (statement of Hale Champion, Undersecretary of HEW) (NHPRDA relies on "atomic bomb theory of penalty").

[82]Manor Healthcare Corp. v. Northwest Community Hosp., 129 Ill. App. 3d 291, 295, 472 N.E.2d 492, 494 (1984) (Illinois would lose $465 million over four years if not in compliance).

centers, medical students, academic health researchers funded by various national institutes of health, and medical, dental, and nursing schools, NHPRDA created a constituency strongly concerned with bringing state certificate of need programs into compliance. Although as a result of repeated congressional postponement of effective dates,[83] the compliance requirements of NHPRDA never became effective, the threat of their enforcement was sufficient to induce every state to make concerted, more or less successful, efforts to comply.

A. NHPRDA Coverage

NHPRDA's certificate of need coverage provisions were a revised version of those in section 1122, which were based on comprehensive health planning and Hill-Burton. Their source thus lay in the concept of systematic management of health care delivery, not in any theory of economic regulation. Although eventually scaled back, their broad scope and mandatory nature led states to adopt certificate of need programs with more extensive coverage than states would otherwise have chosen.

1. NHPRDA Coverage of Facilities.—Regulations adopted in 1977 to implement NHPRDA defined the health care facilities subject to certificate of need review to include: hospitals, psychiatric hospitals, tuberculosis hospitals, skilled nursing facilities, intermediate care facilities, kidney disease treatment centers including freestanding hemodialysis units, and ambulatory surgical facilities. In addition, health maintenance organizations were subject to review.[84]

Although the source of this set of covered facilities was the prior section 1122 coverage provisions, there were several deletions from the pre-NHPRDA definitions.[85] First, providers of outpatient physical therapy were no longer required to be covered. Second, coverage of home health agencies was deleted.[86] The reason seems to have been a belief that market forces would adequately regulate the supply of these two types of facilities.[87] Third, coverage of organized ambulatory health care facilities was deleted. The reasons given were that "the variety of forms

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[83] *See infra* note 166 and accompanying text.

[84] 42 C.F.R. §§ 123.401, 404 (1977).

[85] The original NHPRDA regulations for certificate of need programs also amended the section 1122 regulations, making their health care facility coverage identical to NHPRDA's.

[86] Home health services were also excluded from the health services subject to review, in order to exclude from coverage both home health agencies and home health services offered in or through a health care facility or health maintenance organization. 42 C.F.R. § 123.404(a)(4) (1977).

[87] A later effort to reinstitute coverage of home health agencies was rejected in Congress in part on the grounds that "the supply of those services would not be excessive if they were not regulated and that market forces of supply and demand may appropriately allocate them." H.R. Rep. No. 190, 96th Cong., 1st Sess. 53, 76 (1979).

in which organized ambulatory health care facilities manifest themselves resulted in serious definitional difficulties under Section 1122" and that "in light of the uneven national distribution of organized ambulatory health care facilities in the states, the Secretary has decided against establishing a uniform national method for dealing with the problem at this time."[88] In fact, there was considerable debate in the Department of Health, Education and Welfare over the merits of ambulatory facility coverage, with attention focused on the costs associated with their acquisition of sophisticated medical equipment. A proposal was advanced to cover organized ambulatory health care facilities that generated annual revenues in excess of $1,000,000.[89] Although this proposal was not adopted, NHPRDA was later amended in response to these concerns to require certificate of need review of costly medical equipment used for inpatients but located in non-inpatient settings.[90]

Since 1977, the set of entities subject to certificate of need review under NHPRDA and section 1122 has remained substantially unchanged.[91] To its credit, the Department of Health and Human Services has resisted requests to reimpose coverage by regulation of home health agencies, physician offices, and various types of ambulatory care facilities originally covered under section 1122 or comprehensive health planning programs.[92]

2. Projects Subject to Review.—Over the years, the set of projects subject to review under NHPRDA has been amended frequently, usually but not invariably to reduce the range of projects subject to review. The Act originally required states to review "new institutional health services," as defined by the Secretary.[93] New institutional health services were defined by regulation as:

> 1. Construction, development, or establishment of a new health care facility or health maintenance organization;
> 2. Capital expenditures by or on behalf of a health care facility or health maintenance organization in excess of $150,000;
> 3. Increases in health care facility or HMO bed capacity, bed category changes, and bed relocations; and
> 4. New clinically-related health services offered in or through a health care facility or health maintenance organization.[94]

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[88]41 Fed. Reg. 11,691 (1976) (preamble to proposed regulations).

[89]Iglehart, *The Cost and Regulation of Technology: Future Policy Directions*, 55 MILBANK MEM. FUND Q. 25, 40-43 (1977).

[90]*See infra* notes 237-40 and accompanying text.

[91]*See* 42 C.F.R. § 123.401 (1985). Rehabilitation facilities were added to NHPRDA coverage in 1979 and have been proposed to be added to section 1122.

[92]*See, e.g.*, 50 Fed. Reg. 2009 (1985); 45 Fed. Reg. 69,755 (1980).

[93]42 U.S.C. § 300m-2(a)(4)(A) (1976).

[94]42 C.F.R. § 123.404 (1977).

3. New Construction and Acquisition Coverage.—Coverage of construction, development, etc., was a catch-all phrase for coverage of new hospital construction. It was probably included to clarify that new facilities as well as expansion of existing facilities were subject to review. Most pre-NHPRDA state certificate of need laws contained a similar term, and although it was deleted from the federal requirements in 1980,[95] most continue to do so.[96]

Capital expenditures for acquisitions of existing health care facilities or health maintenance organizations were exempt from mandatory review; states had the option of covering such transactions.[97] A rationale for this exemption was not announced. The Department had previously taken the position that section 1122 coverage of capital expenditures in excess of $100,000 by or on behalf of a health care facility included coverage of acquisitions of facilities, and it was not apparent why the same language would have a different meaning in the NHPRDA context.[98] The basis for the exemption was probably the absence of a strong justification for health planning agency review of transactions that did not necessarily involve changes in patient care services.[99]

4. Health Maintenance Organization Coverage.—As first adopted, much like section 1122, NHPRDA required coverage of new institutional health services offered by or on behalf of health maintenance organizations.[100] Both the health care delivery component of a health maintenance organization and its administrative and insuring aspects were apparently covered, as were physicians and other providers who contracted to serve HMO beneficiaries. An incidental effect of the coverage of health maintenance organizations themselves rather than health care facilities sponsored by HMO's was to require coverage of certain service-related projects offered by health maintenance organizations which were not required to be covered when offered by other health care facilities. For example, the establishment of a non-surgical ambulatory care facility component of a health maintenance organization was required to be covered regardless of cost, although establishment of such a facility by any other proponent would not have been subject to review unless associated with at least a $150,000 capital expenditure.

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[95]45 Fed. Reg. 69,746 (1980) (amending 42 C.F.R. § 123.404 (1977)).

[96]*See* Table 3.

[97]*See* 42 Fed. Reg. 4008 (1977).

[98]*See* 41 Fed. Reg. 11,706 (1976) (proposing 42 C.F.R. § 100.103(c)).

[99]Subsequent NHPRDA amendments added a provision requiring coverage of acquisitions if the SHPDA found that the services or bed capacity of the facility being acquired would be changed in the process. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 117, 93 Stat. 592, 617-18 (codified at 42 U.S.C. § 300m-6(d) (1982)).

[100]42 U.S.C. § 300n(5) (1976).

From the time of their adoption, the HMO coverage requirements of NHPRDA and section 1122 were criticized as overbroad and a potential hindrance to the spread of HMO's.[101] Congress and the Department of Health and Human Services soon began to cut back the HMO coverage provisions. In 1978, all references to HMO's were deleted from section 1122.[102] In 1979, a broad HMO exemption from NHPRDA was adopted. It required state certificate of need programs to exempt HMO's and inpatient health care facilities controlled or leased for a period of years by an HMO if the HMO enrollment was at least 50,000, 75% of the facilities' patients would be enrollees, and the facility would be geographically accessible to the enrollees.[103] The 50,000 enrollee requirement was deleted in 1981.[104] A similar but even broader exemption for facilities used by HMO's was placed in section 1122 in 1983.[105]

5. Increase in Expenditure Threshold.—The $150,000 NHPRDA capital expenditure threshold represented an increase over the $100,000 level under the section 1122 program. This was the first of repeated NHPRDA and section 1122 expenditure threshold increases over the years. The rationales offered for this first, modest increase were essentially the same as those offered each time the thresholds have been increased —that few significant capital expenditures cost less than the new, elevated threshold, and that due to inflation, the increase retained coverage unaltered in constant dollars.[106] Though not articulated by the Department, an additional justification for this and subsequent threshold increases was to remove certificate of need programs' authority over projects not involving major expansion of clinical health services. Health facilities, particularly hospitals, routinely incur capital expenditures for physical plant maintenance and improvement of non-patient care areas and equipment. Health planning agencies tend to be drawn into reviewing these costs by thresholds at the $100,000 level. Yet the agencies possessed no particular expertise to oversee the decisions of health facilities on the timing and amount of such transactions, the relationship between such projects and the rationales for certificate of need regulation were attenuated, and the delay caused by even cursory review of such projects generated considerable objection from regulated facilities.[107]

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[101]*See* Havighurst, *Health Maintenance Organizations and the Health Planners*, 1978 UTAH L. REV. 123, 141.

[102]*See* Health Maintenance Organizations Amendments of 1978, Pub. L. No. 95-559, § 14(b)(1)-(3), 92 Stat. 2141.

[103]Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, Sec. 117(a), 93 Stat. 614 (codified at 42 U.S.C. § 300m-6(b)(1) (1982)).

[104]Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 949(c), 95 Stat. 578.

[105]Social Security Amendments of 1983, Pub. L. No. 98-21 § 607(c), 97 Stat. 172.

[106]42 Fed. Reg. 4008 (1977).

[107]*See, e.g.*, Brown, *supra* note 12, at 485-86.

6. Changes in Bed Capacity.—Regulation adopted after NHPRDA's passage defined bed capacity changes subject to review as

> [a] change in bed capacity of a health care facility or health maintenance organization which increases the total number of beds (or distributes beds among various categories or relocates such beds from one physical facility or site to another) by more than ten beds or more than ten percent (10%) of total bed capacity as defined by the state, whichever is less, over a two year period.[108]

Bed category changes and bed relocations had not been subject to review under the 1122 rules. However, the Department decided to subject such transactions to certificate of need coverage on the grounds that substantial conversions could affect the delivery and cost of health services.[109]

Like the capital expenditure threshold increase, the exemption for "insubstantial" changes, i.e., bed capacity and other changes of ten beds or less or ten percent of total bed capacity, whichever was less, over a two-year period, was intended to shift regulatory review away from relatively minor projects. The Department had considered several versions of this exemption. It initially proposed to cover any addition, relocation, or category change.[110] Then, an extremely generous insubstantial change exemption was announced in the adopted regulations. It exempted bed capacity changes of less than forty beds or twenty-five percent of total bed capacity, whichever was less, over a two-year period.[111] This was a potentially major exemption from certificate of need, particularly for bed category conversions.[112] In recognition of the size of this loophole, shortly thereafter the "forty beds or twenty-five percent" exemption was changed to the "ten beds or ten percent" provision.[113] The current federal regulations cover substantial bed capacity changes associated with any capital expenditure, leaving the definition of exempt insubstantial changes up to individual states.[114]

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[108]42 C.F.R. § 123.404(a)(3) (1977).

[109]42 Fed. Reg. 4008 (1977). Required coverage of bed category changes and bed relocations was deleted from the federal regulations in 1985 in order to allow states greater flexibility in operating their certificate of need programs. 42 C.F.R. § 123.404(a)(2) (1985). *See* 50 Fed.Reg. 2008 (1985).

[110]41 Fed. Reg. 11,702 (1976) (proposing to adopt 42 C.F.R. § 123.404(a)(3)).

[111]42 Fed. Reg. 4029 (1977) (adopting 42 C.F.R. § 123.404(a)(3)).

[112]A forty bed addition would usually generate a capital expenditure in excess of the threshold and therefore come under review notwithstanding the exemption. The same thing would probably be true for bed relocations. However, for bed conversions the provision would, for example, allow a 160-bed acute care hospital facility to convert into a 90-bed acute care facility with a 70-bed skilled nursing unit in two years and a day, assuming no capital expenditure in excess of $150,000.

[113]42 Fed. Reg. 18,607 (1977) (amending 42 C.F.R. § 122.404(a)(3)).

[114]42 C.F.R. § 123.404(a)(2) (1985).

7. Coverage of Changes in Health Services.—The initial NHPRDA regulations provided for coverage of

> [h]ealth services, except home health services, which are offered in or through a health care facility or health maintenance organization and which were not offered on a regular basis in or through such health care facility or health maintenance organization within the twelve-month period prior to the time such services would be offered.[115]

The Department of Health and Human Services has never specified the services that fall within the term "health services," except to indicate that the term refers to clinical services.[116] It has stated, somewhat unhelpfully, that "[a]ny service is covered if it is included in the scope of coverage developed by the state."[117] Additionally, it has never clarified whether increases in the volume, intensity, or type of clinical services provided in a department constitute a new service, or whether only a new department or cost center would be covered.[118]

8. Bed and Service Terminations.—Capital expenditures exceeding the threshold for termination or reduction of beds or health services were also exempted from capital expenditure coverage. This provision represented a departure from section 1122, under which capital expenditures of any amount for termination of services or reduction of beds are covered.[119] Although the Department amended the NHPRDA regulations in 1980 to require coverage of capital expenditures associated with bed and service terminations, it recently deleted the requirement once again, so that at present, states are not required to cover terminations.[120] The Department has also proposed to delete the section 1122 requirement that terminations be covered.[121]

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[115]42 Fed. Reg. 4029 (1977) (adopting 42 C.F.R. § 123.404(a)(4)).

[116]50 Fed. Reg. 2014 (1985) (amending 42 C.F.R. § 123.401).

[117]42 Fed. Reg. 4008 (1977). The Department has occasionally expressed its views on whether certain activities should be considered new services. The 1977 regulations excluded home health services from the "health services" definition. In 1979, the Department adopted regulations requiring coverage of radiological diagnostic health services provided by fixed or mobile computed tomography (CT) scanning equipment under state certificate of need programs. 42 C.F.R. § 123.404(a)(5) (1979) (amended 1981); *see also* 42 C.F.R. § 100.103(a)(2)(iv) (1985) (addition of CT scanning is a substantial change in services under section 1122).

[118]*See* Community Psychiatric Centers of Or., Inc. v. Grant, Civ. No. 79-782 (D. Or. July 8, 1980), *rev'd on other grounds*, 664 F.2d 1148 (9th Cir. 1981) (interpreting federal regulations to cover extensive changes in the level or volume of clinical services).

[119]42 C.F.R. §§ 100.103(a)(2)(iii), (iv) (1985).

[120]42 C.F.R. §§ 123.404(a)(2),(3) (1985).

[121]*See* 48 Fed. Reg. 36,395 (1983) (to be codified at 42 C.F.R. § 125.102).

B. State Certificate of Need Coverage After Passage of NHPRDA

Passage of NHPRDA prompted more states to adopt certificate of need laws so that by 1978, forty states and the District of Columbia had certificate of need programs.[122] All but one of these covered hospitals and nursing homes. Georgia was the exception, covering only nursing homes. Thirty-six states covered ambulatory surgical facilities, an increase from earlier surveys probably due to coverage of such facilities under NHPRDA and section 1122.[123] Twenty-four states covered home health agencies, even though such coverage was not required under either NHPRDA or section 1122.[124]

Virtually every state subjected capital expenditures to review, including physical plant construction and other major capital expenditures. Thresholds varied from state to state, though less than they had in 1973. All but a handful of states had $100,000 or $150,000 thresholds.[125] This consensus on expenditure thresholds was undoubtedly due to the state participation in 1122 or NHPRDA, which had $100,000 and $150,000 thresholds respectively.

All but two states expressly covered increases in bed supply.[126] This was a greater number than had covered such transactions in 1973, probably reflecting national concern with excess bed capacity and the coverage of such transactions under 1122 and NHPRDA. More than half of the states continued to cover even single bed additions, rather than using the insubstantial increase exception permitted by NHPRDA. However, two states had adopted the "forty beds or twenty-five percent" increase exemption proposed by HEW in 1977.[127] Half of the states covered bed supply reductions. All but three states covered additions of new health services. Eighteen states covered deletions of services in one form or another.[128]

C. Health Planning and Resources Development Amendments of 1979

In late 1979, there was dissatisfaction in Congress with implementation of NHPRDA.[129] The costs of health care had continued to increase at a steady pace. Congress believed that excess capacity, the target of NHPRDA, was one cause of the increase. However, a number of econ-

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[122]Cohodes, *supra* note 7, at 87-88.

[123]*Id.*

[124]*Id.*

[125]*Id.*

[126]*Id.*

[127]CHAYET & SONNENREICH, P.C., *supra* note 15, at 11.

[128]Cohodes, *supra* note 7, at 88.

[129]H.R. REP. No. 190, 96th Cong., 1st Sess. 47-101 (1979); S. REP. No. 96, 96th Cong., 1st Sess. 50-93, *reprinted in* 1979 U.S. CODE CONG. & ADMIN. NEWS 1306, 1355-98.

ometric studies circulating at the time had concluded that certificate of need programs, as then constituted, did not have a significant impact on the rate of hospital capital investment.[130]

In addition, certificate of need programs were generating a significant amount of controversy and litigation. A series of well-publicized reversals suggested that the planning agencies wavered between rigidly applying numerical need formulae that ignored the statutory criteria or rulemaking requirements and issuing unpredictable, ad hoc rulings.[131] Legal commentators had suggested a variety of reforms in the review process.[132] There was great concern that certificate of need coverage of expenditures for costly medical equipment was being evaded. Finally, there was concern that the existing pattern of certificate of need coverage in the law and regulations placed a very heavy workload on planning agencies and dictated that nearly as much time be spent on projects with small cost implications as on major projects.

In response, Congress passed the Health Planning and Resources Development Amendments of 1979.[133] In spirit, if not in coverage scope, they narrowed the focus of federally-mandated certificate of need from general health system management to economic regulation.[134] Although cost containment was a dominant purpose of the amendments, they also added statutory provisions mandating as review criteria the accessibility of proposed services and the quality of care previously provided by a certificate of need applicant.[135] A number of important procedural changes were adopted, including provisions requiring comparative review of com-

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[130]*See* Cohodes, *supra* note 7, at 76-77 and studies cited therein.

[131]*See, e.g.*, North Miami Gen. Hosp., Inc. v. Office of Community Medical Facilities, 355 So. 2d 1272 (Fla. Dist. Ct. App. 1978) (inconsistent application of criterion); Huron Valley Hosp., Inc. v. Michigan State Health Facilities Comm'n, 110 Mich. App. 236, 312 N.W.2d 422 (1981) (undisclosed preference for existing facilities over new construction); Irvington Gen. Hosp. v. Department of Health, 149 N.J. Super. 461, 374 A.2d 49 (1977); Sturman v. Ingraham, 52 A.D.2d 882, 383 N.Y.S.2d 60 (1976) (exclusive reliance on bed need formula in disregard of statutory criteria).

[132]*See, e.g.*, Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 111-115; Schonbrum, *Making Certificate of Need Work*, 57 N.C.L. REV. 1259 (1979).

[133]Pub. L. No. 96-79, 93 Stat. 592 (1979).

[134]*See* 42 U.S.C. § 300k-2 (Supp. III 1979) (legislative finding that states should exercise the certificate of need function under NHPRDA to allocate the supply of health services for which, by reason primarily of reimbursement mechanism distortions, the market does not or will not do so).

[135]42 U.S.C. §§ 300m-1(c)(6)(E),(14) (1982). The legislative history of these provisions reveals strong support for planning agency use of certificate of need programs as vehicles for reducing economic barriers to medical care for Medicare and Medicaid beneficiaries and the medically indigent. S. REP. No. 96, 96th Cong., 1st Sess. 78, *reprinted in* 1979 U.S. CODE CONG. & ADMIN. NEWS 1306, 1374-76 (SHPDA's and HSA's should use their full range of authority and influence to remedy access problems).

peting applications and administrative appellate review of SHPDA decisions on certificate of need applications.[136] Several provisions were added to strengthen certificate of need decision-making by improving state health plan development and making consistency with the state health plan the primary review criterion.[137] Finally, after the amendments, NHPRDA required states to cover capital expenditures exceeding $150,000, capital expenditures substantially changing the bed capacity of a health care facility or substantially changing the services of such facility, new institutional health services entailing annual operating costs in excess of an expenditure minimum of $75,000, and acquisitions of major medical equipment costing in excess of an expenditure minimum of $150,000.[138]

1. Capital Expenditure Coverage.—Coverage of general purpose capital expenditures exceeding the expenditure minimum remained essentially as it was prior to the 1979 amendment.[139] Coverage of bed capacity changes and service changes was modified. Previously any bed supply increase, decrease, category redistribution, or relocation exceeding the "ten beds or ten percent" exemption was subject to review. Now such transactions were covered only if a capital expenditure was incurred to accomplish them.[140] In practice, this change probably served to exempt only a few previously-covered bed supply decreases and category redistributions.

Similarly, where previously all health service additions were covered, now such transactions were covered only if associated with a capital expenditure (or, as noted *infra*, if the new service's annual operating costs exceeded the operating cost expenditure threshold).[141] Whether or not this change had any noticeable effect on a state's scope of coverage

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[136]42 U.S.C. §§ 300k-1(b)(12)(D),(13)(A)(iii) (1982).

[137]42 U.S.C. §§ 300m-3, 300m-6(a)(5) (1982).

[138]42 U.S.C. §§ 300m-6(a)(1), 300n(5) (1982).

[139]The 1979 amendments did authorize states, in their discretion, to begin annually adjusting their capital expenditure (and annual operating cost) thresholds upward according to an index of changes in construction costs. Both the capital expenditure and annual operating cost thresholds were eligible for adjustment. A state opting to make full use of the adjustment could have increased its thresholds over the statutory maximum by a total of 23 percent by 1985. Applied to the increased capital expenditure threshold authorized in 1981, the current maximum complying capital expenditure threshold would be $736,200. *See* 50 Fed. Reg. 14,027 (1985).

[140]*Compare* 42 C.F.R. § 123.404(a)(3) (1977) *with* 42 C.F.R. § 123.404(a)(2) (1981) (amended 1985).

[141]The 1979 amendments were also interpreted by the Department of Health and Human Services to provide for coverage of capital expenditures associated with the termination of a health service. 42 C.F.R. § 123.404(a)(3) (1981) (amended 1985). The Department's rationale for covering bed and service terminations was that such coverage would permit states to use certificate of need programs to promote accessibility of health services, especially to the indigent and medically underserved. *See* 45 Fed. Reg. 69,757-81 (1980).

depended greatly on the state's definition of "health service." A state that defined "services" to include some clinical procedures (e.g., open-heart surgery) as well as brick-and-mortar departments might find some formerly-covered projects escaping review, since some clinical services can be commenced without the need to incur capital costs.[142]

2. New Health Services Exceeding an Annual Operating Cost Minimum.—A new category of coverage was added by the 1979 amendments. Implementing regulations provided for coverage in the following terms:

> [t]he addition of a health service which is offered by or on behalf of a health care facility which was not offered by or on behalf of the facility within the twelve-month period before the month in which the service would be offered, and which entails annual operating costs of at least the expenditure minimum for annual operating costs.[143]

The expenditure minimum for annual operating cost was another expenditure threshold, set at $75,000.[144]

The purpose of introducing an annual operating cost threshold into certificate of need coverage of new services was to trim review back to those projects with the greatest cost implications. Annual operating cost thresholds for certificate of need review had been under discussion for some time prior to the 1979 amendments. In 1978, a NHPRDA amendment bill restricting certificate of need coverage to health services entailing annual operating costs of $50,000 or more and acquisitions of medical equipment costing $150,000 or more passed the Senate but was not acted on by the House.[145] During this period, a number of health policy analysts argued that the institutional health services sector was not as capital-intensive as previously assumed and that the overall cost-inflating impact of capital investment came more from the additional operating costs generated by projects than from the capital costs of such projects themselves.[146] It was also observed that although high capital cost projects

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[142]However, non-capital expenditure service additions might be covered as additions of services entailing annual operating costs in excess of the expenditure minimum for annual operating costs. *See infra* note 202 and accompanying text.

[143]42 C.F.R. § 123.404(a)(3)(ii) (1981).

[144]The expenditure minimum for annual operating costs could be adjusted for inflation like the capital expenditure threshold. If a state made full use of the adjustment and increased its annual operating cost threshold to the elevated level authorized by 1981 NHPRDA amendments, its current expenditure minimum for annual operating costs would be $306,750.

[145]S. 2410, 95th Cong., 2d Sess. (1978).

[146]*See, e.g.*, D. SCHNEIDER, THE RELATIONSHIP BETWEEN CAPITAL AND OPERATING COSTS IN HOSPITALS: IMPLICATIONS FOR REGULATORY CONTROL 8-12 (Rennsalaer Polytechnic Inst., Final Report 1981) (estimates that six percent of hospital costs were attributable to capital costs).

were usually associated with high operating costs, some projects and services (e.g., renal dialysis stations) required low initial investment, but generated high costs of operation.[147] This work suggested that it might be appropriate to substitute an annual operating cost threshold for the capital expenditure threshold (or to retain a high threshold only for non-service-related capital expenditures large enough to have a cost impact on their own).[148] The coverage provisions in the 1978 Senate bill seem to have adopted this approach. Unfortunately, the 1979 amendments did not. Although they introduced an annual operating cost threshold for new services, they retained coverage of any service addition associated with a capital expenditure in any amount. Continued coverage of service additions associated with any capital expenditure probably rendered the annual operating cost threshold relatively unimportant, because most service additions require some capital expenditure and consequently are covered regardless of operating cost.

3. Major Medical Equipment.—The 1979 amendments introduced another new element of coverage: acquisition by any person of major medical equipment costing in excess of $150,000. Equipment not owned by or located in a health care facility was excluded unless: (1) the state's SHPDA found, after notice from the person acquiring the equipment, that it would be used to provide services for inpatients of a hospital; or (2) prior to September 30, 1982, the state certificate of need program provided for coverage of such equipment.[149]

Coverage of major medical equipment was adopted to prevent what was seen as a major gap in coverage giving rise to widespread evasion of certificate of need laws. At about the same time as NHPRDA was adopted, several types of expensive high-technology medical devices appeared on the market. Chief among these was the computed tomography (CT) scanner, a diagnostic radiological machine which typically cost in excess of $300,000 to acquire, generated annual operating costs in excess of $250,000, and (though rapidly accepted by clinicians) was of unproven

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[147] *Id.*; *see also* ARTHUR D. LITTLE, INC., DEVELOPMENT OF AN EVALUATION METHODOLOGY FOR USE IN ASSESSING DATA AVAILABLE TO THE CERTIFICATE OF NEED (CON) AND HEALTH PLANNING PROGRAMS 53-95, 187-89, and studies cited at 20-22 (Final Report prepared for Office of the Ass't Sec'y for Health, U.S. Dep't of Health & Human Services, under Contract No. 233-79-4003 (1982)).

[148] Alternatively, a very low capital expenditure threshold and no annual spending cost threshold could be used, but this would result in coverage of some low operating cost, low capital cost projects. *See* Cohen & Cohodes, *Certificate of Need and Low Capital-Cost Technology*, 60 MILBANK MEM. FUND Q. 307, 314-15 (1982).

[149] 42 U.S.C. § 300m-6(e)(1) (1982). The 1980 regulations specified that major medical equipment could be used to provide services to inpatients on a temporary basis in the case of natural disaster, major accident, or equipment failure without undergoing review. 42 C.F.R. § 123.404(a)(4)(iii) (1981).

efficacy.[150] Reports surfaced that hospitals were evading certificate of need and section 1122 coverage of such devices by placing them in adjacent non-hospital buildings or vesting their ownership in persons or entities not subject to review, while using the equipment for inpatients.[151] In response, the Department of Health, Education and Welfare published NHPRDA and section 1122 regulations requiring coverage of CT scanning as a new service.[152] The Department and various others also supported NHPRDA amendments that would have covered large capital projects in non-institutional settings, including acquisitions of costly medical equipment.[153] However, physician groups strongly opposed such a provision on the ground that it would extend certificate of need review into physicians' offices, and argued that the states ought to be given the option of extending coverage to medical equipment outside the institutional setting.[154] The provision adopted in 1979 represented a compromise between these views.

4. Expedited Review and Low-Priority Project Exceptions.—Various groups testifying before Congress about the 1979 NHPRDA amendments or commenting on the 1980 implementing regulations suggested amendments and changes to streamline certificate of need review and exempt certain classes or categories of projects. The leading target for exemption was projects for remodeling and replacement of obsolete facilities and equipment.[155] Because excess capacity is one of the primary rationales for adopting certificate of need statutes, such an exemption appears self defeating. By denying an application for a certificate of need to replace an obsolete facility or equipment, SHPDA's can exercise a "*de facto*" decertification power over existing excess capacity in the industry.[156] The

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[150]AMERICAN HOSP. ASS'N, CT SCANNERS: A TECHNICAL REPORT 43, 51 (1977). *See generally* U.S. CONG., OFFICE OF TECHNOLOGY ASSESSMENT, POLICY IMPLICATIONS OF THE COMPUTED TOMOGRAPHY (CT) SCANNER (1978).

[151]*See Health Planning and Resources Development Amendments of 1979: Hearings on H.R. 3041 and 3167 Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 96th Cong., 1st Sess. 521 (1979) (testimony of Russell Johan, Exec. Dir., Southeastern Wis. Health Systems Agency) ($750,000 CT scanner reportedly installed by physician group in old hamburger stand).

[152]42 C.F.R. §§ 100.103(a)(2)(iv), 123.404(a)(5) (1979) (amended 1981).

[153]*Health Planning Amendments of 1978: Hearings on S. 2410 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources*, 95th Cong., 2d Sess. 128, 134 (1978) (statement of Hale Champion, Secretary of HEW).

[154]Health Planning Amendments of 1978, S. Rep. 845 (to accompany S. 2410), 95th Cong., 2d Sess. 188-89 (1978).

[155]Exemption or streamlined review was not a new idea. The California certificate of need program had for several years provided a broad exemption for projects to remodel or replace facilities or equipment in existence at the time the state's certificate of need program was adopted. CAL. HEALTH & SAFETY CODE § 437.13 (West 1976) (repealed 1984). In addition, the Department of Health, Education and Welfare had advised states in 1977 of the option of "expedited review" of projects. *See* 42 Fed. Reg. 4007, 4009 (1977).

[156]*See* Kopit, Krill & Bonnie, *Hospital Decertification: Legitimate Regulation or a Taking of Private Property?*, 1978 UTAH L. REV. 179.

effect of placing an exemption in a certificate of need law is to forgo the opportunity to close down existing excess capacity and to limit the program's impact to new and expanded services. However, hospital decertification, whether accomplished directly or indirectly through denial of remodeling and replacement project applications, usually encounters powerful political opposition.[157] In addition, generally lower costs of remodeling and replacement, as opposed to new services, and stable or increasing patient populations mean that such projects are seldom turned down on their merits by planning agencies.[158]

The 1979 NHPRDA amendments did not adopt a remodeling and replacement exemption, but they did take a step in that direction by authorizing a form of limited review of certain replacement and high priority projects. The statute and regulations provided that capital expenditures (1) to eliminate or prevent imminent safety hazards (as defined by federal, state, or local fire, building, or life safety codes and regulations); (2) to comply with state licensure standards; and (3) to comply with the accreditation standards necessary for Medicare or Medicaid reimbursement should be approved unless the state agency found that the facility or service for which the capital expenditure was proposed was unneeded or that the obligation of the capital expenditure for the project was inconsistent with the state health plan.[159]

D. Continued Implementation of NHPRDA

Adoption of state certificate of need statutes in response to NHPRDA continued steadily after the passage of the 1979 amendments. By 1980, forty-seven states and the District of Columbia had certificate of need programs. Only Louisiana, Idaho, and Indiana lacked certificate of need statutes, and all three had 1122 programs. By the end of 1980, Idaho and Indiana had adopted certificate of need laws.[160] Several states terminated their 1122 agreements after they adopted certificate of need laws.[161] This change was due in part to the perception that the presence of a certificate of need program rendered section 1122 superfluous.[162] Additionally, the Department of Health and Human Services did not provide any additional funding for the cost of administering both certificate of need and 1122 programs.[163]

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[157] *See, e.g.*, Carpenter & Paul-Shaheen, *Implementing Regulatory Reform: The Saga of Michigan's Debedding Experiment*, 9 J. HEALTH POL. POL'Y & L. 453 (1984).

[158] *See infra* note 174.

[159] 42 U.S.C. § 300m-6(c) (Supp. III 1979).

[160] AMERICAN HEALTH PLANNING ASS'N, SELECTED DATA ON STATE HEALTH PLANNING AND RELATED PROGRAMS (1982).

[161] CONGRESSIONAL BUDGET OFFICE, HEALTH PLANNING: ISSUES FOR REAUTHORIZATION 14-15 (1982).

[162] S. Rep. No. 96, 96th Cong., 1st Sess. 43, *reprinted in* 1979 U.S. CODE CONG. & ADMIN. NEWS 1306, 1348.

[163] *See* 44 Fed. Reg. 44,345 (1979).

E. Recent NHPRDA Amendments

Since the 1979 amendments, NHPRDA has not undergone major revision. However, the relationship between NHPRDA's certificate of need requirements and state certificate of need programs has been drastically altered, and NHPRDA's coverage provisions themselves have been modified.

The provision of NHPRDA authorizing appropriations for funding HSA's and SHPDA's expired September 30, 1982.[164] From that time until the present, Congress has temporarily continued the program in annual appropriations bills.[165] Each year, Congress has appended a rider to the appropriations bills forbidding the Secretary of Health and Human Services from terminating or penalizing a state that fails to have a certificate of need program complying with NHPRDA during the fiscal year covered by the bill.[166] The effect of these provisions has been to release states from the risk of losing federal funds by amending their certificate of need statutes to deviate from NHPRDA.[167] In the wake of these provisions, numerous states have adopted certificate of need coverage provisions differing sharply from NHPRDA.

The NHPRDA coverage provisions themselves also have been substantially cut back. The Health Programs Extension Act of 1980 added a permissive exemption from certificate of need coverage for projects "solely for research."[168] The NHPRDA exemption applies to projects solely for research that would not affect patient charges or substantially change bed capacity or medical and other patient care services of the facility (either initially or after the project has been developed).[169]

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[164]42 U.S.C. § 300n-6 (1982).

[165]Departments of Labor, Health and Human Services and Education and Related Agencies Appropriations Act, 1986, Pub. L. No. 99-178, Title II, 99 Stat. 1102, 1109 (1985); Continuing Appropriations 1985, Pub. L. No. 98-473, § 315(k), 98 Stat. 1837, 1963 (1984); Continuing Resolution 1984, Pub. L. No. 98-151, § 101(c), 97 Stat. 964, 972 (1983); Continuing Appropriations 1984, Pub. L. No. 98-107, § 101(f), 97 Stat. 733, 736 (1983); Further Continuing Appropriations 1983, Pub. L. No. 97-377, § 101(e)(2), 96 Stat. 1830, 1905-6 (1982); Continuing Appropriations Fiscal Year 1983, Pub. L. No. 97-276, § 133, 96 Stat. 1186, 1197 (1982).

[166]*E.g.*, Further Continuing Appropriations for the Fiscal Year 1986, § 124, 99 Stat. 1185, 1320 (1985) ("no penalty shall be applied nor any State or agency agreement terminated pursuant to sections 1512, 1515, or 1521 of the Public Health Service Act during fiscal year 1986.")

[167]A court has also held that the appropriations bills' riders implicitly repeal NHPRDA certificate of need requirements, rendering them unenforceable by third parties (who are not specifically barred from enforcement actions by the express terms of the riders). Harrisburg Hosp. v. Thornburgh, 616 F. Supp. 699 (M.D. Pa. 1985), *aff'd mem.*, 791 F.2d 918 (3d Cir. 1986).

[168]Pub. L. No. 96-538, § 307, 94 Stat. 3183, 3191 (1980) (codified at 42 U.S.C. § 300m-6(h) (1982)).

[169]42 U.S.C. § 300m-6(h)(1982). Proposals to grant special treatment for research and education projects had a long history. *See* 38 Fed. Reg. 31,380 (1973) in which the

In the Omnibus Budget Reconciliation Act of 1981, the NHPRDA capital expenditure threshold was increased to $600,000, the expenditure minimum for major medical equipment was increased to $400,000, and the expenditure minimum for annual operating costs was raised to $250,000.[170] The purpose of these changes was to "promote focusing the resources available for certificate of need reviews on the most expensive and future cost-generating new investments in medical care."[171]

High inflation during this period clearly necessitated some threshold increases simply to retain coverage at the originally adopted level. A $150,000 capital expenditure for construction in 1977 would have cost in excess of $232,000 by 1982.[172] Furthermore, many state CON programs were experiencing great problems keeping up with their review workload.[173] Low thresholds meant agencies were bogged down in review of routine replacement expenditures and expenditures for projects, such as acquisition of computerized medical information systems, telephone systems, and parking structures, that were unrelated to patient care. Approval rates for such projects tended to be very high.[174]

In addition, there was increasing recognition at this time that selectively raising thresholds would focus certificate of need review on the most costly and controversial projects. One study indicated that by

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Secretary rejected a proposal to give special consideration to health-related teaching and research capital expenditures under the section 1122 program. In 1978, Massachusetts added a provision to its certificate of need statute exempting capital expenditures and substantial changes in services if they were essential to the conduct of research in basic bio-medical or health care delivery areas or essential to the training of health care personnel, and would not increase capacity or charges. MASS. GEN. LAWS ANN. ch. 111, § 25(c) (West 1978) (amended 1980, 1981). With the Massachusetts law as a prototype, in 1979 the Association of American Medical Colleges recommended an amendment to NHPRDA which would have exempted from CON review medical education and research projects with only minor health service impacts. *Health Planning Amendments of 1979: Hearing on S. 594 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Labor and Human Resources*, 96th Cong., 1st Sess. 464 (1979) (statement of John A.D. Cooper, President, Association of American Medical Colleges).

[170]Pub. L. No. 97-35, §§ 936(a)(1)-(3), 95 Stat. 572 (1981) (codified as amended at 42 U.S.C. § 300n(5),(6),(7) (1982)).

[171]Omnibus Budget Reconciliation Act of 1981, H.R. REP. No. 208, 97th Cong., 2d Sess. 823 (1981).

[172]*See* U.S. DEP'T OF COMMERCE, CONSTRUCTION REVIEW 754 (December 1982); U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES: 1981 754 (1981). The section 1122 threshold was even further out of adjustment than the NHPRDA thresholds. A $100,000 construction expenditure in 1973 would have cost $225,000 by 1982. *Id.*

[173]The volume of certificate of need applications had increased while agency funding had decreased. See *supra* note 8; OFFICE OF HEALTH PLANNING, U.S. DEP'T OF HEALTH & HUMAN SERVICES, STATUS REPORT ON STATE CERTIFICATE OF NEED PROGRAMS 3 (1985).

[174]For example, from 1973-82 the certificate of need application approval rates in Florida for equipment replacement and expansion/renovation (not involving new services) were 99.4 percent and 98.1 percent respectively, while the approval rate for all other projects was 81.4 percent. OFFICE OF HEALTH PLANNING, FLA. DEP'T OF HEALTH & REHABILITATIVE SERVICES, ANNUAL REPORT ON CERTIFICATE OF NEED ACTIVITY 42 (1984).

increasing the capital threshold in New York from $100,000 to $1,000,000 and setting a $250,000 annual operating threshold for new services, three quarters of the projects reviewed in 1979 would have been exempted. The remaining projects subject to review, however, would account for 77% of the capital cost and over 96% of the operating cost implications of all projects proposed under the lower thresholds.[175] Similarly, a Department of Health and Human Services study indicated that almost 60% of the certificate of need/section 1122 applications in the 1979-1980 study year were for expenditures below $500,000. These projects accounted for less than 10% of the proposed costs. Furthermore, approval rates were higher for lower cost projects.[176] Building on these studies, a number of recommendations for certificate of need coverage reform were put forth at this time.[177] A common theme was the need to redefine coverage terms so as to focus on high priority projects. One study advocated high capital expenditure thresholds and an annual operating cost threshold for new services.[178] However, it also recommended covering, without regard to operating or capital cost, those new services or items of equipment for which quality of care rationales for certificate of need coverage were strongest.[179] Others recommended covering specified services or technologies rather than using expenditure or cost thresholds.[180] The threshold increases adopted by Congress in the 1981 Budget Act did not exactly follow these proposals.[181] Because

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[175]D. SCHNEIDER, *supra* note 146.

[176]E. COLEMAN, VOLUME AND VALUE OF CON/1122 APPLICATIONS (Bureau of Health Planning, U.S. Dep't of Health & Human Services, Program Information Note 81-7 (1981)).

[177]*See, e.g.*, J. HOWELL, REGULATING HOSPITAL CAPITAL INVESTMENT: THE EXPERIENCE OF MASSACHUSETTS (Nat'l Center for Health Serv. Res., Research Summary Series (1981)); D. SCHNEIDER, *supra* note 146; Cohen & Cohodes, *supra* note 148.

[178]D. SCHNEIDER, *supra* note 146, at 11, 15-16.

[179]*Id.*

[180]Cohen & Cohodes, *supra* note 148; *see also* J. HOWELL, *supra* note 177, at 21.

[181]Threshold levels were negotiable items in the political debate over health planning in 1981, with opponents of the program seeking to reduce the number of projects subject to review as much as possible and proponents attempting to hold threshold increases to the level necessary to obtain continued political support for the program. Thus, in the spring of 1981, the Department of Health and Human Services drafted a legislative proposal to "phase-out" NHPRDA which would have increased the capital expenditure threshold to $500,000 and exempted non-clinical projects such as parking lots and heating systems. *Administration Phase-out Bill Amended Consumer Majority Rule*, WASH. REP. ON MEDICINE AND HEALTH (1981). Starting with that figure, the House version of the 1981 Budget Reconciliation Act would have set the capital expenditure threshold at $500,000 and doubled the existing medical equipment and annual operating cost thresholds (then set at $150,000 and $75,000) to $300,000 and $150,000 respectively. It would have also provided for modest reductions in federal health planning funding. Omnibus Budget Reconciliation Act of 1981, H.R. REP. No. 158, Vol. 2, 97th Cong., 1st Sess. 383 (1981). The Senate version of the Budget Act would have radically defunded NHPRDA. Omnibus Budget Reconcilia-

the thresholds were raised across the board, they did not operate to select out specific classes of projects. In addition, because the federal regulations continued to require coverage of service additions associated with *any* capital expenditure, the effect of the annual operating cost threshold increase was not as great as might appear.

F. Section 1122 Amendments and the Medicare Prospective Payment System

Section 1122 program coverage had remained essentially unchanged from 1972. By the end of 1982, only fifteen states still had section 1122 agreements.[182]

However, in late 1982, there was renewed interest in the 1122 program.[183] From a political standpoint, the section 1122 program had certain features attractive to proponents of federally-funded health planning. Because the law required the Department of Health and Human Services to enter into an 1122 agreement with any state able and willing to do so and provided for payment to states for the reasonable cost of running 1122 programs, it seemed to be less vulnerable than NHPRDA to a hostile administration bent on defunding health planning or a Congress unable to decide whether to reauthorize or terminate NHPRDA.

Additionally, because the consequence of a negative 1122 recommendation was at most a partial reimbursement denial, not the denial of a permit to implement a proposed project, section 1122 programs could legitimately be characterized as less "regulatory" than state certificate of need reviews. The Medicare reimbursement sanction operated as a financial disincentive to invest, and projects did sometimes proceed without section 1122 approval.[184] These features were thought to make 1122 more palatable to deregulation proponents.

Interest in the section 1122 program was also sparked by congressional consideration at this time of fundamental reforms in the Medicare program. As part of a major social security bail-out package, Congress adopted a prospective payment system for Medicare.[185] The prospective payment system reimburses most acute care hospitals participating in

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tion Act of 1981, S. REP. No. 139, 97th Cong., 1st Sess. 878-79 (1981). Conference negotiations resulted in restoration of some federal funds in return for increasing each of the thresholds proposed in the House version by $100,000, resulting in the current $600,000, $400,000, $250,000 configuration. Omnibus Budget Reconciliation Act of 1981, H.R. REP. 208, 97th Cong., 2d Sess. 231 (1981).

[182]LEWIN & ASSOCS., *supra* note 73, at 14.

[183]*See* American Health Planning Ass'n, *1122 May Rise Again*, IV TODAY IN HEALTH PLANNING, No. 8 (1982).

[184]LEWIN & ASSOCS., *supra* note 73, at 5.

[185]Social Security Amendments of 1983, Title VI, 97 Stat. 149-152 (codified at 42 U.S.C. § 1395ww (1983)).

Medicare for acute inpatient services on the basis of a fixed amount per patient admission or "case," based on average costs in a base year for comparable classes of hospitals, adjusted for each hospital's mix of high and low cost cases (represented by diagnostic clusters), and capped by a "budget neutrality" ceiling under which total system reimbursement to hospitals may not exceed the amount that would have been paid under earlier payment systems.[186] The prospective payment system was intended to alter the underlying financial incentives in Medicare, encouraging above-average cost hospitals to economize.

Congress was unable to decide how to incorporate capital costs into the per case payment formula.[187] Consequently, incurred cost reimbursement for acute inpatient hospital capital costs (as well as capital costs incurred by other institutional Medicare providers not covered by prospective payment) was retained. However, Congress also provided that if it were unable to devise a method for incorporating capital costs into the per case payments by October 1, 1986, Medicare would cease to pay for capital costs associated with new acute inpatient hospital capital expenditures in a state after that date unless the state had a section 1122 agreement, and under the agreement the state had recommended approval of the capital expenditure associated with the project.[188]

The effect of this provision is to make section 1122 participation effectively mandatory in all states on October 1, 1986, unless Congress enacts contrary legislation.[189] By this provision, Congress sought to assure

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[186] *Id. See generally* 1 Medicare & Medicaid Guide (CCH) ¶¶ 4200-4395 (prospective payment regulations updated to January, 1986).

[187] It considered using a simple percentage increase in the amount paid to each participating hospital for non-capital costs. There were several difficulties with this "capital add-on" approach. On the average, the proportion of individual hospital total costs that is attributable to the cost of capital plant and equipment (*i.e.*, interest, depreciation) is about seven percent. Anderson & Ginsberg, *Prospective Capital Payments to Hospitals*, 2 HEALTH AFF. 52 (1983). However, the actual proportion varies widely from one hospital to the next on the basis of factors unrelated to individual institutional efficiency or prudent business strategy, including regional location, hospital type and ownership, and age of capital plant. A "seven percent add-on" to the per-case payment rates would tend to penalize some high capital-cost facilities on the basis of these unrelated factors and over-reimburse some low-cost facilities. A more generous add-on would avoid the penalty problem, but increase over-reimbursement and raise total Medicare capital costs over current levels. Both alternatives violate the guiding principles of the prospective payment system: rational economic incentives to hospital efficiency and "budget neutrality." This dilemma prompted Congress' indecision. *Id.*

[188] 42 U.S.C. § 1395ww(g)(1) (1983).

[189] Technically, the provision does not require states to adopt section 1122 programs. However, the penalty that hospitals would suffer in states without section 1122 programs would be so great that it is unlikely any state would opt not to participate in 1122. Compare the NHPRDA penalty for noncompliance described *supra* in text accompanying note 81.

that some mechanism for control of capital investment by health care facilities, either in the form of a formula-derived payment added to or otherwise incorporated into the per case payment, or continued payment at cost subject to review and approval by a planning agency, would always be in place. Several proposals have been advanced for incorporating capital costs into the prospective payment system, both with and without mandated planning agency review.[190]

Finally, Congress also amended the section 1122 expenditure threshold from $100,000 to $600,000, bringing it into line with the NHPRDA threshold.[191]

V. Current State Certificate of Need and Section 1122 Programs

A. Level of Participation in Certificate of Need and Section 1122

Table 1 identifies the present level of state participation in certificate of need or section 1122 programs. Forty-two states and the District of Columbia have certificate of need laws. Seven states have repealed certificate of need statutes since 1983: Arizona, Idaho, Kansas, New Mexico, Minnesota, Texas, and Utah. The other state presently without certificate of need, Louisiana, has never adopted a statute.

Fifteen states presently conduct section 1122 programs. Four (Idaho, New Mexico, Minnesota, and Louisiana) do not have certificate of need statutes. Idaho entered into its current section 1122 agreement when it repealed its certificate of need law in 1983. New Mexico and Minnesota retained their programs when they allowed their certificate of need statutes to lapse.

Minnesota and Kansas adopted statutes imposing moratoria on new hospital construction, bed capacity increases, and bed relocations until July 1, 1987,[192] and June 30, 1986,[193] respectively, at the time their certificate of need laws expired. In effect, their moratoria reestablished capital expenditure regulation, with limited coverage but criteria requiring automatic denial.

Thus, with the exception of Arizona, Utah, and Texas, at the beginning of 1986, every state had some form of health facility capital expenditure regulation such as a certificate of need program, a section 1122 agreement, a moratorium on new hospital projects, or some combination thereof.

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[190] *See* Anderson & Ginsberg, *Medicare Payment and Hospital Capital: Future Policy Options*, 3 Health Aff. 35, 40-43 (1984).

[191] 42 U.S.C. § 1320a-1(g) (1983).

[192] 1984 Minn. Sess. Law Serv., ch. 654, § 57 (West).

[193] 1985 Kan. Sess. Laws 970.

B. Coverage of Health Care Facilities

Table 2 identifies the facilities subject to review in each state with a certificate of need or section 1122 program.[194] Hospitals, skilled nursing facilities, and intermediate care facilities are subject to review in every state when covered transactions are undertaken by them or on their behalf. This unanimity is probably due to the fact that the causes of health care market failure justifying certificate of need regulation—generous insurance coverage, reimbursement incentives to excess investment, organizational insulation from cost increases—are most prevalent for services provided in these settings.[195] In addition, these facilities all have been required to be covered by either NHPRDA or section 1122 for several years.

Somewhat surprisingly, almost all jurisdictions cover ambulatory surgical centers. There is accumulating evidence supporting the intuitively plausible idea that ambulatory surgery offers a less expensive substitute for less complicated inpatient surgery, and on that ground one might expect states to exclude it from certificate of need in order to encourage its spread.[196] However, the increase in ambulatory surgery facilities that

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[194]Appendix A contains definitions, notes, and state supplementary comments for Table 2, organized by state. When the notation "N" appears in Table 2, the state-by-state comments in Appendix A contain explanatory information.

[195]The reasons for hospital and nursing home coverage are probably somewhat different. The level of private insurance or governmental third party payment for hospital care is very high (86% of total expenditures for hospital care) while consumer out-of-pocket payment for nursing home care is high (44% of total expenditures for nursing home care). High levels of patient cost-sharing for nursing home services weaken the market-failure argument for certificate of need coverage. However, the share of expenditures for nursing home care not paid out-of-pocket is borne disproportionately by public benefit and insurance programs (a large contributor to which are state Medicaid programs), not private health insurance. Gibson, Waldo & Levit, *National Health Expenditures 1982*, 5 HEALTH CARE FIN. REV. 1, 7 (1983). Consequently, coverage of nursing facilities can probably be attributed to the use of certificate of need programs to limit the availability of such facilities to Medicaid beneficiaries for the purpose of constraining Medicaid costs and encouraging patients to seek less costly, non-institutional forms of care. Thus, it would be no coincidence that Arizona, whose Medicaid program (the Arizona Health Care Cost Containment System) is the only one not providing nursing home benefits, was the only state in recent memory that did not cover nursing facilities under its (recently repealed) certificate of need law. *See* ARIZ. REV. STAT. ANN. § 36-433 (Supp. 1975) (repealed 1985). Similarly indicative of the Medicaid budget control rationale for certificate of need, Indiana's statute covers only those skilled nursing and intermediate care facilities that participate in Medicaid, and North Carolina, Ohio, and Virginia have partial exemptions from certificate of need review for nursing beds in retirement communities that do not participate in Medicaid, presumably on the grounds that the high levels of out-of-pocket payment for non-Medicaid nursing homes mean a price-sensitive consuming public. IND. CODE ANN. § 16-1-3.3-1(a) (West Supp. 1985); 1985 N.C. Adv. Legis. Serv. ch. 445 (to be codified at N.C. GEN. STAT. § 131E-183(c)); 1985 Ohio Legis. Bull. file 23, § 1 (Anderson) (to be codified at OHIO REV. CODE ANN. § 3702.53 (I)); VA. CODE § 32.1-102.3:1 (1985).

[196]*See generally* W. VALENTINE & B. PALMER, AMBULATORY SURGERY SERVICES 15-17 (Alpha Center Monographs: Methodological Note No. 5) (Office of Health Planning, U.S. Dep't of Health & Human Services, 1984) and studies cited therein.

would result from an exemption might have the undesirable short-term effect of increasing excess inpatient surgical capacity and reducing opportunities for hospital internal subsidization of services such as free care surgery revenues.[197] The widespread coverage of ambulatory surgery centers probably reflects concerns about imperfections in the ambulatory surgery market, the impact of such centers on hospital utilization, quality issues, and simply the fact that both NHPRDA and 1122 mandate ambulatory surgery coverage.

Most states have essentially exempted health maintenance organizations (HMO's) and health care facilities controlled by health maintenance organizations from certificate of need by adopting the NHPRDA exemption provisions or similar language. A few have taken the principle behind the NHPRDA exemption a good deal further. For example, California exempts any health care facility project other than a skilled nursing bed addition if over twenty-five percent of the patients served by the project are covered by prepaid health care.[198] It thus exempts facilities not actually controlled by health maintenance organizations if they are subjected to the efficiency incentives of health maintenance organizations or other forms of prepayment.

Coverage of other facilities is much more varied. Twenty states cover medically oriented residential care facilities. The market failure rationale for their coverage is weak, because by definition such institutions provide only minimal medical care services. However, such institutions are often operated by government units or reimbursed almost entirely by Medicaid and social service agencies, and certificate of need review may be simply a vehicle for governmental planning and budgeting for the services these facilities provide.[199] A similar rationale probably supports the remarkably widespread (thirty-one states) coverage of home health agencies.

Fifteen states cover all organized ambulatory care facilities. Several others cover one or more specific types of ambulatory facility. Fifteen cover hospices. In each of these instances, states have consciously decided

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[197]Meritorious cream-skimmers like ambulatory surgery facilities create a perpetual dilemma for health planning agencies, exacerbated by contradictory certificate of need criteria for evaluating such proposals. *Cf.* Collier Med. Center, Inc. v. Department of Health & Rehabilitative Servs., 462 So. 2d 83, 85 (Fla. Dist. Ct. App. 1985) (upholding the denial of a certificate of need for new for-profit hospital construction on the skimmer-favoring ground that an existing outpatient facility provided a less costly alternative and the skimmer-opposing ground that an existing public hospital would incur a revenue loss from the proposed facility's diversion of paying patients).

[198]CAL. HEALTH & SAFETY CODE § 437.10(g) (Deering Supp. 1986). Oregon has recently adopted a potentially even broader provision. It exempts hospitals if sixty percent of their inpatient revenue is received from payers employing prospectively-determined forms of reimbursement. 1985 Or. Laws, ch. 747, § 35 (to be codified at OR. REV. STAT. § 442).

[199]Whether the certificate of need administrative adjudicatory process is an efficient means of doing so is questionable. A few states have amended their statutes recently to exempt government-run health care facilities. *See, e.g.*, MO. ANN. STAT. § 197.315(18) (Vernon Supp. 1985); MONT. CODE ANN. § 50-5-309(1)(b) (1985).

to cover health facilities that are not covered under NHPRDA and that the Department of Health and Human Services has expressly chosen not to cover.

The extent to which these institutions actually undergo certificate of need review depends considerably on the project coverage provisions of their state's certificate of need law. Most of the states that cover ambulatory facilities have sufficiently high capital expenditure and major medical equipment thresholds that the facilities' typically modest capital acquisitions in these areas would escape review. However, most of the states that cover ambulatory facilities would subject the initial establishment or construction of such facilities to review.

The reasons states cover ambulatory health care facilities are not immediately apparent. As with ambulatory surgery centers, coverage is probably justified by concern for impact on hospital use and cream-skimming or by concern for access and quality.[200]

1. Coverage of Capital and Other Projects.—The states have made major changes in project coverage. Going beyond recent NHPRDA amendments and essentially implementing the recommendations of policy analysts in the field, they have de-emphasized review of projects not directly related to patient care and have focused on large expenditures and additions of new technology and services. Table 3 identifies the capital expenditures and other projects subject to review under the states' certificate of need and section 1122 programs.[201]

Project coverage varies widely among the states. However, some of the variation may be more apparent than real. First, states may simply choose different words to cover essentially the same transactions.[202] For example, there is probably no difference in reviewability of bed capacity increases between a state that covers capital expenditures for bed capacity increases and a state that covers bed capacity increases without regard to expenditure, because a bed capacity increase almost invariably involves a capital expenditure (for the beds themselves if nothing else). Second, several states have redundant project coverage provisions. Covering both service additions associated with a capital expenditure and service additions regardless of capital or operating cost is an example. If these kinds of variations are set aside, it is apparent from Table 3 that most

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[200]Stated rationales for ambulatory care facility coverage are extremely difficult to find. *But see* STATEWIDE HEALTH COORDINATING COUNCIL, STATE OF MICHIGAN, 2 MICHIGAN STATE HEALTH PLAN 1983-1987, at 25-26, 28 (1983), which justifies coverage of outpatient facilities and public health centers on quality of care and geographical accessibility grounds.

[201]Appendix A contains definitions, notes, and state-by-state supplementary comments for Table 3, organized by state. When the notation "N" appears in Table 3, the state-by-state comments in Appendix A contain explanatory information.

[202]Some of this may be accounted for by the fact that states drafted their certificate of need statutes and regulations at differing times and attempted to comply with the version of federal certificate of need law and regulations then in effect.

states with certificate of need and/or section 1122 programs cover general-purpose capital expenditures incurred by or on behalf of health care facilities, bed-related changes of various types, additions of new health services, acquisitions of medical equipment, and construction, development, or establishment of new health care facilities. This is essentially the coverage pattern prescribed by NHPRDA in its current form.

The states with wholly distinct coverage provisions are few. Alaska and California do not have general-purpose capital expenditure thresholds; instead they cover specified transactions.[203] All states cover bed and service-related projects, and the states that do not expressly cover equipment acquisitions or new construction probably review such transactions under capital expenditure or service addition provisions.

2. General-Purpose Capital Expenditure Coverage.—As noted above, virtually every state covers capital expenditures undertaken by or on behalf of health care facilities. Coverage of general purpose capital expenditures has been a common feature of health planning agency review of health facility projects since the inception of comprehensive health planning.[204] However, the levels of state capital expenditure thresholds have increased significantly.[205] Many states have raised their thresholds above the maximum federal level (which would be $736,200 in states taking full advantage of the threshold inflator).[206] This practice appears most common in the western states, where Alaska and California have capital thresholds set at one million dollars for certain specified projects and general purpose thresholds in several other states are at similar levels.[207] Five other states have thresholds exceeding the federal level.[208] Colorado's two million dollar threshold is the highest in the country.

However, there have been proposals to raise thresholds still further. In the 97th Congress, the House of Representatives passed, but the

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[203]California has the most unusual coverage. New hospital construction, bed capacity increases, and additions of seven specified hospital services are the only hospital projects covered. By contrast, establishment of surgery clinics, any capital expenditure for expansion of surgical capacity, capital expenditures in excess of $1 million for medical or other equipment, services, or modernization by clinics and additions of services by clinics are covered. None of the rationales for ambulatory surgery coverage under certificate of need programs appear to justify more extensive coverage of ambulatory surgery than of hospitals. The California law also contains a bewildering array of special exemptions, and an extremely broad authorization for the SHPDA to issue certificates of need in disregard of the review criteria in individual cases. CAL. HEALTH & SAFETY CODE § 437.10,.11,.116,.118,.12,.15 (Deering Supp. 1985).

[204]*See supra* note 57 and accompanying text.

[205]*See* Table 3.

[206]*See supra* note 106.

[207]The general purpose threshold for Colorado is $2,000,000; for Montana, $750,000; for North Dakota, $750,000; for Oregon, $1,000,000 or $250,000 plus 0.5 percent of gross revenues; and for Washington, $1,071,000. *See infra* Table 3.

[208]Indiana ($750,000); Mississippi ($1,000,000); New Hampshire ($1,000,000); North Carolina ($1,000,000); and Tennessee ($1,000,000). *Id.*

Senate did not act on, a bill to supplant NHPRDA which would have increased the federal capital expenditure threshold to five million dollars.[209] In the 98th Congress, bills with capital thresholds ranging from one to five million dollars were introduced, and the Administration expressed its preference for the higher of these thresholds.[210] None of these bills passed.

In the states that have not chosen to exceed the NHPRDA threshold level, few have retained the expenditure thresholds they had in 1980. Only four states have kept capital expenditure thresholds at the $150,000 level.[211]

A state elevating its capital and other expenditure thresholds to levels at or above one million dollars greatly increases the temptation to health care facilities to attempt to evade certificate of need review by artificially dividing projects into two or more stages, each costing less than the threshold. When the expenditure threshold is $100,000, the risks of evasion of certificate of need by dividing, for example, a $198,000 project into two $99,000 stages are not likely to be worth the benefit to the facility. But with a five million dollar threshold, project division could permit a project costing nearly ten million dollars to escape planning agency scrutiny. In response to this problem, several states have adopted statutory prohibitions on project division undertaken for the purpose of avoiding certificate of need review.[212]

3. Non-Clinical Exemptions and Streamlined Review Provisions.— Even more often than they have elevated thresholds, the states have reduced project coverage by a variety of categorical exemptions and by expedited review provisions. First, a number of states have adopted exemptions for expenditures not related to clinical services. The state of Washington, for example, exempts capital expenditures that will not substantially affect patient charges and that are for communications and parking facilities; mechanical or electrical ventilation, heating, and air-conditioning systems; energy conservation systems; repairs to physical

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[209]H.R. 6173, 97th Cong., 2d Sess. § 5 (1982).

[210]*See* H.R. 2934, 98th Cong., 1st Sess. (1983); H.R. 2935, 98th Cong., 1st Sess. (1983); Letter from David Stockman, Director, Office of Management and Budget to Rep. Edward Madigan (Aug. 4, 1983).

[211]Delaware, Michigan, Rhode Island, and Vermont. Two states, Oklahoma and South Dakota, have raised their capital thresholds for hospitals to current NHPRDA levels while retaining lower thresholds for nursing facilities.

[212]D.C. CODE ANN. § 32-302(12)(B) (1981); KY. REV. STAT. § 216B.061(2) (Supp. 1982); ME. REV. STAT. ANN. tit. 22, § 315 (1980); MISS. CODE ANN. § 41-7-173(b)(ii) (Supp. 1984); NEB. REV. STAT. § 71-5832 (Supp. 1984); N.H. REV. STAT. ANN. § 151-C:4(I)(C),(II) (Supp. 1983); 1984 Ohio Legis. Bull. § 3702.59(B) (Anderson); OR. REV. STAT. § 442.320(d) (Supp. 1983); S.D. CODIFIED LAWS ANN. § 34-7A-33 (Supp. 1984); VT. STAT. ANN. §§ 2403(a)(3),(b) (1983); W. VA. CODE § 16-2D-2(i)(2)(B) (Supp. 1984); WIS. STAT. ANN. § 150.07 (West Supp. 1985).

plant necessary to maintain state licensure; acquisition of data processing and other equipment; construction of facilities not used for direct provision of health services; land acquisition; and refinancing existing debt.[213] In addition, a significant number of states provide for expedited or streamlined review of various categories of projects. Most states have adopted the NHPRDA-authorized provision for limited review of projects to eliminate safety hazards or to comply with licensure or accreditation requirements.[214] Numerous states also provide for expedited review of projects such as capital expenditures not involving service or bed capacity increases, service terminations, expenditures below a threshold somewhat higher than their statutory coverage minimum, and the like.[215] Some

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[213]WASH. REV. CODE ANN. § 70.38.105(4)(d) (Supp. 1986); *see also* ARIZ. REV. STAT. ANN. § 36-433(E)(6) (Supp. 1975-1984) (energy conservation projects); CAL. HEALTH & SAFETY CODE § 437.10(e)(5) (Deering Supp. 1985) (parking lots and structures, telephone systems, and non-clinical data-processing systems); COLO. REV. STAT. § 25-3-503(7) (1982) (residential units, parking, telephone systems, day-care, mailroom, gift shops, printshops, medical office buildings or clinics organized primarily for the delivery of physician services, morgue, heating and air conditioning, blood bank, dietary/cafeteria, laundry and linen, administration, medical records, business office, housekeeping, central supply, materials management, library, reception, code violations in non-clinical areas, ground transport services (not including air), land acquisition, research, education, non-diagnostic management information systems); CONN. GEN. STAT. ANN. § 19a-155 (West Spec. Supp. 1984) (energy conservation systems); GA. CODE ANN. §§ 31-6-47, 47(c) (1985) (waiver of review of projects including those defined by regulation GA. ADMIN. COMP. ch. 272-2, § 272-2-07 (1984), such as site acquisitions, transfers of previously-approved major medical equipment not resulting in institution of a new clinical health service at the transferee facility, and expenditures below the capital expenditure threshold for minor repair or replacement of equipment associated with the physical plant); HAWAII REV. STAT. § 323D-54(b) (Supp. 1984) (projects determined not to have a significant impact on the health care system, defined by regulation [HAW. ADMIN. CODE § 11-186-96 (1981)] to include acquisition of a capital asset by a means other than purchase; bed supply increases or decreases not exceeding the capital expenditure of annual operating cost threshold; addition or deletion of a service not exceeding an annual operating cost threshold; certain structural repairs; equipment replacement not exceeding twice the expenditure minimum; non-patient care projects such as parking lot structures not exceeding twice the expenditure minimum); MONT. CODE ANN. § 50-5-309(1)(a) (1985) (expenditures for non-medical and non-clinical facilities and services unrelated to the operation of the health care facility); OR. REV. STAT. § 442.320(b) (Supp. 1983) (statutory authorization for adoption of rules providing for waiver of review of expenditures for repairs by replacement of equipment, non-clinically related capital expenditures, and offering or development of a new health service of a non-substantive nature); Executive Budget Bill, Act 29, 1985 Wis. Legis. Serv. 390 (West) (to be codified at WIS. STAT. ANN. § 150.613 (West)) (hospital heating, air conditioning, ventilation, electrical systems, energy conservation, telecommunications, computer systems, or non-surgical outpatient services not part of an otherwise reviewable project and whose capital cost does not exceed 20% of the hospital's gross annual patient revenue for its last fiscal year).

[214]*See supra* note 159 and accompanying text.

[215]ALA. CODE § 22-21-275(4) (Supp. 1984) (non-substantive review of capital expenditures up to $500,000 which: do not result in a substantial change in a service; or propose equipment to upgrade or expand an existing service; or increase bed capacity by not more

states without specific statutory procedures for expedited review have

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than ten percent); ARIZ. REV. STAT. ANN. § 36-433(G) (Supp. 1984) (abbreviated application for all projects except establishment of new services with annual operating costs exceeding $75,000; construction of new health care facilities; and capital expenditures, other than expenditures for equipment replacement, exceeding $150,000); CAL. HEALTH & SAFETY CODE § 437.15 (Deering Supp. 1985) (expeditious processing of applications for projects for sole community provider hospitals with less than 100 beds; projects for skilled nursing or intermediate care facility establishment, projects for addition of skilled nursing or intermediate care beds in facilities other than skilled nursing or intermediate care facilities); FLA. STAT. ANN. § 381.494(1)(n) (West Supp. 1985) (expedited review of transfer of a certificate of need); GA. CODE ANN. § 31-6-47(c) (1985) (statutory authorization for SHPDA to conduct expedited review of projects, where compatible with statutory purposes); IOWA CODE ANN. § 135.67 (West Supp. 1984-85) (summary review procedures for projects costing $150,000 or less; and projects for which the applicant, the state agency, and the HSA agree to summary review); KY. REV. STAT. § 216B.095 (Supp. 1982) (non-substantive review of applications to replace or repair five-year-old worn equipment; repairs, alterations, or improvements to physical plant not resulting in a substantial change in beds/services or equipment addition; and other applications as prescribed by state agency regulations); ME. REV. STAT. ANN. tit. 22, § 304-C (Supp. 1985-86) (waiver of review of new health services projects involving a capital expenditure below $300,000, third year annual operating costs between $155,000 and $250,000 and no increase in reimbursement authorization by rate-setting commission); MICH. COMP. LAWS ANN. § 333.22151 (1980) (non-substantive review of projects for which full review could increase cost by unnecessary delay or require inefficient use of staff review time); MISS. CODE ANN. § 41-7-205 (Supp. 1984) (non-substantive review of: certain transfers of ownership; replacement of equipment; general-purpose capital expenditures not exceeding $700,000; acquisition of major medical equipment not exceeding $460,000; certain project cost overruns; and deletion or relocation of services or facilities); MO. ANN. STAT. § 197.305(12) (Vernon Supp. 1985) (non-substative review of capital expenditures due to an act of God or a normal consequence of maintaining health care services, facilities, or equipment which do not involve bed addition, replacement, modernization, conversion, or new services); MONT. CODE ANN. § 50-5-302 (Supp. 1984) (abbreviated review of proposals that do not significantly affect the cost or use of health care or that have been approved by the legislature); NEB. REV. STAT. § 71-5834 (Supp. 1984) (non-substantive review of replacement of equipment with equipment of similar capability; reduction in bed capacity or termination of a single service which does not involve the closing or relocation of a health facility; expenditures for energy conservation proposals); 1984 Ohio Legis. Bull. § 3702.52(J) (Anderson) (expedited review of: capital expenditures less than $1.5 million not involving bed or service additions, equipment acquisition, new facility construction, or facility category conversion; additions of new services with capital costs less than the expenditure care minimum, annual operating costs less than $500,000 and no bed additions; non-patient-related capital expenditures not affecting patient charges; bed capacity increases or redistributions up to nine beds or ten percent of bed capacity (or bed relocations), whichever is less, in any two year period, and not involving a health service addition or a capital expenditure exceeding the expenditure minimum; acquisition of medical equipment for less than $1.25 million; replacement of medical equipment for less than $1.5 million; and other projects specified by regulation); OR. REV. STAT. § 442.320(b) (Supp. 1983) (statutory authorization for adoption of rules providing for accelerated review of expenditures for repairs and replacement of plant or equipment; non-clinically related capital expenditures, and offering or development of a new health service of a non-substantive nature); PA. STAT. ANN. tit. 35, § 448.702(j)(2) (Purdon Supp. 1984-85) (exemption from comparative review requirements for replacement of equipment not involving a substantial change in functional capacity or capability; energy-saving equipment installations or renovations not

adopted such mechanisms by regulation.[216] Several states provide for exemption or expedited review of projects for replacement of facilities or equipment.[217] A few have implemented the NHPRDA exemption for

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involving new services or expansion of capacity); R.I. GEN. LAWS § 23-15-5 (Supp. 1984) (statutory authorization for adoption of regulations specifying projects eligible for expenditious review); S.D. CODIFIED LAWS ANN. § 34-7A-39 (Supp. 1984) (abbreviated review of projects which: increase bed capacity, redistribute beds among categories, or relocate beds from one facility to another, by less than ten beds or ten percent of bed capacity; capital expenditures to remedy emergency situations; and other projects declared eligible for abbreviated review by regulation); W. VA. CODE § 16-2D-7(v) (Supp. 1984) (statutory authorization for adoption of regulations specifying applications eligible for expedited review); WYO. STAT. § 35-2-206(c) (1977) (department review of temporary addition or subtraction of beds or equipment and replacement services or expenditures which are comparable and necessary to maintain services).

[216]*E.g.*, IDAHO ADMIN. PROC. MANUAL tit. 2, § 16.02, 11300, 02 (1983) (non-substantive section 1122 review of repair or replacement of physical plant and equipment associated with physical plant, *i.e.*, boilers, air conditioning, electrical circuitry); DIVISION OF POLICY, PLANNING & EVALUATION, OFFICE OF MANAGEMENT & FINANCE, LA. DEP'T OF HEALTH & HUMAN RESOURCES, POLICIES AND GUIDELINES FOR REVIEW OF CAPITAL EXPENDITURES UNDER SECTION 1122 OF THE SOCIAL SECURITY ACT 6-7 (1985) (expedited section 1122 review of replacement or modification of equipment, sale of an existing facility with no change in beds or services, lease (or discontinuance of a lease) of an approved existing facility with no change in beds or services, renovation of an existing facility up to $1,000,000 not resulting in a bed or service change; cost overrun; addition of non-medical equipment or purchase of land; addition of a new service in an existing facility not exceeding $600,000; incorporation, reorganization, merger, consolidation, majority stock sale or transfer or other changes in the person owning an approved facility; non-substantial site change; bed capacity reduction; and discontinuance of an approved service); N.J. ADMIN. CODE tit. 8, § 33-2.5 (1985) (administrative review of increase in residential health care facility beds of ten beds or ten percent of licensed capacity, whichever is less; change in bed category not involving a capital expenditure or an increase in total licensed capacity, additions of new services, fixed or moveable equipment, or renovations required by law or to prevent harm to patients; transfer of a patient care service in whole or part to another corporate entity; replacement of equipment; acquisition of telephone or computer systems in excess of $400,000; and acquisition of fixed equipment or renovation dealing exclusively with energy conservation); N.Y. ADMIN. CODE tit. 10, § 710.1(c)(3) (1985) (administrative approval of: proposals not exceeding $3 million for addition or modification of a licensed service, with exceptions for certain specialized services; bed or service decertification; certain bed-category conversions, additions to existing services not involving an additional site or beds, projects for correction of safety deficiencies, ordinary repairs, energy conservation, and modernization in facilities for which there is a continuing need; replacement and updating of equipment in needed facilities; addition or deletion of approval to operate part-time clinics; operation or relocation of extension clinics; emergency room modernization; projects identified as high priority in the state medical facilities plan).

[217]GA. CODE ANN. § 31-6-47(a)(10) (1985) (exemption of expenditures for replacement of equipment including but not limited to CT scanners); KY. REV. STAT. § 216B.095 (Supp. 1982) (nonsubstantive review of replacement of equipment used for five years or more and repairs, alterations, and improvements to physical plant not resulting in bed or services changes or equipment additions); MISS. CODE ANN. §§ 41-7-191(2), 205 (Supp. 1985) (exemption from health facility expansion, construction moratorium for necessary repairs and renovation or replacement of an existing facility); MO. ANN. STAT. § 197.305(12)

research projects.[218] The approval rates for projects eligible for expedited review tend to be very high, making expedited review effectively very similar to an exemption from review.

In short, the majority of states have employed exemptions and expedited review to diminish substantially the range of projects subject to review and to focus review on projects for new or significantly expanded clinical service capacity. The practice is not confined to the states with high thresholds. Two of the four states that have retained thresholds at the $100,000 - $200,000 level have adopted some form of expedited review or non-substantive project exemption.[219]

4. Bed-Related Coverage.—All jurisdictions with certificate of need or section 1122 programs cover bed supply increases in some fashion. Even states like California and Colorado, which have sharply cut back on coverage by repealing or greatly increasing expenditure thresholds, continue to review increases in bed capacity. However, over half the states have adopted insubstantial increase exemptions, an increase from the number reported in earlier surveys.[220] Most states use the "ten beds or ten percent" exemption authorized by NHPRDA. California and Georgia exempt "ten beds or ten percent" increases from review only if the facility meets certain occupancy rate minimums,[221] while Colorado exempts from review a twenty bed increase every two years.[222]

Thirty-five states cover some form of bed category conversion or bed relocation, while over half the states cover bed capacity decreases.

(Supp. 1985) (nonsubstantive review of replacement and modernization projects); NEB. REV. STAT. § 71-5835 (Supp. 1984) (nonsubstantive review of equipment replacement); 1984 Ohio Legis. Bull. § 3702.52(J) (Anderson) (expedited review of replacement of equipment under $1.5 million); OR. REV. STAT. § 442.320(a)(b) (Supp. 1983) (accelerated review of repairs or replacement of plant or equipment); PA. STAT. ANN. tit. 35, § 448.702(j)(2) (Purdon Supp. 1984-85) (exemption from comparative review requirements for equipment replacement and renovation to meet code requirements); WYO. STAT. § 35-2-206(d) (Supp. 1985) (expedited review of expenditures for upgrading and replacing equipment, and replacement services or expenditure to upgrade, acquire, or implement new technology which may be comparable and necessary to maintain services); N.J. ADMIN. CODE tit. 8, § 33-2.7(a)(7) (1985) (expedited review of equipment replacement); N.Y. ADMIN. CODE tit. 10, § 710.1(b)(c)(3) (1985) (administrative review of projects under $3 million for modernization of facilities and replacement and updating of equipment for which there is continuing need).

[218]KY. REV. STAT. § 216B.066 (Supp. 1982); MASS. GEN. LAWS ANN. ch. 111, § 25C (West 1983); NEB. REV. STAT. § 71-5830.01 (Supp. 1984); N.C. GEN. STAT. § 131E-179 (Supp. 1983); TEX. REV. CIV. STAT. ANN. art. 4418h, § 3.01(d) (Vernon Supp. 1984); W. VA. CODE § 16-2D-4(c) (Supp. 1984).

[219]Michigan and Rhode Island have adopted expedited review provisions. *See supra* note 215.

[220]*See supra* note 109 and accompanying text.

[221]CAL. HEALTH & SAFETY CODE § 437.11(4) (Deering Supp. 1985); GA. CODE ANN. § 31-6-47(15) (1985).

[222]COLO. REV. STAT. § 25-3-506(e) (1982).

The recent amendments to the NHPRDA regulations permitting complying state certificate of need programs to make their own determinations as to whether to cover such transactions will probably cause a decrease in these figures.

C. Health Service-Related Coverage

Table 3 indicates that all of the states with certificate of need or section 1122 programs cover additions of new health services. Half cover service terminations, but because only nine states cover terminations not associated with a capital expenditure and terminations do not usually involve capital expenditure, actual review of service terminations appears to be a relatively infrequent practice.

Twenty-six states have adopted annual operating cost thresholds.[223] Thresholds vary widely, from $75,000 in Rhode Island to $536,000 in Washington. Just five states, however, cover health service additions only if they are associated with annual operating costs exceeding the threshold.[224] The remaining states either cover health service additions regardless of cost or, following the NHPRDA model, cover health service additions associated with any capital expenditure. Both of the latter approaches appear inconsistent with the policy underlying annual operating cost thresholds, which is to target the cost containment functions of certificate of need while minimizing the scope of coverage by reviewing only those service additions that generate additional long-term costs.[225]

A number of states have adopted a new approach to coverage of health service additions. These states cover additions of a small number of specified new health services regardless of their capital or operating cost, and all other new services only if their capital or operating costs exceed a threshold. For example, Wisconsin covers additions of organ transplant programs, burn centers, neonatal intensive care units, cardiac programs, and air transport programs without regard to cost.[226] Other

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[223]The states differ in the way they define their annual operating cost thresholds. Maine, for example, uses the projected annual operating costs without any adjustment for inflation for the third fiscal year of operation, including a partial first year. "Annual operating costs" are defined as "total incremental costs to the institution which are directly attributable to the addition of a new health service." ME. REV. STAT. ANN. tit. 22, §§ 303(2)(A), 304-A(4)(B) (Supp. 1984-85). The District of Columbia employs an "annual operating budget" threshold, Maryland an "annual operating revenue" threshold. D.C. CODE ANN. § 32-302(12)(D) (Supp. 1984); MD. HEALTH-GENERAL CODE ANN. § 19-115(j)(2)(ii) (Supp. 1985).

[224]Maryland, Missouri, Montana, Oklahoma, and Wyoming.

[225]The statutory certificate of need coverage approach of Montana and Wyoming appears to come the closest to accomplishing this policy. They have relatively high capital expenditure and major medical equipment thresholds and $100,000-$150,000 operating cost thresholds. Under this approach, projects are subject to review only if they increase long-term operating costs or represent high, one-time capital expenditures.

[226]1985 Wis. Legis. Serv. 390 (West) (to be codified at WIS. STAT. §§ 150.61(1),(2)).

hospital service additions are covered only if capital costs exceed $1,000,000.[227] Similarly, Ohio covers additions of heart, lung, liver, and pancreas transplant programs without regard to cost and other new services only if their annual operating costs exceed $297,500.[228] Other states may achieve a similar coverage pattern through exemptions or streamlined review. New York, for example, provides for "administrative approval" of service additions or modifications unless the project cost will exceed $3,000,000 or relates to certain specified service categories.[229] The purpose of this approach seems to be to cover without regard to cost the services for which non-cost containment rationales for certificate of need review apply and to cover the services for which cost-control is the paramount concern only if project costs exceed the threshold. The

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[227] *Id.*

[228] 1984 Ohio Legis. Bull. § 3702.51(R)(2), (9) (Anderson); *see also* ARIZ. REV. STAT. ANN. §§ 36-433(A)(5),(6) (Supp. 1975-84) (repealed 1985) (coverage of additions of obstetrical units, neo-natal special care units, pediatric inpatient services, open-heart surgery units, cardiac catheterization services, radiation therapy services, end-stage renal dialysis services, computed tomographic scanning, neurological units, spinal injury units, and burn treatment units regardless of cost, and additions of other services only if their operating costs exceed $750,000); COLO. REV. STAT. §§ 25-3-503(10), 506(1)(d) (1982) (repealed 1984) (coverage of tertiary services [i.e., highly specialized services frequently requiring sophisticated technology and support services and limited to open-heart surgery, organ transplantation, burn care, level III intensive care nurseries, and radiation therapy] at any cost, and coverage of only those other services exceeding threshold); ILLINOIS HEALTH FACILITIES PLANNING BOARD, ILLINOIS HEALTH CARE FACILITIES PLAN § 3.02.B.29 (1982) (coverage of acute mental illness, alcoholism treatment, burn treatment, cardiac catheterization, computer systems, end-stage renal disease, intensive care, medical-surgical, non-hospital based ambulatory surgery, obstetrical services, open-heart surgery, pediatric services, perinatal high risk, radiation therapy, rehabilitation services additions regardless of cost; other services exceeding annual operating costs threshold); KY. REV. STAT. § 216B.015(25) (Supp. 1982) (coverage of health service additions exceeding $250,000 annual operating cost or additions of services specified in State Health Plan, regardless of cost. The Kentucky State Health Plan provides for coverage of acute care services, open-heart surgery, cardiac catheterization, radiation therapy utilizing megavoltage equipment, end-stage renal disease services, CT scanners, nuclear magnetic resonance imaging, and long-term care services); ME. REV. STAT. ANN. tit. 22, § 304-A(4) (Supp. 1984-85) (coverage of new services regardless of cost identified in regulations or new services exceeding the annual operating cost threshold; no regulations adopted to date); MASS. GEN. LAWS ANN. ch. 111, § 25B (1983); MASS. ADMIN. CODE tit. 105, § 100.020 (1983) (coverage of "major services" without regard to cost and of only those other services exceeding annual operating cost threshold); 1985 Or. Laws, ch. 747 § 16 (to be codified at OR. REV. STAT. § 442.015(24)); OR. ADMIN. R. 409-03-010(10) (1985) (coverage of new health services exceeding annual operating expense threshold or new health services, regardless of cost, which may compromise quality of care); TENN. ADMIN. COMP. § 0720-2-.02(2)(d) (1985) (coverage of specified set of major health services without regard to cost and other services with projected annual operating budget exceeding $500,000 threshold).

[229] Therapeutic radiology, open-heart surgery, cardiac catheterization, kidney and heart transplant, chronic and acute renal dialysis, CT scanning, burn care, and extracorporeal shockwave lithotripsy require approval regardless of cost. N.Y. ADMIN. CODE tit. 10, § 710.1(c)(3) (1985).

Oregon provision does so most explicitly, by covering new services either if they exceed the annual operating expense threshold or may potentially compromise quality of care through insufficient volume to support needed specialized staff or to maintain skills.[230]

NHPRDA and section 1122 left the states free to define which newly-established "services" would be subject to certificate of need review.[231] Most states appear to have never specified in their statutes or regulations the "health services" they subject to review. However, some have done so. The states listed above as covering some specified health service additions regardless of cost, of course, have at least a partial list. In addition, California's certificate of need provisions cross-reference a statutory list of special services subject to health facility licensure.[232] The Georgia statute contains a non-inclusive list of clinical health services subject to review, which corresponds roughly to the major service departments in a typical large hospital.[233] Finally, a few states cover expansions of existing services.[234] However, most cover only service additions.

D. Major Medical Equipment Coverage

In most states, acquisition of medical equipment by or on behalf of a health care facility is subject to certificate of need review as a capital expenditure if the capital expenditure associated with the acquisition exceeds the expenditure threshold.[235] However, the 1979 NHPRDA

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[230] OR. ADMIN. R. 409-03-010 (1985).

[231] *See supra* notes 122-28 and accompanying text.

[232] CAL. HEALTH & SAFETY CODE § 437.10(c) (Deering Supp. 1985).

[233] GA. CODE ANN. § 31-6-2(5) (1985) provides:

> "Clinical health services" means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are located in a health care facility, and includes, but is not limited to, radiology; radiation therapy; surgery; intensive care; coronary care; pediatrics; gynecology; obstetrics; dialysis; general medical care; medical/surgical care; inpatient nursing care, whether intermediate, skilled, or extended care; cardiac catheterization; open-heart surgery; inpatient rehabilitation; and alcohol, drug abuse, and mental health services.

See also ALASKA STAT. § 18.07.111(8) (1981) (health service defined as major type, program, unit, division, or department of care, including outpatient, psychiatric wing, kidney dialysis, radiotherapy, burn unit, newborn intensive care unit); R.I. GEN. LAWS § 23-15-2(h) (1979) (health services defined as "organized program components" for providing services); MINN. STAT. ANN. § 145.833 Subd. 3 (West 1982) (repealed 1984) (health services defined as cost centers recognized by generally accepted accounting principles and conforming to cost center definitions used by state rate-setting/price disclosure program).

[234] 1985 Nev. Adv. Sh. ch. 454, § 13 (to be codified at NEV. REV. STAT. § 439A.100(2)(c)); OR. ADMIN. R. 409-03-010(6) (1985).

[235] In some states, the acquisition of certain types of equipment may also constitute a covered addition of a new service. For example, acquisition of a CT scanner constitutes a new service in Arizona and Kentucky. *See supra* note 228.

amendments authorized a distinct category of coverage, acquisitions of medical equipment exceeding an expenditure minimum lower than the all-purpose capital expenditure threshold if the equipment is owned by or located in a health care facility or used to provide services for in-patients.[236] Most states have adopted this coverage category, with statutory equipment thresholds varying from $125,000 to $1,000,000.

Seventeen states cover acquisitions of medical equipment that may be used for persons who are not in-patients of a health care facility. Virginia covers acquisition by a physician's office of equipment that is generally and customarily associated with the provision of health services in an in-patient setting.[237] Fifteen states and the District of Columbia cover equipment acquisitions in various non-in-patient settings.[238] Most of these states added their coverage of equipment in non-institutional settings after witnessing placement of CT scanners and, most recently,

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[236]Pub. L. No. 96-79, § 117, 93 Stat. 592, 615 (1979) (codified as amended at 42 U.S.C. § 300m-3).

[237]VA. CODE § 32.1-102.1 (Supp. 1985).

[238]COLO. REV. STAT. § 25-3-506(1)(g) (Supp. 1985) (capital expenditure exceeding $1 million by or on behalf of any person or entity for major medical equipment to provide clinically related health care); CONN. STAT. ANN. § 19a-155(b) (West Spec. Pamp. 1984) (capital expenditure exceeding $400,000, by any person, to acquire imaging equipment); D.C. CODE ANN. § 32-302(11)(A) (Supp. 1984) (acquisition of medical equipment with a value exceeding $400,000 by physicians, dentists, or other individual providers of individual group practice); HAWAII REV. STAT. §§ 323D-53, 54 (Supp. 1984) (acquisition of equipment exceeding expenditure threshold by physicians' offices); IOWA CODE ANN. § 135.61(19)(g) (West Supp. 1984-85) (expenditure exceeding $400,000 by individual or group of health care providers for equipment installed in private office or clinic); MD. HEALTH-GENERAL CODE ANN. §§ 19-1001 *et seq.* (Supp. 1985) (licensure of major medical equipment wherever located costing in excess of $600,000); MISS. CODE ANN. § 41-7-191(1)(f) (Supp. 1985) (acquisition or control of major medical equipment exceeding $750,000 by any person); MONT. CODE ANN. § 50-5-301(d) (Supp. 1984) (acquisition by any person of medical equipment exceeding $500,00 which would have required a CON if acquired by a health care facility); 1985 Nevada Adv. Sh. ch. 454, §§ 9, 13 (to be codified at NEV. REV. STAT. §§ 439A.015(10), .100(d) (acquisition of medical equipment exceeding $400,000 by the office of a health services practitioner); 1985 N.H. Laws, ch. 378, § 378:6 (to be codified at N.H. REV. STAT. ANN. § 151-C:5(II)(D)) (acquisition of equipment exceeding $400,000 by a health care provider); 1985 N.C. Adv. Legis. Serv., ch. 740, § 6 (to be codified at N.C. GEN. STAT. § 131E-176(16)(g)) (acquisition by any person of major medical equipment that includes magnetic resonance imaging and lithotripters, regardless of ownership or location); 1985 Or. Laws, ch. 747, § 31 (to be codified at OR. REV. STAT. § 442.320(1)(b)) (acquisitions of medical equipment exceeding $1 million by any person); R.I. GEN. LAWS § 23-15-2(k) (1977) (acquisition of medical equipment exceeding $150,000 by a health care provider); W. VA. CODE §§ 16-2D-2t, 16-2D-3(h) (Supp. 1985) (acquisition of major medical equipment exceeding $400,000 by any person); WIS. STAT. ANN. § 150.61(3) (West Supp. 1984) (capital expenditure exceeding $1 million for clinical medical equipment by an independent practitioner or medical group); WYO. STAT. §§ 35-2-202(a)(ix), 205(a)(iii) (Supp. 1985); DIV. OF HEALTH & MEDICAL SERVS., WYO. DEP'T OF HEALTH & SOCIAL SERVS., RULES AND REGULATIONS GOVERNING CERTIFICATE OF NEED, ch. III §§ 2, 4 (1985) (acquisitions of major medical equipment exceeding $400,000 by licensed practitioners' offices).

magnetic resonance imaging (MRI)[239] scanners in physician's offices and other non-institutional settings in order to evade certificate of need review.[240] States that did so after September 1982 not only breached NHPRDA's ban on extension of medical equipment coverage after that date,[241] but they also overcame health planners' traditional reluctance to extend certificate of need regulation into physicians' offices.

E. New Facilities and Acquisitions of Existing Facilities

Over half the states cover construction, development, or establishment of a new health care facility. This coverage provision probably does not trigger review of any projects not otherwise covered as service or bed additions or capital expenditures. It is possible that in states with high expenditure thresholds and a restrictive list of covered new services, establishment of inexpensive, non-bed related facilities like home health agencies and hospices might escape review without such a provision.

NHPRDA does not require states to cover acquisitions of existing health care facilities by individual persons or entities.[242] However, a significant minority of states appears to do so. Mississippi covers acquisitions and forbids any person or entity from acquiring more than twenty percent of all skilled nursing or intermediate care facility beds in the state.[243] Nebraska law contains a similar prohibition, applicable to short-term hospitals as well as to nursing facilities.[244] Twelve other jurisdictions cover acquisitions or transfers of ownership interests in health facilities.[245]

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[239]MRI is a non-radiological diagnostic tool that uses magnetic and radio frequency fields to construct an image of body tissue and monitor body chemistry.

[240]The presence of a certificate of need program covering institutional acquisitions of medical equipment tends to encourage the placement of such equipment in non-institutional settings. Hillman & Schwartz, *The Adoption and Diffusion of CT and MRI in the United States*, 23 MED. CARE 1283 (1985). Whether this represents a success or a failing of certificate of need depends on one's calculation of the relative costliness and medical appropriateness of the equipment in the two settings.

[241]42 U.S.C. § 300m-6(e)(1)(B) (1982).

[242]*See supra* note 97 and accompanying text.

[243]MISS. CODE ANN. §§ 41-7-191(1)(b), 41-7-190 (Supp. 1984-85).

[244]NEB. REV. STAT. §§ 71-5830(l) (Supp. 1984).

[245]D.C. CODE ANN. § 32-303(c) (1981); HAWAII REV. STAT. § 323D-43(a)(1) (Supp. 1984); KY. REV. STAT. ANN. § 216B.061(b) (Supp. 1982); ME. REV. STAT. ANN. tit. 22, § 304-A(3) (Supp. 1984-85); 1985 N.H. Laws, ch. 378, § 378:6 (to be codified at N.H. REV. STAT. ANN. § 151-C:(II)(b)); N.J. STAT. ANN. § 26-2H-7 (Supp. 1984-85); OKLA. STAT. ANN. § 2651.1(2)(d) (Supp. 1984); S.C. CODE ANN. § 44-7-320 (Law. Co-op Supp. 1983); W. VA. CODE § 16-2D-3 (Supp. 1985); WIS. STAT. ANN. § 150.61(4) (West Supp. 1985); GA. ADMIN. COMP. ch. 272-2, §§ 272-2-.01(17)(b),(g) (1982) (coverage of capital expenditure to acquire a health care facility under section 1122 and, for publicly owned or operated facilities, under certificate of need); LOUISIANA DEP'T OF HEALTH & HUMAN RESOURCES, POLICIES AND GUIDELINES FOR REVIEW OF CAPITAL EXPENDITURES 5 (1985); MAINE CERTIFICATE OF NEED REGULATIONS, ch. 4, § 7 (1984).

F. Modifications in Certificate of Need Review Procedures

As well as reducing certificate of need coverage requirements, states have been modifying the certificate of need review process. Some states have attempted to distill their review criteria down to a few critical considerations. New Hampshire, for example, recently amended its law to substitute the four criteria of financial feasibility, availability of resources, access, and quality for its previous laundry list of over twenty considerations.[246] Other states have assigned priorities to their criteria.[247]

A recurrent predicament for certificate of need agencies is the receipt of applications for new types of equipment or services of unproven clinical efficacy. For example, planning agencies received numerous applications for MRI scanners well before the Food and Drug Administration had issued premarket approval for their sale.[248] Lacking standards on which to base decisions in these situations, planning agencies have tended either to adopt delaying tactics or to deny applications without properly-adopted criteria, both with disastrous results; or simply to approve all applicants.[249] More recently, however, some agencies have obtained authority to impose moratoria on review of applications for new, untested technology or to establish other limits regarding innovations. West Virginia's statute, for example, empowers the state agency to order a ninety-day moratorium on processing applications for new medical technology when criteria and guidelines for evaluating the need for the new technology have not yet been adopted.[250] Ohio's law authorizes the state agency to condition approval of projects for tech-

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[246]*Compare* 1985 N.H. Laws, ch. 378, § 6 (to be codified at N.H. REV. STAT. ANN. § 151-C:7) *with* N.H. REV. STAT. ANN. § 151-C:6 (Supp. 1983); *compare also* HAWAII REV. STAT. § 323D-43(b) (Supp. 1984) (review criteria of public need, cost and cost effectiveness, and consistency with state health plan) *with* HAWAII REV. STAT. § 323D-43(b), (C)(1)-(25) (Supp. 1983); TENN. CODE ANN. § 68-11-106(h)(2) (Supp. 1985) (criteria of area-wide need, economical cost, and contribution to orderly development of adequate facilities and services) *with* TENN. CODE ANN. §§ 68-11-106(h)(1)(A)-(M) (Supp. 1983).

[247]*E.g.*, OKLA. STAT. ANN. § 2652.1(c) (West 1984) (planning agency authority to establish relative weights of statutory certificate of need criteria); WIS. STAT. ANN. § 150.69 (West Supp. 1985) (cost containment identified as first priority in applying criteria).

[248]OFFICE OF HEALTH PLANNING, U.S. DEP'T OF HEALTH & HUMAN SERVICES, SUMMARY REPORT OF RESPONSES TO NUCLEAR MAGNETIC RESONANCE INFORMATION REQUEST, PROGRAM INFORMATION LETTER 83-23 (1983).

[249]*See* Florida Medical Center v. Department of Health & Rehabilitative Servs., 463 So. 2d 381 (Fla. Dist. Ct. App. 1985) (MRI denial based on unpromulgated criteria reversed); United Hosp. Center, Inc. v. Richardson, 328 S.E.2d 195 (W. Va. 1985) (refusal to process MRI application enjoined).

[250]W. VA. CODE § 16-2D-5(f) (Supp. 1985); *see also* D.C. CODE ANN. § 32-314 (1981) (authorization for 120-day moratorium on certificate of need review of new service if state agency requires additional time to develop and adopt criteria); 1985 N.H. Laws, ch. 378, § 6 (to be codified at N.H. REV. STAT. ANN. § 151-C:4) (prohibition on issuance of certificate of need for service for which state agency has not adopted criteria).

nologically innovative medical equipment on the applicant's agreement to supply the agency with data to establish the equipment's clinical efficacy.[251]

States with health facility rate regulation programs have taken steps to coordinate the decisions of certificate of need and rate-setting agencies. Washington, for example, requires determination of the financial feasibility and cost impact of hospital certificate of need applications by the state's hospital commission, a rate-setting agency, and absent special findings, mandates denial of an application disfavored by the commission.[252] Finally, planning agencies throughout the country are increasingly basing their certificate of need decisions on the project's consistency with state health plans.[253] In part because certificate of need decision-making has become more plan-driven and in part as a result of planning agencies' accumulated experience with administrative adjudication, certificate of need decisions are now seldom overturned for lack of substantive validity.[254]

A substantial number of states have imposed moratoria on some or all certificate of need applications or approvals in recent years. The

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[251]1984 Ohio Legis. Bull. file 234, § 1 (Anderson) (to be codified at OHIO REV. CODE ANN. § 3702.53(E)(5)); *see also* IOWA CODE ANN. § 135.64(3) (Supp. 1985) (certificate of need criterion establishing special consideration for university hospitals with respect to technologically innovative equipment and services); ME. REV. STAT. ANN. tit. 22, § 309(2)(m) (1980) (certificate of need criterion of need for utilizing new technological developments on a limited, experimental basis); WIS. STAT. ANN. § 150.63 (West Supp. 1985) (certificate of need exemption for research, development, and evaluation of innovative medical technology).

[252]WASH. REV. CODE ANN. § 70.38.115(2)(d) (Supp. 1986); *see also* 1985 Wisc. Legis. Serv. 29 § 1980p (West) (to be codified at WIS. STAT. ANN. § 150.69d(5)) (hospital rate-setting commission to provide analysis of reasonableness of certificate of need applicant's proposed costs and charges).

[253]*E.g.*, Princeton Community Hosp. v. State Health Planning & Dev. Agency, 328 S.E.2d 164 (W. Va. 1985).

[254]*See, e.g.*, Humana Medical Corp. v. State Health Planning & Dev. Agency, 460 So. 2d 1295 (Ala. Civ. App. 1984) (area bed supply excess supports denial on need and cost containment criteria); Humana, Inc. v. Department of Health & Rehabilitative Servs., 469 So. 2d 889 (Fla. Dist. Ct. App. 1985) (quality of care considerations supported need methodology prohibiting new cardiac catheterization facilities until existing facilities were fully utilized); Mercy Health Center v. State Health Facilities Council, 360 N.W.2d 808 (Iowa 1985) (denial of application on ground of cross-subsidization of non-health care services upheld); *In re* Certificate of Need Application by Community Psychiatric Centers, Inc., 234 Kan. 802, 676 P.2d 107 (1984) (determination of need on areawide basis upheld); Beatrice Manor, Inc. v. Department of Health, 219 Neb. 141, 362 N.W.2d 45 (1985) (planning agency policy to encourage non-institutional care justified denial of crowded nursing home's application to add beds); Chambery v. Axelrod, 101 A.D.2d 610, 474 N.Y.S.2d 865 (1984) (certificate of need preference for facilities participating in Medicaid upheld); Humana Hosp. Co. v. Oklahoma State Health Planning Comm'n, 705 P.2d 175 (Okla. 1985) (lack of need as measured by state health plan formula justified certificate of need denial).

primary reason for doing so has been to bar new services or expansion in areas in which state plans project no community need for an extended period of time. Missouri, for example, has adopted a moratorium on issuance of certificates of need for new skilled or intermediate care nursing facility beds until July 1, 1988.[255]

Several states have recently resuscitated a proposal that was a key element in the unsuccessful national hospital cost containment strategy of the Carter administration: imposition of a ceiling or "cap" on the total dollar value of projects approveable through certificate of need programs in a given year.[256] A capital ceiling is a mechanism for controlling the total level of capital investment by health facilities for large projects and for compelling health planning agencies to weigh the relative merits of disparate projects.[257] In the presence of a "cap," projects for remodeling existing facilities compete with new construction, and for example, a new open heart surgery service must vie with a new renal dialysis unit for limited capital funds. By contrast, under conventional certificate of need programs, only contemporaneously-filed applications for similar projects are comparatively reviewed.[258] A statutory cap is in operation in Rhode Island and Maine.[259] The Massachusetts hospital rate-setting statute has a maximum on increases in operating costs resulting from capital expenditures.[260] Oregon's law provides for the establishment of a non-enforceable annual capital expenditure target for all hospitals in the state.[261]

VI. The Future of Certificate of Need

State certificate of need and section 1122 capital expenditure review programs have changed significantly over the two decades they have

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[255] Mo. Ann. Stat. § 197.315(1) (Vernon Supp. 1985); *see also* Miss. Code Ann. § 41-7-191(2) (Supp. 1985) (moratorium on nursing home bed increases); 1985 Wis. Legis. Serv. Act 29, § 1980p (West) (to be codified at Wis. Stat. Ann. § 150.62) (moratorium on new hospital establishment or relocation). *See generally* Office of Health Planning, U.S. Dep't of Health & Human Services, Moratoria: A Continuing Process in Regulatory Review, Prog. Inf. Letter 85-32 (1985) (twenty-two states imposed moratoria at some time during 1980-85). For an article reporting on the success of a moratorium in limiting the diffusion of CT scanning, see Lawthers-Higgins, Taft & Hodgman, *The Impact of Certificate of Need on CT Scanning in Massachusetts*, Health Care Mgmt. Rev., Summer 1984, at 71.

[256] *See* D. Abernathy & D. Pearson, Regulating Hospital Costs: The Development of Public Policy 90-92 (1979).

[257] *See generally* Institute for Health Planning, Methods for Establishing Capital Expenditure Limits (1984).

[258] *See, e.g.*, Bio-Medical Applications of Clearwater v. Department of Health & Rehabilitative Servs., 370 So. 2d 19 (Fla. Dist. Ct. App. 1979) (comparative review of "mutually exclusive" kidney dialysis center CON applications required).

[259] Me. Rev. Stat. Ann. tit. 22, § 396-k (Supp. 1985).

[260] Mass. Gen. Laws Ann. ch. 6A, § 32 (West Supp. 1985).

[261] 1985 Or. Laws ch. 747, §§ 21-24.

been in operation. They were initially conceived as an adjunct to community-wide health planning. Later, they were seen as a vehicle for implementation of federal health policy. Today, such programs appear increasingly tailored to fit narrowly-drawn individual state regulatory policies and to compensate for specified market defects.

The persistence of certificate of need regulation in the face of widely-reported studies questioning its efficacy and open hostility from the Reagan administration may seem somewhat surprising. However, research on certificate of need programs has universally assumed that cost-containment was the only purpose of such programs (largely because cost control became the dominant rationale for federal funding for state certificate of need by the mid-70's). This Article has suggested that cost control may be only one of several mixed roles played by state health planning and certificate of need programs. In addition, anecdotal evidence at the state level on the impact of the program on the scope and direction of hospital and other health facility capital investment has never been lacking. Finally, there has probably been a greater awareness at the state level than in the federal government that because certificate of need programs require several years to develop review criteria and administrative procedures needed to function effectively and to survive judicial scrutiny, they could not be evaluated simply on the basis of their first few years of operation.

A. Future State Participation in Certificate of Need

As indicated above, every state except Arizona, Utah, and Texas currently has some form of health facility capital expenditure regulation, whether certificate of need, section 1122, a moratorium, or some combination of these provisions. Eight states' certificate of need laws are scheduled to sunset essentially in their entirety in subsequent years. In addition, two states' laws would expire if NHPRDA were repealed.[262] If all the statutes scheduled to expire (including those linked to NHPRDA repeal) did so and no state entered into a new section 1122 contract or adopted a moratorium, thirty-seven states and the District of Columbia would continue to have some form of capital expenditure review. Thirty-two states and the District of Columbia would have certificate of need statutes, slightly more than had such programs immediately prior to the passage of NHPRDA.

What prompted the states that repealed certificate of need programs to do so? The primary consideration has been recent changes in the

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[262]The Arkansas statute would automatically expire if NHPRDA were to expire or terminate, or if the programs instituted pursuant to NHPRDA ceased to function. ARK. STAT. ANN. § 82-2313.1 (Supp. 1983). The Colorado statute would sunset after the first state legislative session commencing after Congress repealed the state certificate of need requirements of NHPRDA. COLO. REV. STAT. § 25-3-521 (1982).

sources of imperfection in the institutional health services market. As indicated above, the Medicare program has begun to substitute reimbursement at a predetermined rate for incurred-cost payment, and both state Medicaid programs and private health insurers are following suit.[263] The new prospective payment mechanisms, which typically pay individual providers prior-year average costs incurred by all providers, offer a disincentive to above-average cost care and an efficiency incentive in the form of an opportunity to profit from providing below average cost care. There has also been a significant increase in patient enrollment in health maintenance organizations and other health care delivery systems that operate with internal incentives to reduce costs, and some evidence of price competition among such systems and between them and conventional health insurance.[264] For these and other reasons, utilization of institutional health services has been declining, and as with other areas of the economy, the annual rate of increase in health care expenditures has declined. These factors, combined with a general preference for unregulated markets and exasperation with the controversy that often surrounds certificate of need decisions, seem to have prompted the legislatures to repeal certificate of need statutes.

Over half the states repealing certificate of need hedged their bets on deregulation by retaining or re-entering the section 1122 program or adopting construction moratoria. In these states and others that considered but did not repeal certificate of need, there was considerable concern that the increased competitiveness of the institutional health care market had not reached the point at which it would counteract still-existing incentives to capital expansion. An important issue for states was the effect certificate of need repeal itself would have on health facility capital investment and construction. State legislatures, especially those concerned about current spending under Medicaid programs, were concerned with the potential for a large increase in spending immediately after repeal.[265] Evidence from the states that have removed all restrictions on health facility capital investment strongly suggests that a short-term surge does take place when certificate of need controls are lifted.[266]

In Arizona, the certificate of need law expired March 16, 1985.[267] In the six months following, hospitals in Arizona obtained licensure permits for expansion projects, formerly subject to certificate of need

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[263] *See supra* notes 185-91 and accompanying text.

[264] *See, e.g.*, Taylor & Kagay, *The HMO Report Card*, 5 HEALTH AFF. 81, 82 (1986).

[265] A small increase seems almost inevitable, as a consequence of implementation of projects delayed in anticipation of repeal, projects commenced promptly in expectation of reimposition of certificate of need, and the increased attractiveness of the state over still-regulated jurisdictions to new entrants.

[266] *See infra* notes 267-71 and accompanying text.

[267] 1984 Ariz. Sess. Laws ch. 1, § 1.

review, with a total cost of $135 million. By contrast, for the same six-month period in 1984, during which certificate of need review was in effect, hospitals were issued permits for only $7.5 million worth of projects.[268] A total of 674 new hospital beds was included in the 1985 projects, and four new open-heart surgery services were instituted.[269]

Post-repeal expansion also does not seem to taper off after a few months. In Arizona, certificate of need review for nursing homes expired in July 1982. During the subsequent three and one-half year period, the number of facilities and beds in the state increased at a continuous rate. Overall, the number of nursing home beds in the state increased by 51.1%, compared to a 55.8% growth in the preceding nine year period (1974-82) during which certificate of need review was in effect.[270]

Post-repeal expansion appears to be taking place in Utah as well as in Arizona.[271] It seems unlikely that the high level of expansion in Arizona and Utah will continue over the long-term. However, the experience in these states does suggest that certificate of need repeal leads to a short-term increase in construction and expansion whose effects upon excess capacity and costs will linger for years. It also suggests that the recent changes in health facility reimbursement, utilization, and delivery have not purged the institutional health care sector of expansionist tendencies.

The dramatic increases in health facility capital spending in the states that have repealed certificate of need programs will probably discourage a major repeal trend in the remaining states. Of course, the fate of state certificate of need programs is likely to be heavily influenced by

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[268]G. Heller & M. Chase, A Study of the Impact of Health Care Deregulation on Hospitals, Nursing Homes and Health Services in Arizona 242 (report prepared by Office of Planning and Budget Development, Ariz. Dep't of Health Services, Nov. 15, 1985).

[269]The post-repeal expansion does not appear to be attributable to relaxation of overly restrictive prior controls. In 1984, Arizona hospitals had a 57.8% occupancy, well below national averages and guidelines, and an estimated excess capacity of 2,800 beds. Arizona Statewide Health Coordinating Council, Draft Arizona State Health Plan, ch. 10, Appendix A (1985) (1984 Arizona non-federal hospital occupancy rate). *Compare* 42 C.F.R. § 121.202 (1985) (National Guidelines for Health Planning recommended non-federal hospital occupancy rate of 80%); American Hosp. Ass'n, Hospital Statistics 22 (1985) (1984 U.S. non-federal hospital occupancy rate of 71.9%); Arizona Statewide Health Coordinating Council, Current Status/Trends in Arizona's Acute Care Nonfederal Hospital Beds (1984) (1984 excess bed capacity estimate).

[270]G. Heller & M. Chase, *supra* note 268, at 2.

[271]One month after the repeal of Utah's certificate of need law on December 31, 1984, six new hospitals, all previously disapproved under the certificate of need law, were under construction. *Congress Ends Federal Health Planning*, Medicine & Health Perspectives 3 (Oct. 6, 1986). Within a few months after repeal, building permit application had been filed for 2,800 new nursing home beds. Telephone interview with Steven Bonney, Executive Director, Utah Health Systems Agency, May 28, 1985.

the status of NHPRDA and section 1122. Nevertheless, it appears that in the forseeable future, capital expenditure review will continue in the majority of states.

B. Future of State Certificate of Need Programs

Since the relaxation of NHPRDA requirements in 1982, state certificate of need programs have changed considerably. It is likely that the direction and pace of these changes will continue. It seems likely that to the extent states use certificate of need as a mechanism for controlling increases in institutional health care costs, they will increasingly focus certificate of need review on health facility expansions and service additions that generate increased operating expenses. It is these costs, not the capital costs associated with such projects, that have the greatest impact on total costs.[272] Consistent with this focus, one would expect states to increase capital expenditure thresholds, to delete coverage of capital expenditures in any amount for service additions or bed increases, and to retain coverage of service additions or expansions associated with additional annual operating costs. Exemption of the various ambulatory and low-intensity in-patient facilities whose services represent a fraction of total institutional health care costs could also be expected. The recently-amended Indiana certificate of need law seems to follow this approach to an extent. All outpatient facilities, including ambulatory surgery facilities and freestanding hemodialysis units, have been deregulated.[273] Coverage is limited to capital expenditures exceeding $750,000 and to certain bed capacity and category changes affecting beds certified to participate in Medicare or Medicaid.[274]

It also seems likely that states will continue to employ certificate of need review as a vehicle for preserving quality of care by restricting entry to new services having a reasonable probability of meeting minimum volume standards. With an increasingly competitive institutional health care environment and with the potential for large profits from at least some high-intensity, high-technology services, the rationale for this kind of quality-related certificate of need regulation is as great as ever.[275] It

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[272]*See supra* note 146 and accompanying text.

[273]IND. CODE § 16-1-3.3-1 (Supp. 1985). Indiana's law does not, however, provide for coverage of new services not associated with high capital expenditures but with high annual operating costs, e.g., new open-heart surgery services. Compare the Montana and Wyoming coverage patterns discussed *supra* at note 215 and accompanying text.

[274]IND. CODE § 16-1-3.3-1 (Supp. 1985).

[275]The objection is sometimes raised that quality-related regulation should be the domain of facility licensure, not certificate of need. But as the creators of such regulatory regimens, states ought to be free to assign them such roles as they please, irrespective of their labels. Health planning agencies have both the technical tools and the jurisdiction to review the expected utilization of newly proposed services through certificate of need

applies, however, only to a limited set of services which are almost exclusively provided in a hospital setting. States adding the quality-related function to certificate of need programs primarily focused on cost containment can be expected to include in their coverage provisions additions of those specified new services, regardless of capital or operating cost, for which there is a demonstrable relationship between volume and patient outcome. Oregon's newly amended statute, which contains a $1,000,000 capital threshold and coverage of new services that exceed the annual operating cost threshold or are identified with volume-related quality concerns, exemplifies this approach.[276] Alternatively, a state that abandoned certificate of need as a cost containment mechanism but wished to maintain limited entry controls for quality of care purposes might limit its coverage to new hospital services. California's hospital coverage provisions, which exempt all capital expenditures and service additions except for radiation therapy units, burn centers, emergency centers, psychiatric services, newborn intensive care nurseries, cardiac surgery units, and cardiac catheterization units, may reflect this approach.

In recent years, a number of states have increased the role played by certificate of need review in assuring access to institutional health care by persons unable to pay, through preferential treatment of charitable facilities or by outright indigent care quotas.[277] This strategy has attracted attention in other states.[278] However, there is even greater interest at present among the states in programs that redistribute revenues from low indigent care facilities to those treating a disproportionate share of such patients.[279] Typically, such programs authorize a tax on hospital sales or revenues that funds an indigent care account from which facilities with disproportionate indigent care loads may draw.[280] These programs may offer a more precise matching of the benefits or subsidies to a facility with its indigent care burden than certificate of need preferences or quotas. However, these programs may tend to concentrate indigent patients in a limited number of facilities more than certificate of need preferences or quotas do. The redistribution programs are not inconsistent

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programs, while licensing agencies have traditionally fulfilled the role of monitoring the ongoing operations of existing facilities and services. Certificate of need programs can do little in the way of monitoring facility operations, except through enforcement of licensure determinations in subsequent certificate of need proceedings.

[276]*See supra* note 228.

[277]*See supra* note 25.

[278]*See, e.g.*, Subst. S.B. 4403, 48th Wash. Legis., 1984 Reg. Sess. § 22(2)(k), which adopted a certificate of need requirement that each applicant meet or exceed the regional average level of charity care (subsequently vetoed by the governor).

[279]ACADEMY FOR STATE & LOCAL GOV'T, ACCESS TO CARE FOR THE MEDICALLY INDIGENT: A RESOURCE DOCUMENT FOR STATE AND LOCAL OFFICIALS 54-71 (1985).

[280]M. KING, ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT 3 (Nat'l Conf. of State Legislatures 1986).

with certificate of need preferences or quotas. Given the high level of public concern with indigent care and the availability of more direct mechanisms for increasing indigent care access, it seems unlikely that states will make indigent patient access the dominant function of certificate of need programs, but equally likely that it will continue to be one of several functions of such programs.

Employment of certificate of need review as an adjunct to state programs regulating or reimbursing the operating expenses of health facilities is likely to continue as long as states continue to have such programs. However, the number of states with rate regulation programs shows no signs of increasing, and numerous states have changed their Medicaid reimbursement formulae in ways that reduce the incentives to overinvestment and correspondingly reduce the need for compensatory regulatory programs.[281]

C. The Future of Federal Health Planning Law

In the fall of 1986, Congress finally reached the decision to discontinue NHPRDA funding.[282] Congress also passed and sent to the President legislation that would repeal NHPRDA.[283] The possibility of any continued federal funding for state certificate of need and capital expenditure review programs turns on the outcome of the debate over in-patient hospital reimbursement for capital expenditures under the Medicare program. Congress has given itself until October 1, 1987, to devise a mechanism for incorporating payment for such costs into the prospective payment system.[284] Even if it does so, Congress could choose to retain section 1122 either as a mandatory or as a state optional program. However, if Congress succeeds in enacting a new capital reimbursement formula that rewards efficient operations and prudent investment, that maintains an adequate capital plant to assure the long-term availability of hospital services to the increasing Medicare population, and that satisfies budget constraints, it is unlikely that federal interest in supporting state regulatory health planning through section 1122 will continue. Congress might logically conclude that any increment in cost-saving benefits to the Medicare program from state section 1122 programs above and beyond the cost-containment incentives of the prospective payment system would be outweighed by the programs'

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[281] *See supra* notes 185-89 and accompanying text.

[282] Congress' decision took the form of a refusal to include funding for NHPRDA Programs in the 1987 fiscal year continuing resolution, terminating NHPRDA funding as of the end of the 1986 fiscal year (Oct. 1, 1986). *See Congress Ends Federal Health Planning*, MEDICINE & HEALTH PERSPECTIVES, Oct. 6, 1986, at 1.

[283] *See Congress' Health Leaders Agree to Health Legislation Package*, MEDICINE & HEALTH, Oct. 20, 1986, at 3.

[284] Pub. L. No. 98,369, § 2312(c), 98 Stat. 494 (1984).

undesirable enfranchising effect. Congress might also conclude that the benefits of state capital expenditure review programs (both in the area of cost-containment and in the quality of care and access arenas) accrue primarily to states which, on that account, ought to shoulder all or most of the cost of such programs.

Another alternative deserves consideration. The section 1122 program could be retained, but put to a different use. Federally-funded health planning had its origins in planning for the disbursement of federal health facility construction funds through the Hill-Burton program.[285] Today the federal government no longer provides direct support for private health facility construction, even though many of the hospitals and other facilities built with Hill-Burton monies are in need of replacement.[286] Nor is it likely that grants or loans for hospital construction will be reinstituted in the forseeable future. Instead the federal government will support health facility construction primarily through tax exemptions for interest on certain bonds issued for health facility construction[287] and by Medicare reimbursement for capital costs. Both of these supports may be targeted for curtailment in the interest of deficit reduction. Yet it is through the provision of adequate support for health facility capital investments that the Medicare program is assured of the long-term availability of an adequate supply of health care facilities to meet the needs of the Medicare population.

The Medicare program could employ the section 1122 review process to support selected health care facilities in each state and local community that are likely to be needed in the long run to assure the availability of services to Medicare beneficiaries. Health care facilities seeking to make major capital expenditures for replacement or new construction would apply for approval under the section 1122 process.[288] The review would proceed as it has in the past, except that the planning agencies would only determine the need for the proposed expenditure to serve the Medicare population, not the entire community need for the project. Facilities whose projects were identified as needed would be entitled to a Medicare capital allowance in addition to reimbursement for operating expenses associated with treatment of Medicare patients. Facilities not identified as needed would continue to be eligible to participate in Medicare and to receive per-case payment for operating expenses, but Medicare funds would not be given to replace or expand their capital plants.

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[285] *See supra* notes 33-37 and accompanying text.

[286] Ting & Valiante, *Future Capital Needs of Community Hospitals*, 1 HEALTH AFF. 14 (1982).

[287] I.R.C. § 103(a)(1) (1985). *See generally Capital Projects*, 2 TOPICS IN HEALTH CARE FINANCING (Winter 1975).

[288] Minor expenditures, including those associated with moveable equipment acquisitions, could be exempted from section 1122 review and reimbursed through a standard allowance incorporated into the per case payment.

Under this approach, Medicare would selectively support major health facility construction, much as some state Medicaid programs currently contract with a limited group of hospitals or other providers for services to Medicaid beneficiaries, or as Hill-Burton once supported those facilities willing to provide uncompensated care and community service. From a predetermined total federal expenditure for Medicare capital reimbursement, each facility selected for capital payment under this system could receive more generous capital payment than it would receive under a system paying for capital expenses in every Medicare-participating facility.

A simplified version of this process has been proposed. The Office of Management and Budget has suggested that Medicare capital reimbursement to hospitals be limited to those facilities achieving eighty-five percent occupancy rates.[289] The purposes of this approach are to channel Medicare capital reimbursement toward needed facilities, to avoid payment to underutilized, unnecessary facilities, and to permit more generous capital payment within budget constraints by spreading payment over fewer facilities. While the purposes are laudable, a target occupancy rate is a poor substitute for the kind of multi-factored determination of need that health planning programs can make. For example, an eighty-five percent target occupancy rate could penalize small rural hospitals that, although their occupancy rates are low, are needed for reasons of geographical access to services. A high occupancy hospital with a low Medicare patient load might be less deserving of capital support than a lower occupancy facility that treats many Medicare patients. Finally, rather than encouraging closure of excess beds, a target occupancy rate could create an incentive to increase unnecessary admissions and extend hospital stays, contrary to the incentives in the per case system of payment for operating expenses.

Using the section 1122 process to make the federal government a selective investor in health facility capital plants would provide a legitimate participatory role for capital expenditure review in a competitive institutional health services market. It would also reinstitute health planning as a major federal vehicle for management of health care delivery. Medicare is the nation's largest purchaser of institutional health services and few health care facilities do not participate in Medicare. Using health planning agencies operating through the 1122 process as Medicare's purchasing agents would place health planning programs in a central role in determining the allocation of health resources throughout the country.

Whether or not federal funding continues, it appears that a substantial number of states will retain certificate of need programs, at least in the

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[289] WASH. REPORT ON MEDICINE & HEALTH, Dec. 23, 1985, at 3; *see also* 51 Fed. Reg. 19,983 (1986) (HHS request for comments on methods for including adjustment to capital payment for low occupancy hospitals).

near future. It should be apparent that certificate of need regulation continues to satisfy a wide range of state policy roles. However, it also appears that in the absence of federal requirements, a significant number of states will abandon the program in favor of efforts to promote more competitive health service markets. This might well be a fortuitous development. As with any regulatory program that intervenes in the market to accomplish some social good, the necessity for certificate of need programs ought to be continuously evaluated, and the scope of the program tailored to meet specific, concrete, present purposes. It is difficult to do this when the states uniformly adopt the program. The repeal of the program in some jurisdictions provides a natural experiment to measure the impact of the presence or absence of certificate of need review on the direction and scope of health facility expenditures.

APPENDIX

SOURCES: Information contained in the Tables and in this Appendix has been compiled primarily from the author's review of state certificate of need and section 1122 statutes and regulations, supplemented by the author's written and telephonic communications with SHPDA officials, U.S. Department of Health and Human Services officials, and various secondary sources.

EXPLANATORY NOTES: The symbol "X" appearing in the Tables indicates that a particular health care facility or project is subject to certificate of need review in a given state. The symbol "N" appearing in the Tables indicates that additional information regarding a state's coverage of a particular facility or project may be found in the State-by-State Comments section of this Appendix. An asterisk (*) appearing in the "Capital and Other Projects" Table under the coverage categories relating to bed capacity indicates that the state covers the indicated bed-related change only if it exceeds ten beds or ten percent of bed capacity, whichever is less, in any two year period. A dollar amount adjacent to an "X" symbol in the "Capital and Other Projects" Table indicates that the specified project or expenditure is covered only if its cost exceeds the dollar amount.

ABBREVIATIONS USED IN THIS APPENDIX:

AOC = annual operating cost; CCU = coronary care unit; CE = capital expenditure; CON = certificate of need; HHA = home health agency; ICF = intermediate care facility; LF = letter received from; ICU = intensive care unit; LT = letter sent to; MME = major medical equipment; NMR or MRI = magnetic resonance imaging; OAHCF = organized ambulatory health care facility; SHPDA = State Health Planning and Development Agency; SNF = skilled nursing facility; TCF = telephone call from; TCT = telephone call to; 10/10/2 = ten beds or ten percent, whichever is less, in any two-year period; 1122 = section 1122 program.

COVERAGE NOT SHOWN IN THE TABLES: The Tables are intended to comprehensively display the facility and project coverage provisions of state certificate of need and section 1122 programs. A few entities and projects subject to review are not shown. In the "Health Care Facilities, etc." Table, coverage of "persons" is not listed, although virtually all states cover "persons." The "Capital and Other Projects" Table does not list the following transactions, covered under many state CON statutes: (1) Capital expenditure to acquire (either by purchase or under lease or comparable arrangement) an existing health care facility if the person entering into a contractual arrangement for such acquisition does not notify the SHPDA at least thirty days prior to such contractual

arrangement or if the SHPDA finds that the services or bed capacity of the facility will be changed in being acquired. (2) Acquisition of major medical equipment not owned by or located in a health care facility if the person entering into a contractual arrangement to acquire the equipment does not notify the SHPDA at least thirty days before contractual arrangements are made to acquire the equipment. (3) Capital expenditures not otherwise subject to review for proposed changes in previously-approved projects, including cost overruns, and proposed changes not otherwise subject to review in previously-approved projects.

DEFINITIONS OF TERMS IN TABLES:

1. *Definitions used in "Health Care Facilities, etc." Table*: State CON/1122 statutes and regulations employ a variety of definitions and terms to identify the persons and entities subject to CON review. Usually, but not invariably, state statutes first subject "health care facilities" to review and then in statute or regulations list and sometimes define the various types of facilities subsumed under that term. This Table was completed using a standard set of health care facility definitions which does not duplicate any one state's coverage definitions exactly, but which is intended to place comparable types of facilities in distinct categories for comparison purposes. Readers seeking to ascertain whether a particular project would be subject to review in a given state are cautioned to consult the laws of that state. The following definitions apply to the Table: "Hospital" means an institution which primarily provides to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. The term includes psychiatric and tuberculosis hospitals. Individual states may enumerate other categories of general and specialty hospitals falling within their definition of "hospital". "Skilled nursing facility" means an institution or a distinct part of an institution which primarily provides to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term "intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility provides, but who because of their mental or physical condition require health-related care and services (above the level of room and board). The term "medically-oriented residential care facilities" refers to inpatient institutions providing room, board, and personal care services, not including continuous nursing services, to individuals who do not require the degree of care and treatment which a hospital, skilled facility, or intermediate care facility provides but who

by reason of illness, disease, or physical or mental infirmity are unable to effectively or properly care for themselves. The states have various names for these facilities. The term "inpatient rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision. The term "home health agency" means a private or public agency or institution, not part of another health care facility, that provides "home health services" as that term is defined in Section 1861(m) of the Social Security Act, or a similar set of services as provided under state law. The term "hospice" means a public agency or private organization not part of another health care facility that provides "hospice care" as that term is defined in Section 1861(dd) of the Social Security Act, or similar care as provided for under state law. The term "kidney dialysis treatment center (including freestanding hemodialysis units)" means a health care facility, not part of another health care facility, which provides dialysis services. "Health maintenance organization (subject to exemption)" means a public or private organization that falls within the health maintenance organization definition in 42 U.S.C. § 300n(8) or a similar definition under state law, and whose capital expenditures and other projects are largely exempt from CON review under state law. "Ambulatory surgery center" means a facility, not a part of another health care facility, which provide surgical treatment to patients not requiring hospitalization. The term does not include the offices of private physicians or dentists, whether for individual or group practice. "Organized ambulatory health care facilities/outpatient clinics" is a generic term encompassing clinics, health centers, and independent facilities other than ambulatory surgery centers, not part of another health care facility, which are organized and operated to provide general outpatient medical care or specific types of medical care to outpatients. The term does not include the offices of private physicians or dentists, whether for individual or group practice. States with broad, general provisions for coverage of OAHCFs but no breakdown or specification of the facilities included thereunder are listed in this category on the Table. A state whose law and regulations provide for both broad, general coverage of OAHCFs and express coverage of specified ambulatory facilities will be checked on the Table both in the "organized ambulatory health care facilities" box and in the boxes corresponding to the specific facilities covered. Some states do not have general coverage of OAHCFs but do cover some specified ambulatory facilities. They are on the Table accordingly. "Freestanding emergicenter" means a facility, not part of another health care facility, which is, or is licensed as, or presents itself to the public as, a 24-hour facility to provide emergency or urgent medical care. "Ambulatory obstetrical facilities/birthing centers" and "family planning/abortion centers" are facilities, not part of another health care facility, pro-

viding some or all such services. "Community health centers/clinics" means neighborhood health centers and community clinics, not part of another health care facility, and in any given state may include "community health centers" falling within the definition thereof in 42 U.S.C. § 254c, "migrant health centers" falling within the definition thereof in 42 U.S.C. §254b, and "rural health clinics" falling within the definition thereof in 42 U.S.C. § 254aa(2). "Public health center" means an official agency established by state or local government, not part of another health care facility, the primary function of which is to provide public health and medical services. "Community mental health centers" means outpatient facilities, not part of another health care facility, which fall within the definition of "community mental health centers" in 42 U.S.C. § 2691 (1973) or a similar definition under state law and includes facilities for treatment of developmental disabilities, mental retardation, alcoholism, drug abuse, chemical dependency and mental illness. "Facilities for the provision of outpatient therapy services including speech pathology" means clinics, rehabilitation agencies, or public health agencies, not part of another health care facility, which provide outpatient physical therapy and speech pathology services as defined in 42 U.S.C. § 1395x(p). "Outpatient rehabilitation facility" means a facility, not part of another health care facility, which provides outpatient rehabilitative services and may include "comprehensive outpatient rehabilitation facilities" as the term is defined in 42 U.S.C. §§ 1395x(cc).

2. *Definitions of projects and capital expenditures in "Capital and Other Projects" Table*: State certificate of need and section 1122 statutes and regulations employ a variety of categories and terms to identify the expenditures, projects, and transactions subject to CON review. Usually, but not invariably, states subject some combination of capital expenditures, additions of new health services and beds, and acquisitions of major medical equipment to review. Most states employ expenditure or annual operating cost thresholds (i.e., dollar values of the amount of an expenditure or major medical equipment acquisition or of the annual operating costs associated with a non-capital expenditure project below which an expenditure or project is not covered). The Table was completed using a standard set of expenditure, project, and transaction definitions which may not duplicate any one state's definitions exactly, but which is intended to place comparable types of expenditures, projects, and transactions in distinct categories for comparison purposes. Readers seeking to ascertain whether a particular project would be subject to review in a given state are cautioned to consult the laws of that state.

Expenditure and project coverage is divided in the Table into two broad categories: coverage of capital expenditures and coverage of projects. The term "general purpose CE/expenditure threshold" refers to coverage of capital expenditures undertaken by or on behalf of health care facilities

for any purpose. If the state employs an expenditure threshold, that threshold is shown. "CE for bed capacity increases and decreases/expenditure threshold" refers to state coverage of applicable expenditures for both increases and decreases in bed capacity of a health care facility. If an expenditure threshold is applied to such coverage, the threshold is shown. "CE for bed capacity increases only/expenditure threshold" is self-explanatory. "CE for changes in bed categories/expenditure thresholds" refers to state coverage of capital expenditures for redistribution of existing health care facility beds among license categories or other services specified under state law. If an expenditure threshold is applied to coverage of such projects, the threshold is shown. "CE for additions of health services/expenditure threshold" refers to state coverage of capital expenditures by or on behalf of health care facilities which are associated with additions of health services which were not offered by or on behalf of the facility within the previous twelve months. If state coverage is dependent on an expenditure threshold, the threshold is given; otherwise health service additions are covered under this category if they are associated with any capital expenditure. "CE for terminations of health services/expenditures threshold" refers to coverage of capital expenditures which are associated with the termination of health services which were previously offered in or through the facility. If state coverage is dependent on an expenditure threshold, the threshold is given in otherwise health service terminations associated with any CE are covered.

Under the listings for coverage of specified projects, "Bed capacity increases and decreases" refers to coverage of both increases and decreases in the total number of beds offered by or on behalf of a health care facility, regardless of whether the change is associated with a capital expenditure. "Bed category changes" refers to coverage of redistribution of beds among various license or other categories under state law, regardless of whether such redistribution is associated with a capital expenditure. "Bed relocations" refers to coverage of relocations of beds from one physical facility or site to another, regardless of whether such relocation is associated with a capital expenditure. "Additions of new health services/annual operating cost threshold" refers to coverage of the addition of a health service which was not offered by or on behalf of a health care facility within the previous twelve months, regardless of whether the addition is associated with a capital expenditure. If coverage of the health service addition is provided for only if the new health service will entail annual operating costs of at least an expenditure minimum for annual operating costs, then the Table indicates the state's annual operating cost dollar threshold. "Termination of a service" refers to a termination of a health service which was offered in or through a health care facility and which is not associated with a capital expenditure. "Acquisitions of major medical equipment/equipment threshold" refers to state coverage of the acquisition by any person of major medical equipment that will

be owned by or located in a health care facility, or equipment that will be used to provide services for hospital inpatients on other than a temporary basis in case of national disaster, major accident, or equipment failure. If the state employs an expenditure threshold for coverage of medical equipment acquisitions, the threshold is shown. "Construction, development, or other establishment of new health care facilities" refers to construction or commencing operation by any person of entirely new physical plants of health care facilities." "Acquisition of existing facilities" refers to the acquisition by any person of the physical plant of an existing health care facility, or the acquisition of the stock or assets of a corporation or other entity owning an existing health care facility. If a state specifies coverage of other projects, the projects are listed in the state-by-state comments.

STATE-BY-STATE COMMENTS TO TABLES:

ALABAMA: *Inpatient rehabilitation facilities, outpatient rehabilitation facilities*: State law provides for coverage of "rehabilitation centers." State regulations provide for coverage of "health facilities required by federal regulations" (which would include inpatient rehabilitation facilities) and "substance abuse rehabilitation facilities" (which may be inpatient or outpatient). *Other entities, persons*: Alabama covers facilities for the developmentally disabled. *CE for other specified purpose*: Alabama statute and regulations cover CE in excess of $245,000 for AOC. Coverage under this provision unclear. *Additions of new health services*: Alabama regulations contain a non-exclusive list of new services subject to review (e.g., (a) ambulance - air unit; (b) ambulance - ground unit; (c) birthing centers and services; (d) nursing home services (ICF and skilled considered as one service); (e) cardiac catheterization (adult or pediatric); (f) angiography laboratory; (g) cardiopulmonary laboratory; (h) ICU/CCU; (i) hemodialysis; (j) hyberbaric chamber; (k) organ transplant; (1) organ bank; (m) open-heart surgery; (n) pulmonary function laboratory; (o) CT scanners (mobile or fixed); (p) nuclear medicine (includes NMR); (q) megavoltage radiation therapy; (r) neonatal intensive care (level II and III); (s) pediatric inpatient services; (t) extracorporeal lithotresis; (u) rehabilitation services (including physical therapy, speech and hearing); (v) psychiatric; (w) substance abuse; (x) specialty services which have been addressed in the appropriate state plan as being properly allocated on a regional basis). *Other specified projects:* Alabama regulations cover "planning, predevelopmental, and developmental activities in excess of $300,000."

ALASKA: *Other entities*: Alaska statute covers "federal hospitals." *CE for bed supply increases and decreases*: Statute covers "CE in excess of $1M for alteration of bed capacity." Table assumes this language pro-

vides for coverage of bed increases and decreases with no 10/10/2 exemption.

ARIZONA: *General*: Arizona has no CON statute. Prior CON law was repealed 03/15/85. It does not have an 1122 program.

ARKANSAS: *General*: Arkansas has a certificate of need program and an 1122 program, apparently with identical coverage. *Hospice*: coverage unclear. *Other outpatient ambulatory care facilities*: Arkansas also covers "clinical health centers, multidisciplinary clinics, specialty clinics."

CALIFORNIA: *General*: California law provides various general exemptions from certificate of need coverage in addition to the categorical exemptions described below, including an exemption for facilities providing prepaid health care, facilities providing certain volumes of free care, etc. California CON scheduled to sunset Jan. 1, 1987. *Other outpatient ambulatory care facilities*: California also subjects to limited regulation "free clinics", "psychology clinics", "chronic dialysis clinics", and "employees' clinics." *CE for other specified purposes/expenditure threshold*: California covers a capital expenditure in any amount for a specialty clinic (surgical, chronic dialysis, or rehabilitation clinic) for expanded outpatient capacity. California also covers capital expenditures in excess of $1,000,000 for other projects for a surgical clinic or rehabilitation clinic and capital expenditures in excess of $1,000,000 for services, equipment or modernization of a specialty clinic (*e.g.*, surgical clinic, chronic dialysis clinic, rehabilitation clinic). *Bed capacity increases*: California covers bed supply increases, and exempts a bed supply increase less than ten percent of licensed bed capacity or ten beds whichever is less in a two-year period for certain classes of health facilities, if certain occupancy rate and accessibility standards are met by the facility. In addition, California exempts up to two additions of five SNF beds for a distinct part SNF of a Primary Health Service hospital if certain occupancy and cost conditions are met. Certain other bed supply increase project exemptions are available under California law. *Bed category changes*: California covers conversion of beds from general acute, general acute rehabilitative, skilled nursing, intermediate care-developmental disabilities, intermediate care-other, acute psychiatric, specialized care, chemical dependency recovery, bed categories to skilled nursing, psychiatric, intermediate care beds to any other category, except that California exempts conversion of a general acute care hospital's distinct part SNF or ICF beds licensed as of March 1, 1983 to other categories provided that the conversion may not exceed during any three-year period five percent of the existing beds in the category to which the conversion is made. California exempts use of beds licensed in one category for another category of use if such changes do not exceed five percent of total bed capacity at any time, except that a facility may use an additional five percent of its beds in this manner if

seasonal fluctuations justify it. *Health service additions*: California covers establishment of specified new special services, *e.g.*, radiation therapy department, burn center, emergency center, psychiatric service, intensive care newborn nursery, cardiac surgery, cardiac catheterization laboratory. California also covers establishment of certain special services by a surgical or rehabilitation clinic. *Acquisition of major medical equipment*: California covers acquisitions of diagnostic or therapeutic equipment by primary care clinics, psychology clinics, and specialty care clinics in excess of $1,000,000. *Construction, development or establishment of new health care facilities*: Establishment of a new primary care clinic (*e.g.* community clinic, free clinic, employees' clinic), psychology clinic, and chronic dialysis clinic are not subject to review. Also exempt are conversion of an existing specialty clinic to a primary care clinic or conversion of a primary care clinic from one licensure category to another. *Other specified projects:* California covers conversion of an entire existing hospital, SNF, or ICF from one licensure catagory to another. California covers conversion of a primary clinic (community, free, employees' clinic) to a specialty clinic (surgical, chronic dialysis, rehabilitation clinic). California covers conversion of a specialty clinic from one category to another. California covers a project by a health facility for expanded outpatient surgical capacity. California covers relocation of a hospital, SNF, ICF, or specialty clinic (surgical clinic, chronic dialysis clinic, rehabilitation clinic) to a different or adjacent site.

COLORADO: *General*: Colorado's CON law underwent minor amendment in 1985. *Kidney disease treatment centers, ambulatory surgery centers, freestanding emergicenters*: The capital and other projects by or on behalf of these facilities which are subject to review are limited to capital expenditures regardless of purpose in excess of the capital expenditure threshold. *Facilities for the provision of outpatient therapy services including speech pathology*: No such projects have been proposed and it is unclear whether they would be subject to review. LF SHPDA 1/84. *Other ambulatory care facilities*: Colorado covers "facilities for the mentally retarded," "habilitation centers for brain-damaged children," and "pilot project rehabilitative nursing facilities." *General purpose CE/expenditure threshold*: Colorado's general purpose capital expenditure threshold covers expenditures in excess of $2,000,000 for "provision of clinically-related health care services" and excludes expenditures for a set of specified non-clinical services. *Capital expenditures for additions of health services/expenditure threshold*: Colorado covers capital expenditures in excess of $1,000,000 to "create or change" health services. *CE for other specified purposes/expenditure threshold*: Colorado covers the replacement of beds exceeding the capital expenditure threshold. *Bed supply increases only, bed category changes and bed relocations*: Colorado covers bed supply increases, category changes, and relocations in excess of twenty beds over

a two-year period. *Other entities, persons, other specified projects*: Colorado covers expenditures for major medical equipment by or on behalf of any person in excess of $1,000,000 to provide "clinically related health care" which includes equipment not located in or providing services to inpatients of a hospital.

CONNECTICUT: *General*: Connecticut amended its CON law in 1985. *Inpatient rehabilitation facilities, ambulatory surgical facilities, organized ambulatory health care facilities*: Coverage unclear. *Other entities, persons*: Connecticut covers "coordination, assessment and monitoring agencies," student/faculty infirmaries, and "homemaker home health aide agencies." *Bed capacity increases and decreases*: Connecticut statute expressly covers only substantial decrease in total bed capacity. Bed supply increases are apparently included under statutory health service/function addition coverage. *Additions of new health services*: Connecticut covers additions of health services or functions, except additions of ambulatory services by HMOs, by all health care facilities or institutions (including state health care facilities or institutions) except home health care agencies, homemaker-home health aide agencies, and coordination, assessment, and monitoring agencies. *Other specified projects*: Connecticut covers transfer of ownership or control of a health care facility or institution (except home health care agencies and homemaker home health aide agencies) prior to initial licensure. Connecticut covers increases in coordination, assessment, and monitoring agency staffing by a specified percentage. Connecticut covers the termination of its Medicaid provider agreement by a nursing home. *Other entities, persons, other specified projects*: Connecticut covers expenditures by any person in excess of $400,000 to acquire "imaging equipment" which will not be owned by or located in a health care facility.

DELAWARE: *General*: Delaware has certificate of need and 1122. Tables show CON coverage. *Other entities*: Delaware covers independent blood banks. *Other specified projects*: Delaware covers pre-development expenditures in excess of $50,000.

DISTRICT OF COLUMBIA: *General*: The D.C. CON law underwent minor amendment in 1985. *Health care facilities subject to review*: The District of Columbia covers health care facilities only if they have an annual operating budget of at least $250,000. *Other entities, persons*: D.C. covers diagnostic health care facilities. *CE for other specified purposes/expenditure threshold*: D.C. covers capital expenditures intended to permit the increase of patient load or units of service by forty percent over present capacity and capital expenditures to permanently close a health care facility. *Additions of new health services/annual operating cost threshold*: D.C. regulations appear to provide for coverage of new health services both regardless of annual operating cost, and if they exceed an annual operating budget. *Other entities, persons, other specified projects*: D.C.

covers acquisition of MME with a fair market value in excess of $400,000 by or on behalf of physicians, dentists, or other individual providers of individual group practice.

FLORIDA: *General*: Florida CON law underwent minor amendment in 1985. Portions of Florida CON law sunset in 1987. *Home health agency*: HHA coverage limited to HHAs certified or seeking certification as a Medicare home health services provider. Project coverage limited to establishment of a new HHA. *Bed capacity increases and decreases*: Florida covers increases in bed supply and any change in the number of psychiatric or rehabilitation beds. *Bed category changes*: Florida covers bed category conversions only between SNF and ICF beds, and only if the conversion exceeds 10/10/2, unless the facility is licensed for both SNF and ICF. *Other specified projects*: Florida covers conversion from one type of health care facility to another and transfer of a CON.

GEORGIA: *General*: The Georgia CON law was amended in 1985. Georgia has CON and 1122. Facilities and projects identified as covered on Tables may be covered under either or both CON and 1122. *Medically-oriented residential care facilities*: Georgia covers only "personal care homes" not in existence on the effective date of the CON statute. *Family planning/abortion centers/clinics*: Only abortion centers covered. *Acquisition of existing facilities*: Reviewable only under the state's 1122 program, except that acquisitions of publicly owned and operated health care facilities subject to CON review. *Bed capacity increases only*: Georgia exempts bed supply increases less than ten beds or ten percent of bed capacity, whichever is less, in any two-year period if the facility occupancy rate in the preceding year is more than eight-five percent. *Other specified projects*: Georgia covers conversion or upgrading of a health care facility not previously subject to review under the CON law to a health care facility subject to review.

HAWAII: *Medically-oriented residential care facilities*: Coverage unknown. *Other outpatient ambulatory care facilities*: Hawaii also covers centers for dental surgery; dental clinics; cosmetic surgery centers; any provider of medical or health services organized as a not-for-profit or business corporation other than a professional corporation; and any provider of medical or health services which describes itself to the public as a "center," "clinic" or by any name other than the name of one or more of the practitioners providing these services. *CE for other specified purposes*: Hawaii covers capital expenditures in excess of $600,000 for acquisition of existing health care facilities. *Termination of a health service*: Hawaii covers terminations but exempts service terminations by a health care facility that is ceasing its entire operation. *Acquisitions of major medical equipment*: Hawaii has a $250,000 threshold for acquisitions of new medical equipment and a $400,000 threshold for replacement of medical equip-

ment. *Other specified projects*: Hawaii covers change of location of a health service. *Other entities, persons, acquisition of MME*: Hawaii covers acquisitions of MME by offices of physicians, dentists, or other practitioners of the healing arts.

IDAHO: *General*: Idaho has an 1122 program, but no CON program. Table displays 1122 coverage. *Other specified projects, CE for other specified purposes*: Idaho covers development of a new facility, and a capital expenditure for development of a new facility, which will result in the addition of new licensed beds.

ILLINOIS: *General*: Portions of the Illinois CON law are scheduled to sunset Jan. 1, 1986. *Addition of new health services/annual operating cost threshold*: Illinois covers additions of the following services if their annual operating costs exceed the threshold: blood bank; diagnostic imaging; emergency services; laboratory; occupational therapy; outpatient ambulatory care; pharmacy; physical therapy; respiratory therapy; and surgery. Additions of the following services are covered regardless of cost: acute mental illness; alcoholism treatment; burn treatment; cardiac catheterization; computer systems; end stage renal disease; intensive care; medical-surgical; non-hospital based ambulatory surgery; obstetrical services; open heart surgery; pediatric services; perinatal-high risk; radiation therapy; rehabilitation services. *Other specified projects*: Illinois covers discontinuation of a health care facility.

INDIANA: *General*: Indiana's CON law was amended in 1985. Indiana CON law sunsets June 30, 1987. *Skilled nursing facilities and intermediate care facilities*: Indiana exempts CE by or on behalf of health care facilities for SNF/ICF beds which are not certified to participate in Medicare or Medicaid. *Kidney disease treatment centers (including freestanding hemodialysis units)*: Indiana does not cover freestanding hemodialysis units. *CE for changes in bed category*: Indiana covers changes in health care facility bed category from any category to certified long-term care SNF/ICF beds. Indiana covers changes in Medicaid-certified hospital or SNF/ICF beds to Medicaid-reimburseable ICF/mentally-retarded beds. *Other specified projects*: Indiana covers the application of a SNF or ICF for certification to participate in Medicare or Medicaid.

IOWA: *General*: Iowa has CON and 1122. Entities and projects identified as covered in Tables may be covered under either 1122 or CON or both. *Freestanding emergicenter; birthing center; public health center, outpatient physical therapy center*: The state CON statute provides for coverage of "organized outpatient health facilities," (defined as "a facility, not part of a hospital, organized and operated to provide health care to noninstitutionalized and non-homebound persons on an outpatient basis; it does not include private offices or clinics of individual physicians, dentists, or other practitioners, or groups of practitioners who are health care

providers''). State regulations have defined this to include, but not be limited to, ''family planning clinics, neighborhood health centers, community mental health centers, drug abuse or alcoholism treatment centers, and rehabilitation facilities.'' According to the SHPDA, whether or not emergicenters, birthing centers, public health centers, and outpatient physical therapy centers would be covered would depend upon the proposed facilities' relationship to a hospital, if any; the services to be provided by the facility and whether such services constitute ''health care''; and the facilities' characteristic as a private office or clinic of a practitioner or a group of practitioners. LF SHPDA 2/84. *Bed capacity increases and decreases*: CON statute and regulations could be read not to cover. LF SHPDA 2/84 indicates state does review permanent changes in bed capacity whether the changes result in the addition or deletion of beds. 1122 coverage parallels CON coverage under ''election not to review'' regulation. *Other specified projects*: Iowa covers relocation of a health care facility, relocation of one or more health services from one physical facility to another. *Other entities, persons, other specified projects*: Iowa covers expenditure by or on behalf of individual health care provider or group of providers in excess of $400,000 for MME to be installed in a private office or clinic.

KANSAS: *General*: The Kansas CON statute sunsetted July 1, 1985. Kansas has a statutory moratorium on new hospital construction and additions or relocations of hospital beds through July 1, 1986.

KENTUCKY: *General*: Kentucky has CON and 1122. Facilities and projects identified in Tables may be covered under either or both programs. *Public health centers*: Kentucky covers capital expenditures in excess of the threshold by county and district health departments and establishment by such departments of health services for which there are separate licensure categories, *e.g.* primary care centers or home health agencies. CON not required to establish traditional ''public health'' services. LF SHPDA 2/84. *Addition of a new health service/annual operating cost threshold*: Kentucky covers health service additions exceeding an AOC threshold and also covers additions of health services subject to licensure or for which there is a component of the SHP without regard to annual operating costs. The services in the SHP are: acute care services; open heart surgery, cardiac catheterization, radiation therapy which utilizes mega-voltage equipment, ESRD services, CT scanners, NMR, long-term care services. *Acquisitions of existing facilities*: Acquisitions of hospitals, SNFs, ICFs, kidney disease treatment center including freestanding hemodialysis units, and ambulatory surgical facilities subject to 1122 review only if associated with capital expenditure in excess of $100,000. LF SHPDA 2/84. *Other specified projects*: Kentucky requires CON to alter the geographic service area which has been designated on a certificate of need or license, and to transfer a CON for establishment of a new facility or replacement of an existing facility.

LOUISIANA: *General*: Louisiana has a Section 1122 program. Although it does not have a certificate of need law, it does have a statutory program of new home health agency licensure requiring a determination of need for the new home health agency by the designated planning agency. *Home health agency*: Louisiana's home health agency coverage is limited to establishment and licensure of new HHA. *Other specified projects*: Louisiana covers relocation of a previously approved and licensed facility within the same service area.

MAINE: *General*: Maine CON law was amended in 1985. Maine has CON and 1122. It elects not to review under 1122 projects not reviewed under CON. *CE for other specified purpose*: Maine covers a capital expenditure in excess of $350,000 for purchase or other acquisition of a health care facility. *Bed capacity increases and decreases*: Maine covers increases and decreases in licensed bed capacity by more than five beds or ten percent, whichever is less, in any two-year period. *Bed category change*: Maine covers increases or decreases in the number of beds licensed in particular levels of care by more than five beds or ten percent, whichever is less, in any two-year period. *Bed relocations*: Maine covers relocations of bed by more than five beds or ten percent of bed capacity, whichever is less, in any two-year period. *Additions of new health services/annual operating cost threshold*: Maine covers additions of health services with annual operating costs in excess of the threshold. It also covers the addition of any new health service (except an organized outpatient facility) without regard to cost. It also covers addition of the following services if the proposed addition duplicates a service presently offered in the proponent's service area: alcohol rehabilitation (inpatient or outpatient); medical-surgical (adult) (where converted from psychiatric beds); rehabilitation (inpatient or outpatient); and speech pathology. *Other entities, other specified projects*: Maine regulations provide for coverage of the acquisition by any person of NMR scanning equipment that is to be used to provide services to persons other than hospital inpatients.

MARYLAND: *General*: Maryland exempts certain projects to close all or part of a hospital. Maryland's CON law was amended in 1985. *General purpose CE*: Maryland exempts CE for site acquisitions, acquisitions of business or office equipment not directly related to patient care and CE to the extent they are directly related to acquisition and installation of MME. Maryland also exempts certain CE made as part of a health facility merger, consolidation, or conversion to non-health related use. It covers CE for predevelopment activities. *CE for other specified purpose*: Maryland covers capital expenditures which result in any increase or decrease in the volume of one patient service where over a two-year period the change is twenty-five percent or more of that volume. Maryland covers CE that result in a substantial change in the bed capacity of a health care facility. *Bed capacity increases and decreases*: Maryland exempts cer-

tain bed capacity changes undertaken pursuant to a health facility merger, consolidation, or conversion to non-health related use. *Addition of new health service*: Maryland exempts additions of new health services with annual operating revenue exceeding the threshold if such revenue is entirely associated with the use of medical equipment. *Acquisition of MME*: Maryland has a program of licensure of major medical equipment in excess of $600,000 used to provide health services acquired, leased, operated, or received by any person. The program uses review criteria and standards similar to those used under CON, but is separate from the state's CON program. *Construction, development, or other establishment of new health care facilities*: Maryland covers establishment of new health care facilities, relocation of an existing health care facility to a new site, and complete replacement of an existing facility on the same, contiguous, or adjacent site. *Other specified projects*: Maryland covers the addition of an HHA branch office by an existing HHA or home health service, establishment of an HHA or home health service in a new location by an existing HHA, or transfer of ownership of an HHA branch office or service. Maryland covers changes in the number of kidney dialysis stations of a health care facility. Maryland covers any increase or decrease in magnitude of any single patient service over a two-year period, other than change in bed capacity, by which the facility plans to change the volume of the service by twenty-five percent or more. For determination of percentage of planned change, the volume of service shall be that unit which is normally measured for the service, and shall be for the last prior annual recording period used by the facility. Certain services volume changes undertaken pursuant to facility merger, consolidation, or conversion to non-health related uses are exempted.

MASSACHUSETTS: *Freestanding emergicenters*: "Clinic" definition in Mass. regulations appears to include emergicenters and bring them within CON. *Other entities*: Massachusetts covers institutions for care of unwed mothers and clinical laboratories. *Bed capacity increases only*: Massachusetts exempts one-time increases of four beds or a series of increases in bed capacity up to four beds, except in intensive care, coronary care, neo-natal intensive care, or renal dialysis beds and so long as the capital expenditure required for the increase or increases does not exceed $150,000. *Addition of health services/annual operating cost threshold*: Massachusetts covers the addition of major services (*e.g.*, any service in the acute services, chronic rehabilitation, and mental health services categories, and establishment of a satellite clinic or unit of a facility) without regard to annual operating cost. Other service additions are covered if they exceed an annual operating threshold of $250,000. *Acquisitions of existing facilities*: Massachusetts regulations indicate that acquisition of an existing health care facility by another health care facility is covered as a substantial change in services of the acquiring facility.

In addition, transfers of ownership of a health care facility require a finding of need for the facility at the proposed location by the state department of health. *Other specified projects*: Conversion of an entire facility from one licensure category to another is covered.

MICHIGAN: *General*: Michigan has CON and 1122. Facilities and projects identified in Tables may be covered under either or both programs. *Home health agencies*: State CON statute provides that HHAs will be covered once HHAs are licensed in the state. *Other entities*: Michigan covers clinical laboratories. *Bed category changes*: Michigan covers bed category changes that result in an increase or decrease in beds in an obstetrical department, long-term care unit or psychiatric unit.

MINNESOTA: *General*: Minnesota does not have a certificate of need law. State law places a moratorium on all new hospital construction and construction or modification by or on behalf of a hospital that increases bed capacity, relocates beds from one physical facility or to another, or otherwise results in an increase or redistribution of bed capacity, with certain exceptions through June 30, 1987. Minnesota has an 1122 program, and elects not to review or non-substantively reviews most projects.

MISSISSIPPI: *General*: Mississippi CON law amended in 1985. Mississippi CON scheduled to sunset July 1, 1986. *Bed capacity increases, CE for bed capacity increases, CE for bed category changes, CE for bed relocations*: Bed-related coverage after 1985 amendments unclear. The statute covers bed relocations of more than ten beds or ten percent over a two-year period specified by the state agency with a CE below $150,000, bed conversions "of the total bed capacity of a designated licensed category or sub-category of any health care facility" with a similar 10/10/2 and a CE below $150,000, and alteration, refurbishing, or modernizing of a unit or department where such beds are located with a CE under $150,000. Not clear if the foregoing transactions would be covered when associated with a CE *exceeding* $150,000. Additionally, bed capacity additions not clearly covered, although legislative intent to cover them is apparent in statutory moratorium on CONs, which exempts certain bed additions. *Other specified projects*: Mississippi covers relocation of a health care facility, or portion thereof, or major medical equipment, or relocation of a health care service from one site to another. Mississippi covers acquisition of MME exceeding threshold by any person.

MISSOURI: *Health maintenance organizations*: Missouri law and regulations do not provide an HMO exemption. *CE for bed category change*: Missouri exempts nursing facility conversion of beds from practical to professional levels of care if the facility meets the professional level licensure requirements. *Additions of new health services*: Missouri exempts additions of home health services. *Other specified projects*: Missouri covers pre-development expenditures exceeding $150,000.

MONTANA: *General*: Montana CON law sunsets July 1, 1987. The Montana CON statute underwent minor amendment in 1985. *Other entities*: Montana covers infirmaries, *e.g.*, facilities located in a university, college, government institution, or industry for the treatment of the sick and injured on an inpatient or outpatient basis. Montana also covers adult day care centers. *Other specified projects*: Montana covers expansion of the geographic service area of a home health agency. *Other entities, persons, other specified projects*: Montana covers acquisition by any person of MME in excess of the threshold provided such an acquisition would require a CON if undertaken by or on behalf of a health care facility.

NEBRASKA: *General*: Nebraska has 1122 and CON. It elects not to review under 1122 projects not reviewable under CON. *Addition of new health services/annual operating cost threshold*: Nebraska covers additions of new home health services regardless of annual operating cost and additions of other services in excess of the threshold. *Acquisition of existing facility*: Various types of acquisitions of facilities and ownership interests in facilities are covered.

NEVADA: *General*: Nevada statute amended 1985. *Other entitites*: Nevada covers any facility providing health services which is entitled to receive reimbursement from any public agency as a health facility. *Other entities, other specified projects*: Nevada covers any facility which acquires medical equipment with a cost exceeding the MME threshold. *CE for other specified purpose*: Nevada covers CE in excess of $100,000 for expansion or consolidation of a health service. *Other specified projects*: Nevada covers expansion or consolidation of health services exceeding $297,500 annual operating expenses. Nevada covers conversion of an existing office of a health practitioner to a health facility if the establishment of the offices would have exceeded the $100,000 CE or $297,500 annual operating cost threshold.

NEW HAMPSHIRE: *General*: New Hampshire CON law was amended in 1985. *Other entities*: New Hampshire covers independent diagnostic laboratories as health care facilities. New Hampshire covers "mental retardation facilities." *Bed capacity increases, bed category changes*: New Hampshire covers increases in bed capacity or changes in bed category exceeding ten beds or ten percent, whichever is less, in a five-year period. *Addition of new services*: New Hampshire covers addition of "special inpatient services," including but not limited to alcohol and drug dependency, psychiatric services, and physical rehabilitation. *Acquisition of existing facilities*: New Hampshire covers transfers of ownership of health care facilities except where the transfer would be subject to the provisions of revaluation of assets as outlined in the Federal Deficit Reduction Act of 1984. *Other entities, persons, other specified projects*: New Hampshire covers acquisitions of diagnostic or therapeutic equipment in excess of a $400,000 threshold by or on behalf of any health care provider.

NEW JERSEY: *General*: New Jersey has both CON and 1122. Projects and facilities identified in Tables may be covered under either or both programs. *Kidney disease treatment centers, ambulatory surgery centers, organized ambulatory health care facilities, other ambulatory care facilities*: New Jersey covers public health centers, diagnostic centers, treatment centers, rehabilitation centers, outpatient clinics and dispensaries. The identity of these facilities is not further defined in law or regulations. The Tables assume kidney disease treatment centers, ambulatory surgery centers, and organized ambulatory health care facilities are included within these terms. *Other entities*: New Jersey covers certain bio-analytical laboratories. *CE for other specified purpose*: New Jersey covers capital expenditures in excess of $150,000 for facility/service planning and any capital expenditure which will result in a bed capacity decrease. *Additions of new health services*: New Jersey regulations contain a comprehensive list of new health services categories subject to review and components thereof which are not subject to review as new services. *Construction, development, or other establishment of new health care facility*: In addition to coverage of construction, development, or establishment of a new health care facility, New Jersey expressly covers replacement of an existing bed-related health care facility, establishment of a bed-related satellite location for an existing health care facility, relocation and replacement of an existing non-bed-related health care facility into a new health service area or to an area that results in problems of access to populations historically served by the facility, and establishment of a non-bed satellite service of an existing health care facility into a new health service area. *Acquisition of existing facilities*: Acquisition of facilities and of varying types and degrees of ownership interests in health care facilities are covered. *Other specified projects*: New Jersey covers transfer of a patient care service in whole or in part to another corporate entity; addition of regionalized services identified in Dept. of Health planning regulations; addition of renal dialysis stations; and addition of operating rooms.

NEW MEXICO: *General*: New Mexico has 1122, not CON.

NEW YORK: *Home health agencies*: Coverage limited to "public and voluntary" HHAs. *Ambulatory surgery centers and organized ambulatory health care facilities*: New York covers diagnostic centers, treatment centers, rehabilitation centers. ASC and various types of OAHCFS would appear to be covered under these categories, if they meet organizational and other criteria for distinguishing such centers from the private practice of medicine. *Acquisition of major medical equipment*: New York covers addition or replacement of any equipment regardless of cost utilized in the provision of therapeutic radiology, open heart surgery, cardiac catheterization, kidney and heart transplant, acute or chronic renal dialysis, CT scanners, burn care, and extra corporeal shockwave lithotripters that will significantly increase the capacity of providing such service. *Other specified*

projects: New York covers a change in the method of delivery of a licensed service regardless of cost. New York covers addition or deletion of approval to operate part-time clinics. New York covers any proposal involving a total project cost exceeding $10,000 or an increase in operating costs by a medical facility that has been determined to be inappropriate or for which there has been a determination of no public need and which is identified as unneeded in the state medical facilities plan.

NORTH CAROLINA: *General*: North Carolina's statute was amended in 1985. *Hospices, other entities, CE for other specified purposes, other specified projects*: North Carolina covers local health departments, but only to the extent of covering their CE in excess of the expenditure threshold. North Carolina covers construction, development, or establishment of a hospice if the operating budget exceeds $100,000 or if there is a CE in excess of the expenditure minimum by or in behalf of the hospice. No other hospice or local health department projects are covered. *CE for bed capacity increases and decreases*: North Carolina covers CE in any amount for bed supply increases and CE in excess of the expenditure minimum ($1,000,000) for bed supply decreases. *CE for changes in bed category*: North Carolina covers CE for bed category changes only if they involve a CE in excess of the expenditure minimum. *Other specified projects*: Conversion of non-health care facility beds to health care facility beds is covered. *Other entities, other specified projects*: North Carolina covers acquisition by any person of "major medical equipment" that includes magnetic resonance imaging or lithotripters, regardless of ownership or location.

NORTH DAKOTA: *General*: North Dakota's statute was amended in 1985. *Home health agency*: HHA coverage limited to expedited review of establishment of new HHA or expansion of geographic area of service of existing HHA. *General purpose CE*: Capital expenditures for site acquisition are exempt. *CE for service additions*: North Dakota statute defines "capital expenditure" in such a way as to incorporate the expenditure threshold into the definition. Not clear if coverage of capital expenditures for service additions intended to include the threshold. Table assumes it does not.

OHIO: *General*: The Ohio CON statute was amended in 1985. *CE for changes in bed category*: Ohio covers any redistribution of beds by service associated with a capital expenditure in any amount and amounting to nine beds or ten percent of bed capacity, whichever is less, in a two-year period. *CE for other specified purpose*: Ohio covers CE for decrease in bed capacity of more than nine beds or ten percent of bed capacity, whichever is less, within a two-year period. *Bed category changes*: Ohio covers redistribution of beds by service involving beds registered as psychiatric, physical rehabilitation, alcohol rehabilitation, or long-term care.

Bed relocation: Ohio covers bed relocations from one physical facility or site to another excluding relocation within a health care facility or among buildings of a facility at the same location. *Addition of a new health service*: Ohio covers initiation of any program of heart, lung, liver, or pancreas transplant, without regard to cost. Other health services covered if they exceed annual operating cost threshold. *Acquisitions of MME*: Ohio has $200,000 threshold for acquisition of technologically innovative medical equipment; $400,000 for all other major medical equipment. *Other specified projects*: Ohio covers change from one category of health facility to another.

OKLAHOMA: *General*: Oklahoma has CON and 1122. Tables show CON coverage. Not known if 1122 program coverage different. Portions of the Oklahoma CON law to sunset in 1989. *Other entities*: Oklahoma covers such institutions or services operated by the federal government in the state as may be authorized by the U.S. Congress. *CE regardless of purpose/expenditure threshold*: The expenditure threshold for SNF/ICF, and medically-oriented residential care facilities is $150,000; for hospitals and all other health care facilities it is $600,000. *CE for bed supply increases and decreases, relocations and category changes*: Oklahoma covers only SNF/ICF and medically-oriented residential care facilities under these forms of coverage. *Bed capacity increases and decreases, category changes and relocations*: These forms of coverage apply to health care facilities other than ICF, SNF, medically-oriented residential care facilities. *Construction, development, or other establishment of new health care facility*: Regulations cover. However, current statute could be read narrowly to cover only for SNF, ICF, medically-oriented residential care facility.

OREGON: *General*: Oregon's statute was amended in 1985. *Other entities*: Oregon covers college infirmaries. *General purpose CE/expenditure minimum*: Oregon covers expenditures for clinically-related services in excess of the lesser of $1,000,000 or $250,000 plus .5% of the gross revenues for the last fiscal year. Site acquisitions are exempt. *CE for other specified purposes*: Oregon covers non-clinically related capital expenditures in excess of the general purpose CE threshold. *Additions of health services*: Home health services, residential care or treatment of the elderly and residential or outpatient services for alcoholism, drug abuse, or mental or emotional disturbances are exempt. Oregon covers additions of all other health services which could significantly add to the cost of patient care or compromise quality of care. With several exceptions, Oregon regulations define new services with annual operating expenses exceeding $340,000 as significantly adding to patient care costs. *Other entities, other specified projects*: Oregon covers acquisition of MME exceeding a $1 million threshold by any person.

PENNSYLVANIA: *CE for bed category changes*: Pennsylvania exempts bed category changes within levels of care in a nursing home.

RHODE ISLAND: *Other outpatient ambulatory care facilities*: Rhode Island's coverage of organized ambulatory health care facilities includes central service facilities, treatment centers, diagnostic centers, outpatient clinics, and health centers. *Other entities*: Rhode Island covers clinical laboratories. *Addition of a health service*: Rhode Island statute provides for coverage of addition of any health service proposed to be offered to patients or the public by a health care facility which meets criteria defined in state agency rules and regulations. As of December 1985, service additions associated with a $75,000 annual operating cost and service expansions associated with a $150,000 increase in operating expenditures were covered. *Other specified projects*: Rhode Island covers major expansion of an existing program which increases operating expenditures in a health care facility by $150,000 in one year. *Other entities, persons, other specified projects*: Rhode Island covers acquisition of new health care equipment proposed to be utilized by a health care provider (whether practicing alone or as a member of a partnership, corporation, organization, or association) costing in excess of $150,000.

SOUTH CAROLINA: *General*: Project coverage shown is under South Carolina's CON program. Not known if 1122 coverage differs significantly. *Other entities*: South Carolina covers "outpatient facilities," not further specified or defined. South Carolina covers state health laboratories and nurse's training facilities.

SOUTH DAKOTA: *General purpose CE*: South Dakota has a $183,690 threshold for nursing facilities, $670,404 for all other health care facilities. *CE for other specified purposes*: South Dakota covers capital expenditures which decrease licensed bed capacity by ten beds or ten percent, whichever is less, in any two-year period. *Bed category changes*: South Dakota covers permanent changes in bed category in excess of five beds per calendar year. *Additions of health services*: South Dakota covers nursing home service additions with annual operating costs in excess of $91,845; other health facility service additions in excess of $279,336. *Acquisitions of major medical equipment*: South Dakota has a $400,000 threshold for MME in a hospital or physician's office; $150,000 in a nursing care facility.

TENNESSEE: *General*: The Tennessee CON law was amended in 1985. Portions of the Tennessee CON statute sunset June 30, 1991. *Bed capacity increases and decreases*: Nursing homes may increase or decrease licensed bed supply by ten beds or ten percent, whichever is less, in any two-year period. *Bed category changes*: Tennessee covers bed category changes between acute care and long-term care beds only. *Additions of health services, terminations of health services*: Tennessee covers additions and terminations of a specified set of major health care services, regardless of cost (e.g., (1) medical; (2) surgical; (3) obstetrical; (4) psychiatric/retardation/substance abuse treatment—adult, adolescent, children, and youth;

(5) special care units—ICU, CCU, burn, cardiac catheterization, neonatal nursery; (6) open heart surgery; (7) therapeutic radiology; (8) all outpatient services; (9) pediatric; (10) total body and head CT scanners; (11) home health services; (12) ambulatory primary care clinic services; (13) ambulatory surgery; (14) magnetic resonance imaging; (15) extracorporeal shock wave lithotripsy; (16) any service established and staffed as an organized unit with a projected annual operating budget in excess of $500,000; and (17) any service enumerated above provided to a facility or institution on a mobile basis). *Other specified projects*: Tennessee covers resumption of operation of any facilities or services previously discontinued (for reasons other than temporary closure for construction purposes) for one year or more. Tennessee covers change in site of a health care facility other than a primary care center or public health department. *Other entities*: Tennessee covers persons or combinations of persons engaged in a joint or cooperative enterprise designed to provide central facilities and/or services to two or more health care facilities. *General purpose CE, Acquisition of MME*: Tennessee exempts CE and acquisition of MME not directly related to patient care.

TEXAS: *General*: Texas does not have a CON or 1122 program. Current Texas law authorizes the Governor to establish a capital expenditure review program such as section 1122 if necessary to prevent "loss of federal funds."

UTAH: *General*: Utah does not have a CON or 1122 program.

VERMONT: *Medically-oriented residential care facilities*: Vermont covers community care homes having or seeking a CON to acquire a licensed capacity in excess of fifteen beds. *Organized outpatient health care facilities*: Vermont covers facilities or institutions which offer ambulatory care to two or more persons. *Other entities*: Vermont covers independent diagnostic laboratories. *Bed increases, category changes, relocations*: Vermont covers increases, category changes, relocations exceeding four beds or ten percent of capacity, whichever is less in a four-year period.

VIRGINIA: *General*: The Virginia CON statute was amended in 1985. Virginia exempts nursing homes affiliated with nonprofit life care communities not participating in Medicaid. *Inpatient rehabilitation facilities*: Coverage unclear. *Other entities*: Virginia covers specialized centers or clinics developed for the purpose of providing radiation therapy, CT scanning, or other medical or surgical treatments requiring the utilization of equipment not usually associated with the provision of primary health services. *Addition of new health services*: Home health service additions are exempt. *Other persons, entities, other specified projects*: Virginia covers acquisition by or on behalf of a physician's office of medical equipment exceeding $400,000 generally and customarily associated with provision of health services in an inpatient setting.

WASHINGTON: *CE for additions, terminations of health services*: Washington covers CE for substantial change in services, defined as any capital expenditure for addition or termination of the following services: alcohol/substance abuse; burn unit; cardiac catheterization; chronic renal dialysis; kidney lithotripty; CT-computed tomography; NMR-nuclear magnetic resonance; PET-positron emission tomography; emergency services including regular outpatient emergency services staffed by physicians at a health care facility, and the provision of ambulance services, including licensed air ambulance services; inpatient psychiatric services; neonatal special care - level III; obstetrics - level I; obstetrics - level II; obstetrics - level III; open heart surgery; pediatrics - level I; pediatrics - level II; pediatrics - level III; radiation therapy-megavoltage, orthovoltage; rehabilitation - level I; rehabilitation - level II; rehabilitation - level III; change in the number of dialysis stations in a health care facility; and change from mobile to fixed base CT scanning. In addition, Washington covers as substantial changes in services the introduction of a new technology for diagnosis or treatment, a "change in the level of service," and the offering of any services at a new location not formerly part of the health care facility's campus. *Acquisitions of existing facilities*: Washington covers sale, purchase, or lease of part or all of any hospital.

WEST VIRGINIA: *General*: West Virginia CON statute amended in 1985. West Virginia has CON and 1122. Tables show CON coverage. Not known if 1122 coverage is different. *Organized ambulatory health care facilities*: West Virginia covers "ambulatory health care facilities," *e.g.*, freestanding outpatient facilities not including physicians or other health professionals' offices. *Other entities*: West Virginia covers inpatient "community mental health centers" (*e.g.*, private facilities providing comprehensive services and continuity of care as emergency, outpatient, partial hospitalization, inpatient, and consultation and education for individuals with mental illness, mental retardation, or drug or alcohol addiction). *CE for other specified purposes*: West Virginia covers any capital expenditure associated with the partial or total closure of a health care facility. West Virginia also covers capital expenditures in excess of $1,000,000 for acquisitions of an existing health care facility. *Other specified projects*: West Virginia covers a substantial change in bed capacity if the change is associated with and within two years of a previous CE for which a CON was issued. West Virginia covers a substantial change, defined by regulations, in an institutional health service for which a CON is in effect. *Other persons, entities, other specified projects*: West Virginia covers acquisition of major medical equipment exceeding $400,000 by any person.

WISCONSIN: *General*: Wisconsin statute amended 1985. Wisconsin CON law sunsets July 1, 1989. *General purpose CE; acquisition of major medical equipment*: Wisconsin covers all-purpose hospital CEs and clinical medical equipment acquisitions exceeding $1,000,000 and the same transactions

for nursing home health care facilities exceeding $600,000. However, the threshold for hospital CEs to renovate part or all of a hospital or to convert to a new use is $1,500,000. *Bed capacity increases*: Wisconsin covers bed capacity increases by hospitals and nursing homes, and additions of psychiatric or chemical dependency beds by any person. *Addition of new health services*: Wisconsin covers addition of organ transplantation program, burn center, neonatal ICU, cardiac program, and transport services. *Acquisition of existing facilities*: Wisconsin covers acquisitions of hospitals only. *Other specified projects*: Wisconsin covers construction or total replacement of a nursing home and construction or operation of an ambulatory surgical facility or home health agency. *Other entities, other specified projects*: Wisconsin covers obligations of an expenditure exceeding $1,000,000 by or on behalf of an independent practitioner, partnership, unincorporated medical group, or service corporation for clinical medical equipment.

WYOMING: *General*: The Wyoming CON law was amended in 1985. The Wyoming CON law sunsets July 1, 1989. *Other entities*: Wyoming covers "providers of alternative health care" (not otherwise defined). *Acquisition of MME*: Expenditure threshold for acquisition of MME by SNF/ICF is $150,000. Expenditure threshold for acquisition of MME by all other health care facilities is $400,000. *Other specified projects*: Wyoming covers acquisition of MME exceeding threshold by licensed practitioners' offices.

TABLE 1: STATE PARTICIPATION IN CERTIFICATE OF NEED AND SECTION 1122 REVIEW PROGRAMS

State	Year First CON Statute Adopted	Year CON Statute Repealed or Scheduled to Sunset	Year Current Section 1122 Agreement Entered Into
Alabama	1977		
Alaska	1976		
Arizona	1971	1985	
Arkansas	1975		1973
California	1969	1987	
Colorado	1973		
Connecticut	1969		
Delaware	1978		1973
Dist. of Columbia	1964		
Florida	1972	1987*	
Georgia	1974		1974
Hawaii	1974		
Idaho	1980	1983	1983
Illinois	1974		
Indiana	1980	1985	1973

TABLE 1: Continued

State	Year First CON Statute Adopted	Year CON Statute Repealed or Scheduled to Sunset	Year Current Section 1122 Agreement Entered Into
Iowa	1977		1973
Kansas	1972	1985	
Kentucky	1972		1974
Louisiana			1973
Maine	1978		1973
Maryland	1968		
Massachusetts	1971		
Michigan	1972		1973
Minnesota	1971	1984	1974
Mississippi	1979	1986	
Missouri	1979		
Montana	1975	1987	
Nebraska	1979		1973
Nevada	1971		
New Hampshire	1979		
New Jersey	1971		1974
New Mexico	1978	1983	1973
New York	1964		
North Carolina	1978		
North Dakota	1971		
Ohio	1975		
Oklahoma	1971	1989*	1974
Oregon	1971		
Pennsylvania	1979		
Rhode Island	1968		
South Carolina	1971		
South Dakota	1972		
Tennessee	1973	1991*	
Texas	1975	1985	
Utah	1979	1984	
Vermont	1979		
Virginia	1973		
Washington	1971		
West Virginia	1977		1974
Wisconsin	1977	1989	
Wyoming	1977	1989	

*Only some portions of the statute are scheduled to sunset.

SOURCES: CONGRESSIONAL BUDGET OFFICE, HEALTH PLANNING: ISSUES FOR REAUTHORIZATION 14-15 (1982); Author's survey of state statutes and communications with state health planning and development agencies, 1985.

TABLE 2: HEALTH CARE FACILITIES, ETC., SUBJECT TO STATE CON/1122 REVIEW

(See attached notes for explanatory information, definitions, and state-by-state comments. The symbol "N" in the table below indicates that additional information is provided in the state-by-state comments.)

	Ala	Ak	Ariz[N]	Ark[N]	Cal[N]	Colo	Conn	Del[N]	DC[N]	Fla[N]
Hospitals	X	X		X	X	X	X	X	X	X
Skilled Nursing Facilities	X	X		X	X	X	X	X	X	X
Intermediate Care Facilities	X	X		X	X	X	X	X	X	X
Medically-Oriented Residential Care Facilities				X		X	X			
Inpatient Rehabilitation Facilities	X[N]			X	X	X	N		X	
Home Health Agencies	X			X			X	X	X	X[N]
Hospices				N		X			X	X
Kidney Disease Treatment Centers (Including Freestanding Hemodialysis Units)	X	X		X		X[N]	N	X	X	X
Health Maintenance Organization (Subject to Exemption)	X			X	X	X		X	X	X
Ambulatory Surgery Centers	X	X		X	X	X[N]	N	X	X	X
All Organized Ambulatory Health Care Facilities/ Outpatient Clinics				X			N	X	X	
Specified Ambulatory Health Care Facilities, i.e.:										
Freestanding Emergicenters									X	X
Ambulatory Obstetrical Facilities/Birthing Centers										
Family Planning/ Abortion Centers/ Clinics				X						
Community Health Centers/Clinics				X	X	X				
Public Health Centers	X			X						
Community Mental Health Centers	X			X		X		X	X	
Facilities for Provision of Outpatient Therapy Services Including Speech Pathology				X		N				
Outpatient Rehabilitation Facility	X[N]			X	X	X		X		
Other Outpatient Ambulatory Care Facilities				N	X[N]	X[N]	X[N]			
Other Entitites, Persons	X[N]	X[N]				X[N]	X[N]	X[N]	X[N]	

	Ga[N]	Haw	Id[N]	Ill	Ind[N]	Ia[N]	Ks[N]	Ky[N]	La	Me[N]
Hospitals	X	X	X	X	X	X		X	X	X
Skilled Nursing Facilities	X	X	X	X	X[N]	X		X	X	X
Intermediate Care Facilities	X	X	X	X	X[N]	X		X	X	X
Medically-Oriented Residential Care Facilities	X[N]	N		X		X		X		
Inpatient Rehabilitation Facilities	X	X		X	X			X	X	X
Home Health Agencies	X	X						X	X[N]	X
Hospices		X						X		
Kidney Disease Treatment Centers (Including Freestanding Hemodialysis Units)	X	X	X	X	X[N]	X		X	X	X
Health Maintenance Organizations (Subject to Exemption)	X	X		X		X				X
Ambulatory Surgery Centers	X	X	X	X		X		X	X	X
Organized Ambulatory Health Care Facilities/ Outpatient Clinics		X				X		X		
Specified Ambulatory Health Care Facilities, i.e.:										
Freestanding Emergicenters		X				N		X		
Ambulatory Obstetrical Facilities/Birthing Centers	X	X				N		X		
Family Planning/ Abortion Centers/ Clinics	X[N]	X				X		X		
Community Health Centers/Clinics		X				X		X		
Public Health Centers		X				N		X[N]		
Community Mental Health Centers		X				X		X		
Facilities for Provision of Outpatient Therapy Services Including Speech Pathology		X				N		X		
Outpatient Rehabilitation Facility		X				X		X		
Other Outpatient Ambulatory Care Facility		X[N]								
Other Entities		X[N]				X[N]		X[N]		X

	Md[N]	Mass	Mich[N]	Minn[N]	Miss[N]	Mo	Mont[N]	Neb[N]	Nev[N]	NH[N]
Hospitals	X	X	X		X	X	X	X	X	X
Skilled Nursing Facilities	X	X	X		X	X	X	X	X	X
Intermediate Care Facilities	X	X	X		X	X	X	X	X	X
Medically-Oriented Residential Care Facilities	X	X	X				X			
Inpatient Rehabilitation Facilities	X	X			X		X	X	X	X
Home Health Agencies	X		X[N]		X		X	X	X	X
Hospices	X		X				X		—	
Kidney Disease Treatment Centers (Including Freestanding Hemodialysis Units)	X	X	X		X	X	X	X	X	X
Health Maintenance Organizations (Subject to Exemption)	X	X	X		X	X[N]	X	X		X
Ambulatory Surgery Centers	X	X	X		X	X	X	X	X	X
All Organized Ambulatory Health Care Facilities/ Outpatient Clinics		X	X				X			
Specified Ambulatory Health Care Facilities, i.e.:										
Freestanding Emergicenters		X[N]					X			
Ambulatory Obstetrical Facilities/Birthing Centers		X	X				X			
Family Planning/ Abortion Centers/ Clinics		X	X				X			
Community Health Centers/Clinics		X	X				X			
Public Health Centers		X	X				X			
Community Mental Health Centers		X	X				X			X
Facilities for Provision of Outpatient Therapy Services Including Speech Pathology		X	X				X			
Outpatient Rehabilitation Facility		X	X				X			
Other Outpatient Ambulatory Care Facility										
Other Entities		X[N]	X[N]				X[N]		X[N]	X[N]

	NJ[N]	NM[N]	NY	NC[N]	ND[N]	Oh[N]	Ok[N]	Or[N]	Pa	RI
Hospitals	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Facilities	X	X	X	X	X	X	X	X	X	X
Intermediate Care Facilities	X	X	X	X	X	X	X	X	X	X
Medically-Oriented Residential Care Facilities	X		X				X		X	
Inpatient Rehabilitation Facilities	X		X	X	X	X	X	X	X	X
Home Health Agencies	X		X[N]	X	X[N]	X				X
Hospices			X	X[N]						X
Kidney Disease Treatment Centers (Including Freestanding Hemodialysis Units)	X[N]	X	X	X	X	X	X	X	X	X
Health Maintenance Organizations (Subject to Exemption)	X			X	X	X	X	X	X	X
Ambulatory Surgery Centers	X[N]	X	X[N]	X	X	X	X	X	X	X
All Organized Ambulatory Health Care Facilities/ Outpatient Clinics	X[N]		X[N]							X
Specified Ambulatory Health Care Facilities, i.e.:										
Freestanding Emergicenters							X			X
Ambulatory Obstetrical Facilities/Birthing Centers								X	X	
Family Planning/ Abortion Centers/ Clinics										
Communith Health Centers/Clinics										X
Public Health Centers	X		X				X			
Community Mental Health Centers							X			X
Facilities for Provision of Outpatient Therapy Services Including Speech Pathology										
Outpatient Rehabilitation Facility	X									X
Other Outpatient Ambulatory Care Facility										X[N]
Other Entities	X[N]			X[N]			X[N]	X[N]		X[N]

	SC	SD	Tn[N]	Tx[N]	Ut[N]	Vt	Va[N]	Wa	WV[N]	Wi[N]	Wy[N]
Hospitals	X	X	X			X	X	X	X	X	X
Skilled Nursing Facilities	X	X	X			X	X	X	X	X	X
Intermediate Care Facilities	X	X	X			X	X	X	X	X	X
Medically-Oriented Residential Care Facilities		X				X[N]					X
Inpatient Rehabilitation Facilities	X	X	X					X	X	X	X
Home Health Agencies	X	X	X			X		X	X	X	
Hospices							X	X			
Kidney Disease Treatment Centers (Including Freestanding Hemodialysis Units)	X	X				X	X	X	X	X	X
Health Maintenance Organization (Subject to Exemption)	X	X	X			X	X	X	X		
Ambulatory Surgery Centers	X	X	X			X	X	X	X	X	X
All Organized Ambulatory Health Care Facilities/ Outpatient Clinics			X			X[N]			X[N]		
Specified Ambulatory Health Care Facilities, i.e.:											
Freestanding Emergicenters			X								
Ambulatory Obstetrical Facilities/Birthing Centers											
Family Planning/ Abortion Centers/ Clinics			X								
Community Health Centers/Clinics			X								
Public Health Centers	X	X									
Community Mental Health Centers	X					X			X		
Facilities for Provision of Outpatient Therapy Services Including Speech Pathology						X					
Outpatient Rehabilitation Facility											
Other Outpatient Ambulatory Care Facility											
Other Entities	X[N]		X[N]			X[N]	X[N]		X[N]	X[N]	X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Ala	Ak	Ariz[N]	Ark[N]	Cal[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $736,200			X $736,200	
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold		X[N] $1,000,000		X	
CE for Bed Capacity Increases Only/Expenditure Threshold					
CE for Changes in Bed Category/Expenditure Threshold				X	
CE for Bed Relocations/ Expenditure Threshold				X	
CE for Additions of Health Services/Expenditure Threshold		X $1,000,000		X	
CE for Terminations of Health Services/ Expenditure Threshold		X $1,000,000		X	
CE for Other Specified Purpose/Expenditure Threshold	X[N] $245,000				X[N] $1,000,000
PROJECT COVERAGE					
Bed Capacity Increases and Decreases	X				
Bed Capacity Increases Only					X[N]
Bed Category Changes	X				X[N]
Bed Relocations	X				
Additions of New Health Services/Annual Operating Costs Threshold	X[N]			X $306,705	X[N]
Terminations of a Service					
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $245,000			X $400,000	X[N] $1,000,000
Construction, Development or Other Establishment of New Health Care Facilities	X	X $1,000,000			X[N]
Acquisitions of Existing Facilities					
Other Specified Projects	X[N]				X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Colo	Conn	Del[N]	DC[N]	Fla[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X[N] $2,000,000	X $714,000	X $150,000	X $600,000	X $736,200
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold				X	
CE for Bed Capacity Increases Only/Expenditure Threshold					
CE for Changes in Bed Category/Expenditure Threshold				X*	
CE for Bed Relocations/ Expenditure Threshold				X*	
CE for Additions of Health Services/Expenditure Threshold	X[N] $1,000,000		X	X	
CE for Terminations of Health Services/ Expenditure Threshold				X	X
CE for Other Specified Purpose/Expenditure Threshold	X[N] $2,000,000			X[N]	
PROJECT COVERAGE					
Bed Capacity Increases and Decreases		N			X[N]
Bed Capacity Increases Only	X[N]		X*		
Bed Category Changes	X[N]		X*		X[N]
Bed Relocations	X[N]		X*		
Additions of New Health Services/Annual Operating Costs Threshold		X[N]	X	X[N] X[N] $250,000	X $306,750
Terminations of a Service		X			
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $1,000,000	X $400,000	X $150,000	X $400,000	X $400,000
Construction, Development or Other Establishment of New Health Care Facilities	X		X	X	X
Acquisition of Existing Facilities				X	
Other Specified Projects	X[N]	X[N]	X[N]	X[N]	X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Ga[N]	Haw	Id[N]	Ill	Ind[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $736,200	X $600,000	X $600,000	X $736,200	X $750,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold					
CE For Bed Capacity Increases Only/Expenditure Threshold			X		X
CE for Changes in Bed Category/Expenditure Threshold			X		X[N]
CE for Bed Relocations/ Expenditure Threshold					
CE for Additions of Health Services/Expenditure Threshold			X $250,000		
CE for Terminations of Health Services/ Expenditure Threshold					
CE for Other Specified Purpose/Expenditure Threshold		X[N] $600,000	X[N]		
PROJECT COVERAGE					
Bed Capacity Increases and Decreases		X		X*	
Bed Capacity Increases Only	X[N]		X		
Bed Category Changes		X		X*	
Bed Relocations		X		X*	
Additions of New Health Services/Annual Operating Costs Threshold	X	X	X	X[N], X[N] $306,750	
Terminations of a Service		X[N]		X	
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $429,012	X[N] $250,000/ $400,000		X $400,000	X $750,000
Construction, Development or Other Establishment of New Health Care Facilities	X				
Acquisitions of Existing Facilities	X[N]				
Other Specified Projects	X[N]	X[N]	X[N]	X[N]	X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Ia^N	Ks^N	Ky^N	La	Me^N
CAPITAL EXPENDITURE COVERARE					
General Purpose CE/ Expenditure Threshold	X $600,000		X $603,600	X $600,000	X $350,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold				X*	
CE for Bed Capacity Increases Only/Expenditure Threshold					
CE for Changes in Bed Category/Expenditure Threshold				X	
CE for Bed Relocations/ Expenditure Threshold					
CE for Additions of Health Services/Expenditure Threshold	X $250,000			X	X
CE for Terminations of Health Services/ Expenditure Threshold				X	X
CE for Other Specified Purpose/ Expenditure Threshold					X^N $350,000
PROJECT COVERAGE					
Bed Capacity Increases and Decreases	X^N		X		X^N
Bed Capacity Increases Only					
Bed Category Changes	X		X		X^N
Bed Relocations	X		X		X^N
Additions of New Health Services/Annual Operating Costs Threshold			X^N; X^N $251,500		X^N; X^N $145,000
Terminations of a Service	X		X		
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X^N $400,000		X $402,000		X $300,000
Construction, Development or Other Establishment of New Health Care Facilities	X		X		X
Acquisitions of Existing Facilities			X^N	X	
Other Specified Projects	X^N		X^N	X^N	X^N

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Md[N]	Mass	Mich[N]	Minn[N]	Miss[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X[N] $730,000	X $600,000	X $150,000		X $1,000,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold					
CE for Bed Capacity Increases Only/Expenditure Threshold					N
CE for Changes in Bed Category/Expenditure Threshold					X[N]
CE for Bed Relocations/ Expenditure Threshold					X[N]
CE for Additions of Health Services/Expenditure Threshold					X
CE for Terminations of Health Services/ Expenditure Threshold					
CE for Other Specified Purpose/Expenditure Threshold	X[N]				
PROJECT COVERAGE					
Bed Capacity Increases and Decreases	X*[N]				
Bed Capacity Increases Only		X[N]	X		N
Bed Category Changes			X[N]		
Bed Relocations					
Additions of New Health Services/Annual Operating Costs Threshold	X[N] $305,000	X[N],X[N] $250,000	X		X $150,000
Terminations of a Service	X				
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	N	X $400,000			X $750,000
Construction, Development or Other Establishment of New Health Care Facilities	X[N]		X		X
Acquisitions of Existing Facilities		X			
Other Specified Projects	X[N]	X[N]			X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Mo	Mont[N]	Neb[N]	Nev[N]	NH[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $736,000	X $750,000	X $512,100	X $714,000	X $1,000,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold			X*		
CE for Bed Capacity Increases Only/Expenditure Threshold	X* $736,000				
CE for Changes in Bed Category/Expenditure Threshold	X*[N] $736,000		X*		
CE for Bed Relocations/ Expenditure Threshold	X* $736,000		X*		
CE for Additions of Health Services/Expenditure Threshold			X	X $100,000	
CE for Terminations of Health Services/ Expenditure Threshold			X		
CE for Other Specified Purpose/Expenditure Threshold				X[N] $100,000	
PROJECT COVERAGE					
Bed Capacity Increases and Decreases		X*			
Bed Capacity Increases Only				X*	X[N]
Bed Category Changes		X*			X[N]
Bed Relocations		X*			
Additions of New Health Services/Annual Operating Costs Threshold	X[N] $306,000	X $100,000	X[N], X $256,050	X $297,500	X[N]
Terminations of a Service					
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $400,000	X $500,000	X $400,000	X $400,000	X
Construction, Development or Other Establishment of New Health Care Facilities	X $736,000	X	X		
Acquisitions of Existing Facilities			X[N]		X[N]
Other Specified Projects	X[N]	X[N]		X[N]	X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	NJ[N]	NM[N]	NY	NC[N]	ND[N]
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $600,000	X $600,000	X $300,000	X $1,000,000	X[N] $750,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold		X		X[N] $1,000,000	
CE for Bed Capacity Increases Only/Expenditure Threshold					
CE for Changes in Bed Category/Expenditure Threshold				X[N]	
CE for Bed Relocations/ Expenditure Threshold				X	
CE for Additions of Health Services/Expenditure Threshold		X		X	X[N]
CE for Terminations of Health Services/ Expenditure Threshold		X		X	
CE for Other Specified Purpose/Expenditure Threshold	X[N]			X[N]	
PROJECT COVERAGE					
Bed Capacity Increases and Decreases	X		X		
Bed Capacity Increases Only					
Bed Category Changes	X		X		
Bed Relocations	X		X		
Additions of New Health Services/Annual Operating Costs Threshold	X[N]		X	X $306,750	X $300,000
Terminations of a Service	X		X		
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $400,000		X[N]	X $600,000	X $500,000
Construction, Development or Other Establishment of New Health Care Facilities	X[N]		X	X	
Acquisitions of Existing Facilities	X[N]				
Other Specified Projects	X[N]		X[N]	X[N]	

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Oh	Ok[N]	Or	Pa	RI
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $714,000	X[N] $600,000/ $150,000	X[N] $1,000,000	X $736,200	X $150,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold		X[N]			
CE for Bed Capacity Increases Only/Expenditure Threshold				X*	X*
CE for Changes in Bed Category/Expenditure Threshold	X[N]	X[N]		X*[N]	X*
CE for Bed Relocations/ Expenditure Threshold		X[N]		X*	X*
CE for Additions of Health Services/Expenditure Threshold				X	X
CE for Terminations of Health Services/ Expenditure Thresholds	X				
CE for Other Specified Purpose/Expenditure Threshold	X[N]				
PROJECT COVERAGE					
Bed Capacity Increases and Decreases		X[N]			
Bed Capacity Increases Only	X		X*	X*	
Bed Category Changes	X[N]	X[N]			
Bed Relocations	X[N]	X[N]	X		
Additions of New Health Services/Annual Operating Costs Threshold	X[N],X[N] $297,500	X $250,000	X[N] $340,000	X $306,750	X[N] $75,000/ $150,000
Terminations of a Service					
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X[N] $400,000/ $200,000	X $400,000	X $1,000,000	X $400,000	X[N] $150,000
Construction, Development or Other Establishment of New Health Care Facilities	X	X	X	X	X
Acquisitions of Existing Facilities		X			
Other Specified Projects	X[N]		X[N]		X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	SC	SD	Tn^N	Tx^N	Ut^N
CAPITAL EXPENDITURE COVERAGE					
General Purpose CE/ Expenditure Threshold	X $600,000	X^N $670,404/ $183,690	X^N $1,000,000		
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold					
CE for Bed Capacity Increases Only/Expenditure Threshold					
CE for Changes in Bed Category/Expenditure Threshold					
CE for Bed Relocations/ Expenditure Threshold					
CE for Additions of Health Services/Expenditure Threshold	X	X			
CE for Terminations of Health Services/ Expenditure Thresholds		X			
CE for Other Specified Purpose/Expenditure Threshold		X^N			
PROJECT COVERAGE					
Bed Capacity Increases and Decreases			X^N		
Bed Capacity Increases Only	X	X			
Bed Category Changes	X	X^N	X^N		
Bed Relocations			X		
Additions of New Health Services/Annual Operating Costs Threshold	X $250,000	X^N $279,336/ $91,845	X^N,X^N $500,000		
Terminations of a Service	X		X^N		
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $400,000	X^N $400,000/ $150,000	X $1,000,000		
Construction, Development or Other Establishment of New Health Care Facilities	X		X		
Acquisitions of Existing Facilities	X				
Other Specified Projects			X^N		

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Vt	Va[N]	Wa	WV[N]
CAPITAL EXPENDITURE COVERAGE				
General Purpose CE/ Expenditure Threshold	X $150,000	X $600,000	X $1,071,000	X $714,000
CE For Bed Capacity Increases and Decreases/ Expenditure Threshold				X*
CE for Bed Capacity Increases Only/Expenditure Threshold		X		
CE for Changes in Bed Category/Expenditure Threshold				X*
CE for Bed Relocations/ Expenditure Threshold		X*		X*
CE for Additions of Health Services/Expenditure Threshold			X[N]	X
CE for Terminations of Health Services/ Expenditure Threshold			X[N]	X
CE for Other Specified Purpose/Expenditure Threshold				X[N]
PROJECT COVERAGE				
Bed Capacity Increases and Decreases				
Bed Capacity Increases Only	X[N]		X	
Bed Category Changes	X[N]		X	
Bed Relocations	X[N]			
Additions of New Health Services/Annual Operating Costs Threshold	X	X[N]	X $536,000	X $297,500
Terminations of a Service				
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X $125,000	X $400,000	X $1,071,000	X $400,000
Construction, Development or Other Establishment of New Health Care Facilities	X		X	X
Acquisitions of Existing Facilities			X[N]	
Other Specified Projects		X[N]		X[N]

TABLE 3: CAPITAL AND OTHER PROJECTS BY OR ON BEHALF OF HEALTH CARE FACILITIES, ETC. SUBJECT TO STATE CON/1122 REVIEW

	Wi^N	Wy^N
CAPITAL EXPENDITURE COVERAGE		
General Purpose CE/ Expenditure Threshold	X^N $1,000,000/ $600,000	X $714,000
CE for Bed Capacity Increases and Decreases/ Expenditure Threshold		X*
CE for Bed Capacity Increases Only/Expenditure Threshold		
CE for Changes in Bed Category/Expenditure Threshold		
CE for Bed Relocations/ Expenditure Threshold		
CE for Additions of Health Services/Expenditure Threshold		
CE for Terminations of Health Services/ Expenditure Threshold		X
CE for Other Specified Purpose/Expenditure Threshold		
PROJECT COVERAGE		
Bed Capacity Increases and Decreases		
Bed Capacity Increases Only	X^N	
Bed Category Changes		
Bed Relocations		
Additions of New Health Services/Annual Operating Costs Threshold	X^N	X $150,000
Terminations of a Service		
Acquisitions of Major Medical Equipment/ Equipment Expenditure Threshold	X^N $1,000,000/ $600,000	X^N $400,000/ $150,000
Construction, Development or Other Establishment of New Health Care Facilities		X
Acquisitions of Existing Facilities	X^N	
Other Specified Projects	X^N	X^N