Governors State University
College of Health Professions
Health Administration Program

Certificate of Need Programs: A Comparative Assessment

June 30, 2004

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Prepared for the
Illinois Health Facilities Planning Board

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EXECUTIVE SUMMARY

BACKGROUND

In August 2003, Illinois Governor Blagojevich appointed a new board and executive secretary for the State Facility Planning Board, as required by the 2003 amendment to the Health Facilities Planning Board Act. The new board leadership contracted with researchers from Governors State University to identify states that have implemented or have been implementing Certificate of Need (CON) reforms and to conduct a comparative assessment.

SCOPE OF WORK

This report contains a summary of findings regarding CON programs for the selected five states including Illinois. It also carries detailed information mostly in table format. Our sources of information are primarily from CON statutes, and rules/regulations obtained from state websites or from the CON personnel. Therefore, our findings of processes do not necessarily portray the "real", but rather the "expected". For example, the average time to process an application in 2003 may be contingent upon an actual analysis of the CON database. Although some states provide the average review time at the aggregated level, there are many factors that make reasonable comparisons difficult. Therefore, a comparison of states solely based on statutes/rules/regulations should be made cautiously.

FINDINGS

We summarize our findings in five sections with the focus on differences rather than similarities:

A. Identifying states to compare with Illinois:

- The law of each state offers different exceptions, thresholds and review processes, making comparisons difficult.
- Despite the difficulty in comparison, we opted to give in-depth reviews of four states—New York, Michigan, New Jersey and Florida with the following rationale:
  - They have the size of supply and demand for health care similar to Illinois.
  - New York is often considered as a benchmark state not only for CON services but also CON-related methodology for need determination.
  - Michigan is one of the forefront runners in revamping CON standards and criteria, a major source of criticism for CON.
  - New York and Michigan currently have the same level of CON scope that Illinois had prior to the 2003 Amendment Act.
  - Illinois appears to follow the same path that Florida and New Jersey have been taking.

B. Findings related to features that Illinois currently does NOT offer:

- Letter of intent (LOI). Unlike Illinois, Michigan uses the LOI as a tool to provide project-specific feedback to CON applicants. Based on the LOI information, the Michigan Department sends relevant forms to the applicant. An application cannot be submitted until the applicant receives a confirmation letter from the agency.
- An effective call structure to enable comparative review with the potential to minimize inconsistent decision making. Three states—New Jersey, Florida and Michigan—conduct comparative review where similar types of applications (in terms of the planning area, project type, or need methodology) can be batched.

C. Findings related to current issues in selected states:

- Politics that favor local providers by granting exemptions (Michigan/Florida)
  Michigan and Florida have recently or currently been engaged in lawsuits because lawmakers pushed through exemptions for hospitals in their districts. Nebraska (that has phased out CON except for long term care) and Texas (that abandoned its CON program in 1985) had a similar history of favoritism and ineffectiveness that are thought to have mainly undermined the CON function.
- Politics that attempt to force a revision of CON criteria and standards (Michigan)
- Pressure to cut back or deregulate CON further (Florida)
- Emphasis on enforcing post-CON standards (Florida)

D. Compared to selected four states, Illinois:

- Uniquely gives the authority to the State Board for both the duties: 1) approving standards/criteria and 2) making final decisions on applications.
  - The three states—Michigan, New Jersey and Florida—have Health Department directors make final decisions on applications and have independent councils enhance and approve standards/criteria.
  - New York has the Health Department director make final decisions on projects except for full review establishment projects on which the Public Health Council make final decisions.
- Does not have an efficient review structure to facilitate a staff reviewer consistently applying criteria and standards. Michigan ensures each project type (all together 13 types) has its own staff reviewer who is responsible for compiling a report on each application.
- Does not have particularly out-dated standards and criteria.
- Does not have a more expensive CON process at least in terms of application fees.
- Has a limited number of project types that are subject to expedited review.
- Does not have a particularly lengthy application and review process.
- Uniquely has both: 1) removed CON from most of medical equipment; 2) at the same time regulates freestanding physician-sponsored ambulatory surgery and diagnostic centers.
- Has imposed specific deadlines for the review process.

E. The Illinois CON application data shows that:

- The Board approved approximately 88% of all applications received over the last five years, or 427 projects.
- Over the last five years, the average review period, defined as the period from the date the application is deemed complete to the date the *permit* was issued, was short rather than lengthy--68 business days, about 14 weeks, or three and a half months. Because the CON law requests at least four CON board meetings in a year with an approximately three-month interval, this average duration appears to be a reasonable response time.
- Two factors – whether an applicant received an intent-to-deny notice or not and whether an applicant received an initial denial – had the greatest impact on the review period, adding 96 and 62 business days before a permit respectively. However, surprisingly enough, whether an application was classified as substantive (or full) review or non-substantive (or expedited) review had little impact on the review period. Similarly, whether an application involved cost or had a no cost factor had little impact. This may indicate that there may have been inappropriate

arrangements of resources targeting applications assigned to full review or involving a cost factor.

- Although the Illinois CON law requires submission of annual progress reports after one year of permit date, 37% of projects completed and 49% of projects not yet completed as of March 31, 2004 failed to do so. There seems to not be effective enforcement of compliance of CON law after a permit is issued.
- There were few denials compared to approvals as also shown by other three states—New Jersey, Michigan and New York. By contrast, Florida reports a significantly higher number of denials compared to the number of approvals.

CONCLUDING THOUGHTS

To minimize the failure of agency reviewers consistently applying standards/criteria, we recommend considering comparative review where staff reviewers can evaluate the same services in the same area at the same time.

Illinois recently removed CON permit requirements from most medical equipment, and sharply increased the capital threshold to mainly address the issue of leveling the playing field that hospitals have raised against physician groups offering the same service, such as cardiac catheterization. This action seems to us to indicate that Illinois may follow the same path New Jersey and Florida have taken, that is, toward phased-in deregulation and then possibly phasing out CON. We recommend considering the following factors before the State takes further decisive actions:

- The market competitiveness brought by managed care in late 1980s and early 1990s has been a major basis for CON abolitionists. However, there is mounting evidence that managed care is slipping away.
- Demographic changes in the foreseeable future will surely increase the demand for inpatient beds and costly tertiary care. Health care providers will respond by increasing the supply, creating a need for health facility planning.
- A careful evaluation of reforms that other states have started will ensure that their experience can serve as a model for Illinois.
- Particularly, we recommend examining

    - Phased-in implementation of deregulation as begun in Florida and New Jersey.
    - Batch processing as used by Michigan, Florida and New Jersey, and
    - Michigan's efforts to update and enforce review criteria and standards
    - Possible factors that may explain a significantly higher number of denials compared to the number of approvals shown in Florida

Our concluding thought in this report is that the two recent Illinois CON Reform Acts inserted provisions that primarily address concerns raised by stakeholders, mainly the Illinois Hospital Association. The future direction for CON reform efforts should be toward evaluating other states' experiences and alternative healthcare delivery systems before making informed decisions on the future of Illinois CON.

I. INTRODUCTION

BACKGROUND

In August 2003, following the enactment of the 2003 amendment to the Health Facilities Planning Act that abolished the term of office of each member of the Health Facilities Planning Board (hereafter, State Board), the Governor appointed new board members and a new executive secretary as required by the Act. The newly revamped Board, along with the new executive secretary, needed to increase the basis of knowledge for preparing themselves to meet changes imposed by the new Act. On behalf of the Board, Governors State University was contracted to conduct a comparative assessment of Certificate of Need (CON) programs.

CON reform waves started in 1999 when the Illinois Health Association (hereafter IHA) panel called for CON reforms with several recommendations. IHA efforts led to the 2000 Amendatory Act (Public Act 91-0782) with the most notable provision to sunset the Planning Act on July 1, 2003. The following year, an audit of the State Board mandated by the Act found several deficiencies in the Board's functioning, including inconsistent criteria for project approval, rules that unnecessarily lengthen the approval process, and failure to follow the administrative rules on deferring projects. In the same year, IHA convened another panel whose recommendations, along with the Audit's findings, led to the 2003 Amendatory Act that made significant changes in Illinois' CON.

By including a five-year sunset provision, July 1, 2008, the lawmakers decided to continue to examine the new Board's role and performance. The first task for the new Board is to implement the changes required by the Act as summarized, but not limited to the following (For detailed information refer to Appendix A):

- Make rules for decisions on which projects are eligible for an exemption, rather than a permit.
- Shorten the length of the review and the time in which the Board's final determinations must be made.
- Streamline data collection from health care facilities by the Department of Public Health.
- Make changes concerning the way in which rules, standards, criteria, and state norms are reviewed, revised, promulgated, and posted.

SCOPE OF WORK

The following work is intended to help the Board meet the identified above tasks:

1. Overview of states with CON programs and identify four states that meet the following four criteria:
   1) States that have a health care systems similar to Illinois
   2) States that have a level of CON regulation similar to Illinois
   3) States that represent different directions for the future of CON
   4) States that have CON features of special interest

2. Conduct comparative analyses of the selected states' CON programs and reform processes.

a. The recent Act addressed many of the concerns the IHA and other stakeholders had raised. Our comparative analysis will help evaluate the position of Illinois' CON relative to other states with similar health care systems in terms of the following:
    1. Compared to other states, does Illinois have an expensive application and review process?
    2. Compared to other states, does Illinois have a lengthy application and review process?
    3. Compared to other states, do most CON applications in Illinois end up being approved?
    4. Compared to other states, does Illinois regulate by facility?
    5. Compared to other states, does Illinois emphasize review criteria and standards?
    6. Compared to other states, does Illinois have rules that unnecessarily lengthen the approval process?
    7. Compared to other states, what administrative rules does Illinois have regarding deferring projects?
b. We focused on differences rather than similarities among selected states.

OUTLINE OF THE FINAL REPORT

This report is organized in five major sections. Following the Introduction, Chapter II presents an overview of the CON programs across states that currently regulate and do planning on health care facilities. Chapter III discusses briefly a history of CON programs and current issues associated with selected states. Chapter IV compares the CON statutes, rules and regulations governing the type of projects reviewed, review process, procedures, standards and criteria that are used for decision of several other states. Chapter V reports findings from analysis of Illinois CON application-level data. Chapter VI summarizes general findings from comparison of approvals and denials among the five selected states. Chapter VII concludes the report with a summary of findings and concluding thoughts.

II. OVERVIEW OF CERTIFICATE OF NEED

OVERVIEW

We reviewed 36 states and Washington D.C. that have current certificate of need/regulation legislation to select four states for an in-depth review of their CON programs in comparison with Illinois'. The analysis conducted is based on the aforementioned criteria. Based on this review, we identified four states that meet our criteria. They include state programs for New York, Florida, Michigan, and New Jersey.

STATES THAT HAVE HEALTH CARE SYSTEMS SIMILAR TO ILLINOIS

We reviewed the size of health care systems in terms of the demand and supply of health care. The demand for health care, especially costly inpatient care, is driven by the size of the elderly population (ages 65 and over), which is closely related to hospitalization admission rates and thus the demand for inpatient care services. Currently, seniors nationwide account for almost 40 percent of inpatient admissions and 49 percent of beds. As the baby boomer generations get older, demand for acute care beds and hospital specialty services is projected to sharply increase over the next twenty-five years.

Size of Health Care System

From the demand side for health care, Illinois is chronologically among the top three states by the size of population 65 and over, ranking 3rd after Florida and New York **(Table 2.1)**. Ohio, Michigan and New Jersey follow. From the supply side point of view, Illinois is also among the top five states in the total number of beds in health facilities, ranking 4th after New York, Florida, and Ohio in terms of hospital beds. Illinois ranks 1st in terms of nursing home beds; however, the state belongs to the bottom tier in terms of residential facility beds. Illinois is among the top three states in terms of psychiatric beds.

The size of health care systems appears to be moderately related to the number of applications, staff size and budget for CON programs, according to the survey conducted by the American Health Planning Association (AHPA) in 2003 (**Appendix B**). The five states that ranked among the top five states in terms of the size of health care systems were also among the top five states in terms of budget (Budget was not reported for New York, but we safely assume that its budget is higher than any other states). However, there seem to be weak, if any, relationships among the number of applications, staff size and budget. Illinois' lack of staff is obvious with respect to the number of applications. Illinois has only 5 employed staff compared to 46 staff in New York, 19 in New Jersey, 12 in Florida and 10 in Michigan, even though Illinois ranked 1st in terms of CON budget (among states excluding New York).

STATES THAT HAVE A LEVEL OF CON REGULATION SIMILAR TO ILLINOIS

Scope of CON

There are huge variations in the type of health care providers and services subject to CON review across states. While some states—Maine, Connecticut, and West Virginia—still retain broad regulation, some other states—Ohio and Wisconsin—have phased out virtually all of the state's CON laws, except for long-term care. They have left the process in place for long-term care, largely as a way of controlling Medicaid costs.

There are also variations in the threshold for review of a proposed capital expenditure and for major medical equipment. In Florida and New Jersey, no project is reviewable based solely on the amount of capital expenditure proposed, and in Florida no medical equipment is subject to CON review. Illinois has the highest threshold for medical equipment.

Table 2.1 The Size of the Elderly and the Number of Beds in Medical Facilities

		Number of beds in health facilities			
States	*Elderly*	*Hospital*	*Nursing Home*	*Resid Care Fac*	*Psych*
Florida	2,963,204	56,286	80,448	76,828	n/a
New York	2,423,797	63,924	122,310	40,833	6099
Illinois	1,500,025	47,204	125,037	8650	4310
Ohio	1,494,482	47,347	94,925	35,551	404
Michigan	1,219,018	27,707	50,021	n/a	2445
New Jersey	1,113,136	27,317	52,544	6869	2557
North Carolina	1,011,370	20,723	43,512	40,685	4212
Massachusetts	860,162	13,458	51,625	4353	3225
Virginia	792,353	18,791	29,425	27,217	1640
Missouri	792,119	23,990	58,277	21,927	4035
Georgia	785,275	23,604	39,322	15,338	4246
Tennessee	703,311	23,633	38,202	13,894	1724
Wisconsin	697,310	n/a	43,274	n/a	n/a
Washington	679,588	14,065	23,367	24,575	313
Maryland	600,000	10,066	30,301	14,849	1640
Alabama	599,477	20,219	27,680	9865	n/a
Louisiana	516,929	n/a	40,017	6777	1747
Kentucky	500,501	14,398	26,435	8196	4974
South Carolina	492,970	12,038	18,968	16,690	1976
Connecticut	470,183	9054	30,551	2874	407
Oregon	440,038	8217	12,875	8,615	1164
Iowa	436,312	13,982	32,147	4974	n/a
Oklahoma	427,226	n/a	33,968	3,390	n/a
Arkansas	374,019	n/a	25,614	4730	399
Mississippi	343,523	11,618	18,263	353	726
West Virginia	276,677	8820	9818	1666	555
Nevada	249,047	n/a	n/a	n/a	n/a
Nebraska	228,829	4949	17,172	9020	642
Maine	173,798	3985	9033	6170	494
Hawaii	160,601	2631	4,311	n/a	307
Rhode Island	150,547	2828	9,823	3,679	793
New Hampshire	147,796	3333	8,165	3569	111
Montana	124,550	2539	7,827	3700	178
Delaware	102,086	2332	4,771	n/a	126
Vermont	75,255	1487	3,555	2550	202
D.C.	69,898	4992	3,096	n/a	459
Alaska	38,603	1532	733	1538	185

Source: 2004 American Health Planning Association's National Directory

A majority of states have been moving toward deregulation, including Illinois. Some revisions made in recent statutory changes in Illinois are summarized:

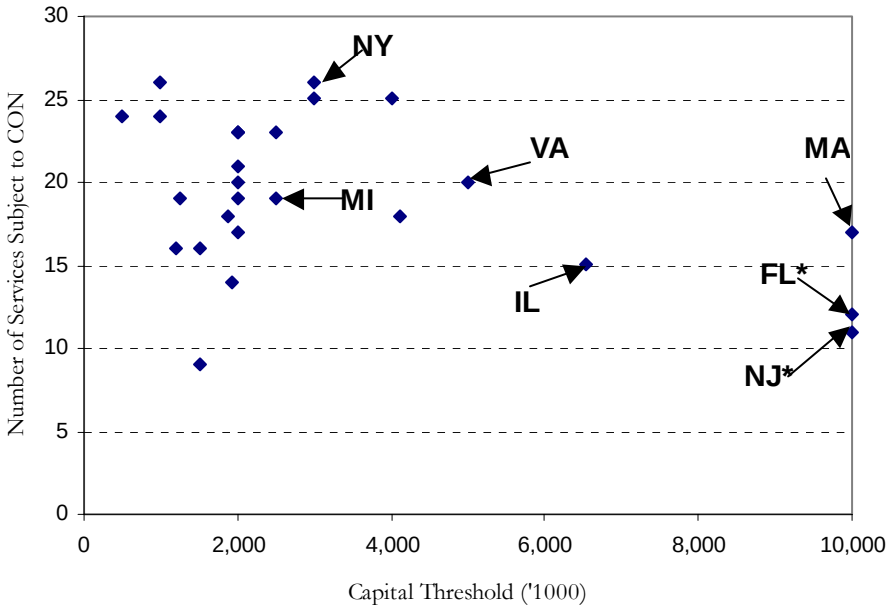
- Increasing the capital minimum expenditure for CON capital projects (from 2 million to 6 million dollars) and major medical equipment (from 1 million to 6 million dollars) in 2000.

- Excluding non-clinical areas from the calculation of capital minimum expenditure
- Repealing four review categories in 2003 including three equipment categories.

Figure 2.1 shows Illinois' relative position with other states that currently regulate open heart surgeries (Refer to Appendix C for detailed information). Ten states do not currently regulate cardiac services including open heart surgeries as their main regulatory efforts are being directed to long-term care.

In terms of the number of review categories, Illinois falls in the lower tier. Similarly, among states with specified capital projects' thresholds, Illinois is the 2nd least stringent state to Massachusetts. However, Figure 2.1 includes Florida and New Jersey as if they had the same amount of threshold for capital projects as Massachusetts, in that they do not require CON review solely on the amount of capital expenditure unless the projects involves services specified in their CON statutes. Thus, if Florida and New Jersey are counted, Illinois is the 4th least stringent state. Overall, New York is more stringent than Illinois in both measures. New Jersey and Florida are less stringent in both measures. Michigan and Massachusetts are similar to Illinois although Michigan is slightly more stringent in both measures.

Figure 2.1
Stringency of CON Regulation



* FL and NY do not require a review solely based on capital cost

The two measures of stringency are not sufficient to determine which states are relatively more stringent than others. One source of variation in stringency involves different types of review processes. Agencies are authorized to add certain types of projects to various types of review processes that require different levels of intensity of analysis. For example, although New York appears to be the most stringent of the states selected for in-depth review, the state has four types of review processes, two of which considerably reduce the burden for both the applicants and CON agency associated with the full review process.

In addition, exemptions for review are granted, with variations in requirements for deciding on exemptions across states. Another variation yet includes the provision that the CON agency can grant waivers for certain types of projects.

STATES THAT REPRESENT DIFFERENT DIRECTIONS FOR THE FUTURE OF CON

We reviewed current legislation activities in the states that retain CON for acute care beds (27 states and D.C.) or for most major medical equipment (Massachusetts and Montana). Thus, the review excluded those states that phased out virtually all of the state's CON laws, except for long-term care (Louisiana, Nebraska, Ohio, Oregon, Wisconsin) and some minor services (Oklahoma, Montana and Arkansas). Arkansas, Oklahoma and Wisconsin were among 7 states that dropped CON for acute care beds immediately after federal support ended, but prior to 1990; Nebraska and Ohio were among 4 states that dropped CON for acute care beds in 1995 or later.

A review of current legislation activities reveals three broad clusters of states (Appendix D). One cluster consists of states that go toward the direction of CON deregulation by continuing to cut back CON. Particularly, two states—New Jersey and Florida—have removed facilities and services from CON regulation to licensure requirements. They have used phased-in implementation—adding services subject to full review to expedited review and later completely removing them from CON regulation, although the services still would be subject to licensure. While these states are at the same time streamlining their CON processes, they are tilted toward deregulation. The second cluster consists of states that focus on improving/streamlining their CON process without an explicit consideration of CON repeal. New York is one of those states. The third cluster consists of states that apparently need to decide on the future direction, either toward deregulation or toward improving CON processes. Categorically, Illinois and Michigan fit best in this cluster.

STATES THAT HAVE CON FEATURES OF SPECIAL INTEREST

In this section, we attempted to identify states that have characteristics or features that Illinois does not. Furthermore, we attempted to identify states that have implemented changes similar to those required by Illinois' 2003 Amendment Act.

CON Structure

Illinois once considered restructuring the CON program so that decisions were made by the Department of Public Health, not by the State Board with the rationale that placing responsibility upon the executive agencies would assure adequate resources (analytical, legal, and political) available and establish clear accountability lines for making the tough decisions (Audit 2001). It is also suggested that an agency, as a final decision maker, avoid being influenced by money and politics. A review of the CON governing body revealed mainly two types of final decision makers: 1) executive agency; and 2) a board with members appointed by the Governor (**Table 2.2**). A majority of the states (21) have a director of an executive agency or head of CON division/program who makes final decisions. Illinois is one of the ten states where a board makes final decisions, and in the remaining three states—New York, Georgia and Washington—either the agency or the board makes decisions depending on the type of project. In Kentucky, a hearing officer (State Attorney) makes the final decisions.

Emphasis on Criteria/Standards

With no exception, all the CON study workgroups' reports across states called for the need to update and enforce criteria and standards. Michigan is a particularly exemplary state.

Michigan's history of CON reform started in 1988 consequent to concerns regarding a lack of clarity regarding both process and standards in CON, which resulted in the overturning of too many CON decisions by the courts. Subsequently, Michigan substantially revised its program. As recently as 2004, Michigan has begun implementing well-defined standards for each service type regulated. Its website posts a list of staff, telephone numbers and email along with the staff members' designated service criteria. Like Michigan, updating and enforcing standards can mark the future direction for Illinois and other CON programs to allow for appropriate responses to the criticism of and justify the well-known, high application approval rates found consistently across states with CON.

We have recently seen a surge in interest for updating and improving methodology for projecting unmet need for cardiac services. Several states have completed or are developing new standards/criteria. This surge was, in the first place, prompted by the litigation that occurred in Maryland in 1997. While states including Illinois have begun to insert a new provision, as ruled by the Maryland court in 1998, (that the projected need for open-heart surgery services remains in effect until superseded by published updated projections), the litigation alerted states to take action, particularly those that have not often updated their need determinations.

Table 2.2 Summary of Decision Making for CON Applications

States	Final Decision Maker	
Alaska	Agency	Commissioner of Health & Social Services
Arkansas	Agency	Health Services Permit Agency (can be appealed to 9 person Commission appointed by Governor)
Connecticut	Agency	Head of Office of Health Care Access
Delaware	Board	Delaware Health Resources Board
D.C.	Agency	Director
Florida	Agency	Agency for Health Care Administration
Georgia	Both	Agency, or Review Board
Hawaii	Agency	Administrator
Illinois	Board	Illinois Health Facilities Planning Board
Iowa	Board	State Health Facilities Council (Five members, appointed by the Governor)
Kentucky	Attorney	Hearing Officers (State Attorneys)
Maine	Agency	Commissioner, Department of Human Services
Maryland	Board	Maryland Health Care Commission (13 member)
Massachusetts	Board	Public Health Council
Michigan	Agency	Director, Michigan Department of Community Health
Mississippi	Agency	State Health Officer
Missouri	Board	Missouri Health Facilities Review Committee (9 members)
Montana	Agency	Directors, Department of Public Health and Human Services
Nebraska	Agency	Nebraska Health and Human Services Regulation and Licensure
Nevada	Agency	Director, Department of Human Resources
New Hampshire	Board	Health Services Planning & Review Board
New Jersey	Agency	Commissioner of Health and Senior Services
New York	Both	Commissioner of Health (services for existing providers), NYS Public Health Council (establishment projects)
North Carolina	Agency	Chief, Certificate of Need Section
Ohio	Agency	Director of Health
Oklahoma	Agency	Commissioner of Health
Oregon	Agency	Public Health Officer
Rhode Island	Agency	Director of Health
South Carolina	Board	Board of Health & Environmental Control
Tennessee	Board	Health Services & Development Agency (9-member board)
Vermont	Agency	Commissioner, Department of Banking, Insurance, Securities, and Health Care Administration
Virginia	Agency	Commissioner of Health
Washington	Two ways	Office Chief makes initial decision; Secretary of DoH makes final decision on appeals
West Virginia	Board	Health Care Cost Review Board (3 members)
Wisconsin	Agency	Secretary, Department of Health and Social Services

Batching

According to the 2001 survey by AHPA, 27 of 37 programs use some type of batching. Illinois and New York are among them, but it is not clear that it is put into use, because no such schedule is in place today. By contrast, New Jersey, Florida and Michigan, those similar to Illinois, use highly structured batch processing. Florida's batching cycle starts with the publication of Summary Need Projections and calls for "a request for proposals" for competitive review. Michigan has improved standards/criteria that intend to facilitate the formal consideration of the relative merits of similar applications in determining the best to meet the projected needs.

New Jersey has improved its structured call by setting up a periodic calling schedule, in response to the criticism that the system of sporadic calls restricted access to the marketplace and that it makes it difficult for hospitals to plan strategically because they had no idea of when they might be allowed to add a new service. New Jersey cycles 15 distinct items or categories. Thus, the New Jersey batching schedule cannot allow for annual reviews for all project types. For instance, some projects are reviewed once every two years, some every three years and others every five years. This can be an obstacle for applicants with incomplete applications or those recommended for withdrawal, given that they will be subjected to a longer waiting period to submit a new CON application for approval.

By contrast, Florida batches for two broad categories: (1) hospital beds and facilities and (2) other beds and programs. Thus the state offers two batch cycles biannually per category. Michigan conducts a comparative review only for selected services for which it has established a need methodology or standard with which it is comfortable and when there is an indication of a need for new facilities and expanded clinical service capacity. Because Illinois is more similar to Michigan than New Jersey and Florida in the number/type/threshold subject to CON review, some process similar to Michigan's type may be a choice for Illinois.

III. CON HISTORY AND CURRENT ISSUES IN SELECTED STATES

OVERVIEW

Since the implementation of the CON program and the creation of the Board by the Planning Act in 1974, the Illinois CON program had remained essentially unchanged for 26 years until the 2000 amendment Act. Illinois CON survived the repeal pressure consequent to the Cost Containment Commission's call for the CON repeal in 1987, when the federal government and nine states repealed their laws. By contrast, Michigan and Florida had their major CON reform around 1986-87. Florida has had a faster paced history of CON deregulation than Michigan. Currently, Michigan focuses on improving standards/criteria, while Florida's current movement focuses on monitoring CON compliance.

New Jersey and Florida show a history of CON deregulation. Florida started its CON reform as early as 1987. By that time, Florida CON had reached a level of stringency similar to the current level of Illinois. Florida resumed its reform efforts in 1997 and New Jersey started its CON reform one year later, in 1998. Tracking Florida and New Jersey's history of deregulation reveals a pattern of review category change – moving projects subject to full review to expedited review then to exemption and finally to removal. Illinois can examine their experiences if it decides to deregulate CON.

These two states had previously considered the end of CON explicitly. Similarly, Illinois, as the only state that has a sunset provision in its CON statute, is currently contemplating phasing out CON. On the other hand, New York, with the oldest and largest CON program processing about 19 percent of US total CON applications, has focused on streamlining CON review and decision making processes.

HISTORY OF CON PROGRAMS IN FIVE STATES

Illinois

1974: *Illinois CON Statute (20 ILCS 3960).* The Health Facilities Planning Act created the Health Facilities Planning Board.

1986: *Illinois Health Care Cost Containment Council.* The Council recommended the CON repeal in 1986 and, in the following year, contracted with Lewin and Associates to conduct a study titled "Certificate of Need and the Changing Market".

1999: *IHA First Report on CON.* Illinois Hospital Association produced its Blue Ribbon Panel Report on CON with 10 recommendations.

2000: *Public Act 91-0782.* The Act included a clause to repeal the CON on July 1, 2003 and increased the capital threshold (to $6 million) and removed non-clinical areas from CON review.

2001: *Auditor General Performance Audit.* The Audit of the CON program was conducted per requirements of the ACT of 2000.

2001: *IHA Second Report on CON.* 9 Recommendations.

2003: *Public Act (93-0041).* Extended the sunset date to July 1, 2008. Board reduced from 15 to 9 consumer members appointed by the Governor.

New York

1964: *NY CON.* created the first CON law, nearly a decade before the federal government mandated similar regulations.

1996: *Health Care Reform Act of 1996*. Although this Act did not directly target the CON, it set the stage for a series of program changes mainly toward less regulation and a more market-oriented health care system.

1998: *CON Report.* The Public Health Council adopted the Report and Recommendations of their *ad hoc* Workgroup on Character and Competence. The recommendations led to major changes such as 1) raising construction project thresholds for a full review from $3 million to $10 million; and 2) substitution of notice or prior limited review for cumbersome administrative review.

2002: *AHPA Report.* Assessed selected aspects of CON review in New York with more than 10 recommendations.

Michigan

1972: *Michigan CON Statute (Public Act 256).* Michigan enacted its first CON Statute in 1972; prior to that time, hospital investment had been informally regulated by Blue Cross of Michigan, with facilities requiring Blue Cross approval to qualify for reimbursement.

1974: *National Health Planning and Resources Development Act* (PL 93-641).

1978: *Revised Michigan CON Statute (Public Act 368).* This Act continues to be Michigan CON Statute.

1986: *Repeal of National Health Planning and Resources Development Act.*

1988: *Michigan CON Reform Act of 1988*. Due to concerns about a lack of clarity regarding both process and standards in CON, resulting in the overturning of too many CON decisions by the courts, Michigan substantially revised its program. This statute, effective October 1, 1988, established a specific process for developing and approving standards used in making CON decisions. It further created a 5-member bipartisan CON Commission within the Department of Public Health. The Commission's members are appointed by the Governor and is responsible for approving review standards.

2002: *Auditor General Performance Audit.* As required by statute, the Office of the Auditor General completed an audit in April 2002 with 5 findings and 7 recommendations.

2003: *CON Evaluation Study.* The Center at the Duke University conducted a study of evaluating the impact of CON for acute care on cost, quality and access.

2003: *CON Reform bill (PA 619)*. became effective March 31, 2003 and exempts certain hospital bed relocation projects from CON review.

New Jersey

1996: *CON Reform Act (*5 HLR 103*).* Created an expedited review process for 14 services that accounted for the bulk of certificate of need applications. The Health Facilities Planning Act created the Health Facilities Planning Board.

1998: *CON Reform Act (S. 1181).* Exempted 16 services including the 14 services above from CON requirements beginning Aug. 14, 1998, although the services still would be subject to licensure by the Health Department. Deregulated services included acute renal dialysis, magnetic resonance imaging, hospital-based medical detoxification for drugs and alcohol, ambulatory care facilities, and inpatient operating rooms. Under the second phase of deregulation, which occurred during the next 20 months, seven other services became exempt which included residential drug and alcohol services, positron emission tomography, and basic obstetric and pediatric services and birth centers. It called for the creation of a Commission to study the likely impact of deregulation on the third phase of the reform process which would deal with health care services and facilities that are statewide or regional in nature or that may have a large impact on the state budget, such as

nursing homes, assisted living residences, home health agencies, burn centers, trauma centers, organ banks, cardiac surgery, and cardiac catheterization.

2000: CON Study *Commission Report*. The Commission recommended retaining CON for certain services. Called for changes in the need methodology and a better "call" schedule allowing institutions to apply for new services. Urged a strengthening of licensing requirements, including a hard look at volume, performance and outcome standards.

Florida

1973: *FL CON*. Started CON program.

1987: *CON Reform Act of 1987*. The following statutory changes occurred: 1) Increased capital expenditure threshold from $600,000 to $1 million; capital expenditure only for inpatient services, excluding outpatient services; 2) Equipment threshold was set at $1 million; specified hospital specialty services subject to review in CON statute.

1997: *Amendment Act of 1997 to CON statute*. Started the second wave of deregulation by removing CON review from acquisition of medical equipment, regardless of cost.

2000: *Amendment Act of 2000 to CON statute*. Redefined eligibility for comparative or expedited reviews, substituting expedited review for comparative review. There is no CON review of cost overruns, and no exemption is required.

2001: *Amendment Act of 2001 to CON statute*. Continue to deregulate by exempting projects that were reviewed as expedited.

CURRENT ISSUES IN CON

Florida

- Florida Governor has proposed another major CON reform bill in January 2004. With the new proposal, hospitals would simply have to receive a license from the state to start a specialty service (e.g., cardiac service/open-heart surgery), but the success of that program would be monitored on a regular basis. If a program was deemed deficient, the hospital would have a chance to improve the program or lose its license.

- Under the proposed bill, "boutique" hospitals would be prohibited in the state. The proposal would allow existing hospitals to add beds without going through the certificate of need process. But the process would still be in place for new hospitals, nursing homes and hospice facilities.

- This statewide reform was triggered by recent failure of local efforts: it was common for the Florida Legislature to ignore the regulatory process and approve new programs on its own. Last year, a Florida court struck down the CON exemption bill (S.B. 460) that took effect upon the July 2003 Governor's signature. If the legislation had not been overturned, hospitals in five counties would have been exempt from CON review for adult open heart surgery services if they meet certain criteria (e.g., at least 5 percent of surgeries to underserved patients).

Michigan: Public Act 619 Lawsuit

- In September 2002, a few hospitals in the Detroit area facing a financial crisis due to high levels of uncompensated care and inadequate reimbursement under the Medicaid program attempted to push CON reform measures through the Michigan legislature to permit hospitals within urban areas to move existing hospital beds beyond the 2-mile relocation zone permitted under CON Commission standards. The legislation was

intended to overrule the CON Commission standards and serve as an "end around" to the current restrictions in the standards for relocation of hospital beds except on a very limited basis.

- The legislative efforts (House Bill 6281) were successful and limited amendments to permit certain bed relocations were added to the current CON statute. However, in June 2003 opponents of the legislation sued the Michigan Department of Community Health and the hospitals that backed the legislation. The opponents alleged that the statutory changes were unconstitutional and/or "special/local act" legislation that required more than just a majority vote of the Michigan House and Senate. Because of the lawsuit, those hospitals seeking to benefit from the statutory changes have been unable to move forward with their proposed bed relocations.

- After the lawsuit was filed, the hospitals seeking more expansive bed relocations realized that the court might not uphold revisions to the CON statute permitting bed relocations. Thus, they turned their attention back to the CON Commission and administrative arena. They then attempted to obtain language in the CON standards that would permit broader relocation of hospital beds under certain circumstances even though a CON application would still need to be filed and CON approval obtained. The purpose of the proposed changes to the CON standards was to implement the same provisions that had been approved in the statute, but which are held up by the lawsuit. The hospitals seeking to relocate beds reasoned that it would be a good idea to have CON standards to address certain bed relocation projects just in case the statute was ultimately declared unconstitutional.

- However, the hospitals seeking the revised CON standards were not successful. In October 2003, the CON Commission voted down the proposed modifications to the CON Standards. Thus, currently, those hospitals seeking broader authority to relocate hospital beds will need to win the pending lawsuit and have the court uphold the changes to the statute that exempt certain kinds of bed relocation projects from having to obtain a CON. If they are not successful in the lawsuit, these hospitals will continue to have to seek CON approval for such projects and under the current CON standards, such projects would not be approvable.

- Officials within Department of Community Health have expressed an interest in convening experts from across the hospital industry and from public health institutions to address the complex issues related to hospital bed need in Michigan, health facility viability, and the appropriate relocation of hospital beds within certain regions of the State.

IV. CON PROCESS

OVERVIEW

This Chapter compiles detailed data and information from specific CON provisions and sections governing two core aspects of CON: application-review and decision-making. We have opted to take this approach to obtain more accurate information than what we would otherwise obtain, for example, by conducting a survey of CON programs. The information tabulated in this Chapter can be used to help the State Board determine areas that may need further changes with respect to the Illinois CON regulation. We compared the following areas:

- CON reviewing and approving body
- Number of covered facilities by type
- Specific services covered
- Thresholds, both overall or distinct, by facility structure/type
- Types of review processes
- Call Structure
- CON fee structure
- Post-CON monitoring procedures
- Review standards/criteria

REVIEW CATEGORY

Table 4.1 summarizes the variations in CON coverage: 1) the number and type of facility; 2) expenditure thresholds; and 3) the number and types of service. While Figure 2.1 showed a similar level of stringency of CON regulations among the selected states, Table 4.1 indicates a broad range of CON specifics on the types reviewed as of March 2004. To facilitate a comparison, review categories are divided into two groups: those regulated versus not regulated in Illinois. Some differences are noteworthy:

- Treatment/surgical centers including dialysis centers are not regulated by New Jersey and Florida. Instead they repealed CON review of major medical equipment, a major source of complaints hospitals have made against freestanding ambulatory surgical centers regarding a level playing field. Illinois also recently repealed CON laws for most major medical equipment, whereas Michigan and New York retain them.
- With regard to long-term care, Illinois alone does not regulate long-term care services/facilities except for nursing homes.
- Florida and New Jersey do not regulate projects solely based on project cost itself, whereas the remaining three states regulate projects with the cost in excess of a given threshold. Illinois has the highest threshold of the three states.
- In Illinois, almost all projects proposing an increase in the number of hospital or nursing home licensed beds are subject to CON review. Similarly, all other states regulate medical/surgical beds and intensive care units with the exception of New Jersey. New Jersey regulates pediatric beds only.
- Illinois and Michigan do not regulate long-term care facilities other than skilled/intermediate nursing homes and specialized nursing homes, whereas New York regulates all types of long-term care facilities. New Jersey removed CON requirements from most long-term care facilities except for residential care facilities. Florida regulates hospice programs and hospice inpatient facilities.

Table 4.1 Relative Scope CON Regulated Services in Comparison to the State of Illinois

Review Categories Regulated by Illinois					
Categories	**Illinois**	**New York**	**Michigan**	**New Jersey**	**Florida**
Facilities					
Hospital	Y	Y	Y	Y	Y
Hospital-Based Ambulatory Surgical Center	Y	Y	Y	Y	**N**
Freestanding Ambulatory Treatment/Surgical Center	Y	Y	Y	2000	**N**
Dialysis Center	Y	Y	**N**	1998	**N**
Skilled/intermediate nursing care facility	Y	Y	Y	Y	Y
Specialized Nursing Facilities (ICF/MR)	Y	Y	Y	Y	Y
Demonstration Research Project*	Y	Y	Y	Y	Y
Expenditure&					
Capital expenditure (only clinical area)	$6 M	$3 M	$2.5 M	**N**	**N**
Equipment expenditure	$6 M	$3 M	any	**N**	**N**
Acute Care					
Acute Care (Medical/Surgical/Pediatric)	Y	Y	Y	1998(M/S) Pediatric only	Y
Intensive Care Unit (ICU)	Y	Y	Y	Pediatric only	Y
Neonatal Intensive Care	Y	Y	Y	Y	Y
Obstetrics Services	Y	Y	**N**	1998	1987
Psychiatric Services	Y	Y	Y	Y	Y
Inpatient Comprehensive Rehabilitation	Y	Y		Y	Y
End-Stage Renal Dialysis (hospital-based)	Y	Y	**N**	1998	**N**
Subacute	Y	Y	**N**	2000	Y
Swing Beds	Y	Y	Y	N	N
Hospital Specialty/Surgical-Related					
Cardiac Catheterization	Y	Y	Y	Y	Y%
Open Heart Surgery	Y	Y	Y	Y	Y
Organ Transplant	Y	Y	Y	Y	Y
Review Categories Not Regulated by Illinois					
Facilities	**Illinois**	**New York**	**Michigan**	**New Jersey**	**Florida**
HMO	1995	Y	Y	**N**	**N**
Hospice	Never	Y	Never	Never	Y
Home Health	Never	Y	Never	Y	Never
Residential Care Facility	Never	Y	Never	2000	Never
Adult Care Facility	Never	Y	Never	Y	Never
Acute Care					
Air Ambulance	Never	N	Y	Y	Never
Mobile HI Tech	1987	Y	Y	Y	Never
Substance Abuse	2000	Y	Never	1998	Y
Burn Care	2003	Y	Never	Y	Y
Medical Equipment					
CT Scanners	n/a	Y	Y	1998	1997
MRI Scanners	2000	Y	Y	1998	1997
PET Scanners	2003	Y	Y	1998	1997
Therapeutic Radiology	2003	Y	Y	2000	1997
Ultra Sound	n/a	Y	N	1998	1997
Gamma Knives	2003	Y	Y	1998	1997
Extracorporeal shockwave lithotripters	1999	Y	Y	1998	1997

Note. **Never** indicates the category has never been regulated in the first place. **N** indicates the category is repealed. When repeal date is available, the repeal year is indicated, instead of N.

* Illinois, under the Alternative Health Care Delivery Act, regulates four types of facilities: Subacute Care Hospital Model, Postsurgical Recovery Care Center, Children's Respite Care, and Community-Based Residential Rehabilitation Center.

& a figure specified by regulation, but adjusted annually.

% Adult diagnostic service is not CON reviewed.

TYPE OF REVIEW PROCESS

All five states have regulations rigidly governing the classification of projects with little discretion given to CON agencies in classifying applications into multiple types of review processes. **Table 4.2** classifies state variants of review processes into four types: Full, Expedited, Exempted and Emergency. Two distinctive aspects of Table 4.2 are noteworthy:

- An application in Michigan receives one of three review processes: *non-substantive*, *substantive*, or *comparative*. The distinction between substantive and comparative was made in the recent Amendatory Act. *Substantive* reviews involve projects that require a full review but on an individual basis, such as a new MRI unit. *Comparative* reviews are conducted for projects where two or more applicants are competing for a project for which the need is limited: hospital beds (including psychiatric hospital), nursing home/hospital long-term care unit beds, lithotripters, and transplantation services (excluding pancreas). In the case of a comparative review, each of the grouped applicants is awarded points varying in accord with the level of compliance of review criteria. For example, higher points are given to an applicant with a higher percentage of Medicaid patient days.
- An application in New York receives one of these processes: *full*, *administrative*, *limited* or *prior limited* review. Project expenditure is a key consideration among others in the classification: In general, applications involving more than $25 million require full review.

Table 4.2 Classification of Projects

Categories	Illinois	New York	Michigan	New Jersey	Florida
Full	Substantive	Full	Substantive/ Comparative	Full	Comparative
Expedited	NonSubstantive	Administrative	Nonsubstantive	Expedited	Expedited
Exempted	Exempted	Limited/ Prior limited	n/a	Exempted	Exempted
Emergency	Emergency	Projects not requiring CON	Emergency	n/a	n/a

Projects Subject to Full Review

Projects subject to full review go through formal CON scrutiny. Major amendments to CON laws we have observed in the selected states clearly reflect the nationwide trend toward less regulation. **Table 4.3** shows the states tend to limit CON regulation to the core set of projects that involve new or expanded clinical service capacity. Certain types of conversion and replacement projects also go through full review. For example, states fully review conversion of one type of health care facility to another and replacement of health care facilities when the project site is more than a certain distance or in another planning area. Discontinuation of an entire health care facility or category of service is fully reviewed, particularly when the facility is a hospital or the category of service is listed for review in CON laws. CON statutes or regulations contain detailed information on projects and transactions subject to full review.

- Illinois enumerates transactions or projects subject to CON, although it does not enumerate the projects subject to substantive review. Instead, it enumerates projects subject to non-substantive, exemption, or emergency reviews. That is, projects not subject to other reviews are considered as subject to substantive review.
- Change of ownership can be classified multiple ways depending on the characteristics or the type of facilities involved. All of the selected states fully review projects involving mergers and consolidations. On the other hand, the change of ownership of an existing health care facility can be exempted.
- Although the category of service or the type of facility regulated varies by state as shown in Table 4.1, major transactions—construction, conversion, change in ownership and discontinuation of an entire facility or a category of service— are subject to full review regardless of state.

- New York has dual capital expenditure thresholds, $10 million required for a full review; $3 million for an administrative review. New York's threshold is, therefore, higher than Illinois' $6 million.

Table 4.3 Projects Subject to Full Review

Projects	Illinois	New York	Michigan	New Jersey	Florida
An increase in licensed bed capacity	by more than 10 beds or 10% of a facility's total bed count, whichever is less	Y	Y	Only for beds in categories listed in Table 4.1	by more than 10 beds or 10% of a facility's total bed count, whichever is less
A change from one licensed use to a different licensed use	Unless subject to expedited or exemption	Only different level of care	Unless subject to expedited or exemption	Unless subject to expedited or exemption	Unless subject to expedited or exemption
Physical relocation of facilities/beds from a licensed site to another geographic location	by more than ten beds or more than ten percent of total bed capacity	n/a	within 2 miles or in another area	Expedited	Expedited (within 1 mile)
Initiation or expansion of services	Unless subject to expedited or exemption	Unless subject to expedited or exemption	Unless subject to expedited or exemption	Only for services listed in Table 4.1	Unless subject to expedited or exemption
Acquisition of medical equipment	Repealed	Only for cardiac catheterization and MRI	Y	repealed	repealed
Amount in excess of which a project involves total project cost	$6 M	$10 M	$2.5 M	repealed	repealed
Change of ownership	Unless subject to expedited	Unless subject to expedited	Unless subject to expedited	Unless subject to exempted	Unless subject to exempted
Discontinuation of an entire health care facility or category of service.	Y	Y	Y	For general hospital only	For general hospital only

Projects Subject to Expedited Review

By expedited review, we mean non-substantive review of Illinois and Michigan, administrative review of New York, and expedited review of New Jersey and Florida. **Table 4.4** contains only projects subject to non-substantive review in Illinois and shows how differently other states deal with them.

- Although Illinois enumerates the projects subject to non-substantive review, the number and type of projects subject to non-substantive review is very limited or specific to Illinois.
- The projects subject to expedited review in other states are well defined. Most importantly, states assign expedited review track for bed-related transactions such as conversion and relocation of beds that account for a significant volume of applications.

Projects Subject to Exemption

By exemption, we mean exempted projects of Illinois and Florida, limited/prior limited (New York) and licensure (New Jersey). Review time for the projects subject to exemption is considerably shorter. **Table 4.5** contains only projects exempted in Illinois and shows how differently other states deal with them.

- Unlike the non-substantive review category, exemption category is well defined in Illinois. Changes in procedures and requirements for application for exemption are currently being reviewed.
- The number and type of projects subject to exemption in Illinois are not as comprehensive as other states.

Table 4.4 Projects Expedited by Illinois

Categories	Illinois	New York	Michigan	New Jersey	Florida
Establishment of long-term care facilities licensed by the state agency	Y	N/A	N/A	N/A	N/A
Discontinuation of beds or service	Y	Prior Limited	N	Y	N
Changes of ownership	Unless subject to exemption	Full or expedited	Full or expedited	Full or expedited	Full or expedited
Long-term care for the Developmentally Disabled	Y	N	N	N	N
Acute Care Beds Certified for Extended Care Category of Service	Y	N	N	N	N
Projects for AIDS only	Y	Y	N	Repeal	N
Medical office buildings, fitness centers, and other non-inpatient space	Y	N	N	N	N
Community-Based Residential Rehabilitation Center	Y	N/A	N/A	N/A	N/A

Table 4.5 Projects Exempted by Illinois

Categories	Illinois	New York	Michigan	New Jersey	Florida
Medical equipment for outpatient services	Y	N/A	N/A	N/A	N/A
Change of ownership for an existing facility	Y	N/A	N/A	except in the case of a general hospital	N/A
Discontinuation of an existing facility or service that meet certain requirements	Y	N/A	N/A	N/A	N/A
Projects by state agencies	Y	N/A	N/A	N/A	N/A
Addition of dialysis stations for an existing site	Y	N/A	N/A	Y	N/A
New or expansion of neonatal beds	Y	N/A	N/A	Full review	N/A

CALL STRUCTURE

Table 4.6 compares the schedule for application filing. Illinois and New York do not have a structured call for applications. That is, applications can be filed on any workday regardless of review type. The CON board—State Board for Illinois and State Hospital Review and Planning Council (SHRPC) for New York—meets approximately every two months. SHRPC reviews them and forwards its recommendations to either the Director of Department of Health or the Public Health Council for final decisions. Unlike SHRPC, the State Board not only reviews but also makes a final decision in its meeting. Because the State Board meets approximately every two months to review and make decisions, an application should be waited for a final decision until the first meeting following completion of CON staff review/analysis. When there are deferral requests made by either the applicant or the State Board, decisions are further delayed.

Michigan conducts a comparative review only for selected services with three calls a year. Applications subject to other review processes need to be filed on the first day of each month. Similarly, applications subject to expedited review in New Jersey are filed on the first day of every month. On the other hand, applications under full review are either batched or non-batched. Batching is categorized by project type (15 types) according to various pre-determined dates. What is unique about the New Jersey batching schedule is that not all project types are reviewed annually. Some projects are reviewed once every two years, every three years or even every five years. By contrast, because Florida batches only for two broad categories, it offers two batch cycles biannually per category.

Table 4.6 Call Structure

	Illinois	New York	Michigan	New Jersey	Florida
Batching Cycles	N	N	3 cycles for comparative review 1st of Feb., June, or Oct.	12 cycles for expedited; different call schedule (ranging from every year to every five years) per category (15 categories) subject to full review	Biannually per category: (1) hospital beds and facilities (2) other beds and programs
Non-batching	Any workday	Any workday	First day of each month	First day of each month	First day of each month

AVAILABILITY OF CON INFORMATION ON THE INTERNET

As the states have electronic CON application forms available on the Internet, new demands for other useful information have been increasing. The 2003 Amendatory Act specified items to be on the Internet. **Table 4.7** compares CON-related items that are currently or required to be on the CON agency's website.

- States project "unmet" needs based on need determination methodology and publish the projected "unmet" need on a schedule specified by their CON statutes.
- Recent changes in the Illinois CON statute requires the State Board to maintain an updated inventory, among others, on the Department's web site reflecting the most recent bed and service changes and updated need determinations.
- The schedule of publishing updated need determinations varies by states.
- Illinois has not completed posting a staff report completed by the reviewer for each application documenting the analysis and findings in compliance with the statutory review criteria and standards.

Table 4.7 CON Information on CON Website

Categories	Illinois	New York	Michigan	New Jersey	Florida
Electronic Application Form	Y	Y	Y	Y	Y
CON Statute	Legislature website	Y	Y	Legislature website	Legislature website
CON regulations/rules	Y	Y	N	Only portion	N
Recent State Agency Action Reports	required	N	Y	N	Y
Need determination/Inventory	Y	N	Y	Y	Y
References used by Agency staff in determining if criteria are met	Y	N	Y	Y	N
Notice of public comments related to the application	required	N	N	N	N
Time Frames for Posting an Unmet Need	at least once every three years	N/A	N/A	N/A	2 times a year per category

Note: **Y** indicates "available"; **N** indicates "not available."; **required** indicates "required by law but not available yet."

REQUIRED TIME FRAME

Concerns about lengthy CON review are addressed mainly by imposing mutual deadlines. There were revisions in the process for appealing in Illinois including imposing a deadline and having the hearing officer chosen not by the Board, but by the Director of Public Health. **Table 4.8** shows a moderate range of deadlines imposed by states. Some states do not impose deadlines for some of the review processes, particularly the process for appealing denials.

Table 4.8 also shows the review process varying by states. New Jersey, Illinois and New York recommend that an applicant discuss the proposed project with the agency prior to applying. In contrast, Michigan and Florida require "prior contact" by law by starting the CON process with the applicant's letter of Intent (LOI). In Michigan, the applicant contacts the Department's Project Review Coordinator regarding a potential project. The Department sends a Letter of Intent form (LOI) to the potential applicant. The applicant files the LOI

with the Department and Regional Review Agency (if applicable.) Based on LOI information, the Department sends relevant forms to the applicant within 15 days. An applicant does not submit an application until the applicant receives the confirmation letter from the agency. On designated application dates, the applicant files completed application forms with the Department and Regional Review Agency (if applicable).

Table 4.8 Required Maximum Time Period*

	Illinois	New York	Michigan	New Jersey	Florida
For Full Review					
Deadline of publication of fixed need pools prior to LOI deadline	No LOI	N/A	N/A	No LOI	15
Due for Letter of Intent (before the application)	No LOI	No LOI	15	No LOI	30
Notice of Application Completeness	10	N/A	15	N/A	15
Submit additional info by incomplete applicant	N/A	N/A	15	N/A	21
Review Period**	120	N/A	120	N/A	N/A
Modification prior to initial decision	60	N/A	N/A	N/A	N/A
Initial decision: intent of denial	N/A	N/A	N/A	N/A	N/A
Maximum extension that applicant can request	N/A	N/A	N/A	60	N/A
Allow agency/board to extend review?	Y&	N/A	N/A	N/A	N/A
Appeal Process					
Request hearing after a denial decision	N/A	N/A	15	N/A	N/A
Schedule of hearing for an appeal after the hearing request	N/A	N/A	90	60	N/A
Maximum Allowed Hearing duration	90	N/A	N/A	N/A	N/A
Appointing a hearing officer after scheduling a hearing	30	N/A	N/A	N/A	N/A
Final decision after an hearing	45	N/A	N/A	30	N/A
For Comparative Review					
Review Period**	N/A	N/A	150	N/A	N/A
For Expedited Review					
Review Period**	60	N/A	45	90	45
For Application for Exemption					
Completeness	30	N/A	N/A	N/A	N/A
Review Period**	60	30	N/A	N/A	N/A

* Units are days unless otherwise specified.
**Defined from application completion to initial decision.
& In Illinois, the agency may extend the review period until the next meeting.

Some aspects of Table 4.8 are summarized:

- In Illinois, the State Board needs to make its final decision within 45 days of receiving the written report of the hearing.
- The fixed need pools for the applicable planning horizon should be specified for each service in the Florida Administrative Weekly at least 15 days prior to the letter of intent deadline for a particular batching cycle.
- Completeness review is done within 10 calendar days of receipt of an application in Illinois, compared to 15 days in other states.
- Illinois regulation does not specify the deadline for starting a hearing for an appeal after the hearing request is made, whereas there are specified deadlines for Michigan (within 90 days after the hearing request) and for New Jersey (within 60 days).
- While there is little variation in review period for full review, there are larger variations in review period for expedited review (a range of 45 and 90 days with 60 days for Illinois) and exemption review (a range of 30 and 60 days with 60 days for Illinois).
- Empirical data of average duration indicates that a full review, on average, takes five months from application completeness to final decision. Both applicants and reviewers may extend the period. Modification or hearing requests also extend the

period. The final approval can be tied up for years if there are legal challenges from other providers in the area. Finally, the number of services subject to expedited review varies by states. Therefore, the statement made by the Illinois Auditor, "Illinois' review period was the 8th lengthiest compared to the 33 other states for which data were available." may be oversimplified.

CON FEE STRUCTURE

CON application fees are a main resource for a CON agency. **Table 4.9** organizes CON fees in three broad groupings: permit fee, exemption fee, and alteration for approved CON.

Table 4.9 Fee Structure

	Illinois	New York	Michigan	New Jersey	Florida
Permit Fee					
contingent on Total Project Cost (TPC)	A) <$350,000: $700; B) > $350,000 or more: $700 plus 0.2% of TPC with a cap of $100,000	$1,000 plus 0.45% of project cost (if reviewed by the Council)	A) <=$150,000: $750 B) > $150,000 and < = $1.5M: $2,750 C) > $1.5M: $4,250	A) <= $1 M: $7,500 B) > $1M: 7,500 + 0.25% of TPC C) Ownership transfer: $7,500	A) No expenditure: $5,000 B) Any expenditure: $5,000 + 1.5% of TPC with a cap of $22,000
Definition of TPC	N/A**	N/A	Only clinical area; only fixed equipment	capital costs, financial costs*	N/A
Exemption Fee					
Change of Ownership/ medical equipment	$2,000	N/A	N/A	N/A	N/A
Neonatal	The greater of $1,000 or 0.1% of TPC with a cap of $20,000 for projects with $20 M or more	N/A	N/A	N/A	N/A
Dialysis station addition	The greater of $1,000 or 0.1% of TPC	N/A	N/A	N/A	N/A
Alteration of Approved Project					
Request for time extension	$500	N/A	N/A	N/A	N/A
Change in cost	The greater of $1,000 or 0.2 % of the dollar amount that exceeds the approved permit amount	N/A	N/A	$7,500 plus 0.2 % of $1 M or more exceeding the approved permit amount	No CON required: 0.25 % of $1M or more exceeding the approved permit amount
Transfer CON	N/A	N/A	N/A	N/A	$5,000
Effective Date	N/A	N/A	N/A	Feb-2004	2000

* carrying and financing costs, net interest on borrowings during construction, debt service reserve fund.
**N/A indicates either not available or not applicable.

CON REVIEWING AND APPROVING BODY

Table 4.10 compiles information on the body that is in charge of reviewing applications and approving/denying them. It also compiles information on the body in charge of promulgating or approving review criteria and standards.

- New York is unique in that there are two levels of reviewers and two decision makers. The system starts with determining the appropriate review track for applications. The Division of Health Facility Planning (DHFP) reviews and makes initial recommendation with approval/denial. If the project requires a full review, it is forwarded to the State Hospital Review and Planning Council (SHRPC). For administrative reviews, the project goes directly to the Commissioner for the final decision. Therefore, SHRPC reviews only full review projects and makes recommendations. If the project involves an "establishment", SHRPC forwards it to the Public Health Council for a final decision. "Establishment" means

establishing a new ownership and control entity for a new or existing facility specified as an Article 28 facility which includes a nursing home, hospital, a freestanding ambulatory surgery center, a dialysis center, a clinic or a similar entity. If the project is not an "establishment", that is, if the project involves existing providers with modification to a current facility or service, SHRPC forwards it to the Commissioner for a final decision.

Table 4.10 CON Body

Categories	Illinois	New York	Michigan	New Jersey	Florida
Review and recommendation for Full Review	State Health Planning Board	State Hospital Review and Planning Council; Regional Hospital Review and Planning Council	Staff reviewer assigned to each of 13 project type groups	Both State Health Planning Board and Department	Local Health Council
Local review board?	No	Yes	Depending on project type	No	Yes
Review and recommendation for Expedited Review	Executive Secretary/ CON staff	N/A	Same as above	Department	Agency: AHCA
Final Decision	State Health Planning Board	Commissioner of Health	Commissioner issues a final decision; if disapproved, a hearing can be requested.	Commissioner for both Full and Expedited	Agency Director
Promulgate criteria and standards	State Health Planning Board	Public Health Council	Commissioner	Commissioner	N/A
Approve criteria and standards	State Health Planning Board	Public Health Council	CON Commission	Health care administration board	N/A

- Projects eligible for prior limited review are forwarded to the Deputy Director of DHFP, while projects eligible for limited review are forwarded to the Director of DHFP.
- In New Jersey, the State Health Planning Board reviews applications subject to full review and makes recommendations to the Commissioner for a final decision.
- In Florida, all applications subject to comparative review are submitted to the Local Health Council on or before the prescribed application deadline and reviewed by the Agency for Health Care Administration (AHCA). Applicants subject to expedited reviews are assessed by AHCA, which issues a State Agency Action Report within 45 days. The Agency Director or Designee approves the CON upon the signing of the report.
- In Illinois, the Board Executive Secretary determines appropriate tracks. With the initial analyses of CON staff, the State Board reviews and makes final decisions.
- Table 4.10 also shows who is in charge of promulgating and revising/approving review criteria and standards. In Michigan, the Certificate of Need Commission (5 members) is responsible for developing proposed CON review standards and proposing modifications in the statutory list of covered medical services. The CON Commission proposed changes in CON review standards and in the statutory list of covered medical services are first subject to comment by the Legislature's health committees, and then any final standards are subject to ultimate approval/veto by either the Legislature or the Governor.
- In addition, the Commission assesses the operations and effectiveness of the CON program based on periodic reports from the Department of Community Health and

other information and makes recommendations to the standing committees in the senate and the house regarding statutory changes to improve or eliminate the CON program.

MONITORING PROCEDURE

All the states have regulations for monitoring the implementation and compliance of projects having received CON approval (**Table 4.11**). The duration of a valid permit varies by state. In New Jersey, CON is valid for a period of five years from the date of approval. Most of the states allow a permit extension for one additional year.

Table 4.11 Regulations on Monitoring Post CON

Categories	Illinois	New York	Michigan	New Jersey	Florida
Approval for alteration required	Change in the number of beds; Increase in GSF* that is greater than 5% of approved GSF or 5,000 additional GSF mandated by other laws; Increase in borrowed funds.	N/A	N/A	N/A	N/A
Request for a renewal of a permit	Must submit 90 days prior to expiration date; Extend one additional year	N/A	N/A	N/A	N/A
Need to have an enforceable contract for majority of the project	N/A	N/A	2 yr. after approval	N/A	N/A
Maximum duration of an unimplemented CON	N/A	N/A	2 yrs	5 yrs	N/A
Threshold for cost overruns*	the lesser of 5% of the permit amount or the capital or major medical equipment minimums	N/A	exceed the permit amount by 15 percent of the first $1 million and 10 percent of all costs over $1 million.	N/A	N/A
Notice before a final decision on the revocation of a permit	30 days	N/A	N/A	30 days	Y
Due for Compliance progress report	between 30 days prior or 30 days after one year of approval	N/A	N/A	Within 20 months of approval; annually for the first two years thereafter	N/A
Submit a report of final realized costs with a notice of completion	Y	Y	Y	Y	Y
On-site inspection of the completed project after the notice from the applicant of completion	15 days	N/A	N/A	N/A	N/A
Penalties, fines and sanctions	No licensure issued; Fine of up to $25,000, plus without a permit	N/A	N/A	N/A	N/A
Fines for non-compliance	Fine not to exceed 1% of approved amount, plus additional 1 % per each month during violation duration; Fines not exceed the sum of the lesser of $25,000 or 2% of approved amount and additional $20,000 for each $1 M in excess of the approved amount of more than $1 M;	N/A	N/A	N/A	N/A

*GSF=gross square footage

** A cost overrun, amount of the final cost that exceeds the approved amount, is not permittable if it exceeds thresholds.

REVIEW CRITERIA/STANDARDS

There is consensus that updating and enforcing review criteria and standards is one of the key future directions that a CON agency should take. Illinois is one of the states that are required to revise them. The 2003 Amendatory Act requires the State Board to review, revise, and promulgate the criteria, standards, and rules used to evaluate applications for permit, before December 31, 2004. It recommends the following considerations for revision:

(1) Whether the criteria and standards reflect current industry standards and anticipated trends.
(2) Whether the criteria and standards can be reduced or eliminated.
(3) Whether criteria and standards can be developed to authorize the construction of unfinished space for future use when the ultimate need for such space can be reasonably projected.
(4) Whether the criteria and standards take into account issues related to population growth and changing demographics in a community.
(5) Whether facility defined service and planning areas should be recognized.

There are three major review criteria for decision, particularly for applications subject to full review: 1) Need, 2) financial feasibility, and 3) technical/engineering standards compliance. This section focuses solely on need determination: State CON statutes require all decisions on CON applications to be based on the projected need compliance with the statutory review criteria. The following five tables summarize standards related to bed, non-hospital based ambulatory surgery, cardiac catheterization, open heart surgery, and organ transplantation.

Table 4.12 presents need methodology and review standards for bed-related services. Specifically, it compares occupancy target rates for an applicant provider within a certain years of operation. It also compares minimum standards for existing providers for need determination. Table 4.12 also presents age-specific utilization rates and age grouping.

Table 4.13 summarizes standards related to volumes for new or existing non-hospital based ambulatory surgery by state as of 2004. The ambulatory surgery center standard is a case-by-case review, without a population-based standard. This formulation should be reformulated, otherwise it is neither dynamic nor responsive to the growing demand for non-hospital based ambulatory surgery.

Table 4.14 summarizes requirements related to volumes for new or existing cardiac catheterization services by state, as of 2004. This formulation has dynamic components such as mortality rates, but the rates are just average, not accounting for trends. Also they do not include age-specific rates.

Table 4.15 summarizes requirements related to volumes for new or existing open heart surgery services by state, as of 2004. On the other hand, Illinois allows institution-specific approval that does not depend on community need assessment.

Table 4.16 summarizes requirements related to volumes for new or existing organ transportation services by state, as of 2004. Illinois does not have specific need standards for other than kidney transplants, whereas other states do.

Table 4.12 Standards Related to Bed Need Determination

	Illinois	New York	Michigan	New Jersey	Florida
Occupancy Target rate					
Intensive Care	0.60	N/A	N/A	N/A	N/A
Medical/surgical/Pediatric *Differ by areas with:*	<100 beds: 0.80 100-199 beds: 0.85 200+ beds: 0.90	**Medical/surgical** Urban: 0.85 Rural: 0.80 **Pediatric** Urban: 0.70 Rural: 0.65	<300 beds 0.80; ≥ 300 beds 0.85; 0.85 Pediatric	Pediatric only	Medical/Surgical: 0.80 Pediatric: 0.65
Obstetric *Differ by areas with:*	<11 beds: 0.60 11-25 beds: 0.70 26+ beds: 0.78	Urban: 0.75 Rural: 0.70	N/A	No CON	No CON
Effective year	2001	1993	2003		
Acute mental illness** The minimum bed need	0.85 0.11 per 1,000	N/A	0.90 for adults 0.75 for children/adolescents	N/A	0.75
Effective Year	1999		1995		1996
Neonatal intensive care	0.75	0.75			0.80
Formula for need determination	Institution-specific only	1 per 1,000 live births[1]	Institution-specific only or by planning area	N/A	Fixed need pool by planning area separated into regions
Effective Year	1999		1995		1996
Rehabilitation	0.85	0.90		0.85	0.85
Use Rate Minimum*	0.60 of state use rate	N/A	N/A	N/A	N/A
Effective Year	1992	1990		?	1995
Minimum unit size					
Obstetric unit within MSA& Outside MSA Intensive care Pediatric unit within MSA	20 beds 7 beds 4 beds 16 beds	N/A	N/A	No CON	No CON
Acute mental illness	20 within MSA&; 10 Outside MSA	N/A	N/A	N/A	15 adult 10 Pediatrics
Rehabilitation					
General Hospital	N/A	N/A	N/A	N/A	20
Specialty Hospital	N/A	N/A	N/A	N/A	60
Age Group Classifications					
General	0-14* 15-64, 65 +	0-9, 10-14, 15-19, 20-44, 45-64, 65-74, 75-84, 85+	0-14* 15 -64, 65 -74, 75 +	N/A	N/A
Obstetric	15-44	15-44		N/A	N/A

* excluding normal newborns
** whichever greater of the estimated need or the minimum bed need
**The minimum will apply if the area's experienced use rate falls below the minimum.
& Metropolitan Statistical Area;
1 The standard is based on a pre-maturity rate of 80/1,000 births and may be adjusted pre-maturity rate in a region.

Table 4.13 Summary of Standards Related to Ambulatory Surgery by State, 2004

Category and Requirement	IL	NY	MI
Calculation of bed need	At the level of facility**	N/A	At the level of facility**
Target Occupancy Rate	0.80	N/A	
Intended geographic area	Within 30-60 min travel time	N/A	within 30 min or 20 miles
New: Minimum occupancy for existing facility	0.80	N/A	N/A
Minimum hrs of use required for a treatment room*	1500 hrs	N/A	1800 hrs for existing services only
Minimum surgical cases required per room***	N/A	N/A	For new or existing (expansion, replacement, or relocation), 1200 cases in second month of operation, and annually thereafter.
If co-owner is hospital, lower charges than for existing hospital	Yes	N/A	N/A
Charge Commitment	Yes	N/A	N/A
Effective Year	1999	N/A	1998

Source: CON standards published in rules/regulations available from online CON programs.
Notes: * Hours of surgery includes cleanup and setup time
* For MI, different volume requirements apply to applicants in rural service area. 1600 hrs of use for Hospital, 1800 hrs of use for Ambulatory Treatment Center. For MI, not comparative review.
** need will be only a facility need. Need will not be calculated at the level of HSA.
*** All operating rooms in which surgery will be performed excluding those used for endoscopy or cystoscopy.

Table 4.14 Summary of Requirements Related to Cardiac Catheterization by State, 2004

Category and Requirement	Illinois	New York	Michigan	New Jersey	FL
Types (Therapeutic=T, Diagnostic=D)	T, D	T, D	T, D	T	T
Use					
Risk-adjusted mortality rates By hospital By surgeon	N/A	Yes Yes Yes	N/A	Yes; low-risk Yes Yes	N/A
Peer Review team	Yes	N/A	N/A	Yes	Yes
Certificates	N/A	Operating Certificate	N/A	Licensure; certification of nondiscriminatory practices	Must be fully accredited by JCAHO or by American Osteopathic Association
Required Minimum Cases Within 2 years after initiation	200	N/A	300**	400 invasive cardiac diagnostic; 200 low-risk procedures; 200 peds.	Adults 300 Peds. 150
Minimum cases for existing area program	400 procedures	N/A	N/A	400 procedures	≥ 300
Or the referral volume in each of the prior three years in excess thereof	400 procedures	N/A	N/A	N/A	N/A
Impact on existing program by lowering	Below 200	N/A	N/A	N/A	N/A
On-site cardiac surgical backup	N/A	Yes	N/A	N/A	N/A
Monitor or enforce standards after the issuance of a CON?	N/A	N/A	Yes	Yes	Yes
Revised date	1987	N/A	2003	2004	1995
Multi-Institutional Variance: Minimum for a second affiliation agreement	750 for applicant; 400 for affiliate	N/A	N/A	N/A	N/A
Geographic Area					
ADD=Area Development District; C=County; D=District; H=HAS; P=Planning area; R=Region; S=State	N/A	N/A	P	C	P

Source: Regulations/Rules from each State
* only fixed units, that is, excluding mobile units

Table 4.15 Summary of Requirements Related to Open Heart Surgery (OHS) Programs by State, 2004

Category and Requirement	IL	NY	MI	NJ	FL
Adult			age 15+		age 15+
New					
Minimum for applicant by third year	200	500	300	350	
Minimum for each existing provider per year	350	500	350	350	350
Expansion			not regulated		not regulated
Minimum for applicant per year	N/A	N/A		N/A	
Minimum for other providers per year					
Pediatrics			age ≤ 14		age ≤ 14
New					
Minimum for applicant by third year	75	50	100	150	N/A
Minimum for each existing provider per year	75	100	350	150	
Expansion			not regulated		not regulated
Minimum for applicant per year	N/A	N/A		N/A	
Minimum for other providers per year					
Institution-specific Approval Referral for surgery following cardiac catheterization at the applicant facility	200 patients	N/A	N/A	N/A	N/A
Institution-specific Approval Minimum cardiac catheterization performed by applicant facility	750 patients	N/A	300 patients	N/A	Must demonstrate documented provision of inpatient cardiac cathe; no min performances listed
Personnel					
Minimum for physician per year	N/A	N/A	50	100	N/A
Minimum for team per year	N/A	N/A	N/A	N/A	N/A
Geographic Area					
ADD=Area Development District; C=County; D=District; H=HAS; P=Planning area; R=Region; S=State	1½ hrs	H 100 miles radius	P	R	2 hrs for at least 90% of pop. D/R
Effective Year	2003	N/A	2003	N/A	2002

Source: Regulations/Rules from each State

Table 4.16 Summary of Standards Related to Organ Transplantation by State, 2004

Category and Requirement	IL	NY	MI	NJ	FL
Kidney Transplantation					
Minimum for applicant by 2nd year	25	15	No CON	N/A	15 for adults; 5 for peds
Minimum for each existing provider per year	N/A	N/A		N/A	30 for adults; 10 for peds
Effective Year	1992	1990		N/A	1994
Bone Marrow					
Minimum for applicant by 2nd year	No standard	N/A	10	N/A	10
Effective Year	N/A	N/A	1997	N/A	1994
Heart and Lung					
Minimum for applicant by 2nd year	No standard	New: 14 Expansion: 30	12	N/A	Heart: 12 Lung: no standard
Minimum for each existing provider per year	N/A	N/A	N/A	N/A	24
Effective Year	N/A	N/A	1997	N/A	1994
Liver					
Minimum for applicant by 2nd year	No standard	N/A	12	N/A	5
Effective Year		N/A	1997	N/A	1994
Pancreas					
Minimum for applicant by 2nd year	No standard	N/A	12	N/A	N/A
Effective Year	N/A	N/A	2002	N/A	N/A
Islet cells			No CON.		
Minimum for applicant by 2nd year	No standard	N/A		N/A	No standard
Effective Year	N/A	N/A		N/A	N/A

Source: Regulations/Rules from each State

V. ANALYSIS OF ILLINOIS CERTIFICATE OF NEED DATA

OVERVIEW

Chapter V reports results from the analysis of Illinois CON application data, from 1975 to 2003. The number of applications received decreased over the last three decades (**Figure 5.1**). When the number of applications received in 1990 is set to 1.0, the overall trend after 1990 is clearly downward. The highest number of applications was recorded in 1979 (321 applications) while the least number of applications was recorded in 2001 (87 applications).

Figure 5.1
Number of Applications Processed

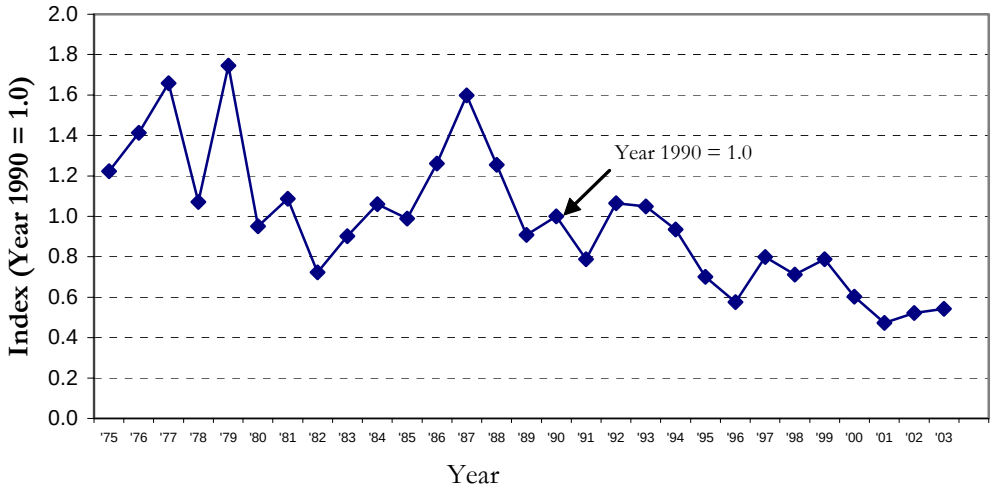


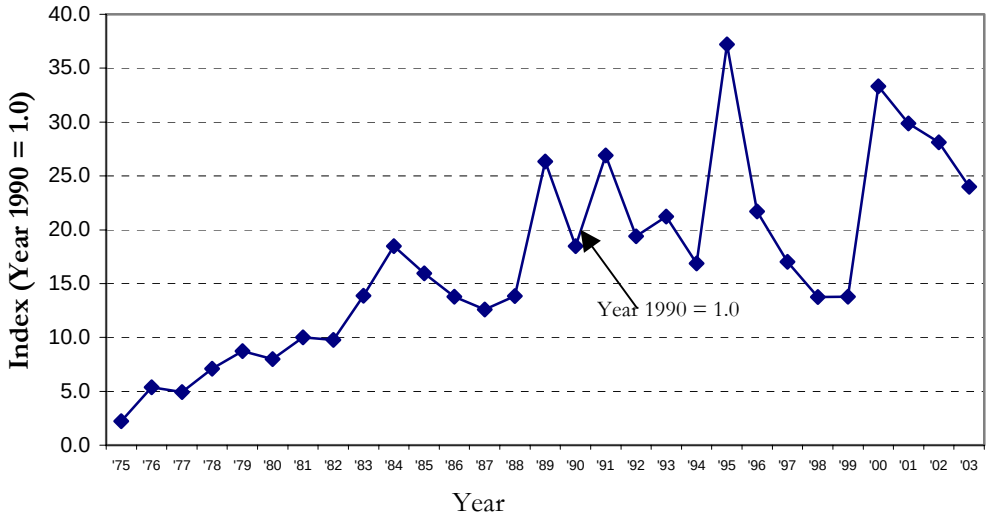
Figure 5.2 examines the percentage of applications with no project cost. **Figure 5.2** indicates the increase in the percentage of projects with no project cost. This is partly attributable to the increase in capital cost threshold and the repeal of CON on expensive medical equipment. On the other hand, projects with no cost – change of ownership due to merger and consolidation and/or discontinuation of services or facilities– have increased.

Because the Illinois CON database does not contain information on bed changes, we do not include a figure depicting a trend of bed changes in terms of the number of beds increased or decreased as a result of various types of projects such as discontinued services/facilities, construction of a new facility or initiating new services. Hospital disclosure data from Illinois Hospital Association shows that 47 hospital closures led to loss of 5,559 beds, from 1980 to 2003 (**Appendix E**).

ANALYSIS OF RECENT FIVE-YEAR DATA

This section focuses only on the most recent 5 years data, excluding data prior to 1999. Because Illinois' CON program was significantly modified by statutory changes that became effective after 1999, variables of primary interest related to CON reform are not available for years prior to 1999.

Figure 5.2
Percentage of Applications Received with No Project Cost



Review Period

To respond to the concern about the seemingly lengthy CON process, we calculated the review period as the period from the date the application is deemed complete to the date the permit was issued. This definition of the review period excludes the applications that did not receive the permit from the calculation of the average review period. Furthermore, the review period was calculated as working days (or business days) excluding holidays from the calculation. Therefore, comparing our results with other data should be done with caution because data from other sources are not calculated by taking into account working days and holidays. In addition, the review period calculated in other data is often defined as the period from the date the application is complete to the date the *initial decision* was made.

The average review period was 68 business days, about 14 weeks, or three and a half months. Because the CON law requests at least four CON board meetings in a year with an approximate three-month interval, this average duration appears to be a reasonable response time.

According to Illinois CON regulations, the maximum review period for substantive (or full) review is 120 days, while half (60 days) is allowed as the maximum review period for non-substantive (or expedited) review. Our finding shows that there was only a modest difference in review time. There was only a five business days (or one week) difference (substantive review =71.6 working days; non-substantive review=66.5 working days). Furthermore, there was little difference in the review period between projects with and without project cost (with project cost=68.3 working days versus without project cost=69.5 working days). This is sharply contrasted with Michigan's data **(Table 5.1)**. The average review time for non-substantive review is approximately one-fourth the non-substantive review time and one-fifth the comparative review time in Michigan.

Table 5.1 Average Review Days by Review Type in Michigan

	1998		1999		2000		2001		2002	
Review Type	TD	AD	TD	AD	TD	AD	TD	AD	TD	AD
Non-substantive	105	27	101	27	70	23	75	29	59	33
Substantive Individual	40	114	44	113	37	118	60	114	88	115
Potential Comparative	11	110	1	57	1	120	7	83	12	119
Comparative	2	120	2	120	0	0	4	120	36	145

Abbreviations. TD=Total Decisions; AD=Average Days
Source: Table 2 in 2002 Certificate of Need Activity Report of Michigan

Determinants of Review Period

Some factors can lengthen the review process. We explored differential effects of some factors on the review period, which is here defined as the period from the date the application was received to the date the permit was issued. In addition to the review type and whether a project incurs cost or not, the factors we considered include a notice of intent to deny, incompleteness of an application, deferral before Board action, and request for modification, and initial denial. Although a request for administrative hearing is known to lengthen the review process, the Illinois CON data we used did not allow us to identify applicants that requested administrative hearings.

Review Type: When an application for a permit has been received by the Board, the Executive Secretary classifies the project into one of the following classifications: Non-Substantive (expedited review)/ Substantive (full review) / Emergency. The application data records the first two review types only. Refer to Table 4.4 in Chapter IV for types of projects that are classified into Non-Substantive/ Substantive reviews. Illinois and the selected four reviewed states require fewer review days for expedited review than for full review.

Incomplete applications: The agency staff performs a completeness review on an application within a maximum ten working day period. The staff sends an incompleteness notice and requests additional information or sends a letter deeming initial completeness. The applicant is given 90 days to provide additional information to complete the application.

Applications deferred before Board action: The applicant has the opportunity to defer initial consideration of a project, but not beyond a scheduled meeting date that is more than one calendar year from the date the application was deemed complete. The Board defers decisions, but the CON database does not record deferrals requested by the Board.

Modification to application: In case the applicant submits information that modifies the project, additional review time may be needed by CON staff.

Intent to deny: If the applicant fails the Board's first review and vote, the applicant receives a notice of intent-to-deny. If no further information is submitted and no request is made for reconsideration, the application is considered withdrawn. If the applicant provides requested information within 60 days, a new State Agency Report is prepared for the Board's second review.

Initial denial: The applicant receives an initial denial if the applicant fails the second review. Some applicants withdraw during the process. An applicant either waives its right to a hearing or a hearing is held and an Agency report is prepared for the Board's third review.

Application with hearing request: The Illinois CON data does not report information on an appeal hearing after the final denial decision. In addition, there is no data on administrative hearings. However, the data contains information on public hearing requests before Board actions.

The percentages of applications on which the actions above were reported over the last five years are:

- One out of 5 applications were incomplete (112 incomplete applications out of 539 applications, or about 21%). Seventy applicants of those 112 applicants (about 63%) submitted the required additional information and received permits. The "incomplete" percent is smaller, compared to the available Michigan data, which show a range of 73% to 92% over the last 5 years **(Table 5.2)**.

- Sixty-six applicants (or 12%) deferred consideration of their applications. Forty-seven applicants of them (71%) received permits. Comparable data is not available from other states. No report of such a statistic may indicate that deferral may not occur as often as in Illinois.

- Forty-two applicants modified projects. All applicants except for one received permits.

- Twenty-six applicants (or 9%) received an intent-to-deny notice. Less than half of them (11 applicants) succeeded in obtaining permits. This is similar to Michigan's data, although receiving a permit seems to be harder in recent years **(Table 5.3)**. In comparison, Florida shows a similar percentage of final decisions as initial decisions, although receiving a permit appears to be easier in recent years, the trend opposite to Michigan's **(Table 5.4)**. There is one sharp contrast in the initial denial rate between Florida on one hand and Illinois and Michigan, on the other hand: the number of applications initially denied in Florida is even greater than those observed in Illinois and Michigan. The probability of getting an initial denial in Florida is more than 50%, whereas it appears to be a lot lower for Illinois and Michigan --less than 15%.

Table 5.2 Incomplete Applications in Michigan

	1998	1999	2000	2001	2002
Complete	37	46	26	19	61
Incomplete	171	173	184	228	169
Total Applications	208	219	210	247	230
Percent Incomplete	82%	79%	88%	92%	73%

Source: Table 4 in 2002 Certificate of Need Activity Report of Michigan

Table 5.3 Disposition of Initial Denial in Michigan

Year	Initial Denial	Withdrawn	Final Denial	Final Approval	No Final Decision as of 9-30-02	
1998	10	2	3	5	0	0%
1999	4	0	2	2	0	0%
2000	8	1	4	3	0	0%
2001	27	7	16	4	0	0%
2002	48	9	2	5	32	67%

Source: Table 6 in 2002 Certificate of Need Activity Report of Michigan

Table 5.4 Disposition of Initial Denial in Florida*

Year	# Initially denied	Denial appealed	% Appealed	Final Decision Complete	% Complete	Final Same as Initial (1)	% Same as Initial
1998	114	65	57.0%	65	100.0%	44	67.7%
1999	66	36	54.5%	30	83.3%	19	63.3%
2000	76	46	60.5%	39	84.8%	22	56.4%
2001	70	51	72.9%	31	60.8%	17	54.8%
2002	58	30	51.7%	n/a	n/a	n/a	n/a

Note. *As of February 2003. (1) Final Action affirmed an initial denial (or initial withdrawal).
Source: Table 6 in 2002 Certificate of Need Activity Report of Florida

Regression Results

Table 5.5 contains the results from the ordinary least square (OLS) regression of modeling review period. The parameters of the regression equation are interpreted as the differential impacts of individual factors on the review period. The probability that is less than 0.05 indicates that there is a statistically significant relationship between the given factor and the review period. Table 5.5 reveals that whether applications received the notice of "intent to denial" or not had the greatest impact—requiring approximately 96 more business days for a permit. Whether the applicant requested deferral before the Board's initial review or not had the second largest impact: it took 59 more days. Whether the application was deemed incomplete or not had the third largest impact (19 more days), not long compared to the 90 days allowed for the applicant to provide additional information to complete the application. Whether applicants submitted information that modified their projects added approximately 12 days to the review process. Whether applicants made a request for hearing or not had only moderate impact (about 9 days), although the impact is statistically significant ($p<0.02$). Finally, the review types had little impact on the review period.

Table 5.5 Regression Results: Differential Impact on Review Period

Individual Factors	Parameter	Probability
Notice of Intent to Denial	95.65	<.0001
Incomplete Application	19.29	<.0001
Request for Deferral	58.59	<.0001
Substantive Review	0.41	0.9037
Request for Public Hearing	8.69	0.0178
Request for Modification	12.41	.008

Source: Author's analysis of Illinois CON data

Approval, Denial, and Withdrawn

There are three outcomes of an application. The following reports the percentages of applications that fall into one of the outcomes:

Withdrawn: An applicant may withdraw by not responding to the request for additional information made by the Board in the event of incomplete application, a notice of an intent-to-deny and initial denial. Fifty two applicants (9.6%) withdrew.

Final denial: If the applicant does not withdraw, the applicant either waives its right to a hearing or a hearing is held and an Agency report is prepared for the Board's third review. Some of the applicants withdraw during the process or some of them received a final denial. Three applicants received final denial after the Board made its third review over the last five years. Fifty-five applications were either withdrawn or denied and accounted for 10.2% of all applications received over the last five years.

Approval: A project can be approved initially, after an intent-to-deny or after initial denial. A project can be reviewed by the Board for a maximum of three times. The Board approved approximately 88% of all applications received over the last five years, or 427 projects.

Monitoring Compliance: Submission of Annual Progress Report

Finally, we examined the percentage of projects that submitted annual progress reports as required by the CON law after one year of permit. The projects that took more than one year for completion were selected and divided into two groups: projects completed and projects not yet completed as of March 31, 2004. There were 32 (or 37%) completed projects that failed to submit annual reports. A higher percentage of projects (49%) that were not yet completed failed to do so (74 projects out of 152 incomplete projects).

Table 5.6 Percent of Projects that Submitted Annual Progress Reports

	No Submission	Submission	Total
Projects Completed	32 (37.2%)	54 (62.8%)	86
Projects Not Yet Completed as of March 31, 2004	74(48.7%)	78(51.3%)	152

Source: Author's analysis of Illinois CON data

VI. COMPARISON OF CON APPLICATION APPROVAL/DENIAL

OVERVIEW

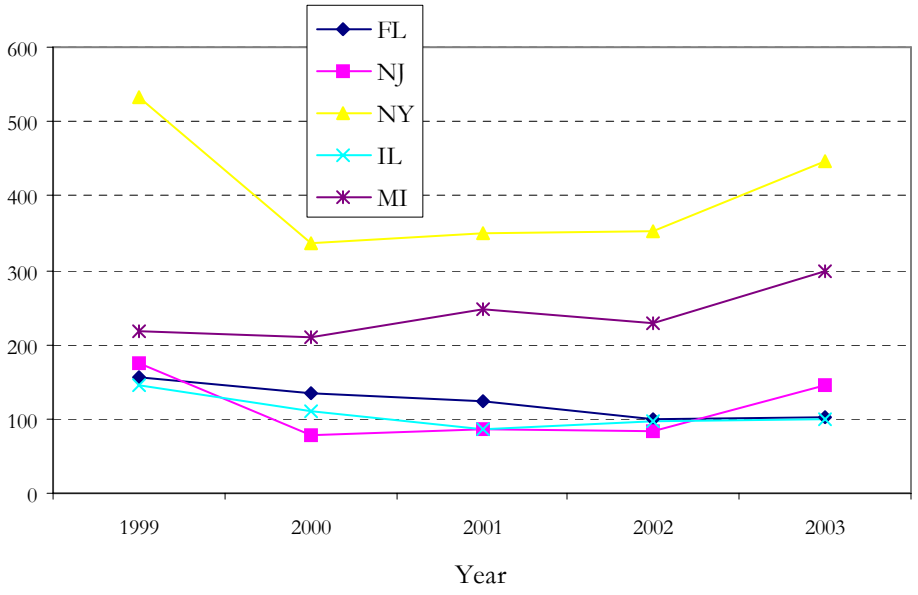
One of the main arguments by anti-CON critics is that CON is useless because agencies rarely deny applications. This chapter reviews a recent five-year history of approval/denial decisions on CON applications for the selected five states. The data for this review came from annual CON activity reported by CON agencies. Although we obtained individual applicant level data from Illinois, we decided to use Illinois' annual reports of CON activity to maintain consistency with other states' sources of information. A direct comparison of approval rates among the states is not desirable for the following reasons:

- Approval/denial tables available from CON reports focus on different project types. For example, approval/denial data from New York focuses on Public Health Council establishment projects only, whereas Illinois focuses on all types of projects.
- Approval/denial tables focus on different stages in the CON process. For example, Michigan focuses on final decisions. That is, they report final approvals and final denials made in a particular year. On the other hand, Florida focuses on initial decisions only. That is, temporary approvals and denials are reported for a particular year.
- Even the "annual" number of applications is measured differently. For example, while Michigan's report takes all applications *received* in a given year as a denominator for that year's analysis, Florida's "annual" report takes the CON applications *reviewed* during that year as the denominator, regardless of when the application was received. An application is considered reviewed when the *initial* agency recommendation is published or when the application is withdrawn prior to an agency recommendation.
- The five-year period was different: 1998 to 2002 data is reported for Michigan and Florida; 1999 to 2003 data for the remainder.

Figure 6.1 compares the number of applications the selected states processed for the recent five years. The number of applications for FL and NY are those *reviewed* in the given year. In comparison, data for the remaining three states are on those *received* in the given year. Applications that received agency initial action to approve, partially approve, deny, or withdraw a project in the particular year are considered *reviewed*. To accommodate both measures, we use the term "processed".

- Three states—Illinois, New Jersey, and Florida—cluster together in terms of the volume of applications processed. The volume of New York is far more than the cluster. Michigan is in between.
- The volume processed by Illinois and Florida did not change much for the last 5 years. In comparison, New York, Michigan and New Jersey had sharp increases in the number of applications processed in 2003.
- The trend observed for Michigan is unique in that the number of applications the State processed tended to increase over the last five years, while all other states showed the volume of the year 2003 was smaller than the volume of the year 1999.

Figure 6.1
The Number of CON Applications Reviewed/Received
1999 to 2003



Note. Data for FL and NY are on applications *reviewed* in the given year; on the other hand, data for the remaining three states are on those *received* in the given year.

APPROVAL/DENIAL BY FACILITY TYPE

Appendix F contains tables of approval/denial by facility type for the selected states. Although each table measures different aspects of approval/denial depending on each state, overall findings are still valid as follow:

- First of all, it is noted that all applications that were not approved were not always denied. Overall, more applications than those denied were withdrawn. They were withdrawn mainly when the applicants failed to meet the request made by agency staff for additional information. Counting those withdrawn as one of the denial types would increase the number of denials. However, all states do not always report the number of applications withdrawn, making a consideration of applications withdrawn difficult.
- As anti-CON critics argue, there were few denial decisions compared to the number of approvals. There were no denials during two recent years in Illinois—2002 and 2003 while there were 104 approvals during the same period (**Table 1 in Appendix F**). There were seven denials compared to 291 approvals. Similarly, there were a small number of denials compared to approvals in New York (**Table 2 in Appendix F**). However, unlike Illinois, there were increases in the number of denials during the recent two years. A direct comparison of two states' data should be made with caution—note that, while Illinois data focus on all project types, New York data deal with only Public Health Council Establishment projects.

- New Jersey also shows a similar pattern. Like Illinois, there appear to be decreases in the number of denials over the recent two years (**Table 3 in Appendix F**). Michigan appears to have relatively more denials than shown in the three states above (**Table 4 in Appendix F**). However, considering that Michigan had a higher number of approvals than the three other states did, the relative number of denials seems to be similar to other states' data. Again, a direct comparison among the four states should be made with caution—note that Michigan focuses on final decisions only.
- Florida appears to have an exceptionally high number of applications that were denied/withdrawn during the period, from 1998 to 2002 (Note that the year 2003 data was not available) (**Table 5 in Appendix F**). Except for 1999, there were more denials/withdrawn than approvals. Although this table reports initial decisions only and, thus, it does not reflect results of any appeals, another table shows that approximately 54.8% to 67.7% of final decisions, depending on the year, had the same as the initial decisions (**Table 6 in Appendix F**).

BED CHANGES

The number of beds certified for category of service subject to CON review can increase when new construction projects are approved, while the number of beds can decrease when projects for facility closure, service discontinuation or decertification are approved. On the other hand, some types of projects, such as conversion or transfer, do not affect the number of beds in total. CON agencies track the changes in the number of beds certified for category of service subject to CON review for the determination of the need of new beds.

Appendix F contains tables that contain changes in the number of beds by type of facility for the recent five years (**Tables 7 to 10**). We decided not to report Michigan's table because Michigan's table was reported not in terms of the number of beds but in terms of the number of applications affecting the number of beds. The data contained in the tables do not have the same information: for example, Illinois' table reports only approved number of beds, while Florida's reports both the number of beds requested and approved but not the number of beds denied.

A direct comparison of bed changes among the states is not desirable due to reasons similar to those mentioned above for approval/denial projects. For example, Illinois data represents final decisions on the bed changes, while other states' data record only initial decisions. Despite the difficulty in a direct comparison of bed changes among the states, we summarize the findings as follow:

- There were recent increases in the number of new hospital beds approved in all states other than Illinois. However, the fewer number of new hospital beds approved in Illinois probably reflected the fact that Illinois data was on final decisions only. Final decisions were pending for some projects requesting new beds—some under review or others for administrative hearings.
- Among the states that report the discontinued number of beds—Illinois, New York and New Jersey, there were more beds discontinued than new beds in total for the recent five years. However, there seems to be more new beds than discontinued beds in the recent two years.

- There appears to be decreases in the number of new long-term care beds for the states. Particularly, Florida has had a moratorium on approval of additional community nursing home beds for freestanding facilities since 2002.
- The two states that report approval/denial—New York and New Jersey—report few denials. Although Florida does not report denials, but the number of new beds requested and approved only, Florida appears to deny requests for new beds more often than the two states. This finding is consistent to Florida's high denial rate observed above in terms of the projects.

VII. CONCLUSIONS

This report contains a comparative assessment of certificate of need programs among the selected five states including Illinois: New York, Michigan, New Jersey and Florida. We conclude the report by summarizing the findings.

FINDINGS

A. Identifying states similar to Illinois:

- The law of each state offers different exceptions, thresholds and review processes, making comparisons difficult.
- Despite the difficulty in comparison, we opted to give in-depth reviews of four states—New York, Michigan, New Jersey and Florida with the following rationale:
  - They have the size of supply and demand for health care similar to Illinois.
  - New York is often considered as a benchmark state not only for CON services but also CON-related methodology for need determination.
  - Michigan is one of the forefront runners in revamping CON standards and criteria, a major source of criticism for CON.
  - New York and Michigan currently have the same level of CON scope that Illinois had prior to the 2003 Amendment Act.
  - Illinois appears to follow the same path that Florida and New Jersey have been taking.

B. Findings related to features that Illinois currently does NOT offer:

- Letter of intent (LOI). Unlike Illinois, Michigan uses the LOI as a tool to provide project-specific feedback to CON applicants. Based on the LOI information, the Michigan Department sends relevant forms to the applicant. An application cannot be submitted until the applicant receives a confirmation letter from the agency.
- An effective call structure to enable comparative review with the potential to minimize inconsistent decision making. Three states—New Jersey, Florida and Michigan—conduct comparative review where similar types of applications (in terms of the planning area, project type, or need methodology) can be batched.

C. Findings related to current issues in selected states:

- Politics that favor local providers by granting exemptions (Michigan/Florida)
  Michigan and Florida have recently or currently been engaged in lawsuits because lawmakers pushed through exemptions for hospitals in their districts. Nebraska (that has phased out CON except for long term care) and Texas (that abandoned its CON program in 1985) had a similar history of favoritism and ineffectiveness that are thought to have mainly undermined the CON function.
- Politics that attempt to force a revision of CON criteria and standards (Michigan)
- Pressure to cut back or deregulate CON further (Florida)
- Emphasis on enforcing post-CON standards (Florida)

D. Compared to selected four states, Illinois:

- Uniquely gives the authority to the State Board for both the duties: 1) approving standards/criteria and 2) making final decisions on applications.

  - The three states—Michigan, New Jersey and Florida—have Health Department Directors make final decisions on applications and have independent councils enhance and approve standards/criteria.
  - New York has a Health Department Director make final decisions on projects except for full review establishment projects on which the Public Health Council make final decisions.
- Does not have an efficient review structure to facilitate a staff reviewer consistently applying criteria and standards. Michigan ensures each project type (all together 13 types) has its own staff reviewer who is responsible for compiling a report on each application.
- Does not have particularly out-dated standards and criteria.
- Does not have a more expensive CON process at least in terms of application fees.
- Has a limited number of project types that are subject to expedited review.
- Does not have a particularly lengthy application and review process.
- Uniquely has both: 1) removed CON from most of medical equipment; 2) at the same time regulates freestanding physician-sponsored ambulatory surgery and diagnostic centers.
- Has imposed specific deadlines for the process of review.

E. The Illinois CON application data shows that:

- The Board approved approximately 88% of all applications received over the last five years, or 427 projects.
- Over the last five years, the average review period, defined as the period from the date the application is deemed complete to the date the *permit* was issued, was short rather than lengthy--68 business days, about 14 weeks, or three and a half months. Because the CON law requests at least four CON board meetings in a year with an approximately three-month interval, this average duration appears to be a reasonable response time.
- Two factors – whether an applicant received an intent-to-deny notice or not and whether an applicant received an initial denial – had the greatest impact on the review period, adding 96 and 62 business days before a permit respectively. However, surprisingly enough, whether an application was classified as substantive (or full) review or non-substantive (or expedited) review had little impact on the review period. Similarly, whether an application involved cost or had a no cost factor had little impact. This may indicate that there may have been inappropriate arrangements of resources targeting applications assigned to full review or involving a cost factor.
- Although the Illinois CON law requires submission of annual progress reports after one year of permit date, 37% of projects completed and 49% of projects not yet completed as of March 31, 2004 failed to do so. There seems to not be effective enforcement of compliance of CON law after a permit is issued.
- There were few denials compared to approvals as also shown by other three states—New Jersey, Michigan and New York. By contrast, Florida reports significantly higher number of denials compared to the number of approvals.

CONCLUDING THOUGHTS

To minimize the failure of agency reviewers consistently applying standards/criteria, we recommend considering comparative review where staff reviewers can evaluate the same services in the same area at the same time.

Illinois recently removed CON permit requirements from most medical equipment, and sharply increased the capital threshold for equipment to mainly address the issue of leveling the playing field that hospitals have raised against physician groups offering the same service, such as cardiac catheterization. This action seems to us to indicate that Illinois may follow the same path New Jersey and Florida have taken, that is, toward phased-in deregulation and then possibly phasing out CON. We recommend considering the following factors before the State takes further decisive actions:

- The market competitiveness brought by managed care in late 1980s and early 1990s has been a major basis for CON abolitionists. However, there is mounting evidence that managed care is slipping away.
- Demographic changes in the foreseeable future will surely increase the demand for inpatient beds and costly tertiary care. Health care providers will respond by increasing the supply, creating a need for health facility planning.
- A careful evaluation of reforms that other states have started will ensure that their experience can serve as a model for Illinois.
- Particularly, we recommend examining

    - Phased-in implementation of deregulation as begun in Florida and New Jersey.
    - Batch processing as used by Michigan, Florida and New Jersey, and
    - Michigan's efforts to update and enforce review criteria and standards
    - Possible factors that may explain a significantly higher number of denials compared to the number of approvals shown in Florida

Our concluding thought in this report is that the two recent Illinois CON reform Acts inserted provisions that primarily address concerns raised by stakeholders, mainly the Illinois Hospital Association. The future direction for CON reform efforts should be toward evaluating other states' experiences and alternative healthcare delivery systems before making informed decisions on the future of Illinois CON.

APPENDIX A
Excerpt of Public Act 93-0041
2003 Amendatory Act

Sec. 12. Powers and duties of State Board.

maintain an updated inventory on the Department's web site reflecting the most recent bed and service changes and updated need determinations when new census data become available or new need formulae are adopted

(1.5) Post the following on the Department's web site: relevant (i) rules, (ii) standards, (iii) criteria, (iv) State norms, (v) references used by Agency staff in making determinations about whether application criteria are met, and (vi) notices of project-related filings, including notice of public comments related to the application.

Sec. 12.3. Revision of criteria, standards, and rules. Before December 31, 2004, the State Board shall review, revise, and promulgate the criteria, standards, and rules used to evaluate applications for permit. To the extent practicable, the criteria, standards, and rules shall be based on objective criteria. In particular, the review of the criteria, standards, and rules shall consider:

(1) Whether the criteria and standards reflect current industry standards and anticipated trends.

(2) Whether the criteria and standards can be reduced or eliminated.

(3) Whether criteria and standards can be developed to authorize the construction of unfinished space for future use when the ultimate need for such space can be reasonably projected.

(4) Whether the criteria and standards take into account issues related to population growth and changing demographics in a community.

(5) Whether facility-defined service and planning areas should be recognized.

Sec. 13. Investigation of applications for permits and certificates of recognition.

Prior to collecting information from health facilities, the State Board shall make reasonable efforts through a public process to consult with health facilities and associations that represent them to determine whether data and information requests will result in useful information for health planning, whether sufficient information is available from other sources, and whether data requested is routinely collected by health facilities and is available without retrospective record

review. Data and information requests shall not impose undue paperwork burdens on health care facilities and personnel.

Before commencing construction

The Department must give a hospital that is planning to submit a construction project for review the opportunity to discuss its plans and specifications with the Department before the hospital formally submits the plans and specifications for Department review.

The Department shall conduct an on-site inspection of the completed project no later than 15 business ~~30~~ days after notification from the applicant that the project has been completed and all certifications required by the Department have been received and accepted by the Department.
The Department may extend this deadline only if a federally mandated survey time frame takes precedence.

Upon application by a hospital, the Department may grant or renew a ~~the~~ waiver or alternative compliance methodology ~~of the hospital's compliance~~ with a ~~construction or physical~~ ~~plant~~ rule or standard, including without limitation rules and standards for (i) design and construction, (ii) engineering and maintenance of the physical plant, site, equipment, and systems (heating, cooling, electrical, ventilation, plumbing, water, sewer, and solid waste disposal), ~~and~~ (iii) fire and safety, and (iv) other rules or standards that may present a barrier to the development, adoption, or implementation of an innovation designed to improve patient care, for a period not to exceed the duration of the current license or, in the case of an application for license renewal, the duration of the renewal period.

Sec. 9.4. Findings, conclusions, and citations. The Department must consider any factual information offered by the hospital during the survey, inspection, or investigation, at daily status briefings, and in the exit briefing required under Section 9.2 before making final findings and conclusions or issuing citations. The Department must document receipt of such information. The Department must provide the hospital with written notice of its findings and conclusions within 10 days of the exit briefing required under Section 9.2. This notice must provide the following information: (i) identification of all deficiencies and areas of noncompliance with applicable law; (ii)

identification of the applicable statutes, rules, codes, or standards that were violated; and (iii) the factual basis for each deficiency or violation.

(210 ILCS 85/9.5 new)

Sec. 9.5. Reviewer quality improvement. The Department must implement a reviewer performance improvement program for hospital survey, inspection, and investigation staff. The Department must also, on a quarterly basis, assess whether its surveyors, inspectors, and investigators: (i) apply the same protocols and criteria consistently to substantially similar situations; (ii) reach similar findings and conclusions when reviewing substantially similar situations; (iii) conduct surveys, inspections, or investigations in a professional manner; and (iv) comply with the provisions of this Act. The Department must also implement continuing education programs for its surveyors, inspectors, and investigators pursuant to the findings of the performance improvement program.

Sec. 4. Health Facilities Planning Board; membership; appointment; term; compensation; quorum. There is created the Health Facilities Planning Board, which shall perform the ~~such~~ functions ~~as hereinafter~~ described in this Act.

Notwithstanding any provision of this Section to the contrary, the term of office of each member of the State Board is abolished on the effective date of this amendatory Act of the 93rd General Assembly, but all incumbent members shall continue to exercise all of the powers and be subject to all of the duties of members of the State Board until all new members of the 9-member State Board authorized under this amendatory Act of the 93rd General Assembly are appointed and take office. Beginning on the effective date of this amendatory Act of the 93rd General Assembly, the State Board shall consist of 9 voting members. No person shall be appointed as a State Board member if that person has served, after the effective date of this amendatory Act of the 93rd General Assembly, 2 3-year terms as a State Board member, except for ex officio non-voting members. The Governor shall designate one of the members to serve as Chairman

Sec. 6. Application for permit or exemption; exemption regulations. The State Board shall establish by regulation the procedures and requirements regarding issuance of exemptions. An exemption shall be approved when information required by the Board by rule is submitted. Projects eligible for an exemption, rather

than a permit, include, but are not limited to, change of ownership of a health care facility. For a change of ownership of a health care facility between related persons, the State Board shall provide by rule for an expedited process for obtaining an exemption.

Sec. 10. Presenting information relevant to the approval of a permit or certificate or in opposition to the denial of the application; notice of outcome and review proceedings.

Such person or organization shall be afforded an opportunity for a hearing before a hearing officer, who is appointed by the Director ~~State Board~~. The State Board shall schedule a hearing, and the Director ~~Chairman~~ shall appoint a hearing officer within 30 days thereafter. The hearing officer shall take actions necessary to ensure that the hearing is completed within a reasonable period of time, but not to exceed 90 days, except for delays or continuances agreed to by the person requesting the hearing. Following its consideration of the report of the hearing, or upon default of the party to the hearing, the State Board shall make its final determination, specifying its findings and conclusions within 45 days of receiving the written report of the hearing.

APPENDIX B
The Elderly, Budget, Staff Size and Volume

States	65 & over	Budget	Staff Size	Volume	Volume Percent
New York	2423797	*	46	385	17.07
Illinois	1500025	1800000	5	100	4.43
New Jersey	1113136	1700000	19	116	5.14
Michigan	1219018	1191020	10	195	8.64
Florida	2963204	1100000	12	113	5.01
Tennessee	703311	1100000	9	118	5.23
Georgia	785275	832513	10	88	3.90
North Carolina	1011370	815000	12	*	0.00
Alabama	599477	735000	6	51	2.26
Connecticut	470183	678019	7	65	2.88
Virginia	792353	596000	6.5	95	4.21
South Carolina	492970	580500	9	92	4.08
New Hampshire	147796	500000	5	7	0.31
Washington	679588	492000	4	29	1.29
Ohio	1494482	370524	4.3	39	1.73
Kentucky	500501	365700	2.5	203	9.00
Rhode Island	150547	359601	3	9	0.40
Maryland	600000	356358	6	154	6.83
Massachusetts	860162	352124	4	29	1.29
Mississippi	343523	350000	5	44	1.95
Arkansas	374019	301438	4	15	0.66
Alaska	38603	268000	2	6	0.27
Oklahoma	427226	250000	4.1	114	5.05
Missouri	792119	209000	3	72	3.19
Maine	173798	150000	2.5	8	0.35
Vermont	75255	140000	*	14	0.62
Wisconsin	697310	100000	1.5	2	0.09
Iowa	436312	80508	1	17	0.75
Nebraska	228829	50000	1	*	0.00
Montana	124550	26000	1	*	0.00
Louisiana	516929	*	1	*	0.00
Oregon	440038	*	0.75	2	0.09
West Virginia	276677	*	4	59	2.62
Nevada	249047	*	1	5	0.22
Hawaii	160601	*	0	*	0.00
Delaware	102086	*	1	8	0.35
D.C.	69898	*	1.5	2	0.09

* Data not reported.
Source: National survey of State CON programs, AHPA, February 2004.

APPENDIX C

Relative Scope and Review Thresholds

As of February, 2004

Rank	Categories	Acute Care	Air Ambulance	Amb Surg Cntrs	Burn Care	Business Cmptrs.	Cardiac Cath.	CT Scanners	Gamma Knives	Home Health	ICF/MR	Lithotripsy	Long Term Care	Med Off Bldg	Mobile HI Tech	MRI Scans	Neo-ntl Int Care	Obstetrics Svcs	Open Heart Svcs	Orgn Transplnt	PET Scnrs	Psych Svcs	Rad Therapy	Rehab	Renal Dialysis	Res Care Fac	Subactute	Substance Abuse	Swing Beds	Ultra-Sound	Other (items not | otherwise covered)	Count (no. of svcs.)	$ Nrsg hm/hops Reviewability Thresholds Capital	Med Eqpt	New Svc	Weight
31.2	Maine																															24	0.5M/0.2M	1,000,000	100,000	1.3
28.8	Connecticut																															24	1,000,000	400,000	0	1.2
26.0	Alaska																													Asstd Lvng		26	1,000,000	1,000,000	1,000,000	1.0
22.5	Vermont																															25	3.0/1.5M	1,000,000	500,000	0.9
20.9	Georgia																															19	1,250,199	694,556	any	1.1
20.7	West Virginia																													Bhvrl hlth		23	2,000,000	2,000,000	23 svcs	0.9
20.0	South Carolina																															20	2,000,000	600,000	1,000,000	1.0
18.4	North Carolina																													IC & others		23	2,000,000	750,000	n/a	0.8
17.0	Mississippi																															17	2,000,000	1,500,000	any	1.0
16.8	Tennessee																													Hospice, meth		21	2,000,000	1,500,000	any beds	0.8
16.1	Dist of Columbia																															23	2,500,000	1,500,000	600,000	0.7
15.2	Rhode Island																															19	2,000,000	1,000,000	750,000	0.8
15.0	New York																															25	3,000,000	3,000,000	any	0.6
15.0	Hawaii																															25	4,000,000	1,000,000	any	0.6
14.4	Maryland																													fed swng bd		16	1,500,000	n/a	any	0.9
14.4	Michigan																													Hosp & Surg		18	2,500,000	any	any clin.	0.8
14.4	Kentucky																													Mobile srvs		18	1,870,973	1,870,973	n/a	0.8
12.8	Washington																													Hospice		16	var. by srv	n/a	any	0.8
12.6	New Hampshire																															14	1,924,579	400,000	any	0.9
12.1	New Jersey																															11	1,000,000	1,000,000	any	1.1
11.9	Illinois																													Othe r		17	6,543,050	6,293,090	any	0.7
10.8	Alabama																													ESRD & ALC		18	4,108,000	2,054,000	any	0.6
8.0	Virginia																													MSI, SPECT		20	5,000,000	n/a	n/a	0.4
7.7	Florida																													Hospice		11	none	none	any	0.7
4.8	Massachusetts																													ECMO		16	10,392,634	651,209	all	0.3

Source: 2004 National Directory of Health Planning, Policy and Regulatory Agencies, published by the American Health Planning Association.

APPENDIX D
Legislative Activities

IMPROVING/STREAMLINING CON

Alaska. Currently working on a new health facilities plan. Home health, hospice, residential care and assisted living methodology changes are under development and study.

Connecticut. Currently evaluating need, utilization and capacity of cardiac services. There is an issue of a level playing field: In 2003, the Assembly made permanent Public Act 03-274 that provides for consistent application of certificate of need requirements to all providers offering the same type of services (e.g., physician office surgery). PA 03-274 requires outpatient surgical facilities using specified levels of sedation or anesthesia to obtain a license from the Department of Public Health (DPH) and a Certificate of Need (CON) from the Office of Health Care Access (OHCA).

- Senate Bill 212: CON letter of intent only accepted with all required information
- Senate Bill 360: Nursing home must file letter of intent before terminating service or decreasing bed capacity.

Michigan. In 2003, there were revisions to review standards for hospital beds, open heart surgery, and cardiac catheterization.

District of Columbia. The comprehensive Health Plan is currently being updated.

Maine. New CON statute provides opportunity for full public comment to be included in the record of a pending application. Increased monetary thresholds required for review. In 2002, Senate Bill 619 was enacted to prohibit building or financing a project that requires a CON without a CON. Specifies what actions require a CON. Specifies facilities for which a CON does not apply. Establishes criteria for subsequent review of a CON.

Kentucky. In 2002, Senate Bill 185 was enacted to require CON for respite beds in ICF/MRs

CUTTING BACK CON AND PHASING OUT CON

Virginia. Was scheduled to sunset its program in 2002 but then decided to retain it. Major action was taken on the CON program in 2000. State lawmakers enacted legislation requiring the Joint Commission on Health Care to develop a plan for eliminating the CON program. The plan was submitted for review to the 2001 General Assembly. The transition was scheduled to take place starting July 1, 2001, and be completed by July 1, 2004. In 2003, a bill passed allowing the combined batching of diagnostic imaging and radiation therapy requests.

Georgia. Stripped a handful of medical services from the law in 2003.

Delaware. In 2003, a bill was passed to require CON review for change of ownership of non-profit hospitals, nursing homes, freestanding birthing centers, freestanding emergency centers, and freestanding surgical centers. In 2002, Senate Bill No. 305 was signed into law on May 9, 2002 and changed the sunset date to June 30, 2005

Florida. Early this year, Governor Jeb Bush announced a health insurance reform package that would revise the CON process for health care facilities. He proposed a major

deregulation of the state's hospital industry. Quality, instead of market share, would become the standard a hospital must meet.

Massachusetts. Legislation establishing a task force to study expansion of open-heart surgery programs in community hospitals and to issue three Section 100.308 exemptions to three community hospitals.

Nebraska. Major changes occurred in the CON Act with legislation in 1997. It phased out virtually all of the state's CON laws. The Nebraska law included a two-year moratorium on new hospital and nursing home beds and phased out the CON review of ambulatory surgical centers by the end of 1999.

New Jersey. In 2001, ACR155 determined that proposed DHSS changes to its certificate of need regulations for cardiac diagnostic facilities and cardiac surgery centers were inconsistent with the legislative intent. In 2000, deregulation was made of subacute beds, MRI, hyperbaric chambers, ambulatory surgery, and linear accelerators. CON Study Commission report on March, 2000 recommended retention of most CON functions.

North Carolina. Effective August 7, 2003 detoxification beds were no longer regulated by CON. In 2001, Established CON requirements for adult care homes.

PENDING THE DECISION

Illinois. Significant revisions to the CON administrative rules commenced in April, 2000. The 2003 Act extended CON statute to June 30, 2008, increased the threshold for CON review, had only clinical projects reviewed and reduced the size of the State Board from 15 to 9 consumer members appointed by the governor.

Iowa. Legislation was introduced in 2003 to eliminate or erode CON standards. House Bill 2416 amended CON rules for intermediate care facilities for persons with mental retardation (ICF/MRs)

Mississippi. In 2003, House Bill 1429 permitted limited expansion of adolescent psychiatric residential treatment facility beds and certain long-term care facility beds within the state. In 2001, extended a CON exemption to certain continuing care retirement home facilities.

Missouri. In 2003, Missouri repealed its oversight of expansion and renovation projects for acute-care hospitals while retaining its regulatory review of new construction.

Nevada. In 2003, CON applies only to new construction over $2 million in rural counties. Counties without a hospital within a 45-minute drive of the nearest trauma center are exempt from CON for a new hospital. CON now required for new medical helicopter services.

New Hampshire. State legislators are considering doing away with a board that approves the construction of health facilities. Under a bill passed last week by the state House, the state Health Services and Planning Review Board would be abolished and the state Health and Human Services department (DHHS) would take full control of the CON process. DHHS will be required to issue a report every two years on the health status of its citizens.

APPENDIX E

Hospital Closures in Illinois, 1980 to 2003, Illinois Hospital Association

Hospital	City	Location	Closed	Beds	FTE Employees
Chicago Eye, Ear, Nose & Throat Hsp	Chicago	Large Urban	1982	37	N/A
Hillman Memorial Hospital	Manteno	Other Urban	1983	16	35
Chicago Center Hospital	Chicago	Large Urban	1985	144	459
Henrotin Hospital	Chicago	Large Urban	1985	201	403
Salvation Army Booth Hospital	Chicago	Large Urban	1985	19	69
Beardstown Health Care Complex	Beardstown	Rural	1986	50	79
Southern Medical Center	Cairo	Rural	1986	44	84
Woodlawn Hospital	Chicago	Large Urban	1986	145	291
Paxton Community Hospital	Paxton	Rural	1987	29	62
Provident Medical Center[1]	Chicago	Large Urban	1987	180	455
Saunders Hospital	Avon	Rural	1987	20	28
Walther Memorial Hospital[2]	Chicago	Large Urban	1987	119	361
Frank Cuneo Memorial Hospital	Chicago	Large Urban	1988	100	274
Hospital of Englewood	Chicago	Large Urban	1988	121	333
Mary Thompson Hospital	Chicago	Large Urban	1988	203	372
White Hall Hospital	White Hall	Rural	1988	30	59
Gateway Community Hospital	East St. Louis	Large Urban	1989	126	274
Lutheran General-Lincoln Park[3]	Chicago	Large Urban	1989	330	592
Mt. Sinai Hospital-North	Chicago	Large Urban	1989	135	202
Pearce Hospital Foundation	Eldorado	Rural	1989	72	140
St. Anne's Hospital	Chicago	Large Urban	1989	239	705
Central Community Hospital	Chicago	Large Urban	1990	110	312
Douglas County Jarman Mem Hsp	Tuscola	Rural	1990	43	88
La Harpe Hospital	La Harpe	Rural	1990	64	58
Lakeside Community Hospital	Chicago	Large Urban	1991	91	155
Martha Washington Hospital	Chicago	Large Urban	1991	175	445
Savanna City Hospital	Savanna	Rural	1993	18	62
Fairbury Hospital	Fairbury	Rural	1994	113	135
Oakwood Hospital of Rockford[4]	Rockford	Other Urban	1994	60	127
Adolph Meyer Mental Health Center[4]	Decatur	Other Urban	1996	114	175
Columbia Chicago Osteo Hsps & MC	Chicago	Large Urban	1996	262	226
CPC Old Orchard Hospital[4]	Skokie	Large Urban	1996	133	31
Saint Cabrini Hospital	Chicago	Large Urban	1996	190	460
Central Community Hospital	Clifton	Rural	1997	33	50
Columbia Chicago Lakeshore Hsp-So[4]	Chicago	Large Urban	1997	123	235
Metro Child & Adolescent Institute[4]	Chicago	Large Urban	1997	83	226
University Hospital[4]	Chicago	Large Urban	1997	102	197
OSF Saint Joseph Hospital	Belvidere	Other Urban	1999	58	202
Doctors Hospital of Hyde Park	Chicago	Large Urban	2000	200	627
Forest Hospital[4]	Des Plaines	Large Urban	2000	80	172
Wood River Township Hospital	Wood River	Large Urban	2000	55	196
Columbus Hospital	Chicago	Large Urban	2001	128	533
Edgewater Medical Center	Chicago	Large Urban	2001	213	612
UMW of America Union Hospital	W. Frankfort	Rural	2001	20	54
Advocate Ravenswood Med. Center	Chicago	Large Urban	2002	324	1,495
Rock Creek Center[4]	Lemont	Large Urban	2002	88	161
Doctors Hospital	Springfield	Other Urban	2003	319	63
Total				5,559	12,374

APPENDIX F
A Five-Year History of Approval/Denial

Approval/Denial by Facility Type

Table 1. Illinois: Final Decisions, Approval/Denial on Projects

Facility Type	Approved					Denied				
	2003	**2002**	**2001**	**2000**	**1999**	**2003**	**2002**	**2001**	**2000**	**1999**
Hospital	29	45	36	42	60	0	0	0	0	1
Psychiatric Hospital/Unit	n/a	n/a	n/a	n/a	n/a	0	0	0	0	0
Residential Health Care Facility*	7	16	13	15	15	0	0	0	1	2
Diagnostic & Treatment Centers	18	29	30	31	49	0	0	1	1	1
TOTAL	54	90	79	88	124	0	0	1	2	4

Source: Certificate of Need Report, Illinois CON Board

Table 2. New York: Final Decisions on Public Health Council Establishment Projects Only

Facility Type	Approved					Denied				
	2003	**2002**	**2001**	**2000**	**1999**	**2003**	**2002**	**2001**	**2000**	**1999**
Hospital	9	7	9	12	16	0	0	0	0	0
Residential Health Care Facility	55	27	15	22	30	1	1	0	0	0
Diagnostic & Treatment Centers	67	46	39	39	70	3	3	0	1	1
Home Health Agency	11	5	9	7	7	0	0	0	0	0
Hospices	2	0	4	1	0	0	0	1	0	0
Central Services Facilities*	0	0	0	0	0	0	0	0	0	0
TOTAL	144	85	76	81	123	4	4	1	1	1

Source: Certificate of Need Annual Report (for each respective year 1999-2003)

Table 3. New Jersey: Initial Decisions, Approval/Denial on Projects

Facility Type	Approved					Denied				
	2003	**2002**	**2001**	**2000**	**1999**	**2003**	**2002**	**2001**	**2000**	**1999**
Hospital	61	14	22	10	22	1	2	6	1	4
Psych Hosp/Unit & Drug/Alc Treat Cntr	0	0	1	2	12	0	0	0	0	3
Residential Health Care Facility*	29	33	48	50	99	0	0	0	1	0
D&T & Surg Center	0	0	0	0	14	0	0	0	0	0
TOTAL	90	47	71	62	147	1	2	6	2	7

Source: Certificate of Need Application Status Report for 1998 to Present (this was a special print out by request)

Table 4. Michigan: Final Decisions, Approval/Disapproval on Projects

Number of Final Decisions				
	Approved	Approved With Conditions	Disapproved	Totals
FY1998	185	1	9	195
FY1999	178	6	2	186
FY2000	153	11	4	168
FY2001	182	4	12	198
FY2002	210	6	8	224
Total Project Costs				
FY1998	$853,035,470	$50,000	$8,496,000	$861,581,470
FY1999	$461,603,485	$42,956,484	$246,910	$504,806,879
FY2000	$467,085,573	$16,666,330	$5,818,762	$489,570,665
FY2001	$974,220,693	$3,205,149	$9,316,888	$986,742,730
FY2002	$1,030,698,218	$11,898,680	$22,141,586	$1,064,738,484

Source: Table 12 Comparison Of Final Decisions By Decision Type FY1998 - FY2002

Table 5. Florida: The Number of Applications Reviewed and Approved* by Facility Type and Review Type

Type		1998			1999			2000			2001			2002		
Facility	Review	Rev	App	Den	Rev	App	Den	Rev	App	Den	Rev	App	Den	Rev	App	Den
Hospital	Comp	86	37	49	67	34	33	60	17	43	78	23	55	79	31	48
	Exp	10	9	1	5	4	1	6	5	1	14	13	1	4	1	3
Nursing Home	Comp	65	23	42	46	26	20	17	10	7	10	5	5	5	5	0
	Exp	24	19	5	19	14	5	23	12	11	3	0	3	6	0	6
Other	Comp	4	3	1	5	3	2	4	3	1	4	1	3	1	1	0
	Exp	23	7	16	13	8	5	25	12	13	15	12	3	5	4	1
Total	All	212	98	114	155	89	66	135	59	76	124	54	70	100	42	58

* initial approvals only; does not reflect results of any appeals.

Abbreviations: Rev=Reviewed; App=Approved; Den=Denied/Withdrawn; Comp=Comparative; Exp=Expedited;

Source: Table 3 - Projects Proposed and Agency Action by Type of Review for Applications Reviewed from 1998 through 2002, 2002 CON Annual Report, Agency for Health Care Administration, Florida Department of Health and Human Services

Table 6. Florida: Litigation Activity By Type Of Review

	# Initially denied	Denial appealed (1)	% Appealed	Final Decision Complete (2)	% Complete	Final Same as Initial (3)	% Same as Initial
1998	114	65	57.0%	65	100.0%	44	67.7%
1999	66	36	54.5%	30	83.3%	19	63.3%
2000	76	46	60.5%	39	84.8%	22	56.4%
2001	70	51	72.9%	31	60.8%	17	54.8%
2002	58	30	51.7%				

Note. (1) Appealed within 21 days after publication of the initial decisions for the last batching cycle of the year (therefore, appeal status is determined as of the third week in January of the following year). (2) As of February 2003, Final Action as specified in a Settlement Agreement with the applicant, or after consideration of the Administrative Law Judge's Recommended Final Order, or consistent with an order of the District Court of Appeal. (3) Final Action affirmed an initial denial (or initial withdrawal).
Source: Table 6 - Characteristics Of Litigation Activity By Type Of Review And Agency Action Applications Reviewed From 1998 Through 2002 Projects Initially Denied

Bed Changes

Table 7. Illinois: Final Decision on Bed Changes

Bed Changes	**Hospitals**		**Long-Term Care Facilities**	
	New	Discontinued	New	Discontinued
2003	74	-185	206	-540
2002	204	-335	199	-1244
2001	173	-1076	329	-750
2000	220	-735	240	-781
1999	48	-405	1158	-422
TOTAL	719	-2736	2132	-3737

Source: Certificate of Need Report, Illinois CON Board

Table 8. New York: Initial Recommendations on Bed Changes by State Council

Beds	**Hospitals**					**Residential Health Care Facilities**				
	Approved			**Denied**		**Approved**			**Denied**	
	New	Decertified	Converted	New	Converted	New	Decertified	Converted	New	Converted
2003	300	2	54	0	18	2	0	0	0	0
2002	65	0	55	0	0	104	0	0	0	0
2001	24	542	34	0	0	0	79	11	0	0
2000	115	546	4	0	0	522	19	0	0	0
1999	83	0	5	0	0	756	25	0	0	0
TOTAL	509	1104	161	0	18	647	98	11	0	0

Source: Certificate of Need Annual Report (for each respective year 1999-2003)

Table 9. Florida: The Number of Beds Requested and Approved by Bed Type

	1998		1999		2000		2001		2002	
Hospital	Req	App	Req	App	Req	App	Req	App	Req	App
New Beds	1254	340	584	244	872	141	1557	542	1940	638
All Beds*	1903	719	1589	982	1398	519	2832	1612	4022	1609
NH										
New Beds	1557	402	1882	540	487	324	515	189	0	0
All Beds*	2699	925	2939	1201	487	324	622	236	168	168

Abbreviations: Req=Requested; App=Approved.
Note. Initial decisions only; does not reflect results of any appeals. Includes partial approvals.
* Including beds that were converted and transferred, excluding beds that were exempted.

Table 10. New Jersey: The Number of Beds Approved and Denied by Type of Facility, Initial Decisions

	Hospitals						**Residential Health Care Facilities***					
	Approved			**Denied**			**Approved**			**Denied**		
Bed Change	New	Transfer/ Converted	Decertified /Closed	New	Transfer/ Converted	De Decertified /Closed	New	Transfer/ Converted	Decertified /Closed	New	Transfer/ Converted	Decertified /Closed
2003	303	9	120	0	0	0	604	4	0	0	0	0
2002	25	110	0	0	0	0	564	317	0	0	0	0
2001	0	0	0	0	0	0	1341	492	0	0	0	0
2000	24	7	291	20	0	0	1846	607	0	67	0	0
1999	36	70	63	0	0	0	5808	175	118	0	0	0
TOTAL	388	196	474	20	0	0	10163	1595	118	67	0	0

Source: Certificate of Need Application Status Report for 1998 to Present (this was a special print out by request)

APPENDIX G

Certificate of Need Agency Directory
As of March 31, 2004

	Contact person	Address	Telephone & Fax	Website
Alaska	David Pierce Certificate of Need Coordinator Section of Community Health and Division of Public Health David_Pierce@health.state.ak.us	Department of Health and Social Services P.O. Box 110616 Juneau, AK 99811-0650	Tel: 907 465-3001 Fax: 907 465-1733	http://health.hhs.state.ak.us/dph/chems/cert_of_need/
Alabama	Set Subject line to CON Board or SHCC info@shpda.state.al.us Swaid Swaid, MD; Chair (Through 2006)	State Health Planning and Development Agency P.O. Box 303025 Montgomery, Alabama 36130-3025	Tel: 334 242-4103 Fax: 334 242-4113	http://www.shpda.state.al.us/
Connecticut		Office of Health Care Access 410 Capitol Avenue MS# 13HCA PO Box 340308 Hartford, CT 06134-0308		www.ohca.state.ct.us
Delaware **District of Columbia**	Gerald Llewellyn, PhD, President Tel: 302 739-6617 Fax: 302 739-6617	Certificate of Public Review (CPR) Health Resources Board	Tel: 302 739-4776	http://delaware.gov/
Florida	Certificate of Need Unit Karen Rivera, Supervisor Tel: 850 488-8673 riverak@fdhc.state.fl.us	Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308	Toll Free: 888 419-3456	http://www.fdhc.state.fl.us/MCHQ/CON_FA/index.shtml

Georgia	Tel: 404-657-2700 gdphinof@dhr.state.ga.us	Health Planning Agency Division of Public Health 2 Peachtree St. NW Atlanta, GA 30303-3186	CON Tel: 404 657-6320	http://www.communityhealth.state.ga.us/
Hawaii	Daryl Shutter, CON Analyst Tel: 808-586-4419	Department of Health Chiuyome Fukino, MD, Director State Health Planning and Development Agency (SHPDA) 1177 Alakea Street, #402 Honolulu, HI 96813	Tel: 808 587-0788 Fax: 808 586-4444	http://www.hawaii.gov/health/shpda.htm
Illinois	Marc Gibbs Tel: 217-782-3516	Illinois Health Planning Facilities Board Illinois Department of Public Health 535 West Jefferson Street, Springfield, IL, 62761	Tel: 217 782-6553 Fax: 217 523-2648 TTY: 800 547-0466	http://www.idph.state.il.us/
Iowa	Jane Colacecchi, Director Tel: 515 281-7689	Iowa Department of Public Health Lucas State Ofc. Bldg 321 E. 12th Street Des Moines, IA 50319	Tel: 515 281-7689	http://www.idph.state.ia.us/admin/cert_of_need.asp
Kentucky		Office of Certificate of Need 275 East Main Street HS 1E-D Frankfort, KY 40621	Tel: 502 564-9589 Fax: 502 564-0302	http://www.chs.state.ky.us/cofn/
Louisiana				http://www.legis.state.la.us/
Maine	Chris Zukas-Lessard, Acting Director Tel: 207 287-2674	Bureau of Medical Services 442 Civic Center Drive		http://www.state.me.us/bms

	Division of Finance & Reimbursement Craig Hitchings, Acting Director Tel: 207 287-3833 Bill Perfetto, Assistant Director & CON Unit Director Tel: 207 287-2769 CON Analysts: Steven King Tel: 207-287-1836 Brad Ronco Tel: 207-287-3757	11 State House Station, Augusta, ME 04333		
Maryland	CON Unit	Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215.	Tel: 410 764-3460 Fax: 410 358-1236	www.mhcc.state.md.us
Massachusetts	Joyce James, Director of DON	Determination of Need Program (DON) 250 Washington Street Boston, Massachusetts 02108	Tel: 617 624-5002	http://www.state.ma.us/dph/dhcq/don.htm
Michigan	Renee Turner-Bailey - CON Commission Chairperson (Democrat) Term Expires: January 1, 2006 Tel: 313 323-0711 E-mail: rtbailey@ford.com	State of Michigan Department of Community Health - Certificate of Need Program Lewis Cass Building, 320 S. Walnut Street Lansing, MI 48913	Tel: 517 241-3343 Fax: 517 241-2962	http://www.michigan.gov/mdch/0,1607,7-132-2945_5106_5409---,00.html
Mississippi	Harold B. Armstrong, Bureau Chief	Mississippi State Department of Health	Tel: 601 576-7400	http://www.msdh.state.ms.us/msdhsite/index.cfm/33,0,198,html

		570 East Woodrow Wilson Drive, Jackson MS 39216 Postal Address: Post Office Box 1700 Jackson, MS 39215-1700		
Montana	Pamela Sourbeer dphhstech@state.mt.us	Quality Assurance Division Certificate of Need Program 2401 Colonial Drive, 3rd Floor, PO Box 202956, Helena, Montana 59620-2953	Tel: 406 444-9519	http://www.dphhs.state.mt.us/about_us/divisions/quality_assurance/certificate_of_need/certificate_of_need.htm
Nebraska	Claire Titus, Program Manager Tel: 402 471-4963 claire.titus@hhss.state.ne.us	Credentialing Division State Office Building 301 Centennial Mall South, (14th and M Street) 3rd Floor PO Box 94986 Lincoln, NE 68509	Tel: 402 471-2115 Fax: 402 471-3577	http://www.hhs.state.ne.us/crl/need.htm
Nevada	Emil Dejan, Bureau Chief	Bureau of Health Planning and Statistics 505 E. King Street Room 102 Carson City NV 89701-4749	Health Planning Tel: 775 684-4218	http://health2k.state.nv.us/vs/letter.htm
New Hampshire		Department of Health Services Office of Community & Public Health Health Service Planning Review 29 Hazen Drive Concord, NH 03301	Tel: 603 271-4606 Fax: 603 271-4141	http://www.dhhs.state.nh.us
New Jersey	*Health Care Systems Analysis* *Administrative/Regulatory Programs* *Marilyn Dahl*	CON and Acute Care Licensure Program New Jersey State Department	Tel: 609 292-6552	http://www.state.nj.us/health/hcsa/hcsadmin.htm#CN

	Senior Assistant Commissioner *Tel: 609-984-3939* CON and Acute Care Licensure Program John Calabria, Director Tel: 609-292-8773 John.calabria@doh.state.nj.us	of Health and Human Services PO Box 360 Room 403 Health Agriculture Building John Fitch Plaza Trenton, NJ 08625		
New York	Edward H. Brown, Jr., Chair foil@health.state.ny.us	Division of Health Facility Planning Records Access Office New York State Department of Health Empire State Plaza Corning Tower, Room 2348 Albany, NY 12237-0044 Or Records Access Office New York State Department of Health Empire State Plaza Corning Tower, Room 2348 Albany, New York 12237-0044	Fax: 518 486-9144	http://www.health.state.ny.us
North Carolina	Department of Health and Human Services Certificate of Need Lee Hoffman, Chief Tel: 919-855-3873 Lee.Hoffman@ncmail.net	North Carolina Division of Facility Services *Certificate of Need Section* 2704 Mail Service Center Raleigh, NC 27696-2704	Tel: 919 855-3873	http://facility-services.state.nc.us/conpage.htm
Ohio	CON@gw.odh.state.oh.us	Ohio Department of Health Certificate of Need Program	Tel: 614 466-3325	http://www.odh.state.oh.us/ODHPrograms/CERTN/certneed1.htm

		246 North High Street P.O. Box 118 Columbus, OH 43216-0118	Fax: 614 752-4157	
Oklahoma	ltccomplaints@health.state.ok.us	Long Term Care Service Location: 1000 N.E. Tenth, Room 1001, Okla. City, Ok 73117	Tel: 405 271-6868 Fax: 405 271-3442	http://www.health.state.ok.us/program/ltc/
Oregon	Jana Fussell	Portland State Office Building 800 N.E. Oregon Street Portland, OR 97232	Tel: 503 731-4320	http://www.dhs.state.or.us/publichealth/hsp/certneed/index.cfm
Rhode Island	Division of Health Services Regulations Michael Dexter Tel: 401 222-2788	Office of Health Systems Development 3 Capitol Hill Room 407 Providence, RI 02908 Or Office of Health System Development Cannon Building Providence, RI 02908	Tel: 401 222-6015	www.health.ri.gov
South Carolina	State Health Planning Committee Joel Grice	Division of Planning & Certification of Need 2600 Bull Street Columbia, SC 29201	Tel: 803 545-4200	http://www.scdhec.net/hr/cofn/
Tennessee	Melanie M. Hill, Executive Director E-mail: Melanie.Hill@state.tn.us	Health Services and Development Agency Andrew Jackson Building, Suite 850 500 Deaderick Street	Tel: 615 741-2364 Fax: 615 741-9884	http://www.state.tn.us/hsda/cert_need_sum.html

		Nashville, TN 37247 Or 1st Floor, Cordell Hull Building 425 Fifth Avenue, North Nashville, TN 37247		
Vermont	Stan Lane, Health Policy Administrator Slane@BISHCA.state.vt.us Paulette Thabault, Deputy Commissioner Bruce Spector, Counsel CON Review: Donna Jerry, Health Policy Administrator Janeen Coyle, Administrative Support	Department of Banking, Insurance, Securities and Health Care Administration 89 Main Street, Drawer 20 Montpelier, VT 05620-3601	Tel: 802 828-3301 Fax: 802 828-3306	http://www.bishca.state.vt.us
Virginia		Center for Quality Health Services and Consumer Protection Virginia Department of Health P.O. Box 2448 Richmond, VA 23218-2448 1500 East Main Street Richmond, VA 23219 Or Virginia Department Health 3600 West Broad Street, Suite 216 Richmond, VA 23230	Tel: 804 367-2126 Fax: 804 367-2206	www.vdh.state.va.us/quality/default.htm
Washington	email: fslcrs@doh.wa.gov	Washington State Department of Health Construction Review Services P.O. Box 47852 Olympia, WA 98504-7852	Tel: 360 236-2944 Fax: 360 236-2901	http://www.doh.wa.gov/hsqa/FSL/CRS/certificate_need.htm
Washington D.C.	CON Unit: Michael Anderson	District of Columbia State Health Facility Planning and	Tel: 202 727-1000	http://www.dchealth.dc.gov

	John A. Wilson Building 1350 Pennsylvania Avenue, NW Washington, DC 20004	Development Agency (SHPDA) 825 N. Capital Street NE Washington, DC 20002		
West Virginia	Health Care Authority Sonia D. Chambers, Chair schambers@hcawv.org	Department of Health and Human Resources State Capitol Complex, Building 3 Room 206 Charleston, WV 25305	Tel: 304 558-0684 Fax: 304 558-1130	www.chawv.org

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