

To: Health Advocates<sup>1</sup>  
From: Jane Perkins  
National Health Law Program  
Date: September 19, 2005  
  
Re: September Q&A—State Certificate of Need Review

Question: The nursing home in my area is proposing to add more beds. Meanwhile, there is a waiting list for the home and community based care services which are offered to Medicaid beneficiaries through a Medicaid waiver. Pursuant to this waiver, Medicaid beneficiaries who meet the nursing home level of care can be cared for at home. It seems to me that the nursing home beds are not needed but that additional home and community based waiver slots are. I am hesitant to file a Medicaid or Americans with Disabilities Act case to challenge the expansion of nursing home beds. Can you suggest other avenues that I might pursue?

Short Answer: Yes. If your state has a certificate of need (CON) program, the nursing home may need to seek permission from the state planning agency before it can add the beds, and you may be able to intervene and participate in this review on behalf of your organization or your clients.

Discussion: Since the 1970s, health planning has played a role in determining the nature and extent of the health care delivery system in the United States. The National Health Planning and Resources Development Act of 1974 required states to adopt state health plans and certificate of need review procedures as a condition on the receipt of federal funding. *See* 42 U.S.C. 300k-1 *et seq.* The states passed certificate of need requirements to implement this federal legislation. On November 14, 1986, the National Health Planning and Resources Development Act was repealed. *See* Pub. L. No. 99-660, Title VII, 701(a), 100 Stat. 3799 (effective Jan. 1, 1987). However, a number of states have maintained certificate of need or similar requirements.

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OTHER OFFICES

## *Background to the state CON process*

Most states use a health planning/certificate of need process. Some states call their certification process a “determination of need.” The states with CON provisions are: Alaska, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Michigan, Nebraska, New Hampshire, Maine, Massachusetts, Mississippi, Missouri, Montana, New Jersey, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Virginia, Washington, and West Virginia.<sup>2</sup>

The states’ CON programs continue to be modeled on the now-repealed Health Planning and Resources Development Act. Thus, all states’ programs have a similar purpose, which, as described a South Carolina statute, is to:

promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State. To achieve these purposes, this article requires:

- (1) the issuance of a Certificate of Need before undertaking a project prescribed by this article;
- (2) adoption of procedures and criteria for submittal of an application and appropriate review before issuance of a Certificate of Need; [and]
- (3) preparation and publication of a State Health Plan; . . . .<sup>3</sup>

Responsibility for the planning process rests with a state agency. States refer to their planning agencies by different names, such as the State Health Planning Commission (Maryland), the State Health Planning and Development Agency (West Virginia), or the Health Facilities Planning Board (Illinois). Your state may also have Health Systems Agencies (HSAs), which are local planning entities that engage in data collection and analysis. Under the old federal planning law, the HSAs

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<sup>2</sup> See Alaska Code § 18.07.031; Cal. Health & Safety Code § 127170; D.C. Code § 44-406; Conn. Gen. Stat. § 17b-351; Florida Code §§ 408.031 to .045; Georgia O.C.G.A. § 31-6-41; Hawaii Code § 323D-43; Illinois Compiled Statutes Annotated tit. 20, 3960/5; Indiana Code §§ 16-29-2-1 to 5-1; Kentucky Rev. Stat. Annotated § 216B.020; Massachusetts Gen’l Laws c. 111, §25B et seq.; Michigan Comp. Laws. §§ 333.22201 et seq.; Nebraska Code §§ 71-5801 to -5870; New Hampshire Code § 151-C:12; Maine Revised Statutes tit. 22, §§ 326-351; Mississippi Code §§ 41-7-171 to 209; Missouri Code §§ 197.300 to .367; Montana Code §§ 50-5-301 to -310; New Jersey Code § 26:2H-7; North Carolina Gen’l Stat. §§ 131E-175 to 190; Ohio Admin. Code §§ 3701-121-01 et seq.; Oklahoma Code tit. 63, § 1-850 et seq.; Oregon Code § 442.315; Rhode Island Gen’l Laws § 23-15-2; South Carolina Code Annotated §§ 44-7-110 to -370; Tennessee Code §§ 68-11-1607; Virginia Code Annotated § 32.1-102.1 et seq.; Washington Code § 70.38.115; and West Virginia Code § 16-2D-1 et seq.

<sup>3</sup> South Carolina Code § 44-7-120 (West 2005) (Declaration of Purpose).

would develop local health systems plans that were then used by the state planning agency to decide local and statewide needs.

As a prerequisite to financing and implementing a capital project, CON laws require that a health care provider must obtain certification from the state health planning agency that the project is needed. CON laws typically extend to hospitals and nursing homes, but also include kidney dialysis centers, health maintenance organizations, and home health agencies. The activities subject to CON review range from capital expansions (such as the addition of beds or renovation of the facility) to the provision of services (such as cardiac catheterization and home health).

### *The Review Process*

Generally, the review process is initiated when a health care provider submits a CON application to the state health planning agency. The application will be reviewed against formal Standards and Criteria, such as: the need for the project, the cost of the project and its feasibility, the availability of less costly alternatives, the extent to which the project meets the needs of medically underserved areas versus the extent to which it will add health care providers in an already well-served area, the project's impact on existing health care providers, community support for the project, relationship of the project to the State Health Plan (see below), the extent to which the project will address access barriers, and the impact of the project on the traditionally medically underserved.

These Standards and Criteria may be published as formal regulations, thus providing the public with notice and the opportunity to comment on the regulation before it is finalized. In other states, the Standards and Criteria are contained in agency manuals.

When assessing the need for the proposed project, states may also measure the application against a State Health Plan. The State Health Plan will typically set forth the projected health care needs of the state, by region, for a three to five year period. For example, the State Health Plan may use a numerical formula for determining the number of nursing home beds needed in the region over the next five years or require the utilization of existing facilities and services to reach a certain percentage before additional services may be added. The Plan is developed by experts at the state health planning agency who assess the current health care delivery system against current and projected demographic and technological trends in the state. In some states, such as Maryland, the State Health Plan is also published as a formal regulation and, as such, is a legally binding document. However, in other states, the State Health Plan is a "planning and development blueprint for health activities" but does not bind the state agency to act in accordance with it. *See Roanoke Memorial Hosp. v. Kenley*, 352 S.E.2d 525, 3 Va. App. 599 (Va. Ct. App. 1987).

CON applications will be the subject of an administrative review, particularly if the application is contested. Notice of the filing of a CON application should be published in the State Register or on the state health planning agency's website. The notice should provide information about the proposed project, the date and location of the administrative hearing, and deadlines for interested parties to intervene. Most states' laws allow "interested persons" to intervene in the CON review. Moreover, if they are adversely affected by an unfavorable decision, interested persons can appeal the decision to state court. The most common interested parties are, of course, competing health care providers; however, they are not the only parties entitled to participate.

The administrative review process varies somewhat from state to state, depending on the requirements of the state's Administrative Procedure Act. In most states, the CON applicant has the burden of proof during the administrative review.<sup>4</sup> In some states, the administrative hearing officer must make specific findings on the Standards and Criteria, while in other states, the hearing officer's decision need only to reflect that the evidence was considered against the proper criteria.<sup>5</sup> The administrative decision can approve or deny the application. It may also "approve with conditions," meaning that the applicant must fulfill specified conditions before it begins to implement the project or before the project comes on line. In the past, state agencies have been creative in imposing conditions, for example requiring the applicant to accept a certain percentage of Medicaid beneficiaries or to work with city transportation officials to secure bus routes from low income neighborhoods to the facility.

In an appeal from a decision granting a CON, the party filing the appeal bears the burden of proof that the application did not meet the review Standards and Criteria.<sup>6</sup> Again, while there is some variation, the CON decision is usually reviewed under a "substantial evidence" standard.<sup>7</sup>

There are numerous cases that illustrate how the CON process works. In a Vermont case, *In re Application of Assurcare of Vermont*,<sup>8</sup> the court upheld the review board's denial of Assurcare's application to operate a new Health Maintenance Organization. Measuring the application against "permissive criteria" and "required findings," the agency concluded that the HMO had not established the feasibility of the project. Among other things, the review board found that Assurecare did not

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<sup>4</sup> For cases mentioning burden of proof during the CON review, *see, e.g.*, *In re application of AssureCare of Vermont*, 686 A.2d 959 (Vt. S. Ct. 1996); *North Memorial Med. Ctr. v. Minnesota Dep't of Health*, 423 N.W.2d 737 (Minn. Ct. App. 1988) (based on CON statute now repealed).

<sup>5</sup> *Compare, e.g.*, *St. Mary's Hosp. v. State Health Planning and Development Agency*, 178 W.Va. 792, 364 S.E.2d 805 (Ct. App. 1987) (requiring CON ruling on all proposed findings and citation to appropriate statutory provisions along with underlying factual support), *with, e.g.*, *Bio-Medical Applications of Arlington, Inc. v. Kenley*, 4 Va. App. 414, 358 S.E.2d 722 (Ct. App. 1987) (stating that administrative decision need not make specific findings regarding each review factor).

<sup>6</sup> For CON cases discussing burden of proof during a state court appeal, *see, e.g.*, *Mississippi State Dep't of Health v. Mississippi Baptist Med. Ctr.*, 663 So.2d 563 (Miss. S. Ct. 1995); *Nebraska Dep't of Health v. Lutheran Hosp. & Homes Society of America*, 227 Neb. 116, 416 N.W.2d 222 (1987). *See also* *Alabama Association of Home Health Agencies, et al. v. ABC Home Health & Hospice of Alabama, Inc., Alabama State Health Planning Agency, et al.*, 601 So.2d 1027 (Ala. Ct. App. 1992) (denying injunctive relief to home health agencies challenging CON grant to a hospice under the doctrine of primary jurisdiction that the planning agency was the proper forum for determining issues regarding the CON program).

<sup>7</sup> For CON cases mentioning the standard of review, *see, e.g.*, *ACSR v. Cabinet for Health Services*, 32 S.W.2d 96 (Ky. Ct. App. 2000); *Manasota Osteopathic General Hosp., Inc. v. Dep't of Health & Rehab. Serv.*, 523 So.2d 710 (Fla. Ct. App. 1988); *Myers v. State, ex rel. Comprehensive Care Corp.* 503 N.E.2d 451 (Ind. App. 1st Dist. 1987).

<sup>8</sup> 686 A.2d 959 (Vt. S. Ct. 1996).

show the existence of an adequate network of providers or adequate support from the community, including support services and ancillary providers.<sup>9</sup>

In *Collier Medical Center, Inc. v. Dept. of Health and Rehabilitative Services*,<sup>10</sup> a Florida court upheld the planning agency's denial of a CON for a new hospital designed to serve only paying patients. The court based its decision on the adverse impact the approval would have upon two nearby competing hospitals serving large numbers of indigent patients. It found that the two competitors had standing to intervene in the administrative hearing because of their "substantive interest" being affected by the proceeding. The court went on to confirm the planning agency's decision denying the new facility as unnecessary and financially infeasible. The proposal was not financially feasible because it would duplicate services that were existing and available at the two competing hospitals. In addition, approval would have increased the intervenors' costs because the applicant planned to draw away the paying patients of its competitors, leaving them with non-revenue generating patients. The competitors successfully argued that they would, in turn, be forced to increase charges to their remaining paying patients. By contrast, an Illinois court affirmed the state planning agency's approval of a new hospital where the evidence showed that there would otherwise be a continued physician shortage and people living in the area would have to travel more than 30 minutes to get to needed care.<sup>11</sup>

In a similar case, *Mississippi State Department of Health v. Mississippi Baptist Medical Ctr.*,<sup>12</sup> the Mississippi Supreme Court affirmed a lower court's reversal of the grant of a CON to River Oaks Hospital, a for-profit hospital, to construct an obstetrical unit. Although the planning agency acknowledged there was no need for additional obstetrical beds, it found that OB beds were needed by Medicaid mothers and approved the project on condition that River Oaks offer 25 percent of its OB care to Medicaid patients. The approval was opposed by other hospitals in the community, obstetricians, and the NAACP. The NAACP testified that the proposal would jeopardize the existing delivery system to the poor and minorities and represented "an attempt by physicians and patients to escape the major Jackson [Mississippi] hospitals that do serve some poor people."<sup>13</sup> In the end, the Supreme Court affirmed the denial of the CON, concluding that the River Oaks facility had not established either the need for additional OB beds or that it would actually serve 25 percent Medicaid patients.<sup>14</sup>

Finally, an abortion-related case from Iowa, illustrates how the CON process can be abused. In *Planned Parenthood of Greater Iowa, Inc. v. Atchison*,<sup>15</sup> the plaintiffs alleged a substantive due

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<sup>9</sup> *Id.* at 961.

<sup>10</sup> 462 So.2d 83 (Fla. Dist. Ct. App. 1985).

<sup>11</sup> *Hinsdale Sanitarium & Hosp. v. Illinois Health Facilities Planning Bd.*, 523 N.E.2d 53, 168 Ill App. 3d 805 (Ct. App. 1988) (based on CON statute now repealed).

<sup>12</sup> 663 So.2d 563 (Miss. S. Ct. 1995).

<sup>13</sup> *Id.* at 569.

<sup>14</sup> *Id.* at 576.

<sup>15</sup> 126 F.3d 1042, 1048 (8<sup>th</sup> Cir. 1997).

process violation when the state planning agency applied rigorous CON requirements to an abortion provider. In *Atchison*, the Iowa Department of Health responded to pressure from anti-abortion groups and citizens by subjecting an abortion provider to an intensive CON regulatory process from which other medical practices had been exempted.<sup>16</sup> Although an interpretation of Iowa law conceivably permitted the CON process to be applied to the Planned Parenthood clinic, the district court found that the state would not have required the clinic to satisfy the requirements were it not an abortion provider.<sup>17</sup> The Eighth Circuit affirmed the district court's judgment that the Department of Health's actions created an undue burden under *Planned Parenthood of Southeastern Pa. v. Casey*,<sup>18</sup> holding that "where a requirement serves no purpose other than to make abortions more difficult, it strikes at the heart of a protected right, and is an unconstitutional burden on that right."<sup>19</sup>

### *What you can do*

*Become involved in the CON review process.* Advocates can become involved in administrative reviews of CON proposals in order to ensure that the proposal is meeting the prescribed Standards and Criteria and is consistent with the State Health Plan. In the past, consumer advocates have used the CON process to achieve a number of successes for their clients, including halting the planned construction of a proprietary hospital that would have provided no care to the poor.<sup>20</sup> Planning advocates have also obtained concessions from applicants by successfully petitioning the planning agency to place conditions on a CON approval.

So, for example, in the case at hand, a nursing home wants to add beds. If your state has a CON process, you can intervene in the CON review and challenge the need for the project. You can participate in the administrative hearing and present evidence about the need for community-based services, as opposed to the costly construction of institutional beds. State planning agencies can ask other state agencies to weigh in on the application under review, so you can ask the planning agency to obtain information and explanation from the Medicaid agency. (In some states, the Medicaid agency contributes its opinion to the CON review as a matter of course.)

*Become involved in the CON rulemaking process.* Most states' CON programs operate pursuant to rules and/or state health plans. Review the Standards and Criteria in your state. They may be out of date. For example, Michigan's CON standards rely upon a numerical formula that does not account for alternatives to nursing home care. The formula results in a situation where the CON

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<sup>16</sup> *Id.* at 1044.

<sup>17</sup> *Id.* at 1046.

<sup>18</sup> 505 U.S. 833, 877 (1992).

<sup>19</sup> 126 F.3d at 1049.

<sup>20</sup> In re: Denial of Request of Human Hosp. Corp., Civ. No. 85-10SC443 (N.C. Ct. App. Jan. 7, 1986); see also Intervenor's Response Brief, *Humana Hosp. Corp. v. North Carolina Dep't of Human Resources*, Civ. No. 84 CVS 2411 (N.C. Super. Cit, Wake County, filed Aug. 17, 1984) (available from NHeLP, Los Angeles, CA).

commission approves applications from nursing homes, thus ballooning the number of nursing home beds unnecessarily.<sup>21</sup> In such a situation, advocates can press for reforming the standards. Some states, including Maryland, have a “community based services” factor as part of the need standard. This factor ratchets down projected nursing home bed need for the substitution that would be felt by expanded community based services. Advocates can also argue for the exclusion of certain entities from the CON process or the application of an expedited review process to them. Depending on the demographics of the state, the affected entities could include small-sized assisted living facilities, home health agencies, adult day care, hospice services, and others. Finally, advocates could press for a CON moratorium on new nursing home bed construction pending an assessment of institutional verses community based needs. States such as West Virginia have implemented such moratoria.

*Track the activities of the CON review authority.* Advocates should also monitor the activities of their state planning agency and the entities that are appearing before it. CON applications and decisions are public documents. These documents will address important issues such as, the financial assumptions used by the facility, past and planned service to Medicaid beneficiaries, and the facilities’ definition of its service area. This information, in turn, can be used in ongoing advocacy efforts. For example, a complaint pending before the U.S. Department of Health and Human Services Office for Civil Rights (OCR) Region V uses CON data to argue that a health care facility is violating Title VI of the Civil Rights Act.<sup>22</sup> South Austin Coalition Community Council and other consumer-oriented organizations have filed an OCR complaint against Advocate Health Care Network. According to the Complaint, Advocate is the largest private provider of health care in metropolitan Chicago and operates eight general acute care hospitals, two children’s hospitals, and over 800 other health care sites. Reviewing the CON applications submitted to the state planning agency by Advocate between 1995 and 2003, the complainants have shown that Advocate has allocated a disproportionate share of its capital resources to hospitals serving primarily white communities, while failing to allocate significant and needed resources to its hospitals serving minority populations. The result, they allege, is a dual, racially discriminatory health care system that delivers the least resources to minority populations with the greatest health care needs.<sup>23</sup>

### *Conclusion*

The CON review process is a long-standing and oft-ignored advocacy tool. You should review the CON process in your state, because it may provide your clients with a convenient forum in which to advocate for community-based health planning and for monitoring the health care delivery system and holding it more accountable.

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<sup>21</sup> Email from Mark Cody, Michigan Protection and Advocacy Inc. (Sept. 15, 2005) (on file with author).

<sup>22</sup> Complaint of South Austin Coalition Community Council, Association of Community Organizations for Reform Now (ACORN)/Illinois, et al v. Advocate Health Care Network (on file with National Health Law Program). Title VI prohibits federal fund recipients from discriminating on the basis of race, color, or national origin. 42 U.S.C. § 2000d.

<sup>23</sup> *Id.* at 6-7.