

Public Health and the Law

State Certificate-of-Need Programs: The Current Status

JAMES B. SIMPSON, JD, MPH

Certificate-of-need (CON) programs are state regulatory mechanisms for review and approval by health planning agencies of capital expenditures and service capacity expansions by hospitals and other health care facilities. In a state with CON, a health care facility is forbidden from undertaking a reviewable project unless it obtains planning agency approval based on review of the project against a set of planning criteria and a finding of community need.

CON programs have changed significantly over the two decades they have been in operation. First conceived to add regulatory clout to voluntary regional health planning programs whose grand aim was systematic restructuring of health care delivery, they later were a vehicle for implementing federal health cost containment policy. Today, state CON programs are increasingly designed to compensate for particular defects in the institutional health services market or to achieve specific quality of care and access-related public policy goals.

Certificate of need is a state invention. The first CON law was adopted by New York in 1964. A decade later, 26 states had passed CON laws. Most early laws provided for state agency review of the public need for capital expenditures that exceeded \$100,000–\$150,000 thresholds, additions of beds, and some service expansions by hospitals and nursing homes. Beginning in 1972, many states adopted so-called "Section 1122" programs, which are a federally funded, state-optional form of certificate of need providing for planning agency review and approval for Medicare and Medicaid reimbursement of capital expenditures proposed by health care facilities. In a state with Section 1122, a health care facility is permitted to undertake a reviewable expenditure without agency permission, but it cannot obtain Medicare/Medicaid payment for the project's capital costs without such approval.¹ By January 1975, 46 states and the District of Columbia had certificate of need, Section 1122, or both.

In 1975, Congress passed the National Health Planning and Resources Development Act of 1974 (NHPDA). The Act authorized funds for various state and local health planning activities including CON programs, which the states were required to reconstitute according to federal standards to avoid severe financial penalties. Although initially more ambitious, NHPDA soon came to be viewed simply as a weapon in the federal government's cost containment arsenal. After NHPDA's passage, the states without certificate of need began adopting statutes, and

states with pre-existing programs took steps to meet federal requirements. By the end of 1982, every state except Louisiana had a CON program resembling the federal model, i.e., a broad regulatory program covering hospitals, skilled nursing and intermediate care facilities, kidney dialysis centers, and ambulatory surgery centers, and reviewing general purpose capital expenditures exceeding \$600,000, additions of new services with annual operating costs exceeding \$250,000, and acquisitions of medical equipment for inpatient use exceeding \$400,000. The hold-out state, Louisiana, had a Section 1122 program with similar coverage.

Purposes of Certificate-of-Need

States adopted certificate of need to achieve various policy goals, foremost among which was controlling health care costs by restricting the growth of institutional health services. CON programs were intended to substitute regulatory controls for weak market restraints on expansion and new technology introduction in the health care sector. Every state CON law incorporates this rationale by providing for allocation of certificates on the basis of community "need", not consumer demand. However, cost containment has not been the only basis for state CON regulation. Other important rationales include preserving quality of medical care and preventing geographic and income-related maldistribution of institutional health services. Thus, certificate-of-need statutes often identify quality of care in existing facilities (either those of the applicant or other health care providers) as a review criterion, and they may also require consideration of expected quality of care in proposed facilities and services.² CON programs are usually intended to bring about an optimal geographic distribution of health facilities,³ and to reward and protect facilities that internally subsidize socially desirable but unprofitable lines of business such as indigent care.⁴ CON programs have also been used as adjuncts to other state regulatory or reimbursement programs.⁵ The great majority of states seem to have originally established CON programs to balance multiple, competing goals relating to cost, quality, and accessibility of health services.

In its heyday, NHPDA provided for over \$150 million in annual funding for state and local health planning programs. In 1980, federal support for state certificate of need fell on hard times. The Reagan Administration entered office with an anti-regulatory platform and a strong interest in using market incentives rather than regulatory controls to restrain the costs of federal health programs. Certificate-of-need was perceived as deserving support, if at all, only on the basis of its cost containment potential, and several econometric studies suggested that certificate-of-need had not been effective, at least by itself, in curbing the rate of hospital cost inflation. Federal funding for state health

Address reprint requests to James B. Simpson, JD, MPH, Director, Legal Services Program, Western Consortium for the Health Professions, Inc., 703 Market Street, Suite 535, San Francisco, CA 94103. (Funded by the Health Resources Administration, HHS, contract HRA 232-79-0037.) This guest column was invited and accepted for publication by George J. Annas, JD, MPH, Editor of the Public Health and the Law section of the Journal.

planning programs dropped sharply. The NHPDA requirement that states adopt complying CON programs was effectively deleted, and the swift demise of certificate-of-need regulation was widely predicted.

Recent Developments

State CON programs have certainly not been static in recent years. Since 1982, seven states (Idaho, New Mexico, Minnesota, Utah, Arizona, Kansas, and Texas) have repealed their certificate-of-need laws. A few other states' statutes are scheduled to expire in 1986-87. However, the majority of the repeal states have either retained or reinstituted Section 1122 or replaced certificate-of-need with moratoria on new hospital construction and expansion projects.⁶ Thus, at the moment every state in the country has either certificate of need, Section 1122, or a moratorium except Arizona, Utah, and Texas. Furthermore, even if all the states with certificate-of-need laws scheduled to expire in 1986-87 allow them to do so, and none were to enter into a new Section 1122 agreement or adopt a moratorium, 41 states and the District of Columbia would continue to have one form or the other of this type of health facility regulation. In short, for the foreseeable future, certificate-of-need will continue to be in place in the majority of states.

There are several reasons why states may have chosen not to follow the federal lead in ending support for certificate-of-need. First, states appear to use certificate-of-need to accomplish goals other than cost containment. A federal shift in preferred mechanisms to control Medicare and Medicaid costs away from certificate-of-need would thus not necessarily induce states to follow. States are more likely than the federal government to favor a regulatory approach to health cost containment because their ability to reform the institutional health care system through market incentives is limited. States cannot promote competition and consumer choice by altering the incentives to excess health insurance in the Internal Revenue Code, nor can they alter the terms of employee health insurance benefits without running afoul of federal law regulating employment benefits and collective bargaining agreements.

Most states have, however, modified their programs by cutting back on the number of projects reviewed. Capital expenditure thresholds have increased significantly, and after NHPDA's compliance requirements were relaxed many states raised their thresholds above the maximum federal level. This practice appears most common among Western states, where Colorado has a \$2 million capital expenditure threshold and several other states have \$1 million thresholds.⁷ Only seven states have kept expenditure thresholds at pre-NHPDA levels.

Exemptions and Streamlined Review

Most states have also cut back on reviews by adopting CON exemptions or by streamlining review procedures for expenditures unrelated to clinical services and other low-impact projects. The state of Washington, for example, exempts capital expenditures that will not substantially affect patient charges and that are for: communications and parking facilities; mechanical, electrical ventilation, heating, and air-conditioning systems; energy conservation systems; repairs to physical plant necessary to maintain state licensure; acquisition of data processing and other equipment; construction of facilities not to be used for direct provision of health services; land acquisition; and refi-

nancing of existing debt.⁸ Most states provide for limited review of projects to eliminate safety hazards or to comply with licensure and accreditation requirements. Numerous states also provide for expedited review of projects such as capital expenditures not involving service or bed capacity increases, service terminations, expenditures below a threshold somewhat higher than their statutory coverage minimum, and the like. Several state statutes provide for exemption or expedited review of projects for replacement of facilities or equipment.⁹ The purpose of exemptions and streamlined review is to remove planning agencies from the business of reviewing routine transactions or minor projects which do not risk excess investment.

A number of states have adopted a new approach to certificate-of-need review of health service and new technology additions. These states cover additions of a limited number of specified new health services regardless of their capital or operating cost, and all other new services only if their costs exceed a high threshold. For example, Ohio covers additions of heart, lung, liver, and pancreas transplant programs without regard to cost and other new services only if their annual operating costs exceed \$297,500.¹⁰ Kentucky covers health service additions with over \$250,000 annual operating costs or additions regardless of cost of acute care services, open-heart surgery, cardiac catheterization, radiation therapy utilizing megavoltage equipment, end-stage renal disease services, CT (computed tomography) scanners, nuclear magnetic resonance imaging (MRI), and long-term care services.¹¹ The purpose of this approach appears to be to cover without regard to expected cost the services for which non-cost containment rationales for certificate-of-need review apply, and to cover the services for which cost control is the paramount concern only if project costs exceed the threshold.

Expansion of Certificate-of-Need

In recent years, many states have increased the regulatory scope of their CON programs. Some important ways states have done so include imposition of moratoria on certificate-of-need approvals, expansion of medical equipment coverage to outpatient, non-hospital settings, and adoption of ceilings or "caps" on the total dollar value of projects approvable in a given year.

A moratorium is simply a categorical ban on certificate-of-need review and approval of certain projects. Moratoria, both statutory and agency-adopted, have a long history of use by CON programs. They have been used to channel investment into or away from particular services, halt the spread of new technology while planners develop criteria for controlled introduction, or suspend the review process while major modifications in the state's CON program are implemented. The use of moratoria has increased in recent years, as states have sought to modify and strengthen certificate-of-need. Missouri, for example, has adopted a statutory moratorium on issuance of certificates-of-need for new skilled and intermediate care nursing facility beds extending through July 1, 1986.¹² Mississippi has a similar moratorium in place through July 1, 1986, with an exemption for certain "swing bed" temporary conversions of acute care beds to nursing care.¹³ Minnesota and Kansas do not have certificate-of-need statutes per se, but their legislatures have adopted moratoria on all new hospital construction, bed capacity increases, and bed relocations through 1987.¹⁴ At

least 11 other states have had moratoria in effect during 1984-85.¹⁵

Some health care providers have tried to evade certificate-of-need by putting their expensive medical equipment in non-institutional settings. A decade ago this tactic led to CT scanners in physicians' offices; today MRI equipment is being located in similar settings. Several states have amended their CON laws to foreclose this tactic. Virginia, for example, covers acquisition of equipment by a physician's office which is generally and customarily associated with the provision of health services in an inpatient setting.¹⁶ Colorado, Connecticut, the District of Columbia, Hawaii, Iowa, Montana, New Hampshire, Rhode Island, and Wisconsin also cover equipment acquisitions in various non-inpatient settings.¹⁷

A capital cap or ceiling on the total dollar value of projects approvable under certificate-of-need in a given year acts as a mechanism for controlling the total level of capital investment by health facilities and compelling health planning agencies to weigh the relative merits of disparate projects. In the presence of a cap, projects for remodeling existing facilities may compete with new construction, and a new open heart surgery service may vie with a new renal dialysis unit for limited capital funds. By contrast, under conventional CON programs only contemporaneously filed applications for similar projects are comparatively reviewed. A statutory cap is in operation in Rhode Island and Maine.¹⁸ The Massachusetts CON program contains an annual ceiling on increases in hospital operating costs resulting from capital expenditures.¹⁹

Anti-competitive Certificate-of-Need Provisions

The best CON law reflects a calculated risk that the benefits of public scrutiny of health facility projects will outweigh the program's unavoidable side effect of enfranchising existing providers. Some certificate-of-need laws are structured such that the side effects seem to overshadow the benefits. Under California's law, for example, existing hospitals may undertake capital expenditures of any value, or medical equipment acquisitions, without obtaining a certificate. On the other hand, surgical clinics must obtain a certificate-of-need for such transactions if costs exceed \$1 million. New hospital and surgery clinic construction is also subject to review, leading to the conclusion that the purpose of the law is to protect existing hospitals from new competitors or low-cost alternatives to inpatient surgical care. A similar objection might be raised to the Minnesota and Kansas moratoria on new construction and bed expansion.

CON programs can also be administered in anti-competitive ways. Several years ago a state program was found to have denied a proprietary hospital's application because of a hidden preference for existing facilities.²⁰ More recently, a state's criterion for approving new home health agencies—full utilization of existing agencies—was struck down by a court that found the rule to have been designed to protect existing agencies from competition.²¹ However, despite episodes like these, most states support a policy of promoting competition through the CON program whenever feasible.²²

Certificate-of-Need Litigation

Certificate-of-need and Section 1122 programs have spawned a great deal of litigation.²³ In the programs' start-up years, applicants often challenged planning decisions on

constitutional grounds (usually unsuccessfully),²⁴ or (more often successfully) on the grounds that the planning agencies had failed to adopt or follow proper review criteria.²⁵ Today certificate-of-need agencies are more sophisticated in administrative practice and are seldom successfully challenged,^{23,26} although agency efforts to extend their powers (such as agency adoption of moratoria without express statutory authorization) are struck down from time to time.²⁷

The Future of Certificate-of-Need

Federal interest in state capital expenditure review may be renewed. As part of a major Social Security bail-out package, in 1983, Congress adopted a prospective payment system for Medicare to replace the existing incurred-cost reimbursement method. The new system provides for payment for routine operating expenses to most acute care hospitals participating in Medicare of a fixed sum per case, based on average operating costs in a base year for comparable classes of hospitals, adjusted for each hospital's mix of high- and low-cost cases represented by diagnosis related groups (DRGs), and capped by a "budget neutrality" ceiling under which total system reimbursement to hospitals may not exceed the amount that would have been paid under the prior method. The prospective payment system was intended to alter the underlying financial incentives in Medicare, creating pressures on above average cost hospitals to economize.

Congress was unable to decide how to incorporate capital expenses, previously reimbursed at cost, into the new system's per case payment rates. It opted to retain reimbursement for capital on an incurred-cost basis. However, Congress also provided that if it were unable to devise a method for incorporating capital into the per case payments by October 1, 1986, then Medicare would cease to pay for capital costs associated with projects for inpatient hospital services in a state unless the state had a Section 1122 program and the program had approved the project's capital cost. By this provision, Congress sought to assure that some mechanism for control of capital investment by health care facilities—either in the form of an average cost-derived amount added into the prospective payment, or continued payment at cost subject to review and approval by a planning agency—would be in place. The effect of the provision, of course, is to make state participation in Section 1122 effectively mandatory on October 1, 1986 unless Congress acts otherwise. Several proposals have been advanced for incorporating capital costs into the prospective payment system.

The Medicare capital reimbursement debate will probably determine the future of federal funding for state certificate-of-need programs. If Congress can enact a capital add-on to the per-case payment that rewards efficient operations and prudent investment while satisfying federal budget constraints, the remaining federal interest in supporting state regulatory health planning will greatly diminish.

On the other hand, either by choice or through inability to devise a capital add-on, Congress may allow the October 1, 1986 mandate to take effect. Doing so would assure continued federal funding for the Section 1122 form of state certificate-of-need review. In addition, because there are a number of flaws and unwieldy steps in the Section 1122 review process, Congress might act prior to the October 1, 1986 deadline to either amend the Section 1122 program's statutory authorization or amend and reauthorize NHPRDA

to permit state CON programs to substitute for the mandatory 1122 programs.

NHPRDA Reauthorization

Congress could choose to renew NHPRDA funding for state health planning and certificate-of-need in order to retain the power to dictate the structure and scope of state CON programs. In the past, one of the unspoken rationales for NHPRDA has been to dissuade states from administering procedurally unfair programs or from excessively regulating alternative delivery systems, physician's offices, and the like. In the absence of federal funding conditioned on not doing so, states might amend their certificate-of-need statutes in ways that were inconsistent with the purposes and incentives of the Medicare prospective payment system or other federal health policy initiatives, or in ways that were anti-competitive. Thus, Congress could decide to reauthorize and fund NHPRDA at a modest level simply to gain the leverage to restrain states from covering activities it preferred to see deregulated, or to induce all states to increase their expenditure thresholds to multi-million dollar levels. However, it seems unlikely that after several years of encouraging states to conduct certificate-of-need programs deviating from the NHPRDA model Congress will ever return to the type of prescriptive requirements for state CON programs that characterized the early years of NHPRDA. Implementing a federally prescribed, state-administered CON program with anything more than minimal requirements would be even more difficult today than it was when NHPRDA was adopted in 1975, since it would occur against a backdrop of even more widely varied state programs.

Redesigning Section 1122

Congress should consider employing Medicare capital reimbursement for hospitals and a revised Section 1122 program as mechanisms to make the federal government a more selective investor in hospital capital plant. In the past, Medicare capital reimbursement has supported unnecessary new hospital construction and perpetuated unneeded existing facilities. It would be more sensible for the federal government to select the facilities needed to assure the availability of hospital services to Medicare patients and to reimburse for major capital investment only in such facilities. By doing so, the government would actively exercise its considerable purchasing power in a more competitive hospital market.

To accomplish this strategy would not require major new legislation. Congress could simply retain the upcoming Section 1122 mandate while amending the statute to focus review on the need for major capital expenditures to treat the Medicare population, and to vest final decision-making authority in federal, not state, hands. Minor capital costs, including those associated with equipment acquisitions, could be reimbursed through a standard allowance incorporated into the per-case payment. States could be permitted to substitute CON programs for Section 1122, and to receive federal funds for the costs of administering either program. Thus, states desirous of opting out of regulatory review of health facility capital projects would be free to do so, except to the limited extent necessary to assist the federal government in cost-effective administration of Medicare. On the other hand, states wishing to retain certificate-of-need would be free to do so, and would receive some federal financial assistance. In short, capital expenditure review could remain

a regulatory program at state level, but at the federal level it would become a prudent purchasing mechanism.

Conclusion

Whether or not federal funding continues, it appears that a substantial number of states will retain certificate-of-need programs since CON regulation continues to satisfy a wide range of state policy roles. However, it also appears that several states may abandon the program in the absence of federal requirements to retain it, in favor of efforts to promote more competitive health service markets. This might well be a fortuitous development. Like any regulatory program that intervenes in the market to accomplish some social good, the need for CON programs ought to be continuously evaluated, and the scope of the program tailored to meet specific, concrete, and current purposes. This is difficult to do when all states adopt a nationally mandated program. The repeal of the program in some jurisdictions would offer a natural experiment to measure the impact of the presence or absence of certificate-of-need on the direction and scope of health facility expenditures.*

REFERENCES

1. See generally 42 U.S.C.A. §1320a-1 (1983).
2. See, e.g. Alaska Stat. §18.07.041 (Supp. 1984); Mont. Code Ann. §50-5-304(n)(1983) *incorporating by reference* 42 C.F.R. §123.412(a)(20) (1983) (CON criteria relating to quality in existing facilities); Ark. Stat. Ann. §82-2311(2)(1983) Cum. Pocket Supp.); R.I. Gen. Laws §23-15-4(2)(7)(1979)(CON criteria relating to quality in proposed facilities).
3. See, e.g. Ala. Code §22-21-264(4)(f) (1984) (CON criterion of "evidence of the locational appropriateness of the proposed facility or service such as transportation accessibility . . .").
4. Ca. Health and Safety Code §437.11(b)(4)(c), 437.117 (Deering 1985 Pocket Supp.) (CON exemption for facilities providing certain volume of free care); D.C. Code Ann. §32-305(a)(2) (1984 Cum. Supp.) (CON requirement that facilities provide a reasonable volume of uncompensated care); N.D. Cent. Code §23-17.2-05 (1983 Cum. Supp.) *incorporating by reference* 42 C.F.R. §123.412(a), (b).
5. See, e.g., Wisc. Stat. Ann. §150.39(1) (West 1984-85 Cum. Ann. Pocket Part) (CON for new nursing home beds conditioned on Medicaid appropriation).
6. Idaho reinstituted Section 1122; Minnesota and New Mexico retained their existing 1122 programs; Minnesota and Kansas adopted moratoria on new hospital construction and addition of beds.
7. Alaska and California have capital thresholds for certain specified projects set at \$1,000,000. General purpose thresholds in several other states are at similar levels, e.g., Washington—\$1,000,000; Oregon—\$1,000,000 or \$250,000 plus 5 per cent of the difference in gross revenues experienced for the last two fiscal years, whichever is less; Montana—\$750,000; Colorado—\$2,000,000. In 1985, legislative sessions in several eastern states increased thresholds, e.g., Tennessee—\$1,000,000; Mississippi—\$1,000,000; West Virginia—\$714,000.
8. Wash. Rev. Code Ann. §70.38.105(4)(d) (1984-85 Cum. Ann. Pocket Part).
9. See, e.g., Ky. Rev. Stat. §216B.095 (1982 Int. Supp.) (non-substantive review of applications to replace or repair five-year-old worn equipment and repairs, alterations, or improvements to physical plant not resulting in a substantial change in beds or services or equipment addition).
10. Ohio Rev. Code: 1984 Legis. §3702.51(R)(2), (9) (1984).
11. Ky. Rev. Stat. §216B.015(25) (1982 Int. Supp.); see also Me. Rev. Stat. Ann. tit. 22 §304-A(4) (1984-85 Cum. Pocket Supp.) (coverage of certain new services identified in regulations regardless of cost and other new

*There are already some preliminary indications from Utah and Arizona that the repeal of certificate-of-need could lead to a surge in health facility construction. Since the repeal of CON in Utah on December 31, 1984, three new hospitals have broken ground, two others have been proposed, and building permit applications have been filed for 2,800 new nursing home beds. (Source: A telephone interview with Steven Bonney, Executive Director, Utah Health Systems Agency, May 28, 1985.) Similarly, one week after the repeal of certificate-of-need and other controls in Arizona, proposals for construction of six new hospitals in the Phoenix area alone were filed with the State Department of Health Services.^{28,29}

- services only if they exceed an annual operating cost threshold); Mass. Gen. Laws Ann. ch. 111, §25 (1983); Mass. Admin. Code tit. 105 §100.020 (1983) (coverage of "2major services" without regard to cost and other services only if they exceed an annual operating cost threshold); Tenn. Admin. Comp. §0720-2-.02(2)(c) (approx. 1983) (coverage of specified set of major health services without regard to cost and other services with projected annual operating budget exceeding threshold). Other states may achieve a similar coverage pattern through exemptions or streamlined review.
12. Mo. Stat. Ann. §197.315(1) (Vernon's 1985 Cum. Ann. Pocket Part).
 13. S.B. 2230 §8, Miss. 1985 Legis. Reg. Sess. amending Miss. Code Ann. §41-7-191(2) (1984 Cum. Supp.).
 14. 1984 Minn. Sess. Law Serv. Ch. 654 §57 (West); H.B. 2667 Ks. 1985 Legis. Reg. Sess. The Minnesota and Kansas moratoria are the functional equivalent of certificate-of-need programs under which all proposed projects are automatically denied.
 15. Office of Health Planning, Bureau of Health Maintenance & Resources Development, US Dept of Health & Human Services, Program Information Letter 85-12, Moratoria: A Continuing Process in Regulatory Review (1985). Non-statutory moratoria may be subject to court challenge. See note 27 *infra*.
 16. Va. Code §32.1-102.1 (1984 Cum. Supp.).
 17. Colo. Rev. Stat. §25-3-506(i)(g) (1984 Cum. Supp.) (capital expenditure exceeding \$1 million by or on behalf of any person for major medical equipment to provide clinically related health care); Conn. Stat. Ann. §19a-155(b) (1984 Spec. Pamp.) (capital expenditure exceeding \$400,000, by any person, to acquire imaging equipment); D.C. Code Ann. §32-302(11)(A) (1984 Cum. Supp.) (acquisition of medical equipment with a value exceeding \$400,000 by physicians, dentists, or other individual providers of individual group practice); Haw. Rev. Stat. §§323D-53, 54 (1984 Supp.) (acquisition of equipment exceeding expenditure threshold by physicians', etc., offices); Iowa Code Ann. §135.61(19)(g) (1984-85 Cum. Ann. Pocket Part) (expenditure exceeding \$400,000 by individual or group of health care providers for equipment installed in private office or clinic); Mont. Code Ann. §50-5-301(d) (1984 Supp.) (acquisition of medical equipment exceeding \$500,000 by any person which would have required a CON if acquired by a health care facility); N.H. Rev. Stat. Ann. §151-C:4(I)(C) (1983 Supp. acquisition of equipment exceeding \$400,000 by a health care provider); RI Gen. Laws §23-15-2(k) (1977) (acquisition of medical equipment exceeding \$150,000 by a health care provider); Wisc. Stat. Ann. §150.61(3) (1984-85 Cum. Ann. Pocket Part) (capital expenditure exceeding \$600,000 for clinical medical equipment by an independent practitioner, medical group, etc.).
 18. Me. Rev. Stat. Ann. tit. 22 §396-k (1984-85 Cum. Pocket Supp.); R.I. Gen. Laws §23-15-6(i) (1984 Cum. Supp.).
 19. See Mass. Admin. Code tit. 105, §100.451 (1984).
 20. *Huron Valley Hospital, Inc. v. Michigan State Health Facilities Commission*, 312 N.W.2d 422 (Mich. App. 1981).
 21. *Dept of Health and Rehabilitative Services v. Johnson and Johnson Home Health Care, Inc.*, 447 So.2d 361 (Fla. Dist. Ct. App. 1984).
 22. See 50 Fed. Reg. 2020 (1985) (to be codified at 42 C.F.R. §123.412(a)(15),(16) (federal pro-competitive CON review criterion).
 23. See J. Simpson & T. Bogue, *The Guide to Health Planning Law*, (Western Consortium/Western Center for Health Planning) (Office of Health Planning, US Dept of Health & Human Services 2d ed. 1984).
 24. *Mount Royal Towers, Inc. v. Alabama State Board of Health*, 388 So.2d 1209 (Ala. 1980); *Merry Heart Nursing and Convalescent Home, Inc. v. Dougherty*, 330 A.2d 370 (N.J. Super. App. Div. 1974); *Attoma v. State Dept. of Social Welfare*, 270 N.Y.S.2d 167 (App. Div. 1966); *Goodin v. Oklahoma ex. rel. Oklahoma Welfare Commission*, 436 F. Supp. 583 (W.D. Okla. 1977). But see *In re Certificate of Need for Aston Park*, 193 S.E.2d 729 (N.C. 1973).
 25. *E.g. Cheshire Convalescent Center, Inc. v. Commission on Hospitals and Health Care*, 386 A.2d 264 (Conn. C.P. 1977), *North Miami General Hospital, Inc. v. Office of Community Medical Facilities*, 355 So.2d 1272 (Fla. Dist. Ct. App. 1978) (CON denial based on need formula not adopted as regulation overturned); *Irvington General Hospital v. Dept. of Health*, 374 A.2d 49 (N.J. Super. App. Div. 1977), *Fairfield Nursing Home v. Whalen*, 407 N.Y.S.2d 923 (App. Div. 1978), *Sturman v. Ingraham*, 383 N.Y.S.2d 60 (App. Div. 1976) (CON denials based exclusively on need formulae overturned for failure to consider other review criteria).
 26. Of the 23 court decisions officially reported in 1984 involving final state decisions to grant or deny certificates-of-need, the agencies were upheld in 17 and overturned in only 6. Most cases involved challenges to agency review criteria. *E.g. Humana Medical Corp. v. State Health Planning and Development Agency*, 460 So.2d 1295 (Ala. Civ. App. 1984) (area bed supply excess supports CON denial on need and cost containment criteria); *Excepticon Midwest, Inc. v. Kansas Dept. of Health and Environment*, 676 P.2d 107 (Kan. 1984) (determination of need on areawide basis upheld); *In re Chambery v. Axelrod*, 474 N.Y.S.2d 865 (App. Div. 1984) (Medicaid access criteria upheld).
 27. See *United Hospital Center, Inc. v. Richardson*, 328 S.E.2d 195 (W.Va. 1985) (Agency moratorium on processing CON applications for magnetic resonance imaging equipment was arbitrary and capricious).
 28. "4 Hospitals Proposed as Rules End." *Phoenix Gazette*, March 18, 1985, at A-1.
 29. "Plans Unveiled to Build 2 More Hospitals in Valley." *Phoenix Gazette*, March 22, 1985, at B-1.

NIH Consensus Statement on Osteoporosis

Osteoporosis is a major public health problem. Although all bones are affected, fractures of the spine, wrist, and hip are typical and most common. The risk of developing osteoporosis increases with age and is higher in women than in men and in whites than in blacks. Its cause appears to reside in the mechanisms underlying an accentuation of the normal loss of bone, which follows the menopause in women and occurs in all individuals with advancing age. There are no laboratory tests for defining individuals at risk or those with mild osteoporosis. The diagnosis of primary osteoporosis is established by documentation of reduced bone density or mass in a patient with a typical fracture syndrome after exclusion of known causes of excessive bone loss. Prevention of fracture in susceptible patients is the primary goal of intervention. Strategies include assuring estrogen replacement in postmenopausal women, adequate nutrition including an elemental calcium intake of 1,000-1,500 mg a day, and a program of modest weight-bearing exercise. There is great need for additional research on understanding the biology of human bone, defining individuals at special risk, and developing safe, effective, low-cost strategies for fracture prevention.

—National Institutes of Health, Consensus Development Conference Statement, Vol. 5, No. 3, 1984

This article has been cited by:

1. Joan F. Van Nostrand. 1996. The Focus of Long-Term Care in the United States: Nursing Home Care. *Canadian Journal on Aging / La Revue canadienne du vieillissement* **15**:S1, 73-90. [[Crossref](#)]
2. Nathan R. Every, Eric B. Larson, Paul E. Litwin, Charles Maynard, Stephan D. Fihn, Mickey S. Eisenberg, Alfred P. Hallstrom, Jenny S. Martin, W. Douglas Weaver. 1993. The Association between On-Site Cardiac Catheterization Facilities and the Use of Coronary Angiography after Acute Myocardial Infarction. *New England Journal of Medicine* **329**:8, 546-551. [[Crossref](#)]
3. Terence Valenzuela, Elizabeth Criss, Kenneth Facter, Daniel Spaite, Harvey Meislin. 1989. Medical versus regulatory necessity: Regulation of ambulance service in Arizona. *The Journal of Emergency Medicine* **7**:3, 253-256. [[Crossref](#)]
4. Cynthia Carter Haddock, James W. Begun. 1988. The Diffusion of Two Diagnostic Technologies among Hospitals in New York State. *International Journal of Technology Assessment in Health Care* **4**:04, 593-600. [[Crossref](#)]